



# 2024 UVA Health Annual Retraining

Click **Start Course** or **Resume** to begin.

## BEGIN

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 **Begin**

## ALL TEAM MEMBER CONTENT


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 **All Team Member Content**

 **Hand Hygiene**

 **Team Member Injury: Heavy Lifting**

 **Hazardous Material Spill/Accident Notification**

 **Securing the Environment**

 **Stroke Recognition**

 **Emergencies and Your Role**

 Gender Health - Delivering Compassionate Care to LGBTQ+ (SOGI)

 Reporting Concerns

 Corp Compliance and Privacy

 Information Security

CHOOSE YOUR ROLE

---

 Choose Your Role

DIRECT PATIENT CARE

---

 All Patient Care

 Advance Care Planning and Advance Directives for Patient Care


 Suspected Abuse

 Bariatric Sensitivity for Patient Care

 Language Services for Patient Care

 Clinical Alarms

 Food and Drink in Patient Areas

 Hand Hygiene and PPE for Patient Care

 Bloodborne Pathogens for Patient Care


 Team Member Injury Prevention: Sharps

 **Team Member Injury Prevention: Patient Handling**

 **Pain Management**

 **Equipment Stickers**

 **Managing Interruptions - Epic Downtime Patient Care**

 **Suicide Prevention**

 **Workplace Violence - SAVE**

 **LVAD Aware**

 **Organ and Tissue Donation for Patient Care**

**DIRECT PATIENT CARE ROLE SECTIONS**

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 **Direct Patient Care Choose Your Role**

**INPATIENT CARE**


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 **Inpatient Care**

 **CLABSI**

 **CAUTI**

 **Instrument Care and Handling**

 **HAPI Prevention: Standard Work**

 **Fall Prevention**


 911, Security, and BERT?

 Restraints

 Infection Control Risk Assessment (ICRA)

 Diet Manual Resources

 Medical Emergency Team (MET Team)

 End of Life

CHOOSE ROLE INPATIENT CARE

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 Choose Your Role Inpatient Care

 Inpatient CNA and PCT

 Inpatient RN

 Inpatient LIP

 Respiratory Therapists

OUTPATIENT CARE

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 Outpatient Care

 Fall Prevention

 Choose Your Role Outpatient Care

 Outpatient LIP

 **Outpatient RN**

 **Outpatient LPN, MA, PCT**

**OTHER PATIENT CARE ROLES**

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 **Emergency Medical Services (EMS)**

 **Perfusionist**

 **Rad Tech**

**PATIENT CONTACT, NOT CARE**

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 **Patient Contact Content**

 **Language Services for Patient Contact**

 **Advance Care Planning and Advance Directives for Patient Contact**

 **Food and Drink in Patient Areas for Patient Contact**

 **Suspected Abuse**

 **Signage**

 **PPE for Isolation Patients**


 **Hand Hygiene for Patient Contact**

 **Workplace Violence - SAVE for Patient Contact**

 **Managing Interruptions - Epic Downtime Patient Contact**


 Pain Management for Patient Contact

 Bariatric Sensitivity for Patient Contact

 Organ and Tissue Donation for Patient Contact

 Patient Contact, Choose Your Role

 Social Worker

 Pharmacy

 Patient Contact (HUC, Patient Access, Other Pt Services)

 Security

#### SPECIMEN CONTACT

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 Specimen Contact

 Bloodborne Pathogens for Specimen Contact


#### PHYSICAL PLANT

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 Physical Plant

#### FINISH

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 Content for Your Role Complete

 Finish

# Begin

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## Why Do I Have to Take This Course?

Many regulatory requirements (laws, policies, and regulations) are in place to help keep our Team Members and Patients as safe as possible. This course helps reinforce requirements for over 55 policies, laws, and guidelines. Your role may have additional requirements in other courses, but in an effort to respect your time we have created a single course to cover as many topics as possible.



**More than 55 laws, policies, regulations  
One Course**

- ✓ **Virginia Requirements**
- ✓ **Joint Commission Requirements**
- ✓ **Licensure Requirements**
- ✓ **OSHA Requirements**
- ✓ **Other Requirements**

**PATIENT + TEAM MEMBER SAFETY  
= EXCELLENT CARE**

## Introduction

For this retraining, you will be asked to respond to questions about things that happen at work. Although the topic may be required for your role, the example may not match with your everyday work area. When you answer the question, consider how it applies to your work.

The course will take about 20 minutes if you don't provide patient care. You can expect up to 70 minutes if you provide patient care.

- You will start with content for all Team Members, followed by content that is specific to your role.
- Clicking on links will open the page in a new window. If you close only the window that was opened, you will return to the course. If you close the browser, it will close Workday, and you will need to start again.
- For any questions regarding the appropriate role to complete or the reasons for its requirement, please reach out to your manager.

## Continue to the Course

**Click Continue to move to the next section.**

CONTINUE



# All Team Member Content

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This content is for all Team Members. Each scenario may look different in your work area, but it is required for you to complete. If your work environment is different than what is explained, think about how it would happen where you work.

It will take about 20 - 25 minutes to complete this section.

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Hand Hygiene

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## Hand Hygiene (i.e. Cleaning Your Hands)

Healthcare-associated infections are a major factor contributing to morbidity and mortality. Hand hygiene is considered the most important measure for preventing health-care associated infections and the spread of antimicrobial resistant pathogens.

- There are many hand hygiene opportunities to prevent HAIs. Hand hygiene monitoring program collects observation data on two of those opportunities.
- Cleaning your hands is required upon entering and exiting a patient's room/space or treatment area.
- Practicing consistent hand hygiene also helps prevent the spread of illnesses at home and in the work place.

**CLEANSE YOUR HANDS** WITH ALCOHOL BASED HAND SANITIZER



Apply the gel product to the palm of one hand



Rub hands vigorously for at least 20 seconds or until completely dry



In most situations alcohol sanitizer is the preferred method of hand hygiene because it is generally more effective.

**Continue to the Next Section**

Click Continue to move to the next section.

CONTINUE

# Team Member Injury: Heavy Lifting

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## Injuries Can Be Prevented



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**Lifting heavy items by yourself can cause injuries that can be avoided. When you need to lift more than **35 pounds**, get help.**

By asking for help and using lifting devices, you can avoid serious injuries related to lifting. If you provide patient care, refer to the Employee Health Intranet for resources on standard work around safety.

The National Institute for Occupational Safety and Health (NIOSH) has developed a model that helps you to know how likely you are to be injured from the amount of weight you are lifting. The NIOSH model can be [found here](#).

You can hurt yourself by lifting even as little as 35 pounds by yourself. It can even cause microfractures to your back.

**Continue to the Next Section**

**Click Continue to move to the next section.**

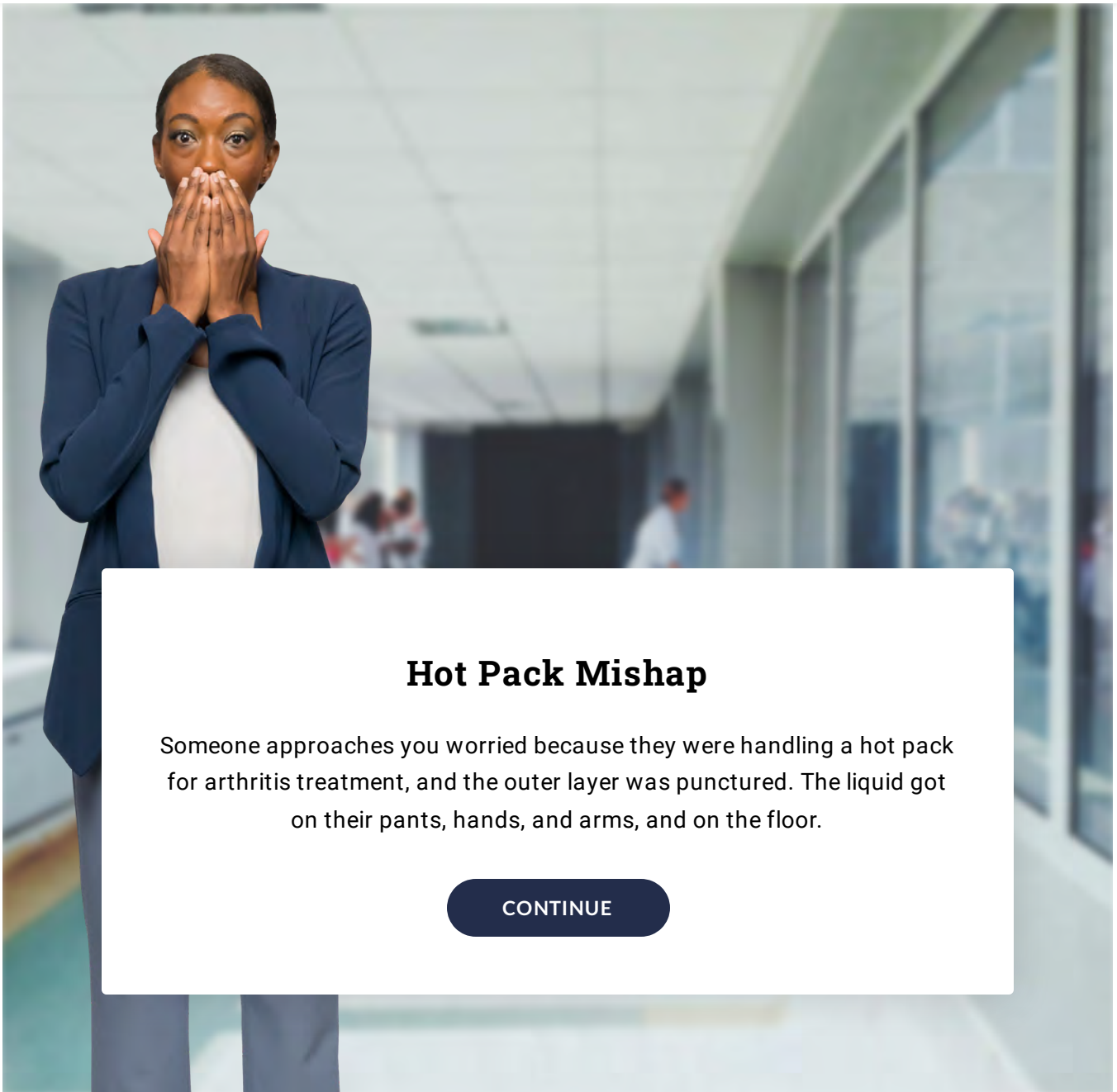
**CONTINUE**

# Hazardous Material Spill/Accident Notification

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## Addressing and Communicating a Spill

Click through the scenario below to learn what to do in the event of a hazardous material spill.



## Hot Pack Mishap

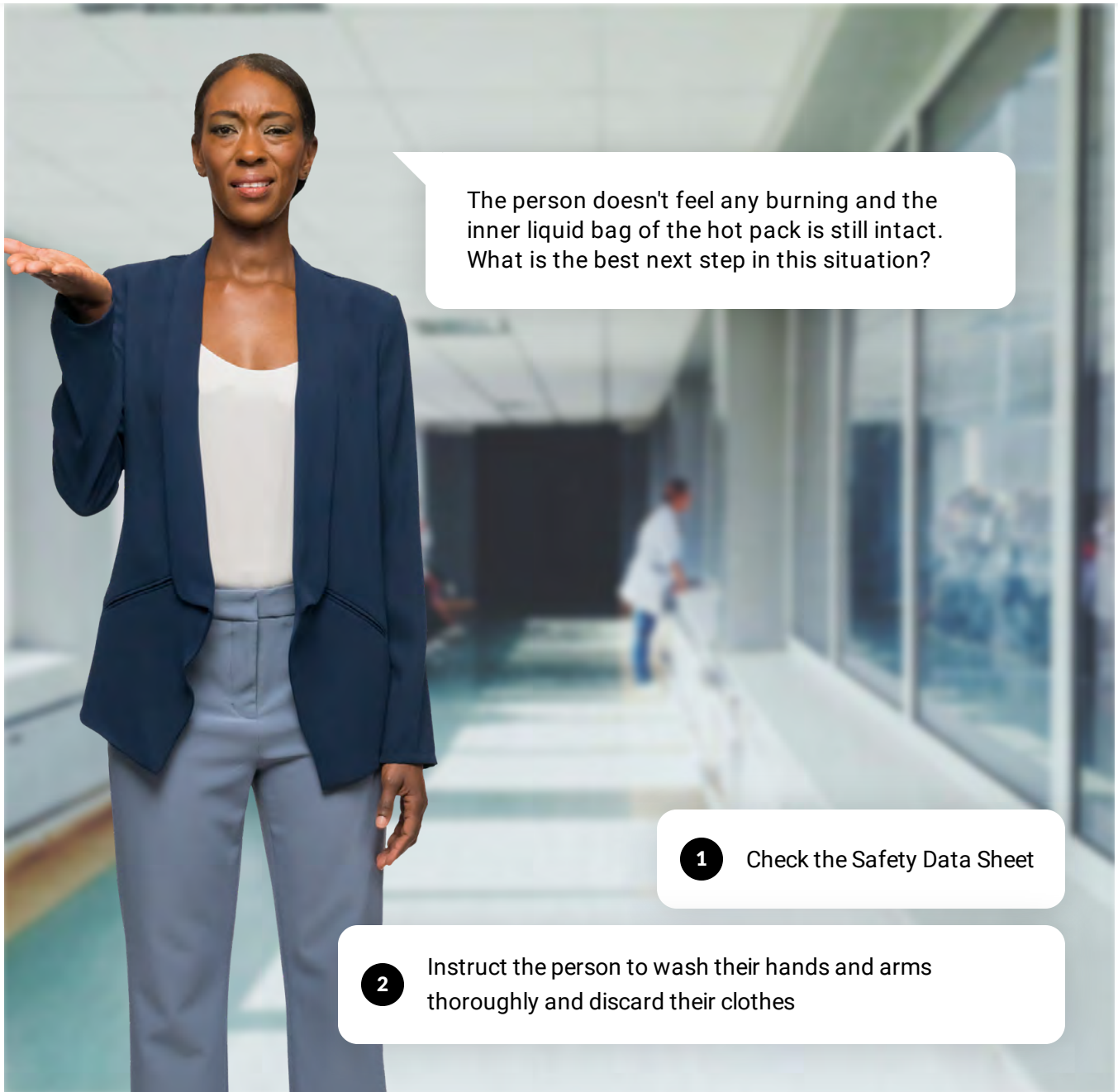
Someone approaches you worried because they were handling a hot pack for arthritis treatment, and the outer layer was punctured. The liquid got on their pants, hands, and arms, and on the floor.

CONTINUE

### Scene 1 Slide 1

Continue → Next Slide





The person doesn't feel any burning and the inner liquid bag of the hot pack is still intact. What is the best next step in this situation?

1 Check the Safety Data Sheet

2 Instruct the person to wash their hands and arms thoroughly and discard their clothes

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



### Scene 1 Slide 3

Continue → End of Scenario



Complete the content above before moving on.



### The Safety Data Sheet (SDS)

You can locate the Safety Data Sheet for products by clicking on the link located on the UVA Health Desktop.

The Safety Data sheet includes the following information for hazardous chemicals:

- **Health risks**
- **Safety precautions**
- **Required personal protective equipment (PPE)**
- **Emergency response procedures**

**Continue to the Next Section**

**Click Continue to move to the next section.**

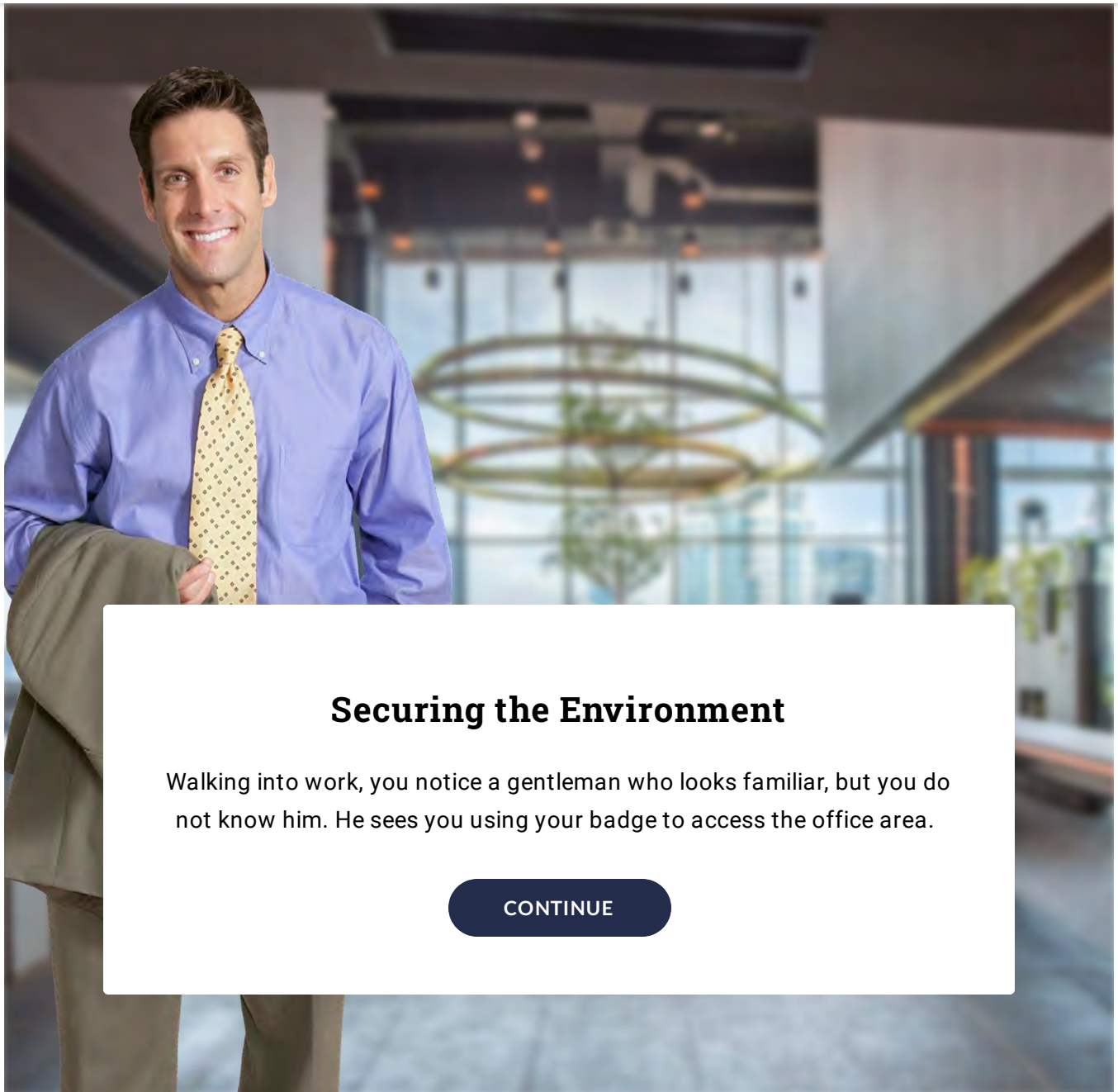
**CONTINUE**

Lesson 6 of 81

# Securing the Environment

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**Securing the Environment**



## Securing the Environment

Walking into work, you notice a gentleman who looks familiar, but you do not know him. He sees you using your badge to access the office area.

CONTINUE

### Scene 1 Slide 1

Continue → Next Slide



He comes up to hold the door and tells you that he forgot his ID badge. What should you do?

1

Let him know that for safety reasons you cannot let him in, and direct him to a main entrance or how he can get a replacement badge.

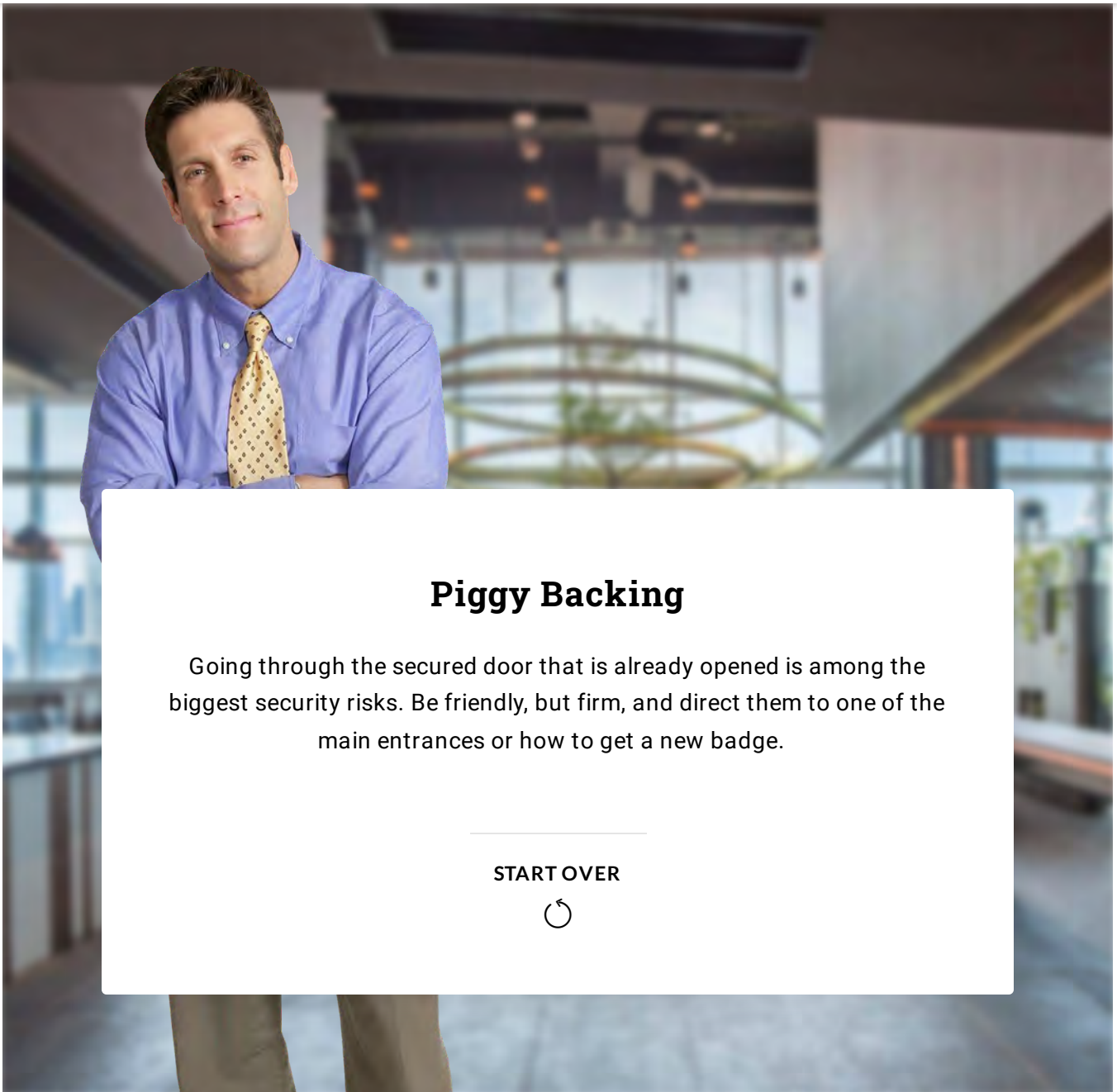
2

He does look familiar. Ask him to remember the badge next time, and let him in.

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



## **Piggy Backing**

Going through the secured door that is already opened is among the biggest security risks. Be friendly, but firm, and direct them to one of the main entrances or how to get a new badge.

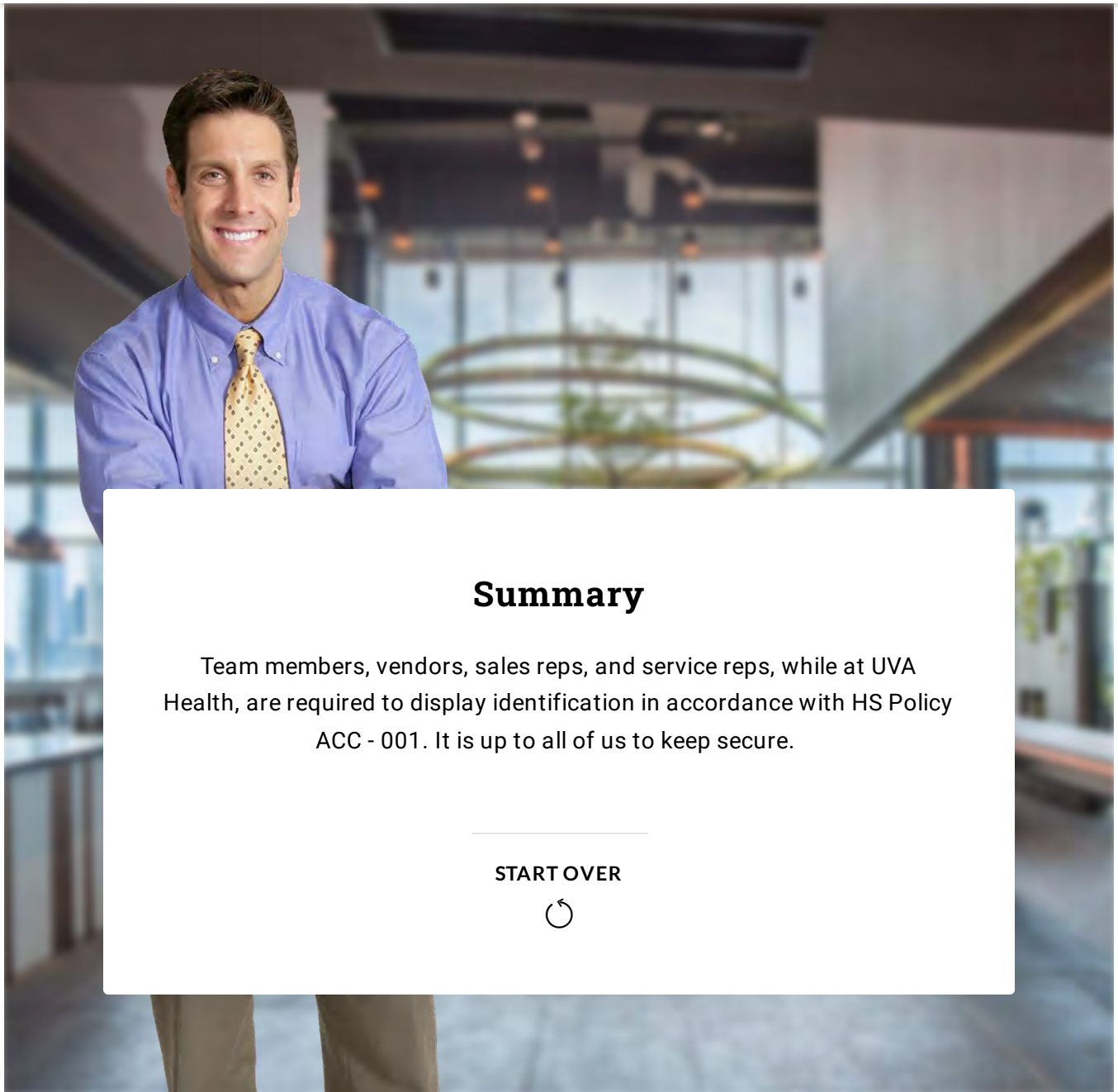
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**START OVER**



### **Scene 1 Slide 3**

Continue → End of Scenario



## Summary

Team members, vendors, sales reps, and service reps, while at UVA Health, are required to display identification in accordance with HS Policy ACC - 001. It is up to all of us to keep secure.

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START OVER



### Scene 1 Slide 4

Continue → End of Scenario





Complete the content above before moving on.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Stroke Recognition

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## Signs of a Stroke - BE FAST

YOU can make a difference if you think someone might be having a stroke! A stroke is an emergency. Know the signs & symptoms.

**B** —

**Balance** - Is there a sudden loss of balance or coordination?

**E** —

**Eyes** - Is there sudden blurred or double vision or sudden difficulty seeing?

**F** —

**Face** - Ask the person to smile. Is one or both sides of the face drooping?

**A** —

**Arms** - Ask the person to raise both arms. Does one side drift downward? Is there weakness or numbness on one side?

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**S** —

**Speech** - Does the person have difficulty speaking or any slurred speech?

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**T** —

**Time** - Seek immediate medical attention if you see any of these signs. Take note of the time when symptoms began.

**Now What?**



Time is the most important factor to good outcomes.

- If you are in the Medical Center, **call 4-2012\*\*** and **activate a stroke alert**. Include patient's name (or MRN, if known), last time known well, and location.

- If you are outside the Medical Center, **call 911\*\*** and let the operator know you suspect stroke.

\*\*Always refer to your unit's Red Book to be familiar with and verify emergency numbers for your location.

## What should you do?

Click the cards below to find out how this scenario should be handled.

In line at Higher Grounds in the hospital, you see a person suddenly stop, confused. You notice that one side of her face is drooping.

What do you do?

Call 434-924-2012 from any phone and activate a stroke alert.

At a clinic, a man in the waiting room is complaining that he can't raise both arms.

What do you do?

A stroke sign/symptom is one sided weakness. Call 911 or 434-924-2012 and tell the operator that you suspect a stroke. Refer to your unit Red Book/Emergency Procedures for full response details.

On the bus, a woman suddenly seems dizzy and loses her balance. She complains of blurred vision.  
What do you do?

Dial 911 and advise the operator that you believe she is having a stroke.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Emergencies and Your Role

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Everyone has a role in keeping everyone safe. In addition to being familiar with your Red Book for your area, consider these things.

## *Violence in the Workplace*

### **Call Police / Security**

Preventing and responding to violence in the workplace can be anyone's job. The key to responding to threats is to **contact police and/or security immediately**.

Review the **Red Book** to learn who to contact for your work area. Don't handle this on your own.

## **Fire Safety**



Applying 'R.A.C.E.' in response to a fire or smoke event is key to fire/smoke safety.



## Step 1

### Rescue



If it is safe to do so, **rescue** any people from immediate danger.

## Step 2

### Alarm



If the fire **alarm** is not active or heard, activate the closest **alarm** pull-station and call 434-924-2012 or 911.

### Step 3

## Contain



**Contain** the fire by closing doors and windows, as well as **clearing corridors** of obstructions.

## Step 4

### Extinguish / Evacuate



Apply 'P.A.S.S.' in use of the nearest fire **extinguisher** if the fire is small and you feel comfortable using one and/or **evacuate** according to your area fire plan.

## Summary

Be prepared for an emergency.

Review your area's Red Book for your fire prevention and response plan. For assistance with your Red Book, contact [HealthSystemEM@virginia.edu](mailto:HealthSystemEM@virginia.edu).

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Gender Health - Delivering Compassionate Care to LGBTQ+ (SOGI)

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## Delivering Compassionate Care to LGBTQ+ Patients

The Department of Health and Human Services, the Institute of Medicine, and The Joint Commission all recommend SOGI data collection as a way to learn about which populations are being served and to measure quality of care provided to LGBTQ + people. UVA is proud to be a community of health, compassion, inclusion, and respect for all. We ask patients to provide Sexual Orientation & Gender Identity (SOGI) data to:

- Help provide high quality, affirming, patient-centered care
- Learn about populations we serve
- Help LGBTQ+ patients feel more comfortable
- Give providers important clinical information
- Help tailor care to unique needs of transgender & non-binary patients

By including this data, we are creating a welcoming and affirming environment by:

- Using the preferred names and pronouns that our patients use, especially (but not exclusively) for transgender and gender non-conforming patients.
- Asking all patients for their preferred names and pronouns, if undocumented.
- Adding patients' preferred names and pronouns to Epic by following directions found in the Epic Learning Library (search Patient Pronouns and Preferred Name).
- Being inclusive and clear in all verbal and written communication.

## Visitation



Ginnie came in with their wife. While talking to them, you notice that their name says Virginia and there are no pronouns listed. What should you do?

- 1 Ask if there is a different preferred name or pronoun when you interact with them.
- 2 Ignore it. If they wanted the information to be there, they should know to provide it.

## Scene 1 Slide 1

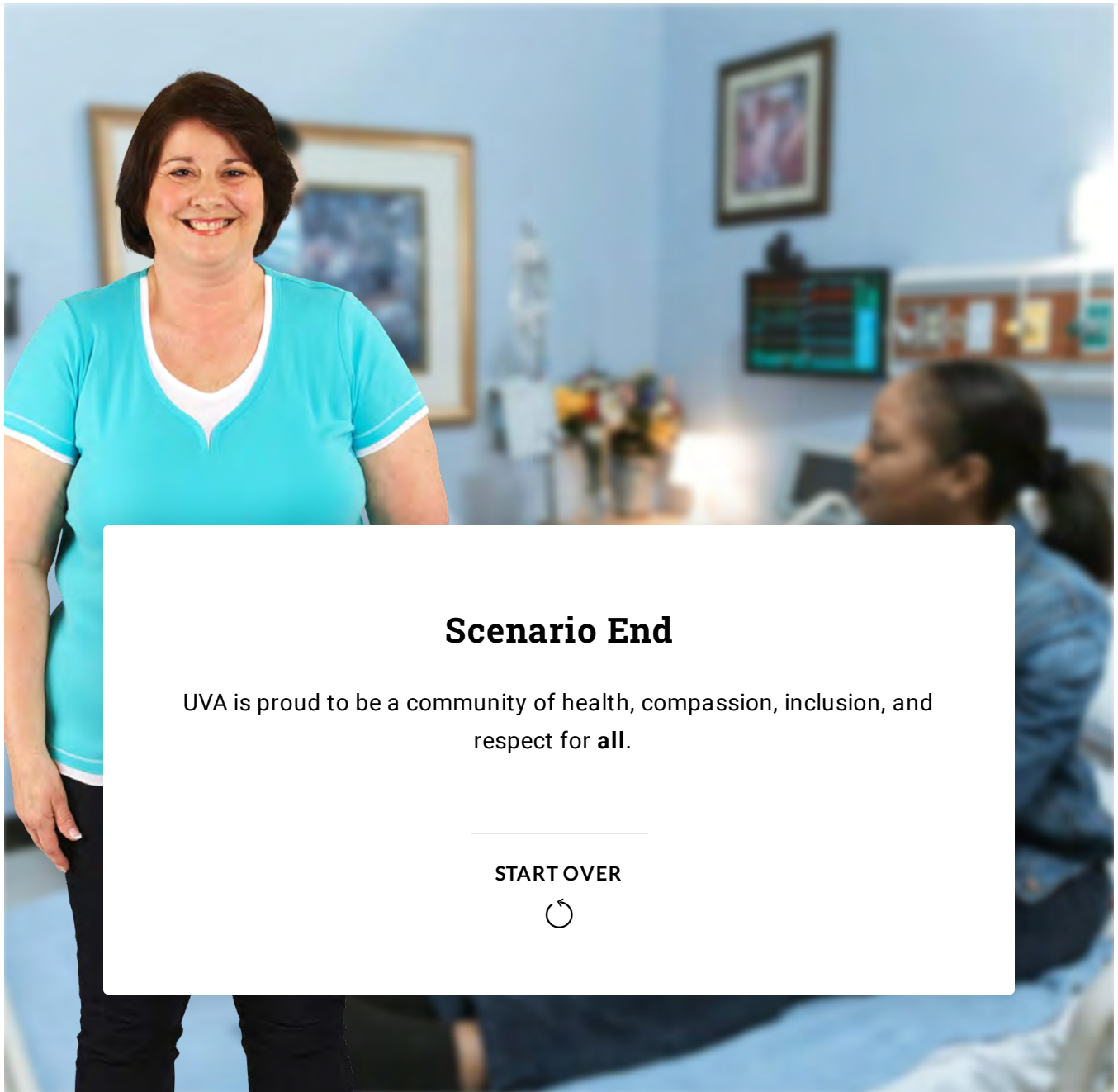
0 → Next Slide

1 → Next Slide



**Scene 1 Slide 2**





## Scenario End

UVA is proud to be a community of health, compassion, inclusion, and respect for **all**.

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START OVER



### Scene 1 Slide 3

Continue → End of Scenario

**CONTINUE**

**Continue to the Next Section**

**Continue to the next section**

**CONTINUE**

# Reporting Concerns

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UVA Health has a goal to be the best place to give and receive care. If there is ever something that happens that you feel is not adequately addressed by your leadership or UVA Health as a whole, it is not only your right, but it is your responsibility to report it.

**Any team member is free to raise concerns** to The Joint Commission or other regulatory agencies when the hospital has not helped to prevent or address problems that have an adverse affect to patients.

**You will not be punished** by UVA Health or your leadership for reporting your concerns.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Corp Compliance and Privacy

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## Start

Corporate Compliance and Privacy are critical components of our work at UVA Health. In this section of the module, you will review the following aspects that are required for all Team Members.

START

## Review UVA Health Code of Conduct

**UVA Health Compliance Code of Conduct:**

Click here to read the code of conduct.

You may be prompted to login.

CODE OF CONDUCT

I have read, and agree to abide by, UVA Health Compliance Code of Conduct.

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Yes, I have read, and agree to abide by UVA Health Code of



Conduct.

No, I did not read, and agree to abide by the UVA Health Code of Conduct.

SUBMIT



Complete the content above before moving on.

## Fraud, Waste, and Abuse Defined



Click each box to see examples



## Fraud

Intentionally submitting false information to get money or a benefit.

### Examples:

- Knowingly billing for services that were not provided.
- Knowingly altering medical records, coding, or claims to receive a higher



## Waste

Includes practices that, directly or indirectly, result in unnecessary costs, such as overusing services.

### Examples:

- Excessive office visits, prescriptions, referrals, and lab tests.
- Prescribing more medications than necessary for treating



## Abuse

Includes actions that may, directly or indirectly, result in unnecessary costs.

### Examples:

- Unknowingly billing unnecessary medical services.
- Unknowingly misusing codes on a claim, such as upcoding or

CONTINUE

## Some Relevant Federal Fraud, Waste, and Abuse Laws

All Team Members at UVA Health play a vital part in the prevention and detection of any potential fraud, waste, or abuse activities. You have an obligation to report any potential non-compliance with fraud, waste, and abuse. A brief overview of some of the laws you should be familiar with are summarized on the following tabs.

STARK LAW  
(PHYSICIAN SELF-  
REFERRAL)

FALSE CLAIMS ACT  
(FCA)

ANTI-KICKBACK  
STATUTE (AKS)

CIVIL MONETARY  
PENALTIES LAW



**Definition:**

A physician can't make a referral for certain designated health services (like lab tests, physical therapy (PT), durable medical equipment (DME), home health services, prescription drugs, etc.) if they or their immediate family member will receive any type of benefit.

**Violation Example:**

- Physician refers a patient to a laboratory they own.

**STARK LAW  
(PHYSICIAN SELF-  
REFERRAL)**

**FALSE CLAIMS ACT  
(FCA)**

**ANTI-KICKBACK  
STATUTE (AKS)**

**CIVIL MONETARY  
PENALTIES LAW**

**Definition:**

- The FCA protects the Federal Government from being overcharged or sold substandard goods or services.
- We cannot submit claims for payment to Medicare or Medicaid that we know or should know are false or fraudulent.
- Retention of overpayments can also be considered an FCA violation. We must report and return overpayments within 60 days of the date

overpayment was identified or the overpayment could be considered a false claim.

**Violation Examples:**

- Billing for a higher level of service than actually performed.
- Altering claim forms or medical records.
- Upcoding patient visits.
- Unbundling billing codes.

**STARK LAW  
(PHYSICIAN SELF-  
REFERRAL)**

**FALSE CLAIMS ACT  
(FCA)**

**ANTI-KICKBACK  
STATUTE (AKS)**

**CIVIL MONETARY  
PENALTIES LAW**

**Definition:**

We cannot knowingly or purposefully offer, give, request, or receive anything of value to encourage patient referrals for items or services that are paid for by a federal health care program like Medicare.

**Violation Examples:**

- A diagnostic lab offers a nurse practitioner \$100 for each Medicare referral.

- An oncologist takes family vacations paid for by a pharmaceutical company in exchange for prescribing the company's drug in lieu of alternatives.
- A medical equipment company and a physician agree that the physician can establish a rent-free office in a space owned by the medical equipment company if the physician refers Medicaid patients to the company.

**STARK LAW  
(PHYSICIAN SELF-  
REFERRAL)**

**FALSE CLAIMS ACT  
(FCA)**

**ANTI-KICKBACK  
STATUTE (AKS)**

**CIVIL MONETARY  
PENALTIES LAW**

**Definition:**

- The beneficiary inducement law prohibits giving patients something of value in an attempt to influence their choice of provider

**Violation Examples:**

- A provider offers to waive copayments for Medicare patients.
- A hospital offers free hotel stays to potential out-of-town patients.

# Excluded Individuals and Entities

The Health and Human Services Office of the Inspector General (“OIG”), has the authority to **exclude** individuals and entities from participating in **Federal health care programs** like Medicare and Medicaid.

Exclusion means that items and services furnished, ordered, or prescribed by the excluded individual or entity are not reimbursable under Federal health care programs. This includes any costs of employing excluded people. **It’s effectively a ban on employing or contracting with excluded people.**

That is why we must check all employees, health care providers, Board members, and vendors against the government’s List of Excluded Individuals/Entities (“LEIE”) and System for Award Management (“SAM”).

If we discover we have an excluded individual working for us, we have to immediately terminate the employee and self-disclose it to the government. We also have to refund any payment we received relating to services they performed or ordered.

CONTINUE

## Emergency Medical Treatment and Labor Act (EMTALA)

(“Patient Anti-Dumping Law”)

EMTALA guarantees access to emergency medical services for individuals who present to a hospital emergency department

regardless of an individual's ability to pay.

It also provides for appropriate transfers if the presenting facility is unable to provide the care or services necessary to stabilize a medical condition.

## **All Individuals Must Be Screened**

All individuals who present to a hospital emergency department must be screened by Qualified Medical Personnel to determine the presence or absence of an emergency medical condition.

EMTALA applies until either (1) the medical screening exam does not identify an emergency medical condition or (2) the patient is provided with stabilizing treatment and/or an appropriate transfer.



**Stabilizing Treatment Must Be Provided**



Hospitals must make sure the patient is provided with stabilizing treatment (within the capabilities of the hospital's staff and facilities) before they can initiate a transfer to another hospital or medical facility or before they can discharge the patient.

**NO DELAY IN EXAMINATION AND TREATMENT.**

Hospitals may not delay providing an appropriate medical screening examination or stabilizing medical treatment for any reason, including asking about an individual's method of payment or health insurance status.

**Four Requirements for Appropriate Transfer**

A patient with an emergency medical condition may only be transferred after screening and the

provision of stabilizing treatment. Four requirements must be met:

1. The transferring hospital minimizes the medical risks (and in the case of a woman in labor, the medical risks of the fetus as well).
2. The receiving medical facility has available space and qualified personnel for the treatment and agrees to accept the transfer.
3. The transferring hospital sends all medical records related to the emergency condition that are available at the time of the transfer and any other records not yet available as soon as practicable.
4. The patient is transferred using appropriate personnel and transportation, including the use of necessary and medically appropriate life support measures during the transfer.

**CONTINUE**

## **Privacy**

Our patients are placing their trust in us to preserve the privacy of their most sensitive and personal information. We each have a responsibility to respect and protect the privacy and security of our patient's health information. The Health Insurance Portability & Accountability Act (HIPAA) and associated privacy rules address the use and disclosure of protected health information (PHI). The information on the following slides note the ways we comply with HIPAA, and how we can protect and safeguard our patients' information.

## **Protecting Protected Health Information**



## **Protecting PHI**

In the event PHI (Protected Health Information) is shared by mistake with the wrong patient, it is important to report it as soon as possible.

## Step 1

### **Protecting PHI**

If you mistakenly provide PHI to the wrong patient, apologize and thank the patient for letting us know. Ask the patient to return it (bring to their next appointment if soon or mail the patient a stamped/self-addressed envelope).

Do not instruct the patient to destroy the documents. Ensure the intended patient has received their documents. Notify the Corporate Compliance & Privacy Office and submit a Be Safe event. Forward the documents to the Corporate Compliance & Privacy Office.

Confidentiality of Patient Information Health System Policy defines what confidential information is and how it is to be handled by all Team Members.

## Step 2

### **Team members should always:**

1. Double-check patient information when mailing PHI or providing PHI to a patient.
2. Be sure to not leave PHI such as patient schedules/lists in patient access areas (e.g., nurses station counters, elevators, cafeteria, waiting area, etc.).
3. Confidentially dispose of PHI that is no longer needed as outlined in the "Where does all the garbage go?" document.
4. As a best practice, quickly check with the patient that it is OK to speak about confidential information in front of others with them.
5. Confirm the identity of the patient per the Patient Identification Policy:
  - Verify two identifiers (name and date of birth).
  - Keep voice low when communicating to or about the patient.
  - Team members can offer a patient the option to write their information down on paper.

## Summary

Additional resources are available on the [Corporate Compliance intranet page](#).

Any questions can be directed to the Compliance & Privacy Department: 434-924-2938 or email [Compliance and Privacy \(Medical Center\)](#).

If you wish to report a compliance concern or issue please notify your manager or directly contact the Compliance & Privacy Department.

You can also report an issue to the Compliance Help Line, anonymously if desired, 24 hours a day/7 days a week: 1-800-235-8700 or you can submit through this [web intake form](#).

CONTINUE

### Release of Patients' Protected Health Information

Patients have a right to review their medical records. They can request a copy through MyChart or the Health Information Management (HIM) Department. For guidelines about release of PHI, see Medical Center Policy: Release of Patients' Protected Health Information.

All requests for record release must go through HIM, with one exception. In ambulatory settings, either the MD or RN may release point-of-care information ONLY to the patient or legal guardian.

### UPG Employees



For **UPG employees** taking this course, please report any Compliance issues to the **CONFIDENTIAL Compliance Helpline: 1-800-235-8700** or report using the choices above.

Policies related to violations of the Code of Conduct are the same between the Medical Center and UPG.

**CONTINUE**

## **UVA Health Corporate Compliance**

This scenario is made for all Team Members at UVA Health. Although the situation may not reflect your work environment, consider the information and how it does apply to your work.

This section has audio on some slides. Closed captioning and a transcript is available for every slide where there is sound. You can click play / pause and adjust the volume as needed.

## Epic Access



Sarah works at UVA Health. Her work ultimately supports the hospital, but she does not provide patient care.

One day, she overhears her coworker, Jeremy, bugging one of their coworkers with access to Epic to PLEASE check on his ex-wife's test results. He is sure she was cheating on him and thinks the test results will prove it. The coworker says no because it is a big violation of privacy. He is frustrated and tells her that he will find someone else to do it.



CONTINUE

## Conclusion

Compliance is part of **all of our jobs** and depends on everyone's participation for continued success!

Continue to Next Section

**Click Continue to move to the next section.**

**CONTINUE**

# Information Security

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## Internet Use at UVA Health

Much of the work done at UVA Health involves connecting to the internet. This includes email, online meetings, Epic, etc. Generally, internet use is required as part of work, but it is important to only use it for work purposes.

The work purposes for using the internet are also important to ensure privacy. You can always review the Electronic Information and Systems Use Health System Policy.

### Acceptable Internet Usage Includes:

- Email Communications
- Research MC forums, blogs, and news groups
- Software approved for use by the MC
- Use of cloud storage provided by the MC: Dropbox (to apply for Dropbox, fill out an online request)

### Unacceptable Internet Usage Includes:

- Business or commercial activity not related to MC business
- Access to a network or computer that violates policies, including P2P networks used to download copyrighted material
- Illegal activities, including the violation of the Digital Millennium Copyright Act (DMCA)
- Sharing of MC data when not authorized



- Disclosing patient information via forums, blogs, news groups, or social networking sites

## Reporting

The Computer Security Incident Report form is used to report all potential electronic information (computer) security incidents including, but not limited to, misuse by authorized users, unauthorized access, computer viruses, worms, hacking, information system failure, and theft. If you know someone that is violating the Electronic Information and Systems Use Health System Policy, it is your responsibility to report it. You can either:

- Write down exactly what occurred and contact the Health IT Helpdesk at 434-924-5334

or

- Complete a Computer Security Incident Report (Search KnowledgeLink for **Computer Security Report**)

If you are involved in an incident:

- Respond to requests for information promptly
- Keep written records
- Maintain confidentiality
- Notify your manager

CONTINUE



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**Passwords protect the organization from hacking and individuals with malintent.**

## **Securing UVA Health Accounts and Credentials**

The Electronic Information and Systems Use UVA Health System Policy outlines the appropriate use of UVA Health workstations, accounts, and credentials.

Click through the cards below to review a few of these security concepts.

Never share passwords

Password sharing is a violation of HS policy.

Electronic signature

The combination of your computing ID and password is equivalent to your electronic signature. Team members will be held accountable for any misuse occurring under their computing ID and password due to neglect on the team member's part.

Report stolen password

If you have reason to believe your computing ID and password, or those of another individual, have been stolen you should report it immediately to the Health IT Security Office via the Computer Incident Form or by calling the Health IT Helpdesk at 434-924-5334.

Only use HIT-approved software and applications

HIT Security **must** perform risk assessments on all applications, software, and cloud services before they are introduced into the UVA Health environment.

Lock or logout of your workstation when you have to step away

Always lock your workstation when you step away from it, regardless of how long you expect to be gone.

Report suspicious emails

Report suspicious messages using the “Report Suspicious Email” button within Outlook.

CONTINUE

**Phishing**

PHISHING

VISHING (VOICE PHISHING)

SMISHING (SMS PHISHING)

SPEAR PHISHING

Phishing is a form of social engineering and scam where attackers trick you into revealing sensitive information or downloading malware.

**Actions to Take:**

- Check for Red Flags (generic greetings, unexpected attachments, artificial sense of urgency, suspicious links)
- Do Not Click on Links or Download Attachments. Clicking on any links or downloading attachments included in a suspicious message is extremely risky. These actions could lead to an attacker gaining access to your credentials or even installing malicious software on your workstation."
- Report the message to the UVA Health Information Technology team using the **"Report Suspicious Email" button in your Microsoft Outlook email client.**



PHISHING

VISHING (VOICE PHISHING)

SMISHING (SMS PHISHING)

SPEAR PHISHING

Vishing is when scammers use phone calls or voicemails to deceive victims. For example: You get a call claiming to be from your bank asking for account details.

**Actions to Take:**

- **Verify the Caller:** Ask for the caller's name and contact information. Be cautious if they refuse to provide this information.
- **Do Not Share Personal Information:** Never share sensitive details like your Social Security number, bank account numbers, or passwords.
- **Hang Up:** If you suspect a vishing attempt, end the call immediately. Don't engage in further conversation.
- **Report the Incident:** Inform your bank or financial institution about the call that you received. They can verify if it was legitimate or a scam.



**PHISHING**

**VISHING (VOICE  
PHISHING)**

**SMISHING (SMS  
PHISHING)**

**SPEAR PHISHING**

Smishing is when scammers use text messages to deceive victims. For example: you get a text message claiming that you won a prize, asking for personal information, or requesting that you click on a link.

**Actions to Take:**

- **Verify the Source:** Check the sender's phone number or the organization claiming to contact you - legitimate institutions rarely ask for sensitive information via text messages.
- **Do Not Share Personal Information:** Never share sensitive details like your Social Security number, bank account numbers, or passwords.
- **Do Not Tap Links:** Tapping on any links or downloading attachments from suspicious messages is risky. These could lead to malware installation or phishing websites.
- **Do Not Respond or Share Personal Information:** If you respond, the engagement alone provides the scammer some information.



<b>PHISHING</b>	<b>VISHING (VOICE PHISHING)</b>	<b>SMISHING (SMS PHISHING)</b>	<b>SPEAR PHISHING</b>
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Spear phishing is a highly targeted (specific individuals or organizations) cyberattack method. Unlike generic phishing, spear phishing involves personalized research and often impersonates someone the victim trusts.

**Actions to Take:**

- **Use Another Communication Channel:** If you receive a suspicious email, verify its legitimacy through another communication channel (e.g., phone call). Do not reply directly to the email.
- **Keep Personal Information Secure:** Never share financial details, passwords, or sensitive data over phone, chat, or email.
- **Stay Suspicious:** Be aware of signs of spear phishing, such as urgent requests, unexpected attachments, or unusual sender behavior.
- **Know How To React:** If you suspect that you have received a suspicious email, report it to the UVA Health Information Technology team using the "Report Suspicious Email" button in your Office mail client.



## Example

Review the email below to see common clues to identify phishing scams.

Click the (+) icons below to learn more. Then click Continue.

The screenshot shows an Outlook email window. The top ribbon includes tabs for File, Home, Send/Receive, Folder, View, and Help. The main area displays an email from Beasley, Cachaca R (mailto:beasleyc@yahoo.com) with the subject "ITS - Service Required". The email body contains the following text:

Team member,

Your access to your business files is about to expire. [Click Here to confirm](http://www.accountaccessrestore-01.org/verifynow) your business need to these records by end of day today.

If you do not confirm your business needs, your access will be disabled and will be unable to get it back.

This is an automatted message. Please do not reply to this email.


Thank you for your prompt response,

Administrater

Several plus signs (+) are overlaid on the interface to indicate where to click for more information: one on the sender's profile picture, one on the sender's name, one on the "Click Here to confirm" link, one on the "Team member," text, one on the "Thank you for your prompt response," text, and one on the "Administrater" signature.

The screenshot shows an Outlook email window. The title bar includes a search bar and window controls. The ribbon at the top has tabs for File, Home, Send/Receive, Folder, View, and Help. The Home tab is active, showing various email actions like New Email, Schedule Meeting, Delete, Archive, Reply, Forward, and Move. The email content area displays the following:

**ITS - Service Required**

Beasley, Cachaca R [mailto:beasleyc@yahoo.com]   
UVA Health Team Member

Team member,

Your access to your business files is about to expire. [Click Here to confirm](http://www.accountaccessrestoration.org/verifynow) your business need to these records by end of day today.

if you do not confirm your business needs, your access will be disabled and will be unable to get it back.

This is an automatted message. Please do not reply to this email.

Thank you for your prompt response,

Administrater

Reply, Reply All, Forward, and a more options menu are visible at the top right of the email content area. The date and time are Fri 4/17/2020 2:48 PM.

## Sender Address

The sender address does not have a Health System address.


The screenshot shows the Outlook application window. The ribbon at the top includes tabs for File, Home, Send / Receive, Folder, View, and Help. The Home tab is active, displaying various icons for email actions like New Email, Schedule Meeting, Delete, Reply, Forward, and Move. The main content area displays an email with the subject "ITS - Service Required" from "Beasley, Cachaca R [mailto:beasleyc@yahoo.com]". The email body contains a security warning: "Your access to your business files is about to expire. Click Here to confirm your business need to these records by end of day today. If you do not confirm your business needs, your access will be disabled and will be unable to get it back. This is an automatted message. Please do not reply to this email. Thank you for your prompt response, Administrater". A small tooltip is visible over a link in the email body, showing the URL "http://www.accountaccessretrieval.org/verifynow" and the instruction "Click or tap to follow link.".

## Report Suspicious Email

Report the suspicious email using the "Report Suspicious Email" button within Outlook.

The screenshot shows an Outlook email window. The title bar includes a search bar and window controls. The ribbon at the top has tabs for File, Home, Send/Receive, Folder, View, and Help. The Home tab is active, showing various email actions like New Email, Schedule Meeting, Delete, Archive, Reply, Forward, and Move. The email content area displays the following:

**ITS - Service Required**

 Beasley, Cachaca R [mailto:beasleyc@yahoo.com]  
UVA Health Team Member

Reply Reply All Forward

Fri 4/17/2020 2:48 PM

Team member,

Your access to your business files is about to expire. [Click Here to confirm](http://www.accountaccessrestoration.org/verifynow) your business need to these records by end of day today.

if you do not confirm your business needs, your access will be disabled and will be unable to get it back.

This is an automatted message. Please do not reply to this email.

Thank you for your prompt response,


Administrater

## False Sense of Urgency

A threat making you feel like you need to respond quickly.

The screenshot shows an Outlook email window. The title bar includes a search bar and window controls. The ribbon at the top has tabs for File, Home, Send/Receive, Folder, View, and Help. The Home tab is active, showing various email actions like New Email, Schedule Meeting, Delete, Archive, Reply, Forward, and Move. The email content area displays the following:

**ITS - Service Required**

 Beasley, Cachaca R [mailto:beasleyc@yahoo.com]  
UVA Health Team Member

Reply Reply All Forward

Fri 4/17/2020 2:48 PM

Team member,

Your access to your business files is about to expire. [Click Here to confirm](http://www.accountaccessretrieval.org/verifynow) your business need to these records by end of day today.

If you do not confirm your business needs, your access will be disabled and will be unable to get it back.

This is an automatted message. Please do not reply to this email.

Thank you for your prompt response,

Administrater

## Link

This box appears if you hover over a hyperlink. This link shows a destination that does not appear to have association with UVA. **DO NOT CLICK THE LINK.**

The screenshot shows an Outlook email window. The title bar includes a search bar and window controls. The ribbon at the top has tabs for File, Home, Send/Receive, Folder, View, and Help. The Home tab is active, showing various email actions like New Email, Schedule Meeting, Delete, Archive, Reply, Forward, and Move. The email content is as follows:

**ITS - Service Required**

Beasley, Cachaca R [mailto:beasleyc@yahoo.com]  
UVA Health Team Member

Team member,

Your access to your business files is about to expire. [Click Here to confirm](http://www.accountaccessretrieval.org/verifynow) your business need to these records by end of day today.

If you do not confirm your business needs, your access will be disabled and will be unable to get it back.

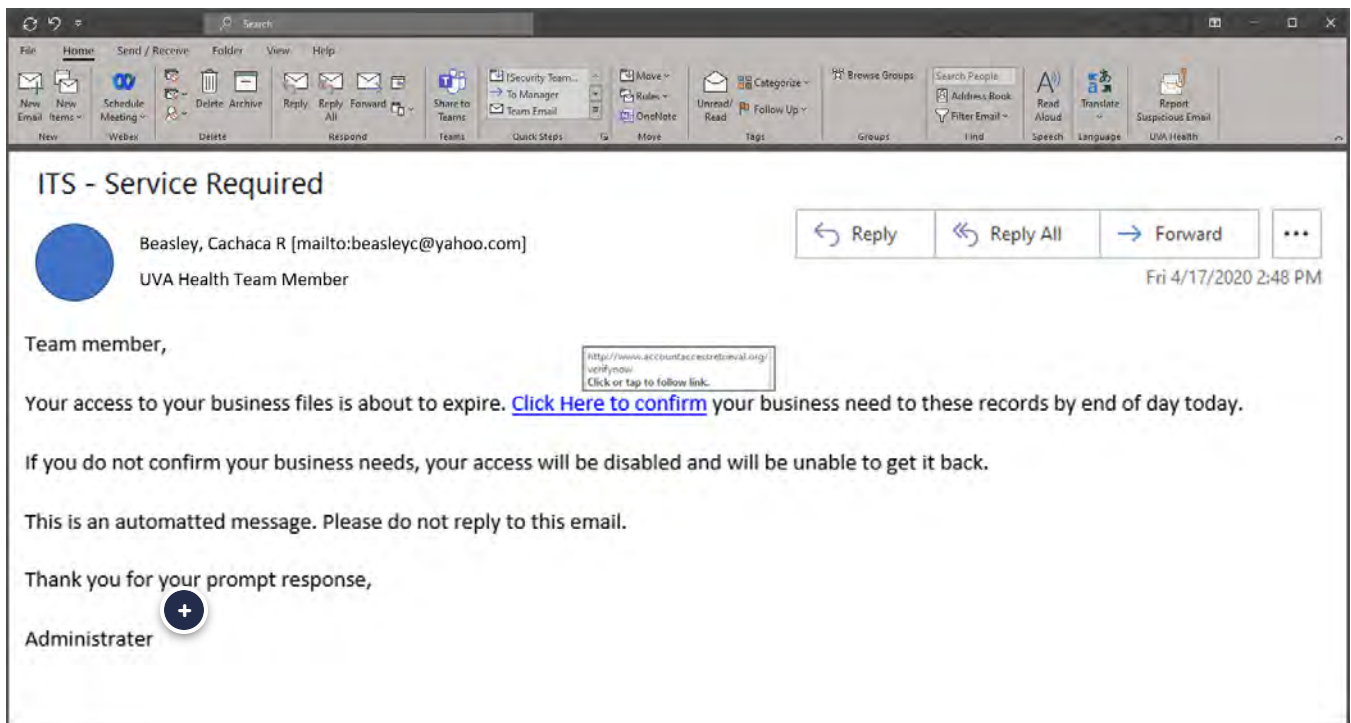
This is an automatted message. Please do not reply to this email.

Thank you for your prompt response,

Administrater

## Grammatical Mistakes

Mistakes in grammar and spelling can be indications that it is not from a legitimate source.



## Signature

The signature is vague, misspelled, and does not include a name, department, or contact information for Health IT.

CONTINUE

Sending ePHI Through Email

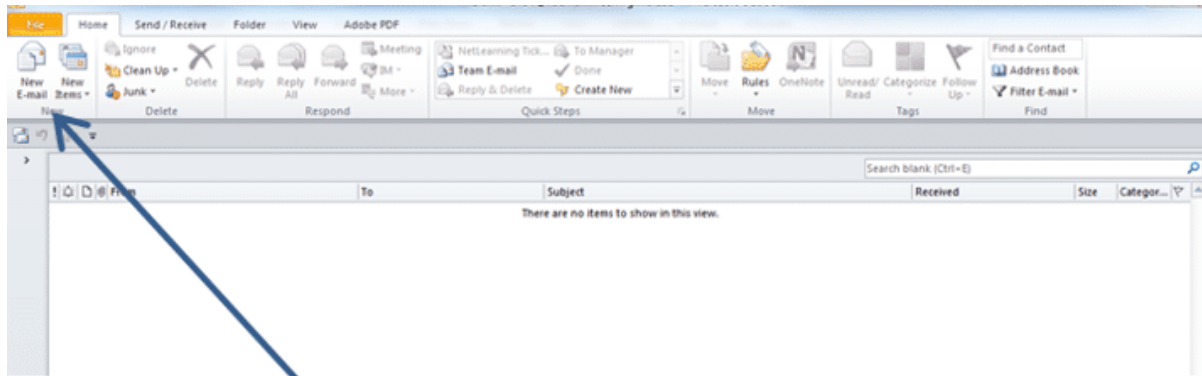


## **Sending ePHI Through Email**

If you need to send an email with sensitive/confidential information and ePHI to a recipient that is not part of UVA Health and does not have a UVAHealth.org email within the firewall, you **must** protect the information in the email by encrypting the message. Follow these steps to send encrypted messages.

## Step 1

### Click on New E-Mail

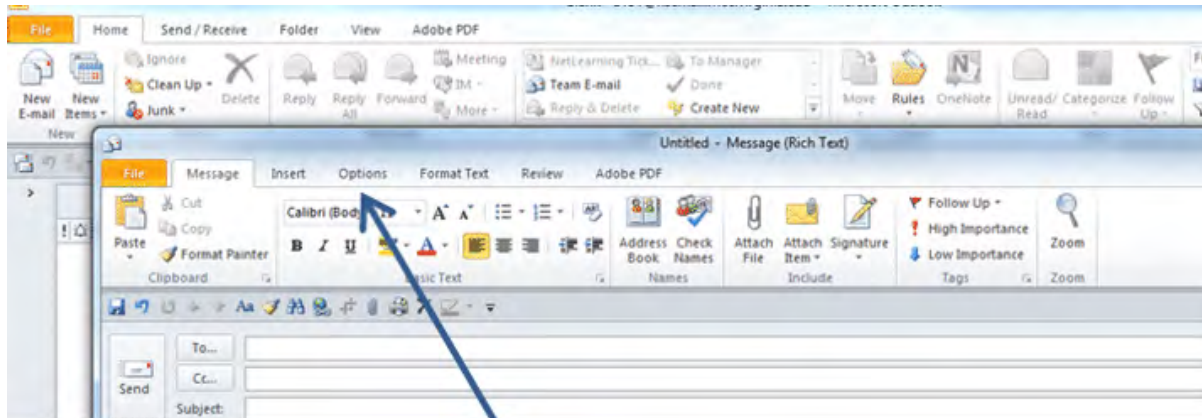


To encrypt an email going outside the organization:

1. Click on **New E-mail**.

## Step 2

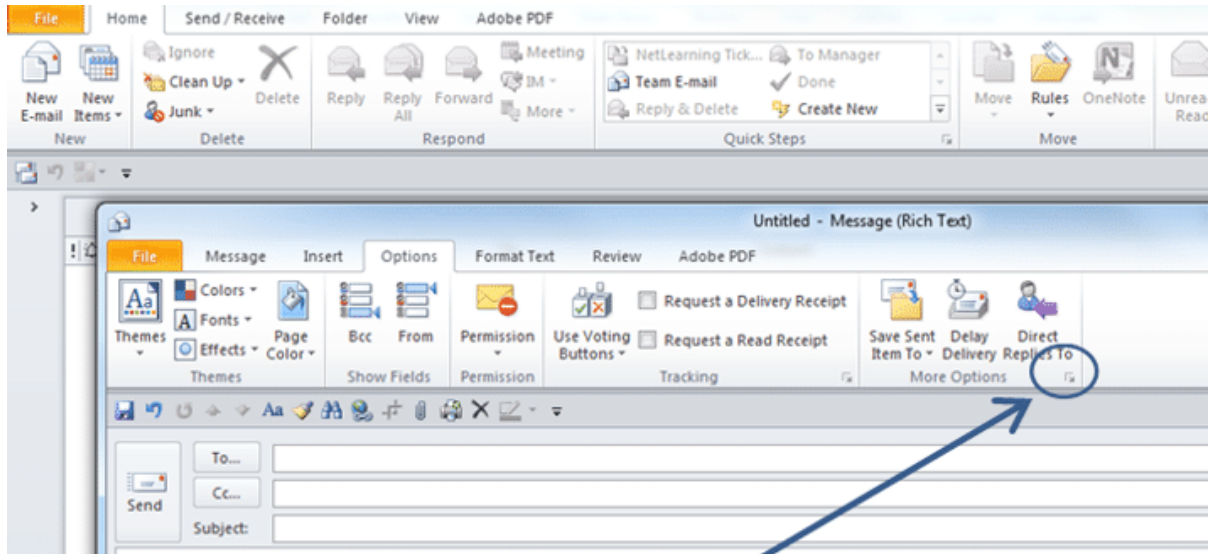
### Click Options



2. Click on **Options** in the new email.

## Step 3

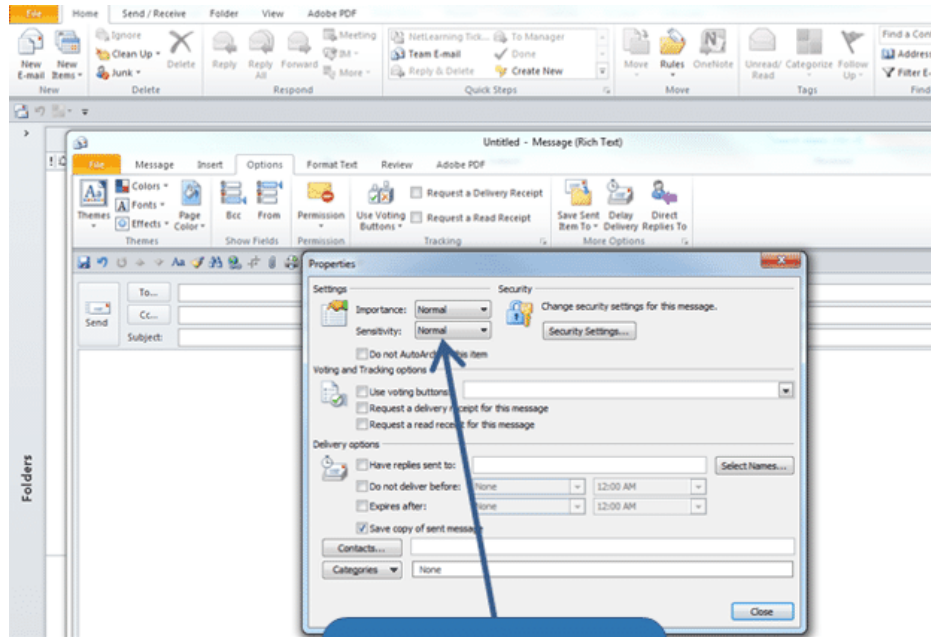
### Click More Options



3. Click on this box to bring up **More Options**.

## Step 4

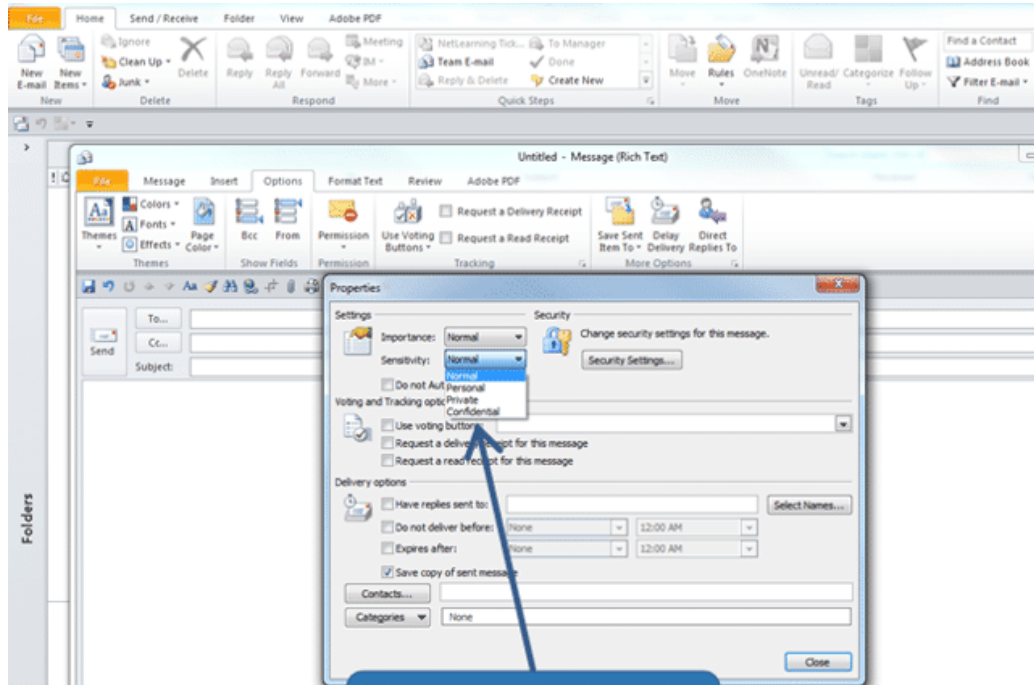
# Change Sensitivity



4. Select the drop down next to "Sensitivity".

## Step 5

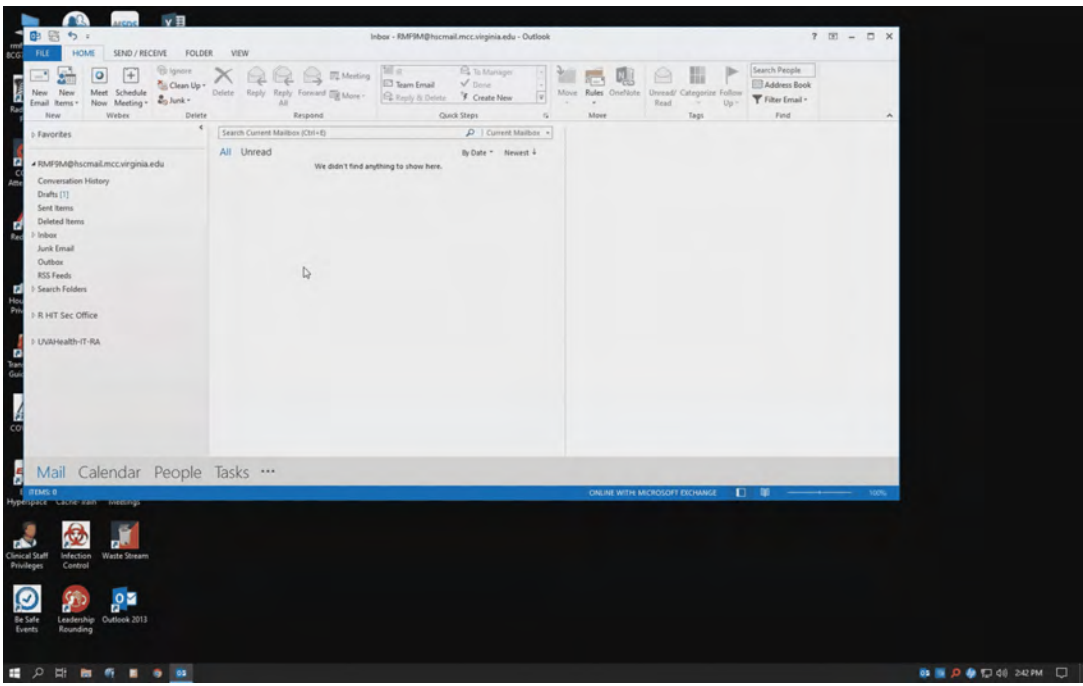
# Change to "Confidential"



5. Select Confidential

Step 6

**Watch a Video of This**





## Finished

By following these steps, you can encrypt your email to be sent outside the MC Outlook account.

Alternative Method for securing email: Type **[SECURE]** in the subject line. **Be sure to include the brackets.**

You should still **be diligent** about making sure the recipient's address is correct.

### Transcript of the Video

To send an encrypted email to an outside recipient in Outlook, start by creating a new message. From here, select the options tab on the ribbon bar and look for the button on the right-hand corner of the more options section change the sensitivity to confidential. Once completed, click close to return to your message and compose as you normally would. An alternative way to send an encrypted email is to simply create a new email. In the subject line, start it with [Secure] (enclosed in square brackets). From there, compose your email as you normally would and send.

## USB Drive Encryption

To encrypt sensitive/confidential information or ePHI on a portable drive:

1. Insert the thumb drive or external storage device into the USB port
2. Follow the prompts to begin the encryption process

3. After installation, create a folder labeled PHI or phi

4. Place ePHI in this folder

a. Only files placed in the PHI/phi folder will be encrypted







b. **IMPORTANT: Do not delete the files that are automatically generated. Doing so may corrupt the encrypted files and make recovery impossible.**

Click the < icons to learn what the files are on an encrypted USB Drive.

R90TFE8H > USB Drive (Q:)

Name	Date modified	Type	Size
_EMS_Config_Data_Dir_	5/5/2020 4:07 PM	File folder	
Access Encrypted Files (Mac).dmg	4/24/2019 9:22 PM	DMG File	9,969 KB
AccessEncryptedFiles.exe	4/23/2019 3:44 PM	Application	393 KB
autorun.inf	4/23/2019 3:16 PM	Setup Information	1 KB
PHI	5/5/2020 4:09 PM	File folder	

R90TFE8H > USB Drive (Q:)

Name	Date modified	Type	Size
 _EMS_Config_Data_Dir_	5/5/2020 4:07 PM	File folder	
 Access Encrypted Files (Mac).dmg	4/24/2019 9:22 PM	DMG File	9,969 KB
 AccessEncryptedFiles.exe	4/23/2019 3:44 PM	Application	393 KB
 autorun.inf	4/23/2019 3:16 PM	Setup Information	1 KB
 PHI 	5/5/2020 4:09 PM	File folder	

## PHI Folder

Place ePHI in this folder. Only files placed in the PHI/phi folder will be encrypted.

R90TFE8H > USB Drive (Q:)

Name	Date modified	Type	Size
_EMS_Config_Data_Dir_	5/5/2020 4:07 PM	File folder	
Access Encrypted Files (Mac).dmg	4/24/2019 9:22 PM	DMG File	9,969 KB
AccessEncryptedFiles.exe	4/23/2019 3:44 PM	Application	393 KB
autorun.inf	4/23/2019 3:16 PM	Setup Information	1 KB
PHI	5/5/2020 4:09 PM	File folder	

### Dell-generated files

Do not modify or delete these files.

CONTINUE

## Information Security – Securing Medical Devices and Systems

Protecting medical devices from cyber threats is essential to maintaining patient safety, privacy, and the overall quality of care provided by UVA Health. It is immensely important to prevent attackers from gaining unauthorized access or control over medical devices and the data they generate.

**We need your help to keep UVA Health medical devices and systems secure.**



Help keep medical devices at UVA Health secure by:

- Only introducing approved medical devices and solutions into the UVA Health environment.
  - All medical devices MUST be **evaluated** and **approved** by UVA Health Clinical Engineering. Search **New Medical Device Request** in KnowledgeLink.

- All medical devices **MUST** have an HIT Security risk assessment performed on them **before** procurement commences. Search **UVA Health Risk Assessment Process** in KnowledgeLink. There you will find the Guide for Purchasers of IT-Enabled Resources.
- Keeping track of medical devices and ensuring that they are returned to their proper storage locations.
- Immediately reporting lost, misplaced, or stolen medical equipment to the UVA Health Clinical Engineering team.
  - Never plug any unapproved device into medical equipment – **medical devices are NOT places to charge your phone.**
  - Only use medical devices for their intended, official purposes - **NEVER use medical devices to browse the internet or check your email.**



**Report misuse of medical devices or systems to Clinical Engineering at 434-924-2391.**

**CONTINUE**

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Choose Your Role

---

## Choose Your Role

To begin the course, choose below on how (or if) you interact with patients.

### **Provide Direct Patient Care**

I provide direct patient care. Including roles such as: Nursing, Credentialed Providers, Techs, Phlebotomist, Therapies, Physicians, Pharmacy, etc..

DIRECT CARE

### **Interaction With Patients: Do Not Provide Direct Care**

I have contact with patients, but do not provide direct care. This includes roles such as: Social Workers, Security, Chaplain, Environmental Services, Food Services, Transporters, Pharmacy, and Patient Access.

PATIENT CONTACT

### **No Patient Contact, but Contact With Specimens**

I do not interact with patients, but I do handle specimens. This includes roles

such as: Lab Specialists and Clinical Research Coordinators.

SPECIMEN CONTACT

**Emergency Medical Services**

I am part of EMS staff and provide patient care, but my role is only with Emergency Medical Services.

EMS

**Physical Plant**

I am a part of Facilities Management and/or Health System Physical Plant (HSPP).

PHYSICAL PLANT

**No Patient Contact At All**

I have no contact with patients nor specimens and am not involved in patient care. This includes roles such as Finance, HIT Support, and Human Resources

NO PATIENT CONTACT



# All Patient Care

---

## Instructions



## Patient Care Section

This content is required for anyone who has direct patient care. Although the education included here is required for your role, it may not be presented in the same way you see these situations in your work environment. Please reflect on how the information is relevant to your role.

This section will take approximately 20 - 25 minutes to complete.

---

### **Don't Provide Direct Care?**

Click here to return to choose your role again.

GO BACK

## **Pediatrics**



The course is created for all of UVA Medical Center. It is recognized that there are nuances in each work environment, but when there are differences in how a pediatric patient situation should be handled, you will see this icon. Click on it to learn about the pediatric situation.

## **Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Advance Care Planning and Advance Directives for Patient Care

---

## What is Advance Care Planning?

Advance Care Planning (ACP) is a process of planning for future healthcare decisions. The process includes understanding what decisions may need to be made in the future; reflecting on personal experiences, values, goals, and preferences for care; and communicating these to loved ones and the healthcare team. Ideally, these conversations begin with a focus on surrogate decision making, occur well before a crisis, and lead to the creation of good-quality ACP documents such as advance directives. Good quality ACP documents provide the kind of information that helps guide medical decision-making. Patients have the right for their ACP documents to be honored and incorporated into their plan of care.

Forms and Education are available in KnowledgeLink - search "Advance Care Planning Form".

## Advance Directives

The Virginia Health Care Decisions Act permits the creation of and reliance upon an advance directive made by an adult to put their wishes regarding medical care in writing.

It provides for any of the following:

- Appointment of an agent (and successor agent) to make health care decisions for an incapacitated patient;
- The patient's health care preferences;

- Stipulation of an anatomical gift(s), after the patient's death.

The University of Virginia Medical Center informs patients in an inpatient or ambulatory setting of their right to complete an advance directive. The health care team uses the advance directive to plan care for patients that align with their care preferences. A copy of the written advance directive must be scanned into the patient's medical record.

To be valid, the advance directive must be signed by the patient and have signatures from **two (2)** adult witnesses. For questions about ACP documents, contact Health Information Management (HIM) at [CLHIMACP@uvahealth.org](mailto:CLHIMACP@uvahealth.org) or 434-924-5136.

## Find Advance Care Planning Documentation in Epic

Advance Care Planning (ACP) Documentation is easily located in Epic. Hovering over the ACP line in the storyboard will display and link to essential ACP documentation:

- Legally authorized health care decision maker(s)
- ACP Notes
- ACP Documents

**RNs, LIPs, and Social Workers:** Information about a patient's legally authorized decision makers should be reviewed at every patient encounter and updated when necessary.

**KB**  
206A  
**Krispy P. Bacon**  
Legal: Kris P. Bacon  
Female, 75 y.o., 1/5/1949  
MRN: 5332208  
Language: English  
Code: Not on file  
**ACP: Click to Review**  
Implants: None  
Blood Collection: Unit

Acuity Level: None  
COVID-19 Vaccine: Unknown  
Isolation: None  
Research: None Active  
No attending provider

**Allergies (2)**  
VTE: High Risk - Surg  
Primary Team: Attending Only  
RN: Nurse E (Pg: 813-241-2353)  
Active Consult(s)  
ED ROOMED: 4/9/2023 (319 D)  
Patient Class: Inpatient  
Psychiatry  
No active principal problem

Height: 185 cm (6' 0.84")  
Last Wt: 81.6 kg (180 lb)  
BMI: 23.86 kg/m<sup>3</sup>  
BSA: —

**Health Care Agent/Surrogate Decision Maker**  
Bacon, Sal T. Healthcare Agent Named In Advance Directive - Father Not Active

**ACP (Advance Care Planning) Notes**  
Create ACP Note  
Date of Service Author Author Type Status  
02/12/24 1606 Addend Carter, Jeffrey Signed  
02/12/24 1550 Addend Worker, Social Social Worker Addendum

**Advance Care Planning Documents**  
Documents without received dates are displayed at the bottom.

Document Type	Status	Effective Date	Expiration Date	Received On	Description
Advance Directives and Living Will NDT VALIDATED	Received			05/28/24	
Durable DNR Scan	Received			03/22/24	
Advance Directive Combined Scan	Received			03/08/24	

**Reference Documents**  
ACP Document Types Virginia Decision Making Hierarchy Glossary Of Patients' Supporting Roles

## Capacity

Check to see if a capacity assessment form has been completed before asking a surrogate to make decisions. Certification by a capacity reviewer is **not** required if the patient is unconscious or experiencing a profound impairment of consciousness due to trauma, stroke, or other acute physiological condition. If there is no capacity assessment, but there are questions about the patient's ability to make decisions, confer with the patient's medical team.

## Continue to the Next Section

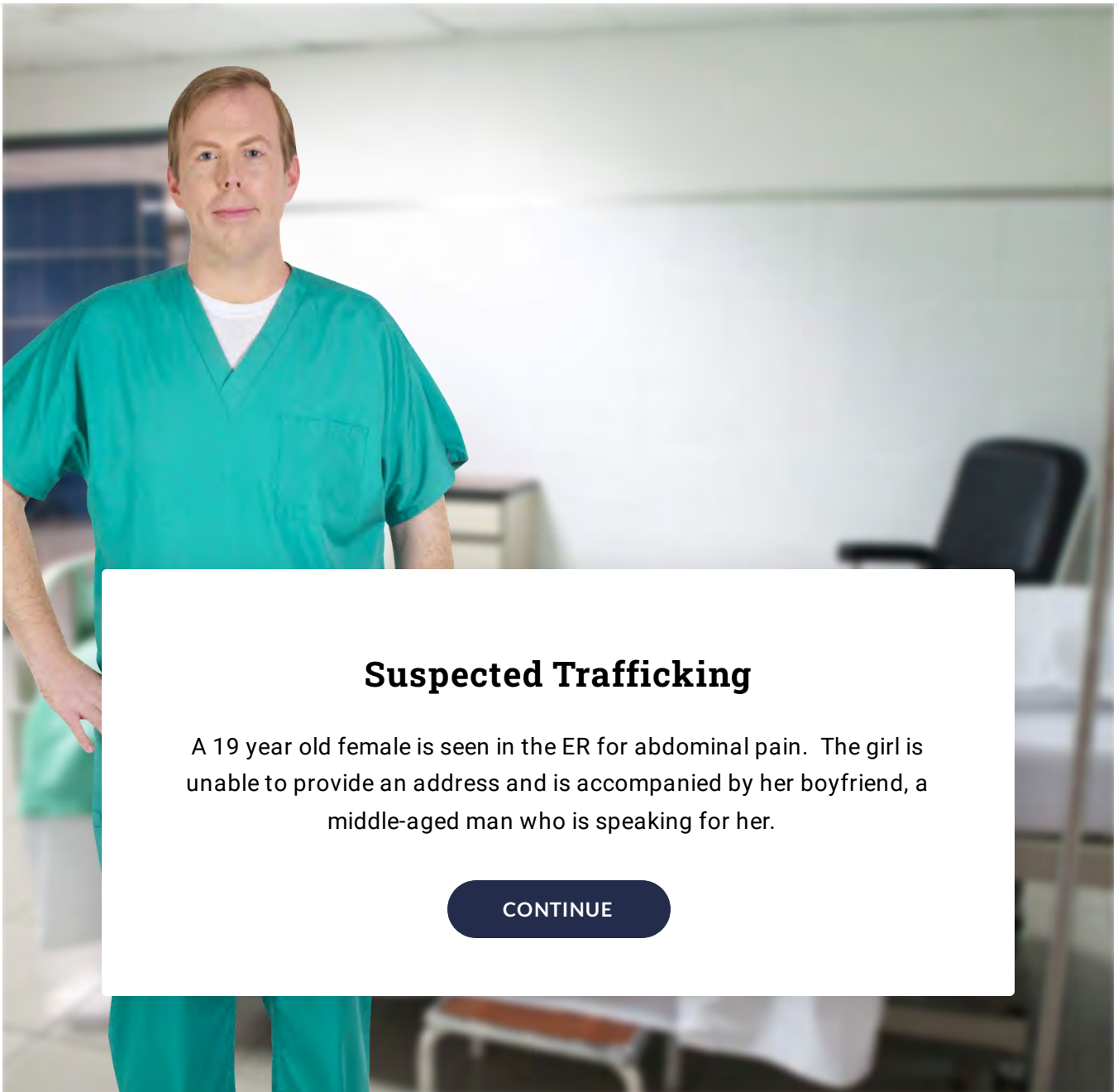
Click Continue to move to the next section.

CONTINUE

# Suspected Abuse

---

## Suspected Abuse of a Patient



## **Suspected Trafficking**

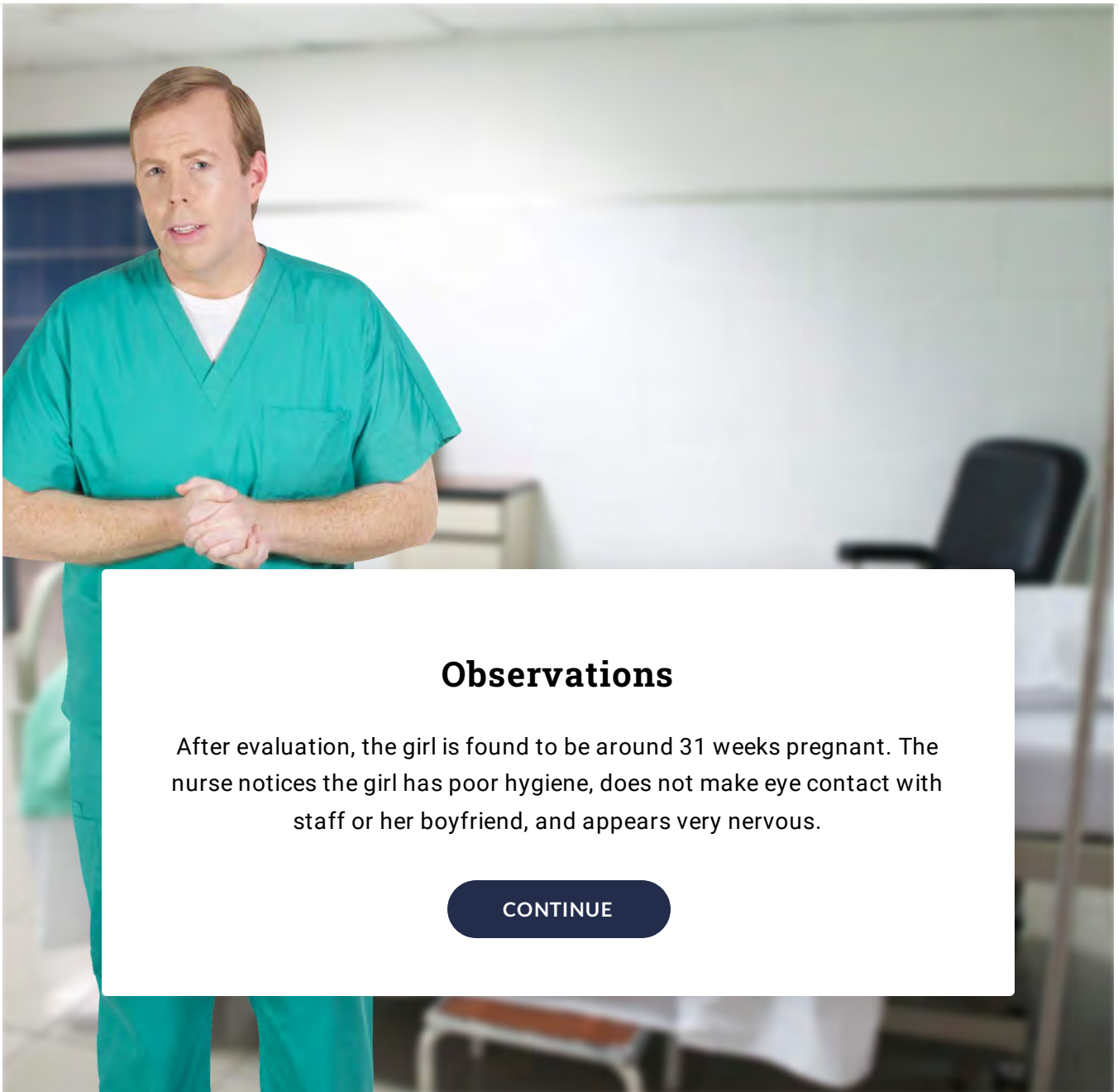
A 19 year old female is seen in the ER for abdominal pain. The girl is unable to provide an address and is accompanied by her boyfriend, a middle-aged man who is speaking for her.

**CONTINUE**

### **Scene 1 Slide 1**

Continue → Next Slide





## Observations

After evaluation, the girl is found to be around 31 weeks pregnant. The nurse notices the girl has poor hygiene, does not make eye contact with staff or her boyfriend, and appears very nervous.

CONTINUE

### Scene 1 Slide 2

Continue → Next Slide



The patient tells you that she has to go to work, so is in a hurry to be discharged. What should you do?

1

The patient is medically stable, so it is safe to send her home with her boyfriend.

2

Report your concerns about the patient to the Social Worker on duty.

3

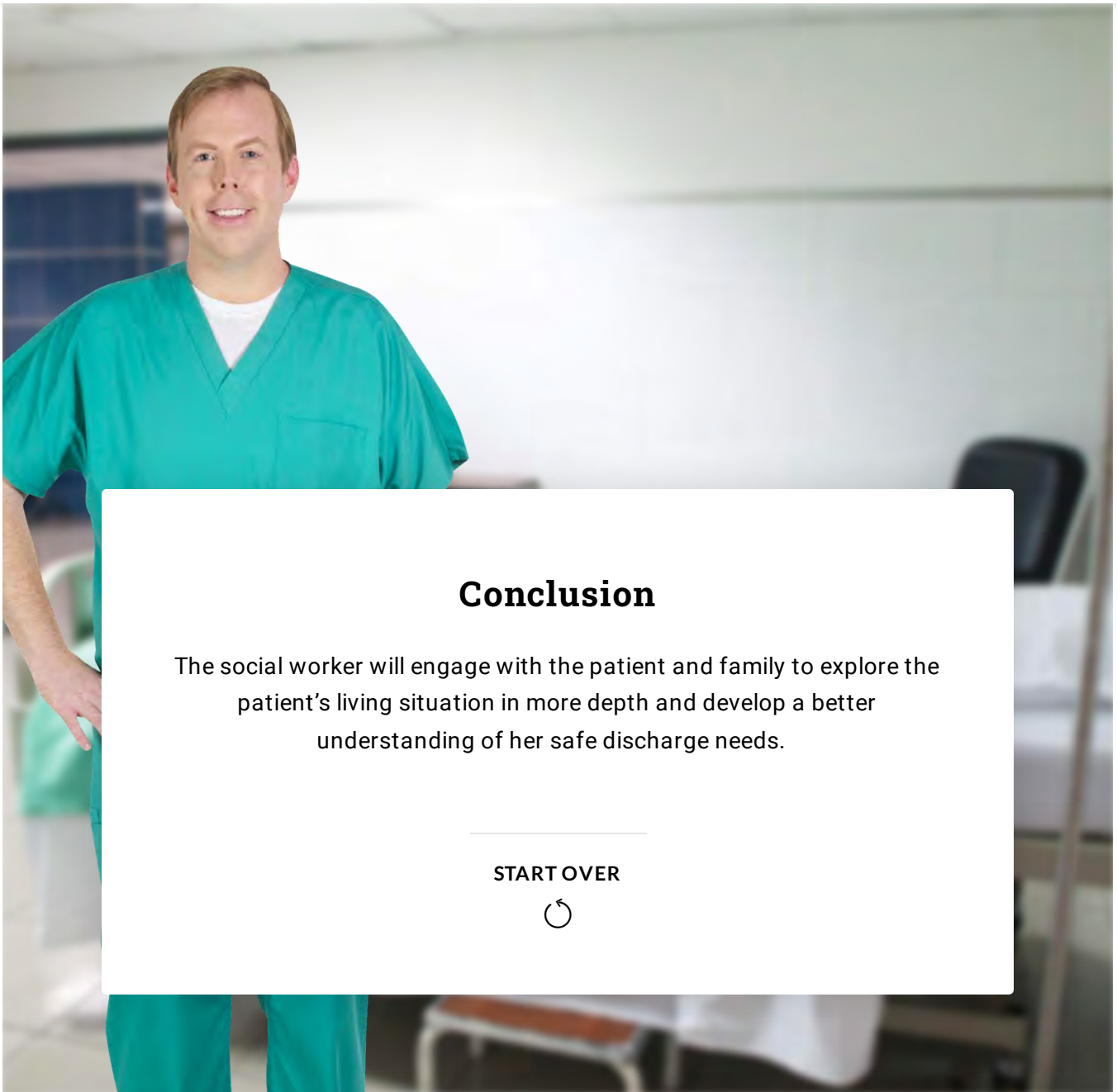
Give the patient information about human trafficking in her discharge instructions and hope she is safe.

### Scene 1 Slide 3

0 → Next Slide

1 → Next Slide

2 → Next Slide



## Conclusion

The social worker will engage with the patient and family to explore the patient's living situation in more depth and develop a better understanding of her safe discharge needs.

---

START OVER



### Scene 1 Slide 4

Continue → End of Scenario

CONTINUE

## What Is Human Trafficking?

### Are you a victim of human trafficking?

Human trafficking is modern-day slavery and involves someone trying to trick, threaten or force you to do work or have sex for money or something of value.

**You may not know you are a victim.**

Has anyone:

- Ever convinced you to have sex for money or something of value?
- Forced you to work to pay off money you owe?
- Lied about the work you would be doing?
- Threatened you or your family?

This is **illegal** – no matter your immigration status.

**You can get help.** There are laws in the United States and Virginia to keep you safe from human trafficking.

If you or someone you know is being scared or forced into any activity (sex for money, housework, farm work or any other activity) and cannot leave, **help** is available.

#### National Human Trafficking Hotline

**Call** 1.888.373.7888  
**Text** **INFO** or **HELP** to:  
**BEFREE (233-733)**

You may also speak to your healthcare provider.

#### The Hotline is:

- 24/7 Toll-Free
- Anonymous
- Confidential
- Available to non-English speakers
- Able to provide help and referral to services, training and general information

### ¿Es usted víctima de tráfico de personas?

La trata o el tráfico de personas es una forma moderna de esclavitud en la que alguien lo(a) trata de engañar, amenazar o forzar para que trabaje o tenga relaciones sexuales a cambio de dinero o de algo de valor.

**Tal vez usted no sepa que es una víctima.**

Alguna vez alguien:

- ¿Lo(a) convenció de que tuviera relaciones sexuales a cambio de dinero o algo de valor?
- ¿Lo(a) forzó a trabajar para pagar una deuda?
- ¿Lo(a) engañó con respecto al trabajo que le dijo que usted iba a hacer?
- ¿Amenazó a usted o a su familia?

Esto es **ilegal**, sea cual sea su situación de inmigración.

**Usted puede conseguir ayuda.** En los Estados Unidos y en Virginia hay leyes que lo(a) protegen contra el tráfico de personas.

Si usted o alguien que conoce está siendo intimidado o forzado a hacer cualquier actividad (por ejemplo, sexo por dinero, labores domésticas o trabajo de granja) y usted no se puede escapar, hay **ayuda** disponible.

#### Línea Nacional Contra la Trata de Personas

**Llame al 1.888.373.7888**  
**Mensaje de texto** **INFO** o **HELP** a:  
**BEFREE (233-733)**

También puede hablar con su profesional de la salud.

#### La línea directa:

- Funciona 24/7 y es gratuita
- Es anónima
- Es confidencial
- Atiende en muchos idiomas
- Puede ofrecerle ayuda y recomendarle servicios, capacitación e información general



You will see the above Human Trafficking signs throughout UVA Health. You may click on the link to enlarge it.

According to one study, 87.8% of trafficking victims encounter a healthcare professional while captive, and few, if any, of these encounters result in the victim being freed because of lack of training to recognize victims of human trafficking. Visit the Human Trafficking Hotline webpage to see the signs and warnings of possible human trafficking.

If you see these signs, are not sure, or just have a hunch, contact the social worker. The social worker will engage with the patient and family to explore the patient's living situation in more depth and develop a better

understanding of her safe discharge needs.

## Continue to the Next Section

**Click Continue to move to the next section.**

CONTINUE

# Bariatric Sensitivity for Patient Care

---

## Respect - Language Matters

Individuals with obesity often report that some healthcare professionals can view them as lacking self-control, lazy, and non-compliant.

Using people first language is a way to make patients feel seen and heard in a respectful way.

Caring, without judgement, and being sensitive to situations that can be embarrassing, such as taking their weight, can improve the patient experience for the patient with obesity.

## Continue to the Next Section

**Click Continue to move to the next section.**

CONTINUE

# Language Services for Patient Care

## Language Services

UVA Health serves the communities we care for. One of the free services provided to patients and guests requiring communication assistance is the availability of an interpreter.

Consider this scenario.

### Language Services

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.

Submit




(Multiple Choice, 10 points, 1 attempt permitted)

**Language Services**

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.

**Submit**



Correct	Choice
	Explain to him that there are no translators, and you can write messages between each other.
X	Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
	Ask him to bring someone with him who can help him communicate with the medical team.

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

That is incorrect.




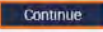
## Correct (Slide Layer)


**Language Services**

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.

 **Correct**  
That's right! You selected the correct response.






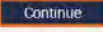
## Incorrect (Slide Layer)


**Language Services**

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.


 **Incorrect**  
That is incorrect.





## 1.2 Transfusion Time Out Education

**Language Services**



**The correct answer is:** Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.

**Additional Information:**

- Interpreters are available for patients who require language services, including foreign languages and American Sign Language (ASL). The language services flag in Epic is what triggers the language services team to know who needs this service.
- If the visit is scheduled, the Language Services Department will attempt to schedule an in-person interpreter based on availability.
- If the in-person interpreter is not immediately available, Globo must be utilized for the video or audio remote interpreting service.
- Documenting the use of interpreters whether in-person, video, or over the phone, must be done in Epic for each encounter or interaction to comply with legal and regulatory requirements.
- If an interpreter was offered, but the offer was declined, this must also be documented in Epic.

**CONTINUE**

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Clinical Alarms

---

Clinical Alarms content is required for many. Due to the navigation of the course, you may see this even if you do not have it as part of your role. If you are not involved with equipment with alarms, you can scroll down to skip this section.

## Clinical Alarms



According to Clinical Alarm Management Medical Center Policy, all health care providers who are involved with patient care are responsible for addressing clinical alarms.

Appropriate actions include:

- Correcting the condition associated with the alarms
- Communicating with the appropriate direct care provider/shift manager for further investigation
- Resolution of any alarms



## Scenario

A Team Member, who is a part of patient care, is sitting at a work station when she hears a clinical alarm sounding for a patient that is not her own. No one else is currently available.

Who is responsible for responding to the alarm?

---

- Only the RN assigned to the patient.
- All patient care providers involved with patient care.
- The HUC
- Environmental Services, who is going to the room in a moment

SUBMIT

**Continue to the Next Section**

Click Continue to move to the next section.

CONTINUE

# Food and Drink in Patient Areas

---

**Food and Drink in Patient Areas**



## Food and Drink in Patient Areas

Answer these two questions.

CONTINUE

### Scene 1 Slide 1

Continue → Next Slide





Paulina is returning with her lunch. When she comes back, she remembers that she needs to send a quick text page from the nurses station before sitting to enjoy her lunch. What should she do?

1

Drop off her lunch in the break room, then go send the text page. After she is finished, she returns to eat her lunch.

2

Take the lunch with her to send the text page. It will just take a minute.

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



A friend of a patient brought in some takeout food from a local restaurant; however, when the friend came, the patient was asleep. Instead of waking her, the friend asks Paulina to give it later.

1 Paulina takes the food and brings it to the refrigerator in the nutrition room, labeling and dating the food.

2 Paulina thinks the patient would appreciate having the food when she wakes, so she leaves it on the bedside table.

### Scene 1 Slide 3

0 → Next Slide

1 → Scene 1 Slide 3



## **Food Procedures**

Food and drink are not allowed in patient areas, and only covered drinks are allowed in common areas. Food brought in for patients must be stored in designated areas and be properly labeled.

---

**START OVER**



### **Scene 1 Slide 4**

Continue → End of Scenario

**Continue to the Next Section**

Click Continue to move to the next section.

CONTINUE

# Hand Hygiene and PPE for Patient Care

---

## Standard Precautions

Standard Precautions are designed to reduce the risk of transmitting microorganisms from sources of infection in healthcare settings. Standard Precautions apply to all patients and in all situations, regardless of diagnosis or presumed infection status.



**All patients can carry infectious agents.**

To reduce the risk of transmitting disease, it is essential that you adhere to Standard Precautions when caring for ALL patients. The six components of Standard Precautions are:

- Hand hygiene
- Personal protective equipment

- Surface disinfection
- Safe injection practices
- Respiratory hygiene / cough etiquette
- Infection control practices for special lumbar puncture situations
- Infection control practices for aerosol-generating procedures (AGP)

---

**Assess every patient situation to determine when and how to use Standard Precautions.**

**Principles of Hand Hygiene**

# The 5 Moments for Hand Hygiene.

**1** Before touching a patient.

**2** Before a clean / aseptic procedure.

**3** After a procedure or body fluid exposure risk.

**4** After touching a patient.

**5** After touching a patient's surroundings.



- There are many hand hygiene opportunities to prevent HAIs.
- Hand hygiene monitoring program collects observation data on two of those opportunities.
- Hand hygiene is required before entering and upon exiting a patient's room/space or treatment area.



- Practicing consistent hand hygiene also helps prevent the spread of illnesses at home and in the work place.

---

## **Gloves Are NOT a Substitute For Hand Hygiene**

**Glove use does not replace the need for hand hygiene.**

Hand cleaning is still necessary before donning and after doffing gloves because:

- When uncleaned hands touch gloves, the outside of the gloves can become contaminated and spread microorganisms to the patient, a device, or the environment.
- Bacteria can multiply rapidly on gloved hands.
- Gloves can have micro tears or become perforated during use.

# **Gloves are single use**

---

**Only wear one pair at a time,  
NO double gloving**



---

**Do not wear gloves beyond patient room/space.**

**Use Alcohol Sanitizer: 20 Seconds**



- For patient care activity when soap and water is not needed

**Use Soap and Water:**



- When your hands feel sticky or are soiled
- After removing PPE when caring for a patient with C. difficile, norovirus, adenovirus, or unexplained diarrhea

**Hand Skin Integrity Tips:**



Skin irritation can be caused by inadequate rinsing: the chemicals and fragrances in soaps can cause reactions if they are allowed to remain on the skin.

Use ONLY the hospital-provided hand lotion several times each day when you can allow it to remain on your hands for at least 30 minutes. The hand care products are formulated to work together.

---

## **Principles for Hand Hygiene**

Flip through the section to see standard work for hand hygiene in a patient care setting, beyond the 5 Moments of Hand Hygiene from above. Click **Start** to begin.

## Hands Full

Perform hand hygiene with alcohol-based hand rub (ABHR) or soap and water: **Immediately after** carrying items into room if hands are full upon entry, or upon exit or after cleaning patient equipment. (Hand hygiene should be performed before gathering items.)

## Food and Medication

Perform hand hygiene with alcohol-based hand rub (ABHR) or soap and water: **Before preparing or serving food** or administering medications.



## Summary

Improving the hand hygiene of health professionals is one of the most effective ways to prevent HAIs.

CONTINUE

### Dress for Success - Personal Protective Equipment (PPE)

- Standard precautions are based on your clinical judgement.
- Remember to use the PPE you need for your patient situation.
- Hospital Epidemiology may order additional PPE based on your patients' specific conditions.

## Gloves



Don gloves when anticipating contact with body fluids.

## Eye Protection



Wear eye protection if spraying, splashing, or splatter to your face is possible.

# Mask



Wear a mask if spraying, splashing, or splatter is possible. Certain conditions require special masks. Pay attention to isolation signs for direction.

CONTINUE

---

**Aerosol-Generating Procedures (AGPs)**

# Aerosol-Generating Procedure (AGP) In Progress

## To Enter:



- Staff wear N95 + Eye Protection (or PAPR)



- Visitors and Roommates, wear Standard Mask

TIME PROCEDURE ENDED:

TIME SIGN TO BE REMOVED\*:

OR

- CONTINUOUS AGP: If , leave sign posted until AGP is discontinued plus the time to achieve 99% removal of aerosols

\*TIME SIGN TO BE REMOVED = End of the AGP plus number of minutes for 99% aerosol clearance for this room (see back for room/area-specific times). Default is 60 minutes unless otherwise specified.

AGP precautions should be followed for all patients during chest compressions (CPR), intubation, or extubation.

For the procedures listed below, AGP precautions apply to patients with known or suspected respiratory infection/condition due to a respiratory pathogen that requires Airborne OR Droplet Precautions.

- Airway surgeries including tracheostomy
- Autopsy, clinical, surgical (sinopulmonary), and laboratory procedures that may aerosolize pathogens, such as operating bone saws, centrifuges, blenders, and aspiration equipment
- Bronchoscopy
- Cardiopulmonary resuscitation
- Endotracheal intubation and extubation
- Pulmonary Function Test
- Open suctioning of airways
- Sputum induction

## Transmission-Based Precautions

The hospital implements transmission-based precautions in response to pathogens that are suspected or identified within UVA Health.

### Precautions include:

- Contact
- Airborne
- Droplet
- Contact & N95 Respirator & Eye Protection
- Enteric precautions

**Visitors: Please See Nurse BEFORE Entering**  
**Visitas: Por favor hablen con la enfermera ANTES de entrar**

# CONTACT ISOLATION



**CLEAN HANDS**  
Lávarse las manos



**GOWN**  
Vestido



**GLOVES**  
Guantes

- Visitors must report to the Nurse's Station **FIRST**
- When entering the room, clean hands, wear a gown, and wear gloves.
- When leaving the room, remove gloves and gown, discard all trash, and clean hands

---

**Special Precautions for Lumbar Puncture**



Wear a mask that **covers the mouth and nose** when performing a lumbar puncture.

An investigation conducted by the Centers for Disease Control and Prevention (CDC) of post-myelography meningitis revealed that germs causing disease in patients came from the mouths of the providers who performed their lumbar punctures.

**Continue to the Next Section**

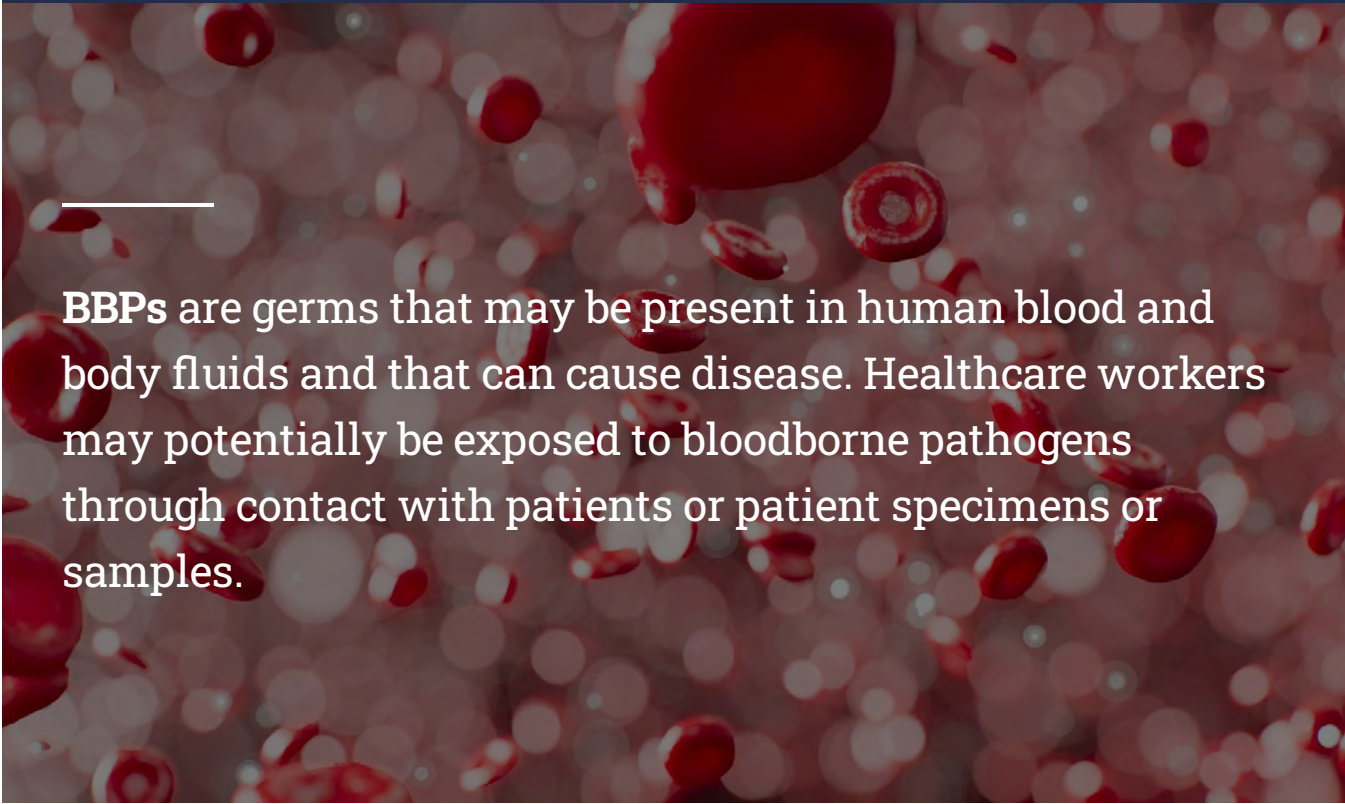
Click Continue to move to the next section.

CONTINUE

# Bloodborne Pathogens for Patient Care

---

## Overview of Bloodborne Pathogens (BBPs)

A microscopic view of red blood cells, showing various sizes and shapes of the cells against a dark red background.

BBPs are germs that may be present in human blood and body fluids and that can cause disease. Healthcare workers may potentially be exposed to bloodborne pathogens through contact with patients or patient specimens or samples.

Some of the diseases that can be transmitted through blood and body fluids include:

- Human Papillomavirus (HPV)
- Hepatitis C (HCV)
- Human Immunodeficiency Virus (HIV)



At UVA Health, we follow the **OSHA** Bloodborne Pathogens Standard. This set of federal regulations outlines "Standard Precautions" to protect team members from exposures to bloodborne pathogens.

CONTINUE

## Bloodborne Pathogen (BBP) Standard



OSHA's **Bloodborne Pathogens Standard (29 CFR 1910.1030)** as amended pursuant to the **2000 Needlestick Safety and Prevention Act**, is a regulation that prescribes safeguards to protect workers against health hazards related to bloodborne pathogens. It has provisions for exposure control plans, engineering and work practice controls, Hepatitis B vaccinations, hazard communication and training, and recordkeeping. The standard imposes requirements on employers of workers who may be exposed to blood or other potentially infectious materials such as certain tissues and body fluids.

In addition to Standards Precautions and Hand Hygiene mentioned in the previous section, also dispose of medical waste in proper containers and consider receiving the Hep B vaccine series.

CONTINUE

## BBP Transmission & Exposure

Flip each card below to see the ways in which BBPs can be transmitted.

Skin injury

Through needlesticks,  
scalpel cuts, etc.

Contact with Infected Fluids

Spray, splash, or splatter into  
the eyes, nose, mouth, or  
broken skin

Perinatally

From an infected mother to child during pregnancy, childbirth, and breastfeeding

Sexual Contact

Through unprotected sex and transfer of blood, semen, or vaginal secretions

High-Volume Blood Contact

Instance of contact with blood covering a large area of skin that seems to be intact

**CONTINUE**

## **What to Do**

At UVA, we take a comprehensive approach to the prevention of bloodborne pathogen transmission. This includes clear guidelines for infection prevention and control, specific policies and practices that provide protection, and education of our staff to limit exposure and reduce transmission if exposure does occur including:

- Surveillance and analysis of exposures and infections through a comprehensive Team Member Injury Prevention Program
- Evidence-based policies and procedures (Infection Control Manual)
- Education and training of staff in safe practices
- Availability of personal protective equipment

- Use of safer medical devices (including invention and study of safety devices)
- Vaccination of those at risk for hepatitis B
- Rapid and effective response in the event of exposure
- Targeted interventions based on role-specific hazards

CONTINUE

## Exposure Follow-up

In Virginia, the deemed consent law is in effect. This means that if a healthcare worker is exposed to a patient's blood or body fluids, the patient's permission is not required to test the patient's blood for bloodborne pathogens and vice-versa. The patient is deemed to have given consent for such testing when admitted. The patient will be notified of the testing and counseled by his or her doctor regarding the results.

### Follow-up Protocol

Testing, follow-up, and counseling are provided after an exposure. Based on evaluation of the incident (PIC #1523), treatment may be indicated. Click each BBP below to see related treatment.

#### HIV —

For maximum effectiveness, antiretroviral medication to prevent infection should be given within the first 2 hours after exposure.

## **HBV** —

For those who are not immune, Hepatitis B Immune Globulin may be given up to 7 days after exposure, the sooner the better.

## **HCV** —

If found to have acquired hepatitis C, the team member will be referred for evaluation. Early antiviral therapy has resulted in a higher cure rate.

## **Preventing BBP Exposures**



Each work area has a written **Exposure Control Plan** and it is kept in the Red Book. Review the plan in your work area to learn more about:

- Potential exposure risks and steps to prevent them
- Sharps safety devices available in your work area
- Steps to take in the event of an exposure

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Team Member Injury Prevention: Sharps

---

Sharps content is required for many. Due to the navigation of the course, you may see this even if you do not have it as part of your role. If you are not involved with injections or other sharps, you can scroll down to skip this section.

## Sharps: Injury Prevention

Click the arrows to navigate through the major steps presented for Sharps Team Member Injury (TMI) Prevention.

### RISK IDENTIFICATION



**Treat all sharps as a  
Hot Needle**



**Understand safety  
mechanism prior to  
use (Vanish Point  
retractable syringes,  
Lovenox, others)**



**Identify potential  
sharps (needles,  
lancets, glass /  
ampules, wires,  
scissors)**



# RISK REDUCTION

## Set Up/Prep



- Use blunt needle for drawing up medications
- Select retractable devices for subcutaneous insulin and heparin
- Avoid recapping

## Giving Injection



- Communicate with patient prior to injection
- Stabilize site with non-dominant hand; Inject using dominant hand
- Keep stabilizing hand on patient until safety is activated
- If retractable safety device, activate while in patient

## After Injection



- Do not touch end of device, even after safety is activated
- Clean up and dispose of sharps properly

# INVOLVING MORE THAN ONE PERSON



**Never pass sharp device**



**Dispose of your own sharps**



**Announce sharps**

# URINE SPECIMEN COLLECTION DEVICES



**Do not touch  
Vacutainer**



**Dispose in  
sharps bin**

## DISPOSAL



**Dispose promptly  
in sharps bin**



**Exchange sharps  
bin when 2/3 full**



**Do not reach into  
sharps bin or  
touch flap.**

## What to Do Following Exposure



If you are in another clinic outside the Medical Center (non-UPG), page PIC 1523 with an exposure / incident.

# WHAT TO DO AFTER EXPOSURE / INCIDENT



Page PIC 1523



**besafe™**

Complete a Be Safe Event

## POTENTIAL BLOOD OR BODY FLUID (BBF) EXPOSURE

*Feel Something? Say Something!*

### Immediate Actions



**Wash area** with soap and water  
**Rinse eyes/mouth** with water or normal saline



**Page PIC 1523**  
to determine exposure and next steps

# FIRST REPORT OF INJURY

*A separate accident form is no longer required.*

**New Process: Be Safe Event Only**



Reported Date (to file for Worker's Compensation for this report)

Give brief description of event, including date:

If 40 hours worked prior to incident:

Consecutive Days worked prior to incident:

Names of witnesses:

**Complete Be Safe  
Event with injury  
information**

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Team Member Injury Prevention: Patient Handling

---

## Patient Handling TMI Prevention (All Inpatients)

**Instructions:** Click the right or left arrow to navigate through the major steps presented in the Standard Work for Patient Handling TMI Prevention (All Inpatients) document.

### BEST PRACTICES



**American Nurses Association  
Guidelines recommend lifting less  
than 35 pounds per person.**



**Use equipment to mobilize  
patients to keep staff safe, under  
35 pound lift per person**

**[ANA Safe Patient Handling & Mobility](#)**

---

# RISK IDENTIFICATION



**Mobility assessment every shift or status change**

# OPTIMIZE RESOURCES



- **Adjust bed height to waist level**
- **Use boost function on bed**
- **Involve patient in their care, ask patient to assist**
- **Include right # of team members needed for move**
- **If not using air device, use 1 person for every 100lbs for log rolling and turning**

# COMMUNICATE MOVE



**Communicate with patient and team members prior to and during move**



**Do not force agitated patients to move. De-escalate to ensure safety.**

# PATIENT SAFETY USING DEVICES



**Never leave a patient on an inflated AFRD (HoverMatt) unattended**



**Do not use more than 3 layers**

# PLAN OF CARE



**Document equipment used for patient mobility in EHR**



**Update patient whiteboard with most current mobility plan**



**Include patient mobility status in HOC**

## SPECIALIZED INTERVENTION FOR HIGH RISK PATIENTS

**Consult Safe Patient Handling and Mobility (PIC 1568) Team for:**



**Patients with weight >350lbs**



**Patients with special mobility needs**



**Questions not answered in mobility equipment selection tool**

**CONTINUE**



## Minimal Lift Equipment

Helping patients with mobility should not cause injury to you. There are tools available for all patients. Review the image below to learn about some of the tools available and when they would be appropriate to use.

# Minimal Lift Equipment

### Mobility Level

### Out of Bed Mobility Tools

#### MAX ASSIST

Criteria: Unable to sit EOB x 2 min



Lift (floor or ceiling):  
Ceiling Lift < 800 lbs  
Golvo < 440 lbs  
Viking < 660 lbs  
PIC#  
1568 for > 800 lbs



#### MODERATE ASSIST

Criteria:



Powered sit to stand:  
Sabina < 440 lbs  
Sara+ < 380 lbs  
EZ way < 800 lbs  
Guldman (Pediatric)



#### MINIMAL ASSIST

Criteria:  
able to stand > 5sec, not  
able to march in place



Non-powered sit to stand:  
Sit to Stand:  
Sara Steady < 400 lbs  
EZ way < 800 lbs



#### AMBULATORY

Criteria:  
able to march in place



High Fall Risk may need  
safety net:  
Lift Pants, Master Vest,  
Gait Belt with Chair follow



CONTINUE

Fall Prevention

## Team Member Safety During Patient Falls

<b>PREVENT</b>	Use appropriate equipment per mobility status above
<b>ASSIST</b>	<b>DO NOT CATCH</b> Patient; ELSA: Ease, Lower, Slow, Assess
<b>RECOVER</b>	<b>DO NOT LIFT</b> ; Hover Jack for patients unable to stand independently

NEVER try to catch a falling patient, 40% of our team member injuries last year were from team members trying to stop a patient from falling.

Instead of trying to catch them or stop the fall just try to control the descent and slowly lower or assist the patient to the floor and then use the HoverJack for fall recovery. We recommend a fall assist method **ELSA: Ease, Lower, Slow, Assess.**

### **E - EASE** —

Ease the patient back onto your knee and take a step back into a staggered stance if possible. DO NOT attempt to hold them up; it is impossible to stay under ANA guidelines of 35 lbs.



## **L - LOWER** —

Slowly lower or slide the patient down your leg onto the floor/ground.



## **S - SLOW** —

Bend your knee and keep your back straight while slowing and controlling the descent of the patient supporting their head.



## **A - ASSESS** —

Once the patient is on the floor assess for injuries. (If spine injury is suspected, page MET team - 4-2012; otherwise, proceed with fall recovery using the Hoverjack.)



Questions? Reach out to the Safe Patient Handling and Mobility Team. PIC #1568 or [SPHMT@hscmail.mcc.virginia.edu](mailto:SPHMT@hscmail.mcc.virginia.edu).

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Pain Management

---

## Pain Management



UVA Health is committed to the identification and management of patient pain using non-pharmacologic, pharmacologic, and a combination of those approaches in a manner that optimizes patient comfort, ability to function, and quality of life and minimizes the risks associated with treatment.

Within their scope of practice, the health care team is responsible for screening and assessing for pain, involving patients in their pain management plan, evaluating the effectiveness of the plan, and educating patients on the safety of pain medications.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**



# Equipment Stickers

---

## Clinical Engineering Stickers for Medical Equipment

Management of Medical Devices used in Patient Care Medical Center Policy used in patient care requires that “any Medical Device, whether purchased, contracted, donated, loaned, or for trial or research, that is to be used in the Medical Center for inpatient or outpatient care purposes shall be registered with Clinical Engineering.” Clinical Engineering must inspect each device **before** clinical use!

Stickers serve as a visual indication that this registration has taken place and also indicate when the next scheduled maintenance is due. Here are the stickers you may find on medical equipment at UVAHS:



### Asset Sticker

All inventoried medical devices purchased after January 2022 are given a unique asset number that also serves as the Clinical Engineering control number. This Asset Sticker thus serves as the CE Sticker or Barcode Sticker. Devices purchased

prior to January 2022 will have this sticker only if their purchase price was greater than or equal to \$2000.



**CE Sticker or Barcode Sticker**

All inventoried medical devices purchased prior to January 2022 should have this sticker which contains the 8-digit control number used to uniquely identify each device (with the exception of a few which use the manufacturer's serial number instead as the control number). Medical devices purchased after January 2022 will use the Asset Sticker in lieu of this sticker.



**Green Sticker or Teal Sticker**

Not all medical devices require scheduled maintenance. This sticker indicates that the device has been registered with CE and passed its initial safety inspection. No additional inspection is required.

**DATE** **SER. #**

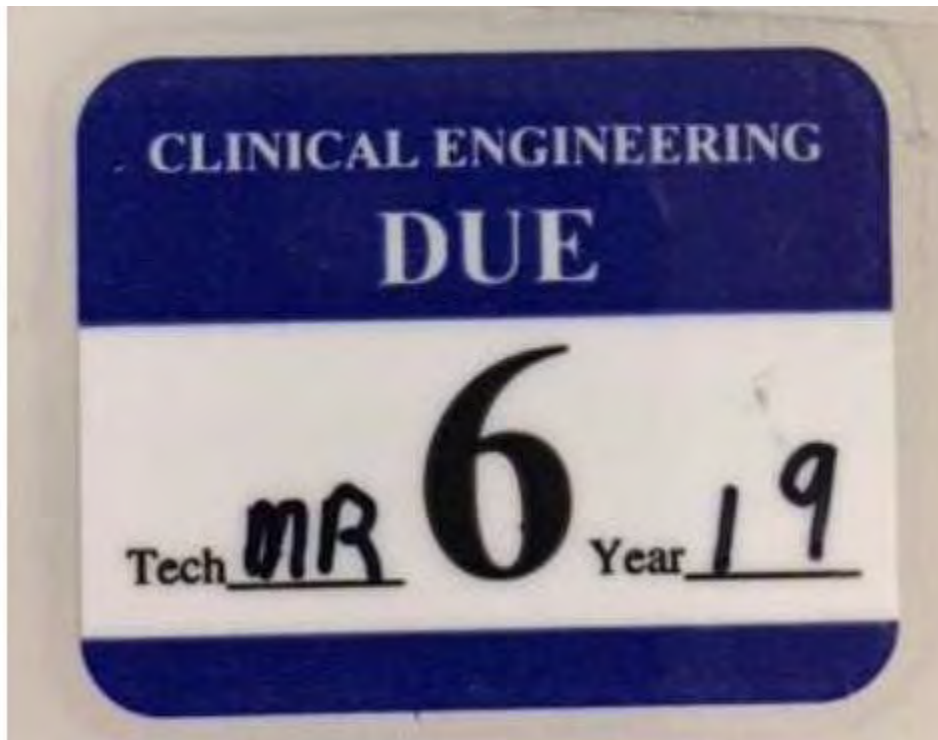
**SAFETY CHECK**

<b>Equipment Check</b>	
<b>Ground wire OK</b>	
<b>Leakage current</b>	
<b>Tested by</b>	
<b>Date next check</b>	
<b>Comments</b>	

UAL BE209

**Orange Sticker**

Devices that are not owned by UVAHS still need to be registered. This sticker indicates that a demo, loaner, or patient-owned device has been registered with CE and passed its initial safety inspection. If the device remains at UVAHS up to the “date next check” date, it will need to be re-inspected by CE.



#### **PM Sticker or Date Sticker**

All medical devices with scheduled maintenance have this sticker which indicates when the next PM is due. Here, the next PM is due by the end of June 2019. Each month has a different color.

If you see a medical device with no sticker on it, immediately call CE 434-924-2391 to arrange registration.

If a medical device has a PM sticker indicating that the PM is due, or an orange sticker with an upcoming "next check" date, notify CE 434-924-2391 to arrange maintenance.

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

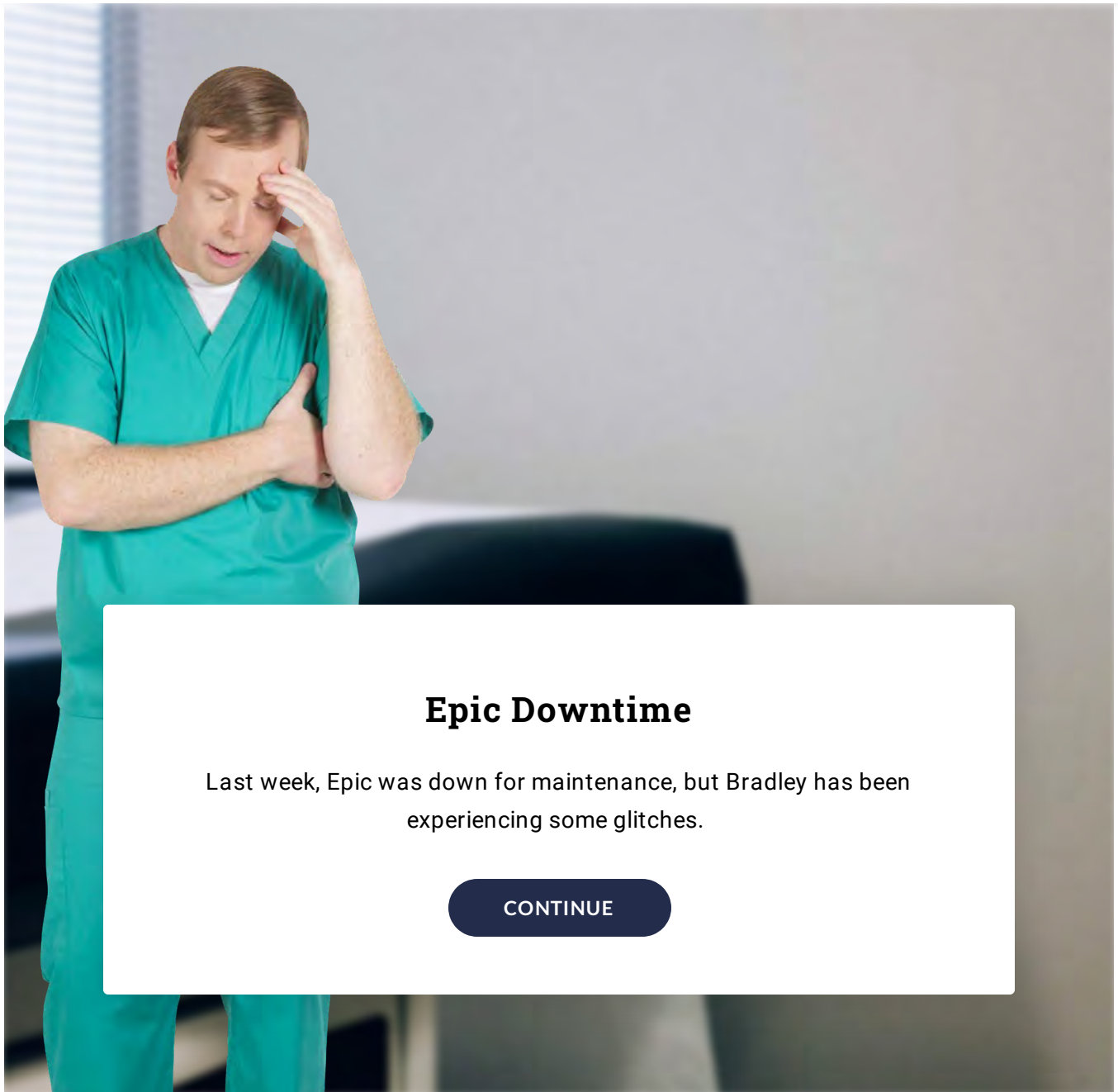
# Managing Interruptions - Epic Downtime Patient Care

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## Managing Interruptions - Epic Downtime

Having an effective response plan is critical for mitigating the impact of downtime. Patient records are critical to providing the best possible care. To ensure you are prepared for downtime, make sure that you:

- Check your required forms weekly to ensure you have a supply in case of down time.
- The team should check the Business Continuity Access (BCA) PC weekly if you have one in your area.
- Validate that the information you need is accessible and test print one record to ensure your printer is set to local and default.



## **Epic Downtime**

Last week, Epic was down for maintenance, but Bradley has been experiencing some glitches.

**CONTINUE**

### **Scene 1 Slide 1**

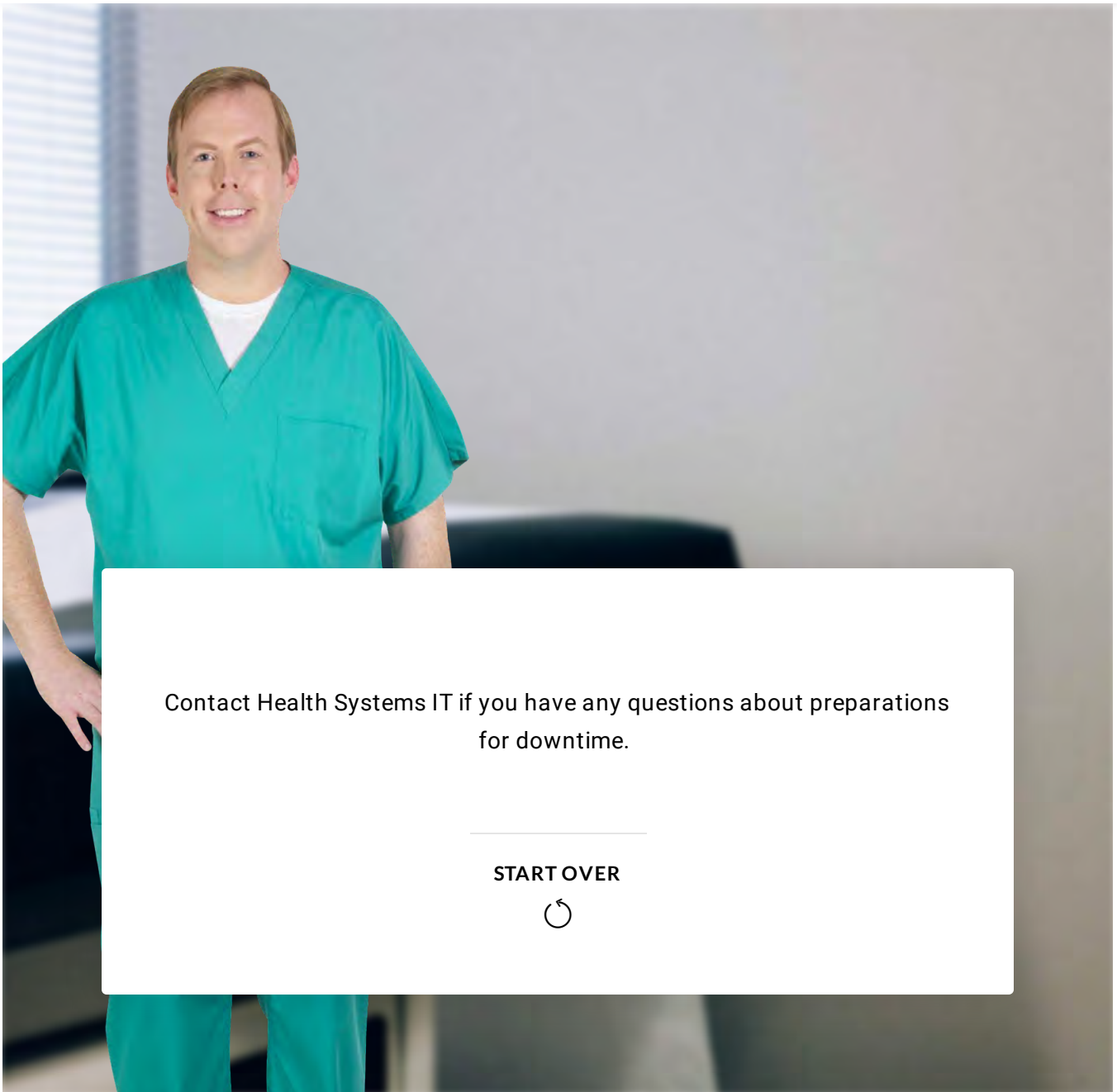
Continue → Next Slide



## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



Contact Health Systems IT if you have any questions about preparations for downtime.

---

**START OVER**



## Scene 1 Slide 3

Continue → End of Scenario





Complete the content above before moving on.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Suicide Prevention

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## Suicide Prevention

The Joint Commission (TJC) requires healthcare organizations to identify individuals at risk for suicide using evidence-based screening for patients aged 12 years or older.

- Patients with suicidal ideation can be identified in a variety of settings including emergency departments, outpatient clinics, or during admission using standardized screenings:
  - Inpatient/ED utilizes the Columbia Suicide Severity Rating Scale (CSSR-S)
  - Ambulatory uses the Ask Suicide-Screening Questions (ASQ)

Refer to Suicide Risk Assessment and Prevention Medical Center Policy.

## Screening Criteria

- Suicidal ideation
- Injuries from a suicide attempt
- Physical or behavioral indications warranting further screening
- Annually for patients in a behavioral or psychiatric clinic with a primary psychiatric or behavioral diagnosis or complaint
- 12 – 17 years of age with a history of depression (inpatient)

Note: If the patient's risk stratification changes based on the rescreening, the LIP shall be notified and the patient's Suicide Precautions order modified accordingly.



## Safety

Staff members once trained may be responsible for constant 1:1 visual observation of patients on suicide precautions which includes:

- Establish a secure environment to ensure safety.
- Removing harmful objects and equipment:

- Regularly assess and secure patient surroundings.
- Promptly remove any items that may pose a threat.
- Minimize risks by having patients remove personal clothing and shoes, and wear paper scrubs or a green gown with no ties (inpatient).
- Checking Visitor Belongings and Gifts:
  - Screen belongings and gifts to prevent harmful items from entering.

## Documentation

Documentation is required by all team members caring for a patient on suicide precautions.

Based on your role and scope of practice:

- Screenings
- Observation
- Risk Stratification & Assessment (LIP)
- Care Planning
- Discharge
- Safety Planning (LIP/Social Work)



**Note:** To find out more type Suicide into Policy Tech.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Workplace Violence - SAVE

---

## Workplace Violence - SAVE

UVA Health takes a zero-tolerance position on violent or threatening behavior in the workplace. Team Members are responsible for being alert to signs of potential aggression and reporting **all** violent or threatening behavior.

The purpose of the SAVE Program is to provide oversight and guidelines to team members to prevent injury associated with violent events within the UVA Health.



The workplace violence prevention program, titled SAVE, stands for:

- Situational
- Awareness
- Violent

- Events

Resources can be found in the SAVE desktop icon, pictured here. This desktop icon is available on any shared Health System computer desktop.



All episodes of workplace violence (including verbal, physical, & sexually inappropriate behaviors) are to be reported in **Be Safe**, under the **Workplace Violence** tile.

## Do Not Wait

### Reach out if you need help!

If you can see an escalation coming get help. Don't wait and then say 'I knew that would happen.'

Consider putting safety measures in place, such as flags in epic, security assessments, or any other tools available in the save icon.

- Contact Lauren Mathes (LEM9R@UVAHealth.org) or Janine Smith (JMS4CF@UVAHealth.org) for assistance.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**



# LVAD Aware

---

## LVAD (Left Ventricular Assist Device) Aware



An LVAD is a surgically implanted pump used to partially or completely replace the function of the failing left ventricle.

The LVAD pump is designed to continuously push blood into the circulation so this results in making it hard to feel a pulse.

LVADs require constant power from electricity or rechargeable batteries- never disconnect a patient's power.

These are examples of equipment you will see to help you identify LVAD patients.

## What To Do For A LVAD Patient In Trouble

Emergency Situations and Contacts:

- Perform usual emergency care to a LVAD patient.
- Remember it may be hard to feel a LVAD patient's pulse even when they are in their usual good health.
- **DO NOT disconnect any batteries or LVAD equipment from patient.**

Contact emergency help in accordance with your Unit Red Book.. If you are in an inpatient area, contact RN staff **then** contact the UVA Health Call Center, a.k.a. Operator to Page:

- Heart Failure Cardiologist On-Call: 9489
- LVAD Coordinator On-Call: 9823
- Perfusionists: 1286

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Organ and Tissue Donation for Patient Care

---

## Organ and Tissue Donation

Families of potential Organ and Tissue donors are grieving. Because it is typically a hard time, it is important to be particularly sensitive to their beliefs, circumstances, and wishes.

The University of Virginia Medical Center maintains a well-coordinated, compassionate, and respectful approach to organ, tissue, and eye donation that complies with state and federal laws and regulations. The Medical Center coordinates with the contracted Organ Procurement Organization, LifeNet Health, to facilitate a systematic process for notifying the OPO of potential donors, evaluating potential donors, seeking consent for donation in a respectful and sensitive manner, and recovering donated organs.

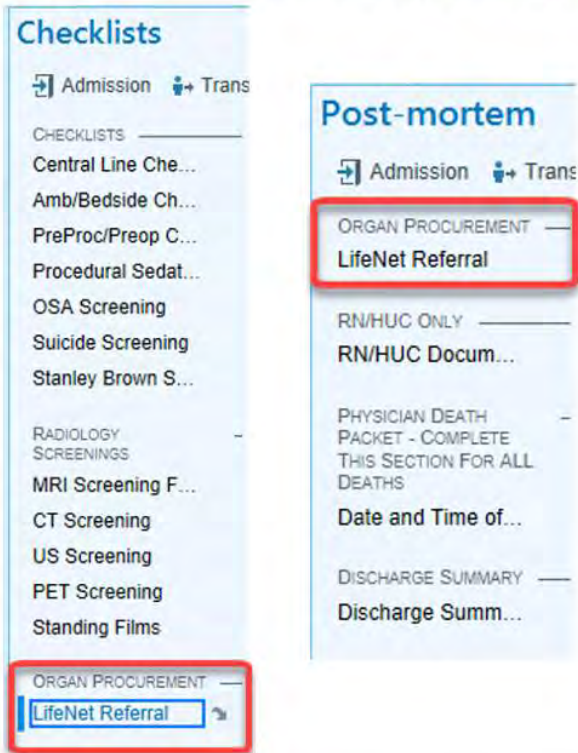
Contact LifeNet (**1-866-LIFENET** or via the electronic link in Epic) within 60 minutes when any of the following criteria are met:



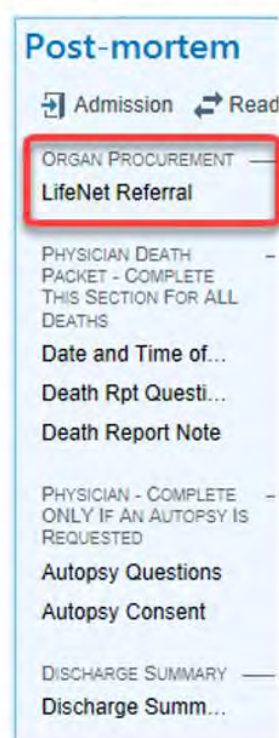
- When a patient dies in the hospital.
- When a ventilated patient has a GCS of 4T or less (including sedated patients, but excluding patients who are in the anesthetic/sedation recovery period after a procedure).
- When a goals of care discussion that may include withdrawal of life-sustaining treatment is planned.
- When brain death testing is anticipated.
- When donation is mentioned by the family/surrogate.

An electronic referral link is (or will be) available in Epic to facilitate LifeNet notification and decrease phone calls. This will continue to be expanded to all inpatient areas. The electronic referral is accessible as indicated below. After clicking the link, follow the on-screen instructions to submit the referral.

**RNs:** Use RN Navigator to select “LifeNet Referral” from “Checklists” or from “Post-Mortem” under Discharge tab.



**APPs, MDs, others:** Select “LifeNet Referral” from Post-Mortem navigator.



According to HRSA, 90% of US adults support organ donation. For a patient to be eligible for organ donation, the patient **must be ventilated**. Please ensure you preserve this opportunity for donation by working closely with LifeNet Health and ensure the **patient remains ventilated** until a determination of eligibility can be made.

For more information, refer to Organ, Tissue, and Eye Donation Medical Center Policy.



**LifeNet Health**<sup>®</sup>  
Saving Lives. Restoring Health. Giving Hope.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Direct Patient Care Choose Your Role

---

The next section of this course will provide you with information that is required for you based on your role. In some instances, the information is required for your role, but may not match your work environment. In those cases, consider how the topic would relate to your role.

## Choose Your Role

### **Inpatient and Emergency Department RN, LIP, PA, CNA, PCT, or Surg Tech**

Nurses, Physician Assistants, CNA's, PCT's, Physicians, Nurse Practitioners, Surg Techs, EMTs (in the Emergency Department). Care provided in the hospital setting or procedure area (even if the space is sometimes considered "out patient").

CONTINUE

### **Outpatient RN, LIP, LPN, MA, PCT**

Nurses, Physician Assistants, Physicians, Nurse Practitioners, CNA's, or PCT's. Care provided **only outside** the inpatient or procedure area.

CONTINUE

### **Emergency Medical Services**

CONTINUE

### Respiratory Therapist

CONTINUE

### Perfusionist

CONTINUE

### Radiation Tech

CONTINUE

### Pharmacy

CONTINUE

### I Do Not Provide Direct Care

If you do not provide direct care to patients, click here to **return to the beginning** and choose your role.

RETURN

**I provide direct patient care, but my role is not listed.**



CONTINUE

# Inpatient Care

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 10-15 minutes to complete.

**If you do not provide inpatient care, click here to return to the previous section.**

[RETURN TO PREVIOUS](#)

## Continue to the Next Section

**Click Continue to move to the next section.**

[CONTINUE](#)

# CLABSI

---

## Central Line-Associated Bloodstream Infection (CLABSI)

All patients with a Central Line are at risk for CLABSI. We can mitigate this risk by adhering to our insertion and maintenance bundles.

Here are some tips and tricks for challenging Central Line dressings.

### Insert Central Line Catheters **ONLY** for Appropriate Indications (**ARE** indicated for):

- ✓ Medications/Infusions not indicated for peripheral infusion
- ✓ Invasive hemodynamic monitoring
- ✓ Large volume resuscitation
- ✓ Inability to obtain alternate access.
- ✓ Hemodialysis/Apheresis

## Insertion - CL Insertion Checklist



Perform hand hygiene before donning gloves and opening tray



Skin prep with ChloroPrep prior to maximal barrier drape

Scrub for **30 seconds\*** using repeated back and forth motion      Femoral site requires **2 min\*** scrub for 1st scrub      **WAIT until completely dry**

It is critical to apply ChloroPrep skin prep (CHG/alcohol) in a repeated back and forth motion for at least 30 seconds (2 minutes for groin or moist skin folds) for required antimicrobial effect



**STOP** if sterile field violated or 3 unsuccessful attempts



Apply dressing - All **3** pieces, correctly placed  
**stabilize** the catheter and help prevent infection

## Maintenance Practices: General

Screen for Central Line Necessity



- > Assess & document indication every shift
- > If not necessary, page LIP to discuss removal

Hand hygiene prior to glove use and all Central Line access/care

Maintain a closed system



- > Minimize add-on devices/extensions to maintain a closed system

Site Assessment/Documentation



- > Every shift & PRN
- > Assess insertion site and dressing for erythema, drainage, and condition of dressing/CHG gel pad

Alternative to central delivery - can medication be given PO or peripherally?

## HAIR-CLIP! DON'T SHAVE



### PRIOR TO INSERTION AND PRN

- To avoid contaminating the insertion site, peel back adhesive, keeping the CHG gel pad in place and clip hair
- Brush hair away, then proceed with the sterile dressing change

## BLEEDING/OOZING-STAT SEAL



- IMMEDIATELY POST-INSERTION even with small ooze
- Utilize stat seal if bleeding is a concern at insertion or with dressing changes
- Leave stat seal in place until next dressing change
- Apply pressure for at least two minutes to activate stat seal

## ORAL SECRETIONS-DROOL



- To avoid contamination of central line dressing, control secretions with suctioning and/or utilize mud flap or aqua guard barrier.
- Cut barrier if necessary. Place adhesive strip on skin above dressing, drape barrier over dressing to allow for airflow.
- Use Steri-drape (aka "mudflap")-BIN 97163
  - Cut in half, place adhesive strip on skin above dressing
  - Helpful for femoral lines-stool contamination

## NOT STICKING!



- PATIENCE!!!
- Wait for Chloraprep AND Cavilon to dry (minimum 30 seconds)
- Apply pressure to edges to engage adhesive of dressing
- Pro-tip: once dressing applied, utilize cavilon swab to apply a "seal" along dressing/skin border

## SKIN BREAKDOWN



- Identify root cause skin injury vs. chemical irritation from improper chloraprep drying time.
- In the event of skin breakdown use mepitel as a protective barrier between skin and adhesive.
- Cut to size and only use around the outer edges of dressing not near insertion site.

## TENSION ON LINE



- PICCs-utilize burn netting over dressing
- Heavy-multiple lines (i.e. IJs with PA cath; MACs; HD)
  - Secure PA cath with duoderm/tegaderm to shoulder
  - Secure lines with "driveline anchor" -BIN 91736

## DRESSING REINFORCEMENT



Full Contact

NOT Full Contact

- Reinforce adhesive border between dressing changes ONLY if transparent window remains intact.
- Utilize a new roll of medipore H tape for reinforcement.

## NEED HELP?



### CLABSI Coalition

- Email: [CLABSIcoalition@uvahealth.org](mailto:CLABSIcoalition@uvahealth.org)
- PIC: 9661

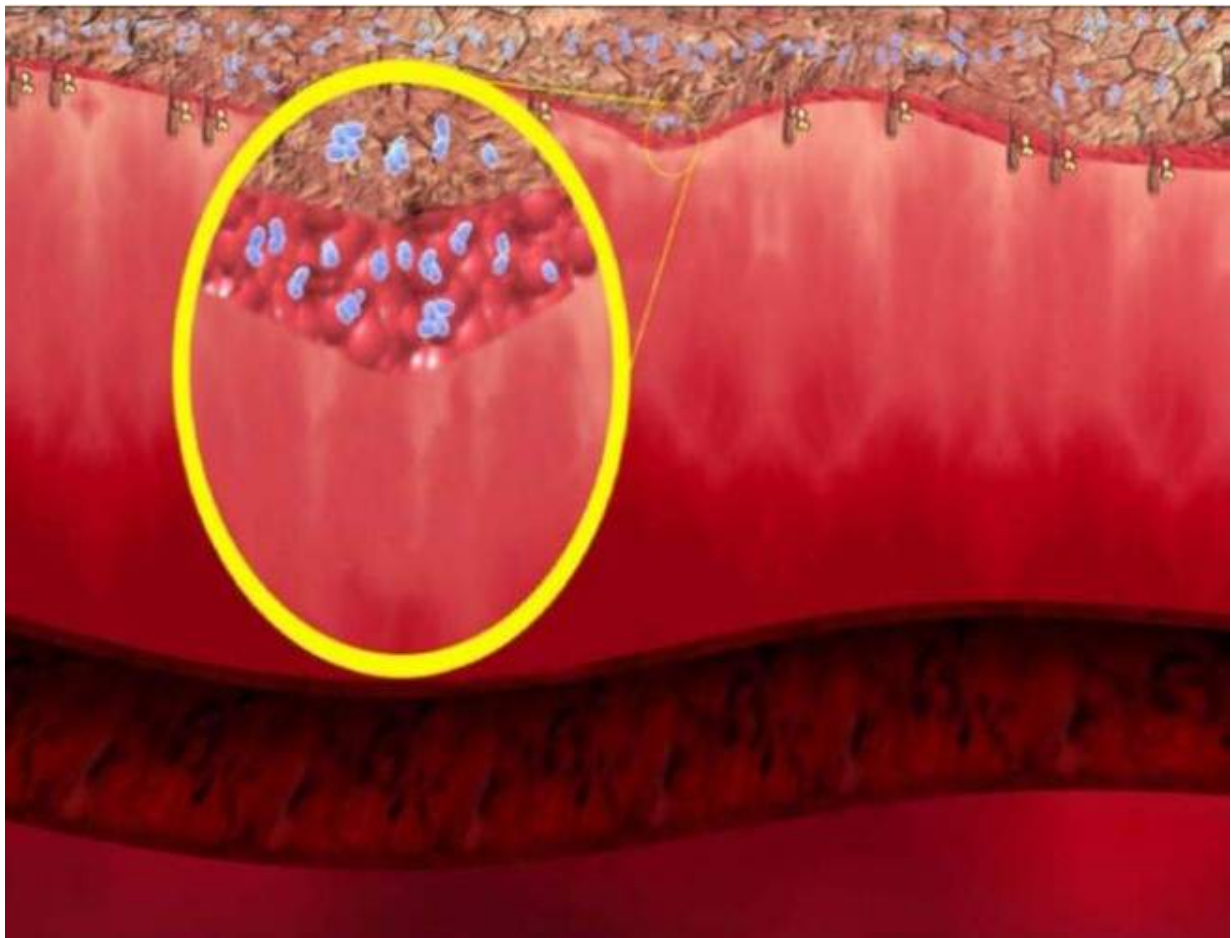
## Microbiology of the Skin and Reducing Bloodstream Infections



**It is critical to apply ChloroPrep skin prep (CHG/alcohol) in a repeated back and forth**

**motion for at least 30 seconds. Apply for 2 minutes for groin/or other moist areas (i.e., IJ site in a patient with skin folds in the neck) for required antimicrobial effect.**

- 80% of the resident bacteria exist within the first 5 layers of the stratum corneum.
- 20% of bacteria are found in biofilms within hair follicles and sebaceous glands.
- Complete recolonization of the epidermis can occur within 18 hours of ChloroPrep application.



**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**



# CAUTI

---

## Catheter Associated Urinary Tract Infections (CAUTI)

**Reminder: CAUTI is avoidable.** The BEST way to avoid CAUTI is to avoid placing indwelling urinary catheters (IUC).

We know IUCs may be necessary for patient care. BUT - every day during rounding, you should ask yourself and the rest of the care team if the IUC is still necessary.

- Performing best practices, in conjunction with patient education, can **reduce infections**.

---

Click the cards below for how YOU can avoid harm to our patients starting today.

**Here Is How YOU Can Improve CAUTI Starting TODAY**



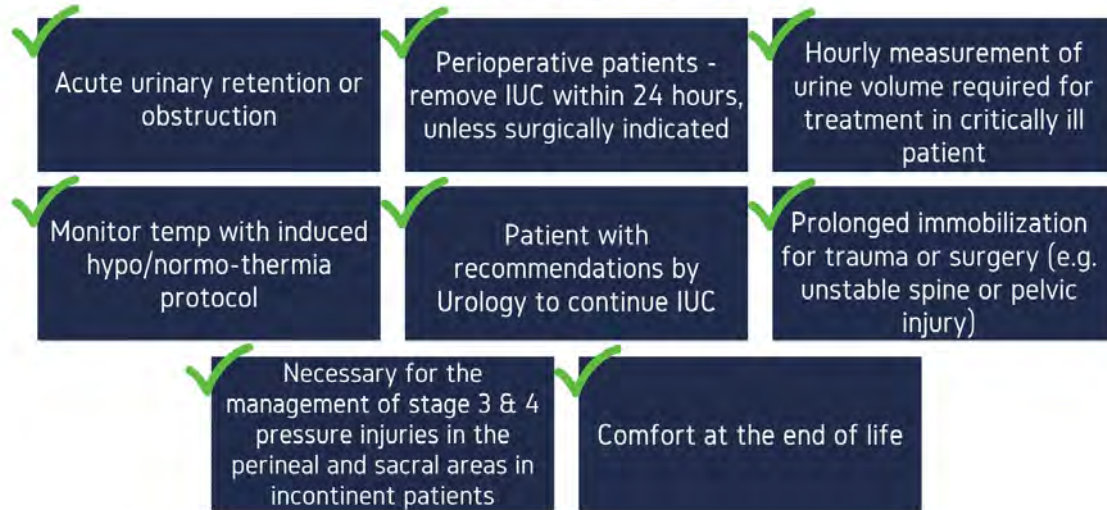
If the indwelling urinary catheter is needed for patient care, then assure that daily CHG bath, including perineal cleansing and pristine catheter care is provided. See Chlorhexidine Bathing Treatment SOP.



The care team will review patient's baseline urinary pattern, past medical and surgical history prior to IUC removal. Those patients anticipated to have difficulty voiding may benefit from scheduled intermittent catheterization and measurement of their post-

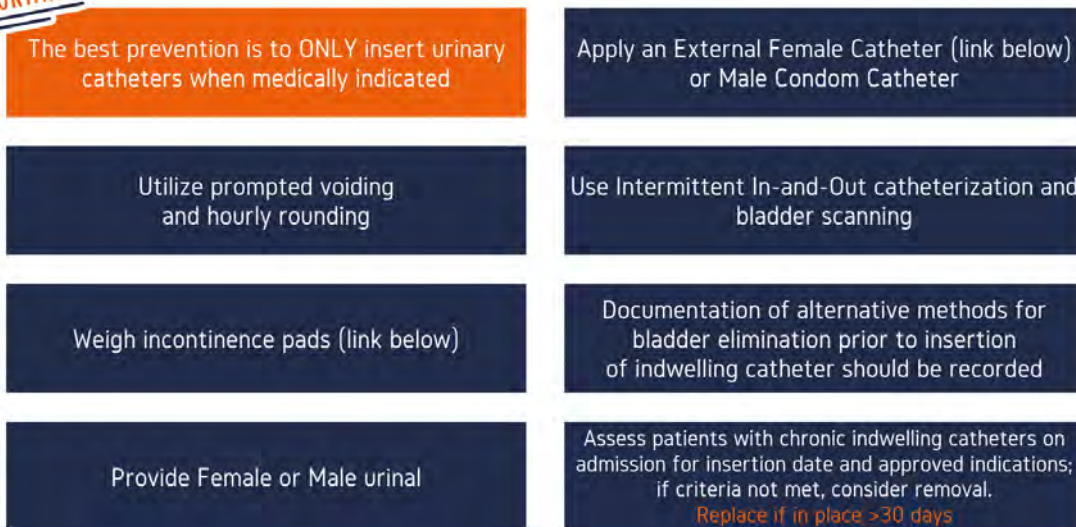
## When Are Urinary Catheters Indicated?

## Urinary Catheters ARE indicated for:



## Alternatives to Indwelling Urinary Catheters (IUC)

**IMPORTANT!**



**Continue to the Next Section**

Click Continue to move to the next section.

CONTINUE

# Instrument Care and Handling

---

## Instrument Care and Handling



Reusable instruments used after a procedure must be handled appropriately to prevent the risk of organism transmission from remaining bioburden. Consider the following question, and how it might apply in your workspace.

Review the Guidance documents for Pre-Cleaning, Transport, and Storage of Instruments, Scopes, and Probes.

## Matching

A procedure is done on a patient using instrumentation. The procedure has been completed and you are cleaning up. Match the appropriate answer to the correct response.

---

≡ Single-sterile instruments should be disposed of using \_\_\_\_

sharps or biohazard bin.

≡ Reusable instruments should be free of gross soil, placed in an open position, and \_\_\_\_

lightly sprayed with PreKlenz.

≡ If an instrument is found to be defective, place \_\_\_\_ on the instrument prior to transport

repair tag.

≡ Sharp instruments should always be placed in their designated container and \_\_\_\_

label it as biohazard.

SUBMIT

## Multiple Choice

Which steps are in the correct order for proper pre-cleaning of re-usable instrumentation?

---

- Spray instruments with PreKlenz, wipe gross soil from instrument, place in biohazard container, transport to SPD or soiled utility room.
- Place instruments in biohazard container, saturate with PreKlenz, transport to SPD or soiled utility room.
- Obtain biohazard container or bag, place chux on clean work surface, cleanse hands, don PPE, open all instruments, flush lumens, place instruments in a biohazard labeled bag or container, lightly coat instruments with PreKlenz, remove gloves, cleanse hands, secure lid on container, transport to SPD or soiled utility room.
- Leave instruments as is, place in biohazard container, transport to SPD or soiled utility room.

SUBMIT

**CONTINUE**

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# HAPI Prevention: Standard Work

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## HAPI Prevention: Standard Work

**Instructions:** Click the right or left arrow to navigate through the major steps presented in the Critical to Safety Standard Work for HAPI Prevention for Adult Inpatients document.

### Risk Identification



**Braden Score**  
once every shift



**Head to toe skin assessment**  
once every shift



Two Person Skin Assessment on admission,  
unit transfer, or off the unit for >2 hours

---



## Positioning/Repositioning

2

Reposition at minimum **every two hours**



Use appropriately sized wedges; ensure sacral gap



Use Hover Matt with air for any patient >200 lbs. (91 kg) or <200 lbs. (91 kg) with limited bed mobility (contraindication = unstable spines) to reduce friction/shear



Keep HOB <30° if possible



Use waffle cushion for patients in chairs >1 hour



Follow details in Pressure Injury Prevention and Management Guideline for patients with hemodynamic instability



Offload heels, using offloading heel boots to float heels (do not use pillows); Heel foam dressing when Braden Score <18, immobile, or redness on the heel

## Devices and Bony Prominences

Foam dressings to bony prominences

Pad under all medical devices including but not limited to:  
(NG tube, casts, splints, cervical collars, orthotic devices, and tubing)

Respiratory Therapist will apply padding to respiratory devices and tracheostomies when indicated by their patient assessment

EEG Tech to provide standard work for continuous EEG monitoring

Rotate ear oxygen saturation probes **every two hours**

## Moisture Management



Use moisture barrier cream/absorbent pads/Sage wipes

3

No more than three layers under patient



Use external waste containment devices only for persistent incontinence and according to the existing algorithm.

## Nutrition Optimization



Trigger automated Nutrition referral by:

Completing Malnutrition Screening Tool on Admission in Navigator

Documenting percent eaten with every meal

## Specialized Interventions for High Risk Patients



Use fluidized positioner for the head of completely immobilized patients



Consult Wound Ostomy and Continence (WOC) Team for:

Suspected HAPIs

Pressure injuries present on admission

Specialty prevention needs



**Refer to HAPI Quick Guide Education or Pressure Injury Prevention and Management Guideline for additional practice expectations and resources.**

**Continue to the Next Section**

Click Continue to move to the next section.

CONTINUE

# Fall Prevention

---

## Fall Prevention: Critical to Safety Standard Work

**Instructions:** Click the right or left arrow to navigate through the major steps in the Standard Work for Fall Prevention (Adult Inpatient, High Fall Risk).

### Communicate Risk

**Epic**

Note Fall Risk Banner/High Fall Risk identifier in Epic

**Mobility/  
Toileting**

Complete Mobility/Toileting section of White Board



Review PT/OT recommendations/communications to nursing/Shared JHFRAT\*



Share Fall Prevention information and guidance in Hand-off of Care

\*Our adult inpatient fall risk assessments tool is the **Johns Hopkins Fall Risk Assessment Tool (JHFRAT)**. Other practice areas use patient-specific screening tools.

---

## Mobility Alarm Use



Mobility alarms  
(Bed and Chair)  
**will be in use  
at all times**  
while patient at  
high risk



Do NOT use the  
least sensitive  
setting



Use "Silence" button  
to pause alarm rather  
than turning off  
alarm

(therapy services may  
have work that  
requires off setting)

---

## Mobility Alarm Use Continued



Patients/Family will  
not be entitled to  
refuse alarm use



Use the Self-  
Releasing Safety Belt  
for patients sitting in  
chairs.



Use alternate  
languages for bed  
alerts for non-English  
speaking patients

(see Centrella Bed User  
Manual for instructions)

## In Arm's Reach with Direct Visual Observation



Staff remain in arm's reach  
with direct visualization of patient  
whenever the patient is out of alarmed bed/chair.

## Cognitively Impaired Patient Support

Cognitively impaired patients (dementia, delirium, impulsive, etc.)  
who are highly mobile require additional support.  
These patients need direct observation strategy if they are able to  
move out of bed/chair faster than the team can respond to the alarm.



Place close to  
nursing station



Padded floor mats  
to reduce injury



Telesitting or Patient  
Companion with  
patient

**CONTINUE**



**Refer to Fall Prevention for Adult and Pediatric Patients Guideline for additional practice expectations and resources.**

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# 911, Security, and BERT?

---

## When to Call 911, Security, and BERT

The Medical Center has several resources to help make this a safe place to both give and receive care. Although you will receive help regardless of who is called, calling the correct place the first time will help save precious minutes when you need help immediately.

**Instructions:** Take the card from the top pile and drag it to the appropriate pile, saying when to call 911, Security, or BERT.



Call 911



**You see a person with a gun .**

**You witness active physical violence.**

**Call Security**

**A patient under an  
Emergency Custody Order  
left the unit and is in the  
elevator.**

**Call BERT**

**A delirious patient is agitated,  
and you don't know what  
medication to use.**



**Complete the content above before moving on.**

Calling the right place the first time saves valuable time in emergencies.

- Call BERT if you need help with a behavioral emergency of a patient.
- Call Security for any situation that appears to be escalating towards violence, and/or the Patient has left the unit and does not have capacity or is in mental health crisis.
- Call 911 if you see a weapon or there is active violence occurring to include a specific verbal threat of violence (i.e. I am going back to my car to get a gun).

**Continue to the Next Section**

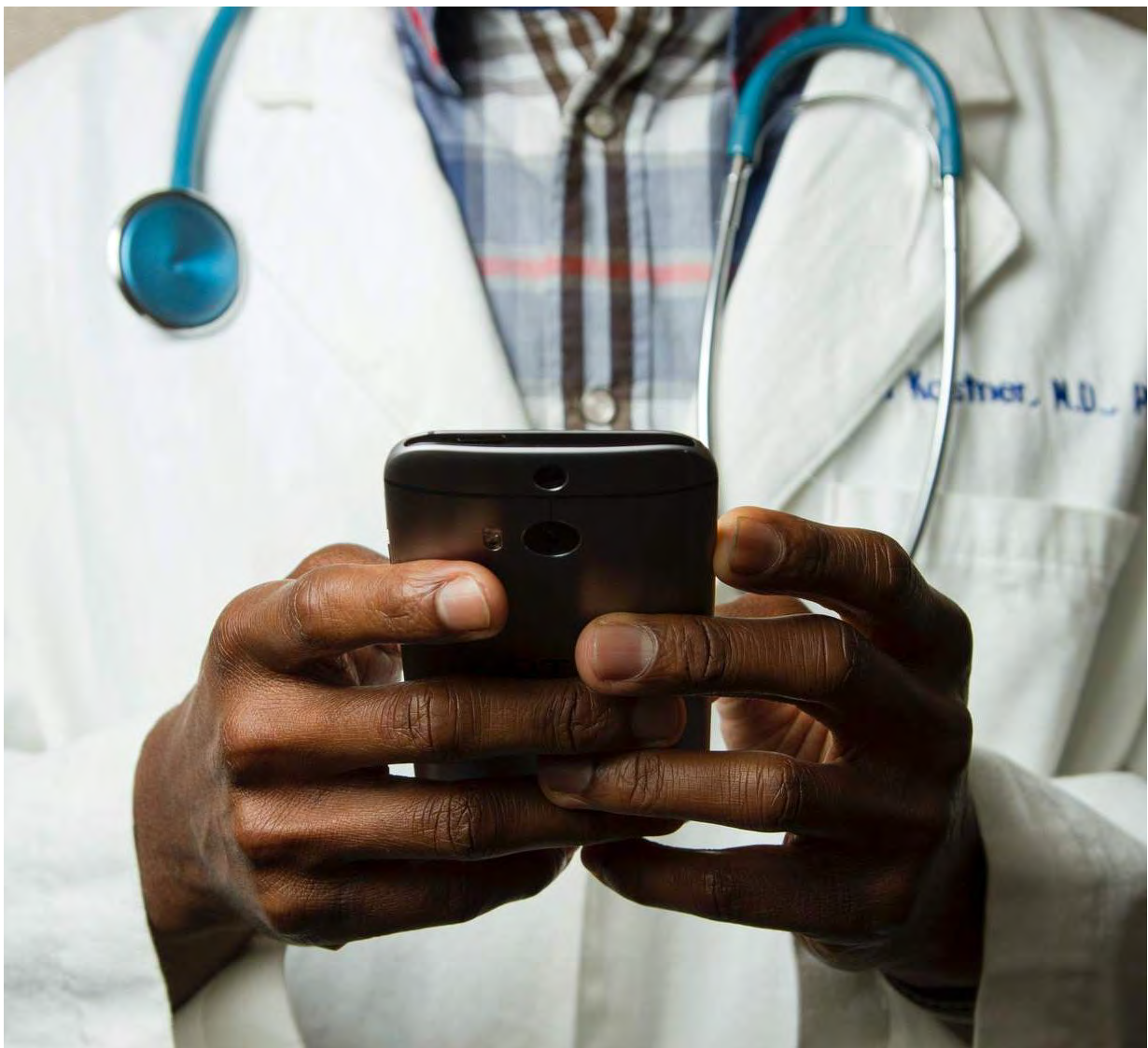
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**CONTINUE**

# Restraints

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## Restraints



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

We are committed to minimizing the use of restraint or seclusion. We will limit use of restraint to only clinically appropriate and adequately justified situations. Restraint or seclusion will only be imposed to ensure the immediate physical safety of the patient, a staff member, or others.

Review the types of restraints below.

**Non-Violent Restraints** —

Restraint Type	Non-Violent Restraints
Description/ Behaviors	Used when a patient’s behavior puts them at risk for injury or interferes with medical treatment necessary to support medical healing: <ul style="list-style-type: none"> <li>• Remove invasive device(s) necessary for medical management</li> <li>• Routine fall prevention measures have been ineffective.</li> <li>• Repeated non-compliance with ordered activity restrictions</li> </ul>
Methods/devices	side rails, roll belt, enclosure bed, limb restraints
LIP ordering/ documentation	New order every calendar day
Documentation	Every two hours by RN

**Violent Restraints** —

Description/ Behaviors	Used in an urgent or escalating situation when severely aggressive, violent, or self-destructive behavior jeopardizes the immediate physical safety of the patient, a staff member, or others.
---------------------------	--

Methods/devices	limb restraints, physical hold, medications, seclusion (5 East only)
LIP ordering/ documentation	<p>At initiation, enter a violent restraint order, which includes the following documentation requirements:</p> <ol style="list-style-type: none"> <li>1. Complete a face-to-face evaluation</li> <li>2. Notification of the Attending Physician</li> <li>3. Factors/conditions contributing to the need for restraints</li> </ol> <p>Requires a new order every:</p> <ul style="list-style-type: none"> <li>• 4 hours for adults.</li> <li>• 2 hours for children 9-17 years old.</li> <li>• 1 hour &lt;9 years old.</li> </ul>
Documentation	Every 15 minutes by RN

## Restraint Documentation

Click the buttons below to review what requires information, at which stage.

Search (Alt+Comma)	0400	0600	0800	1000	1030
<b>Restraint</b>					
Restraint	Non-Violent				
<b>Non-Violent Restraints (Document Upon Initiation)</b>					
Patient Behaviors (Non-Violent Restraints)	Attempting to di...				
Ineffective Alternatives Attempted (Non-Violent Restraints)	1:1 Observation...				
Restraint Type (Non-Violent Restraints)	Soft Cloth Restr...				
Non-Violent Restraint Care Plan Status	Initiated				
<b>Restraint Status (Document Upon Initiation Or Change)</b>					
RUE Restraint Status	Initiated				Discontinued
LUE Restraint Status	Initiated				Discontinued
RLE Restraint Status					
LLE Restraint Status	Initiated				Discontinued
<b>Education</b>					
Restraint Education Provided	Yes				
<b>Safety Documentation (Document Upon Initiation, Every 2 hours for Non-Violent, Every 15 minutes for Violent, and when Discontinued)</b>					
Are Restraints Safely Applied?	No Signs of Injury	No Signs of Injury	No Signs of Injury	No Signs of Injury	Restraints Disc...
Needs Attended	Ensured Safety...	Ensured Safety...	Ensured Safety...	Ensured Safety...	Ensured Safety...
Does The Patient Behavior Warrant Ongoing Restraint Use?	Yes - Continue	Yes - Continue	Yes - Continue	Yes - Continue	No - Discontinue

Initiation

Continuation

Discontinuation

## Discontinuation of Restraints

Discontinue restraints as soon as possible, once criteria are met for release.

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and **must be discontinued at the earliest possible time**.

The RN may consider a phased discontinuation. The process for a phased discontinuation of restraints is one limb at a time, for purposes of observing behavior and response to intervention once a patient has moved to a calm state (should not exceed 2 hours).

Order discontinuation can be by the RN via protocol order or LIP as order discontinuation.

For more information, refer to Medical Center Policy: Restraint and Seclusion.

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Infection Control Risk Assessment (ICRA)



## Infection Control Risk Assessment (ICRA)

### **Infection Control Risk Assessment (ICRA) for Construction, Renovation, and Maintenance**

In the event that Facilities is called to address a problem in a patient room, Health System Physical Plant (HSPP) will assess interventions and partner with team members to complete the work.

Construction dust can carry harmful particles and microorganisms such as *Aspergillus*, that may cause or worsen respiratory issues and cause serious infections in susceptible patients. Transmission occurs through inhaling airborne spores. Healthcare-associated infections are sporadic and associated with dust exposure during building renovation or construction. Occasional outbreaks of cutaneous infection have been linked to contaminated medical devices.

Infection Control interventions include:

1. Patients must be removed from the work area while the work is being performed.
2. Contractor executes work by methods to mitigate dust from construction operations.
3. Ceiling tile should be immediately replaced if displaced.
4. Contractor is educated before the start of the project about the importance of adhering to Infection Prevention & Control measures.



5. The person who did the work should clean (wipe down or HEPA vacuum) work area upon completion.



**CONTINUE**

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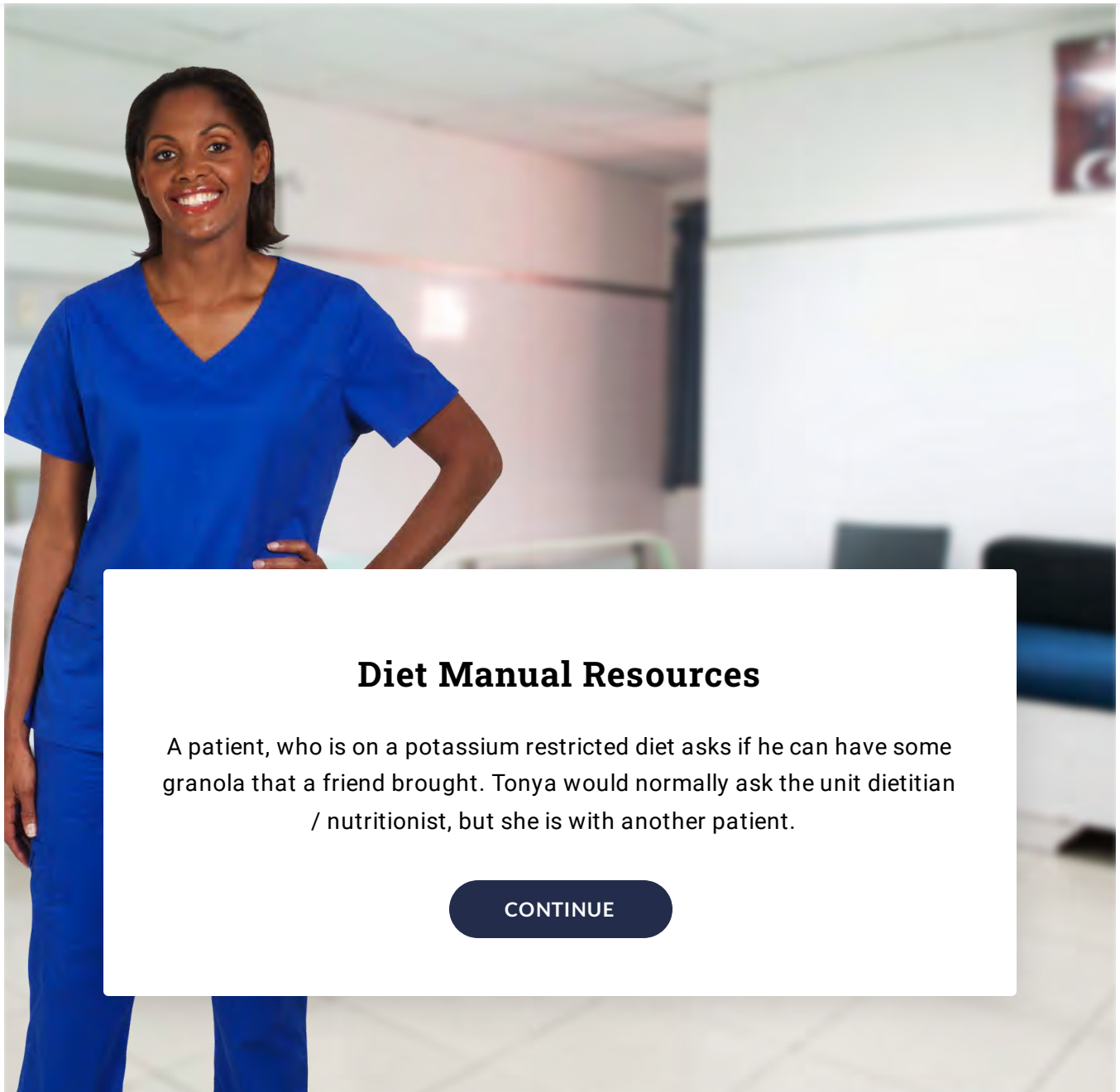
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**CONTINUE**

# Diet Manual Resources

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**Diet Manual Resources**



## Diet Manual Resources

A patient, who is on a potassium restricted diet asks if he can have some granola that a friend brought. Tonya would normally ask the unit dietitian / nutritionist, but she is with another patient.

CONTINUE

### Scene 1 Slide 1

Continue → Next Slide



Where else can Tonya get information about what food is allowed or not allowed?

1

The information can be found in the Diet Manual available on Knowledge Link.

2

It is OK because a patient in a nearby room is eating some.

3

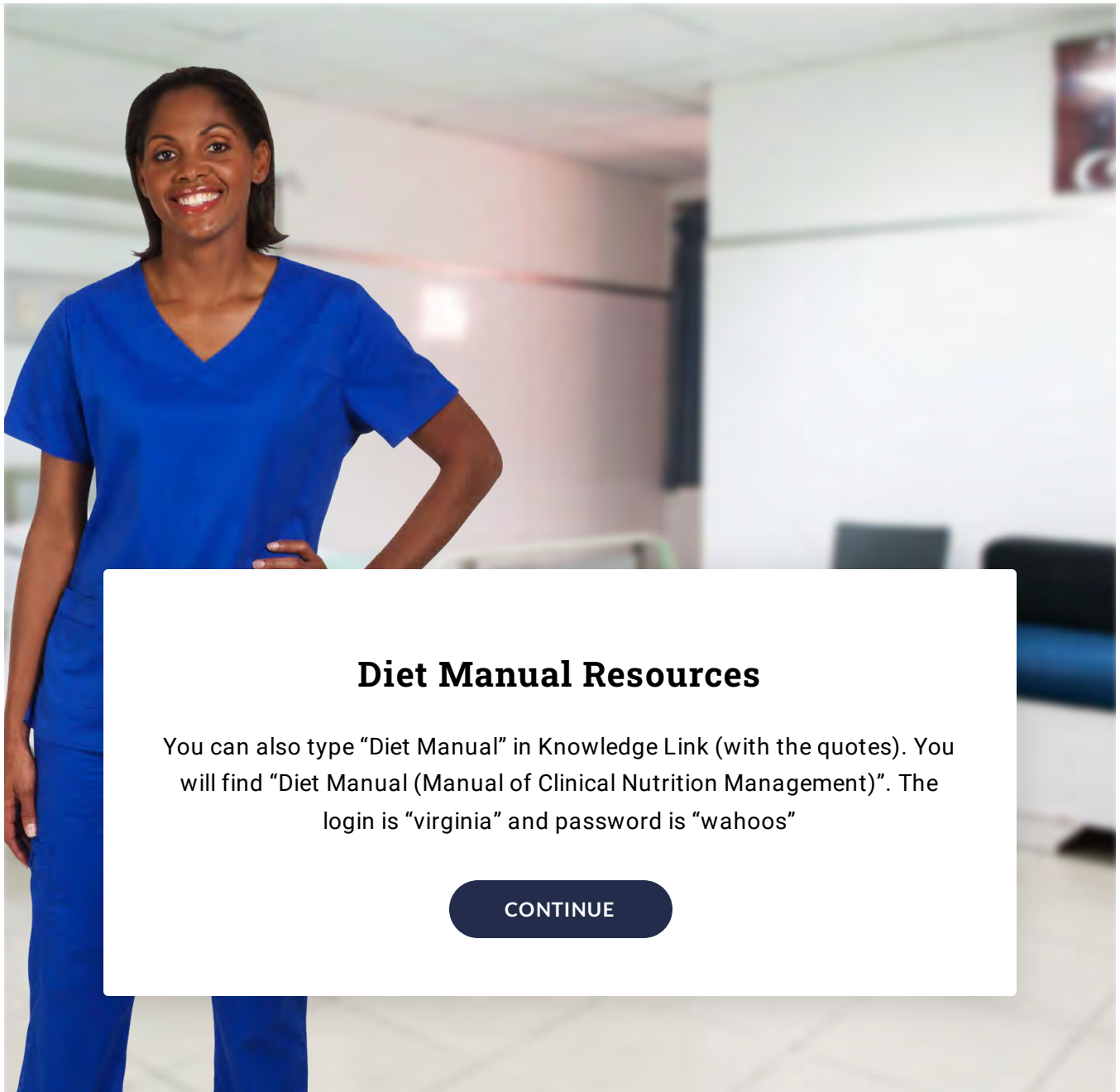
This question requires a dietitian/nutritionist consult.

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide

2 → Next Slide



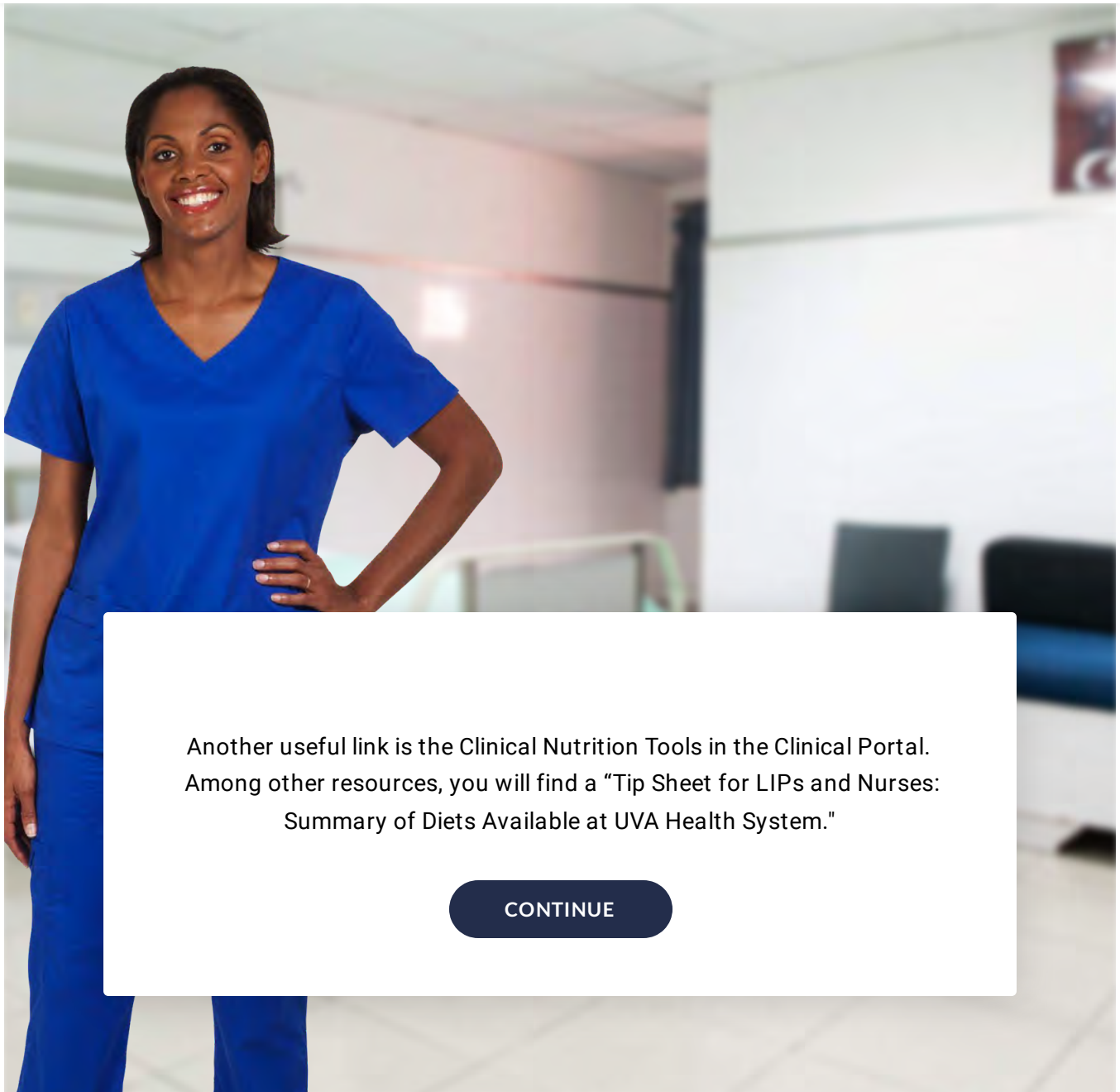
## **Diet Manual Resources**

You can also type "Diet Manual" in Knowledge Link (with the quotes). You will find "Diet Manual (Manual of Clinical Nutrition Management)". The login is "virginia" and password is "wahoos"

**CONTINUE**

### **Scene 1 Slide 3**

Continue → Next Slide

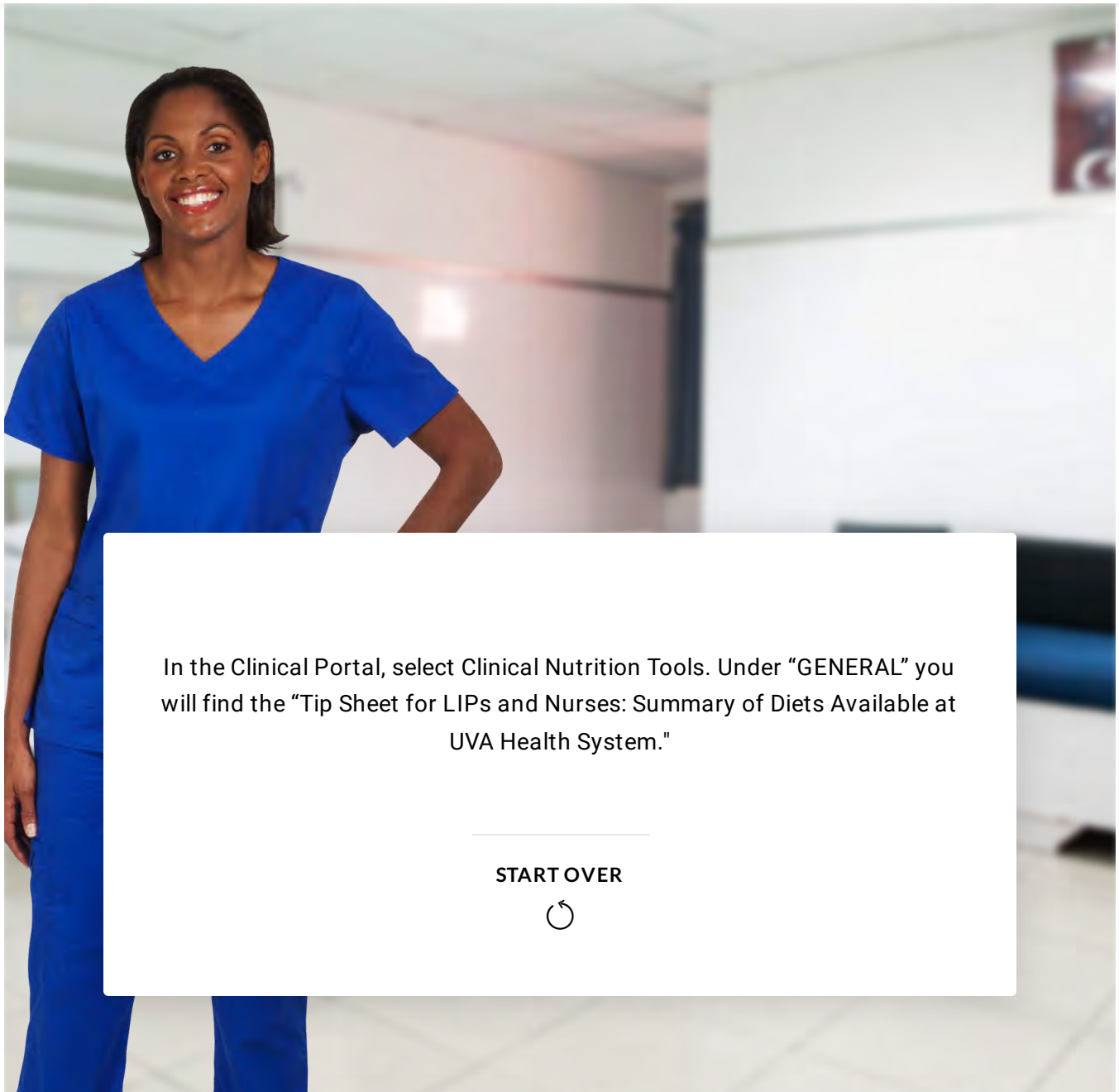


Another useful link is the Clinical Nutrition Tools in the Clinical Portal. Among other resources, you will find a “Tip Sheet for LIPs and Nurses: Summary of Diets Available at UVA Health System.”

CONTINUE

## Scene 1 Slide 4

Continue → Next Slide



In the Clinical Portal, select Clinical Nutrition Tools. Under “GENERAL” you will find the “Tip Sheet for LIPs and Nurses: Summary of Diets Available at UVA Health System.”

---

**START OVER**



## Scene 1 Slide 5

Continue → End of Scenario





Complete the content above before moving on.

## Malnutrition Screening Tool

The Malnutrition Screening Tool (MST) screens adult patients for malnutrition risk on admission. A score of 2 or greater will trigger a referral to a registered dietitian/nutritionist. Joint Commission requires that the screening tool (MST) be completed within 24 hours of admission.

If the MST has not been completed, please complete it regardless of the amount of time that has elapsed since admission.

The screenshot shows the 'Admission' section of a clinical system with the 'Nutrition' tab selected. The 'Malnutrition Screening Tool (MST)' form is displayed with the following data:

- Time taken: 7/8/2024, 1233
- Have you lost weight recently without trying? **Yes** (0=No, 2=Unsure, Unable to Assess)
- How much weight have you lost? **2=14-23 lb** (1=2-13 lb, 3=24-33 lb, 4=> 33 lb, 2.0=Unsure)
- Weight Loss Score: 2
- Have you been eating poorly because of a decreased appetite? **1=Yes** (0=No)
- MST Score: 3
- Formula: MST loss score = Weight loss score + Appetite Score

## The Pediatric Nutrition Screening Tool (PNST)



The Pediatric Nutrition Screening Tool (PNST) is used to screen pediatric patients for nutrition risk on admission. The tool is comprised of four questions with yes/no responses.

A positive screen occurs when two of the four questions receive a “yes” response.

1. Has the child unintentionally lost weight lately?
2. Has the child had poor weight gain over the last few months?
3. Has the child been eating/feeding less in the last few weeks?
4. Is the child obviously underweight/significantly overweight?

## % Meal Intake in I/O's Flowsheets

The screenshot displays the Epic EHR interface for a patient named Olivia Zlabbuild. The 'Flowsheets' section is open, showing the 'Intake/Output' tab. The 'Intake (ml)' row is highlighted, showing a value of 1500. Below the table, there is a section for 'Non-Volume Intake' with a dropdown menu for '% Meal Intake' set to '100%'. A pop-up window shows the dropdown options: 'None-0%', 'Poor-25%', 'Fair-50%', 'Good-75-100%', and 'Comment (ft)'.

Patient % meal intake documentation is helpful for identifying patients at risk for malnutrition. Consistently poor intake documented in the Epic “% meal intake” row automatically trigger for dietitian intervention.

**Continue to the Next Section**

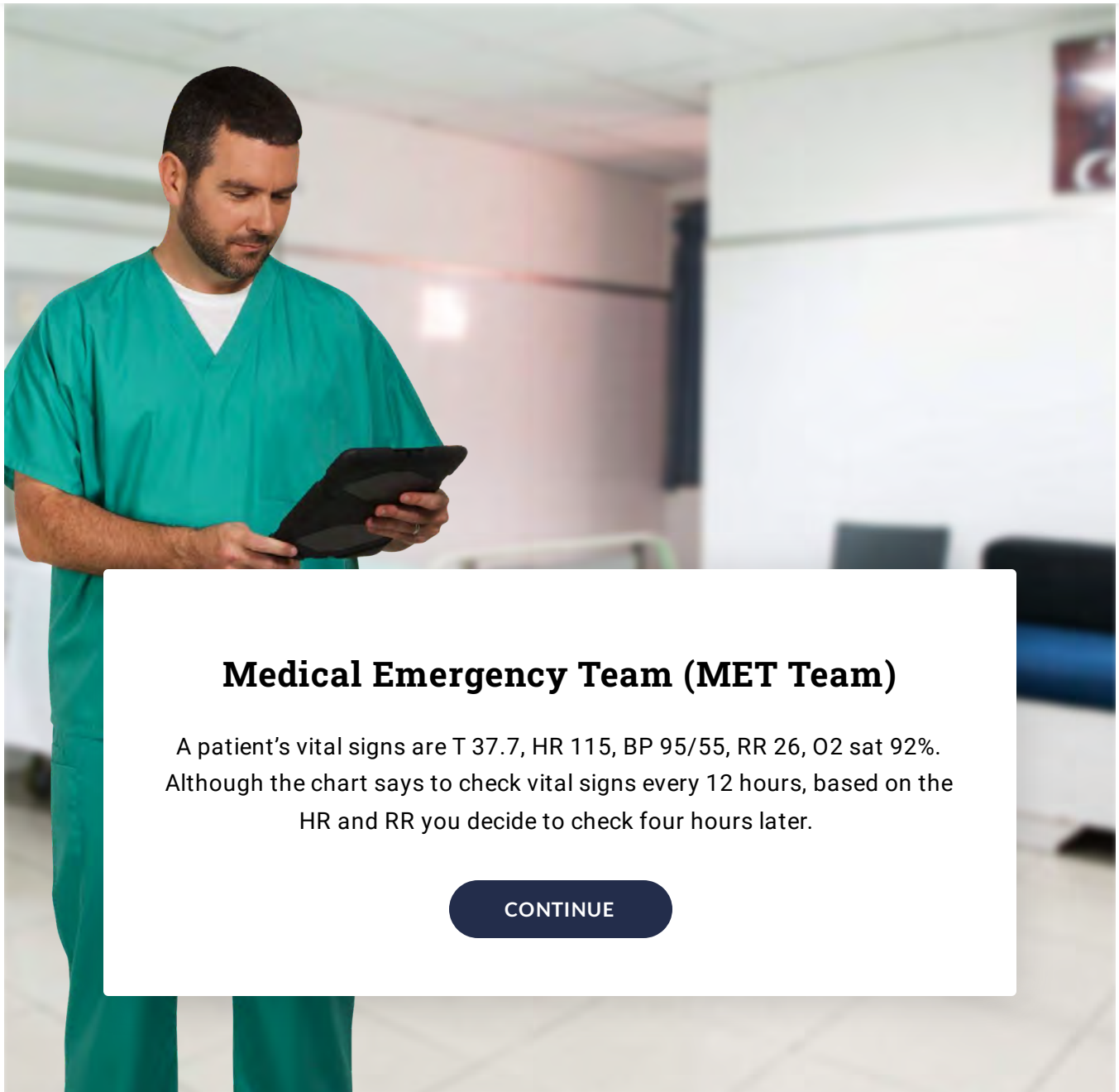
**Click Continue to move to the next section.**

**CONTINUE**

# Medical Emergency Team (MET Team)

---

**Medical Emergency Team (MET Team)**



## **Medical Emergency Team (MET Team)**

A patient's vital signs are T 37.7, HR 115, BP 95/55, RR 26, O2 sat 92%.  
Although the chart says to check vital signs every 12 hours, based on the  
HR and RR you decide to check four hours later.

**CONTINUE**

### **Scene 1 Slide 1**

Continue → Next Slide



At the four hour check the signs are now T 38.3, HR 125, BP 92/51, RR 30, O2 sat 90%. What should your next course of action be?

1 Check again in 2 hours.

2 Notify your manager.

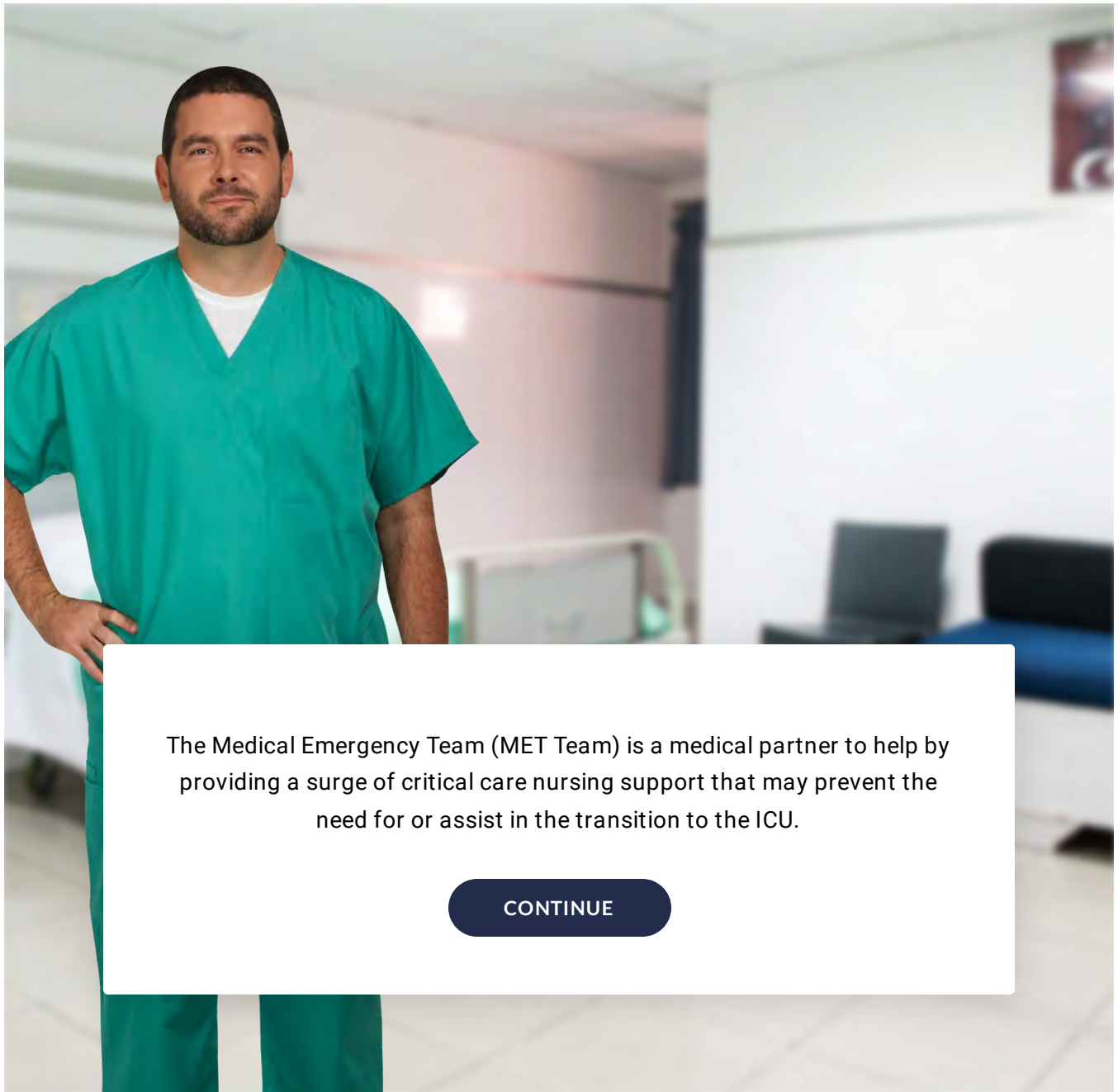
3 Activate MET Team and include your primary team.

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide

2 → Next Slide



The Medical Emergency Team (MET Team) is a medical partner to help by providing a surge of critical care nursing support that may prevent the need for or assist in the transition to the ICU.

CONTINUE

### Scene 1 Slide 3

Continue → Next Slide



**Anyone may activate the MET response. No approval is needed.**

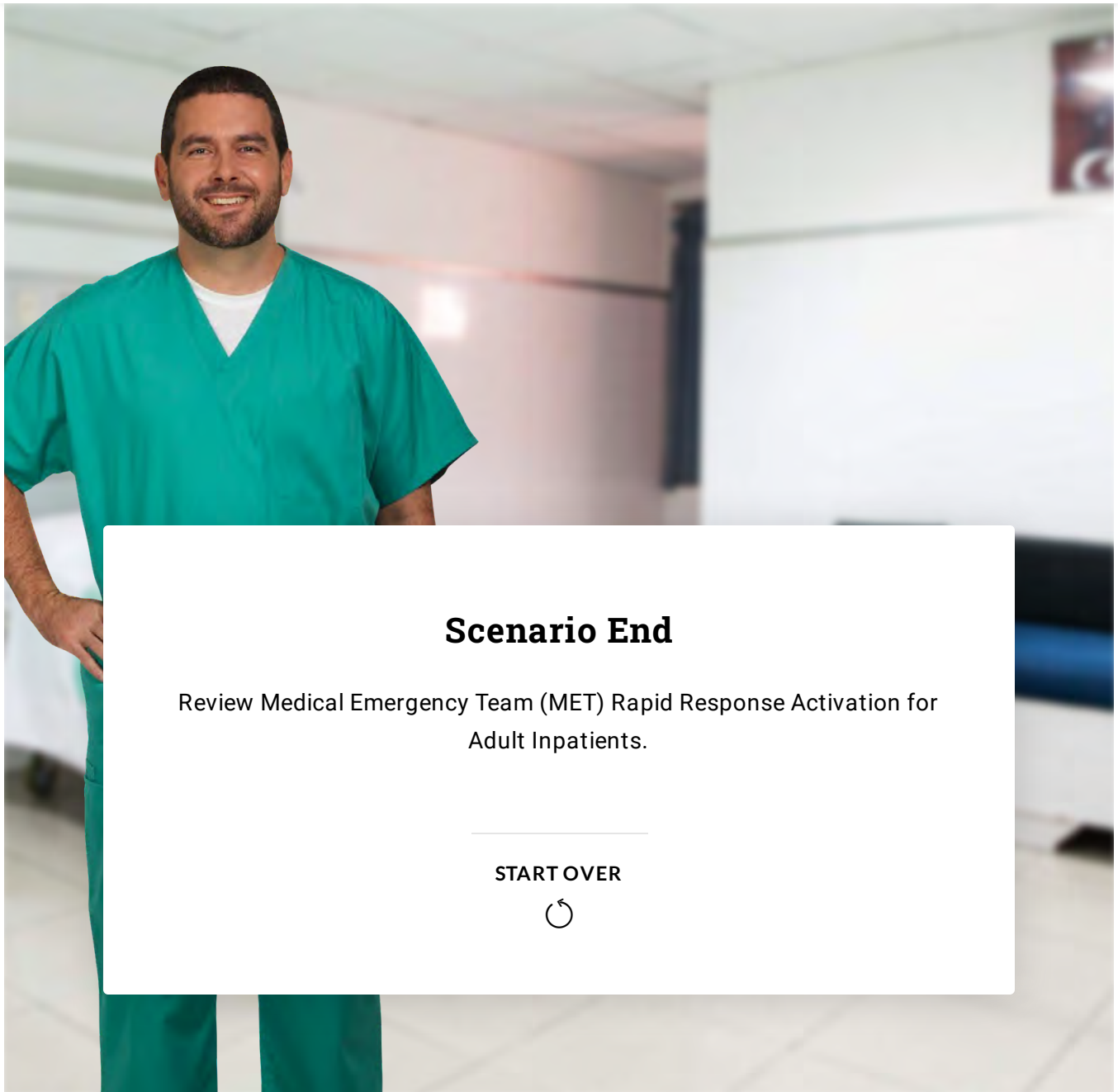
If you are concerned about the potential deterioration of a patient you are encouraged to activate MET.

CONTINUE

## Scene 1 Slide 4

Continue → Next Slide





## Scenario End

Review Medical Emergency Team (MET) Rapid Response Activation for Adult Inpatients.

START OVER



### Scene 1 Slide 5

Continue → End of Scenario

**CONTINUE**

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# End of Life

---

## Advance Care Planning (ACP) Documents at End of Life

Patients have the right for their decisions and healthcare preferences to be honored and incorporated into their plan of care at all times, including at end of life.

Patients decisions and healthcare preferences may be found in the ACP section we saw earlier in the course.

This section includes information about the patient's legally authorized decision maker(s), ACP Documents, and ACP Notes.

The screenshot displays a patient's EHR profile for Krispy P. Bacon. The interface includes a navigation bar at the top with tabs for Summary, Chart Review, Flowsheets, Intake/Output, MAR, Notes, and Education. The patient's name and MRN (5332208) are prominently displayed. A red box highlights the 'ACP: Click to Review' link in the patient's profile. The main content area is divided into several sections:

- Health Care Agent/Surrogate Decision Maker:** Lists Sal T. Bacon as the Healthcare Agent Named In Advance Directive - Father, with a 'Not Active' status.
- ACP (Advance Care Planning) Notes:** A table showing two entries:
 

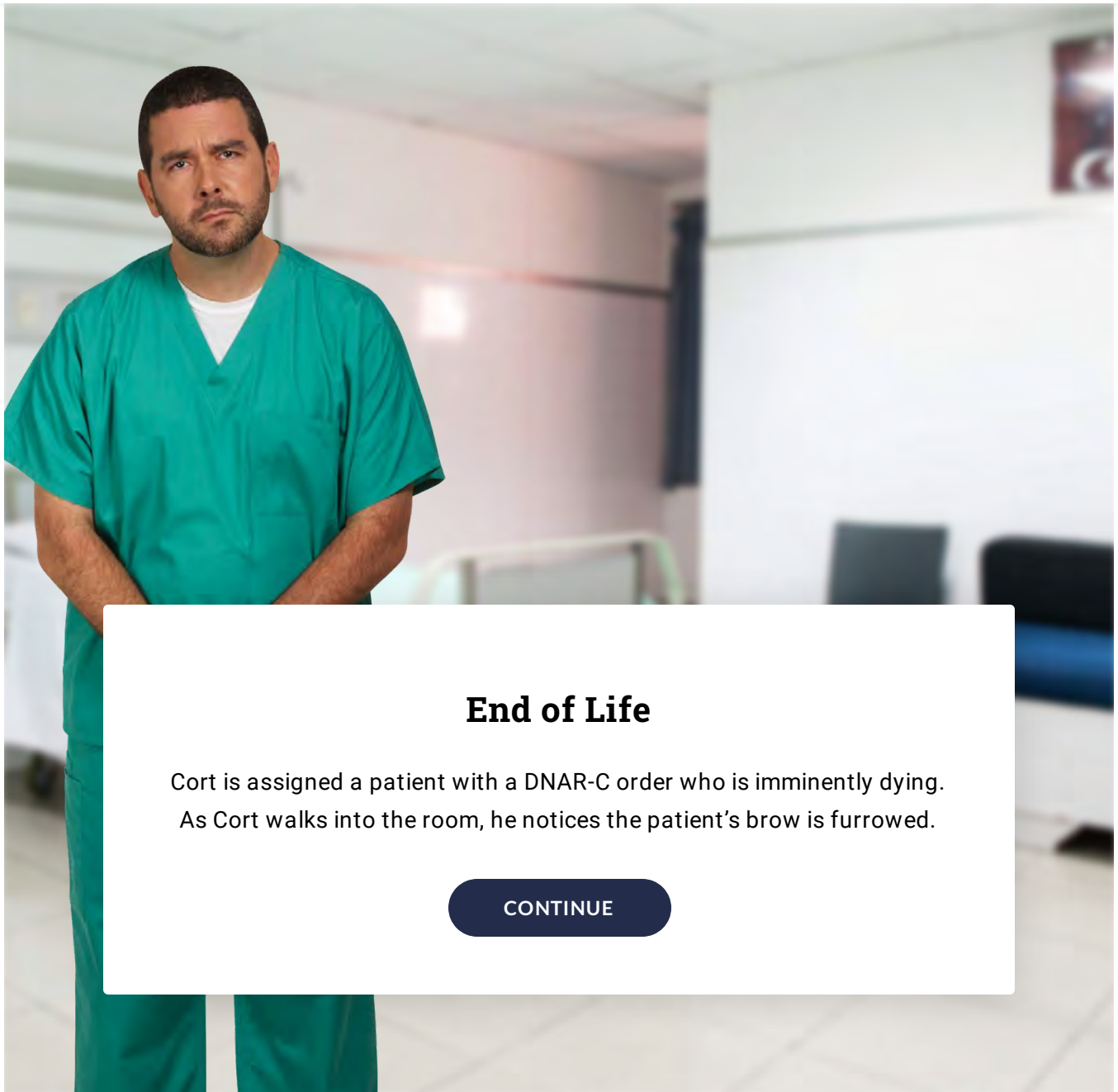
Date of Service	Author	Author Type	Status
02/12/24 1606	Carter, Jeffrey		Signed
02/12/24 1550	Worker, Social	Social Worker	Addendum
- Advance Care Planning Documents:** A table showing three documents:
 

Document Type	Status	Effective Date	Expiration Date	Received Received On	Description
Advance Directives and Living Will NDT	Received			05/28/24	VALIDATED
Durable DNR Scan	Received			03/22/24	
Advance Directive Combined Scan	Received			03/08/24	
- Reference Documents:** Lists 'ACP Document Types', 'Virginia Decision Making Hierarchy', and 'Glossary Of Patients' Supporting Roles'.

The left sidebar contains additional patient information, including demographics, allergies (VTE: High Risk - Surg), and physical characteristics (Height: 185 cm, Weight: 81.6 kg, BMI: 23.86 kg/m<sup>2</sup>).

## End of Life

Different roles have different requirements at the end of life, but in this scenario you see not only the steps that may happen, but how the patient and the family may be respected.



## End of Life

Cort is assigned a patient with a DNAR-C order who is imminently dying.  
As Cort walks into the room, he notices the patient's brow is furrowed.

CONTINUE

### Scene 1 Slide 1

Continue → Next Slide



What should Cort do first?

1

Assess the patient for signs and symptoms of pain, anxiety, and/or labored respirations.

2

Call the primary team.

3

Console the family and reposition the patient.

## Scene 1 Slide 2

0 → Scene 2 Slide 1

1 → Next Slide

2 → Next Slide



The patient's respirations are 35 and he is using accessory muscles to breathe. The family is at the bedside, concerned and tearful. What is the next step?

1

Explain to the family that we have withdrawn care because the patient is dying and has a DNAR-C order.

2

Bag the patient using an ambu bag and oxygen

3

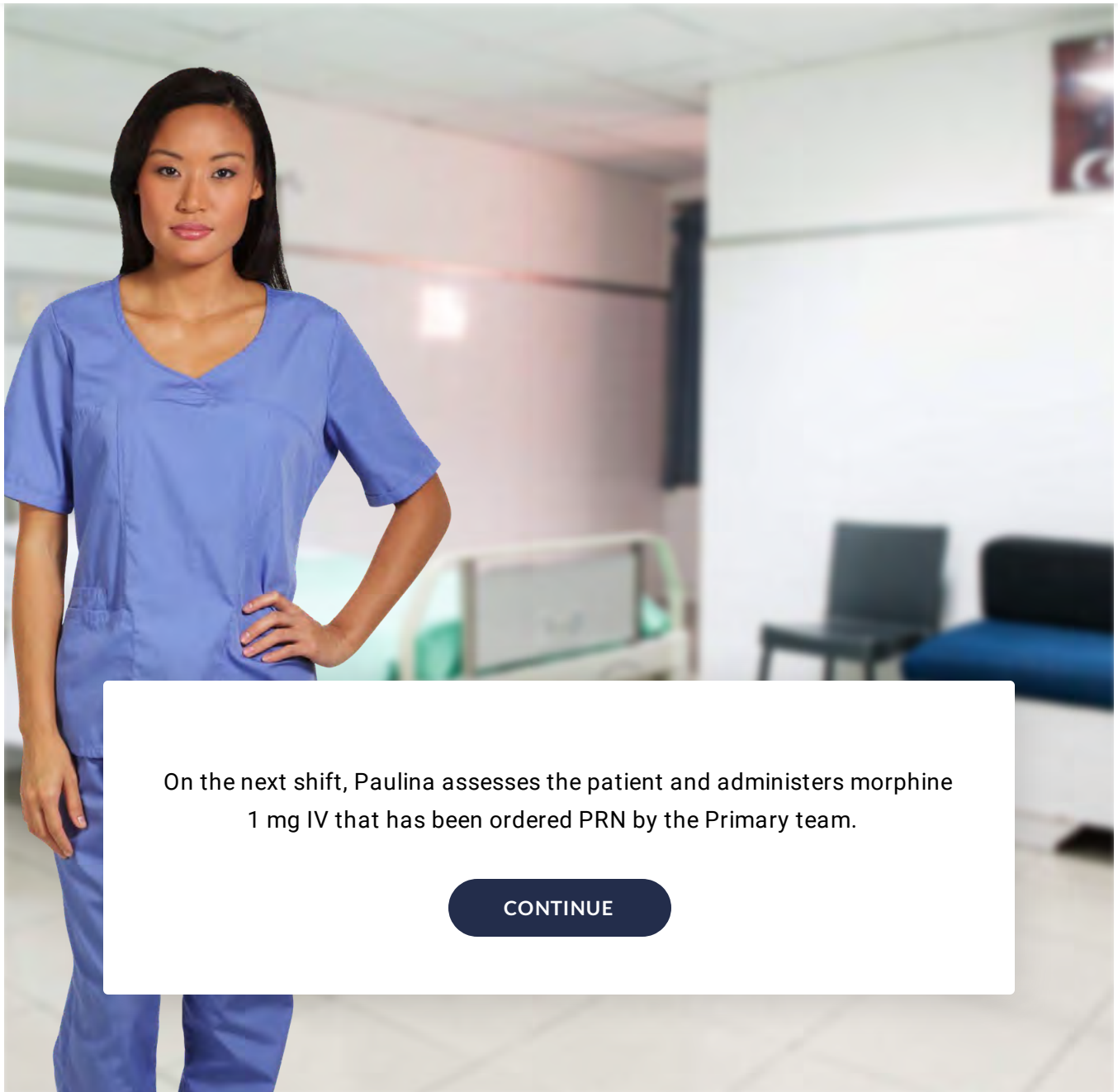
Call the primary team and consider a palliative care consult.

### Scene 1 Slide 3

0 → Next Slide

1 → Scene 2 Slide 1

2 → Next Slide



On the next shift, Paulina assesses the patient and administers morphine 1 mg IV that has been ordered PRN by the Primary team.

CONTINUE

## Scene 2 Slide 1

Continue → Next Slide





Within a few minutes, the patient appears calmer, and his brow unfurrows. His respirations are 20. The family expresses concern that the morphine will cause the patient to die. How should she respond?

- 1 Make every effort to support the family. Explain, in simple terms, that the morphine was given to treat symptoms.
- 2 Reassure the family that morphine does not hasten death, but you will use Tylenol next time.

## Scene 2 Slide 2

0 → Next Slide

1 → Next Slide



## **Support the patient and family before and after death**

It is essential to provide a quiet, professional presence with empathy and compassion. Attempt to address concerns of the family in simple and accurate terms.

**CONTINUE**

### **Scene 2 Slide 3**

Continue → Next Slide



## End of Life

It is important to facilitate an environment that supports the beliefs of the patient and family related to dying as needed and possible.

---

START OVER



### Scene 2 Slide 4

Continue → End of Scenario

**End of Life**

Resources available at UVA Health in the care of the dying patient and patient's family can be found by accessing the Nursing Policy: Palliative Care, End of Life, and Postmortem Care, found in PolicyTech.

Other Resources Available: Adult population: The Palliative Care Nurse Navigator, PIC 1539.  
Pediatric Palliative Care: PIC 1244.

## Palliative Care

Palliative care is a service available to those patients who are facing a life limiting disease. Unlike hospice (which requires a 6 month or less diagnosis), Palliative care can be initiated any time a patient is facing a life limiting illness. The Palliative care team is expert in addressing complex symptoms and pain that patients with life limiting illness may be experiencing. The Palliative care team is also expert in facilitating serious illness and goals of care conversations. Palliative care can help patients understand and articulate their goals so the primary team can provide care that is in alignment with those goals thus assuring the best care is being provided for our patients facing life limiting illness.

[CONTINUE](#)

[Continue to the Next Section](#)

**Click Continue to move to the next section.**

[CONTINUE](#)

# Choose Your Role Inpatient Care

---

## Choose Your Role

**Inpatient RN** or other roles that align with the knowledge and work.

CONTINUE

**Licensed Independent Practitioner, MD, Nurse Practitioner**, or other roles that align with the knowledge and work.

CONTINUE

**Inpatient CNA or PCT** or other roles that align with the knowledge and work.

CONTINUE

**Emergency Medical Services**

EMT's or other roles that align with the knowledge and work.

CONTINUE

**Respiratory Therapist** or other roles that align with the knowledge and work.

CONTINUE

**My Role Is Not Listed:** If you provide inpatient care, but your role is not listed here.

CONTINUE

**I do not provide Inpatient Care**

If you do not provide inpatient care, click here to return to choose another patient care role.

RETURN TO PREVIOUS

# Inpatient CNA and PCT

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

It will take approximately 2 - 3 minutes to complete this section. It may take a moment for the content to load, but it is an important part of this course.

When you are finished with this section, scroll to the bottom to continue the course.

## Start Content for Inpatient CNA and PCTs



The content that follows is intended for Inpatient CNA, PCT, and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**



Complete the content above before moving on.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.

**CONTINUE**



## 1.1 Start

### Start Content for Inpatient CNA and PCTs



The content that follows is intended for Inpatient CNA, PCT, and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

Click **Next** to continue

### Notes:

## 1.2 Pain Management

(Multiple Choice, 10 points, 1 attempt permitted)

### Pain Management

The patient reports new back pain that started today. What is the correct action to take?

- Ask the patient to bend over and touch their toes to see if stretching helps.
- Ask the patient's spouse if they have any over the counter pain relievers that can be provided to the patient.
- Ask the patient to describe the pain along with location, duration, characteristics, and intensity. Report the findings to the RN.

Submit



Correct Choice

Ask the patient to bend over and touch their toes to see if stretching helps.

Ask the patient's spouse if they have any over the counter pain relievers that can

be provided to the patient.

- X Ask the patient to describe the pain along with location, duration, characteristics, and intensity. Report the findings to the RN.


**Notes:**

**Correct (Slide Layer)**


**Pain Management**

The patient reports new back pain that started today. What is the correct action to take?

- Ask the patient to bend over and touch their toes to see if stretching helps.
- Ask the patient's spouse if they have any over the counter pain relievers that can be provided to the patient.
- Ask the patient to describe the pain along with location, duration, characteristics, and intensity. Report the findings to the RN.

 **Correct**  
That's right! You selected the correct response.

[Continue](#)




**Incorrect (Slide Layer)**


**Pain Management**

The patient reports new back pain that started today. What is the correct action to take?

- Ask the patient to bend over and touch their toes to see if stretching helps.
- Ask the patient's spouse if they have any over the counter pain relievers that can be provided to the patient.
- Ask the patient to describe the pain along with location, duration, characteristics, and intensity. Report the findings to the RN.

 **Incorrect**  
That is incorrect.

[Learn More](#)



## 1.3 Pain Management



The correct answer is. Ask the patient to describe the pain along with location, duration, characteristics, and intensity. Report the findings to the RN.

Any new report of pain can be important to the care of the patient. Report anything new to the nurse.

**Notes:**

## 1.4 End



**Notes:**

# Inpatient RN

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

It will take approximately 10 - 15 minutes to complete this section.

## Inpatient Nurses

It may take a moment for the content to load, but is an important part of this course.

When you are finished with this section, scroll down to continue the course.

## Start Content for Inpatient Nurses



The content that follows is intended for Inpatient Nurses and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match every work environment, but we ask that you review each of the following scenarios and consider how it may impact your work.

**Click Next to continue**



Complete the content above before moving on.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.

**CONTINUE**

## 1.1 Start

Start Content for Inpatient Nurses



The content that follows is intended for Inpatient Nurses and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match every work environment, but we ask that you review each of the following scenarios and consider how it may impact your work.

Click Next to continue

Notes:

## 1.2 Advance Care Planning


(Multiple Choice, 10 points, 1 attempt permitted)

Advance Care Planning (ACP)

Jonathan is a new patient admitted to the hospital. When should he be asked if he has an advance directive?

- Within 24 hours of admission
- It is not necessary to ask
- Before care is given
- Anytime is fine

Submit



Correct	Choice
X	Within 24 hours of admission
	It is not necessary to ask

Before care is given

Anytime is fine

### Correct (Slide Layer)


**Advance Care Planning (ACP)**

Jonathan is a new patient admitted to the hospital. When should he be asked if he has an advance directive?

- Within 24 hours of admission
- It is not necessary to ask
- Before care is given
- Anytime is fine

**Correct**  
That's right! You selected the correct response.

[Continue](#)



### Incorrect (Slide Layer)


**Advance Care Planning (ACP)**

Jonathan is a new patient admitted to the hospital. When should he be asked if he has an advance directive?

- Within 24 hours of admission
- It is not necessary to ask
- Before care is given
- Anytime is fine

**Incorrect**  
That is incorrect.

[Learn More](#)



### 1.3 Advance Care Planning Information

**Advance Care Planning (ACP)**

The correct answer is: **Within 24 hours of admission.**  
The Advance Directive section of Social History in Epic is required admission documentation that must be completed within 24 hours of admission.

The Inpatient RN looks in the patient record to see what Advance Care Planning (ACP) documents are on file and confirms these with the patient.

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.

Patients have the right for their Advance Care Planning documents to be honored and incorporated into their plan of care.

**Social History**  
**Advance Directive**

Do you have an Advance Directive?  No, patient declines discussion  Yes, found in EMR  Yes, patient completed paper form  Yes, is elsewhere  Unable to ask  Other

Date asked (update advance directive status once a year minimally and on every admission) 03/15/2023

Notes:

### Pediatric Information (Slide Layer)

**Advance Care Planning**

The correct answer is: **Within 24 hours**  
The Advance Directive section of Social History in Epic is required admission documentation that must be completed within 24 hours of admission.

The Inpatient RN looks in the patient record to see what Advance Care Planning (ACP) documents are on file and confirms these with the patient.

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.

Patients have the right for their Advance Care Planning documents to be honored and incorporated into their plan of care.

**Social History**  
**Advance Directive**

Do you have an Advance Directive?  No, patient declines discussion  Yes, found in EMR  Yes, patient completed paper form  Yes, is elsewhere  Unable to ask  Other

Date asked (update advance directive status once a year minimally and on every admission) 03/15/2023

**Pediatric Information (Slide Layer)**

Pediatric nuances, or differences can be found here.

### 1.4 Transfusion Time Out

(Multiple Response, 10 points, 1 attempt permitted)



## Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.



Submit

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

## Incorrect (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

**Incorrect**  
That is incorrect.

[Learn More](#)

## Correct (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.




- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

**Correct**  
That's right! You selected the correct response.

[Continue](#)

## 1.5 Transfusion Time Out Education

### Transfusion Time Out Standard Work



The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LIP, or Perfusion Clinician) and the Verifier prior to blood being administered to a patient. This is a two-person safety check where the Transfusionist and Verifier are verifying the issued blood product is for their patient. This is done by verifying the information on the patient's ID armband and Typenex armband matches what is on the Transfusion Tag and the information on the Transfusion Tag matches what is on the Blood bag. The Transfusionist and Verifier read line by line and in a "read back" method.

If there are any discrepancies, stop and call the blood bank immediately.

Refer to the Transfusion Time-Out Standard Work. The blood bank sends this with every blood product.

Notes:

## 1.6 Antimicrobial Stewardship

(Pick Many, 10 points, 1 attempt permitted)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website
- PolicyTech

Correct	Choice
	Group 8
	Group 7
X	Group 6
X	Group 5

## Incorrect (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

Google

UpToDate

Clinical Portal/Antimicrobial Stewardship Program website

**Incorrect**  
That is incorrect.

[Learn More](#)

[Submit](#)

## Correct (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

Google

UpToDate

Clinical Portal/Antimicrobial Stewardship Program website

**Correct**  
That's right! You selected the correct response.

[Continue](#)

[Submit](#)

## 1.7 Antimicrobial Stewardship Info

**Antimicrobial Stewardship**

**The right answer is:** Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech

When looking for correct antibiotic prophylaxis recommendations, the institutional guidelines "Surgical and Procedural Antimicrobial Prophylaxis Guidelines" are the most suitable resources to ensure quality clinical care.

These and other guidelines for best antimicrobial practices can be accessed via the Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech.


## 1.8 Pain Management

(Multiple Choice, 10 points, 1 attempt permitted)

**Pain Management**

After informing the LIP about the patient's report of pain, Tonya, the RN, administers 5mg of Oxycodone to be given orally. Since Oxycodone is an opioid, when should the patient's pain and sedation level be reassessed?

- Within 24 hours of admission
- Pain should be reassessed every 15 minutes until pain relief is reported. Sedation level is not required.
- Pain should be reassessed within 4 hours and sedation level assessed within 90 minutes.




Correct	Choice
	Within 24 hours of admission
	Pain should be reassessed every 15 minutes until pain relief is reported. Sedation level is not required.
X	Pain should be reassessed within 4 hours and sedation level assessed within 90 minutes.

## Correct (Slide Layer)


**Pain Management**

After informing the LIP about the patient's report of pain, Tonya, the RN, administers 5mg of Oxycodone to be given orally. Since Oxycodone is an opioid, when should the patient's pain and sedation level be reassessed?

- Within 24 hours of admission
- Pain should be reassessed every 15 minutes until pain relief is reported. Sedation level is not required.
- Pain should be reassessed within 4 hours and sedation level assessed within 90 minutes.

 **Correct**  
That's right! You selected the correct response.

[Continue](#)




## Incorrect (Slide Layer)


**Pain Management**

After informing the LIP about the patient's report of pain, Tonya, the RN, administers 5mg of Oxycodone to be given orally. Since Oxycodone is an opioid, when should the patient's pain and sedation level be reassessed?

- Within 24 hours of admission
- Pain should be reassessed every 15 minutes until pain relief is reported. Sedation level is not required.
- Pain should be reassessed within 4 hours and sedation level assessed within 90 minutes.


 **Incorrect**  
That is incorrect.

[Learn More](#)



## 1.9 Pain Management


**Pain Management**



**The correct answer is:** Pain should be reassessed within 4 hours and sedation level assessed within 90 minutes.

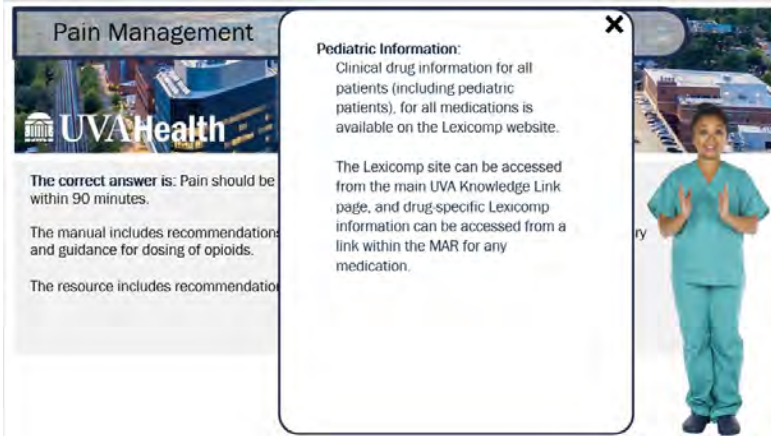
The manual includes recommendations for non-opioid analgesics on the UVA inpatient formulary and guidance for dosing of opioids.

The resource includes recommendations that is useful for all clinicians, including pediatrics.



Notes:

## Pediatric Information (Slide Layer)



The screenshot shows a slide layer titled "Pain Management" with the UVA Health logo. The main content area contains text about pain management. A white pop-up box titled "Pediatric Information" is overlaid on the slide, containing text about clinical drug information and Lexicomp access. To the right of the pop-up is a small image of a female healthcare professional in teal scrubs.

**Pain Management**

**UVA Health**

The correct answer is: Pain should be within 90 minutes.

The manual includes recommendations and guidance for dosing of opioids.

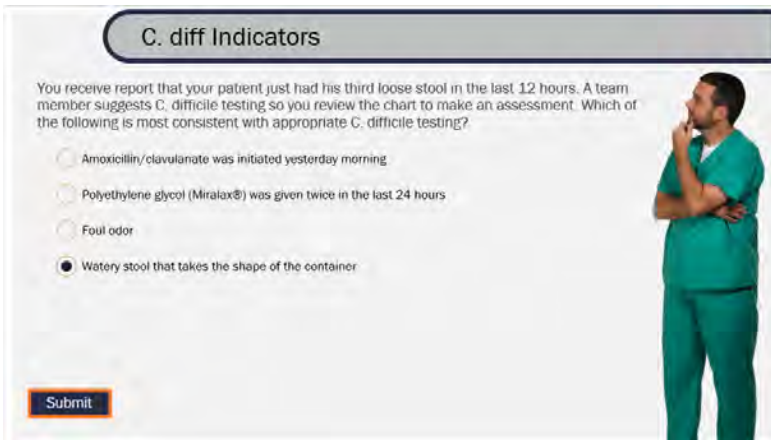
The resource includes recommendation

**Pediatric Information:**  
Clinical drug information for all patients (including pediatric patients), for all medications is available on the Lexicomp website.

The Lexicomp site can be accessed from the main UVA Knowledge Link page, and drug-specific Lexicomp information can be accessed from a link within the MAR for any medication.

### 1.10 C. diff Indicators

(Multiple Choice, 10 points, 1 attempt permitted)



The screenshot shows a multiple-choice question titled "C. diff Indicators". The question asks which indicator is most consistent with appropriate C. difficile testing. The options are: Amoxicillin/clavulanate was initiated yesterday morning, Polyethylene glycol (Miralax®) was given twice in the last 24 hours, Foul odor, and Watery stool that takes the shape of the container. The correct answer is "Watery stool that takes the shape of the container". A "Submit" button is visible at the bottom left. To the right of the question is a small image of a male healthcare professional in teal scrubs.

**C. diff Indicators**

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours
- Foul odor
- Watery stool that takes the shape of the container

Submit

Correct	Choice
	Amoxicillin/clavulanate was initiated yesterday morning
	Polyethylene glycol (Miralax®) was given twice in the last 24 hours

	Foul odor
X	Watery stool that takes the shape of the container

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

That is incorrect.

**Correct (Slide Layer)**

**C. diff Indicators**

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours
- Foul odor
- Watery stool that takes the shape of the container

**Correct**  
That's right! You selected the correct response:

[Continue](#)



## Incorrect (Slide Layer)

### C. diff Indicators

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning.
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours.
- Foul odor
- Watery stool that takes the shape of the container.


**Incorrect**  
That is incorrect.

[Learn More](#)



## 1.11 C. diff Indicators Info

### C. diff Indicators



**The right answer is:** Watery stool that takes the shape of the container.

If the specimen takes the shape of the container, it may be appropriate for testing.

General guidance for approaching C. difficile testing decisions among adult inpatients is available in the Resources section of the Infection Prevention and Control website or desktop icon.



**Should I send stool for C. difficile testing?**  
Send recommendations for testing in adult inpatients.

**1. FREQUENCY, SYMPTOMATOLOGY, AND RISK FACTORS**  
At least **3** watery stools within the last **24** hours AND clinical signs/symptoms or risk factors? (e.g. fever, T > 38°C, abdominal pain/cramping, recent antibiotics, recent admission/surgery, age > 65)

**2. CONSISTENCY**  
Stools take the **shape** of the container?

**3. PAST TESTING** (assuming that *Stenotrophomonas* is not the cause)  
Is there a C. difficile test in the last **7** days for the same episode of diarrhea?  
Is there a **POSITIVE** test in the last **28** days?

**4. ALTERNATIVE EXPLANATIONS** for diarrhea  
Is the diarrhea explained by another cause such as other medications? (e.g. laxatives, chemotherapy, antibiotics, tube feeding)

**Testing is likely appropriate: discuss with LIP.**

## 1.12 End

### End of This Section

Thank you for completing this section. Please scroll down to continue.



# Inpatient LIP

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

It will take approximately 15 minutes to complete this section

It may take a moment for the content to load, but it is an important part of this course.

When you are finished with this section, click continue to continue the course.

## Start Content for Inpatient LIP's



The content that follows is intended for Inpatient Licensed Independent Practitioners, and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**



Complete the content above before moving on.

**Continue to the Next Section**

**You have completed content related to your role.**

## 1.1 Start

Start Content for Inpatient LIP's



The content that follows is intended for Inpatient Licensed Independent Practitioners, and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**

### Notes:

## 1.2 Advance Care Planning


(Multiple Response, 10 points, 1 attempt permitted)

Advance Care Planning

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow unit procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the content of the Advance Directive.
- Ask the patient to make sure that the document gets scanned to his medical record.
- Place a copy in the red folder in the door side chart.

Submit



Correct	Choice
X	Make a copy, give the original to the patient. Then, follow unit procedures for having items scanned into the medical record.

X	Review the advance directive with the patient to ensure mutual understanding of the content of the Advance Directive.
	Ask the patient to make sure that the document gets scanned to his medical record.
X	Place a copy in the red folder in the door side chart.

### Incorrect (Slide Layer)

**Advance Care Planning**

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow unit procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the content of the Advance Directive.
- Ask the patient to make sure that the document gets scanned to his medical record.
- Place a copy in the red folder in the door side chart.

**Incorrect**  
That is incorrect.

[Learn More](#)

### Correct (Slide Layer)

**Advance Care Planning**

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow unit procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the content of the Advance Directive.
- Ask the patient to make sure that the document gets scanned to his medical record.
- Place a copy in the red folder in the door side chart.

**Correct**  
That's right! You selected the correct response.

[Continue](#)

## 1.3 Advance Care Planning



**Advance Care Planning**

The correct answer is:

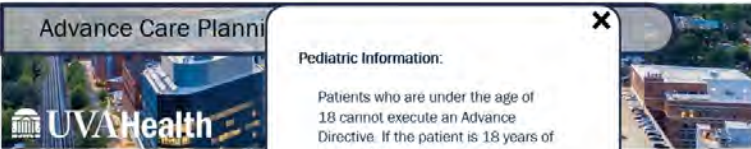
- Make a copy, give the original to the patient. Then, follow unit procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the content of the Advance Directive.
- Ensure a copy is placed in the red folder in the door side chart.

The goal is to have conversation between the patient and the care team to ensure that the patient's preferences are accurately reflected in the document and the care team understands and provides care that is in alignment with those preferences.

These preferences should be documented properly in Epic. In your progress note, use dot phrase "acpbegin" and "acpend" to document your ACP conversation. This will display in Epic as an ACP note.

**Notes:**

## Pediatric Information (Slide Layer)



**Advance Care Planning**

The correct answer is:

- Make a copy, give the original to the patient. Then, follow unit procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the content of the Advance Directive.
- Ensure a copy is placed in the red folder in the door side chart.

The goal is to have conversation between the patient and the care team to ensure that the patient's preferences are accurately reflected in the document and the care team understands and provides care that is in alignment with those preferences.

These preferences should be documented properly in Epic. In your progress note, use dot phrase "acpbegin" and "acpend" to document your ACP conversation. This will display in Epic as an ACP note.

**Pediatric Information:**

Patients who are under the age of 18 cannot execute an Advance Directive. If the patient is 18 years of age or older (and has capacity), you can follow this Standard Work.


## 1.4 Advance Care Planning Information

**Advance Care Planning (ACP)**

The correct answer is: **Within 24 hours of admission.**  
The Admissions Department staff will make the initial request and provide an advance directive form. The Inpatient RN looks in the patient record to see what Advance Care Planning (ACP) documents are on file and confirms these with the patient.

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.

Patients have the right for their Advance Care Planning documents to be honored and incorporated into their plan of care.



The screenshot shows a form titled "Social History" with a sub-section "Advance Directive". It includes a question "Do you have an Advance Directive?" with radio buttons for "No", "No, patient declines discussion", "Yes, listed in EMR", "Yes, patient completed paper form", "Yes, in elsewhere", and "Unable to ask". Below this is a date field "Date asked (publish advance directive guidelines once a year annually, and on every admission)" with a dropdown menu showing "12/13/2023". At the bottom, there is a field for "If in EMR or on paper, review and note date patient signed".

Notes:

## Pediatric Information (Slide Layer)


**Advance Care Planning**

Pediatric nuances, or differences can be found here.

The correct answer is: **Within 24 hours**  
The Admissions Department staff will make the initial request and provide an advance directive form. The Inpatient RN looks in the patient record to see what Advance Care Planning (ACP) documents are on file and confirms these with the patient.

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.

Patients have the right for their Advance Care Planning documents to be honored and incorporated into their plan of care.



The screenshot shows the same "Social History" form as above, but with a slide layer overlay. The slide layer is a white box with a close button (X) in the top right corner. It contains the text "Pediatric nuances, or differences can be found here." and partially obscures the text on the right side of the form.

## 1.5 Antimicrobial Stewardship

(Pick Many, 10 points, 1 attempt permitted)

### Antimicrobial Stewardship

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website
- PolicyTech

Submit

Correct	Choice
	Group 8
	Group 7
X	Group 6
X	Group 5

### Incorrect (Slide Layer)

### Antimicrobial Stewardship

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website



**Incorrect**  
That is incorrect.

Learn More

Submit



## Correct (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

Google

UpToDate

Clinical Portal/Antimicrobial Stewardship Program website

**Correct**  
That's right! You selected the correct response.

[Continue](#) [Submit](#)

## 1.6 Antimicrobial Stewardship Info

**Antimicrobial Stewardship**

**The correct answer is:** Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech

When looking for correct antibiotic prophylaxis recommendations, the institutional guidelines "Surgical and Procedural Antimicrobial Prophylaxis Guidelines" are the most suitable resources to ensure quality clinical care.

These and other guidelines for best antimicrobial practices can be accessed via the Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech.

## 1.7 Transfusion Time Out

*(Multiple Response, 10 points, 1 attempt permitted)*

## Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.



Submit

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

## Incorrect (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
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- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

**Incorrect**  
That is incorrect.

[Learn More](#)

## Correct (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.




- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

**Correct**  
That's right! You selected the correct response.

[Continue](#)

## 1.8 Transfusion Time Out Education

### Transfusion Time Out Standard Work



The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LIP, or Perfusion Clinician) and the Verifier prior to blood being administered to a patient. This is a two-person safety check where the Transfusionist and Verifier are verifying the issued blood product is for their patient. This is done by verifying the information on the patient's ID armband and Typenex armband matches what is on the Transfusion Tag and the information on the Transfusion Tag matches what is on the Blood bag. The Transfusionist and Verifier read line by line and in a "read back" method.

If there are any discrepancies, stop and call the blood bank immediately.

Refer to the Transfusion Time-Out Standard Work. The blood bank sends this with every blood product.

Notes:

## 1.9 Pain Management

(Multiple Choice, 10 points, 1 attempt permitted)

Pain Management

Which statement indicates the development of opioid tolerance?

- Stimulants are needed to counteract the sedating effects of opioids.
- The patient no longer experiences constipation from the usual dose of opioid.
- The patient becomes anxious about knowing the exact time of the next dose of opioid.
- Larger doses of opioids are needed to control pain, as compared to several weeks earlier.

Submit



Correct	Choice
	Stimulants are needed to counteract the sedating effects of opioids.
	The patient no longer experiences constipation from the usual dose of opioid.
	The patient becomes anxious about knowing the exact time of the next dose of opioid.
X	Larger doses of opioids are needed to control pain, as compared to several weeks earlier.

Notes:

## Correct (Slide Layer)

**Pain Management**

Which statement indicates the development of opioid tolerance?

- Stimulants are needed to counteract the sedating effects of opioids.
- The patient no longer experiences constipation from the usual dose of opioid.
- The patient becomes anxious about knowing the exact time of the next dose of opioid.
- Larger doses of opioids are needed to control pain, as compared to several weeks earlier.

 **Correct**  
That's right! You selected the correct response.

[Continue](#)



## Incorrect (Slide Layer)

**Pain Management**

Which statement indicates the development of opioid tolerance?

- Stimulants are needed to counteract the sedating effects of opioids.
- The patient no longer experiences constipation from the usual dose of opioid.
- The patient becomes anxious about knowing the exact time of the next dose of opioid.
- Larger doses of opioids are needed to control pain, as compared to several weeks earlier.


 **Incorrect**  
That is incorrect.

[Learn More](#)



## 1.10 Pain Management

**Pain Management**



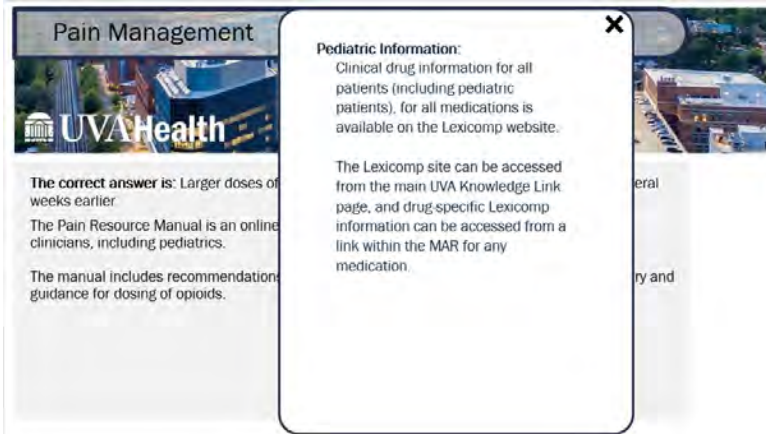
**The correct answer is:** Larger doses of opioids are needed to control pain, as compared to several weeks earlier.

The Pain Resource Manual is an online UVA-specific resource in PolicyTech that is useful for all clinicians, including pediatrics.

The manual includes recommendations for non-opioid analgesics on the UVA inpatient formulary and guidance for dosing of opioids.

Notes:

## Pediatric Information (Slide Layer)



**Pain Management**

**UVA Health**

The correct answer is: Larger doses of weeks earlier.

The Pain Resource Manual is an online clinicians, including pediatrics.

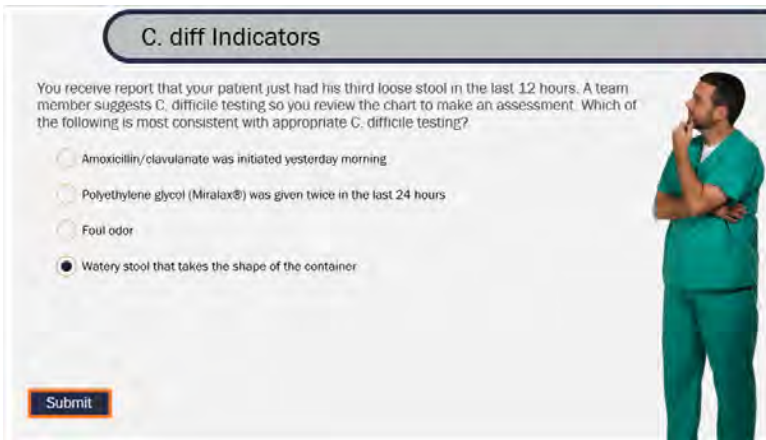
The manual includes recommendations guidance for dosing of opioids.

**Pediatric Information:**  
Clinical drug information for all patients (including pediatric patients), for all medications is available on the Lexicomp website.

The Lexicomp site can be accessed from the main UVA Knowledge Link page, and drug-specific Lexicomp information can be accessed from a link within the MAR for any medication.

### 1.11 C. diff Indicators

(Multiple Choice, 10 points, 1 attempt permitted)



**C. diff Indicators**

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours
- Foul odor
- Watery stool that takes the shape of the container

Submit

Correct	Choice
	Amoxicillin/clavulanate was initiated yesterday morning
	Polyethylene glycol (Miralax®) was given twice in the last 24 hours

	Foul odor
X	Watery stool that takes the shape of the container

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

That is incorrect.

**Correct (Slide Layer)**

**C. diff Indicators**

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours
- Foul odor
- Watery stool that takes the shape of the container

**Correct**  
That's right! You selected the correct response:

[Continue](#)

## Incorrect (Slide Layer)

### C. diff Indicators

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning.
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours.
- Foul odor
- Watery stool that takes the shape of the container.



**Incorrect**  
That is incorrect.

[Learn More](#)



## 1.12 C. diff Indicators Info

### C. diff Indicators



**Should I send stool for C. difficile testing?**  
Send recommendations for testing in adult inpatients

**1. FREQUENCY, SYMPTOMATOLOGY, AND RISK FACTORS**  
At least **3** watery stools within the last **24** hours **AND** clinical signs/symptoms or risk factors? (e.g. fever, T tend, abdominal pain/discomfort, recent antibiotics, prior abdominal surgery, age >65)

**2. CONSISTENCY**  
Stools take the **shape** of the container.

**3. PRIOR TESTING** (assuming that Prior Negative Stooling)  
Is there a C. difficile test in the last **7** days for the **same** episode of diarrhea?  
Is there a **POSITIVE** test in the last **28** days?

**4. ALTERNATIVE EXPLANATIONS** (if positive)  
Is the diarrhea explained by another cause such as other medications? (e.g. laxatives, chemotherapy, antibiotics, tube feeding)

Testing is likely appropriate. Discuss with LIP.

**NO** → Do NOT test

**YES** → Do NOT test

**NO** → Do NOT test

**YES** → Do NOT test

**NO** → Do NOT test

**YES** → Do NOT test

**The right answer is:** Watery stool that takes the shape of the container.


If the specimen takes the shape of the container, it may be appropriate for testing.


General guidance for approaching C. difficile testing decisions among adult inpatients is available in the Resources section of the Infection Prevention and Control website or desktop icon.



## 1.13 Informed Decision Making

### Informed Decision Making






Click each check mark to review requirements for Informed Consent.

Patients have the right to not only be informed, but make informed decisions about their care.



### Icon 01 Layer (Slide Layer)

Informed Decision Making




Patients 18 years of age or older who are capable of making an informed decision shall provide consent to healthcare for themselves.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 02 Layer (Slide Layer)

Informed Decision Making




Consent for patients under the age of 18 years must be obtained from at least one of a minor's parents, a legally appointed guardian, or an attorney-in-fact authorized by a properly executed power of attorney pursuant to Virginia Code 20-167. Legally appointed guardians are required to provide

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 03 Layer (Slide Layer)

Informed Decision Making




Use of a form to document informed consent is required for all procedures performed in the operating room, all procedures under anesthesia or moderate/deep sedation, and invasive procedures performed outside of the operating room where there is more than minimal risk to the patient.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 04 Layer (Slide Layer)

Informed Decision Making




The attending physician who proposes a treatment plan or procedure or his/her designee is responsible for obtaining consent prior to provision of care. A "designee" is another attending physician, a GME Trainee, or an Advanced Practice Provider acting within the scope of their clinical practice and approved privileges.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 05 Layer (Slide Layer)

Informed Decision Making




An adult patient is "incapable of making an informed decision" when the patient is unable to understand or evaluate the proposed treatment or evaluate the risks and benefits.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 06 Layer (Slide Layer)

Informed Decision Making





Two physicians or one physician and one clinical psychologist perform and document the capacity assessment.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 07 Layer (Slide Layer)

Informed Decision Making





When a patient has not appointed a healthcare agent in an Advance Directive, there is a hierarchy designated by state law as to who may authorize healthcare decisions for the patient as surrogate decision makers. Medical Center policy on Informed Decision Making lists this hierarchy.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 08 Layer (Slide Layer)

Informed Decision Making



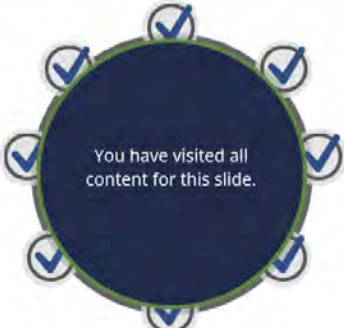

Consent forms are valid six months (6) from the date of signature with **three** exceptions:

- Consent for Procedures in the Adult Intensive Care Unit is valid for the duration of the patient's care under the critical care team specified on the consent form.
- Blood Administration

Patients have the right to not only be informed, but make informed decisions about their care.

### Complete (Slide Layer)

Informed Decision Making



You have visited all content for this slide.

Patients have the right to not only be informed, but make informed decisions about their care.

## 1.14 End

End of This Section

Thank you for completing this section. Please scroll down to continue.



**Notes:**

Click continue to complete the course.

**CONTINUE**

# Respiratory Therapists

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please answer each question and reflect how the topic may be relevant in your work.

This section of the course will take approximately 3 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## 1.1 Transfusion Time Out


(Multiple Response, 10 points, 1 attempt permitted)

**Transfusion Time-Out**

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

Submit

Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

## Incorrect (Slide Layer)

**Transfusion Time-Out**

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag

**Incorrect**  
That is incorrect.

[Learn More](#)

## Correct (Slide Layer)

**Transfusion Time-Out**

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.




- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag

**Correct**  
That's right! You selected the correct response.

[Continue](#)

## 1.2 Transfusion Time Out Education

**Transfusion Time Out Standard Work**



**The correct answers are:**

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LIP, or




**Notes:**

### ***1.3 End***

End of This Section

Thank you for completing this section. Please scroll down to continue.

A photograph of three healthcare professionals standing side-by-side. From left to right: a man in light blue scrubs, a woman in dark blue scrubs, and a woman in teal scrubs. They are all smiling and looking towards the camera. The background is plain white.

**Notes:**

## Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

**Check all that apply.**



Submit

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag



Complete the content above before moving on.

**Continue to the Next Section**

**You have completed content related to your role.**

Click Continue to complete the course.

CONTINUE

# Outpatient Care

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

It will take approximately 3-5 minutes to complete this section.

If you do not provide outpatient care, [click here to return to the previous section.](#)

RETURN TO PREVIOUS

## Continue to the Next Section

Click Continue to move to the next section.

CONTINUE

# Fall Prevention

---

## Ambulatory Clinic Fall Prevention Standard Work

Preventing patient falls in the ambulatory setting is as important as in the inpatient setting. Because each unit is unique, each area determines the level of individual assessment necessary to maximize safety based on patient population, setting, and services provided. Consider these things when determining level of help a patient may need:



**Have a Known  
History of Falls**



**Use of Assistive  
Device for Mobility**



**On a Bed, Stretcher,  
or Exam Table**



**Has Dementia or  
Other Cognitive  
impairment**



**Asks for Help  
Getting From One  
Place to Another**



**"High Fall Risk" Using  
Clinic-specific Fall  
Risk Screening Tools**

- In clinical areas that use yellow fall risk identifiers as applicable.
- Offer assistance with ambulation or provide a wheelchair at arrival and/or for any sign of impaired gait/mobility.
- Remain within arm's reach with direct visualization during ambulation.
- Assist patients onto and down from examination tables, stretchers, chairs, or beds.
- Keep within view (keep doors open when unattended, etc.).
- Offer hydration, nutrition, and elimination assistance as appropriate.
- Monitor closely while in the bathroom and inform patient on how to call for help.
- Confirm return transportation arrangements when the patient arrives in clinic.
- Provide Home Safety Check List (PE15001) and/or Outpatient Handbook (English or Spanish).



**Note:** Refer to Fall Prevention for Adult and Pediatric Patients Guideline for additional practice expectations and resources.

**Continue to the Next Section**

**Click Continue to move to the next section.**

# Choose Your Role Outpatient Care

---

## Choose Your Role

**Outpatient RN** or other roles that align with the knowledge and work.

CONTINUE

**Outpatient Licensed Independent Practitioner, MD, Nurse Practitioner**, or other roles that align with the knowledge and work.

CONTINUE

**Outpatient LPN, MA, PCT**, or other roles that align with the knowledge and work.

CONTINUE

**Rad Technician** or other roles that align with the knowledge and work.

CONTINUE

**Another Outpatient Care Role:** If your role is not listed here, click here to continue in the course.

[CONTINUE](#)

**If you do not provide Outpatient Care, click here to choose another patient care role.**

[RETURN TO PREVIOUS](#)



# Outpatient LIP

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please answer each question and reflect how the topic may be relevant in your work.

This section will take approximately 15 - 20 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## 1.1 Start

Start Content for Outpatient LIP's



The content that follows is intended for Outpatient Licensed Independent Practitioners (LIP's) and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**

### Notes:

## 1.2 Advance Care Planning


(Multiple Response, 10 points, 1 attempt permitted)

Advance Care Planning

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.
- Ask the patient to make sure that the document gets scanned to his medical record.

Submit



Correct	Choice
X	Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.

X	Review the advance directive with the patient to ensure mutual understanding of the document.
	Ask the patient to make sure that the document gets scanned to his medical record.

**Incorrect (Slide Layer)**

**Advance Care Planning**

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.
- Ask the patient to make sure that the document gets scanned to his medical record.

**Incorrect**  
That is incorrect.

[Learn More](#)

**Correct (Slide Layer)**

**Advance Care Planning**

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.
- Ask the patient to make sure that the document gets scanned to his medical record.

**Correct**  
That's right! You selected the correct response.

[Continue](#)

### 1.3 Advance Care Planning



**Advance Care Planning**

The correct answer is:

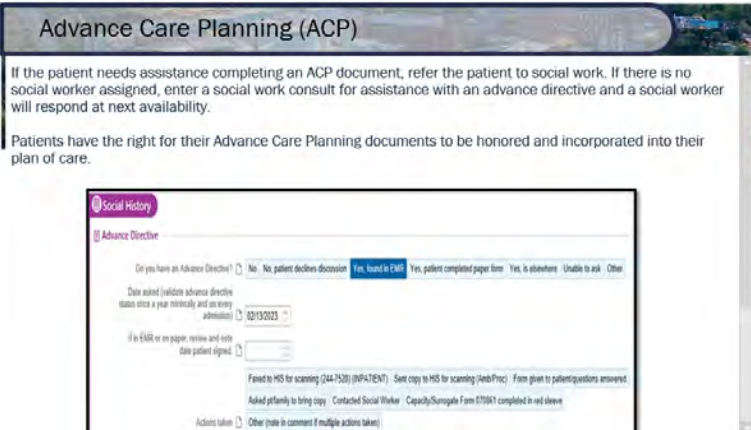
- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.

The goal is to have conversation between the patient and the care team to ensure that the patient's preferences are accurately reflected in the document and the care team understands and provides care that is in alignment with those preferences.

These preferences should be documented properly in Epic. In your progress note, use dot phrase "acpbegin" and "acpend" to document your ACP conversation. This will display in Epic as an ACP note.

Notes:

### 1.4 Advance Care Planning Information



**Advance Care Planning (ACP)**

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.

Patients have the right for their Advance Care Planning documents to be honored and incorporated into their plan of care.

**Social History**

**Advance Directive**

Do you have an Advance Directive?  No, no patient declines discussion  Yes, found in EMR  Yes, patient completed paper form  Yes, is elsewhere  Unable to ask  Other

Date asked (update advance directive status once a year, annually and on every admission)

If in EMR or on paper, review and note date patient signed

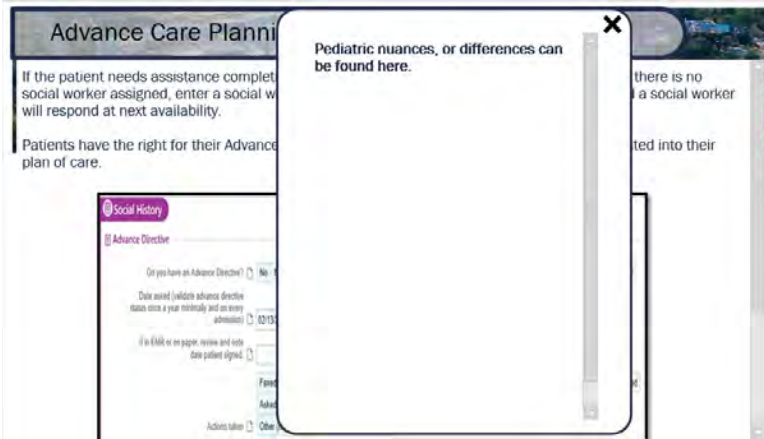
Forward to H&S for scanning (244-7530) (IMPATIENT) Sent copy to H&S for scanning (JambProc) Form given to patient/questions answered

Asked pt/family to bring copy Contacted Social Worker Capacity/Surrogate Form 07081 completed in red sleeve

Actions taken  Other (note in comment if multiple actions taken)

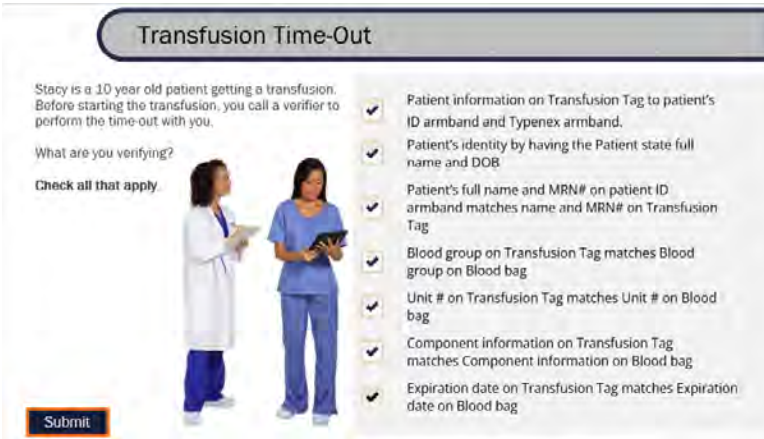
Notes:

## Pediatric Information (Slide Layer)



### 1.5 Transfusion Time Out

(Multiple Response, 10 points, 1 attempt permitted)



Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag

X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

### Incorrect (Slide Layer)

#### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag



**Incorrect**  
That is incorrect.

[Learn More](#)

[Submit](#)

### Correct (Slide Layer)

#### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag




**Correct**  
That's right! You selected the correct response.

[Continue](#)

[Submit](#)

## 1.6 Transfusion Time Out Education

**Transfusion Time Out Standard Work**



The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LIP, or Perfusion Clinician) and the Verifier prior to blood being administered to a patient. This is a two-person safety check where the Transfusionist and Verifier are verifying the issued blood product is for their patient. This is done by verifying the information on the patient's ID armband and Typenex armband matches what is on the Transfusion Tag and the information on the Transfusion Tag matches what is on the Blood bag. The Transfusionist and Verifier read line by line and in a "read back" method.

If there are any discrepancies, stop and call the blood bank immediately.

Refer to the Transfusion Time-Out Standard Work. The blood bank sends this with every blood product

### Notes:

## 1.7 Antimicrobial Stewardship

*(Pick Many, 10 points, 1 attempt permitted)*

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration)

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website
- PolicyTech

**Submit**

Correct	Choice
	Group 8
	Group 7

X	Group 6
X	Group 5

### Incorrect (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website
- Incorrect**  
That is incorrect.

[Learn More](#) [Submit](#)

### Correct (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Correct**  
That's right! You selected the correct response.

[Continue](#) [Submit](#)



## 1.8 Antimicrobial Stewardship Info

**Antimicrobial Stewardship**

The correct answer is: Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech

When looking for correct antibiotic prophylaxis recommendations, the institutional guidelines "Surgical and Procedural Antimicrobial Prophylaxis Guidelines" are the most suitable resources to ensure quality clinical care.

These and other guidelines for best antimicrobial practices can be accessed via the Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech.

## 1.9 Pain Management

(Multiple Choice, 10 points, 1 attempt permitted)

**Pain Management**

Which statement indicates the development of opioid tolerance?

- Stimulants are needed to counteract the sedating effects of opioids.
- The patient no longer experiences constipation from the usual dose of opioid.
- The patient becomes anxious about knowing the exact time of the next dose of opioid.
- Larger doses of opioids are needed to control pain, as compared to several weeks earlier.



Correct	Choice
	Stimulants are needed to counteract the sedating effects of opioids.
	The patient no longer experiences constipation from the usual dose of opioid.
	The patient becomes anxious about knowing the exact time of the next dose of opioid.
X	Larger doses of opioids are needed to control pain, as compared to several weeks

earlier.


## Notes:

### Correct (Slide Layer)

**Pain Management**

Which statement indicates the development of opioid tolerance?

- Stimulants are needed to counteract the sedating effects of opioids.
- The patient no longer experiences constipation from the usual dose of opioid.
- The patient becomes anxious about knowing the exact time of the next dose of opioid.
- Larger doses of opioids are needed to control pain, as compared to several weeks earlier.



**Correct**  
That's right! You selected the correct response.

[Continue](#)

### Incorrect (Slide Layer)

**Pain Management**

Which statement indicates the development of opioid tolerance?

- Stimulants are needed to counteract the sedating effects of opioids.
- The patient no longer experiences constipation from the usual dose of opioid.
- The patient becomes anxious about knowing the exact time of the next dose of opioid.
- Larger doses of opioids are needed to control pain, as compared to several weeks earlier.



**Incorrect**  
That is incorrect.

[Learn More](#)

## 1.10 Pain Management



**Pain Management**

**UVA Health**

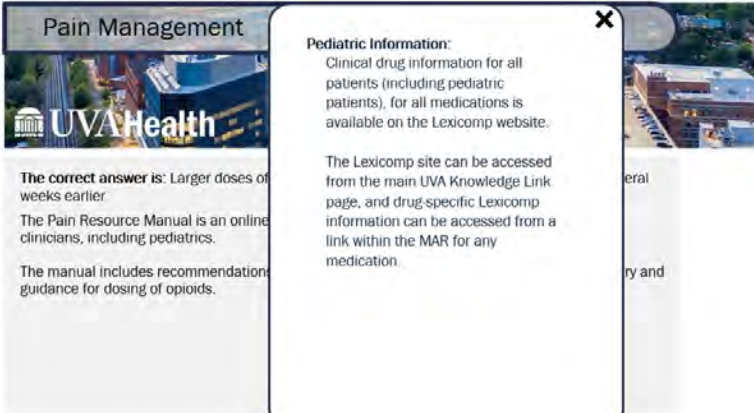
The correct answer is: Larger doses of opioids are needed to control pain, as compared to several weeks earlier.

The Pain Resource Manual is an online UVA-specific resource in PolicyTech that is useful for all clinicians, including pediatrics.

The manual includes recommendations for non-opioid analgesics on the UVA inpatient formulary and guidance for dosing of opioids.

Notes:

### Pediatric Information (Slide Layer)



**Pain Management**

**UVA Health**

The correct answer is: Larger doses of opioids are needed to control pain, as compared to several weeks earlier.

The Pain Resource Manual is an online UVA-specific resource in PolicyTech that is useful for all clinicians, including pediatrics.

The manual includes recommendations for non-opioid analgesics on the UVA inpatient formulary and guidance for dosing of opioids.


**Pediatric Information:**

Clinical drug information for all patients (including pediatric patients), for all medications is available on the Lexicomp website.

The Lexicomp site can be accessed from the main UVA Knowledge Link page, and drug-specific Lexicomp information can be accessed from a link within the MAR for any medication.

## 1.11 Informed Decision Making

Informed Decision Making




Click each check mark to review requirements for Informed Consent.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 01 Layer (Slide Layer)

Informed Decision Making




Patients 18 years of age or older who are capable of making an informed decision shall provide consent to healthcare for themselves.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 02 Layer (Slide Layer)

Informed Decision Making




Consent for patients under the age of 18 years must be obtained from at least one of a minor's parents, a legally appointed guardian, or an attorney-in-fact authorized by a properly executed power of attorney pursuant to Virginia Code 20-167. Legally appointed guardians are required to provide.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 03 Layer (Slide Layer)

Informed Decision Making




Use of a form to document informed consent is required for all procedures performed in the operating room, all procedures under anesthesia or moderate/deep sedation, and invasive procedures performed outside of the operating room where there is more than minimal risk to the patient.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 04 Layer (Slide Layer)

Informed Decision Making




The attending physician who proposes a treatment plan or procedure or his/her designee is responsible for obtaining consent prior to provision of care. A "designee" is another attending physician, a GME Trainee, or an Advanced Practice Provider acting within the scope of their clinical practice and approved privileges.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 05 Layer (Slide Layer)

Informed Decision Making



An adult patient is "incapable of making an informed decision" when the patient is unable to understand or evaluate the proposed treatment or evaluate the risks and benefits.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 06 Layer (Slide Layer)

Informed Decision Making

Two physicians or one physician and one clinical psychologist perform and document the capacity assessment.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 07 Layer (Slide Layer)

Informed Decision Making

When a patient has not appointed a healthcare agent in an Advance Directive, there is a hierarchy designated by state law as to who may authorize healthcare decisions for the patient as surrogate decision makers. Medical Center policy on Informed Decision Making lists this hierarchy.

Patients have the right to not only be informed, but make informed decisions about their care.

### Icon 08 Layer (Slide Layer)

Informed Decision Making

Unless there is a change in modality selection, a lapse in treatment, or change in the patient's condition where the risk, benefit, alternatives to treatment and anticipated outcomes differ from the current patient authenticated consent form.

Patients have the right to not only be informed, but make informed decisions about their care.

## Complete (Slide Layer)

Informed Decision Making




You have visited all content for this slide.

Patients have the right to not only be informed, but make informed decisions about their care.

## 1.12 End

End of This Section

Thank you for completing this section. Please scroll down to continue to the slides that are required for all UVA Health Team Members.



## Notes:

## Start Content for Outpatient LIP's



The content that follows is intended for Outpatient Licensed Independent Practitioners (LIP's) and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**



Complete the content above before moving on.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.



# Outpatient RN

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please answer each question and reflect how the topic may be relevant in your work.

This section will take approximately 10 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## Start Content for Outpatient RN



The content that follows is intended for Outpatient Nurses and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match every work environment, but we ask that you review each of the following scenarios and consider how it may impact your work.

**Click Next to continue**




Complete the content above before moving on.

**Continue to the Next Section**

**You have completed content related to your role.**

## 1.1 Start

Start Content for Outpatient RN



The content that follows is intended for Outpatient Nurses and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match every work environment, but we ask that you review each of the following scenarios and consider how it may impact your work.

Click Next to continue

Notes:

## 1.2 Advance Care Planning


(Multiple Response, 10 points, 1 attempt permitted)

Advance Care Planning

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.
- Ask the patient to make sure that the document gets scanned to his medical record.

Submit



Correct	Choice
X	Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.

X	Review the advance directive with the patient to ensure mutual understanding of the document.
	Ask the patient to make sure that the document gets scanned to his medical record.

**Notes:**

**Incorrect (Slide Layer)**

**Advance Care Planning**

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.
- Ask the patient to make sure that the document gets scanned to his medical record.

**Incorrect**  
That is incorrect.

[Learn More](#)

**Correct (Slide Layer)**

**Advance Care Planning**

Jonathan, your patient, has completed an advance directive and hands you the original signed document. What is your appropriate action? (Check all correct answers)

- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.
- Ask the patient to make sure that the document gets scanned to his medical record.

**Correct**  
That's right! You selected the correct response.

[Continue](#)

## 1.3 Advance Care Planning



**Advance Care Planning**

The correct answer is:

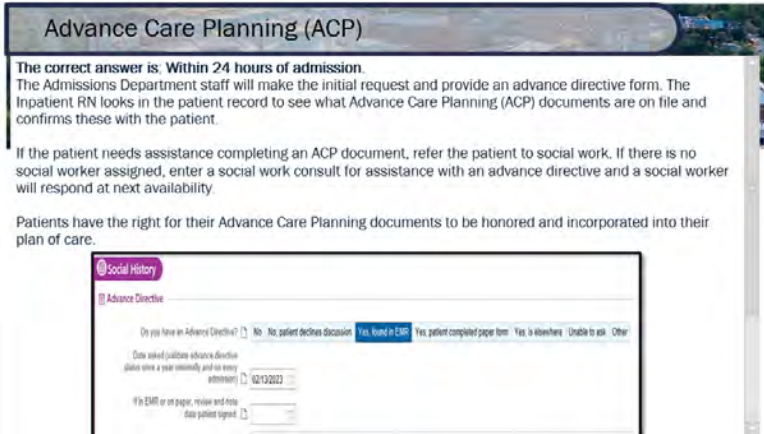
- Make a copy, give the original to the patient. Then, follow clinic procedures for having items scanned into the medical record.
- Review the advance directive with the patient to ensure mutual understanding of the document.

The goal is to have a conversation between the patient and the care team to ensure that the patient's preferences are accurately reflected in the document and the care team understands and provides care that is in alignment with those preferences.

These preferences should be documented properly in Epic. In your note, use dot phrase "acpbegin" and "acpend" to document ACP conversation. This will display in Epic as an ACP note.

### Notes:

## 1.4 Advance Care Planning Information



**Advance Care Planning (ACP)**

The correct answer is: **Within 24 hours of admission.**  
The Admissions Department staff will make the initial request and provide an advance directive form. The Inpatient RN looks in the patient record to see what Advance Care Planning (ACP) documents are on file and confirms these with the patient.

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.

Patients have the right for their Advance Care Planning documents to be honored and incorporated into their plan of care.

**Social History**

**Advance Directive**

Do you have an Advance Directive?  No  No, patient declines discussion  Yes, found in EMR  Yes, patient completed paper form  Yes, in elsewhere  Unable to ask  Other

Date added (update advance directive within one year annually and on every admission)

If in EMR or on paper, review and note date patient signed

### Notes:

## Pediatric Information (Slide Layer)

**Advance Care Planning**

The correct answer is: Within 24 hours  
The Admissions Department staff will m  
Inpatient RN looks in the patient record  
confirms these with the patient.

If the patient needs assistance complet  
social worker assigned, enter a social w  
will respond at next availability.

Patients have the right for their Advance  
plan of care.

**Social History**

**Advance Directive**

Do you have an Advance Directive?  No  Yes

Once asked (publish advance directive  
gives care a year normally and on every  
admission)

If in EMR or on paper, review and have  
date patient signed

## 1.5 Transfusion Time Out

(Multiple Response, 10 points, 1 attempt permitted)


**Transfusion Time-Out**

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

**Check all that apply.**

Submit



This is not part of my role.

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag

X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

### Incorrect (Slide Layer)

#### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

✘

**Incorrect**

That is incorrect.

[Learn More](#)

### Correct (Slide Layer)

#### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, you call a verifier to perform the time-out with you.

What are you verifying?

Check all that apply.

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

✔


**Correct**

That's right! You selected the correct response.

[Continue](#)

## 1.6 Transfusion Time Out Education

Transfusion Time Out Standard Work



The correct answers are:

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LIP, or

### Notes:

## 1.7 Antimicrobial Stewardship

(Pick Many, 10 points, 1 attempt permitted)

Antimicrobial Stewardship

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration)

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website
- PolicyTech

Submit

Correct	Choice
	Group 8
	Group 7



X	Group 6
X	Group 5

### Incorrect (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website
- Incorrect**  
That is incorrect.

[Learn More](#) [Submit](#)

### Correct (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Correct**  
That's right! You selected the correct response.

[Continue](#) [Submit](#)

## 1.8 Antimicrobial Stewardship Info

**Antimicrobial Stewardship**

The correct answer is: Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech

When looking for correct antibiotic prophylaxis recommendations, the institutional guidelines "Surgical and Procedural Antimicrobial Prophylaxis Guidelines" are the most suitable resources to ensure quality clinical care.

These and other guidelines for best antimicrobial practices can be accessed via the Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech.


## 1.9 Pain Management

(Multiple Choice, 10 points, 1 attempt permitted)

**Pain Management**

You are rooming a patient who is here for a follow up visit from a recent procedure. When should the patient be screened for pain?

- No screening is required.
- Only if the patient is having difficulty ambulating.
- During the visit as part of the intake process.



Correct	Choice
	No screening is required.
	Only if the patient is having difficulty ambulating.
X	During the visit as part of the intake process.

## Correct (Slide Layer)


**Pain Management**

You are rooming a patient who is here for a follow up visit from a recent procedure. When should the patient be screened for pain?

- No screening is required.
- Only if the patient is having difficulty ambulating.
- During the visit as part of the intake process.

**Correct**  
That's right! You selected the correct response.

[Continue](#)



## Incorrect (Slide Layer)


**Pain Management**

You are rooming a patient who is here for a follow up visit from a recent procedure. When should the patient be screened for pain?

- No screening is required.
- Only if the patient is having difficulty ambulating.
- During the visit as part of the intake process.


**Incorrect**  
That is incorrect.

[Learn More](#)



## 1.10 Pain Management


**Pain Management**



**The correct answer is:** During the visit as part of the intake process.

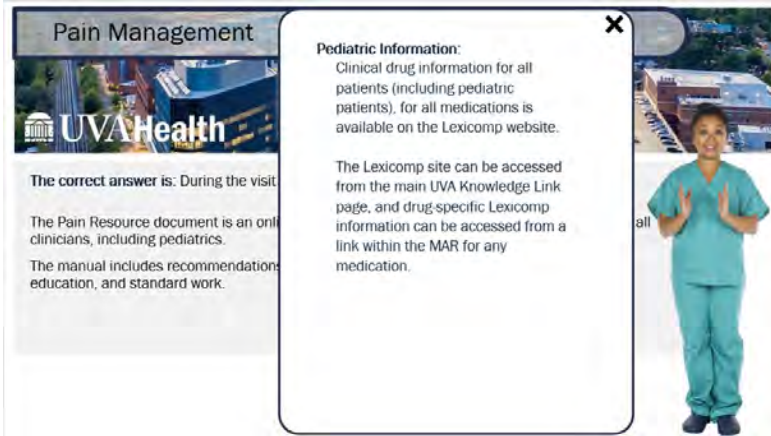
The Pain Resource document is an online UVA-specific resource in PolicyTech that is useful for all clinicians, including pediatrics.

The manual includes recommendations for pain assessment, controlled substances, patient education, and standard work.



Notes:

## Pediatric Information (Slide Layer)



The screenshot shows a slide layer titled "Pain Management" with the UVA Health logo. The main content area contains text about the Pain Resource document. A white pop-up box titled "Pediatric Information" is overlaid on the slide, containing text about clinical drug information and Lexicomp access. To the right of the pop-up is a small video thumbnail showing a healthcare professional in scrubs.

**Pain Management**

**UVA Health**

The correct answer is: During the visit

The Pain Resource document is an online manual for all clinicians, including pediatrics.

The manual includes recommendations, education, and standard work.

**Pediatric Information:**  
Clinical drug information for all patients (including pediatric patients), for all medications is available on the Lexicomp website.

The Lexicomp site can be accessed from the main UVA Knowledge Link page, and drug-specific Lexicomp information can be accessed from a link within the MAR for any medication.

## 1.11 End



The screenshot shows a slide titled "End of This Section" with a dark blue header. The main content area contains a thank you message. Below the text is a photograph of two healthcare professionals, a man in green scrubs and a woman in blue scrubs, standing side-by-side.

**End of This Section**

Thank you for completing this section. Please scroll down to continue.

Notes:

Click Continue to complete the course.

**CONTINUE**

# Outpatient LPN, MA, PCT

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please answer each question and reflect how the topic may be relevant in your work.


This section will take approximately 2 - 5 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## Pain Management

## 1.1 Start

Start Content for Outpatient LPN, MA, PCT



The content that follows is intended for Outpatient LPN, MA, PCT, and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

Click **Next** to continue

### Notes:

## 1.2 Advance Care Planning


(Multiple Choice, 10 points, 1 attempt permitted)

Advance Care Planning (ACP)

Jonathan is a new patient. When should he be asked if he has an advance directive?

- At least yearly
- It is not necessary to ask
- It is not part of my responsibility
- Anytime is fine

Submit



Correct	Choice
X	At least yearly
	It is not necessary to ask

It is not part of my responsibility

Anytime is fine

### Correct (Slide Layer)


**Advance Care Planning (ACP)**

Jonathan is a new patient. When should he be asked if he has an advance directive?

- At least yearly
- It is not necessary to ask
- It is not part of my responsibility
- Anytime is fine

**Correct**  
That's right! You selected the correct response.

[Continue](#)



### Incorrect (Slide Layer)


**Advance Care Planning (ACP)**

Jonathan is a new patient. When should he be asked if he has an advance directive?

- At least yearly
- It is not necessary to ask
- It is not part of my responsibility
- Anytime is fine

**Incorrect**  
That is incorrect.

[Learn More](#)






### 1.3 Advance Care Planning Information

**Advance Care Planning (ACP)**

The correct answer is: **At least yearly**.  
The person who rooms the patient in the ambulatory setting completes the advance directive section in Social History at least yearly.

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.



Notes:

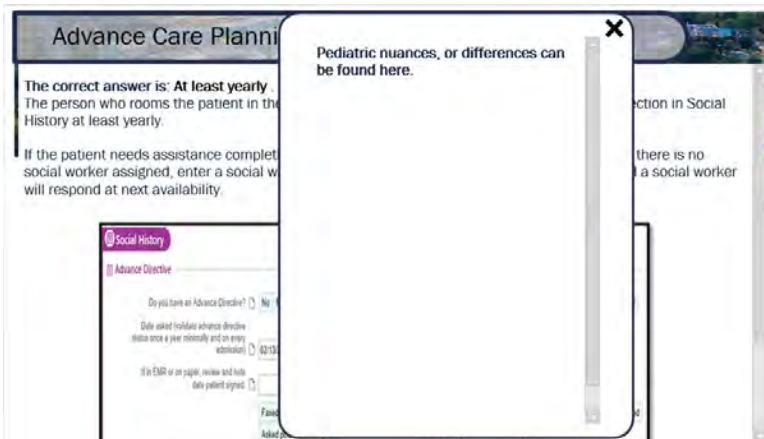
### Pediatric Information (Slide Layer)

**Advance Care Planning**

The correct answer is: **At least yearly**.  
The person who rooms the patient in the ambulatory setting completes the advance directive section in Social History at least yearly.

If the patient needs assistance completing an ACP document, refer the patient to social work. If there is no social worker assigned, enter a social work consult for assistance with an advance directive and a social worker will respond at next availability.

Pediatric nuances, or differences can be found here.



### 1.4 Transfusion Time Out

(Multiple Response, 10 points, 1 attempt permitted)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.

Patient information on Transfusion Tag to patient's ID armband and Typenex armband.

Patient's identity by having the Patient state full name and DOB

Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag


Blood group on Transfusion Tag matches Blood group on Blood bag

Unit # on Transfusion Tag matches Unit # on Blood bag

Component information on Transfusion Tag matches Component information on Blood bag

Expiration date on Transfusion Tag matches Expiration date on Blood bag

**This content does not relate to my role.**



Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

## Incorrect (Slide Layer)

**Transfusion Time-Out**

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.

[Submit](#)



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

**Incorrect**  
That is incorrect.

[Learn More](#)

## Correct (Slide Layer)

**Transfusion Time-Out**

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.

[Submit](#)




- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

**Correct**  
That's right! You selected the correct response.

[Continue](#)

## 1.5 Transfusion Time Out Education

**Transfusion Time Out Standard Work**



**The correct answers are:**

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LIP, or

**Notes:**

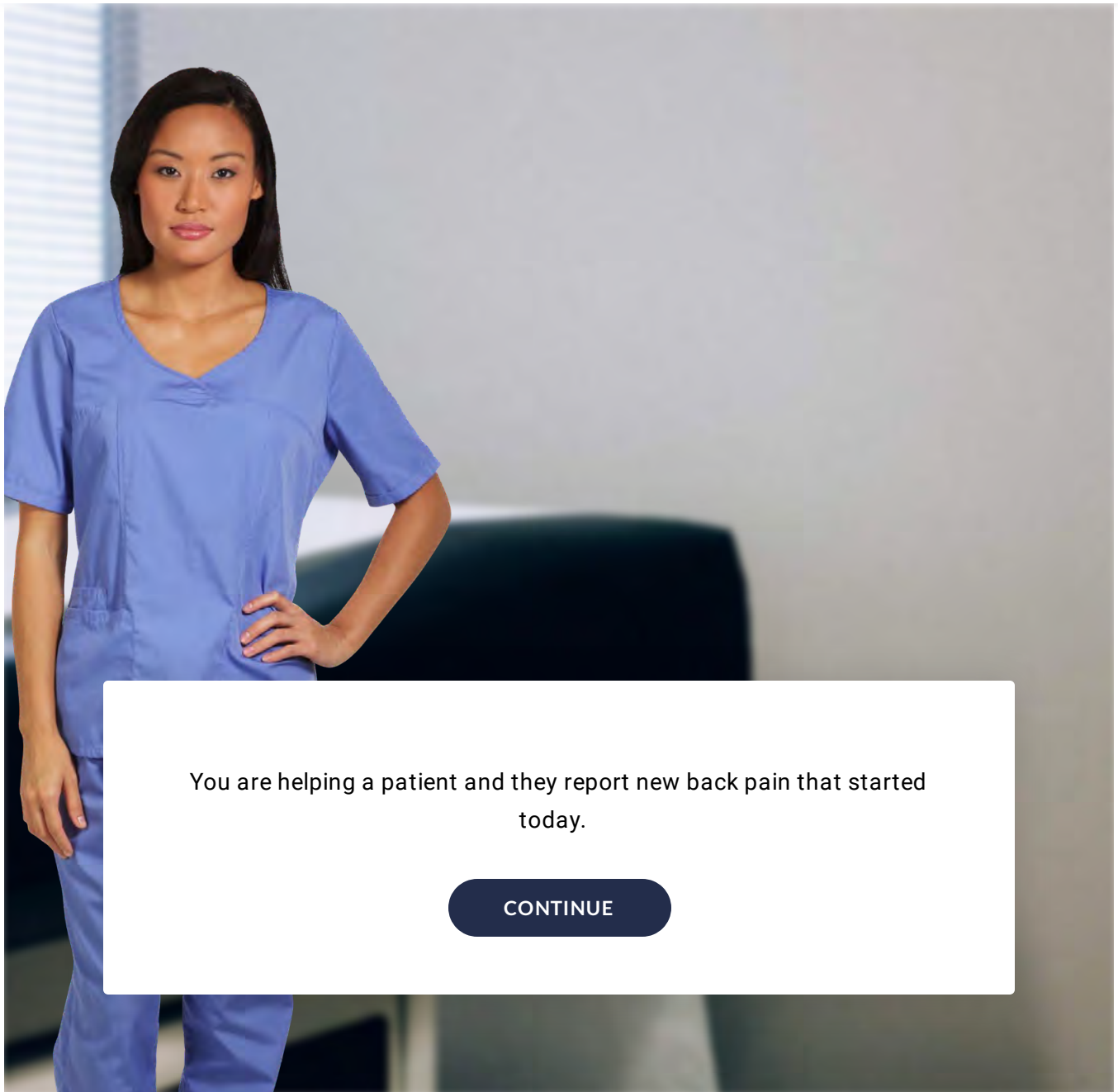
## **1.6 End**

End of This Section

Thank you for completing this section. Please scroll down to continue.



**Notes:**



You are helping a patient and they report new back pain that started today.

CONTINUE

## Scene 1 Slide 1

Continue → Next Slide



## Scene 1 Slide 2

- 0 → Next Slide
- 1 → Next Slide
- 2 → Next Slide



Any new report of pain can be important to the care of the patient.  
Report anything new to the nurse.

---

START OVER



### Scene 1 Slide 3

Continue → End of Scenario

## Start Content for Outpatient LPN, MA, PCT



The content that follows is intended for Outpatient LPN, MA, PCT, and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**

**CONTINUE**

**Continue to the Next Section**

**You have completed content related to your role.**

Click Continue to complete the course.

**CONTINUE**



# Emergency Medical Services (EMS)

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 3 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## Start Content for Emergency Medical Services



The content that follows is intended for EMS and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**



Complete the content above before moving on.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.

## 1.1 Start

Start Content for Emergency Medical Services



The content that follows is intended for EMS and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**

### Notes:

## 2. Blood Transfusion

### 2.1 Transfusion Time Out

(Multiple Response, 10 points, 1 attempt permitted)

Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.

Patient information on Transfusion Tag to patient's ID armband and Typenex armband

Patient's identity by having the Patient state full name and DOB

Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag


Blood group on Transfusion Tag matches Blood group on Blood bag

Unit # on Transfusion Tag matches Unit # on Blood bag

Component information on Transfusion Tag matches Component information on Blood bag

Expiration date on Transfusion Tag matches Expiration date on Blood bag

This is not part of my role.



Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag


### Incorrect (Slide Layer)


Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.





- Patient information on Transfusion Tag to patient's ID armband and Typenex armband
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

✘

Incorrect

That is incorrect.

[Learn More](#)

## Correct (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.

Patient information on Transfusion Tag to patient's ID armband and Typenex armband

Patient's identity by having the Patient state full name and DOB

Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag

Blood group on Transfusion Tag matches Blood group on Blood bag


Unit # on Transfusion Tag matches Unit # on Blood bag

Component information on Transfusion Tag matches Component information on Blood bag

Correct  
That's right! You selected the correct response.

## 2.2 Transfusion Time Out Education

### Transfusion Time Out Standard Work



The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LP, or Perfusion Clinician) and the Verifier prior to blood being administered to a patient. This is a two person safety check where the Transfusionist and Verifier are verifying the issued blood product is for their patient. This is done by verifying the information on the patient's ID armband and Typenex armband matches what is on the Transfusion Tag and the information on the Transfusion Tag matches what is on the Blood bag. The Transfusionist and Verifier read line by line and in a "read back" method.

If there are any discrepancies, stop and call the blood bank immediately.

Refer to the Transfusion Time-Out Standard Work. The blood bank sends this with every blood product.

### Notes:

## 2.3 End

End of This Section

Thank you for completing this section. Please scroll down to continue.



**Notes:**

CONTINUE

# Perfusionist

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 3 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## Transfusion Time-Out



## 1.1 Transfusion Time Out


(Multiple Response, 10 points, 1 attempt permitted)

Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband
X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

## Incorrect (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.



- Patient information on Transfusion Tag to patient's ID armband and Typenex armband
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

**Incorrect**  
That is incorrect.

[Learn More](#)

## Correct (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.




- Patient information on Transfusion Tag to patient's ID armband and Typenex armband
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag

**Correct**  
That's right! You selected the correct response.

[Continue](#)

## 1.2 Transfusion Time Out Education

### Transfusion Time Out Standard Work



\* CAPTURED DATE ON TRANSFUSION TAG MATCHES CAPTURED DATE ON BLOOD BAG.

The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LIP, or Perfusion Clinician) and the Verifier prior to blood being administered to a patient. This is a two-person safety check where the Transfusionist and Verifier are verifying the issued blood product is for their patient. This is done by verifying the information on the patient's ID armband and Typenex armband matches what is on the Transfusion Tag and the information on the Transfusion Tag matches what is on the Blood bag. The Transfusionist and Verifier read line by line and in a "read back" method.

If there are any discrepancies, stop and call the blood bank immediately.

Refer to the Transfusion Time-Out Standard Work. The blood bank sends this with every blood product.

## Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

**Check all that apply.**



Submit

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag



Complete the content above before moving on.

**Continue to the Next Section**

**You have completed content related to your role.**

Click Continue to complete the course.

CONTINUE

# Rad Tech

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 3 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## 1.1 Start

### Start Content for Role Specific Content



The content that follows is intended for Rad Techs, and for those whose role is aligned with the knowledge needed for this kind of care.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**

### Notes:

## 1.2 Transfusion Time Out

(Multiple Response, 10 points, 1 attempt permitted)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply

Patient information on Transfusion Tag to patient's ID armband and Typenex armband.

Patient's identity by having the Patient state full name and DOB

Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag


Blood group on Transfusion Tag matches Blood group on Blood bag

Unit # on Transfusion Tag matches Unit # on Blood bag

Component information on Transfusion Tag matches Component information on Blood bag

Expiration date on Transfusion Tag matches Expiration date on Blood bag

This is not part of my role.



Correct	Choice
X	Patient information on Transfusion Tag to patient's ID armband and Typenex armband.

X	Patient's identity by having the Patient state full name and DOB
X	Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
X	Blood group on Transfusion Tag matches Blood group on Blood bag
X	Unit # on Transfusion Tag matches Unit # on Blood bag
X	Component information on Transfusion Tag matches Component information on Blood bag
X	Expiration date on Transfusion Tag matches Expiration date on Blood bag

### Incorrect (Slide Layer)

Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.



[Submit](#)

- Patient information on Transfusion Tag to patient's ID armband and Typenex armband.
- Patient's identity by having the Patient state full name and DOB
- Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag
- Blood group on Transfusion Tag matches Blood group on Blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

✘

**Incorrect**

That is incorrect.

[Learn More](#)

## Correct (Slide Layer)

### Transfusion Time-Out

Stacy is a 10 year old patient getting a transfusion. Before starting the transfusion, the nurse calls a verifier to perform the time-out.

What are you verifying?

Check all that apply.

Patient information on Transfusion Tag to patient's ID armband and Typenex armband.

Patient's identity by having the Patient state full name and DOB

Patient's full name and MRN# on patient ID armband matches name and MRN# on Transfusion Tag

Blood group on Transfusion Tag matches Blood group on Blood bag

Unit # on Transfusion Tag matches Unit # on Blood bag

Component information on Transfusion Tag matches Component information on Blood bag

Correct  
That's right! You selected the correct response.

## 1.3 Transfusion Time Out Education

### Transfusion Time Out Standard Work



- blood group on transfusion tag matches blood group on blood bag
- Unit # on Transfusion Tag matches Unit # on Blood bag
- Component information on Transfusion Tag matches Component information on Blood bag
- Expiration date on Transfusion Tag matches Expiration date on Blood bag

The Blood Transfusion Time-Out is completed between the Transfusionist (RN, LP, or Perfusion Clinician) and the Verifier prior to blood being administered to a patient. This is a two-person safety check where the Transfusionist and Verifier are verifying the issued blood product is for their patient. This is done by verifying the information on the patient's ID armband and Typenex armband matches what is on the Transfusion Tag and the information on the Transfusion Tag matches what is on the Blood bag. The Transfusionist and Verifier read line by line and in a "read back" method.

### Notes:



## 1.4 End

End of This Section

Thank you for completing this section. Please scroll down to continue.



**Notes:**

## Start Content for Role Specific Content



The content that follows is intended for Rad Techs, and for those whose role is aligned with the knowledge needed for this kind of care.

It is not possible to create a scenario that will exactly match your work environment, but we ask that you review each of the following scenarios and consider how it may impact your department.

When you are finished, you will see a slide like this one that lets you know that you are done. It will ask you to continue to the next section.

**Click Next to continue**



Complete the content above before moving on.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.

CONTINUE

# Patient Contact Content

---

## Instructions

This content is required for anyone who has contact with patients, but may not provide direct care. Although everything here may not be required for your day to day, or it may not be presented in the same way you see these situations in your work environment, please reflect on how the information could be relevant to your contact with patients.

This section will take about 20 - 25 minutes to complete.

### **Don't have patient contact?**

Click here to return to choose another role.

[RETURN TO START](#)

## Continue to the Next Section

**Click Continue to move to the next section.**

CONTINUE

# Language Services for Patient Contact

---

## Language Services

UVA Health serves the communities we care for.

One of the free services provided to patients and guests requiring communication assistance is the availability of an interpreter.

Consider this scenario.



## Language Services

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.

Submit



CONTINUE

Continue to the Next Section

Click Continue to move to the next section.

CONTINUE


(Multiple Choice, 10 points, 1 attempt permitted)

**Language Services**

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.

**Submit**



Correct	Choice
	Explain to him that there are no translators, and you can write messages between each other.
X	Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
	Ask him to bring someone with him who can help him communicate with the medical team.

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

That is incorrect.




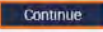
## Correct (Slide Layer)


**Language Services**

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.

 **Correct**  
That's right! You selected the correct response.






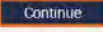
## Incorrect (Slide Layer)


**Language Services**

A patient comes to see you and is moving his hands in what looks like sign language. He writes a note saying that he is deaf. You look at his medical record and see a language flag that alerts you to the patient needing language assistance. What should be your next steps?

- Explain to him that there are no translators, and you can write messages between each other.
- Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.
- Ask him to bring someone with him who can help him communicate with the medical team.


 **Incorrect**  
That is incorrect.





## 1.2 Transfusion Time Out Education

**Language Services**



**The correct answer is:** Utilize Globo for Video Remote Interpreting or contact Language Services if further assistance is needed.

**Additional Information:**

- Interpreters are available for patients who require language services, including foreign languages and American Sign Language (ASL). The language services flag in Epic is what triggers the language services team to know who needs this service.
- If the visit is scheduled, the Language Services Department will attempt to schedule an in-person interpreter based on availability.
- If the in-person interpreter is not immediately available, Globo must be utilized for the video or audio remote interpreting service.
- Documenting the use of interpreters whether in-person, video, or over the phone, must be done in Epic for each encounter or interaction to comply with legal and regulatory requirements.
- If an interpreter was offered, but the offer was declined, this must also be documented in Epic.

# Advance Care Planning and Advance Directives for Patient Contact

---

## What is Advance Care Planning?

Advance Care Planning (ACP) is a process of planning for future healthcare decisions. The process includes understanding what decisions may need to be made in the future; reflecting on personal experiences, values, goals, and preferences for care; and communicating these to loved ones and the healthcare team. Ideally, these conversations begin with a focus on surrogate decision making, occur well before a crisis, and lead to the creation of good-quality ACP documents such as advance directives. Good quality ACP documents provide the kind of information that helps guide medical decision-making. Patients have the right for their ACP documents to be honored and incorporated into their plan of care.

Forms and Education are available in KnowledgeLink - search "Advance Care Planning".

## Advance Directives

The Virginia Health Care Decisions Act permits the creation of and reliance upon an advance directive made by an adult to put their wishes regarding medical care in writing.

It provides for any of the following:

- Appointment of an agent (and successor agent) to make health care decisions for an incapacitated patient;
- The patient's health care preferences;

- Stipulation of an anatomical gift(s), after the patient's death.

The University of Virginia Medical Center informs patients in an inpatient or ambulatory setting of their right to complete an advance directive. The health care team uses the advance directive to plan care for patients that align with their care preferences. A copy of the written advance directive must be scanned into the patient's medical record.

## Find Advance Directives in Epic

Advance Care Planning (ACP) Documentation is easily located in Epic. Hovering over the ACP line in the storyboard will display and link to essential ACP documentation:

- Legally authorized health care decision maker(s)
- ACP Notes
- ACP Documents

Information about a patient's legally authorized decision makers should be reviewed at every patient encounter and updated when necessary.

**KB**

**206A**

**Krispy P. Bacon**  
 Legal: Kris P. Bacon  
 Female, 75 y.o., 1/5/1949  
 MRN: 5332208  
 Language: English  
 Code: Not on file  
 ACP: Click to Review  
 Implants: None  
 Blood Collection: Unit

Acuity Level: None  
 COVID-19 Vaccine: Unknown  
 Isolation: None  
 Research: None Active  
 No attending provider

**Allergies (2)**  
 VTE: High Risk - Surg  
 Primary Team: Attending Only  
 RN: Nurse E (Pg: 813-241-2353)  
 Active Consult(s)  
 ED ROOMED: 4/9/2023 (319 D)  
 Patient Class: Inpatient  
 Psychiatry  
 No active principal problem

Height: 185 cm (6' 0.84")  
 Last Wt: 81.6 kg (180 lb)  
 BMI: 23.86 kg/m<sup>2</sup>  
 BSA: —

**Health Care Agent/Surrogate Decision Maker**  
 Bacon, Sal T. Healthcare Agent Named In Advance Directive - Father Not Active

**ACP (Advance Care Planning) Notes**  
 Create ACP Note

Date of Service	Author	Author Type	Status
02/12/24 1606	<a href="#">Addend</a> Carter, Jeffrey		Signed
02/12/24 1550	<a href="#">Addend</a> Worker, Social	Social Worker	Addendum

**Advance Care Planning Documents**  
 Documents without received dates are displayed at the bottom.

Document Type	Status	Effective Date	Expiration Date	Received Received On	Description
Advance Directives and Living Will NDT	Received			05/28/24	VALIDATED
Durable DNR Scan	Received			03/22/24	
Advance Directive Combined Scan	Received			03/08/24	

**Reference Documents**  
[ACP Document Types](#) [Virginia Decision Making Hierarchy](#) [Glossary Of Patients' Supporting Roles](#)

## Continue to the Next Section

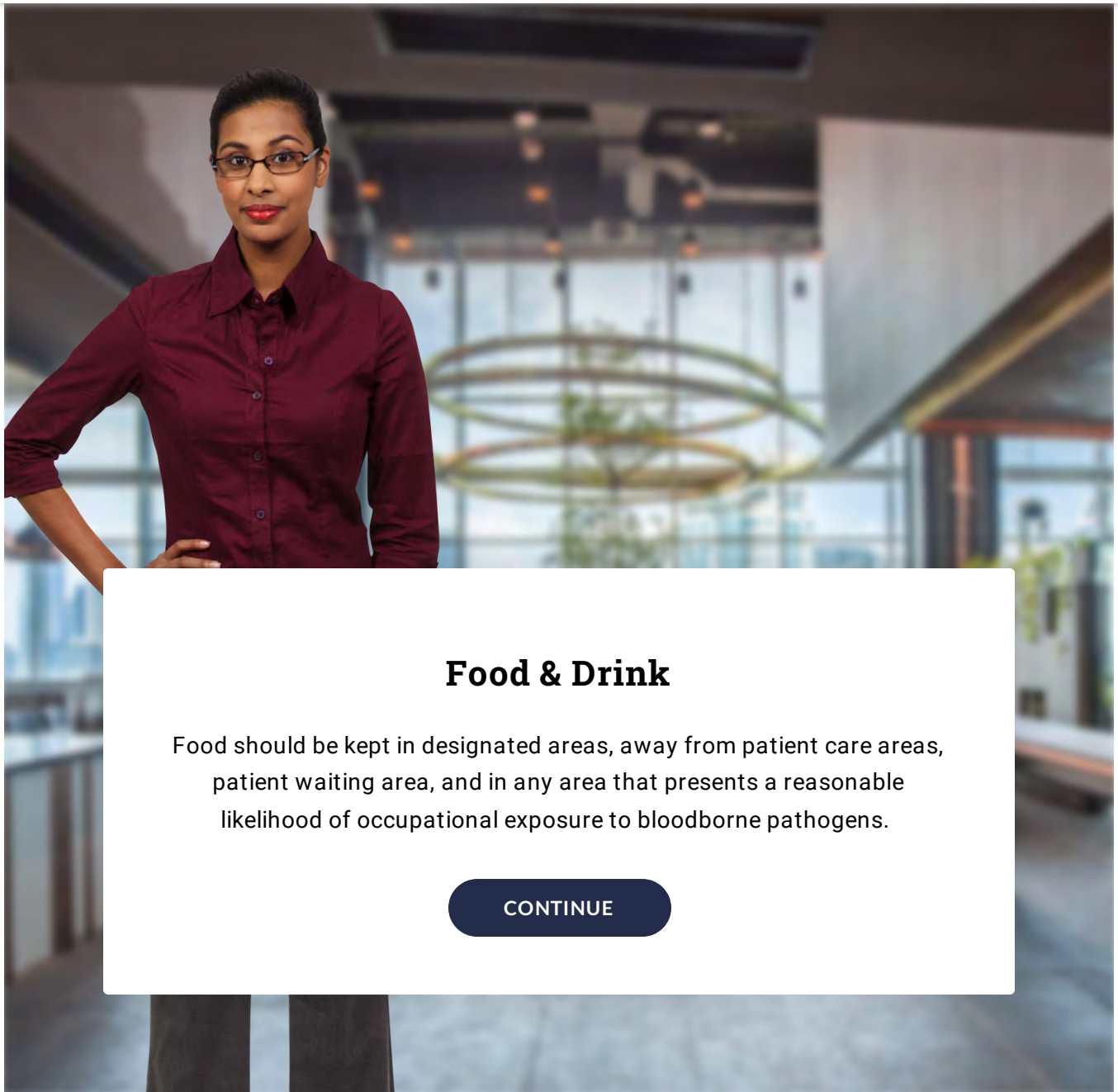
Click Continue to move to the next section.

CONTINUE

# Food and Drink in Patient Areas for Patient Contact

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**Food & Drink in Patient Area**



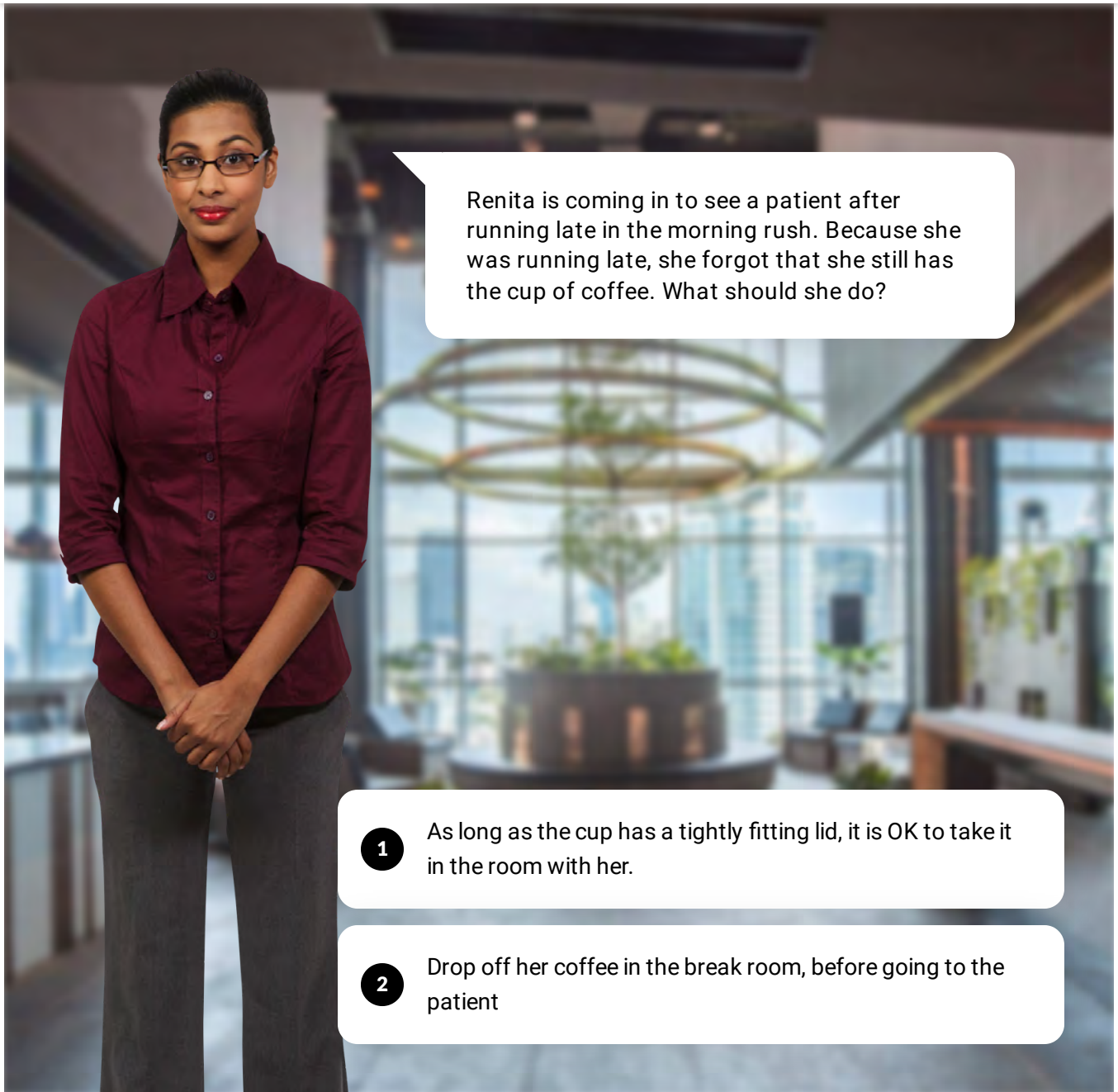
## **Food & Drink**

Food should be kept in designated areas, away from patient care areas, patient waiting area, and in any area that presents a reasonable likelihood of occupational exposure to bloodborne pathogens.

**CONTINUE**

### **Scene 1 Slide 1**

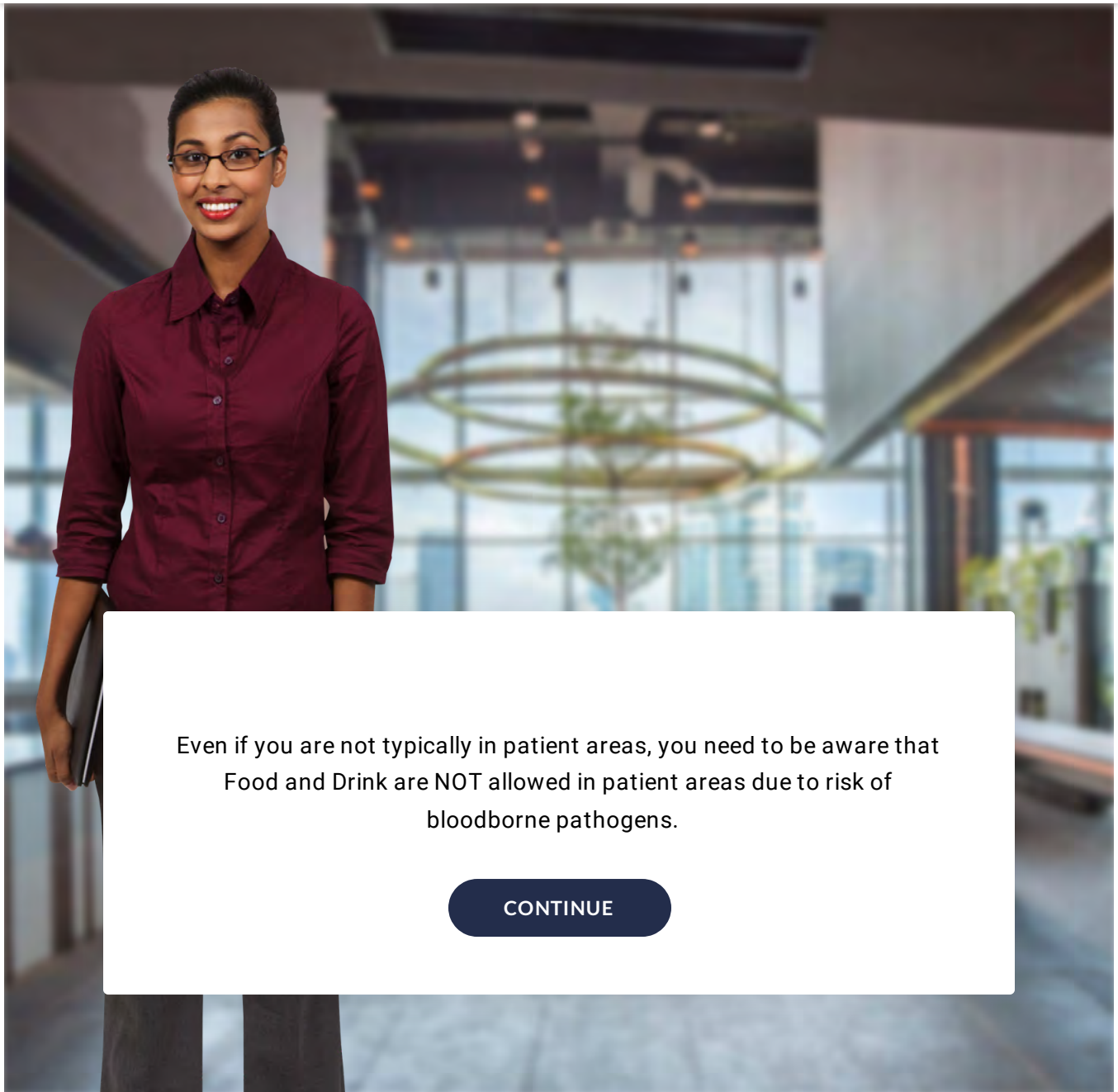
Continue → Next Slide



## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



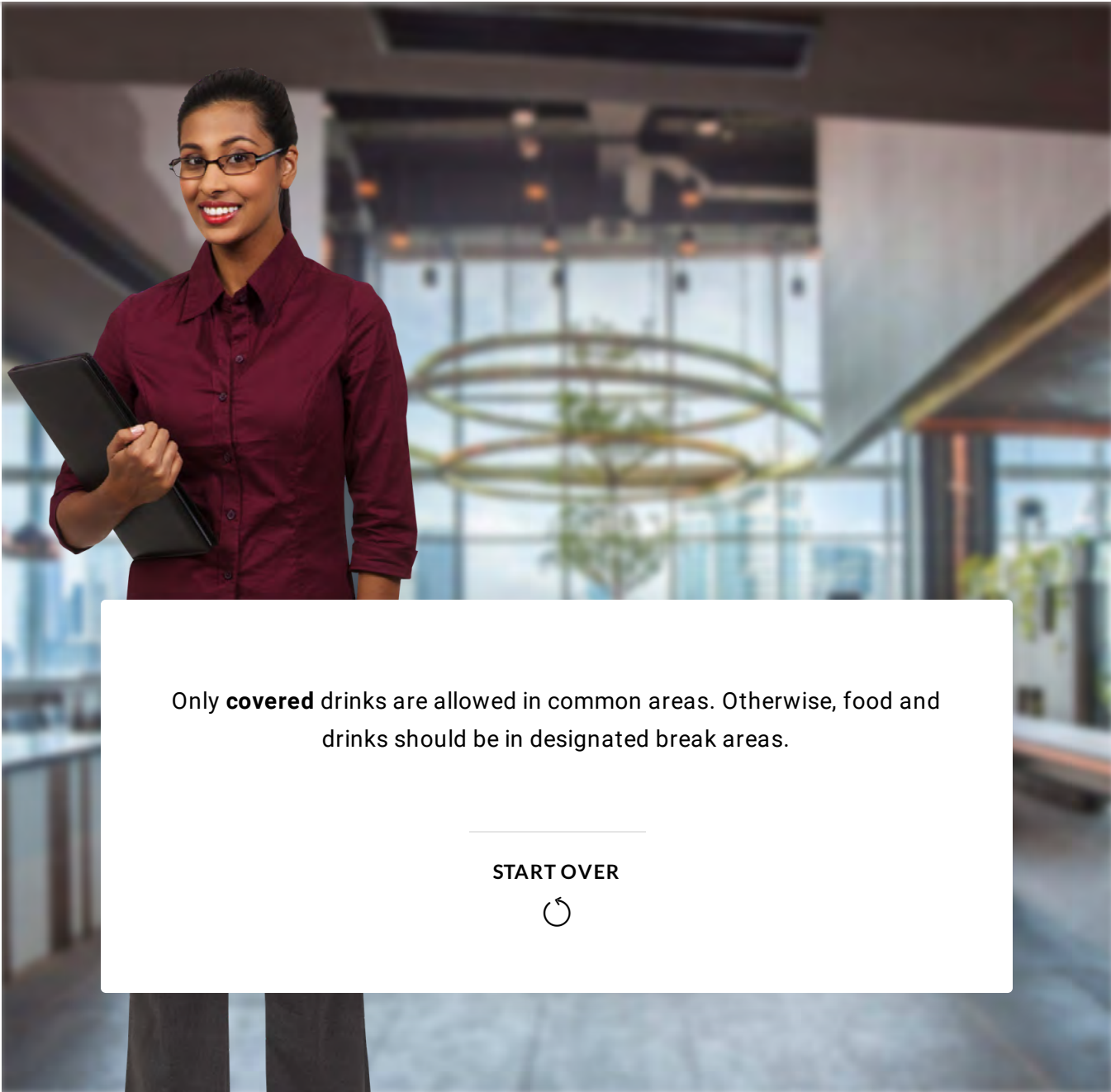
Even if you are not typically in patient areas, you need to be aware that  
Food and Drink are NOT allowed in patient areas due to risk of  
bloodborne pathogens.

CONTINUE

### Scene 1 Slide 3

Continue → Next Slide





Only **covered** drinks are allowed in common areas. Otherwise, food and drinks should be in designated break areas.

---

START OVER



**Scene 1 Slide 4**

Continue → End of Scenario



**Continue to the Next Section**

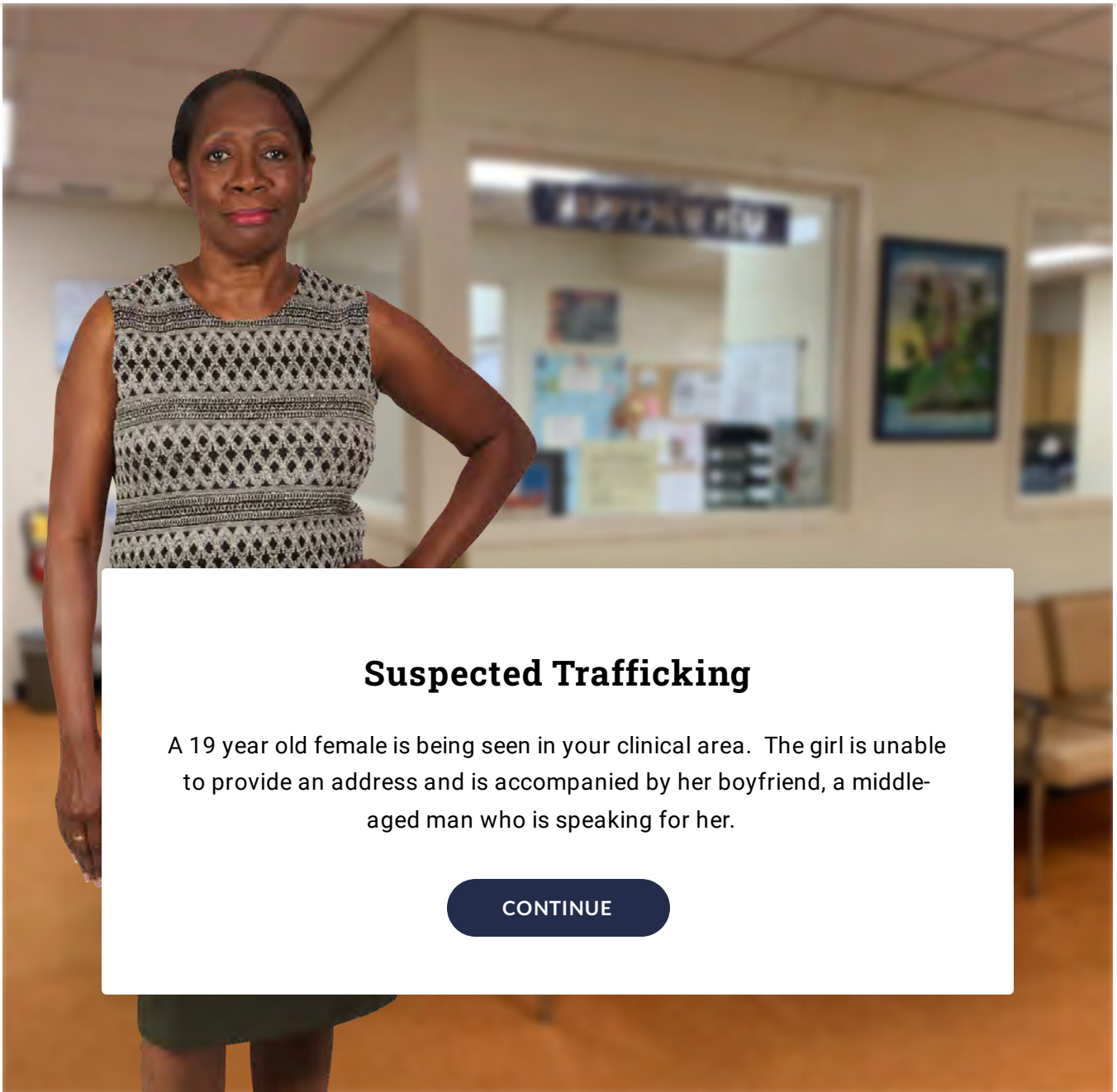
**Click Continue to move to the next section.**

**CONTINUE**

# Suspected Abuse

---

## Suspected Abuse of a Patient



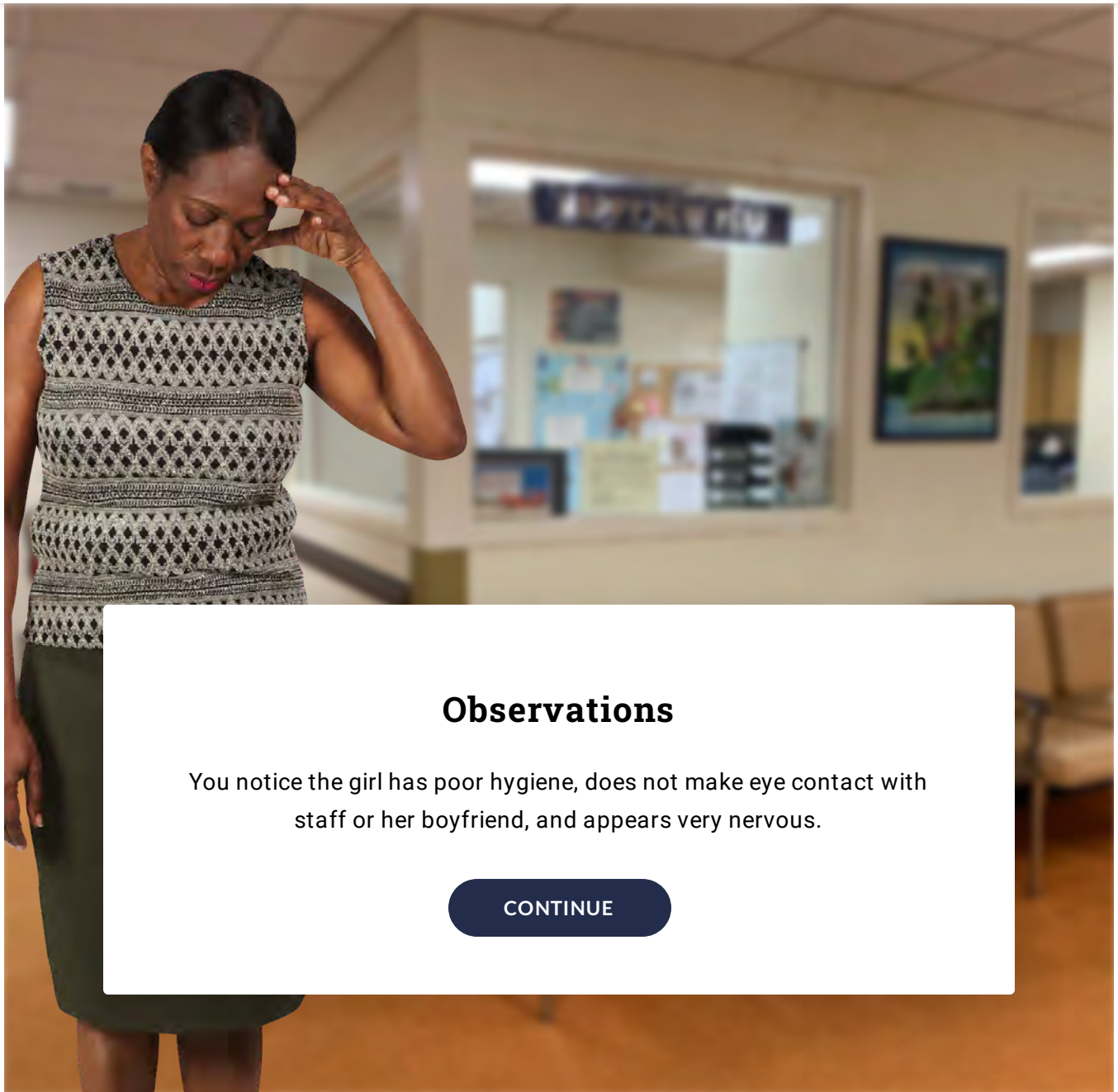
## **Suspected Trafficking**

A 19 year old female is being seen in your clinical area. The girl is unable to provide an address and is accompanied by her boyfriend, a middle-aged man who is speaking for her.

**CONTINUE**

### **Scene 1 Slide 1**

Continue → Next Slide



## Observations

You notice the girl has poor hygiene, does not make eye contact with staff or her boyfriend, and appears very nervous.

CONTINUE

### Scene 1 Slide 2

Continue → Next Slide



The patient tells you that she has to go to work, so is in a hurry to leave. What should you do?

1

The patient insists that she is fine, so it is safe to send her home with her boyfriend.

2

Report your concerns about the patient to the Social Worker on duty.

3

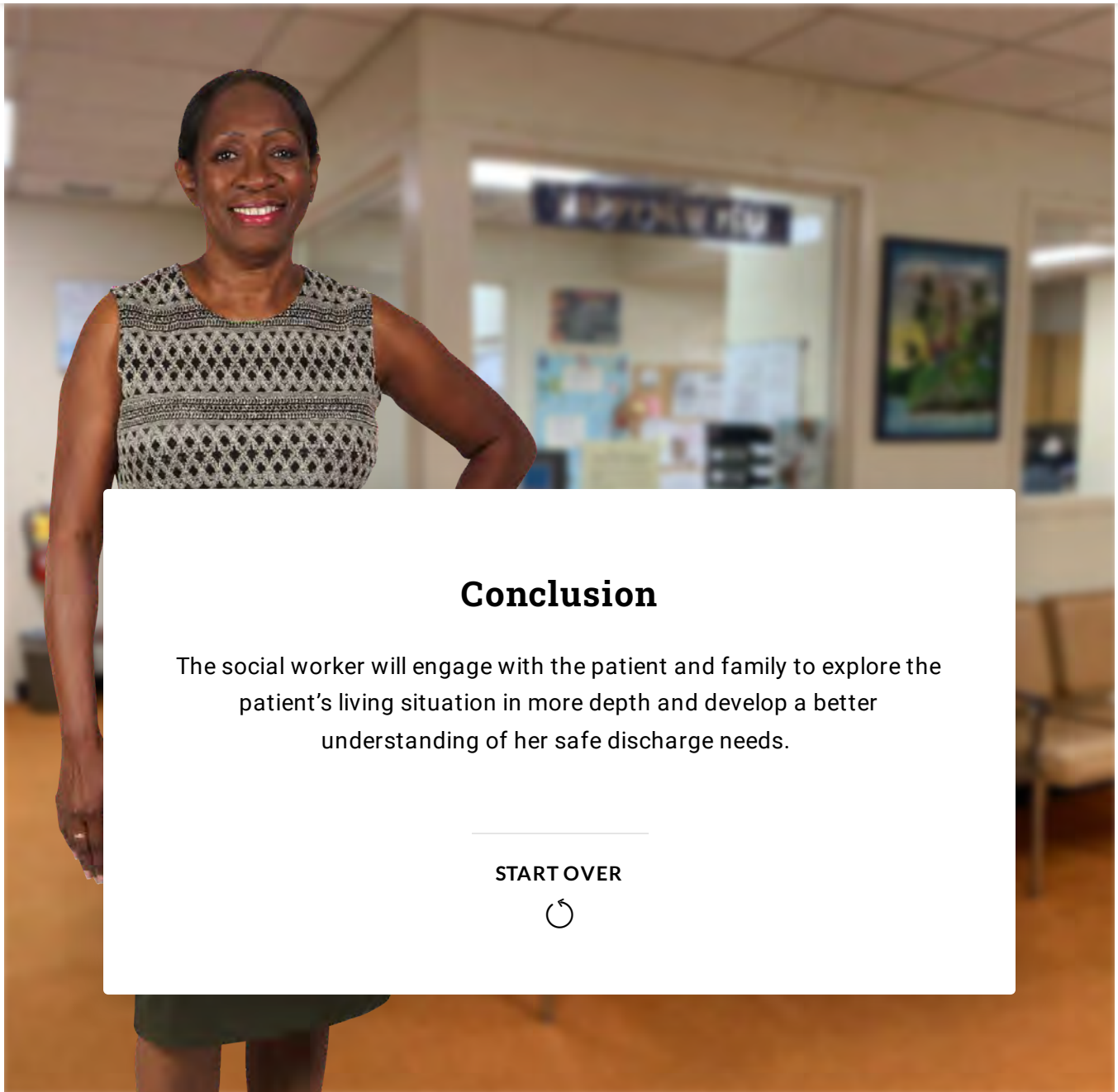
Give the patient information about human trafficking in her follow up instructions and hope she is safe.

### Scene 1 Slide 3

0 → Next Slide

1 → Next Slide

2 → Next Slide



## Scene 1 Slide 4

Continue → End of Scenario

CONTINUE

## What Is Human Trafficking?

### Are you a victim of human trafficking?

Human trafficking is modern-day slavery and involves someone trying to trick, threaten or force you to do work or have sex for money or something of value.

**You may not know you are a victim.**

Has anyone:

- Ever convinced you to have sex for money or something of value?
- Forced you to work to pay off money you owe?
- Lied about the work you would be doing?
- Threatened you or your family?

This is **illegal** – no matter your immigration status.

**You can get help.** There are laws in the United States and Virginia to keep you safe from human trafficking.

If you or someone you know is being scared or forced into any activity (sex for money, housework, farm work or any other activity) and cannot leave, **help** is available.

#### National Human Trafficking Hotline

**Call** 1.888.373.7888  
**Text** **INFO** or **HELP** to:  
**BEFREE (233-733)**

You may also speak to your healthcare provider.

#### The Hotline is:

- 24/7 Toll-Free
- Anonymous
- Confidential
- Available to non-English speakers
- Able to provide help and referral to services, training and general information

### ¿Es usted víctima de tráfico de personas?

La trata o el tráfico de personas es una forma moderna de esclavitud en la que alguien lo(a) trata de engañar, amenazar o forzar para que trabaje o tenga relaciones sexuales a cambio de dinero o de algo de valor.

**Tal vez usted no sepa que es una víctima.**

Alguna vez alguien:

- ¿Lo(a) convenció de que tuviera relaciones sexuales a cambio de dinero o algo de valor?
- ¿Lo(a) forzó a trabajar para pagar una deuda?
- ¿Lo(a) engañó con respecto al trabajo que le dijo que usted iba a hacer?
- ¿Amenazó a usted o a su familia?

Esto es **ilegal**, sea cual sea su situación de inmigración.

**Usted puede conseguir ayuda.** En los Estados Unidos y en Virginia hay leyes que lo(a) protegen contra el tráfico de personas.

Si usted o alguien que conoce está siendo intimidado o forzado a hacer cualquier actividad (por ejemplo, sexo por dinero, labores domésticas o trabajo de granja) y usted no se puede escapar, hay **ayuda** disponible.

#### Línea Nacional Contra la Trata de Personas

**Llame al 1.888.373.7888**  
**Mensaje de texto** **INFO** o **HELP** a:  
**BEFREE (233-733)**

También puede hablar con su profesional de la salud.

#### La línea directa:

- Funciona 24/7 y es gratuita
- Es anónima
- Es confidencial
- Atiende en muchos idiomas
- Puede ofrecerle ayuda y recomendarle servicios, capacitación e información general



You will see the above Human Trafficking signs throughout UVA Health. You may click on the image to enlarge it.

According to one study, 87.8% of trafficking victims encounter a healthcare professional while captive, and few, if any, of these encounters result in the victim being freed because of lack of training to recognize victims of human trafficking. Visit the Human Trafficking Hotline webpage to see the signs and warnings of possible human trafficking.

If you see these signs, are not sure, or just have a hunch, contact the social worker. The social worker will engage with the patient and family to explore the patient's living situation in more depth and develop a better



understanding of her safe discharge needs.

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Signage

---

## Signs on Patient Doors

In order to keep patients and team members safe, various signs may be displayed. All signs posted inside and outside of patient rooms should be read and followed.

Questions about the signs should be directed to the nurse. Examples of signs may include:

- Fall Risk
- Isolation Precautions
- Name Alert



**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# PPE for Isolation Patients

---

## Safety In the Workplace

UVA Health System is committed to eliminating Team Member injury whenever possible and has heightened this commitment by placing team member injuries as a goal for the Medical Center.

## Personal Protective Equipment: Gowns in Isolation Rooms

Joyce is getting ready to enter the room of a patient on contact precautions. She puts on an isolation gown and then remembers she forgot to grab her badge she put down on the counter at the nurse's station.

She doesn't plan on touching the patient at all, and care is not part of her role. Should she remove her gown before exiting the room to get her badge?

No, it is OK because she is not going to touch anything in the room.

Yes, the gown should not be worn outside of the patient room with few exceptions.

SUBMIT

CONTINUE

## Personal Protective Equipment: Gowns in Isolation Rooms

If you are going into an isolation room, you must follow the signage and required PPE to keep yourself and the patient safe. Required PPE may include:

- Gloves
- Eye protection
- Gown
- Mask
- Respirator

**The only exceptions include if direct care givers transporting or ambulating isolation patient or as part of Standard Precautions.**

**PPE should be worn:**

- To prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures.
- As the OSHA Bloodborne Pathogens Standard mandates the wearing of gowns and protective apparel under specified circumstances to reduce the risk of exposures to bloodborne pathogens.
- By personnel during the care of patients infected or colonized with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from

patients or items in their environment to other patients or environments.

- In some instances, as with extensive burns or extensive wounds, sterile gowns may be worn when changing dressings.

## Continue to the Next Section

**Click Continue to move to the next section.**

CONTINUE

# Hand Hygiene for Patient Contact

---

**Gloves Are NOT a Substitute For Hand Hygiene**

**Use Alcohol Sanitizer: 20 Seconds**



- For patient care activity when soap and water is not needed

**Use Soap and Water:**





- When your hands feel sticky or are soiled
- After removing PPE when caring for a patient with C. difficile, norovirus, adenovirus, or unexplained diarrhea

**Hand Skin Integrity Tips:**



Skin irritation can be caused by inadequate rinsing: the chemicals and fragrances in soaps can cause reactions if they are allowed to remain on the skin.

Use ONLY the hospital-provided hand lotion several times each day when you can allow it to remain on your hands for at least 30 minutes. The hand care products are formulated to work together.

**Continue to the Next Section**

**Click Continue to move to the next section.**

CONTINUE

# Workplace Violence - SAVE for Patient Contact

---

## Workplace Violence - SAVE

The Medical Center takes a zero-tolerance position on violent or threatening behavior in the workplace. Team Members are responsible for being alert to signs of potential aggression and reporting **all** violent or threatening behavior.

The purpose of the SAVE Program is to provide oversight and guidelines to team members to prevent injury associated with violent events within the UVA Medical Center.



The workplace violence prevention program, titled SAVE, stands for:

- Situational
- Awareness
- Violent

- Events

Resources can be found in the SAVE desktop icon, pictured here. This desktop icon is available on any shared health system computer desktop.

### SAVE Quick Links



All episodes of workplace violence (including verbal, physical, & sexually inappropriate behaviors) are to be reported in **Be Safe**, under the **Workplace Violence** tile.

## Do Not Wait

### Reach out if you need help!

If you can see an escalation coming get help. Don't wait and then say 'I knew that would happen.'

Consider putting safety measures in place, such as flags in Epic, security assessments, or any other tools available in the save icon.

- Contact Ava Speciale (AB3YK@UVAHealth.org) or Lauren Mathes (LEM9R@UVAHealth.org) for assistance.

## Continue to the Next Section

Click Continue to move to the next section.

CONTINUE

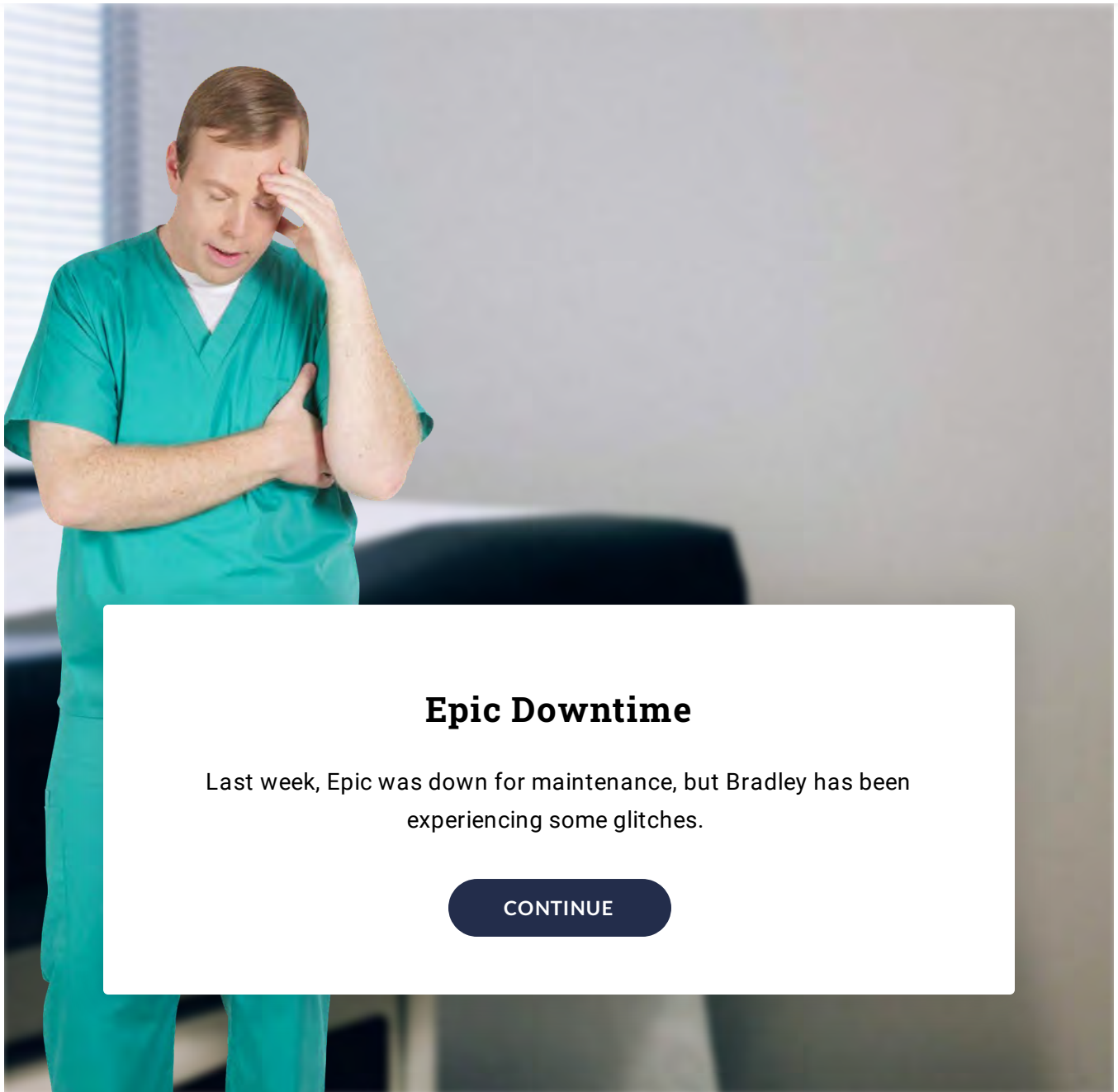
# Managing Interruptions - Epic Downtime Patient Contact

---

## Managing Interruptions - Epic Downtime

Having an effective response plan is critical for mitigating the impact of downtime. Patient records are critical to providing the best possible care. To ensure you are prepared for downtime, make sure that you:

- Check your required forms weekly to ensure you have a supply in case of down time.
- The team should check the Business Continuity Access (BCA) PC weekly if you have one in your area.
- Validate that the information you need is accessible and test print one record to ensure your printer is set to local and default.



## **Epic Downtime**

Last week, Epic was down for maintenance, but Bradley has been experiencing some glitches.

**CONTINUE**

### **Scene 1 Slide 1**

Continue → Next Slide





While Health System IT is working on this he wants to make sure his unit is prepared for downtime. What should he do to prepare?

1

Check the required forms, the Business Continuity Access (BCA), and validate that the information needed is accessible, printing a test.

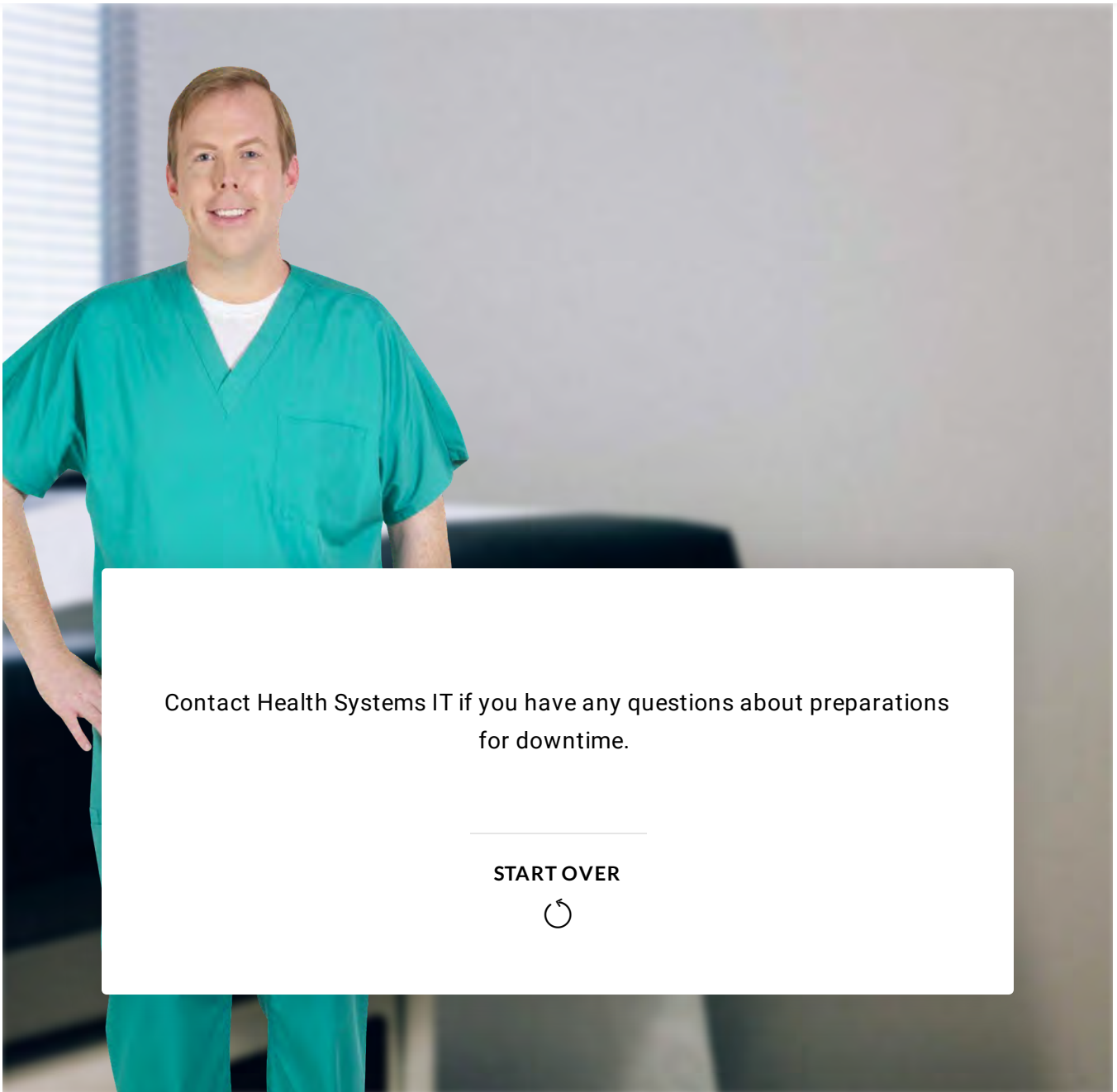
2

All he has to do is call Health Systems IT, and give all the relevant information about what is happening with the glitches.

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



Contact Health Systems IT if you have any questions about preparations for downtime.

---

**START OVER**



## **Scene 1 Slide 3**

Continue → End of Scenario



Complete the content above before moving on.

**Continue to the Next Section**

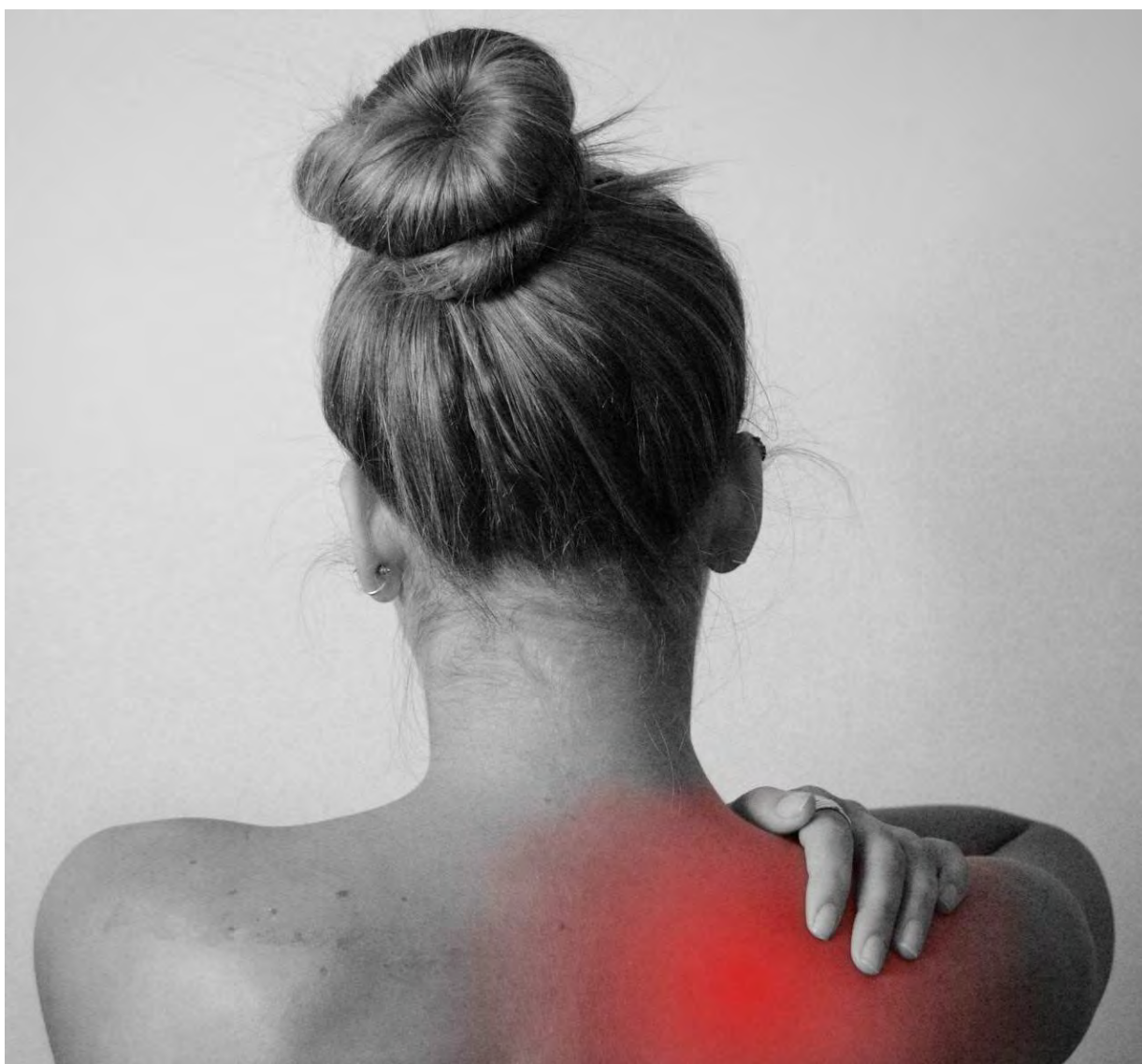
**Click Continue to move to the next section.**

**CONTINUE**

# Pain Management for Patient Contact

---

## Pain Management



The University of Virginia Medical Center is committed to the identification and management of patient pain using non-pharmacologic, pharmacologic, and a combination of those approaches in a manner that optimizes patient comfort, ability to function, and quality of life and minimizes the risks associated with treatment.

Within their scope of practice, the health care team is responsible for screening and assessing for pain, involving patients in their pain management plan, evaluating the effectiveness of the plan, and educating patients on the safety of pain medications.

## **Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Bariatric Sensitivity for Patient Contact

---

## Respect

Individuals with obesity often report that some healthcare professionals can view them as lacking self-control, lazy, and non-compliant.

Using people first language is a way to make patients feel seen and heard in a respectful way.

Caring, without judgement, and being sensitive to situations that can be embarrassing, such as taking their weight, can improve the patient experience for the patient with obesity.

## Continue to the Next Section

**Click Continue to move to the next section.**

CONTINUE

# Organ and Tissue Donation for Patient Contact

---

## Organ and Tissue Donation

Families of potential Organ and Tissue donors are grieving. Because it is typically a hard time, it is important to be particularly sensitive to their beliefs, circumstances, and wishes.

The University of Virginia Medical Center maintains a well-coordinated, compassionate, and respectful approach to organ, tissue, and eye donation that complies with state and federal laws and regulations. The Medical Center coordinates with the contracted Organ Procurement Organization, LifeNet Health, to facilitate a systematic process for notifying the OPO of potential donors, evaluating potential donors, seeking consent for donation in a respectful and sensitive manner, and recovering donated organs.

Contact LifeNet (**1-866-LIFENET** or via the electronic link in Epic) within 60 minutes when any of the following criteria are met:

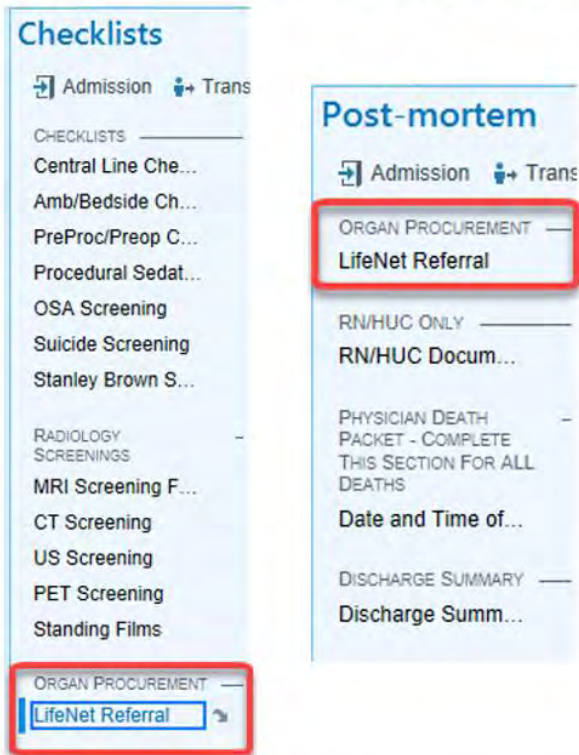


- When a patient dies in the hospital.
- When a ventilated patient has a GCS of 4T or less (including sedated patients, but excluding patients who are in the anesthetic/sedation recovery period after a procedure).
- When a goals of care discussion that may include withdrawal of life-sustaining treatment is planned.
- When brain death testing is anticipated.
- When donation is mentioned by the family/surrogate.

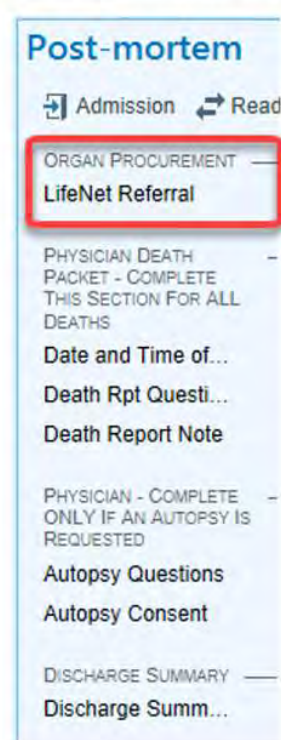
An electronic referral link is (or will be) available in Epic to facilitate LifeNet notification and decrease phone calls. This will continue to be expanded to all inpatient areas. The electronic referral is accessible as indicated below. After clicking the link, follow the on-screen instructions to submit the referral.



**RNs:** Use RN Navigator to select “LifeNet Referral” from “Checklists” or from “Post-Mortem” under Discharge tab.



**APPs, MDs, others:** Select “LifeNet Referral” from Post-Mortem navigator.



According to HRSA, 90% of US adults support organ donation. For a patient to be eligible for organ donation, the patient **must be ventilated**. Please ensure you preserve this opportunity for donation by working closely with LifeNet Health and ensure the **patient remains ventilated** until a determination of eligibility can be made.

For more information, refer to Organ, Tissue, and Eye Donation Medical Center Policy.



**LifeNet Health**<sup>®</sup>  
Saving Lives. Restoring Health. Giving Hope.

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Patient Contact, Choose Your Role

---

For the next section, you will choose your role to receive content more closely aligned to your role.

## **Social Worker**

CONTINUE

## **Pharmacy**

CONTINUE

## **Security**

CONTINUE

## **Patient Access or HUC**

HUC, Patient Access, and any other similar role.

CONTINUE

**Other Patient Contact**

You have contact with patients, but your role is not listed, click here.

[CONTINUE](#)

**Patient Care or No Patient Contact**

If you provide direct care or have no contact with patients at all, click here to return to the beginning and choose another role.

[RETURN TO START](#)

# Social Worker

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 7 - 10 minutes to complete.

[CONTINUE](#)

[Advance Care Planning \(ACP\) Documents - Patient Rights and Capacity](#)



Patients have the right for their ACP Documents to be honored and incorporated into their plan of care. This can only happen if they are on file.

All patients should be asked if they have an advance directive and be offered assistance with Advance Care Planning (ACP) conversation and documents. The Team Members may ask a Social Worker for assistance in completing these documents.

## **Capacity**

Check to see if a capacity assessment form has been completed before asking a surrogate to make decisions. Certification by a capacity reviewer is **not** required if the patient is unconscious or experiencing a profound impairment of consciousness due to trauma, stroke, or other acute physiological condition. If there is no capacity assessment, but there are questions about the patient's ability to make decisions, confer with the patient's medical team.

## 1.1 Advance Directive

(Multiple Choice, 10 points, 1 attempt permitted)

**Advance Care Planning Documents**

Jonathan has completed an Advance Directive and hands you the original signed document.

What is your appropriate action?



- Make a copy, give the original to the patient. Then, follow unit or clinic procedures for having items scanned into the medical record. For inpatients, also place a copy in the red folder in the door side chart.
- Make a copy, give the original to the patient. Then, give a copy to your manager.
- Scan the form and email it to the patient and physician who requested it.

**Submit**

Correct	Choice
X	Make a copy, give the original to the patient. Then, follow unit or clinic procedures for having items scanned into the medical record. For inpatients, also place a copy in the red folder in the door side chart.
	Make a copy, give the original to the patient. Then, give a copy to your manager.
	Scan the form and email it to the patient and physician who requested it.

### Feedback when correct:

Your answer is correct.

### Feedback when incorrect:

Your answer is incorrect.

## Congrats! (Slide Layer)

**Advance Care Planning Documents**

Jonathan has completed an Advance Directive and hands you the original signed document.

What is your appropriate action?

- Make a copy, give the original to the patient. Then, follow unit or clinic procedures for having items scanned into the medical record. For inpatients, also place a copy in the red folder in the door side chart.
- Make a copy, give the original to the patient. Then, give a copy to your manager.
- Scan the form and email it to the patient and physician who requested it.

 **Congrats!**  
Your answer is correct.

**Continue**

## Sorry! (Slide Layer)

**Advance Care Planning Documents**

Jonathan has completed an Advance Directive and hands you the original signed document.

What is your appropriate action?


- Make a copy, give the original to the patient. Then, follow unit or clinic procedures for having items scanned into the medical record. For inpatients, also place a copy in the red folder in the door side chart.
- Make a copy, give the original to the patient. Then, give a copy to your manager.
- Scan the form and email it to the patient and physician who requested it.

 **Sorry!**  
Your answer is incorrect.

**Continue**

## 1.2 Advance Directive Info

**Advance Care Planning Documents**



**The right answer is:** Make a copy, give the original to the patient. Then, follow unit or clinic procedures for having items scanned into the medical record. For inpatients, also place a copy in the red folder in the door side chart.

Provide a copy of the document to the HUC (inpatient) or Patient Access Team Member (ambulatory) who will ensure the document gets to Health Information Management (HIM) for review and uploading to the Medical Record.

- The copy should be placed in the red folder in the door side chart with a pink dot in the corner to show it was sent to HIM (Inpatient).
- The original, signed advance directive should be returned to the patient.
- Forms and Education are available through Care Forms and Consents.



It may take a moment for the following scenario to load. Complete this question before moving on.

## Advance Care Planning Documents

Jonathan has completed an Advance Directive and hands you the original signed document.

What is your appropriate action?



- Make a copy, give the original to the patient. Then, follow unit or clinic procedures for having items scanned into the medical record. For inpatients, also place a copy in the red folder in the door side chart.
- Make a copy, give the original to the patient. Then, give a copy to your manager.
- Scan the form and email it to the patient and physician who requested it.

Submit



Complete the content above before moving on.

## Suicide Prevention

The Joint Commission (TJC) requires healthcare organizations to identify individuals at risk for suicide using evidence-based screening for patients aged 12 years or older.

- Patients with suicidal ideation can be identified in a variety of settings including emergency departments, outpatient clinics, or during admission using standardized screenings:

- Inpatient/ED utilizes the Columbia Suicide Severity Rating Scale (CSSR-S)
- Ambulatory uses the Ask Suicide-Screening Questions (ASQ)

Refer to Medical Center Policy Suicide Risk Assessment and Prevention.

## Screening Criteria

- Suicidal ideation
- Injuries from a suicide attempt
- Physical or behavioral indications warranting further screening
- Annually for patients in a behavioral or psychiatric clinic with a primary psychiatric or behavioral diagnosis or complaint
- 12 – 17 years of age with a history of depression (inpatient)

Note: If the patient's risk stratification changes based on the rescreening, the LIP shall be notified and the patient's Suicide Precautions order modified accordingly.



## Safety

Once trained, staff members may be responsible for constant 1:1 visual observation of patients on suicide precautions which includes:

- Establish a secure environment to ensure safety.
- Removing harmful objects and equipment:
  - Regularly assess and secure patient surroundings.
  - Promptly remove any items that may pose a threat.
- Minimize risks by having patients remove personal clothing and shoes and wear paper scrubs or a green gown with no ties (inpatient).

- Checking Visitor Belongings and Gifts:
  - Screen belongings and gifts to prevent harmful items from entering.

## Documentation

Documentation is required by all team members caring for a patient on suicide precautions.

Based on your role and scope of practice:

- Screenings
- Observation
- Risk Stratification & Assessment (LIP)
- Care Planning
- Discharge
- Safety Planning (LIP/Social Work)





**Note:** To find out more type Suicide into Policy Tech.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.

CONTINUE

# Pharmacy

---

## Introduction


The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 5 - 7 minutes to complete.

It may take a moment for the following scenarios to load. Complete these questions before moving on.

## 1.1 Start

Start Content for Pharmacists



The content that follows is intended for Pharmacists and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match every work environment, but we ask that you review each of the following scenarios and consider how it may impact your work.

Click Next to continue

Notes:

## 1.2 Antimicrobial Stewardship

(Pick Many, 10 points, 1 attempt permitted)

Antimicrobial Stewardship

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration)

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

- Google
- UpToDate
- Clinical Portal/Antimicrobial Stewardship Program website
- Policy/Tech

Submit

This is not part of my role

Correct	Choice
	Group 8
	Group 7

X	Group 6
X	Group 5

### Incorrect (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

Google  
 UpToDate  
 Clinical Portal/Antimicrobial Stewardship Program website

**Incorrect**  
That is incorrect.

[Learn More](#)

[Submit](#)

This is not part of my role

### Correct (Slide Layer)

**Antimicrobial Stewardship**

A patient comes into the main OR in need of a surgical procedure. Joe, a team member in this area, needs to find correct antibiotic prophylaxis recommendations for a specific procedure (e.g. which antibiotic, dose, infusion time, timing prior to procedure, duration).

Where can he go to find UVA-specific guidelines for surgical and procedural antimicrobial prophylaxis?

Google  
 UpToDate  
 Clinical Portal/Antimicrobial Stewardship Program website

**Correct**  
That's right! You selected the correct response.

[Continue](#)

[Submit](#)

This is not part of my role



### 1.3 Antimicrobial Stewardship Info

**Antimicrobial Stewardship**

The correct answer is: Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech

When looking for correct antibiotic prophylaxis recommendations, the institutional guidelines "Surgical and Procedural Antimicrobial Prophylaxis Guidelines" are the most suitable resources to ensure quality clinical care.

These and other guidelines for best antimicrobial practices can be accessed via the Clinical Portal/Antimicrobial Stewardship Program website and PolicyTech.


### 1.4 C. diff Indicators

(Multiple Choice, 10 points, 1 attempt permitted)

**C. diff Indicators**

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours
- Foul odor
- Watery stool that takes the shape of the container



Correct	Choice
	Amoxicillin/clavulanate was initiated yesterday morning
	Polyethylene glycol (Miralax®) was given twice in the last 24 hours
	Foul odor
X	Watery stool that takes the shape of the container

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**


That is incorrect.

**Correct (Slide Layer)**


**C. diff Indicators**

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours
- Foul odor
- Watery stool that takes the shape of the container

 **Correct**  
That's right! You selected the correct response.

[Continue](#)



**Incorrect (Slide Layer)**

**C. diff Indicators**

You receive report that your patient just had his third loose stool in the last 12 hours. A team member suggests C. difficile testing so you review the chart to make an assessment. Which of the following is most consistent with appropriate C. difficile testing?

- Amoxicillin/clavulanate was initiated yesterday morning
- Polyethylene glycol (Miralax®) was given twice in the last 24 hours
- Foul odor
- Watery stool that takes the shape of the container

 **Incorrect**  
That is incorrect.

[Learn More](#)



## 1.5 C. diff Indicators Info

**C. diff Indicators**



**The right answer is:** Watery stool that takes the shape of the container.

If the specimen takes the shape of the container, it may be appropriate for testing.

General guidance for approaching C. difficile testing decisions among adult inpatients is available in the Resources section of the Infection Prevention and Control website or desktop icon.



**Should I send stool for C. difficile testing?**  
General recommendations for testing in adult inpatients

**1. FREQUENCY, ILLNESS/TOILET, AND RISK FACTORS**  
At least **3** watery stools within the last **24** hours  
AND: Clinical signs/symptoms or risk factors?  
e.g. fever, T-tube, abdominal pain/distention, recent antibiotics, intra-abdominal surgery, age > 60

NO → **Do NOT test**  
YES → **Test**

**2. CONSISTENCY**  
Stool take the **shape** of the container 

NO → **Do NOT test**  
YES → **Test**

**3. POUCH TESTED (assuming three diarrhoeal samples)**  
Is there a C. DIFFICILE test in the last **7** days for the same episode of diarrhea?  
Is there a **POSITIVE** test in the last **28** days?

NO → **Test**  
YES → **Do NOT test**

**4. ALTERNATIVE EXPLANATIONS (to diarrhea)**  
Is the diarrhea explained by another cause such as viral **respirations**?  
e.g. hepatitis, gastroenteritis, antibiotics, tube nursing 

NO → **Test**  
YES → **Do NOT test**


**Testing is likely appropriate for diarrhea with LIP**

See the Guidelines for Infection Prevention and Control website for more information

## 1.6 End

**End of This Section**

Thank you for completing this section. Please scroll down to continue.



**Notes:**

## Start Content for Pharmacists



The content that follows is intended for Pharmacists and for those whose role is aligned with the knowledge needed for this kind of work.

It is not possible to create a scenario that will exactly match every work environment, but we ask that you review each of the following scenarios and consider how it may impact your work.

**Click Next to continue**



Complete the content above before moving on.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.

**CONTINUE**

# Patient Contact (HUC, Patient Access, Other Pt Services)

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 5 minutes to complete.

## When to Call 911, Security, and BERT

This content is for HUC's and other similar roles. If this is not part of your role, you can skip this activity.

The Medical Center has several resources to help make this a safe place to both give and receive care. Although you will receive help regardless of who is called, calling the correct place the first time will help save precious minutes when you need help immediately.

**Instructions:** Take the card from the top pile and drag it to the appropriate pile, saying when to call 911, Security, or BERT.

---

Call 911

You see a person with a gun .

You witness active physical violence.

Call Security

A patient under an  
Emergency Custody Order  
left the unit and is in the  
elevator.

Call BERT

**A delirious patient is agitated  
and someone is requesting  
support.**

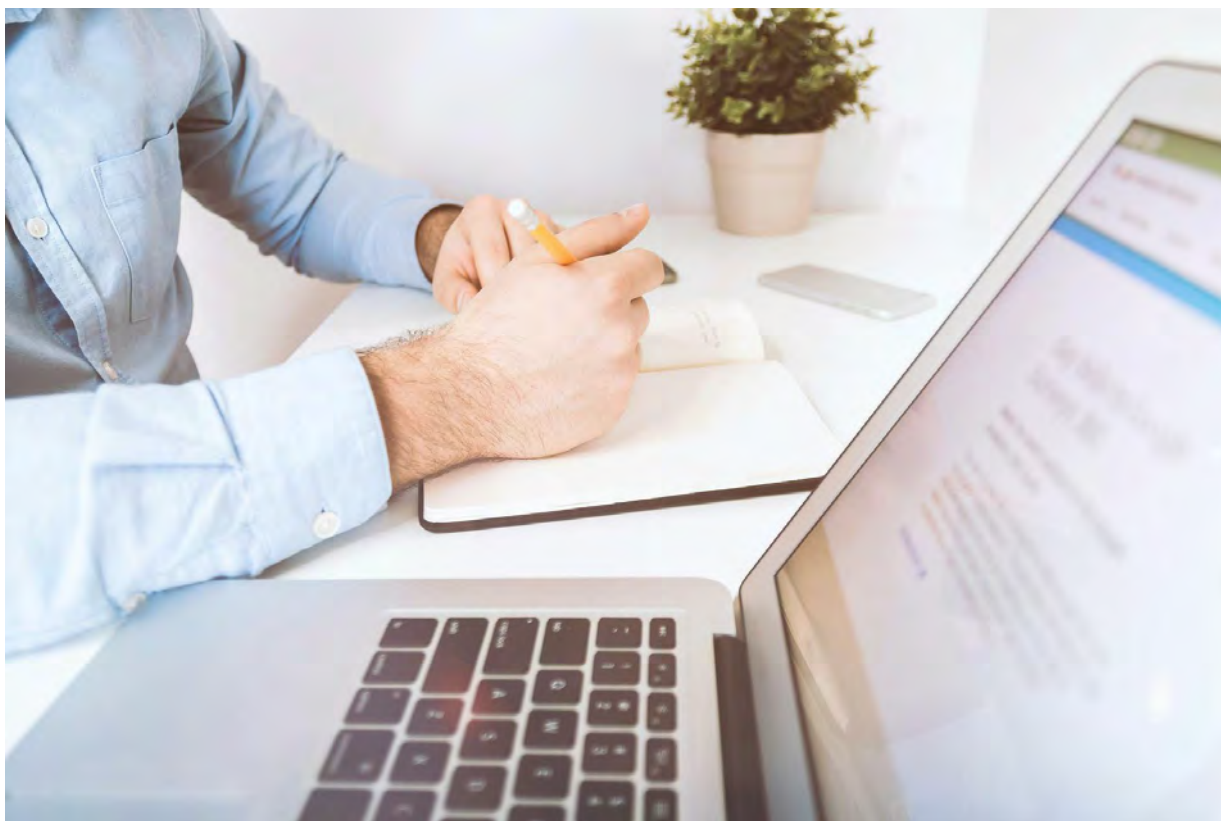
**CONTINUE**

Calling the right place the first time saves valuable time in emergencies.

- Call BERT if you need help with a behavioral emergency of a patient.
- Call Security for any situation that appears to be escalating towards violence and/or the Patient has left the unit and does not have capacity or is in mental health crisis.
- Call 911 if you see a weapon or there is active violence occurring, including a specific verbal threat of violence (i.e. I am going back to my car to get a gun).

**CONTINUE**

**Advance Care Planning Documents- What to Do With Them**



Make a copy of the patient's Advance Care Planning (ACP) Documents. The original should be returned to the patient. Access Associates, HUCs and Unit Secretaries **with** the ability to scan full page documents:

- Scan the copy to Document Type: Advance Directive/Living Will NOT VALIDATED in FOS

Access Associates, HUCs or Unit Secretaries **without** the ability to scan full page documents:

- Fax to HIM (MC) at (9)244-7528 or 434-244-7528 (CH) **(use duplex mode to ensure all pages are faxed.)**
- Send paper forms to HIM for scanning via HIM Courier
- E-mail the R HIM Doc Import group Document Import Process.docx (live.com)

**Inpatient:** In addition, a copy should be placed in the red folder in the door side chart with a pink dot in the corner to show it was sent to HIM.

**Ensure documents get to Health Information Management (HIM) AS SOON AS RECEIVED.**



To be valid, the advance directive must be signed by the patient and have signatures from **two (2)** adult witnesses. For questions about ACP documents, contact Health Information Management (HIM) at [CLHIMACP@uvahealth.org](mailto:CLHIMACP@uvahealth.org) or 434-924-5136.

CONTINUE

**Continue to the Next Section**

**You have completed content related to your role**

Click Continue to complete the course.

CONTINUE

# Security

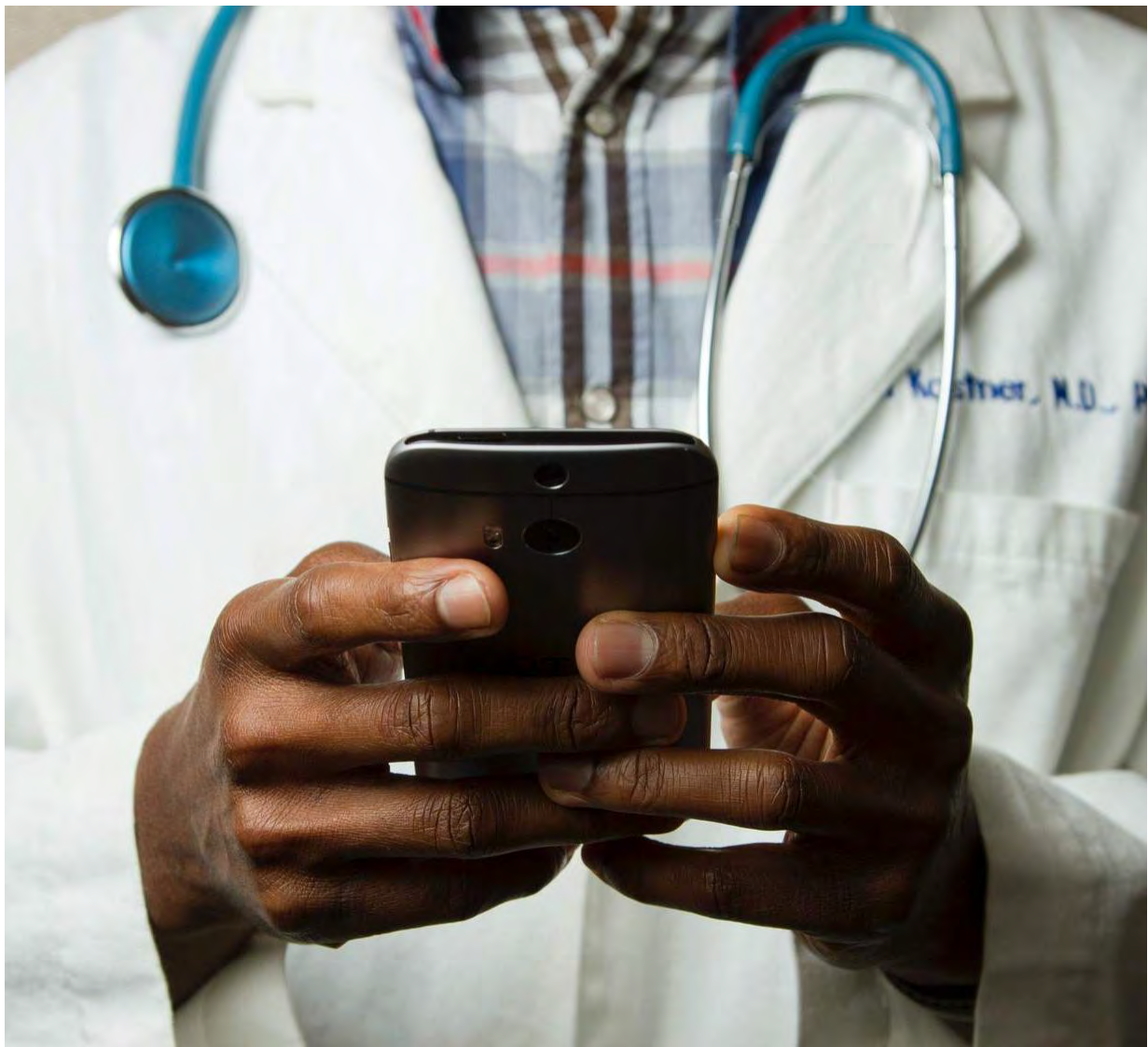
---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please review each section and reflect how the topic may be relevant in your work.

This section will take approximately 5 - 7 minutes to complete.

## Restraints



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

We are committed to minimizing the use of restraint or seclusion. We will limit use of restraint to only clinically appropriate and adequately justified situations. Restraint or seclusion will only be imposed to ensure the immediate physical safety of the patient, a staff member, or others.

Review the types of restraints below.

## **Non-Violent Restraints** —

<b>Restraint Type</b>	<b>Non-Violent Restraints</b>
Description/ Behaviors	Used when a patient's behavior puts them at risk for injury or interferes with medical treatment necessary to support medical healing: <ul style="list-style-type: none"> <li>• Remove invasive device(s) necessary for medical management</li> <li>• Routine fall prevention measures have been ineffective.</li> <li>• Repeated non-compliance with ordered activity restrictions</li> </ul>
Methods/devices	side rails, roll belt, enclosure bed, limb restraints
LIP ordering/ documentation	New order every calendar day
Documentation	Every two hours by RN

## **Violent Restraints** —

Description/ Behaviors	Used in an urgent or escalating situation when severely aggressive, violent, or self-destructive behavior jeopardizes the immediate physical safety of the patient, a staff member, or others.
Methods/devices	limb restraints, physical hold, medications, seclusion (5 East only)
LIP ordering/ documentation	Requires a new order every: <ul style="list-style-type: none"> <li>• 4 hours for adults.</li> <li>• 2 hours for children 9-17 years old.</li> <li>• 1 hour &lt;9 years old.</li> </ul>
Documentation	Every 15 minutes by RN

## Type of Restraint and Discontinuation

Restraints or seclusion is initiated upon the order of an LIP who is responsible for the ongoing care of the patient. In urgent situations, a Registered Nurse may initiate restraints or seclusion to maintain safety prior to obtaining an LIP order.

Oversight of the application of restraints is the responsibility of the Registered Nurse with the assistance of additional trained personnel as needed. Restraint(s) must be applied maintaining proper body alignment and without causing undue physical discomfort to the patient.

### **Patient Positioning**

1. A patient must be placed in a position that allows airway access and does not compromise respiration.
2. A patient placed with one arm overhead may only have one arm at a time placed over the head.
3. A patient must not be restrained in the face down (prone) position. If a patient must be temporarily held in a prone position during application of a restraint, staff must ensure that the airway is unobstructed at all times (for example, do not cover or "bury" the patient's face) and reposition the patient as quickly as possible. Also, staff must ensure that expansion of the patient's lungs is not restricted by excessive pressure on the patient's back (special caution is required for children, elderly patients, and very obese patients).



Law Enforcement Devices such as handcuffs, manacles, shackles, and other chain-type restraint devices applied and monitored by law enforcement are NOT healthcare restraint-related interventions. Law enforcement officers are responsible for monitoring and maintaining custody of the patient (their prisoner) in these devices.

## Discontinuation of Restraints

Discontinue restraints as soon as possible, once criteria are met for release.

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and **must be discontinued at the earliest possible time.**

The RN may consider a phased discontinuation. The process for a phased discontinuation of restraints is one limb at a time for purposes of observing behavior and response to intervention

once a patient has moved to a calm state (should not exceed 2 hours).

Order discontinuation can be by the RN via protocol order or LIP as order discontinuation.

For more information, refer to Medical Center Policy Restraint and Seclusion.

## Continue to the Next Section

**You have completed content related to your role.**

Click Continue to complete the course.

CONTINUE

# Specimen Contact

---

## Instructions

This content is required for anyone who has contact with specimen, but does not provide direct care. Although everything here may not be required for you day to day, or it may not be presented in the same way you see these situations in your work environment, please reflect on how the information could be relevant to your role.

It will take approximately 10 - 12 minutes to complete this section.

### **Don't have specimen contact?**

If you do not have contact with specimen or have another role, [click here](#) to return to the previous section.

[RETURN TO START](#)

## Clinical Engineering Stickers for Medical Equipment

Any Medical Device, whether purchased, contracted, donated, loaned, or for trial or research, that is to be used in the Medical Center for inpatient or outpatient care purposes, shall be registered with Clinical Engineering. Clinical Engineering must inspect each device **before** clinical use! For more information, refer to Medical Center Policy: Management of Medical Devices Used In Patient Care.



Stickers serve as a visual indication that this registration has taken place and also indicate when the next scheduled maintenance is due. Here are the stickers you may find on medical equipment at UVA Health:



**Asset Sticker**

All inventoried medical devices purchased after January 2022 are given a unique asset number that also serves as the Clinical Engineering control number. This Asset Sticker thus serves as the CE Sticker or Barcode Sticker. Devices purchased prior to January 2022 will have this sticker only if their purchase price was greater than or equal to \$2000.



**CE Sticker or Barcode Sticker**

All inventoried medical devices purchased prior to January 2022 should have this sticker which contains the 8-digit control number used to uniquely identify each device (with the exception of a few which use the manufacturer's serial number

instead as the control number). Medical devices purchased after January 2022 will use the Asset Sticker in lieu of this sticker.



**Green Sticker or Teal Sticker**

Not all medical devices require scheduled maintenance. This sticker indicates that the device has been registered with CE and passed its initial safety inspection. No additional inspection is required.

---

**DATE** **SER. #**

**SAFETY CHECK**

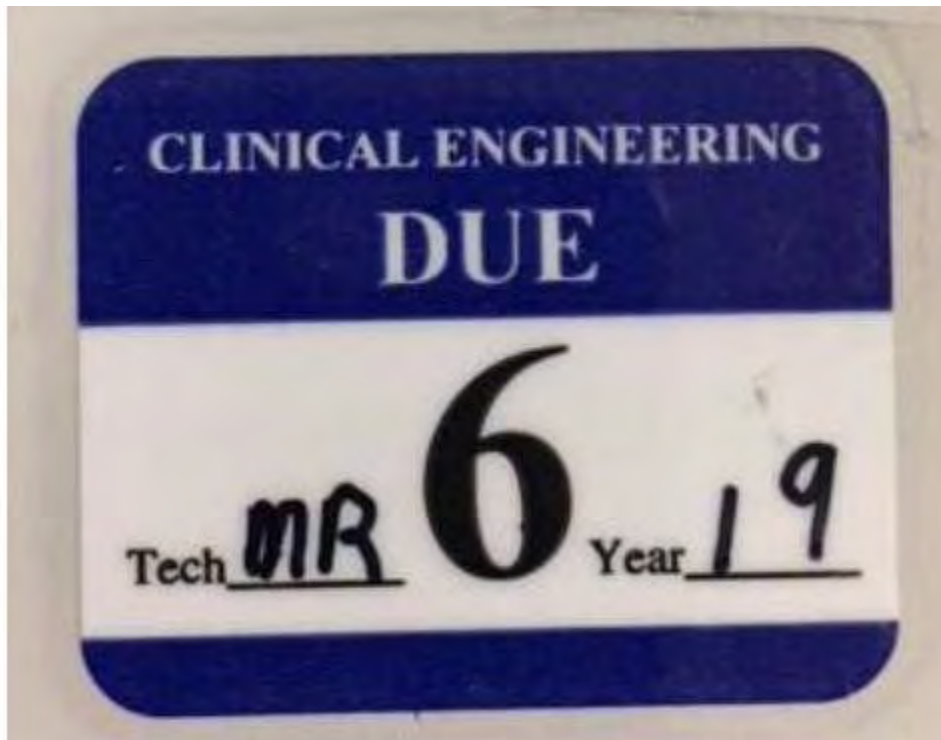
<b>Equipment Check</b>	
<b>Ground wire OK</b>	
<b>Leakage current</b>	
<b>Tested by</b>	
<b>Date next check</b>	
<b>Comments</b>	

UAL BE209

**Orange Sticker**

Devices that are not owned by UVAHS still need to be registered. This sticker indicates that a demo, loaner, or patient-owned device has been registered with CE and passed its initial safety inspection. If the device remains at UVAHS up to the “date next check” date, it will need to be re-inspected by CE.

---



#### **PM Sticker or Date Sticker**

All medical devices with scheduled maintenance have this sticker which indicates when the next PM is due. Here, the next PM is due by the end of June 2019. Each month has a different color.

---

If you see a medical device with no sticker on it, immediately call CE 4-2391 to arrange registration.

If a medical device has a PM sticker indicating that the PM is due, or an orange sticker with an upcoming "next check" date, notify CE 4-2391 to arrange maintenance.

**CONTINUE**

**Hand Hygiene**

**Clean Hands Save Lives**

Hand hygiene is accepted as the single most important procedure to reduce the transmission of nosocomial infections. Good hand hygiene can save lives! Proper hand hygiene for interactions with patients are defined below. Click the two cards to learn more.



### **Alcohol-Based Hand Rub**

1. Dispense alcohol into palm
2. Rub the alcohol well over fingers, fingernails, finger webs, and backs of hands until the alcohol has dried.

Use enough to require at least 20 seconds or until dry.



### **Hand Washing**

1. Wet hands thoroughly with water and apply soap.
2. Rub together all surfaces of lathered hands vigorously for at least 20 seconds.
3. Rinse hands thoroughly under a stream of water.
4. Use a paper towel to turn off the faucet, discard the

**Get Into the Habit**

CONTINUE

**Personal Protective Equipment: Preventing Team Member Injury**



All laboratories will observe standard precautions in order to prevent the transmission of blood-borne pathogens transmitted by blood, body fluids, tissue, infectious waste, and other potentially infectious material. Barrier protection is to be routinely used to prevent skin and mucous membrane contamination with blood, body fluids containing visible blood, or other body fluids to which standard precautions apply.

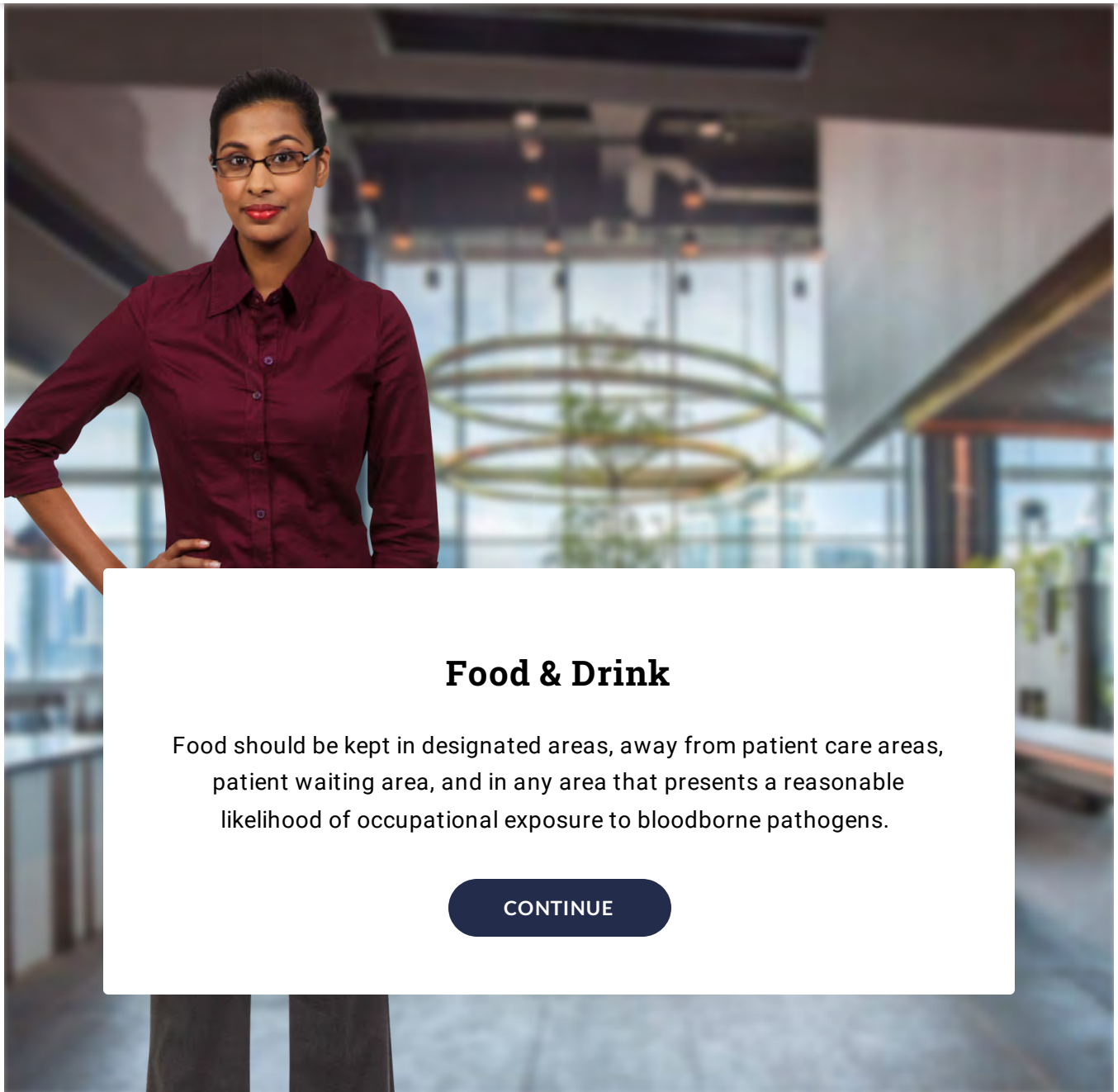
Types of Barrier Protection include:

- Gloves
- Laboratory coats
- Gowns
- Aprons combined with safety sleeves
- Goggles and mask
- Face shield
- Bench top shield

**CONTINUE**

**Food & Drink in Work Area**





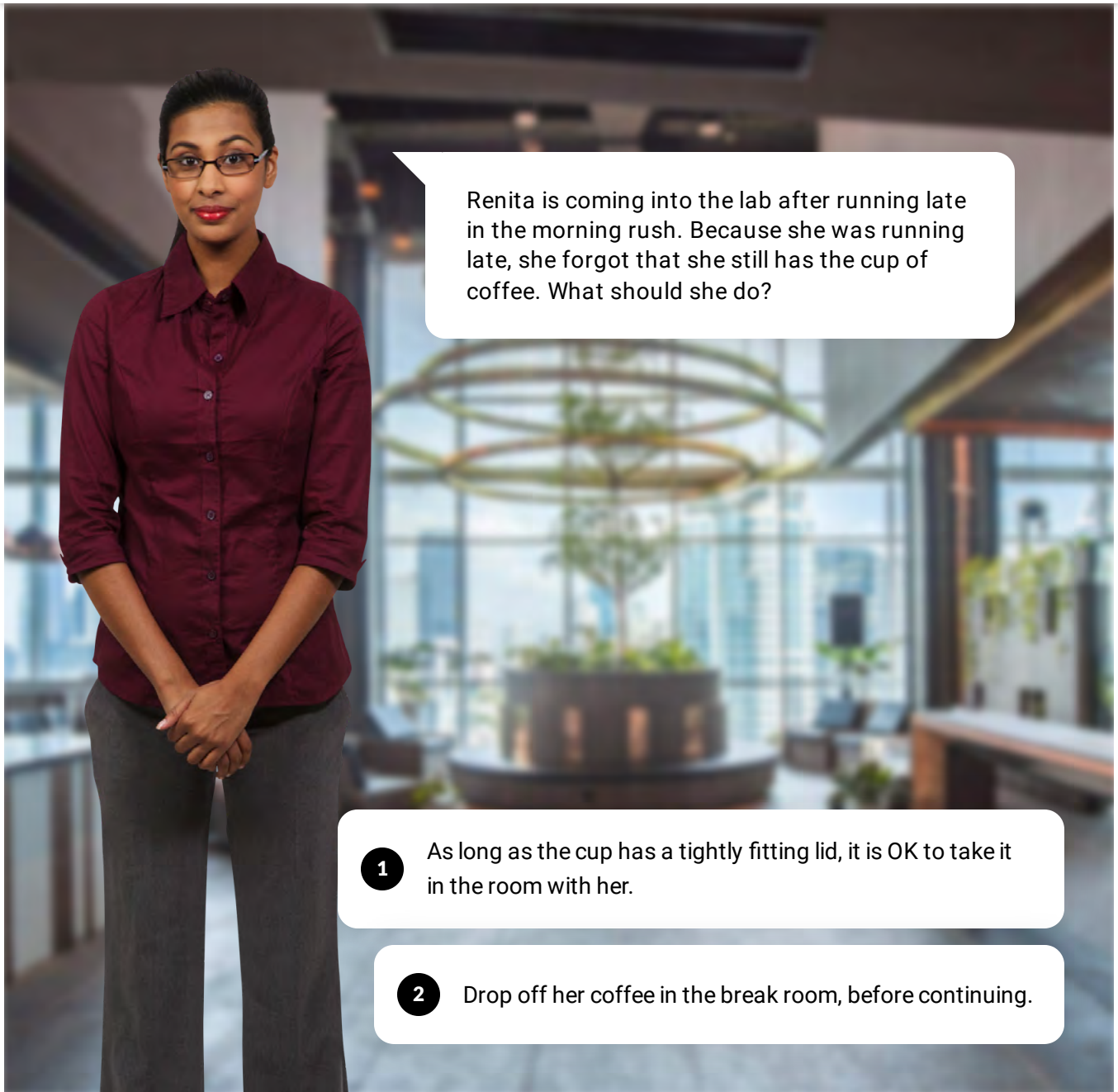
## **Food & Drink**

Food should be kept in designated areas, away from patient care areas, patient waiting area, and in any area that presents a reasonable likelihood of occupational exposure to bloodborne pathogens.

**CONTINUE**

### **Scene 1 Slide 1**

Continue → Next Slide



Renita is coming into the lab after running late in the morning rush. Because she was running late, she forgot that she still has the cup of coffee. What should she do?

1

As long as the cup has a tightly fitting lid, it is OK to take it in the room with her.

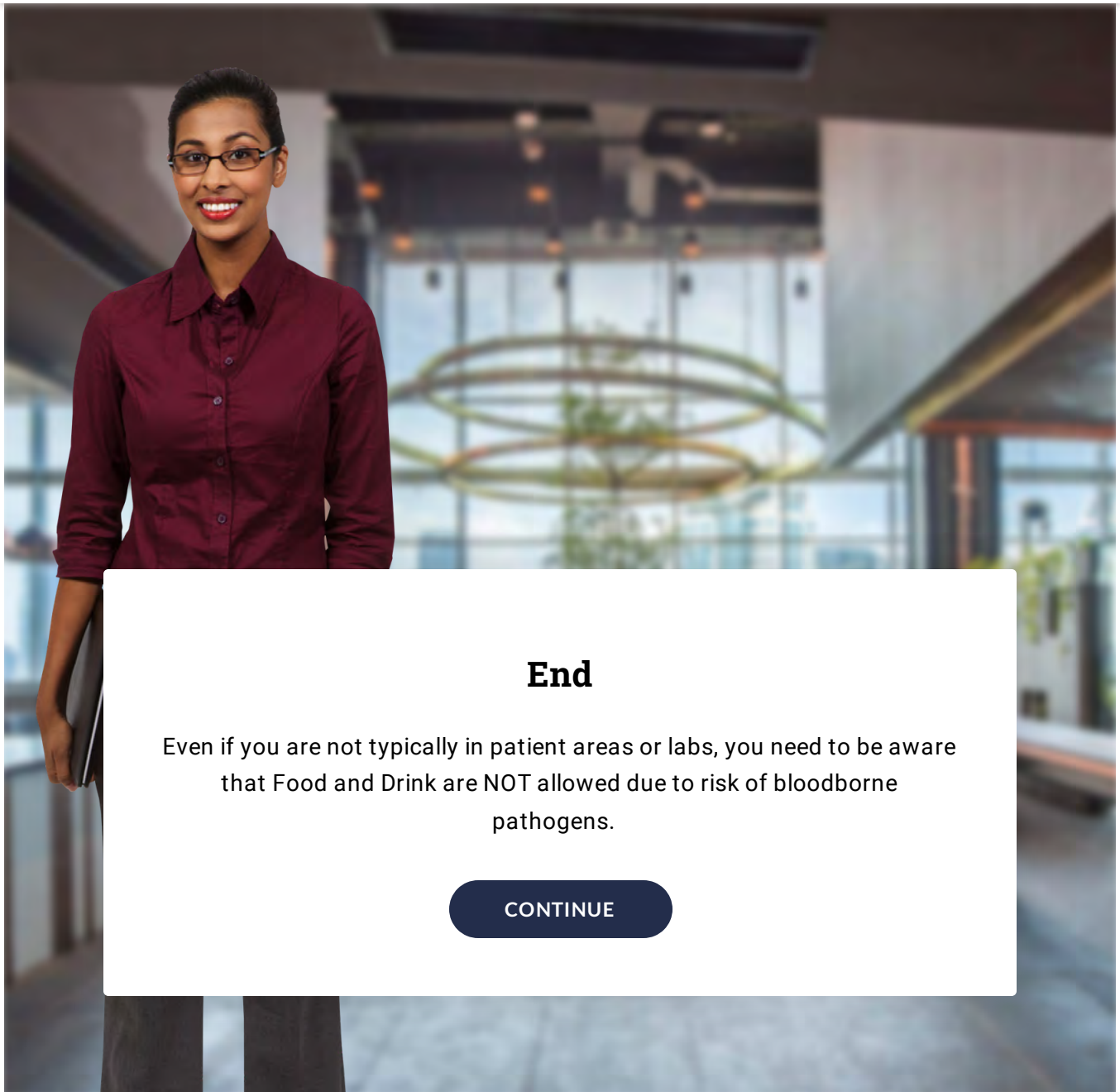
2

Drop off her coffee in the break room, before continuing.

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



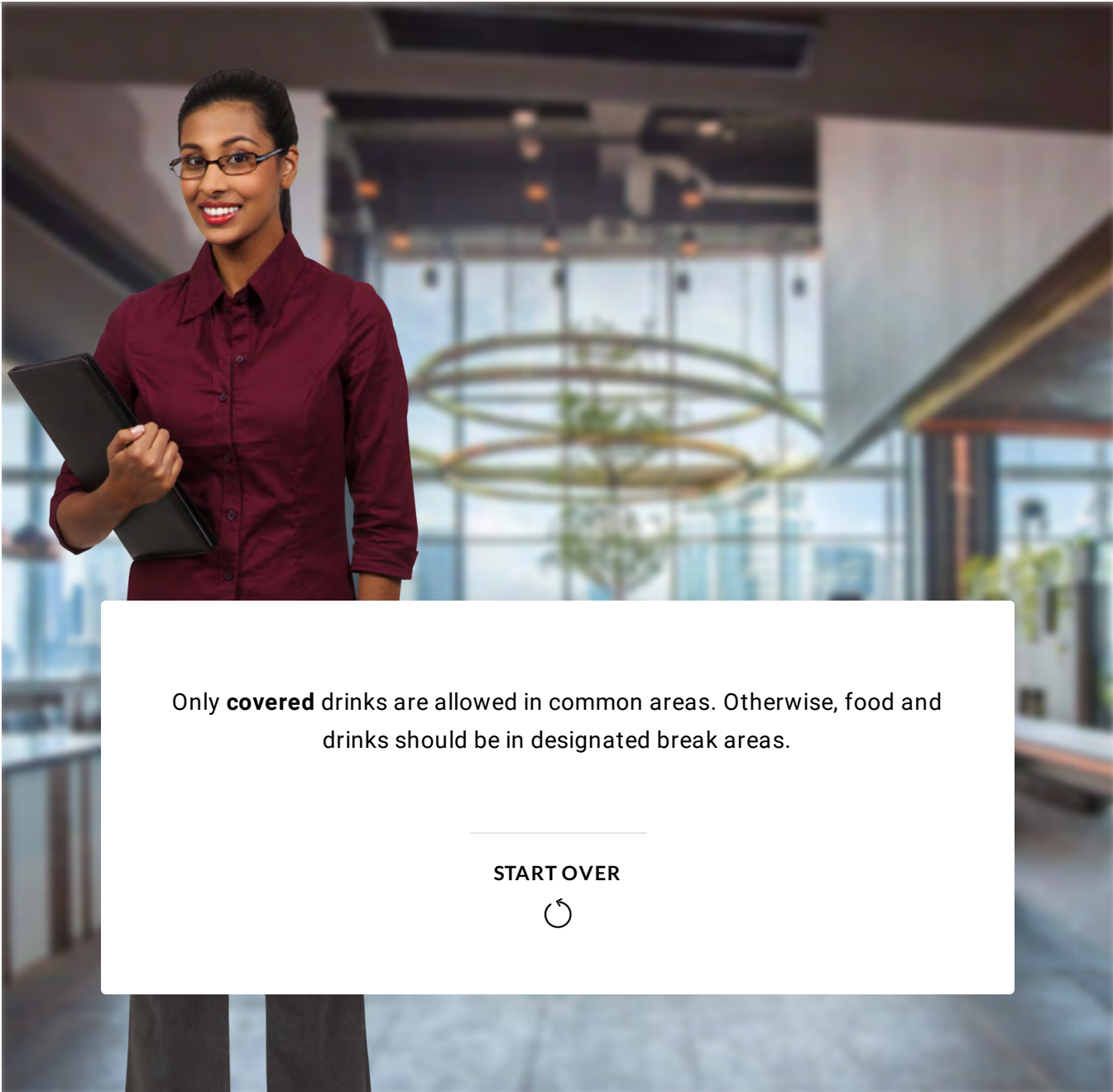
## End

Even if you are not typically in patient areas or labs, you need to be aware that Food and Drink are NOT allowed due to risk of bloodborne pathogens.

CONTINUE

### Scene 1 Slide 3

Continue → Next Slide



Only **covered** drinks are allowed in common areas. Otherwise, food and drinks should be in designated break areas.

---

START OVER



## Scene 1 Slide 4

Continue → End of Scenario

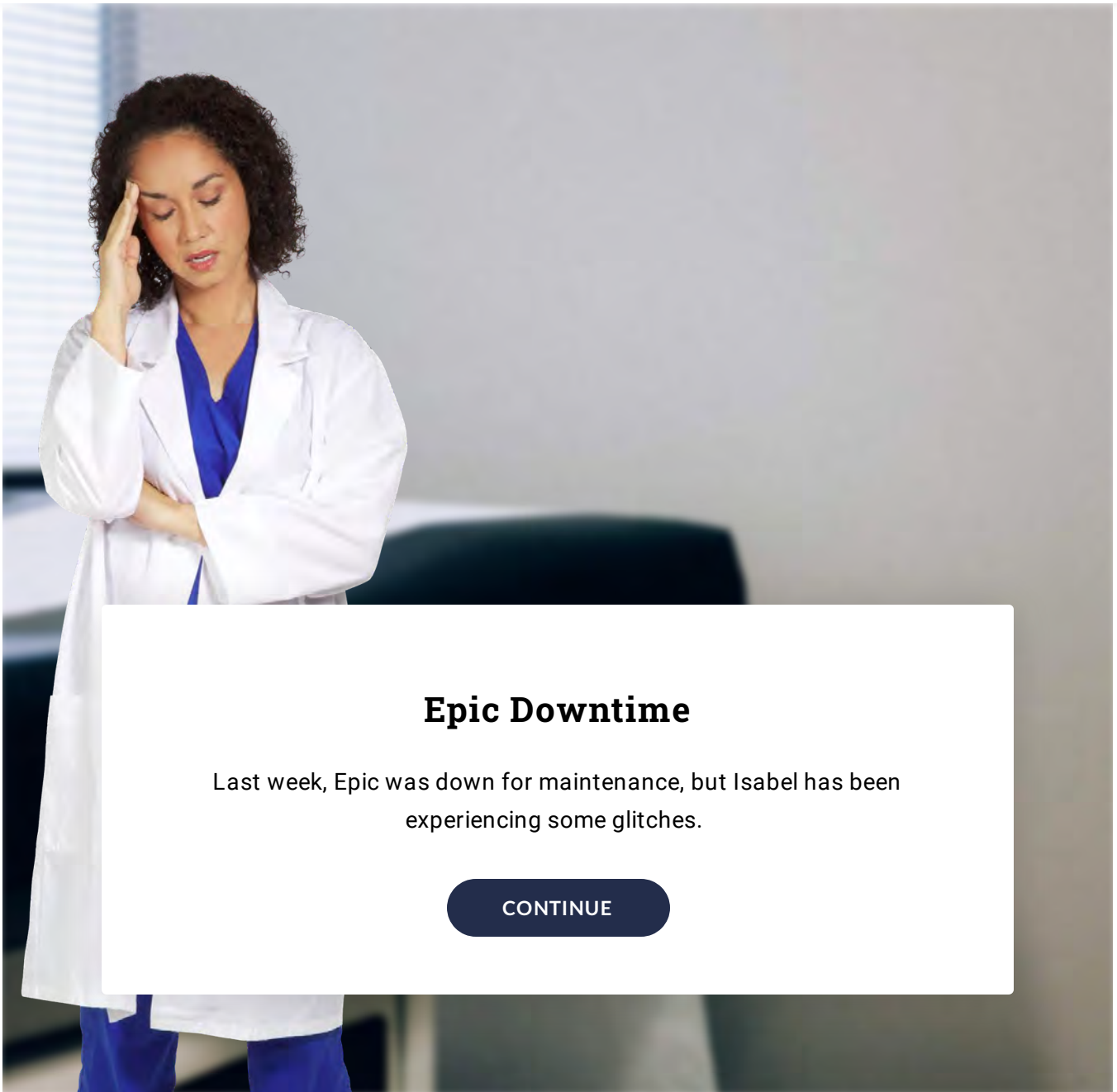


Complete the content above before moving on.

## Managing Interruptions - Epic Downtime

Having an effective response plan is critical for mitigating the impact of downtime. Patient records are critical to providing the best possible care. To ensure you are prepared for downtime, make sure that you:

- Check your required forms weekly to ensure you have a supply in case of down time.
- The team should check the Business Continuity Access (BCA) PC weekly if you have one in your area.
- Validate that the information you need is accessible and test print one record to ensure your printer is set to local and default.



## **Epic Downtime**

Last week, Epic was down for maintenance, but Isabel has been experiencing some glitches.

**CONTINUE**

### **Scene 1 Slide 1**

Continue → Next Slide



While Health System IT is working on this she wants to make sure she is prepared for downtime. What should she do to prepare?

1

Check the required forms, the Business Continuity Access (BCA), and validate that the information needed is accessible, printing a test.

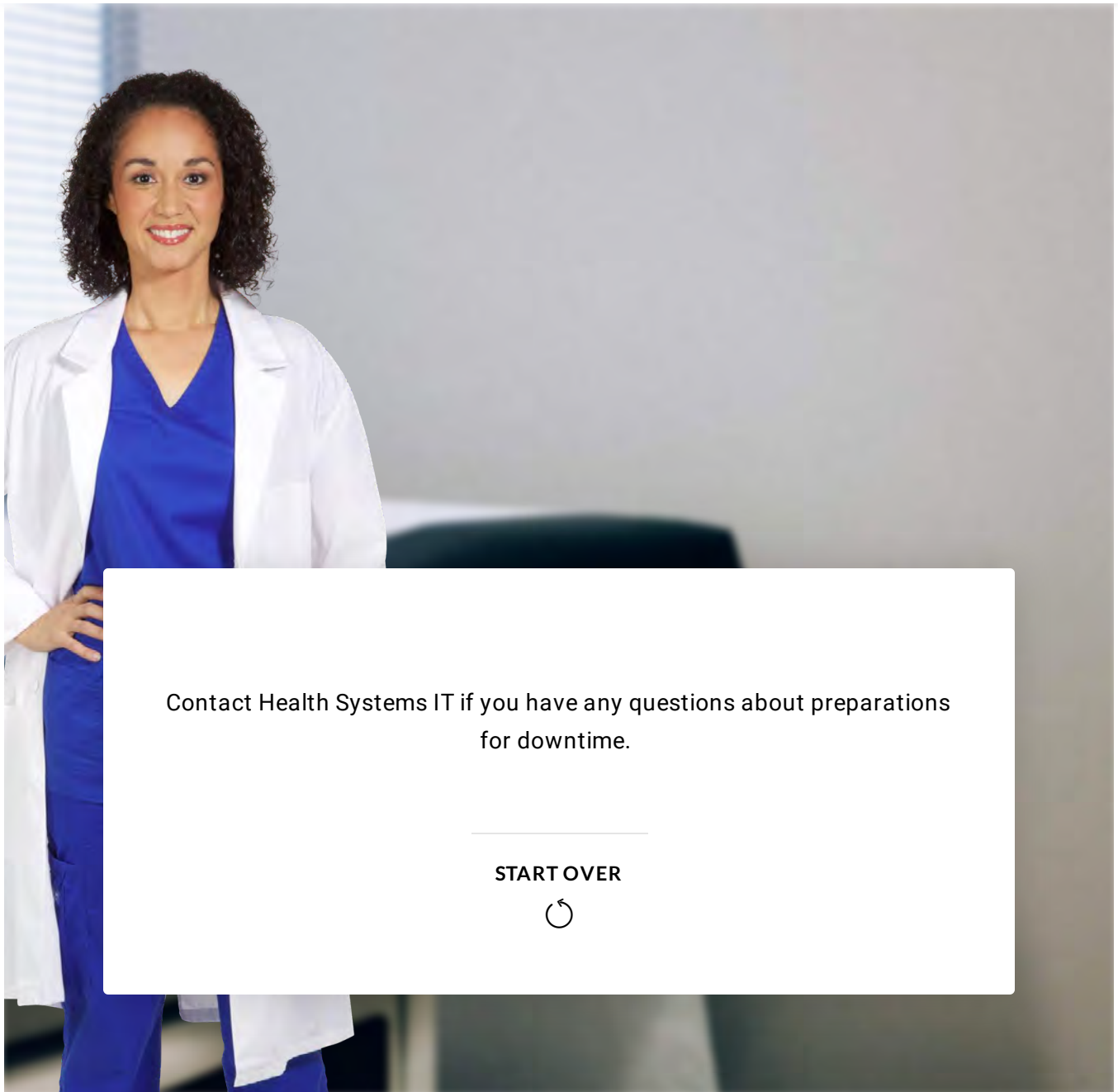
2

All she has to do is call Health Systems IT and give all the relevant information about what is happening with the glitches.

## Scene 1 Slide 2

0 → Next Slide

1 → Next Slide



Contact Health Systems IT if you have any questions about preparations for downtime.

---

START OVER



## Scene 1 Slide 3

Continue → End of Scenario





Complete the content above before moving on.

**Continue to the Next Section**

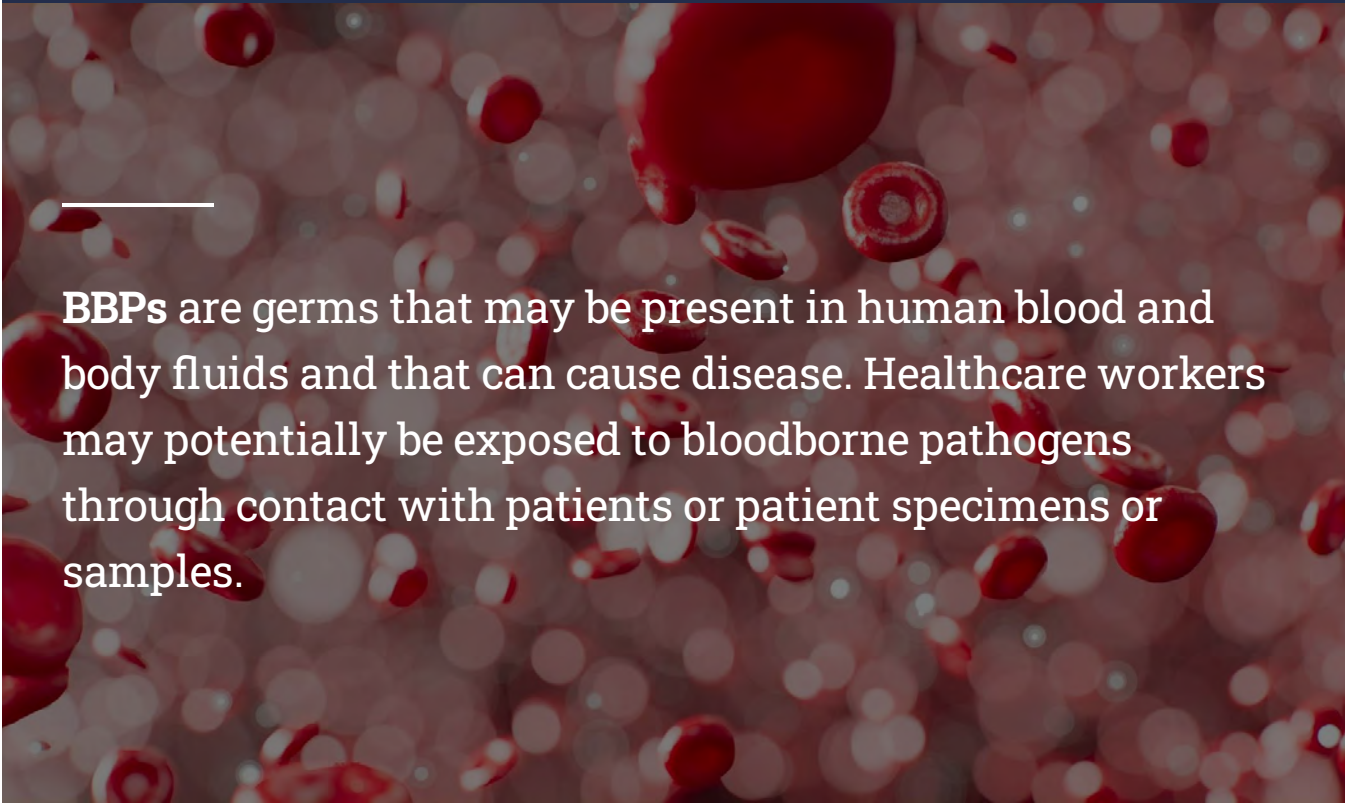
Click Continue to move to the next section.

**CONTINUE**

# Bloodborne Pathogens for Specimen Contact

---

## Overview of Bloodborne Pathogens (BBPs)

A microscopic view of red blood cells, showing various sizes and shapes, some with visible nuclei, set against a dark red background.

BBPs are germs that may be present in human blood and body fluids and that can cause disease. Healthcare workers may potentially be exposed to bloodborne pathogens through contact with patients or patient specimens or samples.

Some of the diseases that can be transmitted through blood and body fluids include:

- Human Papillomavirus (HPV)
- Hepatitis C (HCV)
- Human Immunodeficiency Virus (HIV)

At UVA, we follow the **OSHA** Bloodborne Pathogens Standard. This set of federal regulations outlines "Standard Precautions" to protect team members from exposures to bloodborne pathogens.

CONTINUE

## Bloodborne Pathogen (BBP) Standard



OSHA's **Bloodborne Pathogens Standard (29 CFR 1910.1030)** as amended pursuant to the **2000 Needlestick Safety and Prevention Act**, is a regulation that prescribes safeguards to protect workers against health hazards related to bloodborne pathogens. It has provisions for exposure control plans, engineering and work practice controls, hepatitis B vaccinations, hazard communication and training, and recordkeeping. The standard imposes requirements on employers of workers who may be exposed to blood or other potentially infectious materials such as certain tissues and body fluids.

### What to Do

Using Standard Precautions, each of us is required to:

- Treat all human blood and body fluids as if they have bloodborne pathogens
- Practice hand hygiene before and after every patient contact

- Wear PPE if there is a reasonable anticipation of spray, splash or splatter - whether the patient is on isolation or not
- Dispose of medical waste in appropriate containers
- Consider receiving the Hepatitis B vaccine series

CONTINUE

## BBP Transmission & Exposure

Flip each card below to see the ways in which BBPs can be transmitted.

Skin injury

Through needlesticks,  
scalpel cuts, etc.

Contact with Infected Fluids

Spray, splash, or splatter into the eyes, nose, mouth, or broken skin

Perinatally

From an infected mother to child during pregnancy, childbirth, and breastfeeding

Sexual Contact

Through unprotected sex and transfer of blood, semen, or vaginal secretions



Complete the content above before moving on.



A work-related bloodborne pathogen **exposure** occurs during any of the following:

- Injury with a contaminated sharp object (e.g., needle, catheter, scalpel, blade, suture needle, etc.)
- Spill, splash, or splatter of blood or body fluids into nonintact skin (cuts, hangnails, dermatitis, abrasions, chapped skin)
- Spray, splash, or splatter of blood or body fluids into mucous membranes (eyes, nose, mouth)
- Instance of contact with blood covering a large area of skin that seems to be intact.

## **What to Do**

At UVA, we take a comprehensive approach to the prevention of bloodborne pathogen transmission. This includes clear guidelines for infection prevention and control, specific policies

and practices that provide protection, and education of our staff to limit exposure and reduce transmission if exposure does occur including:

- Surveillance and analysis of exposures and infections through a comprehensive Team Member Injury Prevention Program
- Evidence-based policies and procedures (Infection Control Manual)
- Education and training of staff in safe practices
- Availability of personal protective equipment
- Use of safer medical devices (including invention and study of safety devices)
- Vaccination of those at risk for hepatitis B
- Rapid and effective response in the event of exposure
- Targeted interventions based on role-specific hazards

**CONTINUE**

## **Exposure Follow-up**

In Virginia, the deemed consent law is in effect. This means that if a healthcare worker is exposed to a patient's blood or body fluids, the patient's permission is not required to test the patient's blood for bloodborne pathogens and vice-versa. The patient is deemed to have given consent for such testing when admitted. The patient will be notified of the testing and counseled by his or her doctor regarding the results.



## Follow-up Protocol

Testing, follow-up, and counseling are provided after an exposure. Based on evaluation of the incident (PIC #1523), treatment may be indicated. Click each BBP below to see related treatment.

### HIV —

For maximum effectiveness, antiretroviral medication to prevent infection should be given within the first 2 hours after exposure.

### HBV —

For those who are not immune, Hepatitis B Immune Globulin may be given up to 7 days after exposure, the sooner the better.

### HCV —

If found to have acquired hepatitis C, the team member will be referred for evaluation. Early antiviral therapy has resulted in a higher cure rate.

## Preventing BBP Exposures



Each work area has a written **Exposure Control Plan** and it is kept in the Red Book. Review the plan in your work area to learn more about:

- Potential exposure risks and steps to prevent them
- Sharps safety devices available in your work area
- Steps to take in the event of an exposure

**Continue to the Next Section**

**Click Continue to move to the next section.**

**CONTINUE**

# Physical Plant

---

## Introduction

The topics included are required for your role, although the scenario may not match your work environment. Please answer each question and reflect how the topic may be relevant in your work.

It will take approximately 5 - 7 minutes to complete this section.

## Clinical Engineering Stickers for Medical Equipment

Medical Center Policy Management of Medical Devices Used In Patient Care requires that “any Medical Device, whether purchased, contracted, donated, loaned, or for trial or research, that is to be used in the Medical Center for inpatient or outpatient care purposes shall be registered with Clinical Engineering.” Clinical Engineering must inspect each device **before** clinical use!

Stickers serve as a visual indication that this registration has taken place and also indicate when the next scheduled maintenance is due. Here are the stickers you may find on medical equipment at UVA Health:



**Asset Sticker**

All inventoried medical devices purchased after January 2022 are given a unique asset number that also serves as the Clinical Engineering control number. This Asset Sticker thus serves as the CE Sticker or Barcode Sticker. Devices purchased prior to January 2022 will have this sticker only if their purchase price was greater than or equal to \$2000.



**CE Sticker or Barcode Sticker**

All inventoried medical devices purchased prior to January 2022 should have this sticker which contains the 8-digit control number used to uniquely identify each device (with the exception of a few which use the manufacturer's serial number instead as the control number). Medical devices purchased after January 2022 will use the Asset Sticker in lieu of this sticker.

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**Green Sticker or Teal Sticker**

Not all medical devices require scheduled maintenance. This sticker indicates that the device has been registered with CE and passed its initial safety inspection. No additional inspection is required.

---

**DATE** **SER. #**

**SAFETY CHECK**

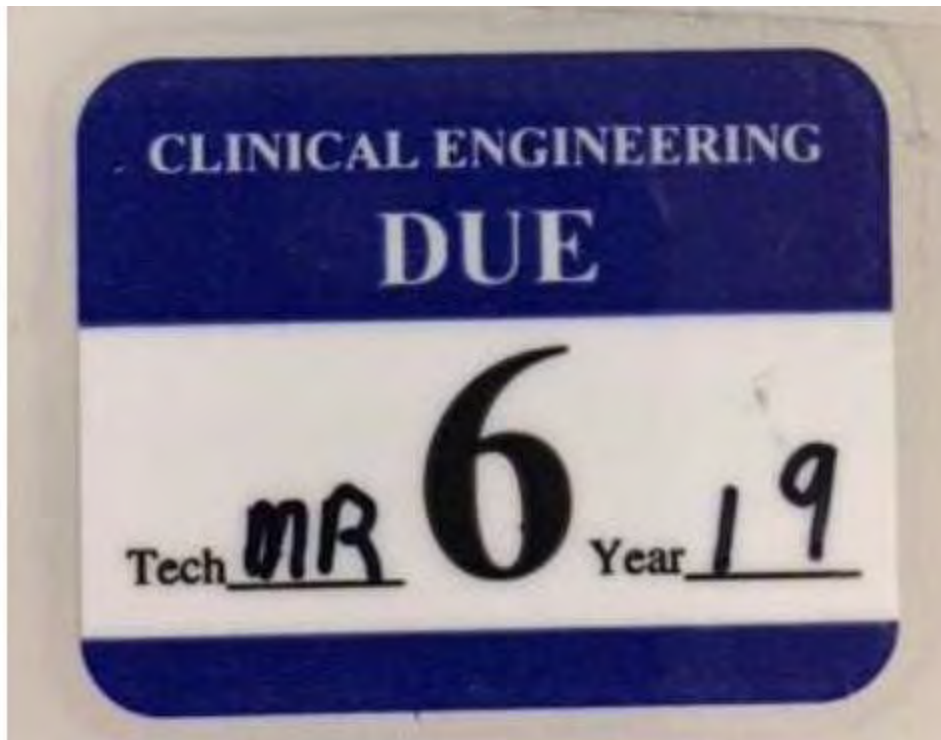
<b>Equipment Check</b>	
<b>Ground wire OK</b>	
<b>Leakage current</b>	
<b>Tested by</b>	
<b>Date next check</b>	
<b>Comments</b>	

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**Orange Sticker**

Devices that are not owned by UVAHS still need to be registered. This sticker indicates that a demo, loaner, or patient-owned device has been registered with CE and passed its initial safety inspection. If the device remains at UVAHS up to the “date next check” date, it will need to be re-inspected by CE.

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**PM Sticker or Date Sticker**

All medical devices with scheduled maintenance have this sticker which indicates when the next PM is due. Here, the next PM is due by the end of June 2019. Each month has a different color.

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If you see a medical device with no sticker on it, immediately call CE 4-2391 to arrange registration.

If a medical device has a PM (Preventative Maintenance) sticker indicating that the PM is due, or an orange sticker with an upcoming "next check" date, notify CE 4-2391 to arrange maintenance.

**CONTINUE**

**Infection Control Risk Assessment (ICRA)**

## **Infection Control Risk Assessment (ICRA) for Construction, Renovation, and Maintenance**

In the event that Facilities is called to address a problem in a patient room, Health System Physical Plant (HSPP) will assess interventions and partner with team members to complete the work.

Construction dust can carry harmful particles and microorganisms, such as Aspergillus, that may cause or worsen respiratory issues and cause serious infections in susceptible patients.

Transmission occurs through inhaling airborne spores. Healthcare-associated infections are sporadic and associated with dust exposure during building renovation or construction.

Occasional outbreaks of cutaneous infection have been linked to contaminated medical devices.

### **Infection Control interventions include:**

1. Patients must be removed from the work area while the work is being performed.
2. Contractor executes work by methods to mitigate dust from construction operations.
3. Ceiling tile should be immediately replaced if displaced.
4. Contractor is educated before the start of the project about the importance of adhering to Infection Prevention & Control measures.
5. The person who did the work should clean (wipe down or HEPA vacuum) work area upon completion.





**Continue to the Next Section**

**You have completed content related to your role.**

Click Continue to complete the course.

**CONTINUE**

# Content for Your Role Complete

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## Finish

Thank you for taking the time to complete the course. This year, there is no additional content for your role.

In order to mark the course as complete in Workday Learning, you must continue to the next page.

**Click here to reach the final page of the course.**

[CONTINUE TO END](#)

# Finish

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**Click the Button Below to Complete the Course**

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Thank you for completing 2024 Annual Retraining.

After clicking below, the course will be marked as complete in Workday Learning.

**Click Here to Complete the Course**

## 1.1 Start





Thank you for completing 2024 Annual Retraining.

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Notes:

## Untitled Layer 1 (Slide Layer)



Congratulations!



You may close this window to return to Workday Learning.  
There is a survey as the next lesson. Completing that is optional and does not affect the completion of the course.  
Information compiled from the anonymous survey is used to improve future courses.