



BLACKTOWN MT DRUITT HOSPITAL
WE'RE GROWING



Health
Western Sydney
Local Health District

Allied Health Assistant Student Placement

Student Orientation Manual



This project was possible due to funding made available by Health Workforce Australia.

Blacktown /Mt.Druitt Hospital (WSLHD)

Allied Health Assistant Placement Information

Name of centre	Blacktown Hospital
Address	Blacktown Road, Blacktown NSW 2148
Phone	(02) 9881 7076
Fax	(02) 9881 7077
Email	Samantha.Doddrell@swahs.health.nsw.gov.au Regil.Abraham@swahs.health.nsw.gov.au
Student contact person	Samantha Doddrell/ Regil Abraham
Description of clinical experience	<ul style="list-style-type: none">- Supervising functional tasks exercises- Organising equipment- Patient education- Home visit assessment with occupational therapist- Diversional therapy- Working with multidisciplinary team- Administrative activities such as order supply, update resources in files and computer etc- Exercise practice with patients on acute medical and surgical wards- Assist therapists in carrying out physiotherapy/ occupational therapy treatment- Organising equipment- Fracture clinic/ assist casting- Working with multidisciplinary team
Clinical area	Acute Care
Hours of work	0800-1630
Uniform requirement	<ul style="list-style-type: none">- Uniform as per TAFE- Blue pants- Black shoes- Hospital ID badge (\$15 deposit)- Minimum jewellery to be worn
Additional Information (pre-reading etc)	Review course material from TAFE e.g. medical terminology, infection control, manual handling and OH&S policies
Travel Instructions	Blacktown Station – 15 minute walk Bus service by BUSWAY Parking on street

Blacktown /Mt.Druitt Hospital (WSLHD)

Allied Health Assistant Placement Information

Name of centre	Blacktown Mt Druitt RACS
Postal Address	Railyway Road, Mt Druitt Hospitals 2770
Phone	(02) 9881 7076
Fax	(02) 9881 7077
Email	Samantha.Doddrell@swahs.health.nsw.gov.au Regil.Abraham@swahs.health.nsw.gov.au
Student contact person	Samantha Doddrell/ Regil Abraham
Description of clinical experience	Rehabilitation, Geriatrics, Stroke, Acute to Sub-Acute. Groups and individual therapies, Physiotherapy, Occupational Therapy and Speech Therapy. <ul style="list-style-type: none">- Supervising individual exercise program- Assisting in group sessions e.g. breakfast club, cooking group, community access, physiotherapy exercise class- Assisting therapist in individual's treatment- Administrative activities such as maintain hygiene of equipment and treatment area,
Clinical area	Rehabilitation
Hours of work	0800-1630
Uniform requirement	<ul style="list-style-type: none">- Uniform as per TAFE- Blue pants- Black shoes- Hospital ID badge (\$15 deposit)- Minimum jewellery to be worn
Additional Information (pre-reading etc)	Review course material from TAFE e.g. medical terminology, infection control, manual handling and OH&S policies
Travel Instructions	Mt. Druitt Station – 15 minute walk Parking on street

Allied Health Assistant Student Placement
Blacktown/ Mt.Druitt Hospital (BMDH)
Western Sydney Local Health District (WSLHD)

Blacktown Hospital

Blacktown Road, Blacktown NSW 2148 Tel: (02) 9881 8000

Blacktown hospital is a 390-bed acute facility providing the following services:

Accident and Emergency	Special Care Nursery
Theatres/ day procedures	Maternity
Intensive care and cardiac	Medical imaging
Acute Medical	Mental Health
General Surgery	Drug and Alcohol
Trauma Orthopaedics	Outpatients/pre-admission
Allied Health Services*	Regional Dialysis Centre
Antenatal and Gynaecology	Oncology Service
PACC and Community Services	

*AHS: Physiotherapy, Occupational Therapy, Speech Pathology, Diversional Therapy, Podiatry, Nutrition and Dietetics, Social Work

Mt. Druitt Hospital

75 Railway Street, Mt. Druitt NSW 2770 Tel: (02) 9881 1555

200 bed facility providing the following services:

Accident and Emergency	Pre-admission Clinic	Cardiac	Paediatric
Day Procedure	Elective Surgery	AHS	High Dependency
Palliative care	Rehab Hub	Cardiac and Pulmonary Rehabilitation	
CADE	Children's outreach		

Documents prior to commencing the placement

- National Police Certificate/ Clinical Placement Authority Card
- Vaccination personal record card
- CPR certificate
- Prohibited Employment Declaration form if working with children or young people

Please note failure to provide the documents could result in termination of clinical placement

Hours of work

Monday to Friday 0800-1630 (unless instructed otherwise)

Morning tea 1040-1100 (optional)

Lunch (varies at different site)

Please contact your supervisor if you are sick or unable to come to work. If you are running late for any reason, please contact your supervisor if possible

Contact numbers

Blacktown Hospital: 9881 8000

Mt.Druitt: 9881 1555

Therapy Reception: 9881 8302

Rehab Hub: 9881 1123

Rehabilitation unit: 9881 8406

Dress code

- As per TAFE requirement
- Black shoes
- Must tie hair up above shoulders
- No Jewellery except wedding band
- Hospital ID badge

Area of work

You will spend the majority of your clinical time on acute inpatient wards or rehabilitation. We can organise time for you to possibly spend on outpatient, fracture clinic, home visit.

Emergency Procedure

- If your patient is in cardiac arrest, becomes unresponsive or you are very worried then Press the Red button (code Blue) next to the patient bed
- Alert your clinical supervisor or staff member around on your ward
- Call the emergency number 111 and inform them of patient location, and patient details
- If it is code Red, Purple, Orange where evacuation is required, the assembly point is the grassed area outside rehabilitation unit for Blacktown Hospital or Car park for Mt. Druitt Hospital

Paging/Phone System

To page, Dial *2 then page number followed by #. You should hear “your page has been sent” message if successful. Then hang up and wait for the person to call you.

To make an outside call in the hospital: press 0 before you dial your number

To contact switchboard: dial 9 and wait for reply

Electronic Records

- Cerner Millennium/ Cerner Allied Health – clinical documentation and results reporting
- Centricity – electronic imaging online system linked to Cerner Millennium
- ICU/HDU electronic medical records program

Inservices/ Staff meeting

Blacktown Physiotherapy: Thursday 0800-0900

Blacktown Occupational Therapy: Wednesday 1330-1430

Rehabilitation:

Medical Record Documentation

- Must be done straight after seeing your patient for accuracy
- Use black pen to write
- Need to be clear, accurate and readable

Assessment

A final assessment will be given at the end of your clinical placement and feedback is also given on a regular basis.

Library

UWS clinical library at Blacktown Campus

Loan/Purchase of equipment

Equipment for ward use is available on the wards

Equipment for discharge can be organised with equipment loan pool

Certain equipment are not for loan please discuss with your supervisor

Report of Incidence

Report to your supervisor and fill out the IIMS report on intranet

Staff

Physiotherapy Head of Department: Luke Elias

Physiotherapy Inpatient senior: Ken Poon

Occupational Therapy Head of Department: Julianne Gibbons

Occupational Therapy Senior: Yogi Moodley

Rehabilitation Unit senior: Alice Lance (PT)

Therapy Assistants:

Physiotherapy assistant

Occupational therapy assistant

Blacktown Rehabilitation therapy assistant

Mt.Druitt Rehabilitation therapy assistant

Weekend Physiotherapy assistant

What is Expected?

You are expected to be working as a team under supervision throughout your clinical placement. The role of your supervisor is to facilitate your learning and provide assistance to you in order for you to apply knowledge into a real clinical setting, but don't forget your supervisors will also have their own clinical workload too!

You are also expected to be professional:

- Be punctual
- Wear uniform with ID badge
- No absence from work without reasons/ late notification
- Good phone manner
- Be polite when communicating with other health professionals, clients and their families
- Ensure client's privacy and confidentiality

Documentation:

You are expected to document client's notes every time you finish seeing your clients and get your supervisor to countersign. More documentation instruction will be given in the orientation.

Patient management:

You will have your own caseload and clients are given by your supervisor. You are expected to see clients independently by the end of this clinical placement. **You must check client's observation charts and review client's progress notes before performing/ administering treatments.** It is also important to observe clients clinically and discuss about their current symptoms or complains prior to treatment. (Therapy

Clinical Review version 1 updated 09/01/2013 Draft). You are not allowed to change the treatment in any time and should there be any changes of client's medical condition or incidence, your supervisor should be notified immediately. At the end of your treatment, you should also report to your supervisor or handover to the therapist who is responsible to that client. However, if any adverse events or unplanned outcomes occur during treatment, you should inform your supervisor ASAP.

Feedback:

You will receive feedback on your performance on a regular basis, a final assessment will be given at the end of your unit. You are expected to complete the assessment as well prior to it.

Be a A-Rated teachable learner

- Attitude (not arrogant, anxious or overawed)
- Aptitude (has baseline of clinical skills, communication skills and knowledge)
- Attuned (focused on learning and not bored or perfunctory)
- Awareness (has good insight into abilities and is able to accept feedback and modify behaviour)

WHAT IS YOUR EXPECTATION????

Abbreviation

This is the list of acceptable abbreviations that may be used at Blacktown—Mount DrUITT Health. Only these approved abbreviations may be used.

/c	With
/7	Indicating days
/12	Indicating months
/24	Indicating hours
/52	Indicating weeks

A	
Ax	Assessment
ACAT	Aged Care Assessment Team
ADL	Activities of Daily Living
AE	Air Entry
AKA	Above Knee Amputation
Alb	Albumin
ALO	Aboriginal Liaison Officer
Amt	Amount
APTT	Activated Partial Thromboplastin Time
ASAP	As Soon As Possible
AXR	Abdominal XRay

B	
BIBA	Brought In By Ambulance
BMI	Body Mass Index
BMDH	Blacktown Mt DrUITT Hospital
BMR	Basal Metabolic Rate
BKA	Below Knee Amputation
BNO	Bowels not open
BO	Bowels open
BP	Blood Pressure
BSL	Blood Sugar Level

C	
CAH	Community and Allied Health
CAR	Child at Risk
CDT	Combined Diptheria and tetanus
Chemo	Chemotherapy
CHO	Carbohydrate
Chol	Cholesterol
CNP	Coverage near point
CNS	Central Nervous System

C/O	Complains of
CO2	Carbon Dioxide
CPR	Cardiopulmonary resuscitation
Creat or Cr	Creatinine
Creps	Crepitations
CSF	CerebroSpinal Fluid
CSU	Catheter Specimen of urine
CTD	Cover Test Distant
CTN	Cover test near
CT scan	Computerised tomography scan
CVA	Cerebrovascular accident
CVC	Central Venous Catheter
CVP	Central Venous pressure
CXR	Chest Xray

D	
D/W	Discussed with
D&A	Drug and Alcohol
D&C	Dilation of cervix and curettage of uterus
DB&C	Deep breathing and coughing
D/C	Discharge
DEC	Diabetes education centre
DEPT	Department
DNA	Did not Attend
DOA	Dead on Arrival/ Division of Adhesion
DOB	Date of birth
DOCS	Department of Community Services
D of H	Department of Housing
DOH	Department of Health
Dr	Doctor
DSP	Disability Support Pension
DSS	Department of Social Security
DV	Domestic Violence
DVA	Department of Veterans Affairs
Dx	Diagnosis

E	
ECG	Eletrocardiograph
ECH	Early Childhood Health
ECHC	Early Childhood Health Centre
EEG	Electroencephalogram

ESR	Erythrocyte Sedimentary Rate
ETOH	Alcohol
EUA	Examination under anaesthetic
EUC	Electrolyte, urea and creatinine

F	
#	Fracture
FASF	Forearm support frame
FBC	Full blood count
Fe	Iron
FHx	Family History
FR	Fluid Restriction
FTA	Failed to attend
FTT	Failure to thrive
F/U	Follow up

G	
GDM	Gestational Diabetes Mellitus
GI	Glycaemic Index
GP	General Practitioner

H	
Ht	Height
H2O	Water
Hb	Haemoglobin

HbA1C	Glycosylated Haemoglobin
HBGM	Home blood glucose monitoring
HepB	Hepatitis B
HIB	Haemophilias Influenza bacteria
HNPU	Has not passed urine
HP	Health promotion
HT	Hypertension
HV	Home visit
HWR	Healthy weight range
Hx	history

I	
IDC	Indwelling catheter
IGT	Impaired glucose tolerance
IMI	Intramuscular injection
INR	International Normalised ratio
IUCD	Intra uterine contraceptive device
IVC	Intravenous cannula
IVI	Intravenous injection
IVP	Intravenous pyelogram
IVT	Intravenous therapy

K	
K+	Potassium
Kj	Kilojoule

KCL	Potassium Chloride
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L	
(L)	Left
L	Length
LFT	Liver function test/ Lung function test
LMO	Local medical officer

M	
Mane	Morning
MAP	Mean arterial pressure
MBA	Motorbike accident
MINs	Minutes
Mmol/L	Millimols per litre
MMR	Measles, mumps, rubella
MOW	Meals on wheels
MSU	Mid stream urine
MVA	Motor vehicle accident
Mx	management

N	
N/A	Not applicable
Na+	Sodium
NAD	No abnormalities detected
NBM	Nil by mouth

NFA	No further action
NFO	No further orders
NFR	Not for resuscitation
N/G	Nasogastric
NGT	Nasogastric tube
NH	Nursing home
NKA	No known allergy
No	Number
NOF	Neck of femur
NSAID	Non steroidal anti inflammatory durgs

O	
O/E	Objective examination
O2	Oxygen
O2 Sat	Oxygen saturation
OCP	Oral contraceptive pill
OD	Overdose
OM	Ocular movement
Ortho	Orthopaedic
O/wt	overweight

P	
P	Plan
PAC	Pressure area care
PACC	Post acute community care

PANOC	Physical abuse and neglect of children
PAS	Patient advisory service
PEARL	Pupils equal and reacting to light
PEG	Percutaneous endoscopic gastostomy
pH	Hydrogen ion concentration
PI	Prothrombin index
PMHx	Past medical history
POP	Plaster of paris
Postop	Post operative
PPE	Personal protective equipment
PR	Per Rectum
Pre-op	Pre-operative
PRO	Protein
Pt	Patient
PU	Passed urine
PUO	Pyrexia unknown origin
PUF	Pick up frame
PV	Per vagina

R	
®	Right
r/f	Referral or referred
r/v	Review
RDI	Recommended dietary intake
Re:	Regarding

Rehab	Rehabilitation
Rh	Rhesus factor
RMO	Resident medical officer
ROM	Range of motion
Rx	treatment

S	
S/E	Subjective examination
s/b	Seen by
SBR	Serum bilirubin
SHx	Social history
SOL	Space occupying lesion
SR	Sinus rhythm
SS	School screening
ST	Sinus tachycardia
SVRT	Super voltage ray therapy
SVT	Supra ventricular tachycardia

T	
TA	Triple antigen/transverse abdominus/tibialis anterior
TENS	Transcutaneous electrical nerve stimulation
TKVO	To keep vein open
TM	Tympanic membrane
TOP	Termination of pregnancy
TRIG	Triglycerides

U	
u/a	Urinalysis
Ur	Urea
UWSD	Underwater seal drain
U/wt	underweight

V	
VA	Visual acuity
VMO	Visiting medical officer
VF	Ventricular fibrillation

W	
w/s	Walking stick
w/c	Wheelchair
WCC	White cell count
w/e	Weekend
WHR	Waist to hip ratio
Wk	week
WMH	Westmead hospital
Wt	weight

Diseases

AF	Atrial fibrillation
ARDS	Adult respiratory distress syndrome
ARF	Acute renal failure

BCC	Basal cell carcinoma
Ca	Cancer
CABG	Coronary artery bypass graft
CAL	Chronic airways limitations
CCF	Congestive cardiac failure
CPAP	Continuous positive airways pressure
CRF	Chronic renal failure
CVA	Cerebral vascular accident
Dts	Delirium tremours
DVT	Deep vein thrombosis
IBD	Inflammatory bowel diseases
IDDM	Insulin dependent diabetes mellitus
IHD	Ischaemic heart disease
LVD	Left ventricular failure
MI	Myocardial infarction
MRSA	Multi resistant staphylococcus aureus
NIDDM	Non insulin dependent diabetes mellitus
PE	Pulmonary embolus
PUD	Peptic ulcer disease
PVD	Peripheral vascular disease
RVF	Right ventricular failure
SCC	Squamous cell carcinoma
SIDS	Sudden infant death syndrome
TB	Tuberculosis
URTI	Upper respiratory tract infection

UTI	Urinary tract infection
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Medication abbreviations for prescribing on medication charts

Morning, mane	(in the) morning
Midday	(at) midday
Night, nocte	(at) night
Bd	Twice a day
Tds	Three times a day
Qid	Fours times a day
Every 4 hrs, 4 hourly, 4hrly	Every 4 hours
Every 6 hrs, 6 hourly, 6hrly	Every 6 hours
Every 8 hrs, 8hourly, 8hrly	Every 8 hours
Once a week and specify the day in full e.g. once a week on Tuesday	Once a week
Three times a week and specify the exact day in full e.g. three times a week on Mondays, wednesday and saturday	Three times a week
Prn	When required
Stat	Immediately
Before food	Before food
After food	After food

With food	With food
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IM	Intramuscular
IV	Intravenous
NEB	Nebuliser
NG	Nasogastric
PO	Oral
PEG	Percutaneous enteral gastrostomy
PV	Per vagine
PR	Per rectum
PICC	Peripherally inserted central catheter
Subcut	Subcutaneous

Allied Health Assistant Student Tutorials

1. Normal Values
2. Medical terminology and abbreviations
3. Multidisciplinary team
4. Physiotherapy and Occupational Therapy Equipment
5. Functional Ward Mobility policy
6. Body system
7. Exercise prescription
8. Cardiopulmonary Physiotherapy treatment
9. Common Medical Conditions
10. Assessment Tools
11. Delirium and Dementia
12. Aggression minimisation/ social and communication skills
13. Diversional Therapy
14. Falls Education
15. Occupational therapy

Normal Values

Respiratory

Arterial Blood Gases (ABG's)

pH	7.35-7.45	Low pH = Acidic ;High pH = Alkalotic
PaCO ₂	35-45 mmHg	↑PaCO ₂ = Hypoventilation
PaO ₂	80-100 mmHg	↓PaO ₂ = Hypoxaemia
BE	± 3	
HCO ₃	22-28 mmol	Buffer
SpO ₂	95-100%	↓SpO ₂ = ↓O ₂ carrying capacity

Respiratory Rate (RR)

RR	12-16 Breath/min
↓ RR (<12 BPM)	Hypoventilation → CO ₂ retention, if V _t doesn't ↑ to compensate (e.g. narcotic overdose) may indicate respiratory distress, ↑ WOB
↑ RR (>16 BPM)	

Pulmonary Function Test (Spirometry)

FEV ₁ /FVC	80%	Indicates large airway function
FEV ₁ : ↓ FVC: Normal, ↓ or ↑	Ratio: <75%	Obstructive pattern: COPD, Asthma, Cystic Fibrosis, Bronchiectasis
FEV ₁ : ↓ FVC: ↓	Ratio: Normal or ↑	Restrictive pattern: (extra/intra pulmonary) ↓ ability of full chest expansion → ↑ RR, shallow breathing
MMEFR (maximum mid flow rate)	Between 25-75% of FVC	To assess the small airways

Cardiovascular

Blood Pressure

Normal	110-140/60-80 mmHg	Care with MHI, CPAP, upright position
Hypotension	<100/60	
Hypertension	>160/90	Avoid HDT
Labile BP		Avoid MHI
Mean Arterial Pressure (MAP)	70-95 mmHg * (CO x SVR) + CVP * DBP+1/3 (SBP-DBP)	Perfusion pressure for organs. If < 60mmHg → ↓ blood flow → ischaemic organs

Central Venous Pressure

Normal	3-15 cmH ₂ O	<ul style="list-style-type: none"> * Normal hydration/fluid status * Amount of blood returning from thoracic vena cava to RA * the ability for the heart to pump back to arterial system * approx of right atrial pressure (RVEDV)
CVP	< 3cm H ₂ O	<ul style="list-style-type: none"> * RHF: hypovolaemia, shock * Deep inhalation
CVP	> 12-15 cmH ₂ O	<ul style="list-style-type: none"> * RHF: fluid overload → avoid HDT * Tension pneumothorax * Pleural effusion * ↓ CO * forced exhalation

Heart Rate

Normal	60-100 BPM	
Sinus Tachycardia	>100 BPM	Precaution for HDT and exercises (>130BPM)
Sinus Bradycardia	<60 BPM	Inadequate SV may lead to ↓ CO

Intracranial pressure

Pressure exerted by the cranium on to the brain, CSF, and the brain's circulating blood volume. Varies depends on activities

Supine: 7-15 mmHg	
Upright: -10 mmHg	
↑ ICP: 25-30 mmHg	<ul style="list-style-type: none"> * TBI: intracranial haematoma, cerebral oedema * contraindicated for HDT, suction

Swan Ganz Catheter

Pulmonary Artery Pressure (PAP)	20-30/8-15 mmHg	
	> 30-15 mmHg	Pulmonary hypertension: ↑ work of RV
Pulmonary Capillary Wedge (PCWP)	8-12 mmHg	<ul style="list-style-type: none"> * Indicates left heart functioning e.g. aortic valve stenosis, regurgitation, mitral regurgitation * quantify the degree of mitral valve stenosis
	18 mmHg	Optimal for filling pressure
	18-25 mmHg	Pulmonary congestion: ↑ pulmonary vascular resistance, ↑ pulmonary

		blood volume and pulmonary venous pressure due to LHF, AVD, MVD
	>25 mmHg	Pulmonary Oedema. LAP is the outflow or venous pressure of pulmonary circulation
Cardiac output (CO)	4-6 L/min * SV x HR	* regulates by the demand of O ₂ in the body * Change of posture, ↑ sympathetic/parasympathetic NS * sepsis/infection → ↑ CO * heart failure/ cardiomyopathy → ↓ CO
Cardiac index (CI)	2-4 L/min *CO/ body surface area (BSA)	* heart performance in relation to size of an individual
Stroke Volume (SV)	40-80 ml/beat * EDV-ESV	
Systemic vascular Resistance (SVR)	800-1200 dynes/sec/cm ⁻⁵	* Depends of metabolic demands, neurological control and endothelial factors * ↑ CO ₂ content or ↑ O ₂ demand → vasodilation → ↓ SVR
Ejection Fraction (EF)	* > 55% * (EDV-ESV)/EDV	* blood ejected by the LV during contraction /systole * EDV: filling phase of LV * ESV: ejection phase at minimal capacity * myocardium e.g. MI, cardiomyopathy, heart failure → ↓ EF

ECG

ST depression	Myocardial ischaemia
ST elevation (NSTEMI)	Myocardial infarct STEMI: Rx – thrombolysis or percutaneous coronary intervention e.g. stent, angioplasty NSTEMI: Rx – medication
T wave inversion	Ischemia or subendocardial AMI
↑ Q wave	Transmural MI (full thickness)

AMI

Creatine Kinase (CK)	Normal: 25-200U/L	* Enzyme released with muscle damage
	> 200U/L	
	1000U/L	

	MB (myocardial specific) (N)= 0.9 Ug/L	* indicates AMI, ↑ 's as size of AMI
Troponin (TnT)	<0.01	* to differentiate unstable angina and MI

JVP

Normal 2-4 cm, lying at 45°	Indicates blood volume, RH function
↑ JVP – 6 cm	RHF; fluid overload → avoid HDT

FBC

Haemoglobin (Hb)	130-180	* Fe containing O2 transport metalloprotein * anaemia: ↓ O2 carrying capacity → lethargy, ↓ exercises tolerance, dyspnoea
White Cell Count (WCC)	4-11 x 10 ⁹ /L * > 11 x 10 ⁹ /L * < 4 x 10 ⁹ /L	* sign of infection * Leucocytosis → infection e.g. pneumonia * leucopenia → poor resistance to infection
Activated Partial Thromboplastin time (APTT)	27-42 seconds	* measure intrinsic pathway of coagulation and tissue factor pathway * monitor Rx effect with Heparin
Prothrombin time(PT)	12-16 seconds	* measure extrinsic pathway of coagulation * clotting tendency of blood monitor warfarin * the time it takes for plasma to clot after addition of tissue factor
Platelets	150-400 x 10 ⁹ /L * <150 * 20-100 * < 20	* Function to form haemostatic plug * thrombocytopenia * bruises, nose bleeds, abnormal bleeding * gross haemorrhage → care with suctioning/ percussion/ vigorous techniques if low platelets
International normalised ratio (INR)	0.8- 1.2	* measures extrinsic pathway of coagulation
Blood sugar level (BSL)	4.7-8.0 mmol/L	* hypoglycemia: lethargy, impaired mental functioning, irritability, sweaty, tachycardia, tremor, dizziness and loss of consciousness →coma → death * hyperglycemia: vascular deterioration in diabetes

UEC

Na ⁺	Normal: 137-146mmol/L
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	<p>↑ or ↓ -- both may cause neurological signs ranging from confusion, lethargy, muscles weakness to coma</p>
K^+	<p>Normal: 3.5-5.0 mmol/L – to maintain membrane polarisation < 3.5 – muscles weakness, fatigue, tachycardia, hypotension, confusion, arrhythmias > 5.0 – weakness, confusion, vomiting, ECG changes > 7 – cardiac arrest</p>
Mg^{2+}	<p>Normal: 0.7 – 1.0 mmol/L – this is required for enzyme systems, neuromuscular activity, peripheral vasodilator Acute: ↓ mg < 0.7 – neuromuscular hyperexcitability, cardiac arrhythmias Chronic: ↓ mg – contributes to HT, vascular disease, bone disease ↑ mg – rare: mainly occur in CRF → hypotension, drowsiness, ECG changes, respiratory depression</p>
Ca^{2+}	<p>Normal : 2.1-2.6 mmol/L – this is required for recalcification of bones and teeth, cell metabolism, cell excitability, cardiac conduction ↑ or ↓ -- neuromuscular dysfunction, arrhythmias</p>
Urea	<p>3.0-8.5 (can be up to 10 x normal: waste product; renal failure, hypovolaemia)</p>
Creatinine	<p>0.7 – 1.4 mg/100ml (renal failure)</p>
Urinary output	<p>Normal: 1ml/kg/hour ↓ U/O = oliguria → renal dysfunction, dehydration No U/O = anuria → renal failure; IDC/ ? Lasix Haematuria = blood in urine → trauma, infection, carcinoma</p>

Medical Terminology and Abbreviation

Medication:

1. Bd
2. Tds
3. Qid
4. Mane
5. Nocte
6. Q4H
7. Q6H
8. Q8H
9. PRN

Surgery:

1. AKA
2. BKA
3. -ectomy
4. -ostomy
5. -scopy
6. -desis
7. AAA
8. CABG
9. ERCP
10. ERCP
11. VAT
12. TURP
13. ORIF
14. TKR/ THR
15. NWB/ PWB/ WBAT

Medical:

1. CVA
2. AF
3. ARF
4. CRF
5. ARDS

6. COPD/ CAL
7. CCF
8. APO
9. CPAP
10. DVT
11. NIDDM
12. PE
13. IHD
14. LVF
15. MI
16. MRSA
17. PUD
18. PVD
19. SCC
20. URTI
21. UTI
22. GORD
23. ABG's
24. ADL
25. ECG/ CXR/US?BP
26. BSL
27. IDC
28. IVC/CVC

Multidisciplinary Team (Acute)

Occupational Therapy

Role:

- To maintain or develop an individual's skills for ADL's
- To provide assistance and training for those individuals who have difficulty in tasks performance due to physical, cognitive and psychological limitations.
- To perform assessment and management of personal and industrial ADL's
 - functional mobility assessment e.g. toilet transfer, bed to chair transfer
 - wheelchair assessment and seating
 - home environment assessment for home modification and prescription of equipments
 - cognitive and perceptual assessment and retraining
 - stress management
 - functional upper limb assessment and retraining
 - falls preventions and home safety
 - energy conservative management

Referral:

- verbal or written referrals can be made to OT
- Occupational therapists must be paged to inform

Physiotherapy

Role:

- To provide comprehensive assessments and evidence based therapeutic interventions based on diagnosis and clinical reasoning
- To provide education, recommendation and self management strategies to patients who suffer from acute or chronic illness
- Area to cover cardiopulmonary, musculoskeletal and neurological rehabilitation

Acute care

- Provides treatments to patient with acute or chronic cardiopulmonary problems e.g. pneumonia, acute exacerbation of COPD, ARF requires mechanical ventilation and post surgery. Treatments such as ACBT, suctioning and mobilisation and exercise prescription to assist secretion clearance, improve lung function and to restore muscle strength due to prolonged hospitalisation.
- Involves in multidisciplinary team decision making for discharge planning

Social Work

Role:

- To provide support, counselling and information for patients and their families when they encounter emotional and practical changes or difficult situation due to illnesses and hospitalisation.
- To enable patients and their families to examine all available options, resolve difficulties and make informed decision about the patient situation and future

- Referral can be made for:
 - Placements for respite, hostel and nursing
 - Assistance in process of Aged Community Based Transition (ACBT)
 - Elderly or patients with disability who have difficulty to cope at home
 - Child at risk of abuse
 - Domestic violence
 - Sudden death
 - Emotional problems such as depression or anxiety
 - Marital or parental/relational problems
 - Grief or bereavement issues
 - Parasuicidal after assessment by acute mental health team
 - Legal issues and financial difficulties
 - Immigration, including hospitalisation for overseas visitors
 - Practical problems e.g. child care
 - Accommodation
 - Drug and alcohol issues

Referral:

- verbal referral via paging or advising SW on ward
- phone messages can be left at the department on 48353 for Blacktown and 41692 for Mt. DrUITT

Nutrition and Dietetics

Role:

- To improve nutritional status of patients by ensuring optimal nutrition is achieved
- To provide education and support to patients, families and staff regarding their dietary requirements
- Services included:
 - nutritional assessment
 - provision of therapeutic and enteral diets, assessing and monitoring patients require parenteral nutrition
 - preventative nutritional counselling

Referral:

- verbal or written referral can be made

Speech Pathology

Role:

- To assess patients with speech, language, communication, voice, swallowing deficit and provide therapy for rehabilitation.
- To provide education and support to patient, families and staff in dealing with communication or swallowing difficulties

Referral:

- medical referral is required

Continuing Care Service

Role:

- To assess patients' home situation and plan for discharge
- To ensure appropriate follow up is done post discharge
- The planning process involves health professionals, patients and carers to collaborate information and explore options, which enable them to regain and maintain their level of function
- Continuing care service provides information for: community support services, home management advice, palliative care, liaising with aged care facilities, home oxygen.
- Services that can be arranged by continuing care are:
 - home oxygen
 - family conference
 - COMPACKS
 - Day care service for dementia
 - Domestic tasks service
 - Community transport
 - Link up with palliative care service
 - Referral for DVA, across and interstate, transfer to TCU
 - Liase with hostel and nursing regarding patients premorbid status and the progress throughout the hospital stay. Asses patient's ability to return to aged care facilities. Arrange aging in place

Referral:

- written and verbal referral by nursing, medical or allied health staff

Post Acute Community Care

Role:

- a multidisciplinary team provides continuing care for patients who are in the post acute stage after they discharge from hospital or from ED for a period of up to 2 weeks
- aims to reduce hospital LOS; to prevent unnecessary admission and readmission to hospital
- a team consists of physiotherapist, occupational therapist, nurses, pharmacists, community care aide, administrative officers, clinical coordinators and manager
- services that can be provided by PACC:
 - respiratory management
 - wound and drain management
 - early discharge post orthopaedic surgery and breast surgery
 - IV therapy
 - Anit-coagulation
 - Post surgical care
 - Aged care/ geriatric
- role of PACC physio

- orthopaedic
- respiratory
- medical
- post surgical
- aged care

Referral:

- indications: post surgery, medical, aged care, history of falls, multiple readmission, complex discharge, early discharge
- patients criteria:
 - live in SWAHS
 - has a carer or Independent with ADL's and mobility
 - not a risk to themselves or the PACC team
 - be admitted under a medical team
 - consent to PACC service
 - needs post-acute care that can be provided safely in the community
- referrals are made to PACC central intake office on ext 46336 (mon-fri) or page 08626 (weekend or P/H) or through WMH switch on 9845 5555 for PACC service

Definitions of ward mobility and ADL Status

Independent (I)

- No supervision or assistance required

Supervision

- Patient within view but not necessarily close to the person supervising
- This level of assistance will not prevent a fall
- E.g. if the patient can walk independently but needs prompts only
- Patient must remain in view while engaged in showering or toileting tasks

Standby assistance (S/B A)

- Standing directly next to the patient ready for hands on assistance if required
- This is the minimum level of assistance required if a patient is assessed to be at risk of falling
- E.g. standing directly next to a patient when they are completing showering or toileting tasks

Minimal assistance (min A)

- Hands on assistance with or without a walk belt/equipment
- Only a small amount of assistance at times or throughout mobility tasks
- No lifting assistance, only steadying
- Moderate risk of fall, or injury following a fall
- E.g. in assisting someone with poor balance to mobilise, hands on assistance may be required to prevent fall

Moderate assistance (mod A)

- Some lifting by assistant (s) required but within the safe lifting limits
- Always with a walk belt +/- other equipment

Maximal assistance (max A)

- This is not recommended for ward mobility
- For transfer, specify mechanical lifter. Hoist if need rather than maximum assistance
- Can be used as a descriptor of assistance required if more than the recommended assistance is given in an unpredicted event

- E.g. fall, acute deterioration or with unexpected performance in an initial assessment or treatment session

Please noted that there may be fluctuations in the amount of assistance required for some patients

Definitions specific for orthopaedic patients

Weight bearing status and the affecting limbs need to be documented for patients after orthopaedic surgeries

FWB: full weight bearing (no weight bearing restriction)

WBAT: weight bear as tolerated (no weight bearing restriction; as per patient comfort)

NWB: non weight bearing (no body weight through the affected leg)

TWB: touch weight bearing (<20% of body weight, only toe and ball of foot)

HWB: heel weight bearing (weight bearing through the heel part of foot only)

PWB: partial weight bearing (<50% of body weight)

Body Systems

Integumentary System

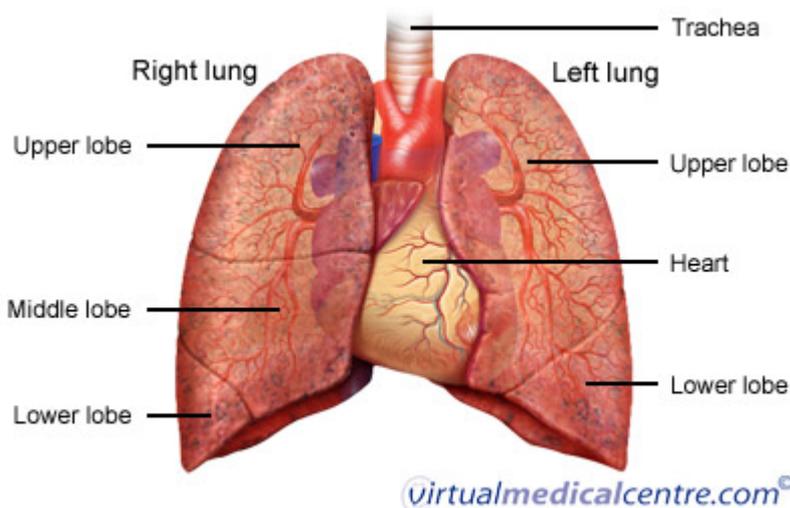
This system composed of skin, sweat, oil glands, hair and nails. It covers the whole body to regulate body temperature and give protection to external harmful substances

Musculoskeletal System

This system composed of Soft tissues such as cartilages, tendons (muscles to bone connection), ligaments (bone to bone connection) and bones, Skeletal and smooth muscles. The Soft tissues and bones form a frame for muscles and other internal organs as site of attachment and protection. Skeletal muscles provide support and movement under voluntarily control whereas smooth muscles provide movement to internal organs involuntarily.

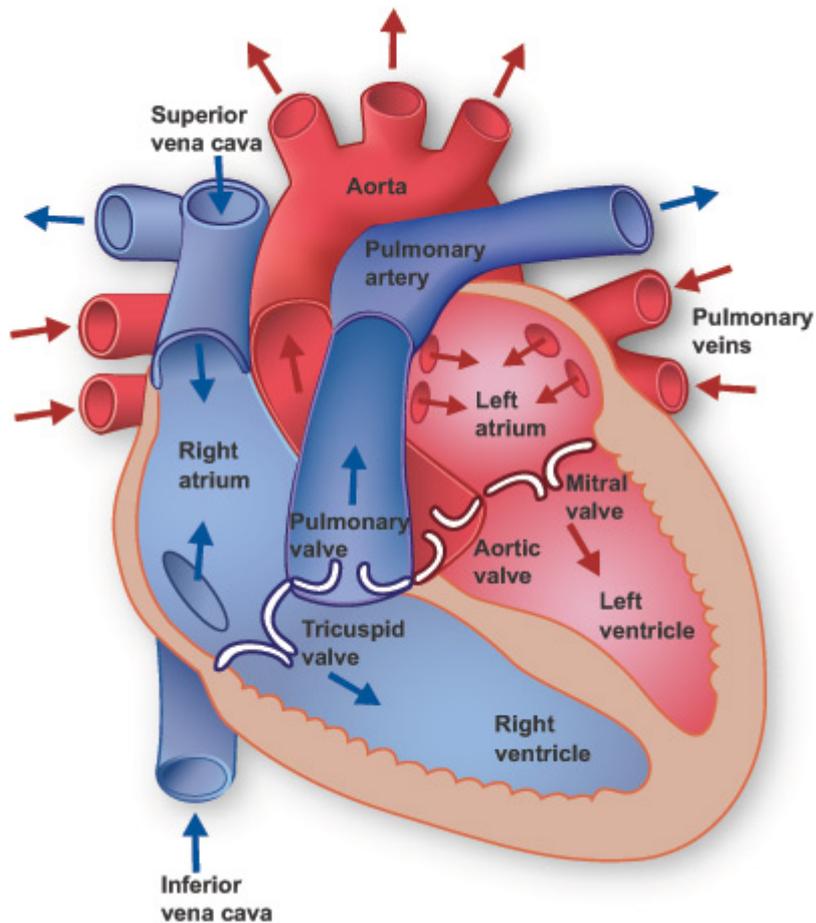
Respiratory System

This system composed of nose, trachea, bronchi, bronchioles, small airways and alveoli. Gas exchange takes place in the lungs for the removal of carbon dioxide and absorbing of oxygen.



Circulatory System

This system composed of heart, blood vessels and blood. It has a major role of transporting nutrients, oxygen and carbon dioxide, body waste, hormones, antibodies as well as water. Under certain environmental changes, the blood vessels dilate and constrict to regulate for a normal body function

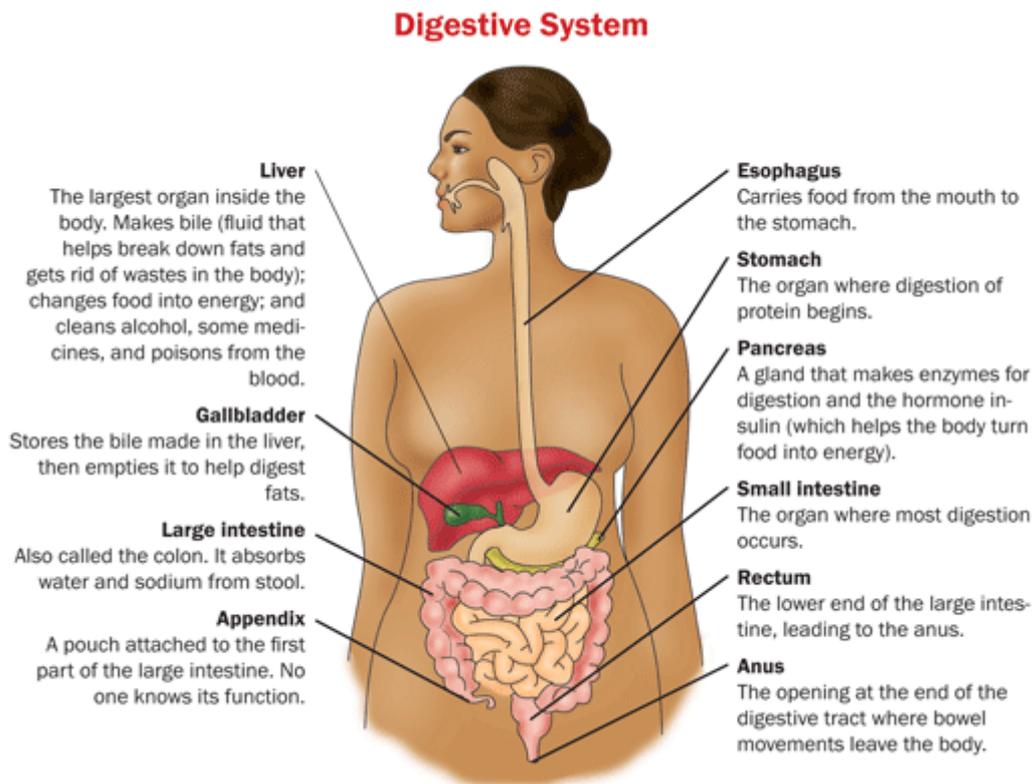


Nervous System

This system composed of brain, spinal cord and peripheral nerves. It relays electro-chemical signals to direct all muscle movement either voluntarily or involuntarily.

Digestive System

This system composed of mouth, oesophagus, stomach, liver, pancreas, small intestine, and large intestine. Food is broken down from large pieces into small particles through the digestive journey in order for absorption. The nutrient will be circulates around for growth and maintenance and the unused will be stored in liver.



Excretory System

This system composed of kidneys, ureters, bladder and urethra. It eliminates body waste from the blood stream such as toxin, urea and mineral salts and excretes out of body. Water, salts and electrolytes are retained.

Lymphatic System

This system is composed of lymph, lymph nodes and vessels, white blood cells, and T- and B-cells. It destroys and removes invading microbes and viruses from the body. It also removes fat and excess fluids.

THE EXERCISE PRESCRIPTION

Whether the purpose is athletic training or treatment of disease, the exercise program and prescription must include mode, frequency, duration, and intensity.

Mode, the type of exercise, utilizes the specificity of exercise principle to choose a type of exercise that will stimulate the desired outcome.

Frequency is number of sessions per week or the number of session per day. Frequency is prescribed in sessions per day and in days per week

Duration is the total time, measured in minutes, for each exercise session. The lower exercise duration, between 5 to 10 minutes, will be used in the clinical setting for chronic disease and disabilities.

The minimum duration to achieve an improvement in cardiorespiratory fitness is 20 minutes; the range is 20 to 60 minutes.

The minimum duration to maintain fitness is 20 minutes.

Intensity, measured as percent of capacity (VO₂max), is the effort. Frequency, duration and intensity combine to produce an overload.

In exercise programming/prescription, the recommended frequency, duration, or intensity is called target. Additional aspects of the exercise prescription include progression, precautions, and recommendations when appropriate. Guidelines for the progression of exercise become a factor in the success of individuals who are beginning an exercise program or who are engaging in specific types of exercise programs.

Precautions for exercise are the modifications in the prescription or the additional concerns that must be addressed for each disease process, co-morbidity, or disability to make exercise safe. For example, individuals with diabetes who exercise will be given several precautions for the timing of meals, insulin injections, and glucose monitoring that will not be given to apparently healthy individuals without diabetes who exercise. Precautions given to individuals with angina will not be the same as those given to individuals with low back pain. Each chronic disease and disability will have a specific set of precautions.

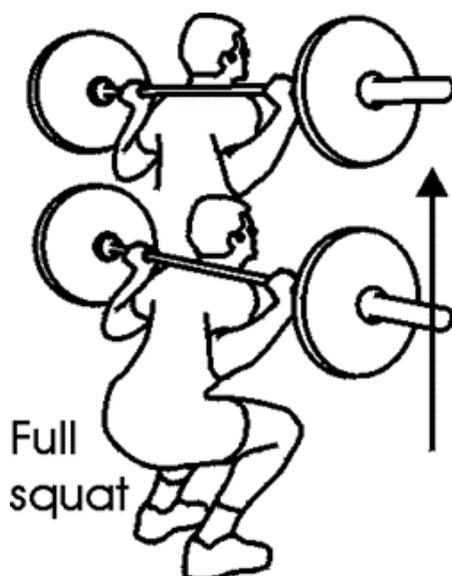
Recommendations are additional life-style changes appropriate to the client or patient. For the most part, these recommendations include

- Diet
- Target Weights
- Smoking Cessation
- Stress Management

Borg's Rating of Perceived Exertion (RPE)

Category Scale	Category-Ratio Scale
6	0 Nothing at all "No, Intensity"
7 Very, very light	0.3
8	0.5 Extremely weak "Just noticeable"
9 Very light	0.7
10	1 Very weak
11 Fairly light	1.5
12	2 Weak "Light"
13 Somewhat hard	2.5
14	3 Moderate
15 Hard	4
16	5 Strong "Heavy"
17 Very Hard	6
18	7 Very strong
19 Very, very hard	8
20	9
	10 Extremely strong "Strongest Intensity"

Muscle contractions are classified according to the movements they cause and in fitness we are primarily concerned with the following three types of contraction:



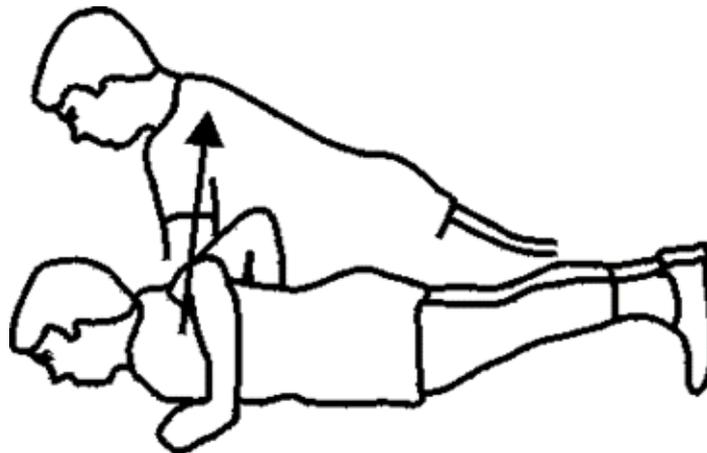
1. Concentric contraction: Any contraction where the muscle shortens under load or tension is known as a concentric contraction. For example, the quadriceps muscles in the thigh contract concentrically (shorten) during the upward phase of the squat movement (in the direction of the arrow), as can be seen in the adjacent picture.

2. Eccentric contraction An eccentric contraction refers to any contraction where the muscle lengthens under load or tension. So in the squat exercise, the quadriceps muscles will contract eccentrically (lengthen) in the downward phase of the movement (the opposite direction of the arrow), as can be seen in the picture.

3. Isometric contraction: An isometric contraction refers to any contraction of muscles where little or no movement occurs. If during the squat the person stopped moving at a certain point (say halfway up) and held that position for 10 seconds, the quadriceps muscle would be contracting isometrically, it would still be under load/tension but no movement would occur.

Many skeletal muscles contract isometrically in order to stabilise and protect active joints during movement. So while the quadriceps muscles are contracting concentrically during the upward phase of the squat, and eccentrically during the downward phase, many of the deeper muscles of the hip contract isometrically to stabilise the hip joint during the movement.

Concentric and eccentric are also terms used to describe the phase of a movement. The concentric phase is the phase of the movement that is overcoming gravity or load, while the eccentric phase is the phase resisting gravity or load. So for push ups the concentric phase is the up phase where gravity is overcome, and the eccentric phase is the downward phase where gravity is resisted.



What roles do skeletal muscles play during movement?

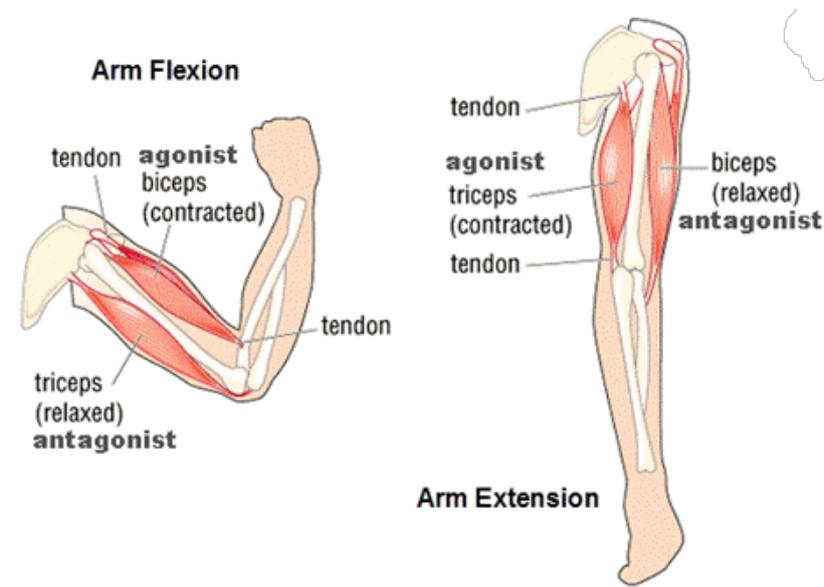
When completing movements such as walking or squatting, there are a lot of different muscles involved in order to complete the movement smoothly and effectively. They achieve this as they each adopt the appropriate type of contraction (concentric, eccentric or isometric) and have their own specific role that they play during the movement.

There are four different roles that a muscle can fulfil during movement, these roles are:

1. Agonist: The agonist in a movement is the muscle(s) that provides the major force to complete the movement. Because of this agonists are known as the 'prime movers'. In the bicep curl which produces flexion at the elbow, the biceps muscle is the agonist, as seen in the image below.

The agonist is not always the muscle that is shortening (contracting concentrically). In a bicep curl the bicep is the agonist on the way up when it contracts concentrically, and on the

way down when it contracts eccentrically. This is because it is the prime mover in both cases.



2. Antagonist: The antagonist in a movement refers to the muscles that oppose the agonist. During elbow flexion where the bicep is the agonist, the tricep muscle is the antagonist. While the agonist contracts causing the movement to occur, the antagonist typically relaxes so as not to impede the agonist, as seen in the image above.

The antagonist doesn't always relax though, another function of antagonist muscles can be to slow down or stop a movement. We would see this if the weight involved in the bicep curl was very heavy, when the weight was being lowered from the top position the antagonist tricep muscle would produce a sufficient amount of tension to help control the movement as the weight lowers.

This helps to ensure that gravity doesn't accelerate the movement causing damage to the elbow joint at the bottom of the movement. The tricep becomes the agonist and the bicep the antagonist when the elbow extends against gravity such as in a push up, a bench press or a tricep pushdown.

3. Synergist: The synergist in a movement is the muscle(s) that stabilises a joint around which movement is occurring, which in turn helps the agonist function effectively. Synergist muscles also help to create the movement. In the bicep curl the synergist muscles are the brachioradialis and brachialis which assist the biceps to create the movement and stabilise the elbow joint.

4. Fixator: The fixator in a movement is the muscle(s) that stabilises the origin of the agonist and the joint that the origin spans (moves over) in order to help the agonist function most effectively. In the bicep curl this would be the rotator cuff muscles, the 'guardians of the shoulder joint'. The majority of fixator muscles are found working around the hip and shoulder joints.

Cardiopulmonary Physiotherapy Treatment

“Chest” Physiotherapy is indicated patient has problems with:

- secretion clearance and excessive production
- gas movement
- lung volume
- work of breathing
- muscles weakness due to immobility leading to prolonged bed rest

Potential causes of the problems are:

- infection e.g. pneumonia
- acute exacerbation of COPD, bronchiectasis, asthma
- post surgery
- patient required mechanical ventilation
- pulmonary oedema
- pulmonary embolism/ DVT
- pneumothorax

“Chest” Physiotherapy interventions

- Active Cycle of Breathing Technique (ACBT)
- Deep Breathing exercises/ Cliniflo
- Forced Expiration Technique
- Positive Expiratory pressure (PEP)
- Pursed Lip Breathing in Lean forward position
- Postural Drainage
- Percussion and Vibration
- Mobilisation

Implication as a AHA??

COMMON MEDICAL CONDITIONS

Stroke

Sudden damage to cells of the brain that causes symptoms that last for more than 24 hours in the parts of the body controlled by those cells. Stroke happens when blood supply to the brain is disrupted, either by blockage of an artery (ischaemic) or by bleeding within the brain (haemorrhagic). Functions controlled by the damaged part of the brain can be lost or impaired and leave the individual with mild to severe disabilities. It is one of the leading causes of death in Australia and also a leading cause of disability in adults.

Warning Signs of Stroke: * Numbness or weakness of face, arm or leg (usually on one side of the body)

- * Trouble speaking, understanding or confusion
- * Trouble walking, dizziness or loss of balance or coordination
- * Trouble with eyesight in one or both eyes
- * Sudden severe headaches with no known cause

Risk factors: Age, gender, ethnicity, hypertension, family history, CVD, smoking, diabetes, high cholesterol, inactivity, obesity, excessive alcohol use, drug abuse

Effects of Stroke: The effects of a stroke depend on what part of the brain is damaged. These effects can include:

- Hemiplegia/Hemiparesis – Paralysis of, or muscle weakness, on one side of the body
- Aphasia - Aphasia is an impairment of language, affecting the production or comprehension of speech and the ability to read or write
- Loss of face, upper & lower limb, body control
- Dysphagia - Difficulty, or partial inability, to swallow
- Vision problems
- Impaired memory
- Incontinence
- Neglect - involves the inability to report, respond, or orient to stimuli, generally in the contralesional space
- Depression

Parkinson's Disease

Parkinson's Disease (PD) is a progressively degenerative neurological disorder which affects the control of body movements. The degeneration of neuronal cells causes a decrease in the availability of dopamine, a

chemical neurotransmitter (messenger) that is needed for the production of smooth controlled movements. Symptoms can include:

- Tremor – shaking/trembling
- Rigidity or stiffness of muscles
- Bradykinesia (slowness of movement) – occurs as the brain is not able to control smooth and delicate movements. This may lead to slow shuffling gait and periods of freezing (difficulty initiating movements).

There is no cure for PD but symptoms can be reduced with medications.

Dementia

Dementia is a general term that includes a number of different disorders which lead to decline in cognitive function. Alzheimer's Disease is the most common form of dementia and accounts for between 50-70% of dementias. Other forms of dementia include Vascular Dementia and Lewy body Dementia. The symptoms of dementia vary with the specific type but can include trouble with: memory, thinking and problem solving, performing simple tasks, speaking, understanding, wandering and getting lost, loss of bowel and bladder control, behavioural issues, as well as many others.

Currently there is no cure for most forms of dementia although treatments/medications can be used to help reduce symptoms.

COPD

Chronic obstructive pulmonary disease is a term used to describe a number of conditions including chronic bronchitis, emphysema and chronic asthma. Symptoms can include:

- Breathlessness after exertion
- In severe cases, breathlessness even when at rest
- Wheezing
- Coughing
- Coughing up sputum
- Fatigue
- Cyanosis – a blue tinge to the skin caused by insufficient oxygen
- Increased susceptibility to chest infections

How the lungs work

The lungs are spongy lobes inside the chest, protected by the ribcage. Inhaled air is directed down the trachea (windpipe) into two tubes (bronchi) that each service a lung. The bronchi divide into smaller tubes called bronchioles, and further still into tiny air sacs called alveoli.

Each alveolus has a fine mesh of capillaries where the exchange of oxygen and carbon dioxide takes place. Oxygen molecules dissolve and migrate across a thin film of moisture from the air sac to the bloodstream. Oxygenated blood is sent to the heart, and then pumped around the body.

At the same time, carbon dioxide in the blood crosses from the capillaries to the air sacs using the same film of moisture. The carbon dioxide is then breathed out.

How COPD affects lung function

A person with emphysema has damaged alveoli and bronchi. The weakened and ruptured air sacs are unable to efficiently move oxygen from the air to the blood. As the disease progresses and damages more air sacs, the person may eventually feel breathless even when they are resting.

Bronchitis means inflammation of the bronchi. The lungs normally produce a small amount of fluid to keep healthy, but chronic bronchitis causes an overproduction of fluid. This leads to frequent and productive coughing (producing mucus or phlegm).

Typically, COPD develops so slowly that the person doesn't realise their ability to breathe is gradually becoming impaired. The damage done to the lungs can be considerable before the symptoms are severe enough to notice.

Causes and Risk Factors

- Cigarette smoking – the most significant risk factor. Around one in five smokers will develop COPD. Ex-smokers remain at risk and should be aware of symptoms of breathlessness
- Long-term exposure to lung irritants – such as chemical vapours or dust from grain or wood. Severe air pollution can make COPD worse in smokers
- Genes – a genetic disorder known as alpha-1-antitrypsin deficiency can trigger emphysema, even if no other risk factors are present.

ASSESSMENT TOOLS

Whilst these are not generally carried out by therapy assistants, it is good to know some of the tests/assessments tools used by physiotherapists and occupational therapists.

6 Minute Walk Test (6MWT)

Is an objective test used to assess exercise capacity and records the distance walked in a period of 6 minutes. Instructions are standardised throughout the test and patients are told that they need to cover as much ground as they can in the 6 minute time period.

Timed Up and Go (TUG)

Used as an objective measure of functional mobility . The test includes timing the patient standing up from a chair, walking 3m, turning around, walking back to the chair and sitting down.

Berg Balance Scale (BBS)

Is used to test balance by getting patients to perform a number of tasks which challenge their balance. The test is scored out of 64 and is often used as an objective measure to see how people have improved after a period of therapy.

Mini-Mental State Exam (MMSE)

The MMSE is used as a cognitive screening tool and is widely used in hospital settings. The test is scored out of 30 and is often used in conjunction with other tests to get a more accurate overall picture of cognitive status. It is commonly used to screen for dementia and is a quick questionnaire that only takes about 10 minutes to administer.

RUDAS (Rowland Universal Dementia Assessment Scale)

The RUDAS is a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance. It is therefore widely used with people from culturally and linguistically diverse backgrounds.

Motor Assessment Scale (MAS)

The Motor Assessment Scale (MAS) is a performance-based scale that was developed as a means of assessing everyday motor function in patients with stroke. The MAS is based on a task-oriented approach to evaluation that assesses performance of functional tasks rather than isolated patterns of movement.

Functional Independence Measure (FIM)

Measures functional independence, assessing physical and cognitive disability. The scale focuses on the level of disability indicating the burden of care. It rates 18 activities of daily living on a 7- point scale ranging from fully dependent (1) to independent with no aids (7). The maximum total score is 126, indicating functional independence, and the lowest score 18, suggesting complete functional dependence. The items are grouped into two themes; 13 motor items (personal care, sphincter control, mobility, and locomotion), and five cognitive items (communication and social cognition). FIM scores are collected at the beginning of a rehabilitation stay and again on discharge.

Aggression minimisation / management of patients.

Aggression: Any incident where staff are abused, threatened or assaulted in circumstances related to their work, invoking an implicit or explicit challenge to their safety, wellbeing or health.

If a patient is being aggressive and you feel threatened, you should :

Remove yourself and other people from danger.

Alert near by staff.

Activate duress button. Or Dial the emergency number 111

State clearly: 1. CODE BLACK

2. The exact location

3. Your name and title.

Aggression minimisation / management in a patient therapy setting.

Some patients may become aggressive or defiant during therapy. If this happens we can talk to the patient in a calm manor, listen to their complaint and try to resolve the issue. If the patient is unable to calm down or they are harping on the issue and being quite distracted from the task ahead the safest thing is to end the therapy session and try again later. If aggressive patients are not listening to you when you are trying to calm them, they are not going to listen to your instructions during the therapy session.

If a patient is known to be difficult we can strategise ways to encourage patients to attend therapy by :

ENVIRONMENT – Changing the environment, using a gym can represent therapy time.

INTERPERSONAL – speech the way you address the patient and ask them to do something. You need to be clear, direct and calm. Building a rapport with the patient will make it easier for them to follow your direction.

INSTRUCTION –clear, few words, repeat key words, first step of task, step through task, reduce and vary prompts,

USING TWO PEOPLE – Working along side a therapist is a great strategy. The therapist can be direct and the secondary can be sympathetic but still following the therapist direction.

PAUSES AND REST – stimulation management, positive reinforcement, cognitive fatigue management.

The idea is not to resolve the aggressive issue, unless it is something you can resolve. The issue is to conduct a safe and successful therapy session with a patient that has become aggressive or has aggressive tendencies.

These might be patients who have behavioural issues secondary to dementia, stroke or traumatic brain injury. Or people with known with difficult personalities.

Social and communication skills.

Social skills are the behaviours, verbal and non-verbal, that we use in order to communicate effectively with other people. Social skills are governed by culture, beliefs and attitudes.

Some examples of social skills are:

- Eye contact with others during conversation
- Smiling when greeting people
- Shaking hands when meeting someone
- Using the right tone and volume of voice
- Expressing opinions to others
- Perceiving how others are feeling and showing empathy
- Appropriate emotional responses (e.g. sympathising when something sad happens; laughing when someone says something funny)

Communication comes in many forms especially when working with patients that are deaf or have verbal difficulties.

Diversional Therapy

Diversional Therapy offers leisure and recreation activities to patients in hospital which are designed to support, challenge and enhance their psychological, spiritual, social, emotional, cultural and physical wellbeing. (www.diversionaltherapy.org.au)

We currently have a full time Diversional Therapist between Blacktown and Mt Druitt hospitals Monday – Friday, 1pm – 4pm. Diversional Therapy referrals can be made to the Therapy Assistant directly from the Diversional Therapist or by the Occupational Therapist in the absence of the Diversional Therapist.

Activities are varied depending on the needs of each individual patient. Some examples of activities offered here at Blacktown throughout all wards are: card games, puzzles, reading materials, psychosocial, newspaper readings, reminiscence and quizzes.

Patients that are generally targeted for Diversional Therapy services are also varied and include those with Delirium, and Dementia and Depression.

Dementia:

Dementia is the term used to describe the symptoms of a large group of illnesses which cause a progressive decline in a persons functioning. This is a broad term used to describe a loss of memory, intellect, rationality, social skills and what would be considered normal emotional reactions. (www.alzheimers.org.au)

Depression:

Depression is usually described as feelings of extreme sadness. It describes both a mood and a syndrome. It includes loss of interest in previously enjoyed activities together with other symptoms such as lack of energy, poor sleep, loss of appetite, and feelings of guilt. Depression is very common among people with Dementia. (www.alzheimers.org.au)

Delirium:

Delirium is sudden severe confusion and rapid changes in brain function that occur with physical or mental illness. It is most often caused by physical or mental illness and is usually temporary and reversible. It involves quick changes between mental states (for example, from lethargy to agitation and back again). Many disorders cause delirium, including conditions that deprive the brain of oxygen or other substances. Such causes include: alcohol/drug withdrawal, infections such as urinary tract infections, or surgery. (www.ncbi.nlm.nih.gov/pubmedhealth)

Occupational Therapy

The relationship between meaningful activity and intervention with patients.

Occupational Therapists assess patients in the context of their occupation. They focus on a patient's Activity of Daily Living (ADL) which includes toileting, showering, personal care, and a patient's Instrumental Activity of Daily Living (IADL) which includes cooking, cleaning, and driving.

The Occupational Therapist will prescribe an intervention for a patient to the Therapy Assistant which will be a task within the patient's capability and meaningful to their everyday life. This activity will relate to their ADL or IADL status.

Energy Conservation

After the Occupational Therapist has assessed a patient as requiring education on conserving energy they will refer the patient to the Therapy Assistant. The Occupational Therapist will advise the Therapy Assistant on what material from the Energy Conservation booklet the patient requires education on. The booklet teaches patients how to minimise their energy expenditures per task making them practical and also to read and listen to their bodies. (Booklet Attached)

Falls Prevention

After the Occupational Therapist has assessed a patient as requiring education on Falls Prevention they will refer the patient to the Therapy Assistant. The Occupational Therapist will advise the Therapy Assistant about the patient's fall history and on which material from the Staying Active and on Your Feet booklet the patient requires education. The booklet simply provides patients with information on staying active, healthy lifestyle, tips on preventing falls and safety in the home. (Booklet Attached)

Documentation

Purpose: It is a written communication between all health professionals in relations to patient's medical condition and their management. It is a legal document. It needs to be legible and appropriate abbreviation should be used.

Format of SOAP

Subjective (S/E)

Report/Complaints of client in regard to his/her current medical status or outcomes from the previous treatments or his/her social and medical history.

Informed consent from clients prior for assessment and treatment

Objective (O/E)

Report from your observation and assessment e.g. functional mobility status, equipment used e.g. attachments, vital signs, ward mobility status, upper limb functions

You should also clearly document the outcome of client's clinical status review prior to treatment. According Therapy Clinical Review procedure (draft), this should be documented as described below:

1. Clients with normal results from therapy clinical review
e.g. ***Patient file, observation chart, and clinical observation all within normal range***
2. Change in patient condition revealed from therapy clinical review
Document the change in condition and a description of new signs and symptoms. As well as your action taken ie informing relevant staff
3. Immediate concerns raised from therapy clinical review
Document the change in condition and a description of new signs and symptoms. As well as your action taken
e.g. ***Patient unable to be roused, respiratory rate reduced, nursing team leader informed for urgent patient observations. RACE call made by OT on request of team leader. Team leader liaised with medical team and observed clinical status of the patient***
4. Less urgent concerns revealed by therapy clinical review that are amenable to change

If review of the patient raises concern about the patient's suitability for therapy, and this can be acted on by a responsible staff member to alleviate the concern, then this should proceed. The communication and action taken by the therapy staff and person responsible needs to be documented. If concerns are alleviated and evidence documented, then therapy may proceed.

e.g. *Blood sugars last checked 0830 recorded as 3.2*

blood sugar review requested to nursing staff prior to therapy (0930), blood sugars recorded as 5.1 within normal range for therapy

5. Adverse events or observations during therapy

If during therapy, adverse events or unplanned outcomes occur, these need to be documented

Treatment/ Assessment (Rx/Ax)

- Activities or exercises completed
- Amount of assistance and equipment/ assistive devices required
- Number of repetitions and frequency
- Distance mobilised
- Time of day

Plan (P)

Plan for next session based on the outcome of the completed therapy e.g.

to continue therapy as per PT

to liaise with PT/OT

review in 1 day, regarding medical plan and suitability for ongoing therapy (in case of clinical deterioration)

SAMPLE

02/01/13 1500 (Sticker)

S/E: nil complaint voice. Informed consent obtained from patient

O/E: patient file, observation chart, and clinical observation all within normal range

SOOB, alert

IDC, IVC insitu

Bed mobility: x1 min A

STS: x1 S/B A

Mobility: x1 S/B A with walk belt

Rx: mobilised with walk belt x1 S/B A x 30 metres

STS practice x5 reps x2 sets

Ax: SpO2 95% on RA post Rx

P: Continue Rx as per therapist

Signature (Pring last name, designation)

Supervisor countersign

Emergency codes

Code RED indicates fire or fire alarm activated within the hospital

Remove patients, patient's files, visitors and staff from immediate fire area

Alarm dial 111

Contain the fire by closing doors/ or windows

Extinguish if you can do so safely

If fire alarm is activated and you don't know where the fire is, evacuate out of the building and meet in the assembly area

Code ORANGE indicates evacuation is required. Evacuate patients to the designated area in the order of: ambulatory patients, wheelchair patients and non ambulant patients

Code YELLOW indicates internal emergencies ie services failures: power, water, telecommunications, computer system, medical gases, internal hazardous substance contamination

Code PURPLE indicates bomb threat: mobile phones/ two-way radios should not be used within 25 metres of a suspicious item

Code BLUE serves the purpose of early recognition of the acutely deteriorating patient and activation of the Medical Emergency Team (MET) or Registrar Activating Clinical Emergency (RACE) will provide rapid response and effective management of medical/ clinical emergencies.

Code BLACK indicates endangered personnel including:

- Any incident where staff/patients/ visitors are being verbally or physically threatened and fear for their safety
- Any incident where there is the potential for physical harm to staff/ patient/ visitor- including aggressive physical or verbal behaviour
- Any incident which could escalate into an uncontrollable, local situation

Code BROWN indicates external disaster. It has the purpose to control and coordinate the resources of BMDH in preparation for, response to, and recovery from , a major incident or disaster situation

Between the Flags

It's a state wide roll out in responding to patients who are clinically deteriorating

Patient who are at risk of clinical deterioration:

- Observations are moving to abnormal range
- Observations are in yellow/red zone
- Observations continue to move to yellow/red zone despite treatment

How to escalate if your patient is clinical deteriorating?

- Calling for assistance
- Bringing advanced skills to patient
- Increase level of care provided to patient
- Notify senior staff

Standard Adult General Observation (SAGO)/ paediatric/ maternity

Yellow Zone – need a clinical review

- Abnormal observations reflect deterioration
- Adverse trend in observation
- Altered calling criteria in observation

Inform the Team Leader/Nurse in Charge, who will decide:

1. That escalation is not required, according to documentation in the notes or patient stability
2. To escalate to a R.A.C.E. by calling 111 (patient to be seen within 5 mins and improving within 30 minutes)
3. To escalate to a MET (code Blue) if patient seems highly unstable

If options 2 and 3 are activated, always

- Repeat and record observation
- Document action taken in the progress notes
- Stay with patient and continue observations

If options 1 or 2 are followed and patient's observations move into the RED ZONE – escalate to a MET call

Red Zone – call a rapid response

If patient observations meet one rapid response criterion call for a rapid response unless relevant documentation to the contrary is provided

- Press the MET call buttons and/or call 111
- Inform the Team Leader Nurse in Charge
- Start basic life support as required
- Document as required on the MET form and in the patients progress notes
- If patient has been made “not for CPR” – the above triggers may not apply

Normal values:

Respiratory rate: 12-16

SpO₂: 96-100%

O₂ requirement

Blood Pressure: 120/80

Heart Rate: 60-100

Temperature: 36.8 +/- 0.2

WHS INDUCTION CHECKLIST

REQUIREMENT	STUDENT INITIALS
Introduced to relevant staff	
Aware of building amenities, parking arrangements, places to obtain lunch etc.	
Instructed in the use of telephones/pagers, telephone/communications directory	
Aware of Hospital emergency number	
Orientation (face to face or on-line) has been completed.	
Aware of location and use of office equipment (eg. Photocopiers, fax, printers, scanner)	
Are aware of and/or understand : emergency exits emergency assembly points fire extinguishers, hose and blankets fire evacuation plans	
Aware of content of Emergency Procedures Flipchart	
Aware of and demonstrated MET call procedures	
Aware of local first aid arrangements	
Aware of the hazards in the workplace and have received training in appropriate risk control measures and safe work procedures	
Local Safe Work Practices have been read, understood and the register of signatures completed	
Aware of local waste management and recycling arrangements	
Incident reporting procedures explained and understood.	
Aware of manual handling policies	
Aware the location of Personal Protective Equipment (PPE)	
Aware of infection control procedures	
Understand documentation standards	
Adult vaccination card/staff health assessment	
Criminal record check	
Understand the need to disclose any pre-existing health conditions that may affect own health and safety or impact on work	
Prepared the skills and background knowledge required to do this placement	

I have read and understood the information provided to me on the above topics. If I do not understand the information provided, I will discuss any concerns I have with my supervisor

Student's Name

Signature

Date

Supervisor Name

Signature

Date

Manager to retain a copy of this checklist as evidence for OHS&IM profile purposes.

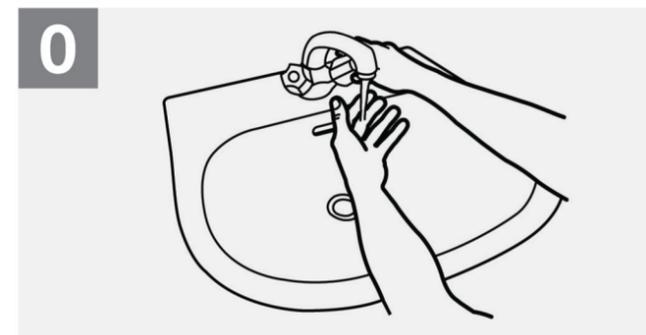
April 2013

How to Handwash?

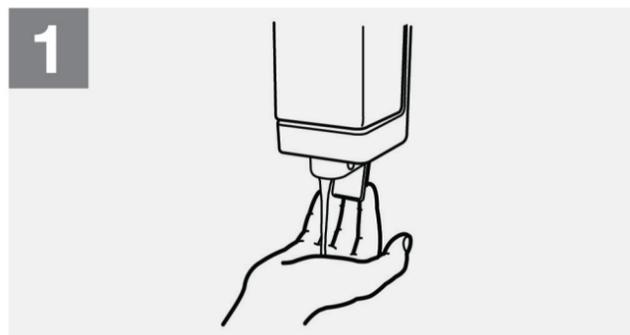
WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

 Duration of the handwash (steps 2-7): 15-20 seconds

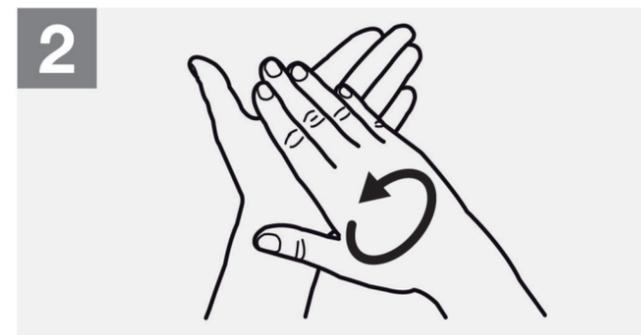
 Duration of the entire procedure: 40-60 seconds



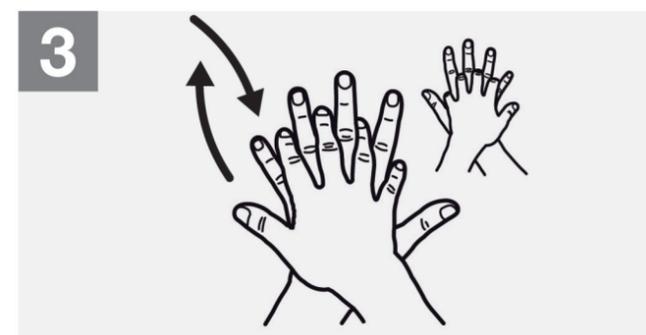
Wet hands with water;



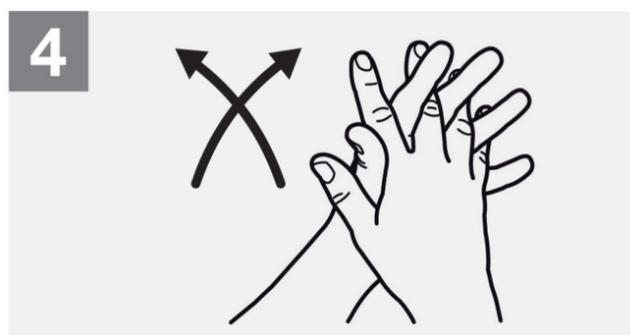
Apply enough soap to cover all hand surfaces;



Rub hands palm to palm;



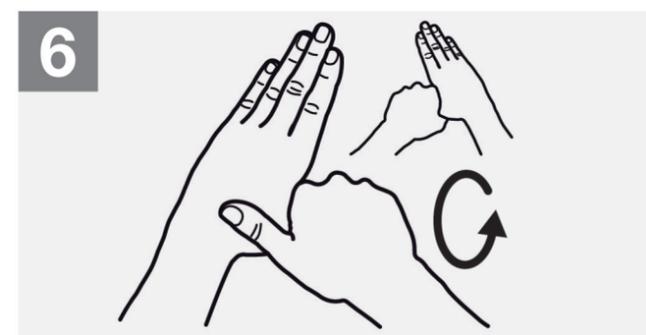
Right palm over left dorsum with interlaced fingers and vice versa;



Palm to palm with fingers interlaced;



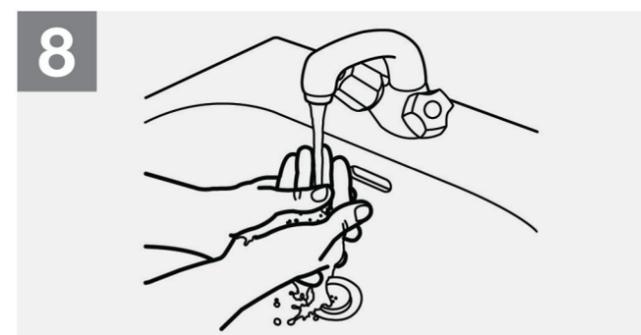
Backs of fingers to opposing palms with fingers interlocked;



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



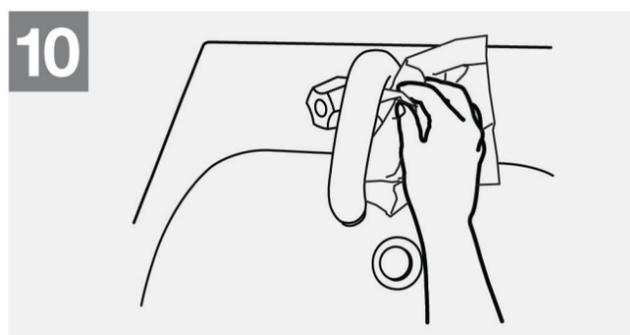
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



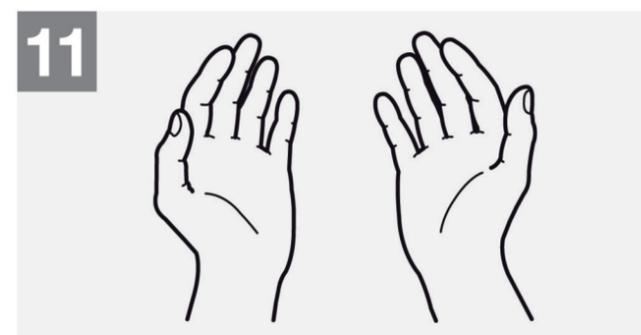
Rinse hands with water;



Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;



Your hands are now safe.



World Health Organization

Patient Safety

A World Alliance for Safer Health Care

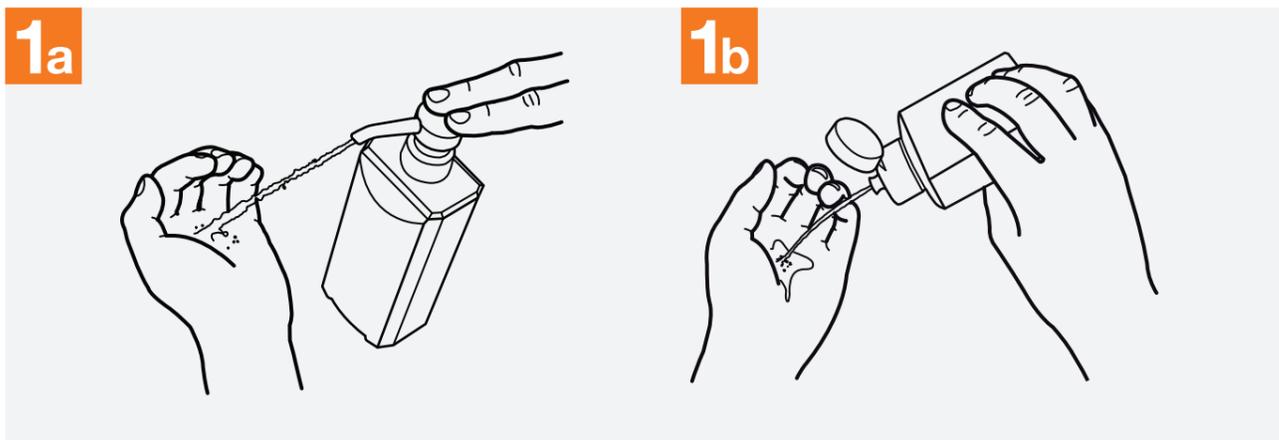
SAVE LIVES

Clean Your Hands

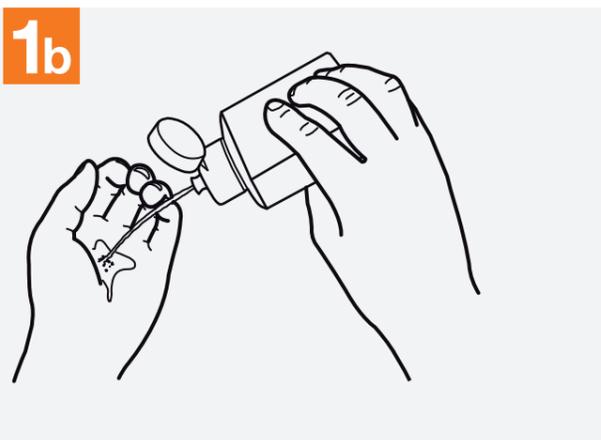
How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

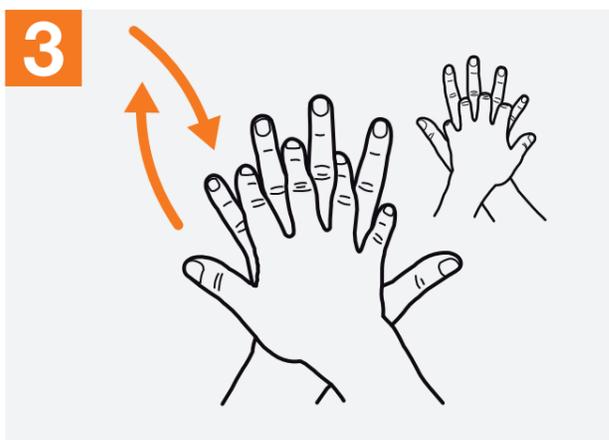
 **Duration of the entire procedure: 20-30 seconds**



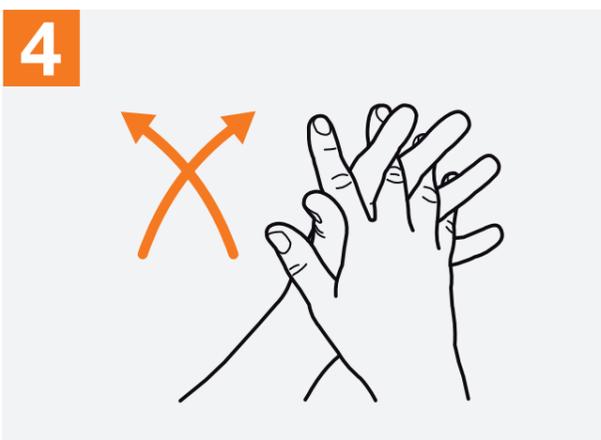
1a Apply a palmful of the product in a cupped hand, covering all surfaces;



2 Rub hands palm to palm;



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



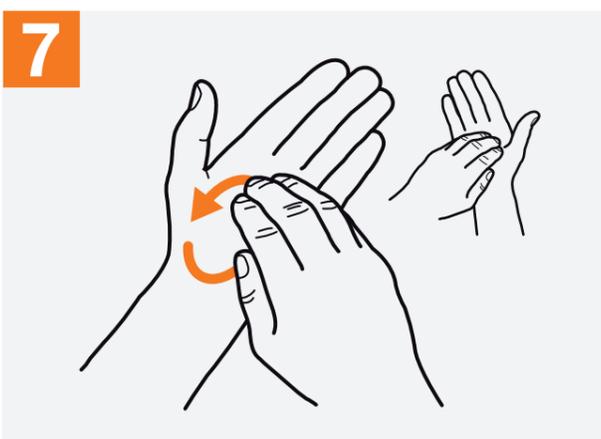
4 Palm to palm with fingers interlaced;



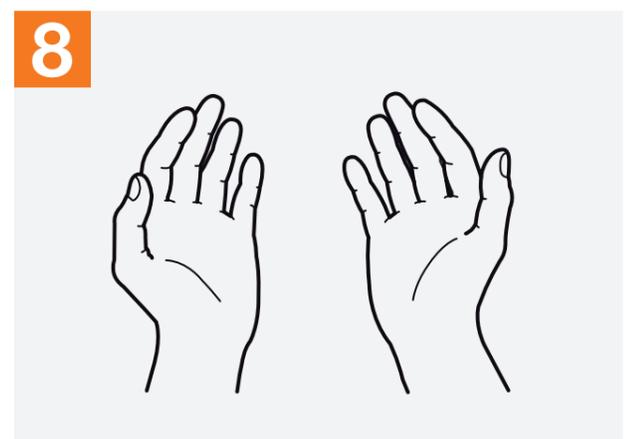
5 Backs of fingers to opposing palms with fingers interlocked;



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



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



8 Once dry, your hands are safe.



World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES
Clean Your Hands

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

HAND WASHING AND HAND RUB COMPETENCIES

NAME: _____ WARD: _____ Cost Code: _____
EMPLOYEE NO: _____ DESIGNATION: _____

Indicator	Performance Criteria	Performed	Not Performed
1. Knowledge of active and non-active products.	Makes a distinction between an active and non-active product.		
2. Uses for an active and non-active product.	Verbally provides relevant example/s of when an active and non-active product should be used to perform hand hygiene.		
3. Items, that interfere with effective hand hygiene (e.g. rings, watch, bracelet), removed	Clinical staff removes items that may become contaminated and cause cross infection. <i>HCW involved in direct pt care, sterilisation staff and laboratory workers <u>must not</u> wear artificial fingernails, nail extenders or any nail enhancements. Natural nails should be less than 0.5 cm long</i>		

PART 1: HAND WASHING WITH SOAP AND WATER

4. Technique for using wrist and elbow tap handles.	Demonstrates the technique for using wrist and elbow tap handles without contaminating hands		
5. Hands are wet before applying any product.	Water is put onto the hands before applying product to ensure there is no possible irritation to the skin.		
6. Amount of product applied to the hands.	3 – 5 mls of product is applied to hands. Excessive product may leave residual that can damage hands. Too little may not be effective in reducing micro organisms (germs)		
7. The correct technique for hand hygiene is demonstrated.	Performs a 10 – 15 second hand wash using appropriate hand washing solution, either: antimicrobial; or, non-antimicrobial liquid soap		
8. Hands are rinsed thoroughly.	Demonstrates effective rinsing of products from hands. Product left on hands may irritate the skin.		
9. The water is turned off without contaminating the hands from the tap handles.	Demonstrates technique for using wrist or elbow tap handles without contaminating hands. Or, uses paper towel for hand operated tap handles.		



10. The hands are completely dried using single use towels.	Dries hands using single use towel and in a manner that does not damage the skin.		
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PART 2:HAND RUB

4. Applies alcohol based, water free skin cleanser on clean, dry hands.	Applies and rubs alcohol based, water free skin cleanser to all surfaces of clean, dry hands.		
5. The alcohol based, water free skin cleanser is allowed to dry completely.	Rubs hands covering all surfaces using the correct technique until the alcohol based, water free skin cleanser has completely dried.		

NAME OF ASSESSOR			
SIGNATURE OF ASSESSOR			
DATE OF ASSESSMENT		DATE PASSED	
DATE OF REASSESSMENT IF NOT DEEMED COMPETENT		SIGNATURE OF THE AGREED	

BMDH Physiotherapy

Manual Handling Evaluation

Name:

Reason for Evaluation:

Task	Date Assessed	Assessor	Passed Y/N
Use of bed: Adjust bed head and height (with remote and control panel)/ Bedrail			
Assist patient to move up the bed			
Assist patient to turn in bed			
Assist patient to transfer bed to chair			
Assist patient from lying to sitting over the edge of bed			
Assist patient to transfer from chair to chair			
Assist patient to transfer sit to stand			
Transport patient in wheelchair			
Assist patient to transfer onto commode chair			
Use of lifting devices (Hoist/ standing lifter)			
Transfer patient with slide board/ patslide			
Walk patient up the steps			
Transfer with 1-2 assist			
Use of mobility aides (4WRF, 2WRF, crutches)			

I agree with the above evaluation (sign) _____

Date: _____

Reviewed: February 2013

Mandatory training

- Disability awareness
- Patient rights, privacy and responsibilities
- Work Health and Safety
- Manual Handling
- Infection control and Hand hygiene
- Between the Flags
- DETECT
- Emergency Codes

Disability Awareness

It is important to increase our awareness towards disability because our attitude and language use to this group of people can greatly influence the experience of a person with a disability.

The attitude to people with disabilities are influenced by

- our own familiarity and experience with people with disabilities
- fear or discomfort with particular difference in people
- assumptions and stereotypes, cultural or social values

It is important to be aware that all people are different and a disability is just an individual difference.

It is important to focus on the person rather than the disability.

People with a disability generally do not want to be considered as special or inspirational, this is their life and they are leading it as we all do

As a health care worker, we are to provide support for people with disability to ensure that they are treated as individuals with rights and that they don't miss out on the usual conditions of everyday life.

It is also important to use language that puts the person first to empower and dignify the individual.

The Commonwealth Disability Discrimination Act (1992) defines disability as

- total or partial loss of a person's bodily or mental functions
- total or partial loss of a part of the body
- presence in the body of organisms capable of or causing disease or illness
- malfunction, malformation or disfigurement of a part of a person's body
- disorder or malfunction that results in a person learning differently
- disorder, illness or disease affecting thought processes, perception of reality, emotion or judgment or that results in disturbed behaviour

Type of Disabilities

- Physical disabilities tend to result in some degree of restricted activity in the areas of mobility and communication. A degree of physical disability may also occur as part of the ageing process
- Intellectual disabilities: impaired ability in relation to thinking, reasoning and remembering which occurred in childhood. it can be caused by various genetic disorders and infections. These conditions result in limitation or slowness in the general ability to learn, and difficulties in communication and retaining information
- Learning disabilities: impact on the development and use of listening, spelling, reading, writing, reasoning or mathematical skills
- Psychiatric disabilities: disability resulting from a number of underlying medical conditions such as schizophrenia, bi-polar, phobias and neuroses
- Sensory disabilities: deafness, hearing impairment, blindness, vision impairment

Level of disabilities

The core activity restriction is defined as self care, mobility and communication and it can be impacted by the severity of the disability

- mild: where a person has no difficulty with self care, mobility or communication but uses aids or equipment
- moderate: where a person does not need assistance, but has difficulty with self care, mobility or communication
- severe: where a person sometimes needs assistance with self care, mobility or communication
- profound: where a person is unable to perform self care, mobility and/or communication tasks, or always needs assistance.

Patient rights and responsibility

The understanding on patient rights and responsibility can improve safety, standards of care and patient and carer experience. For example, having patients/carers involved in determining the expected date for transfer of care (discharge and planning for home). This uses communication and participation aspects of Patient Rights and Responsibilities to promote a smooth transition for the patient. Other examples would relate to issues such as same gender wards and respect of patient's rights in relation to dignity and privacy. Removing dogs during home visits demonstrated utilising Patient Rights and Responsibilities to manage the risks for staff undertaking home visits and the responsibility of patients to provide a safe working environment.

Right defined

My Rights	What this means
Access: I have a right to health care	I can access services to address my healthcare needs
Safety: I have a right to receive safe and high quality care	I receive safe and high quality health services, provided with professional care, skill and competence
Respect: I have a right to be shown respect, dignity and consideration	The care provided shows respect to me and my culture, beliefs, values and personal characteristics
Communication: I have a right to be informed about services, treatment, options and costs in a clear and open way	I receive open, timely and appropriate communication about my health care in a way i can understand
Participation: I have a right to be included in decisions and choices about my care	I may join in making decisions and choices about my care and about health service planning
Privacy: I have a right to privacy and confidentiality of my personal information	my personal privacy is maintained and proper handling of my personal health and other information is assured e.g. patient information should not be openly discussed in public such as corridor or social media such as facebook, patient's medical notes should not be left out in the open area

My Rights	What this means
Comment: I have a right to comment on my care and to have my concerns addressed	I can comment on or complain about my care and have my concerns dealt with properly and promptly

Values

Patient Right and Responsibilities are based on the following valuesS:

- Trust
- Respect
- Partnership
- Acceptance
- Responsiveness
- Mutual accountability expectations
- Understanding of difference

Benefits of implementing Patient's Rights and Responsibilities

- The time savings from reduced problems/ complaints
- Reduced stress levels for staff from less issues arising --> higher job satisfaction and reduced turnover
- Shortened length of stay or minimise re-admission due to early identification of possible discharge or transfer of care issues
- improved health outcomes and higher standard of care for patients through patient engagement in the decision making and goal setting -- patient taking more responsibility for their own health outcomes
- patients who are well informed, trust the service provider and feel respected
- overall improved environment for staff and patients due to : greater understanding of patients needs and better understanding for the patient and their family/ carers of what to expect through the contract of care
- meeting accreditation requirements

Work Health and Safety

Work health and safety (WH&S) means promoting and protecting the health, safety and welfare of all people at work and in workplaces

NSW WH&S Act 2011 is regulated by a state government organisation called WorkCover NSW. This law is designed to protect the health, safety and welfare of all people at work, including non-employees (visitors, students, contractors, volunteers etc)

The role of WorkCover NSW is to oversee work health and safety in NSW including:

- developing WH&S law with NSW employers and employee groups
- providing education, advice and support regarding how to follow the WH&S law
- monitoring and ensuring compliance with the WH&S law requirements

Health and Safety Representatives

The function of a Health and Safety Representative (HSR) is to represent the workers in the work group in matters relating to work health and safety. The HSR has the power to:

- inspect the workplace after giving reasonable notice to the LHD
- accompany a WorkCover NSW Inspector during an investigation into an incident
- Accompany a WorkCover NSW Inspector during an inspection of the work group's workplace
- Represent members of their work group in health and safety consultations with the LDH
- investigate health and safety complaints
- represent a worker at an interview with a WorkCover Inspector or the LHD about work health and safety
- Request the establishment of a Health and Safety Committee

What are my WH&S responsibilities as a worker of the LHD?

- Take reasonable care for my own health and safety
- Take reasonable care that my acts or omissions do not adversely affect health and safety of others

- Comply, so far as worker is reasonably able, with any reasonable instruction relating to H&S
- Co-operate with any reasonable policy or procedure relating to H&S

The term “workers” includes:

- employees of the LHD
- contractors and subcontractors
- employees of a contractor or subcontractor
- employees of an agency or labour hire company who has been assigned to work in the LHD
- apprentices and trainees
- students gaining work experience or undertaking training
- volunteers

What is Risk Management?

4 Steps in the risk management process:

1. Hazard Identification
2. Assessing the Risk: determine the potential of a hazard to cause injury or illness and the potential severity of that injury or illness
3. Eliminating or Controlling the Risk: Substitution, Isolation, Engineering, Administrative Control, Personal Protective Equipment
4. Monitor and Review

How do I report and WH&S hazard or incident?

The LHD has an Incident Report Form (NBMLHD)(WSLHD) which must be completed whenever an incident occurs.

Incidents that involve patients need to be reported on the electronic incident reporting system called IIMS.

What is an Incident?

Any work-related event which results in actual injury, illness or damage to property or has the potential to cause injury, illness or damage to property

What is a Near-miss?

A situation or event that happened that did NOT cause actual injury, illness or property damage but which had the potential to do so.

What is Hazard?

Something that has the potential to cause harm to a person or property

Why Would I need to report a Near miss?

Near miss incidents must be reported because they provide management with the opportunity to put in place corrective actions before an actual harm to a person or property occurs

Other important reasons for reporting incidents include:

- it is a responsibility of all employees
- it is required by worker's compensation procedures
- it promotes continuous improvement of WH&S systems in the workplace
- it provides statistics to help check patterns and trends of incidents so they can be investigated and solutions can be developed and implemented.

What can I expect after I have reported an incident, hazard or near miss?

Your supervisor or manager, in consultation with yourself and other staff, is required to investigate the incident and develop appropriate corrective actions. This information is recorded on the Incident Report Form.

What should I do if I suffer a work related injury or illness?

1. Complete an LHD incident report Form and hand it to your manager or supervisor.
2. Seek medical attention, including a WorkCover medical certificate to give your manager
3. Contact your manager or supervisor to advise of your expected return to work date

Safe Work Practice (SWP) are written instructions that detail the preferred safe method for performing a work procedure or task. It ensures the health, safety and welfare of those people performing the task/procedure.

Infection Control and Hand Hygiene (<http://www.hha.org.au/home.aspx>)

1. Hand Hygiene: Hand wash and Hand rub
2. Applying P2 Mask
3. Donning and Removing PPE

What is Hand Hygiene?

Effective Hand Hygiene is the single most important strategy in preventing health care associated infections.

Hand Hygiene

- Is a general term referring to any action of hand cleansing.
- Includes:
 - Washing hands with the use of a water and soap or a soap solution, either non-antimicrobial or antimicrobial
OR
 - Applying a waterless antimicrobial hand rub to the surface of the hands (e.g. alcohol-based hand rub).
 - When performed correctly, hand hygiene results in a reduction of microorganisms on hands.

Hand hygiene practices have been universally poor among health care workers.

Why:

- Heavy workloads - the busier you are the less likely you are to wash your hands
- Time consuming - there just isn't enough time to wash your hands as often as you need to if using the traditional Hand Hygiene techniques
- Hands don't appear dirty - Bugs are there even if you can't see them
- Problems with skin irritation - frequent washing with soap and water removes skin lipids, and in some health care workers causes dryness, skin irritation and damaged skin
- Sinks poorly located - if it's hard to get to a sink you are less likely to use it.

Indications for Hand Hygiene

Use an alcohol based hand rub for all clinical situations where hands are visibly clean.

Wash with soap and water when visibly dirty or contaminated with proteinaceous material, or visibly soiled with blood or other body fluids, or if exposure to potential spore forming organisms is strongly suspected or proven, or after using the bathroom.

Gloves

Inappropriate glove use often undermines efforts to sustain correct hand hygiene according to the 5 Moments for Hand Hygiene.

Gloves can protect both patients and HCWs from exposure to infectious agents that may be carried on hands (66). As part of standard precautions gloves must be worn as a single-use item for (68):

- Each invasive procedure
- Contact with sterile sites and non-intact skin or mucous membranes
- Any activity that has been assessed as carrying a risk of exposure to blood, body substances, secretions and excretions.

However, gloves do not provide complete protection against hand contamination. Pathogens may gain access to the HCWs hands via small defects in gloves or by contamination of the hands during glove removal. Bacterial flora colonising patients may be recovered from the hands of approximately 30% of HCWs who wear gloves during patient contact (3, 67, 69).

The recommendation to wear gloves during an entire episode of care for a patient who requires contact precautions, without considering indications for their removal, such as for HH, could lead to the transmission of germs. Hayden and colleagues found that HCWs seldom enter patient rooms without touching the environment, and that 52% of HCWs whose hands were free of VRE upon entering rooms contaminated their hands or gloves with VRE after touching the environment without touching the patient (60).

Hand hygiene products and gloves should be made available inside isolation/contact precaution rooms to allow for appropriate hand hygiene to occur during the care of a patient.

Wearing gloves does not replace the need for hand hygiene.

When should gloves be changed?

Gloves should be changed:

- Between episodes of care for different patients, to prevent transmission of infectious material (70-71)
- During the care of each patient, to prevent cross-contamination of body sites (3)
- If the patient interaction involves touching portable computer keyboards or other mobile equipment that is transported from room to room (71)

Sterile gloves must be used for surgical ANTT procedures and contact with sterile sites (68). Single use gloves should always be discarded.

Hand hygiene is required with glove use at the following times:

- Before putting on gloves
- Immediately after removing gloves
- Gloves should be removed to perform HH during the care for a single patient as indicated by the 5 Moments for Hand Hygiene
- Hand hygiene products should not be applied to gloves

Prolonged and indiscriminate use of gloves should be avoided as it may cause adverse reactions and skin sensitivity (70).

Applying P2 Mask and PPE

What is P2 or N95 Mask?

- A P2 or N95 mask offers protection from diseases spread by airborne transmission

- A P2 or N95 mask is indicated for infections requiring additional airborne precautions such as Tuberculosis (pulmonary)
- Brands of P2 or N95 masks vary slightly. It is important to always understand the type of P2 or N95 mask used by your facility and refer to the manufacturers instructions

Applying PPE could prevent spreading Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococci (VRE) when it comes to patient contact.

Staphylococcus aureus are bacteria that are found on the skin and in the nose of people. Some strains of staph have become resistant to the antibiotic methicillin and to other antibiotics.

MRSA and other staph can be spread by:

- Direct contact to the infected area
- Reuse of contaminated equipment and linen or other personal equipment
- Inadequate hand hygiene

Enterococci are generally harmless bacteria which live in the intestines of most people. VRE is a bacteria that has become resistant to, and cannot be destroyed by, vancomycin (antibiotics used to treat serious infection)

To prevent the spread of MRSA and VRE:

- Apply PPE
- Should aware the source of MRSA/VRE
- Ensure all the equipment or area being contacted by the patients are cleaned after use

It is important to clean all shared equipment with Tuffie wipes after each treatment to prevent the spread of germs.

Some equipment are single use only such as mouthpiece and should be disposed after treatment.

Equipment such as PEP T-piece should be sterilised after the course of treatment

Between the Flags

It's a state wide roll out in responding to patients who are clinically deteriorating

Patient who are at risk of clinical deterioration:

- Observations are moving to abnormal range
- Observations are in yellow/red zone
- Observations continue to move to yellow/red zone despite treatment

How to escalate if your patient is clinical deteriorating?

- Calling for assistance
- Bringing advanced skills to patient
- Increase level of care provided to patient
- Notify senior staff

Standard Adult General Observation (SAGO)/ paediatric/ maternity

Yellow Zone – need a clinical review

- Abnormal observations reflect deterioration
- Adverse trend in observation
- Altered calling criteria in observation

Inform the Team Leader/Nurse in Charge, who will decide:

1. That escalation is not required, according to documentation in the notes or patient stability
2. To escalate to a R.A.C.E. by calling 111 (patient to be seen within 5 mins and improving within 30 minutes)
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If options 2 and 3 are activated, always

- Repeat and record observation
- Document action taken in the progress notes
- Stay with patient and continue observations

If options 1 or 2 are followed and patient's observations move into the RED ZONE – escalate to a MET call

Red Zone – call a rapid response

If patient observations meet one rapid response criterion call for a rapid response unless relevant documentation to the contrary is provided

- Press the MET call buttons and/or call 111
- Inform the Team Leader Nurse in Charge
- Start basic life support as required
- Document as required on the MET form and in the patients progress notes
- If patient has been made “not for CPR” – the above triggers may not apply

Normal values:

Respiratory rate: 12-16

SpO₂: 96-100%

O₂ requirement

Blood Pressure: 120/80

Heart Rate: 60-100

Temperature: 36.8 +/- 0.2

DETECT

DETECT stands for Detecting Deterioration, Evaluation, Treatment, Escalation and Communicating in Teams. This tutorial gives you an idea what is DETECT and some signs and symptoms if patient deteriorates

D: Detect Deterioration

- Recognise that you have a problem by gathering information relating to your patient
- Use the ABCDEFG algorithm
- Identify early and late warnings signs

E: Evaluate

- Likely causes of deterioration
- Whether your skills and the skills of those around you will meet the patient's needs
- If and when to call for help
- The urgency of the response
- Continue to constantly re-evaluate

T: Treatment

- Prioritise interventions using the ABCDEFG algorithm to guide your decision
- Commence simple treatments such as oxygen, positioning your patient, establishing IV access
- Call for help if you can't manage

E: Escalate

- Be aware of signs of further deterioration, or failure to reverse deterioration
- Know how and who to call for more assistance
- Know when the patient's clinical management requires advanced skills

C T: Communication in Teams

- Provide leadership where appropriate
- Coordinate activities within the team
- Use the ISBAR Algorithm to communicate clearly
- Document clearly the patient's outcome in the healthcare record

ABCDEFG Algorithm

		Look	Listen	Feel
A	Airway	Any signs of airway obstruction Evidence of mouth/neck/swelling/haematoma Security of artificial airway	Noisy breathing e.g. gurgling, snoring or stridor	The presence of air movement Security of artificial airway
B	Breathing	The chest wall movement, to see if it is normal and symmetrical See if the patient is using their neck and shoulder muscles to breathe (accessory muscle) The patient to measure to measure their respiratory rate	The patient talking to see if they can complete full sentences Noisy breathing	The position of the trachea to see if it is central Surgical emphysema or crepitus If the patient is diaphoretic (sweaty)
C	Circulation	The skin colour for pallor and peripheral cyanosis The capillary refill time The patient's central venous pressure and jugular venous pressure	The patient for complaints of dizziness and headaches Patient's blood pressure and heart sounds	Your patient's hands and feet if they are warm or cold Your patient's peripheral pulses for presence, rate, quality, regularity and equality
D	Disability	The level of consciousness Facial symmetry, abnormal movements, seizure activity or absent limb movements Pupil size, equality and reaction to light	Patient's response to external stimuli and pain Slurred speech Patient's orientation to person, place and time	Patient's response to external stimuli Muscle power and strength
E	Exposure	Any bleeding e.g. investigate wounds and drains that may be hidden by bed clothes	Air leaks in drains Bowel sounds	Patient's abdomen

F	Fluids	The observation and fluids charts, noting the fluid input and output Losses from all drains and tubes The amount and colour of patient's urine and urinalysis	Patient's complaints of thirst	Skin turgor
G	Glucose	Blood glucose levels <3 mmol/L or 3-5 mmol/L with decreased conscious state For signs of low glucose, including confusion and decreased conscious state Medication chart for insulin and oral hypoglycaemics	Patient's complaints of thirst Patient's orientation to person, place and time	The patient is diaphoretic (sweaty, cold or clammy)

Action:

1. Give oxygen: based on your assessment decide an appropriate oxygen flow rate or percentage. If in doubt commence on 4L/min on a Hudson mask and increase as indicated by oxygen saturation or patient condition
2. Position your patient:
 - Position your patient to optimise their breathing – usually this is as upright position as possible and as tolerated by the patient
 - Place the patient in the left lateral position if they are unconscious but have adequate breathing and circulation and where there is no evidence of spinal injury
3. Call for help if you can't manage: establish IV if not present +/- fluids
4. Never leave a deteriorating patient without a priority management and review plan
 - Document and communicate clearly all treatment provided, outcomes of treatment implemented and what care is still required
 - The plan should be include expected outcomes and when the patient will be reviewed again

Warning signs:

Early warning signs:

- SpO₂ 90-95%
- Respiratory Rate 5-9 bpm or 30-40 bpm
- Pulse rate 40-50 or 120-140
- SBP 80-100 mmHg or 180-240 mmHg
- Poor peripheral circulation
- Urine output <200mls Over 8 hours
- Greater than expected drainage fluid loss
- A drop in GCS of 2 points or GCS <12 or any seizure
- New or uncontrolled pain (including chest pain)
- ABG's: PaO₂ 50-60, PCO₂ 50-60, pH 7.2-7.3, BE -5 to -8 mmol/L
- BSL 1-3 mmol/L
- Partial airway obstruction (excluding snoring)

Late warning signs:

- Airway obstruction or stridor
- SpO₂ <90%
- Respiratory rate < 5bpm or >40bpm
- Pulse rate <40 or >140
- SBP <80 or >240 mmHg
- Excess blood loss not controlled by ward staff
- Unresponsive to verbal command or GCS <8
- Urine output <200mls in 24 hours or anuria
- ABG's PaO₂ <50, PaCO₂ >60, pH <7.2, BE < -7
- BSL <1 mmol/L

Emergency codes

Code RED indicates fire or fire alarm activated within the hospital

Remove patients, patient's files, visitors and staff from immediate fire area

Alarm dial 111

Contain the fire by closing doors/ or windows

Extinguish if you can do so safely

If fire alarm is activated and you don't know where the fire is, evacuate out of the building and meet in the assembly area

Code ORANGE indicates evacuation is required. Evacuate patients to the designated area in the order of: ambulatory patients, wheelchair patients and non ambulant patients

Code YELLOW indicates internal emergencies ie services failures: power, water, telecommunications, computer system, medical gases, internal hazardous substance contamination

Code PURPLE indicates bomb threat: mobile phones/ two-way radios should not be used within 25 metres of a suspicious item

Code BLUE serves the purpose of early recognition of the acutely deteriorating patient and activation of the Medical Emergency Team (MET) or Registrar Activating Clinical Emergency (RACE) will provide rapid response and effective management of medical/ clinical emergencies.

Code BLACK indicates endangered personnel including:

- Any incident where staff/patients/ visitors are being verbally or physically threatened and fear for their safety
- Any incident where there is the potential for physical harm to staff/ patient/ visitor- including aggressive physical or verbal behaviour
- Any incident which could escalate into an uncontrollable, local situation

Code BROWN indicates external disaster. It has the purpose to control and coordinate the resources of BMDH in preparation for, response to, and recovery from , a major incident or disaster situation

AHA Student Safe Work Practices

NAME:

DATE:

Physiotherapy

SWP1 Transporting a patient using a manual wheelchair

SWP2 Hot water urns

SWP4 Principles for safe use of lifting devices

SWP5 lifting an inanimate object

SWP7 Assist client to move up bed

SWP8 Patient transfer from chair to chair/toilet

SWP9 patient transfer from bed to chair

SWP10 patient transfer from sit to stand

SWP11 microwave oven

SWP12 cast saw

SWP 15 exercise bike

SWP16 computers

SWP17 printer

SWP18 refrigerator

SWP19 photocopying

SWP20 filing cabinet

SWP23 use of treadmill

SWP24 training mobility with crutches on stairs

SWP26 transferring/ mobilising patient with walking belt

SWP28 adjusting bed head

SWP32 chair (five wheel base)

SWP35 using sandwich press

SWP39 chair (no wheel)

SWP40 using a telephone

SWP42 using scissors

SWP 43 transferring patient with one assist

SWP44 standing lifter

SWP45 raising/lowering medicraft bed side rail model NO FE500

SWP46 cast removal

SWP52 transferring larger patients (over 100kg)

SWP53 routine hand hygiene

SWP (nursing) assisting a patient from supine to sitting on edge of the bed

SWP (nursing) assisting a patient to raise their head or sit up in bed

Occupational therapy

SWP2 transporting equipment and loan pool storage

SWP3 lifting hoist for transportation

SWP4 lifting manual wheelchair into and out of the back of a station wagon/utility

SWP5 moving tables

SWP6 using a transporter commode to transport a patient

SWP7 using trolley for equipment transport

SWP9 installation of raised toilet seat

SWP11 installation of shower chair, shower toll, over toilet aid and toilet surround

SWP12 fitting/ transporting a monkey bar (portable) including base, pole and triangle

SWP13 manually adjusting extension legs to an appropriate height

SWP16 raising the height of chairs using elephant feet

SWP18 generic safety rules for all patient handling tasks

SWP21 use of sling hoist to transfer from bed to chair

SWP30 using lift sheet for transferring collapsed patient from floor to trolley/bed

SWP32 raising a fallen patient from the floor

SWP34 roll dependent patient in bed

SWP36 use of slide sheets to reposition dependent patient

SWP39 guidelines for portable ramp use with patient confined to a wheelchair

SWP40 sliding transfer of patient into car with assistance of two

SWP41 retrieve patient from car

SWP 43 dealing with aggressive and/or abusive persons

ACHIEVING A PERFECT FIT

HOW TO DON AND FIT CHECK P2 (N95) MASKS



1
SEPARATE THE EDGES OF THE MASK TO FULLY OPEN IT



2
SLIGHTLY BEND THE NOSE WIRE TO FORM A GENTLE CURVE



3
HOLD THE MASK UPSIDE DOWN TO EXPOSE THE TWO HEADBANDS



4
USING YOUR INDEX FINGERS AND THUMBS, SEPARATE THE TWO HEADBANDS



5
WHILE HOLDING THE HEADBANDS CUP THE MASK UNDER YOUR CHIN



6
PULL HEADBANDS UP AND OVER YOUR HEAD



7
PLACE AND POSITION THE LOWER HEADBAND AT THE BASE OF YOUR NECK (UNDER YOUR EARS)



8
PLACE THE UPPER HEADBAND ON THE CROWN OF YOUR HEAD. THE BAND SHOULD RUN JUST ABOVE THE TOP OF YOUR EARS



9
GENTLY CONFORM/PRESS THE NOSEPIECE ACROSS THE BRIDGE OF YOUR NOSE BY PRESSING DOWN WITH FINGERS UNTIL IT FITS SNUG



10
CONTINUE TO ADJUST THE MASK AND EDGES UNTIL YOU FEEL YOU HAVE ACHIEVED A GOOD AND COMFORTABLE FACIAL FIT

FIT CHECK

GENTLY INHALE. WHEN YOU BREATHE IN THE MASK SHOULD DRAW IN SLIGHTLY TOWARD THE FACE AND COLLAPSE



11

A 'FIT CHECK' MUST BE PERFORMED EACH TIME A P2(N95) MASK IS WORN

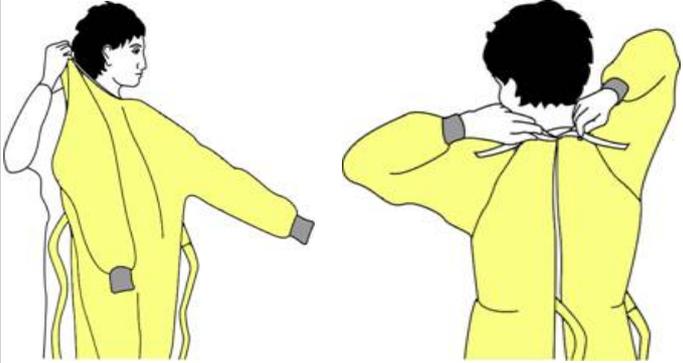
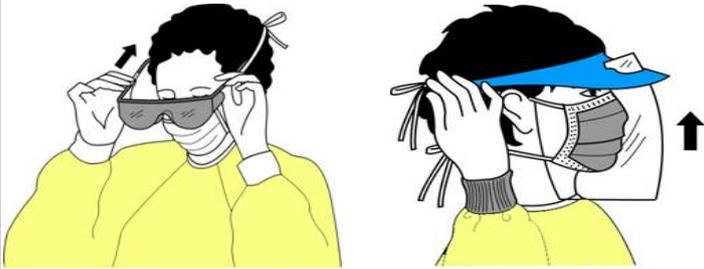
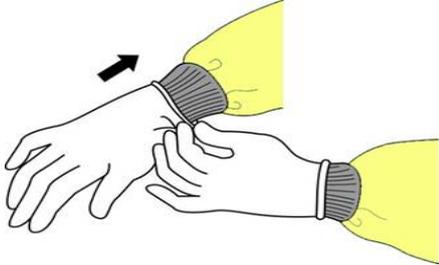


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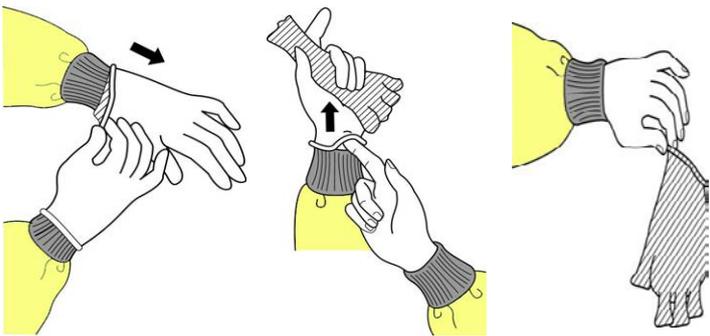
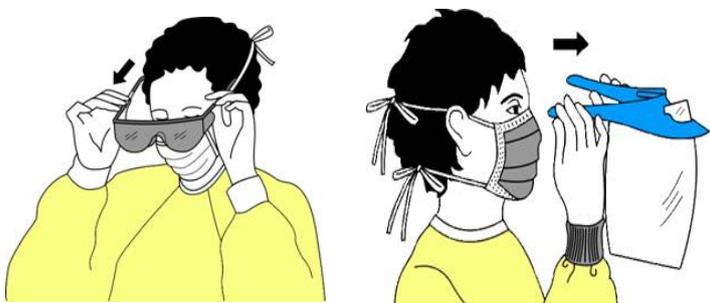
GENTLY EXHALE. THE MASK SHOULD FILL UP WITH AIR. IT IS IMPORTANT AT THIS STAGE THAT THERE IS NO AIR LEAKAGE AROUND EDGES OF MASK.

If you have not achieved a successful fit as instructed above it is important that you seek advice or have someone assist you with fitting and checking your mask, as an incorrectly fitted mask will not provide you with the intended level of protection.

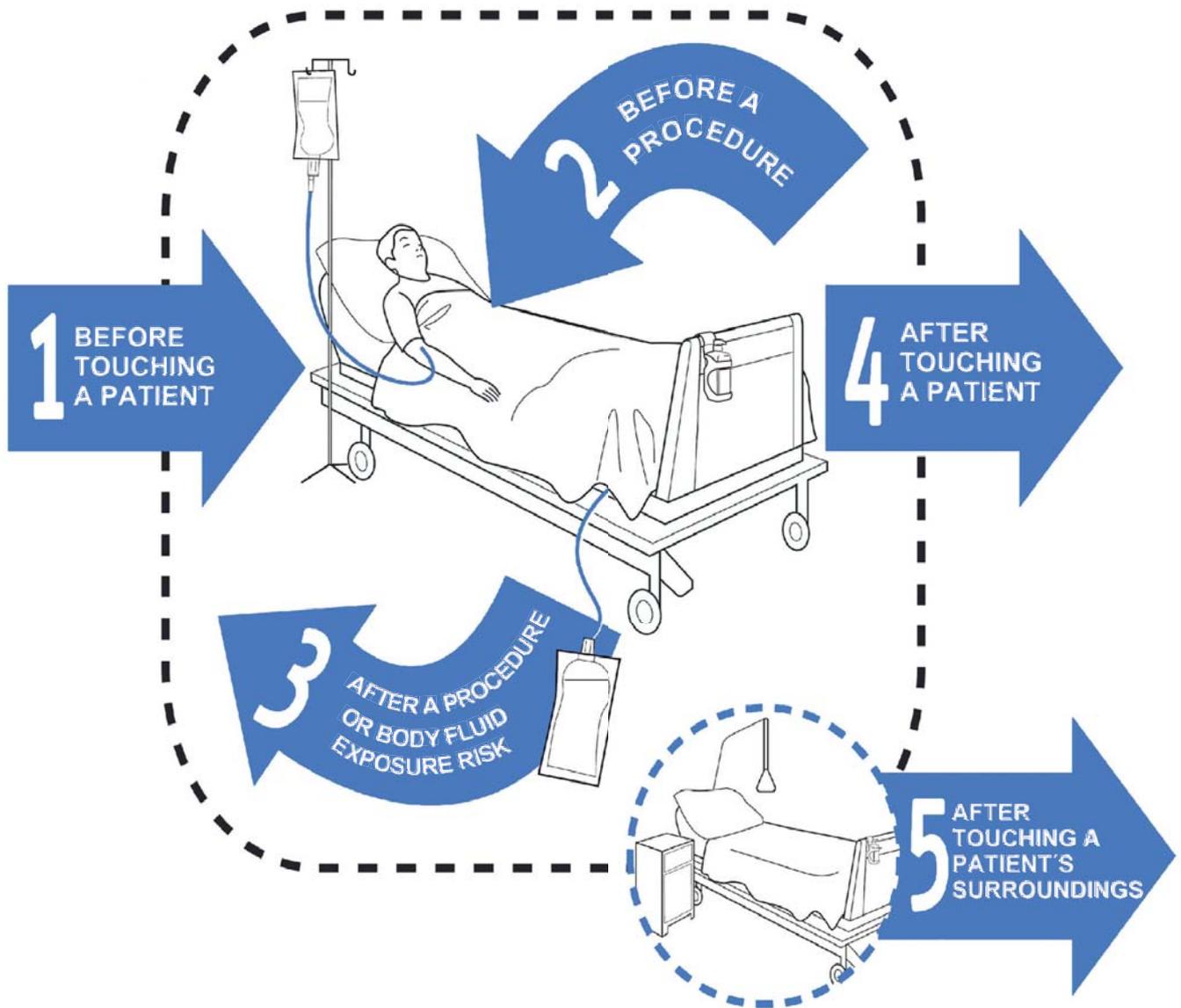
Sequence for Donning PPE

<p>Step 1. Hand Hygiene</p> <p>Perform hand hygiene before putting on Personal Protective Equipment</p>	
<p>Step 2. Gown/Apron</p> <p>Fully cover torso from neck to knee, arms to end of wrist, and wrap around the back.</p> <p>Fasten in back at neck and waist.</p>	
<p>Step 3. Mask or Respirator</p> <p>Secure ties or elastic bands at middle of head and neck</p> <p>Fit flexible band to nose bridge</p> <p>Fit snug to face and below chin</p> <p>Fit check mask/respirator</p>	
<p>Step 4. Protective Eyewear</p> <p>Place goggles or face shield over face and eyes and adjust to fit</p>	
<p>Step 5. Gloves</p> <p>Extend to cover wrist of gown</p>	

Sequence for Removing PPE

<p>Step 1. Gloves</p> <p>Outside of gloves is contaminated</p> <p>Grasp outside of glove with opposite gloved hand; peel off</p> <p>Hold removed glove in gloved hand</p> <p>Slide fingers of un-gloved hand under remaining glove at wrist</p> <p>Peel glove off over first glove</p> <p>Discard gloves in waste</p>	
<p>Step 2. Hand Hygiene</p> <p>Perform hand hygiene following removal of gloves</p> <p>The use of a water-free skin cleanser is appropriate</p>	
<p>Step 3. Protective Eyewear</p> <p>Outside of goggles or face shield is contaminated</p> <p>To remove, handle by head band or ear pieces</p> <p>Place reusable eyewear in designated receptacle for cleaning or discard disposable eyewear into waste container for disposal</p>	
<p>Step 4. Gown</p> <p>Gown front and sleeves are contaminated</p> <p>Unfasten ties</p> <p>Pull away from neck or shoulders, touching inside of gown only</p> <p>Turn gown inside out</p> <p>Fold or roll slowly into a bundle and discard into designated waste container</p>	
<p>Step 5. Mask or Respirator</p> <p>Front of mask/respirator is contaminated</p> <p>Remove by touching tapes or ties only</p> <p>Discard in designated waste container</p>	
<p>Step 6. Hand Hygiene</p> <p>Perform hand hygiene following removal of all Personal Protective Equipment</p>	

5 Moments for HAND HYGIENE



1 BEFORE TOUCHING A PATIENT	When: Clean your hands before touching a patient and their immediate surroundings. Why: To protect the patient against acquiring harmful germs from the hands of the HCW.
2 BEFORE A PROCEDURE	When: Clean your hands immediately before a procedure. Why: To protect the patient from harmful germs (including their own) from entering their body during a procedure.
3 AFTER A PROCEDURE OR BODY FLUID EXPOSURE RISK	When: Clean your hands immediately after a procedure or body fluid exposure risk. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
4 AFTER TOUCHING A PATIENT	When: Clean your hands after touching a patient and their immediate surroundings. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
5 AFTER TOUCHING A PATIENT'S SURROUNDINGS	When: Clean your hands after touching any objects in a patient's surroundings when the patient has not been touched. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.



CLINICAL ASSESMENT: DONNING PERSONAL PROTECTIVE EQUIPMENT

Name: _____ Designation: _____ Employee No. _____

Department: _____ Cost Centre No. _____

(tick appropriate column)

Indicator	Performance Criteria	Performed	Not Performed
1. Skin integrity checked	Visually checks hands. Covers cuts/abrasions with waterproof occlusive dressing if necessary.		
2. Items, that interfere with effective hand hygiene (e.g. rings, watch, bracelet), removed	Removes items that may become contaminated and cause cross infection.		
3. Hand hygiene performed (Routine)	Performs a 10 – 15 second hand wash using appropriate hand washing solution, either: antimicrobial; or non-antimicrobial liquid soap, <u>or</u> Applies alcohol based, water free skin cleanser all over clean, dry hands and rubs vigorously until dry.		
4. Disposable protective gown/apron put on	Opens gown/apron ensuring it does not touch any surfaces such as floor or wall. Places gown/apron on with opening to the back. Wraps gown/apron around back. Ensures all tapes/ties are secured safely.		
5. Appropriate mask or respirator, e.g.: Surgical mask; P2 mask, put on	Examines mask for defects. Slightly bends nose piece. Secure ties or elastic bands at middle of head and neck. Fits flexible band to nose bridge. Fits snug to face and below chin. Fit checks mask/respirator.		
6. Protective eyewear put on	Places goggles or face shield over face and eyes and adjusts to fit.		
7. Gloves donned	Gloves go on with ease. Glove size and fit is appropriate. Glove cuffs cover gown cuffs.		
8. PPE checked	Checks PPE in mirror, <u>or</u> Asks colleague to check PPE.		

NAME OF ASSESSOR		SIGNATURE OF ASSESSOR	
DATE PASSED			
DATE OF REASSESSMENT		SIGNATURE OF AGREED	

CLINICAL ASSESMENT: REMOVING PERSONAL PROTECTIVE EQUIPMENT

Name: _____ Designation: _____ Employee No: _____

Department: _____ Cost Centre No _____

Indicator	Performance Criteria	Performed	Not Performed
1. Gloves removed	Grasps outside of glove with opposite gloved hand and peels off. Holds removed glove in gloved hand. Slides fingers of un-gloved hand under remaining glove at wrist. Peels glove off over first glove. Discards gloves in waste.		
2. Hand hygiene performed after removing gloves	Performs a 10 – 15 second hand wash using appropriate hand washing solution, either: antimicrobial; or non-antimicrobial liquid soap, <u>or</u> Applies alcohol based, water free skin cleanser all over clean, dry hands and rubs vigorously until dry.		
3. Protective eyewear removed	Handles by the head band or ear pieces. Places reusable eyewear in designated receptacle for cleaning or discards disposable eyewear into waste container for disposal.		
4. Disposable protective gown/apron removed	Unfastens ties. Pulls away from neck or shoulders, touching inside of gown only. Turns gown inside out. Folds or rolls slowly into a bundle and discard into designated waste container.		
9. Appropriate mask or respirator, e.g.: Surgical mask; 5. P2 mask, removed	Removes by touching tapes or ties only. Discards in designated waste container.		
6. Hand hygiene performed following removal of all PPE	Performs a 10 – 15 second hand wash using appropriate hand washing solution, either: antimicrobial; or non-antimicrobial liquid soap, <u>or</u> Applies alcohol based, water free skin cleanser all over clean, dry hands and rubs vigorously until dry.		

NAME OF ASSESSOR:		SIGNATURE OF ASSESSOR	
DATE PASSED			
DATE OF REASSESSMENT		SIGNATURE OF AGREED	



CLINICAL ASSESSMENT: APPLICATION OF P2 MASK

Name: _____ Designation: _____ Employee No. _____

Department: _____ Cost Centre No _____

Performance Criteria (Putting on a mask)	Rationale	Performed	Not performed
P2 mask is separated to open (if required). Top and bottom of mask is identified.	Mask is not put on upside down.		
Nosepiece is bent to conform the mask to nose.	Assists for easier fitting over the bridge of the nose.		
a) P2 mask with head bands: Index fingers and thumb are used to separate the two headbands. While holding the headbands with index fingers and thumbs, the respirator is cupped under chin.	For easier application for applying the mask.		
The lower part of the mask or respirator is placed on the chin and both bands are brought over the head.	For easier fitting and removes the hands away from the mask.		
The headbands are pulled over the head. The lower headband is released from the thumb and positioned at the base of the neck. The remaining headband is placed on the crown of the head.	To ensure the mask is securely in place.		
a) P2 mask with ties: The ties of the mask are secured at the crown of the head. The ties of the mask are secured at the base of the neck.	To ensure the mask is securely in place.		
The nosepiece is moulded tightly to ensure a secure facial fit. The P2 mask is adjusted and the edges moulded until a good facial fit has been achieved.	To ensure the mask is fitted correctly.		
A facial fit check is performed. (refer to Fit check)			

Fit check	Rationale	Performed	Not performed
Inhales gently. Mask is drawn in slightly towards the face and collapses.	To ensure the mask is fit snug to the face and there are no gaps for air to leak in.		
Exhales gently. Mask should fill with air and there is no air leakage around the edges of the mask.	To check if there are any air leakages.		



CLINICAL ASSESMENT: REMOVAL OF P2 MASK

Name: _____ Designation: _____ Employee No. _____

Department: _____ Cost Centre No _____

Performance Criteria (Removing a mask)	Rationale	Performed	Not performed
The P2 mask is only handled by the bands or ties (front of the mask is considered contaminated).	Decrease the risk of contaminating hands.		
The lower band is pulled over the head first, and then the upper band is removed, or The tie at the base of the neck is undone and then the tie at the crown is undone. The P2 mask is removed without contaminating self.	Safely remove the mask to decrease the risk of contamination.		
The P2 mask is discarded into an appropriate receptacle. The headbands or ties being the only part to touch the hands.	Appropriate waste disposal and lessen the risk of contaminating the hands.		
Hand hygiene is performed following the removal of the P2 mask	Performs a 10 – 15 second hand wash using appropriate hand washing solution, either: antimicrobial; or non-antimicrobial liquid soap, or Applies alcohol based, water free skin cleanser all over clean, dry hands and rubs vigorously until dry.		

NAME OF ASSESSOR		SIGNATURE OF ASSESSOR	
DATE PASSED			
DATE FOR REASSESSMENT		SIGNATURE OF AGREED	

Activity -- Role of health professionals

1. Occupational Therapy
2. Speech Pathology
3. Social Work
4. Continuing Care Clinical Nurse Consultant (CCCNC)
5. Dietitian
6. PACC
7. Registered Nurse/ Enrolled Nurse

Clinical Experience Record

Name:

Placement:

Activity	Patient/ Group type (condition)	Intervention	Other Special Features
e.g. Patient education	COPD aged over 70	Energy Conservation	Falls history, decreased mobility due to Shortness of Breath

4. How was the situation successfully resolved? If not, why?

5. Would you do anything differently in future if you encountered a similar situation?

6. What did you learn from this experience?

Clinical Placement Survey

Placement date:

Clinical area:

Preparation

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The hospital description provides a clear outline of the experience I would potentially gain out of this placement					
The orientation I received was informative and helpful for the clinical placement					
I clearly understand the expectation from supervisor and hospital					
Other comments:					

Clinical experience

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I was made to feel welcome by the staff in the department/ clinical area					
I was able to contact the appropriate person when I needed assistance					
I was exposed to a wide variety of clinical area and conditions					
I was able to apply the knowledge in the clinical setting					
I was able to access different resources for my learning					
Appropriate tutorials were given					
Other comments:					

Clinical Supervisor

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
My supervisor was approachable and available					
My supervisor was organised					
I felt that I had appropriate amount of supervision					
I felt that I had appropriate amount of hands on experience					
I received adequate amount of feedback					
The feedback I received were constructive and clear					
I was encouraged to self reflect on my performance throughout the placement					
Strategies were discussed for area of improvement					
My assessment accurately reflect my performance on this placement					
Other comments:					