Safety NCLEX Review

I. Environmental Safety

A. Fire Safety

“RACE”

- **R**escue clients who are in immediate danger.
- **A**ctivate the fire alarm.
- **C**onfine the fire.
- **E**xtinguish the fire.

“PASS”

- **P**ull the pin on the fire extinguisher.
- **A**im at the base of the fire.
- **S**queeze the extinguisher handle.
- **S**weep the extinguisher from side to side to coat the area of the fire evenly.

Further actions by the nurse:

1. Keep open spaces free of clutter.
2. Clearly mark fire exits.
3. Know the locations of all fire alarms, exits, and extinguishers (
4. Know the telephone number for reporting fires.
5. Know the fire drill and evacuation plan of the agency.
6. Never use the elevator in the event of a fire.
7. Turn off oxygen and appliances in the vicinity of the fire.
8. In the event of a fire, if a client is on life support, maintain respiratory status manually with an Ambu bag (resuscitation bag) until the client is moved away from the threat of the fire and can be placed back on life support.
9. In the event of a fire, ambulatory clients can be directed to walk by themselves to a safe area and, in some cases, may be able to assist in moving clients in wheelchairs.
10. Bedridden clients generally are moved from the scene of a fire by stretcher, their bed, or wheelchair.
11. If a client must be carried from the area of a fire, appropriate transfer techniques need to be used.
12. If fire department personnel are at the scene of the fire, they will help to evacuate clients.

B. Electrical safety

1. Electrical equipment must be maintained in good working order and should be grounded; otherwise, it presents a physical hazard.
2. Use a 3-pronged electrical cord.
3. In a 3-pronged electrical cord, the third, longer prong of the cord is the ground; the other 2

prongs carry the power to the piece of electrical equipment.
4. Check electrical cords and outlets for exposed, frayed, or damaged wires.
5. Avoid overloading any circuit.
6. Read warning labels on all equipment; never operate unfamiliar equipment.
7. Use safety extension cords only when absolutely necessary, and tape them to the floor with electrical tape.
8. Never run electrical wiring under carpets.
9. Never pull a plug by using the cord; always grasp the plug itself.
10. Never use electrical appliances near sinks, bathtubs, or other water sources.
11. Always disconnect a plug from the outlet before cleaning equipment or appliances.
12. If a client receives an electrical shock, turn off the electricity before touching the client.

NCLEX!!! Any electrical equipment that the client brings into the health care facility must be inspected for safety before use.

C. Radiation safety

1. Know the protocols and guidelines of the health care agency.
2. Label potentially radioactive material.
3. To reduce exposure to radiation, do the following:

- Limit the time spent near the source.
- Make the distance from the source as great as possible.
- Use a shielding device such as a lead apron.

1. Monitor radiation exposure with a film (dosimeter) badge.
2. Place the client who has a radiation implant in a private room.
3. Never touch dislodged radiation implants.
4. Keep all linens in the client's room until the implant is removed.

D. Disposal of infectious wastes

1. Handle all infectious materials as a hazard.
2. Dispose of waste in designated areas only, using proper containers for disposal.
3. Ensure that infectious material is labeled properly.
4. Dispose of all sharps immediately after use in closed, puncture-resistant disposal containers that are leak-proof and labeled or color-coded.

NCLEX!!! Needles (sharps) should not be recapped, bent, or broken because of the risk of accidental injury (needle stick).

E. Physiological changes in the older client that increase the risk of accidents

Musculoskeletal Changes - Strength and function of muscles decrease. Joints become less mobile and bones become brittle. Postural changes and limited range of motion occur.

Nervous System - Changes Voluntary and autonomic reflexes become slower. Decreased ability to respond to multiple stimuli occurs. Decreased sensitivity to touch occurs.

Sensory - Changes Decreased vision and lens accommodation and cataracts develop. Delayed transmission of hot and cold impulses occurs. Impaired hearing develops, with high-frequency tones less perceptible.

Genitourinary - Changes Increased nocturia and occurrences of incontinence may occur.

F. Risk for falls assessment

1. Should be client-centered and include the use of a fall risk scale per agency procedures
2. Include the client's own perceptions of their risk factors for falls and their method to adapt to these factors. Areas of concern may include gait stability, muscle strength and coordination, balance, and vision.
3. Assess for any previous accidents.
4. Assess with the client any concerns about their immediate environment, including stairs, use of throw rugs, grab bars, or a raised toilet seat.
5. Review the medications that the client is taking that could have a side or adverse effect or side/ adverse effects that could place the client at risk for a fall.
6. Determine any scheduled procedures that pose risks to the client.

G. Measures to prevent falls

- Assess the client's risk for falling.
- Assign the client at risk for falling to a room near the nurses' station.
- Alert all personnel to the client's risk for falling.
- Assess the client frequently.
- Orient the client to physical surroundings.
- Instruct the client to seek assistance when getting up.
- Explain the use of the nurse call system.
- Use safety devices such as floor pads, and bed or chair alarms that alert health care personnel of the person getting out of bed or a chair.
- Keep the bed in the low position with side rails adjusted to a safe position (follow agency policy).
- Lock all beds, wheelchairs, and stretchers.
- Keep clients' personal items within their reach.
- Eliminate clutter and obstacles in the client's room.
- Provide adequate lighting.
- Reduce bathroom hazards.
- Maintain the client's toileting schedule throughout the day.

Using Bed and Chair Monitoring Devices:

H. Measures to promote safety in ambulation for the client

1. Gait belt may be used to keep the center of gravity midline.

- Place the belt on the client prior to ambulation.
- Encircle the client's waist with the belt.
- Hold on to the side or back of the belt so that the client does not lean to 1 side.
- Return the client to bed or a nearby chair if the client develops dizziness or becomes

unsteady.

I. Steps to prevent injury to the health care worker

- Use available safety equipment.
- Keep the weight to be lifted as close to the body as possible.
- Bend at the knees.
- Tighten abdominal muscles and tuck the pelvis.
- Maintain the trunk erect and knees bent so that multiple muscle groups work together in a coordinated manner

J. Restraints (safety devices)

1. Restraints (safety devices) are protective devices used to limit the physical activity of a client or to immobilize a client or an extremity.

- The agency policy should be checked when applying side rails.
- The use of side rails is not considered a restraint when they are used to prevent a sedated client from falling out of bed.
- The client must be able to exit the bed easily in case of an emergency when using side rails. Only the top 2 side rails should be used.
- The bed must be kept the in the lowest position when using side rails.

2. Physical restraints restrict client movement through the application of a device.

3. Chemical restraints are medications given to inhibit a specific behavior or movement.

4. Interventions

- Use alternative devices, such as pressure sensitive beds or chair pads with alarms or other types of bed or chair alarms, whenever possible.
- If restraints are necessary, the health care provider's (HCP's) prescriptions should state the type of restraint, identify specific client behaviors for which restraints are to be used, and identify a limited time frame for use.
- The HCP's prescriptions for restraints should be renewed within a specific time frame according to agency policy.
- Restraints are not to be prescribed PRN (as needed).
- The reason for the safety device should be given to the client and the family, and their permission should be sought.
- Restraints should not interfere with any treatments or affect the client's health problem.
- Use a half-bow or safety knot (quick release tie) or a restraint with a quick release buckle to secure the device to the bed frame or chair, not to the side rails.
- Ensure that there is enough slack on the straps to allow some movement of the body part.
- Assess skin integrity and neurovascular and circulatory status every 30 minutes and remove the safety device at least every 2 hours to permit muscle exercise and to promote circulation (follow agency policies).
- Continually assess and document the need for safety devices.
    - Reason for safety device
    - Method of use for safety device

    - Date and time of application of safety device
    - Duration of use of safety device and client's response
    - Release from safety device with periodic exercise and circulatory, neurovascular, and skin assessment
    - Assessment of continued need for safety device
    - Evaluation of client's response
- Offer fluids if clinically indicated every 2 hours.
- Offer bedpan or toileting every 2 hours.

NCLEX!!! An HCP's prescription for use of a safety device (restraint) is needed. Alternative measures for safety devices should always be used first.

5. Alternatives to safety devices

- Orient the client and family to the surroundings.
- Explain all procedures and treatments to the client and family.
- Encourage family and friends to stay with the client and use sitters for clients who need supervision.
- Assign confused and disoriented clients to rooms near the nurses' station.
- Provide appropriate visual and auditory stimuli, such as a night light, clocks, calendars, television, and a radio, to the client.
- Place familiar items, such as family pictures, near the client's bedside.
- Maintain toileting routines.
- Eliminate bothersome treatments, such as nasogastric tube feedings, as soon as possible.
- Evaluate all medications that the client is receiving.
- Use relaxation techniques with the client.
- Institute exercise and ambulation schedules as the client's condition allows.
- Collaborate with the HCP to evaluate oxygenation status, vital signs, electrolyte/laboratory values, and other pertinent assessment findings that may provide information about the cause of the client's confusion.

K. Poisons

1. A poison is any substance that impairs health or destroys life when ingested, inhaled, or otherwise absorbed by the body.
2. Specific antidotes or treatments are available only for some types of poisons.
3. The capacity of body tissue to recover from a poison determines the reversibility of the effect.
4. Poison can impair the respiratory, circulatory, central nervous, hepatic, gastrointestinal, and renal systems of the body.
5. The toddler, the preschooler, and the young school-age child must be protected from accidental poisoning.
6. In older adults, diminished eyesight and impaired memory may result in accidental ingestion of poisonous substances or an overdose of prescribed medications.
7. A Poison Control Center phone number should be visible on the telephone in homes with small children; in all cases of suspected poisoning, the number should be called immediately.
8. Interventions

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    - Remove any obvious materials from the mouth, eyes, or body area immediately.
    - Identify the type and amount of substance ingested.
    - Call the Poison Control Center before attempting an intervention.
    - If the victim vomits or vomiting is induced, save the vomitus if requested to do so, and deliver it to the Poison Control Center.
    - If instructed by the Poison Control Center to take the person to the emergency department, call an ambulance.
    - Never induce vomiting following ingestion of lye, household cleaners, grease, or petroleum products.
    - Never induce vomiting in an unconscious victim.

NCLEX!!! The Poison Control Center should be called first before attempting an intervention.

II. Health Care–Associated (Nosocomial) Infections

A. Health care–associated (nosocomial) infections also are referred to as hospital-acquired infections.

B. These infections are acquired in a hospital or other health care facility and were not present or incubating at the time of a client's admission.

C. Clostridium difficile is spread mainly by hand-to-hand contact in a healthcare setting. Clients taking multiple antibiotics for a prolonged period are most at risk.

D. Common drug-resistant infections: Vancomycin resistant enterococci, methicillin-resistant Staphylococcus aureus, multidrug-resistant tuberculosis, carbapenem-resistant Enterobacteriaceae (CRE)

E. Illness and some medications such as immunosuppressants impair the normal defense mechanisms.

F. The hospital environment provides exposure to a variety of virulent organisms that the client has not been exposed to in the past; therefore, the client has not developed resistance to these organisms.

G. Infections can be transmitted by health care personnel who fail to practice proper hand-washing procedures or fail to change gloves between client contacts.

H. At many health care agencies, dispensers containing an alcohol-based solution for hand sanitization are mounted at the entrance to each client's room; it is important to note that alcohol-based sanitizers are not effective against some infectious agents such as Clostridium difficile spores.

III. Emergency Response Plan and Disasters

A. Know the emergency response plan of the agency.

B. Internal disasters are those that occur within the health care facility.

C. External disasters occur in the community, and victims are brought to the health care facility for care.

D. When the health care facility is notified of a disaster, the nurse should follow the guidelines specified in the emergency response plan of the facility.