

# NOTICE OF PRIVACY PRACTICES

*Effective May 16, 2003*

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT PATIENTS MAY BE USED AND DISCLOSED

The purpose of this notice is to provide you with information on Boston Reed's information protection practices.

Boston Reed students will abide by the terms of this notice currently in effect by maintaining the privacy of personal information. You will be provided with notice of our legal duties and privacy practices with respects to Protected Health Information.

**Confidentiality:** You are required to maintain confidentiality of patient information in accordance with state and federal law. No student will have access to or have the right to review any medical record, except where necessary in the regular course of the clinical program. The discussion, transmission or narration in any form by students of any patient information obtained in the regular course of the clinical program is forbidden except as permitted by law.

### Definitions

**Business Associate**

A person or entity that uses Protected Health Information to perform a function or activity on behalf of an agency.

**Protected Health Information**

Information relating to a patient's past, present or future health or condition, the provision of health care to a patient, or payment for the provision of health care to a patient.

Protected Health Information includes, but is not limited to:

- Patient name, address and phone number
- Social Security number
- Service date
- Diagnosis information
- Billing records

**Authorization:** Agencies may use and disclose Protected Health Information for purposes of treatment & health care operations. Any other uses or disclosure require a specific authorization by the patient or his or her representative. The authorization must be written in plain language and there are specific requirements for its content. For an authorization to be valid, it must contain required information, must not have expired and must be completely filled out.

Agencies can use and disclose Protected Health Information without a person's authorization when necessary for:

- coordination of specific treatment
- disclosure to health insurance carrier to the extent permitted by law
- payment
- health care operations
- as required or permitted by law

Protected Health Information will only be disclosed to Business Associates who have agreed in writing to maintain the privacy of Protected Health Information as required by law.

**Use or Disclosure  
Required or  
Permitted by Law**

Use or disclosure of Protected Health Information to the extent that the law requires the use or disclosure:

- *Public Health:* For public health activities or as required by the public health authority.
- *Health Oversight:* To a health oversight agency for activities such as audits, investigations and inspections. Oversight agencies are government agencies that oversee the health care system, government benefit programs, government regulatory programs and civil rights laws.
- *Legal Proceedings:* In response to an order of a court administrative tribunal, a subpoena, discovery request or other lawful process.
- *Law Enforcement:* For law enforcement purposes, including:
  - legal process or as otherwise required by law;
  - limited information requests for identifications and location
  - use or disclosure related to a victim of a crime;
  - suspicion that death has occurred as a result of criminal conduct;
  - in a medical emergency where it is likely that a crime has occurred.
- *Criminal Activity:* As requested by law enforcement, if the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Persons are able to request restrictions on the use and disclosure of their Protected Health Information. If the request prevents an agency from providing service to said persons, the request can be denied.

**BOSTON REED COLLEGE®**  
Orthopedic Technician Program  
Week 1 Handout

**PATIENT AND TECHNOLOGIST SAFETY IN THE CAST ROOM/CLINIC**

“Safety is an active process that systematically employs preventative and corrective actions to avoid injury.”

This quote is taken from Feb. 2003, AAOS “Bulletin” on Patient Safety by James H. Herndon, M.D., President (2003-4) of the AAOS.

This major concern over patient and staff safety is reflected in the data from the New England Journal of Medicine, dated December 12, 2002 that stated:

“...40% of patients have experienced a medical error, whether themselves directly or with a family member... In addition, one third of doctors reported seeing a medical error.”

Further evidence that safety is becoming a point of strong concern is the establishment of the Patient Safety Coalition formed in November of 2002. This group consists of the AAOS, NAON, and Orthopedic Corporate Advisory Council, & Orthopedic Military Physicians. These, normally very independent, groups actually formed an alliance to deal with safety issues!

“The Cast Room” is a treatment area, a place where procedures from wound care to pin removal to fracture reduction take place. The direct responsibility for establishment and maintenance of a safe environment in the Cast Room is that of the Orthopedic Technologist. Both patient and technologist safety are the subject of this paper. The specifics are not as important as the concept that we, the Orthopedic Technologists, must engage in the “active process” of preventing problems. This means we must look at all procedures that take place in our areas and set up controls and actions that deal with possible safety issues. We must develop protocol for any actions within our area of control.

**HAND WASHING:** Wash your hands! The single most effective contamination control according to the Joint Commission on Accreditation of Healthcare Organizations (JACHO)

- Does your cast room have foot controls for the sink? If not, you have a great source of contamination right on the handles of the water supply!
- Does the soap dispenser have foot controls? Is the soap an appropriate type that destroys the types of pathogens we deal with?
- Did you know that while hand washing is a good mechanical (rubbing, rinsing) means of removing bacterial, the aqueous alcohol (62% Ethyl Alcohol) based and cleaners now used are actually more powerful at the elimination of microbes? That means it would be a very good policy to follow every hand wash with the “Hand Sanitizers.” For that reason there should be one dispenser at each hand washing location.

- What about the cast room phone? Do you clean your hands before answering it? Just taking off the gloves is not enough. This is another great place to put a Hand Sanitizer dispenser. You still need to wash your hands; however this might cut down on the phone “bugs.”
- When you wash your hands the towel used to dry and the disposal of it should be a concern.
- Hand washing and sanitizing should be between each and every glove change, which should be any time there is a possibility that we might come in contact with contaminants. If you dress a wound, change gloves BEFORE you roll the cast on the same patient. The contaminants from your gloves will end up in the cast bucket and be passed on to...you. Change gloves.
- Strict aseptic technique should always be followed. This is a method where the basic idea is to isolate contamination. So, you washed and sanitized your hands...

**GLOVES:** Single use, disposable gloves “shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood or other infectious materials.”

Put on gloves to do anything and everything. I do not wash my gloves; I change them, every time. They are our best barrier from the patient’s fluids and they are also a barrier that keeps the normal bacteria that live on our hands from getting in the patient’s wound. Dispose of gloves after each exposure, possibly several times on the same patient.

**BANDAGE SCISSORS:** Who cleaned the scissors after cutting off the draining wound dressing? No one, that’s who. Yes, your hands are clean, your gloves were clean, until you picked up the bandage scissors that is. Or maybe you just pulled them from your pocket, where you put them after the last cast!

In my opinion, one great source of pathogen spread is the bandage scissor. Please think about that when you go from patient to patient.

Do not use “instrument milk” to soak scissors or instruments as a disinfectant.

This solution is not the solution. It has been basically outlawed and if JCAHO finds the practice in use it is a major infraction. Substantial colonies of bacteria and virus live just fine in this “milk.”

One possible solution to eliminate the problem is alcohol swabs used after each procedure to wipe down the scissors; then to use an external holder for the scissor, not your pocket. Visualize what has made contact with these instruments after each use.

**EYE PROTECTION/MASK:** “Mask and eye protection or combination face shields shall be worn whenever splashed, spray spatter or droplets of blood may be generated and contamination can be reasonably anticipated.” Your eyes are the “window to the rest of your body.” Consider the dust from a cast saw, consider that the cast covered a post-op wound, think about the airborne nature of the dust. Consider the not airborne particles that end up on your arm just proximal to the end of your gloves. Think about wiping that sweat from your brow with the back of your gloved arm, you know the place where the particles of contaminant are...eye infection, exposure to pathogens...wear eye protection whenever you put on gloves (every time you treat patients.)

**REGULATIONS (STANDARDS -29CFR):** “The employer shall provide, at no cost, to the employee, APPROPRIATE personal protective equipment such as, but not limited to gloves, gowns, lab coats, face shields, masks or other ventilation devices.”

“Employer shall clean, launder, and dispose of personal protective equipment at no cost to the employee.”

**THE SAW:** The saw? Yes, this device is, once again, one of the most overlooked sources of contaminants in the cast room. Think about it, we wash our hands, wear eye and mask protection, we wear lab coats...yet no one wipes the saw or the saw’s blade clean! That blade that passed through the draining, purulent, diabetic ulcer is now to be used on a three year olds SAC...who will pull away and who you will then, ever so slightly, scratch!

Please respect the fact that it is a saw. Think about the contamination of the grip of the saw. Not to worry those gloves you changed were great protection for you. But now you are just changing the blade of the saw, so you do not wear gloves to change the blade... That’s why we need to wipe down with alcohol the handle and grip of the saw on a regular basis...hey, what about the switch?

Did you remember to UNPLUG the saw before doing any service or cleaning?

Does anyone know who emptied the cast saw vacuum bag last? Has anyone EVER emptied the one in the O.R.? Airborne pathogens are a major risk. Deep within the dark reaches of that filthy, unchanged vacuum bag the bacteria have a nice, worm place to live and thrive.

What do you mean you don’t have a vacuum? “It’s too hard to use” or “It is too expensive” or whatever. Your health and that of the staff and patients in your office is at risk from airborne pathogens. Wear a mask and change to bag on the vacuum (wear a mask and gloves to do that too!) They are both cheaper than treating you for systemic infections.

**WATER BOTTLES:** Or any other food or beverage items are NOT to be in clinical treatment areas. While proper hydration is important...you can become exposed to contaminants and spread them to others. Keep your supplies isolated from the cast room.

By the way, makeup, lip balm or anything you “apply” to yourself is absolutely forbidden in the clinical area. Like food, the application of these materials can contaminate you. Never have food, beverages or anything you ingest or apply around patient areas.

**SHARPS:** “Engineering controls (sharps containers, needless systems, self-sheathing, etc.) shall be examined and replaced on a regular schedule to ensure their effectiveness.”

Sharps containers must be highly visible, puncture proof, containers with “Biohazard” labels as well as labels to designate the clinic or hospital source of the container. The device must allow easy sharps entry without risk of stick. It must be locked to the wall or cart. They must be disposed of in an approved manner. When the sharps container is half full ... it’s full! This is very hazardous waste. Objects sticking out of the container can kill you, literally.

Saw blades are...sharps! Yup, go ahead and run your finger across the blade (don’t)...ouch, that was sharp! Therefore they are disposed of in a sharps container!

**PREVENTING SLIP & FALLS:** The cast room is, by its very nature, a place where water will inevitably end up on the floor. Where there is water on the floor there will eventually be people laying in it. Accidents can be prevented. Safety is NO accident. We need to recognize the existing environmental problem of wet surfaces and patients who are on crutches or who are incapacitated from injury or orthopedic condition. These patients might fall just walking on a clean dry surface, but they most assuredly will fall if there is a loss of traction or an obstacle they can’t see because they are supporting their fractured arm in front of them as they walk.

You and I need to make the cast room environment one that makes patients aware of the hazards (signs, posters in the waiting room...) and then to lessen the risks that are present. We need to look at the way we do things and look at the ways we can change those actions to lessen the possible harm they can call.

A spot of water on the floor is a disaster waiting to happen. How can we address this, the simplest of hazards? Prevention. We must deal with the fact that the floor will get wet in a cast room. The Orthopedic Technologist must make sure the appropriate signs are in the lobby and the cast room itself allows patients and visitors know that risk does exist. This disclaimer does not free the technologist from responsibility, nor does it demonstrate a sense of concern for patient and staff safety.

Hey what about those little plastic cores in the center of fiberglass cast tape. Those little guys like to travel and are hard to keep track of. They seem to enjoy reappearing under patient and staff feet, who then take on a Gravity Games sort of “360” and occasionally “wipe out.” Solution to material on the floor, well a helpful hint anyway...I use 2 (two) cast buckets (paper because I dispose of them as often as several times a day.) One bucket is for the clean, cool water for the cast. The other is a TRASH bucket for dressings, padding ends, and plastic cores, whatever. This helps to isolate such things and then, if they are contaminated with body fluid, I dispose of them. Cast Buckets are great for temporarily keeping isolation materials in a

controlled space until they can be placed in the proper receptacle. Again I think the waxed paper buckets help to keep down cross contamination.

**IF YOU ARE INJURED OR EXPOSED TO PATHOGENS OR HAZARDS:** Immediately, not later or the next day, report to your supervisor in a formal written manner exactly what happened and the effect on you. The “Source Individual” (patient or person who is the source of the contamination) must be documented. This is critical for your proper care and follow-up.

Worker’s Compensation has many rules and regulations, but the above protocol will insure that there is a proper documentation from the beginning.

Talk to your supervisor regarding specific protocols. Do that now BEFORE an incident.

**ONCE AGAIN:** Safety is an active process that systematically employs preventative and corrective actions to avoid injury.

- Think, anticipate problems and solve them in advance.
- Educate your staff and administrators.
- Educate the patients in your waiting room with story boards or cautions regarding cast care, or just slippery floors.

We as Orthopedic Technologist are experts our field. We must take leadership roles when it comes to our own health and that of our patients.

**PATIENT SAFETY:** A strong emphasis has been placed on the accuracy of patient information. Patient labels, I. D. arm bands, date of birth and verbal identification of patients are all critical points when identifying a patient. Surgeons are now required to “Sign The Site”, that is they must put their written initials on the patients affected limb PRIOR to going in for surgery. In the O.R. a “Time Out” is taken to verify that this is the right patient and the appropriate limb has been designated.

Is the person you are treating the right person? How many times have you called out a name to a row of patients and had someone respond to “Tom Byrne” when their actual name was Joel Smith? It really does happen! Folks are anxious to get out of that waiting room; they’ll answer to anything just to get behind that door!

How do you identify a patient who is confused, or non-responsive? Was it the left or right side for the splint or was the cast on the left? You, the Orthopedic Technologist, the one treating the patient, must know definitively exactly who you are treating, what your treating them for, who the ordering physician is and which limb and in what position the device or cast is to be applied. That’s a lot of information. Is it on the written order? Is it written down, word for word, as a verbal order? If not then you are going to assume you know what you’re doing. There is an attorney waiting for you as well as a patient who has a left SAC as treatment for her right navicular (tarsal) fx. Oops!

Date of birth and first name are great ways of differentiating patients who have similar names or speak another language.

Write “right” or “left.” How many times have you changed the R to an L?