COMPREHENSIVE TESTING
Core Competency Reading Material
January 2015
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ABUSE AND NEGLECT

Core Competency Reading Material

December 2014

Introduction

Anyone, any age, can be a victim of abuse, neglect, and/or assault.

Abuse is defined as treating (a person or an animal) with cruelty or violence, especially regularly or repeatedly.

Neglect is defined as the state or fact of being uncared for or fail to care for properly.

Assault is defined as making a physical attack on.

Anyone can be a victim of physical or psychological abuse or neglect and/or physical assult. The signs and symptoms are often the same, regardless of age or sex; these include: burns, bruises, fractures, poor hygiene, malnutrition, and behavioral changes. Often, injuries are not visible because they are on areas normally covered by clothing.

They three groups that are the most vulnerable to abuse are: elderly, children and women.

Forms of Abuse and Neglect

Physical Abuse

Physical abuse is an act that results in bodily harm, injury, impairment, or disease. It usually takes the form of hitting, slapping, pushing, punching, pinching, burning, or striking. It may also include sexual coercion or assault, incorrect positioning of an elder, forced feeding, and improper use of physical restraints. Some forms of physical abuse are hard to recognize, including:
Rushing an elder or pulling him too fast when helping him walk.

Tying a wandering elder to a chair so he will not get lost while the healthcare provider is busy.

Giving an elder too much or too little medication.

**Psychological Abuse**

Psychological abuse inflicts emotional pain or distress on its victims. It comprises of verbal scolding, harassment or intimidation, threatening punishment or deprivation, treating the victim like a child or infant, or isolating the elder from family, friends, or social activities. Generally, the victim’s demeanor and behavior offer clues of abuse. Depression, fear, hopelessness, withdrawal, or isolation can signal psychological abuse.

You may not recognize some of the more subtle forms of psychological abuse, such as taking something away from a patient/resident when you are angry, scolding someone in front of others when he has done something embarrassing like soiled his pants, or isolating someone. These acts create an environment where the person may feel shame, insecurity, or a lack of control and can be psychologically damaging.

**Financial Abuse**

Financial abuse in the elderly population occurs when someone takes control of their resources through misrepresentation, coercion, or outright theft for their own gain. Financial abuse may include stealing money or possessions, forcing the elder to sign contracts or assign durable powers of attorney to someone, or charging the older adult for unnecessary services or services never rendered. The elderly can be victims of financial abuse, as evidenced by a sudden inability to pay bills or large decreases in bank accounts.

**Physical Neglect**

Physical neglect involves failure to provide goods and services necessary for the health and well-being of an elder. Physical neglect may include withholding adequate meals or hydration, physical therapy, or hygiene. It may also include failure to provide physical aids such as hearing aids, glasses, and false teeth, or safety precautions such as night lights or safety bars. You are neglecting elders if you take your time answering a call bell, if you move the call button out of reach, or if you unplug it, even if the patient/resident uses the call button inappropriately. You are also neglecting someone if you leave that person on the toilet for an extended time, even if you just forgot. If you remove an elder’s cane or walker from the side of the bed and it keeps the person from getting around, you are neglecting that elder. It is also physical neglect if you mark on the chart that the elder was repositioned in bed as ordered in the plan of care, but then fail to do so.
Psychological Neglect

Psychological neglect is failure to provide social stimulation. That may mean leaving an older person alone for long periods of time, ignoring him or giving him “the silent treatment,” or failing to provide companionship, changes in routine, or links to the outside world.

Financial Neglect

Financial neglect consists of failure to use available resources to sustain or restore the health and security of an older adult. Signs might include a family seeking care that does not meet the senior’s needs even though the money is available to provide the proper level of care, or an elder’s confusion about his or her financial situation or a sudden transfer of assets.

Elder Abuse

Elder abuse and neglect is all too common in our society. It is estimated that hundreds of thousands of elders are abused at home and in institutions each year. Our picture of elder abuse is limited, due to the problem’s hidden and complex nature. Many times, victims remain unnoticed and untreated because they are isolated. Another challenge for healthcare workers is that subtle forms of mistreatment can be hard to spot. When you learn how to recognize and respond to mistreatment, you prepare yourself to break the cycle of abuse and neglect. The American Medical Association defines elder abuse and neglect as physical, psychological, or financial mistreatment of an elderly person. It may or may not be intentional, and an older adult will often suffer several forms of abuse and neglect at the same time.

Who is subject to elder abuse or neglect?

Research indicates that older adults from all walks of life can be victims of abuse – men and women from all racial, ethnic, and economic groups. Seniors who are alert, full of life, and independent despite advancing age may fall victim to abuse. Likewise, elders who are more dependent on others because they are physically or mentally frail also experience abuse. Elders aged 80 and older and those with physical or mental impairments are more likely to be abused than are others. Many elderly victims are relatively isolated from society with little, if any, outside support. They are often dependent on their abusers and are reluctant or even too embarrassed to complain. Victims may have mixed feelings about their abusers and thus find it difficult to consider removing themselves from the abuser’s care.

Who are the abusers?

Abusers can be family members, caregivers, or strangers, including both men and women. Family members are most often the abusers outside of healthcare facilities. They may continue abusing elders even after the person has entered a long-term care facility or a hospital. You should keep careful records if any patient or resident routinely develops injuries after a visit from a certain family member. This may reveal a pattern of abuse you need to assess. Strangers can also be abusers, particularly in instances of
assault or financial abuse. Be on the lookout for con artists or anyone who appears out of place in or around the facility. Report suspicious activity to security or to your supervisor.

Why does abuse and neglect occur?
Abuse and neglect can arise from misunderstanding or ignorance. Sometimes people feel frustration with the elderly because they don’t really understand the effects of aging. They fail to give elders the extra time they may need to process information, respond to questions, or perform tasks. Those people may not mean to abuse anyone, but they do. Several risk factors that have been identified as contributors to abuse and neglect include:

- Caregivers with an abusive history may continue that behavior at work
- Caregivers, particularly those with little or no formal training or support, can be overwhelmed by the strain of caring for a dependent elder
- Seniors who are abusive to their caregivers compound the stress factor
- Seniors may have abrasive personalities or have Alzheimer’s disease and a lack of self-control
- Unresolved conflicts between family members or an elder’s history of abusive relationships are warning signs
- Mental illness, alcoholism, or drug abuse – in elders or caregivers – signal the potential for abuse and neglect

It is important to step away from the patient/resident if you feel angry or frustrated. Return only after you have calmed down.

What are the warning signs?
Many times, the possible victim can’t or won’t help you uncover the truth. Physical abuse should be suspected when the reported cause of injuries is inconsistent with medical findings, or if the elder and caregiver give contradictory accounts. Physical evidence may include bruises, welts, lacerations, fractures, burns, and rope or restraint marks. Genital injuries may be symptomatic of sexual abuse.

Signs of neglect may include dehydration, malnutrition, decubitus ulcers, poor personal hygiene, or lack of compliance with medical regimes. You may be encountering psychological abuse or neglect in patients/residents who are extremely withdrawn, depressed or agitated, behaving childishly, or acting indifferently toward others. Financial abuse or neglect should be considered if the senior appears to be receiving an inadequate level of care despite adequate financial resources.

What should be done if abuse or neglect is suspected?
Anytime you suspect abuse or neglect, you must take action. It is your ethical and legal responsibility. Intervene immediately when you see abuse or neglect, even when you just suspect it. Anytime abuse is witnessed, it must be documented and investigated further. When abuse or neglect is suspected, the
patient/resident should be assessed without the suspected abuser present. The patient/resident should be asked directly if someone hurt or threatened them, or took anything without asking. The patient/resident should be asked directly who has abused them. The charge nurse, case manager, or social worker should be alerted immediately if abuse or neglect is suspected. Failure to report can result in a claim of negligence.

**Domestic Violence**

Although domestic violence is usually directed at women, some men have been abused by their wives. Wife abuse is an epidemic. According to the Office on Domestic Violence, there are 3 – 6 million cases of wife abuse each year. Only 1 in 10 cases is reported. Men of all socio-economic classes and races can abuse their wives. Violence against women does not usually occur until the man feels some type of ownership or possession of the woman. The violence escalates, becoming more severe and prolonged. Finally, it is coupled with psychological terrorism.

Battered women usually do not tell a friend, a family member, or the police until they feel that their life is threatened. They do not tell others about abuse by their husbands/male friends primarily because they are in denial, they hope for change, they want to protect their husband/male friend, and/or they fear retaliation from the abuser.

Battered women do not want to hurt their husband/friend. They just want the abuse to stop and to be able to share a healthy, happy relationship. Abuse of wives is almost exclusively a private experience. Battering men are usually very pleasant and generous in public to both their wives and others. The violence can only be dealt with when the situation is no longer kept a secret.

Battered women are fearful and immobilized by abuse. The woman frequently goes through the following psychological phases in dealing with the abuse:

1. Denial
2. Recognition
3. Forgiveness
4. Fear
5. Guilt
6. Failure
7. Depression
8. Anger
9. Change in the Relationship
Domestic violence affects approximately 50% of American families. Approximately 3.3 million children witness their mothers being beaten. Children in violent homes are 15 times more likely to be abused or seriously neglected. Domestic violence is one of the biggest predictors of child abuse. In addition, children in violent homes are more likely to become violent as adults.

What are the Types of Domestic Violence

Below are different types of domestic violence/abuse and examples of how the abuser may act.

Physical Abuse
- Has power and control

Emotional Abuse
- Puts the woman down
- Plays mind games
- Makes her feel bad about herself
- Calls her names

Economic Abuse
- Tries to keep the woman from getting/keeping a job
- Gives her an allowance
- Makes her ask for money

Sexual Abuse
- Makes the woman do sexual things against her will
- Physically attacks the sexual parts of her body
- Treats her like a sex object

Using Children
- Makes the woman feel guilty about attention given to children
- Uses the children to communicate his negative messages to the abused woman

Threats
- Makes and/or carries out threats to hurt her emotionally
- Threatens to take the children, commit suicide, or report her to welfare

Uses Dominating Behavior
- Treats her like a servant
- Makes all the “big” decisions
Acts like the “Master”

Isolation

Controls what she does, who she sees, who she talks to, where she goes

Healthcare workers’ responsibilities for victims of domestic abuse include: providing direct medical care as needed, emotional support, and referral services. If the victim chooses to make the decision to return to a violent home, we must not be judgmental.

Victims of sexual assault should be given appropriate medical care at the time of the assault and provided with emotional support.

Child Abuse

Child abuse is more than bruises and broken bones. While physical abuse might be the most visible, other types of abuse, such as emotional abuse and neglect, also leave deep, lasting scars. The earlier abused children get help, the greater chance they have to heal and break the cycle—rather than perpetuate it.

While physical abuse is shocking due to the scars it leaves, not all child abuse is as obvious. Ignoring children’s needs, putting them in unsupervised, dangerous situations, or making a child feel worthless or stupid are also child abuse. Regardless of the type of child abuse, the result is serious emotional harm.

Types of Child Abuse

There are several types of child abuse, but the core element that ties them together is the emotional effect on the child. Children need predictability, structure, clear boundaries, and the knowledge that their parents are looking out for their safety. Abused children cannot predict how their parents will act. Their world is an unpredictable, frightening place with no rules. Whether the abuse is a slap, a harsh comment, stony silence, or not knowing if there will be dinner on the table tonight, the end result is a child that feel unsafe, uncared for, and alone.

Emotional child abuse

Sticks and stones may break my bones but words will never hurt me? Contrary to this old saying, emotional abuse can severely damage a child’s mental health or social development, leaving lifelong psychological scars. Examples of emotional child abuse include:

- Constant belittling, shaming, and humiliating a child.
- Calling names and making negative comparisons to others.
- Telling a child he or she is “no good,” "worthless," "bad," or "a mistake."
- Frequent yelling, threatening, or bullying.
- Ignoring or rejecting a child as punishment, giving him or her the silent treatment.
- Limited physical contact with the child—no hugs, kisses, or other signs of affection.
- Exposing the child to violence or the abuse of others, whether it be the abuse of a parent, a sibling, or even a pet.

**Child neglect**

Child neglect—a very common type of child abuse—is a pattern of failing to provide for a child's basic needs, whether it be adequate food, clothing, hygiene, or supervision. Child neglect is not always easy to spot. Sometimes, a parent might become physically or mentally unable to care for a child, such as with a serious injury, untreated depression, or anxiety. Other times, alcohol or drug abuse may seriously impair judgment and the ability to keep a child safe.

Older children might not show outward signs of neglect, becoming used to presenting a competent face to the outside world, and even taking on the role of the parent. But at the end of the day, neglected children are not getting their physical and emotional needs met.

**Physical child abuse**

Physical abuse involves physical harm or injury to the child. It may be the result of a deliberate attempt to hurt the child, but not always. It can also result from severe discipline, such as using a belt on a child, or physical punishment that is inappropriate to the child’s age or physical condition.

Many physically abusive parents and caregivers insist that their actions are simply forms of discipline—ways to make children learn to behave. But there is a big difference between using physical punishment to discipline and physical abuse. The point of disciplining children is to teach them right from wrong, not to make them live in fear.

Child abuse is reportable because the child is vulnerable and cannot leave the situation. Typically, a report must be made when the reporter suspects or has reasons to suspect that a child has been abused or neglected. Waiting for absolute proof may result in significant risk to the child. It is not the caregiver’s job to validate the abuse; this is the job of CPS caseworkers or law enforcement officers who have been trained to undertake this type of investigation.

**References**


What is Elder Abuse? Accessed Nov. 2014
http://www.aoa.gov/AoA_programs/elder_rights/EA_prevention/whatisEA.aspx

http://www.domesticviolence.org/
Introduction

Federal law gives every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject, or discontinue.

Federal law also gives every patient/resident the right to be told about the nature of their illness in terms they can understand, the general nature of proposed treatments, the risks of failing to undergo these treatments, and any alternative treatments or procedures that may be available.

The Patient Self-Determination Act (PSDA)

The 1990 Patient Self-Determination Act (PSDA) encourages each individual to make decisions about the types and extent of medical care they want to accept or refuse if they become unable to make those decisions due to illness. The PSDA requires all healthcare agencies to recognize the living will and durable power of attorney for healthcare. The Act applies to hospitals, long-term care facilities, and home health agencies that receive Medicare and Medicaid reimbursements. Under the PSDA, healthcare agencies must ask whether the patient has an advance directive and must give information to patients about their rights under state law.

Each individual receiving medical care in hospitals or extended care facilities (nursing homes), enrolling in HMOs, or entering into hospice or home care agreements must be given certain information in writing. This must include information about state laws regarding the individual’s right to make decisions about medical care (e.g., the right to accept or refuse medical or surgical treatment). Patients
are also entitled to receive information about the right to create an advance directive. Most hospitals have advance directive forms for patients to use if they do not already have one.

**What are Advance Directives?**

Advance directives are documents which state a person’s choices about medical treatment or name someone to make decisions about his/her medical treatment if he/she cannot make his/her own decisions. These documents are called advance directives because they are signed in advance to let healthcare providers know what a person’s wishes are concerning medical treatment.

Advance directives can also include extra instructions about healthcare decisions. For instance, they allow patients to specify when they do not want to be resuscitated, or if they want to make organ or tissue donations.

Advance directives usually let patients include instructions for other situations, too, such as when they may be unconscious for a short time, or are impaired by Alzheimer’s disease or a similar condition.

If a patient does not have a written advance directive, some states recognize spoken (oral) advance directives as legal. Generally, a person may make a verbal statement that is then recorded by someone else and properly witnessed.

Patients/residents may have one or more of these documents. Any patients/residents seeking or receiving healthcare are to be asked if they have an advanced directive. If they do not, they are to be offered information on advance directives. Most states have pre-printed information for patients/residents that are kept on hand at healthcare facilities.

There are many different advance directive formats. Some follow forms outlined in state laws. Others are created by lawyers or even the patients themselves. State law and the courts decide whether these documents are valid. All states and the District of Columbia have laws about advance directives, but the documents may be called different names in different states.

**Types of Advance Directives**

Types of advance directives vary based on state law and individual preferences within the state’s legal requirements. The two most common types of advance directives are the living will and the durable power of attorney for healthcare, which is sometimes called the health care power of attorney or health care proxy.

The living will covers healthcare decisions when patients are terminally ill and unable to make decisions, or permanently unconscious.

The durable power of attorney for health care allows patients to name an agent or proxy (substitute person) to make healthcare decisions if the time comes when they are unable to do so.
The Living Will

A living will is a document designed to control future healthcare decisions when a patient becomes unable to make decisions and choices on their own.

State laws vary, but generally allow doctors to discontinue trying to prolong life in the case of terminal illness (i.e., one that cannot be cured) or permanent unconsciousness (often called a “persistent vegetative state”). If a person has hope of recovery, the living will generally does not apply. The living will describes the type of medical treatment the person would want in these situations and under what conditions an attempt to prolong life should begin or end. This applies to treatments such as dialysis, tube feedings, or artificial life support.

The living will is a formal legal document that must be written and signed by the patient. Some state laws include a model form. For most states, the form is optional, but others require that their form be used. Most laws require that the document is witnessed and notarized. Spouses, potential heirs, a doctor caring for the patient, or employees of healthcare facilities are usually not allowed to witness living wills.

There are many things to think about when drafting a living will. These include:

- The use of equipment such as dialysis (kidney) machines or ventilators (breathing machines)
- “Do not resuscitate” orders (instructions to NOT use CPR if breathing or heartbeat stops)
- Whether fluids (usually by IV) and/or nutrition (tube feeding into the stomach) is to be given if he/she cannot eat or drink
- Whether food and fluids should be administered even if he/she is not able to make other decisions
- Whether treatment for pain, nausea, or other symptoms would be given even if he/she is not able to make other decisions (this may be called “comfort care”)
- Whether he/she wishes to donate organs or other body tissues

It is also important to note that choosing to not have “aggressive medical treatment” is different from refusing all medical care. A person can still get antibiotics, nutrition, pain medicines, and other treatments. The difference is that the goal of treatment becomes comfort rather than cure.

Patients may revoke (end or take back) a living will at any time. A few states will automatically void the living will after a certain number of years.

A living will is more limited than a healthcare power of attorney. The living will generally applies only when a patient is unable to speak for his/her self and is terminally ill or permanently unconscious. It also only gives written instructions about certain things that might happen and does not cover every healthcare situation that could arise. A living will does not include choosing an agent or proxy to make decisions or ensure that wishes are carried out.
Durable Power of Attorney for Healthcare

A durable power of attorney for healthcare is also called a healthcare power of attorney. It is a legal document in which patients choose a proxy (agent) to make healthcare decisions for them if they become unable to do so.

The proxy can speak with doctors and other caregivers on behalf of the patient and make decisions according to directions given earlier. The person chosen decides which treatments or procedures the patient would want. If the patient’s wishes in a certain situation are not known, the agent will decide based on what he or she thinks the patient would want and what he or she considers to be in line with their wishes. Some states restrict the ability of agents to carry out some requests. For example, a few states do not allow agents to stop artificial nutrition (feeding) and hydration (giving fluids).

The person named as the proxy or agent should be someone the patient can trust to carry out their wishes. If needed, this person must be able to do this in a time of great stress, uncertainty, and sadness. Patients are encouraged to talk to their proxy to ensure that he or she is comfortable in this role. The law does not allow the agent to be a doctor, nurse, or other person providing healthcare to the patient at the time chosen, unless that person is a close relative.

State laws that allow a proxy or agent to be chosen usually require that the request be in writing, signed by the person choosing the proxy, and witnessed. In many cases, the proxy also signs the document. Some states have a special form for this.

The “Five Wishes” and Similar Directives

Advance directives vary greatly by state, but many states allow patients to include instructions for certain situations, such as when they are unconscious for a short time, or are impaired by Alzheimer’s disease. For example, the “Five Wishes” form, recognized in 42 states as of 2011, asks the patient whom they would want to make their healthcare decisions if they cannot, their choice of medical treatment, how they want to be treated, instructions on comfort care, and final expressions or wishes for family and friends.

“Do Not Resuscitate” Orders

While in a hospital, patients can ask their doctor to add a “Do Not Resuscitate” or DNR order to their medical record. This is done when the patient does not want the hospital staff to try to revive them if their heart or breathing stops. Some hospitals require a new DNR each time a patient is admitted. In-patient DNR orders are only good while the patient is in the hospital.

Some states have an advance directive that is called a “Do Not Attempt Resuscitation” (DNAR) or “Out-of-Hospital Do Not Resuscitate” (DNR) order for use outside of the hospital. The out-of-hospital DNR or DNAR is intended for Emergency Medical Service (EMS) teams, who answer 911 calls and are usually required to try to revive and prolong life in every way they can. Even though families expecting a death are advised to call other sources for help, when the patient worsens a moment of uncertainty
sometimes results in a 911 call. This can mean unwanted measures that prolong life. The out-of-hospital DNR or DNAR order offers a way for patients to refuse the full resuscitation effort in advance, even if EMS is called. It must be signed by both the patient and the doctor.

Situations Involving Advance Directives

Terminal Illness

State definitions of terminal illness may make a living will less useful. A terminal illness is an irreversible condition that in the near future will result in death or a state of permanent unconsciousness from which you are unlikely to recover. In most states, a terminal illness is defined as one in which the patient will die “shortly” whether or not medical treatment is given. Still, state definitions vary. For example, some states require death to be expected within a certain number of hours or days. In those states, life-sustaining treatment could continue, even though the patient is terminally ill and mentally incompetent, until just hours or days before death would be expected.

Permanent Unconsciousness

State definitions of permanent unconsciousness are more precise, but in some cases are also limiting. A persistent vegetative state results from a partial death of the brain from which a person cannot recover. It is different from a coma, because sometimes patients wake up from comas. The diagnosis of persistent vegetative state takes time to make. A person in a persistent vegetative state may survive for years on artificial feeding and other life support, so a few states do not permit life-sustaining treatment to be stopped in these cases. On the other hand, all states have legally adopted a standard definition of brain death as an “irreversible cessation (stopping) of all functions of the entire brain, including the brainstem.” Brain death is when all parts of the brain have stopped working. It is determined by a flat electroencephalogram (EEG) and certain medical signs. When brain death happens, the person is considered dead, and life support can be stopped.

Pregnant patients should also very clearly state their decisions in case something happens during pregnancy. Whether the healthcare provider will honor decisions at this time depends on the following:

- The risks to both mother and the fetus
- How far along the pregnancy is
- The policies of the doctors and health care facilities involved

In most cases, in the second or third trimester of pregnancy, doctors will give all the medical care they think is necessary to keep both mother and fetus alive.
Organ Donation

Organ and tissue donation instructions can be included in advance directives. Many states also provide organ donor cards or add notations to driver’s licenses.

Patients/residents may have one or more of these documents. Any patients/residents seeking or receiving healthcare are to be asked if they have an advanced directive and if they do not—they are to be offered information on advanced directives. Most states have pre-printed information for patients/residents that are kept on hand at health care facilities.

References


AGE SPECIFIC

Core Competency Reading Material

December 2014
### Newborn/Infant: Birth – 1 Year

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<td>Head circumference increases rapidly during the first year of life as the brain increases in size. By an infant’s first birthday, the brain is 2/3 of its adult size. Skull fontanels are not usually fused until 16-18 months. Temp: 97.6°F-98.6°F (oral/tympanic); 99.6°F (rectally) Heart Rate: newborn rate range of 120-160 bpm to 100-120 bpm by 1 year of age Respiration: 20-40 breaths/min (by 1 year of age) Blood Pressure: 80/40 to 100/60 mmHg Height: Grow about 1-2 inches per month Weight: Gain 1-2 lbs. per month (21-22 lbs. by 1 year) Most double their birth weight at 4-6 months, and triple it by 1 year. Abdomen protrudes. Physiologic system matures.</td>
<td>Able to recognize faces Respond to light and can see objects at a distance of 20 ft. Near and far distance is blurred. Color vision usually improves at 1-2 months of age. Hearing is sensitive from birth. Newborns can hear a wide variety of sounds. Prefer complex sounds such as noises and voices Develop neck and leg muscle strength Develop intentional rather than reflexive muscle movements Begin to grasp objects Can shake a rattle or other object Drop objects when no longer interested in them</td>
<td>Begin to imitate the behavior of others Communicate problems by crying or through body posture Have short attention spans Tie words to actions and can understand simple directions</td>
<td>Establish trust in the caregiver(s) and the world around that life’s essential needs will be provided Need to be held close and feel secure May speak first word by 12 months of age Anxiety in the parents may be transmitted to an infant. Loud noises, bright lights, and sudden environmental changes can trigger the startle response.</td>
<td>Sudden infant death syndrome Congenital malformations Unintentional injuries Septicemia Homicide Influenza and pneumonia</td>
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## Toddler: 1 – 3 Years

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| Growth slows considerably. Head circumference is usually equal to chest circumference by 1-2 years. Usual total increase in head circumference during the second year is 1 inch. Height: Grow about 3 inches per year and growth occurs mainly in elongation of the legs rather than the trunk. Weight: Gain 4-6 lbs. per year Birth weight is quadrupled by 2½ years. Temp: 99.0°F–99.7°F (oral/tympanic) Heart Rate: 80-120 bpm Respirations: 20-30 breaths/min Blood Pressure: 90/50 to 100/60 mmHg Begin to walk independently at about 15 months and progress to running, jumping, and climbing at about 18 to 24 months By end of the 2nd year, can stand on one foot, walk on tiptoe, and climb stairs with alternate footing Able to feed themselves At 12 months, able to grasp a small object, but unable to release it at will At 15 months, can build a tower of two cubes By 18 months, can throw a ball overhand without losing balance Achieve visual acuity of 20/20 Develop taste preferences Language development begins with generally a few words and short phrases or sentences. Develop concepts by the use of language See things from their own point of view and can group similar things and shapes Generally have short attention spans Concepts with memory begin to develop Like to imitate and copy gestures and words Begin to tie words to actions and begin to understand simple directions and requests Identify parents as the significant persons in their environment Capable of exploring and manipulating their environment Assert independence and control with a sense of will Express temper when they do not get their way Develop an understanding of their gender Able to put toys away, play simple games, enjoy being read to, and can play alone A favorite toy or blanket can provide security when stressed, tired, or separated from parents. Toilet training Unintentional injuries Congenital anomalies Homicide Malignant neoplasms Heart disease Influenza and pneumonia Septicemia
## Preschooler: 4 – 6 Years

<table>
<thead>
<tr>
<th>PHYSICAL</th>
<th>MOTOR SENSORY ADAPTATION</th>
<th>COGNITIVE</th>
<th>PSYCHOSOCIAL</th>
<th>COMMON DISEASES/DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature: 97.6°F-98.6°F (oral/tympanic); 99.6°F (rectal)</td>
<td>By age 4, proficiently skip and hop on one foot and catch a ball consistently</td>
<td>Language in preschool is of two main types: egocentric and socialized. Egocentric speech fails to take into account the listener’s needs and may be used to guide behavior rather than communicate. Socialized speech is intended to communicate.</td>
<td>The important event in this stage is independence. Continue to become more assertive and to take more initiative. The significant relationship is family. Harbor the greatest number of new fears. Common fears are: The unknown Darkness Mutilation Bodily injury Being left alone</td>
<td>Unintentional injuries Malignant neoplasms Congenital anomalies Homicide Heart disease Benign neoplasms Septicemia</td>
</tr>
<tr>
<td>Heart Rate: 70-110 bpm</td>
<td>By age 5-6, skip on alternate feet, jump rope, and begin to skate and swim</td>
<td>Learn through simple imitation, requiring interaction with adults 6-year-olds use complex grammar and have a vocabulary of some 2,500 words. Communication ability improves as egocentrism diminishes.</td>
<td></td>
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</tr>
<tr>
<td>Respiration: 20-25 breaths/min</td>
<td>Show rapid gains in hand-eye coordination</td>
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<tr>
<td>Blood Pressure: 95-105/53-66 mmHg</td>
<td>Fine motor development is evident in the child’s increasingly skillful manipulation, such as drawing and dressing.</td>
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<tr>
<td>Height: Minimal change (2-3½ in or 6-8 cm per year)</td>
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</tr>
<tr>
<td>Weight: Weight gain is slight (avg 4.5 lbs./2kg per year)</td>
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</tr>
<tr>
<td>Become thinner and taller during this stage of development.</td>
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</tbody>
</table>
**School Age: 7 – 12 Years**

<table>
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<tr>
<th>PHYSICAL</th>
<th>MOTOR SENSORY ADAPTATION</th>
<th>COGNITIVE</th>
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<th>COMMON DISEASES/DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height: Grow an average of 2 inches per year</td>
<td>By age 7, able to use eating utensils and some tools; have developed skills for drawing and painting; cut, fold, and paste paper; color within lines of pictures; and learn to roller skate, skip rope, and ride a bicycle</td>
<td>Develop an understanding of relationships between things and ideas</td>
<td>The peer group assumes an increasingly important role. The peer group has a powerful influence on the self-concept of the child and is important in the development of identity and values.</td>
<td>Unintentional injuries</td>
</tr>
<tr>
<td>Weight: Gain 4-6½ pounds per year</td>
<td>By ages 8-10, able to use a knife and fork simultaneously; learn to thread a needle and tie a knot; become proficient at writing in cursive; learn to play jacks and marbles; can catch, throw (70 feet), and hit a baseball; and engage in alternate rhythmic hopping and complex styles of skipping rope accompanied by verbal jingles</td>
<td>Able to use thought processes and experience events and actions</td>
<td>It is also a powerful socializing agent.</td>
<td>Malignant neoplasms</td>
</tr>
<tr>
<td>Boys tend to be slightly taller and heavier than girls.</td>
<td>By ages 11-12, learn to peel apples and potatoes; sew simple garments on a machine; build simple objects; learn to play a musical instrument; can do a standing long jump of 5 ft.; can do a standing high jump of 3 ft.; and play games involving simultaneous use of two or more complex motor skills.</td>
<td>Able to master symbols and use their memory store of past experiences in evaluating and interpreting the present</td>
<td>Can assist in household chores</td>
<td>Suicide</td>
</tr>
<tr>
<td>Dental growth is prominent. By 12 years, all primary teeth have been shed and the majority of permanent teeth have erupted.</td>
<td>Master the concept of conservation</td>
<td>Master the concept of conservation</td>
<td>Able to participate in quiet as well as active games</td>
<td>Congenital anomalies</td>
</tr>
<tr>
<td>Posture is more similar to an adult’s.</td>
<td>Develop classification skills</td>
<td>Develop classification skills</td>
<td>Have an understanding of the importance of caring for a pet</td>
<td>Homicide</td>
</tr>
<tr>
<td>Facial bones grow and remodel. In girls 10-12, pubescent changes may begin to appear.</td>
<td>Acquire the ability to read</td>
<td>Acquire the ability to read</td>
<td></td>
<td>Heart disease</td>
</tr>
</tbody>
</table>

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## Adolescence: 13 – 18 Years

<table>
<thead>
<tr>
<th>PHYSICAL</th>
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<th>COGNITIVE</th>
<th>PSYCHOSOCIAL</th>
<th>COMMON DISEASES/DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid growth of skeletal size, muscle mass, adipose tissue, and skin</td>
<td>Awkward in gross motor activity</td>
<td>Increased ability to use abstract thought and logic</td>
<td>Interested and confused by own development</td>
<td>Trauma</td>
</tr>
<tr>
<td>Maturation of the reproductive system; development of primary and secondary sexual characteristics</td>
<td>Easily fatigued</td>
<td>Able to handle hypothetical situations or thoughts</td>
<td>Often critical of own features and concerned with physical appearance</td>
<td>Homicide</td>
</tr>
<tr>
<td>Onset of menarche in girls and nocturnal emissions in boys</td>
<td>Early adolescents may need more rest and sleep.</td>
<td>Able to use introspection</td>
<td>Belonging to a peer group is important and valued; may criticize parents</td>
<td>Suicide</td>
</tr>
<tr>
<td>Vital signs approximate to those of the adult</td>
<td>Fine motor skills are improving.</td>
<td>Develop more internal growth of self-esteem</td>
<td>Interested in the opposite sex: achieving female/male social role</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Beginning development of occupational identity (what I want to be)</td>
<td>Accept criticism or advice reluctantly</td>
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<td></td>
<td>Long for independence but also desire dependence</td>
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<td></td>
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<td></td>
<td>Achieve new and more mature relations</td>
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<td></td>
<td>Participate in physical activities that are socially determined</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Identity is threatened by hospitalization because adolescents are concerned about bodily changes and appearances</td>
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## Early Adulthood: 19 – 45 Years

<table>
<thead>
<tr>
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<th>COMMON DISEASES/DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth of skeletal system continues until age 30. Skin begins to lose moisture. Muscular efficiency is at its peak between 20-30 years. GI system decreases secretions after age 30.</td>
<td>Visual changes in accommodation and convergence Some loss in hearing, especially high tones</td>
<td>Mental abilities reach their peak during the 20’s (reasoning, creative imagination, information recall, and verbal skills).</td>
<td>Searching for and finding a place for self in society Initiating a career, finding a mate, developing loving relationships, marriage, establishing a family, and parenting Begin to express concerns for health Achievement-oriented; working up the career ladder Move from dependency to responsibility Responsible for children and aging parents</td>
<td>Trauma HIV Malignancies Heart disease</td>
</tr>
</tbody>
</table>
## Middle Adulthood: 46 – 60 Years

<table>
<thead>
<tr>
<th>PHYSICAL</th>
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<th>COGNITIVE</th>
<th>PSYCHOSOCIAL</th>
<th>COMMON DISEASES/DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone mass begins to decrease.</td>
<td>Slowing of reflexes</td>
<td>Mood swings</td>
<td>Future-oriented or self-absorbed</td>
<td>Malignancy</td>
</tr>
<tr>
<td>Loss of skeletal height; calcium loss occurs, especially after menopause.</td>
<td>Muscle activity may increase or decrease.</td>
<td>Decreased short-term memory or recall</td>
<td>May experience empty nest syndrome, expressed positively or negatively</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Decreased muscle strength and mass if not used; endurance declines.</td>
<td>Visual changes, especially farsightedness</td>
<td>Re-evaluation of current lifestyle and value system</td>
<td>Working way up career ladder</td>
<td>Trauma</td>
</tr>
<tr>
<td>Loss of skin elasticity, dry skin, and increased appearance of wrinkles.</td>
<td>Noticeable loss of hearing and taste</td>
<td>Synthesis of new information is decreased.</td>
<td>Adjustment to changes in body image</td>
<td>Cerebrovascular conditions</td>
</tr>
<tr>
<td>Decreased renal functioning, metabolic rate, heat/cold tolerance, and more prone to infection.</td>
<td>Muscles and joints respond more slowly.</td>
<td>Decrease in mental performance speed</td>
<td>Mid-life crisis</td>
<td></td>
</tr>
<tr>
<td>Receding hairline in males, more facial hair in females</td>
<td>Decreased balance and coordination</td>
<td></td>
<td>Recognition of limitations</td>
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</tr>
<tr>
<td></td>
<td>More prolonged response to stress</td>
<td></td>
<td>Adjustment to possibility of retirement and life-style modifications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Slowing of reflexes</td>
<td>fade in and out</td>
<td>Measuring accomplishments against goals</td>
<td></td>
</tr>
</tbody>
</table>

**Future-oriented or self-absorbed**
- May experience empty nest syndrome, expressed positively or negatively
- Working way up career ladder
- Adjustment to changes in body image
- Mid-life crisis
- Recognition of limitations
- Adjustment to possibility of retirement and life-style modifications
- Measuring accomplishments against goals
Late Adulthood (Geriatric): 61 – 79 Years

<table>
<thead>
<tr>
<th>PHYSICAL</th>
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<th>COGNITIVE</th>
<th>PSYCHOSOCIAL</th>
<th>COMMON DISEASES/DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased tolerance to heat/cold</td>
<td>Decreased visual acuity</td>
<td>Decline depends upon earlier cognitive abilities, general health, and involvement in society.</td>
<td>Retirement</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Decreased peripheral circulation</td>
<td>Hearing loss</td>
<td>Sharing wisdom with others</td>
<td>Death of spouse and friends; acceptance of death</td>
<td>Malignancy</td>
</tr>
<tr>
<td>Declining cardiac/renal function</td>
<td>Decreased sensitivity of taste buds and smell</td>
<td>Shifting in memory; slowing of mental functions</td>
<td>Adapting to change of social role</td>
<td>Cerebrovascular disease</td>
</tr>
<tr>
<td>Decreased response to stress and sensory stimuli</td>
<td>Decreased tolerance to pain</td>
<td></td>
<td>Developing supportive relationships</td>
<td>COPD and lung disease</td>
</tr>
<tr>
<td>Atrophy of reproductive organs</td>
<td>Hesitant to respond; skills declining</td>
<td></td>
<td>Pursuing second career, interests, hobbies, community activities, and leisure activities</td>
<td></td>
</tr>
<tr>
<td>Loss of teeth, leading to changes in food intake</td>
<td></td>
<td></td>
<td>Coming to terms with accomplishments</td>
<td></td>
</tr>
<tr>
<td>More skeletal changes</td>
<td></td>
<td></td>
<td>Children leave home; reestablished as a couple; grandparenthood</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Concern for health increases.</td>
<td></td>
</tr>
</tbody>
</table>
Age Specific Interventions

Newborn/Infant

General
Encourage parent to participate in care: bathing, feeding, and holding.
Encourage parent to respond to cries and to meet the infant’s needs consistently.
Teach parent to be aware of rapidly changing locomotive ability.

Clinical
Handle the infant gently and speak in a soft, friendly tone of voice.
Maintain eye contact.
Use a security toy or pacifier to reduce the infant’s anxiety and elicit cooperation.

Toddler

General
Encourage expression of fears.
Encourage self-care and decision-making when possible.
Teach parents safety measures that guard against the child’s increased motor ability and curiosity.

Encourage parents to allow for brief periods of separation under familiar surroundings.
Provide child with peer companionship.
Tell the truth.

Clinical
Allow child to perform some self-care tasks.
Give the child simple, direct, and honest explanations just before treatment or surgery.
Use puppets or coloring books to explain procedures.
Let the child play with equipment to reduce anxiety.
Give the child choices whenever possible.
Allow for expression of fear, pain, and/or displeasure.
Expect resistant behavior to treatments; reinforce treatments, not punishments.

Preschooler

General
Encourage expression of fears.

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Practice definite limit-setting behavior.
Offer choices.
Allow child to express anger verbally, but limit motor aggression.
Teach safety precautions about strangers.
Teach parents to be consistent and firm.

**Clinical**
Use simple, neutral words to describe procedures and surgery to the child.
Explain when procedure will occur in relation to daily schedule (e.g. after lunch, after bath).
Encourage the child to fantasize to help plan his/her responses to possible situations.
Use body outlines or dolls to show anatomic sites and procedures.
Let the child handle equipment before a procedure.
Use play therapy as an emotional outlet and a way to test the child’s sense of reality.
Reinforce reality of body image.
Involve parents in teaching.

**School Age**

**General**
Provide privacy.
Teach injury prevention.
Promote family and peer interactions.
Maintain limit-setting and discipline.
Expect fluctuations between mature and immature behavior.
Promote responsibility.
Promote exploration and development of skills.

**Clinical**
Use body outlines and models to explain body mechanisms and procedures.
Explain logically why a procedure is necessary; be direct.
Describe the sensations to anticipate during a procedure.
Encourage the child’s active participation in learning.
Praise the child for cooperating with a procedure.
Encourage questioning and active participation in care.
Involve parents, but make direct care the child’s decision.

**Adolescent**

**General**
Supplement explanations with rationale.
Provide privacy.
Involve adolescent in planning and decision-making.
Do not talk about the individual in front of the individual.
Age Specific

**Early Adult**

**General**
- Involve individual/significant other in the plan of care.
- Watch for body language as a cue for feelings.
- Allow for as much decision-making as possible.
- Provide wheelchair access.
- Provide handicapped parking.
- Use a language interpreter as needed.
- Utilize TTY as needed.

**Clinical**
- Encourage questions regarding fears.
- Allow adolescent to maintain control; a major fear is the loss of control.
- Provide essential teaching based on how the individual learns best.
- Provide information on pain control methods, the assessment scale, the schedule for pain management, and the need to ask for pain medications as soon as pain begins.
- Provide information on the degree of pain relief, the types of pain medications, and methods for pain reduction.
- Use visual aids; be concrete and specific.
- Relate to the adolescent’s abilities.

**Middle Adult**

**General**
- Allow choices if possible.
- Provide decision-making opportunities related to care.
- Provide wheelchair access.
- Provide handicapped parking.
- Use a language interpreter as needed.
- Provide adequate lighting for decreasing visual acuity.
- Print in adequate font size for decreasing visual compensation.

**Clinical**
- Explore the relation of illness/disease to body image and career.
- Encourage as much self-care as possible.

**Clinical**
- Explore the impact of hospitalization/illness on work/job, family, and children.
- Assess for potential stresses related to multiple roles of the young adult.
- Assess and manage pain based on patient needs and responses.
- Use a preventative approach.
- Provide information on pain control methods, the assessment scale, the schedule for pain management, and the need to ask for pain medications as soon as pain begins.
- Provide information on the degree of pain relief, types of pain medications, and methods for pain reduction.
- Provide essential teaching based on how the individual learns best.
Provide information on pain control methods, the assessment scale, the schedule for pain management, and the need to ask for pain medications as soon as pain begins. Provide information on the degree of pain relief, types of pain medications, and methods for pain reduction.

**Late Adult**

**General**

Explore the individual’s support system.
Explore related existing conditions.
Involves the family with care.
Be aware of the possible need for a warmer environment (room temperate, need for an extra blanket, etc.).
Provide wheelchair access.
Provide handicapped parking.
Use a language interpreter as needed.
Utilize TTY as needed.
Provide adequate lighting, but not too bright (decreasing visual acuity and increasing sensitivity).
Provide written materials as reminders.

**Clinical**

Speak slowly, clearly, and of adequate volume for decreasing hearing ability.
Provide adequate nutrition.
Keep the environment safe (e.g., bed: side rails up, wheels locked, etc.).

Turn/assist q 2 hours.
Asses skin integrity frequently.
Monitor bowel elimination q 24 hours.
Continue with pain assessment and management. Narcotics with a long half-life may cause problems with side effects (e.g., confusion, constipation).
Use adjuvant analgesics with caution; increases side effects.
Apply lotion to skin immediately after bathing.
References

AGE-SPECIFIC CONSIDERATIONS IN PATIENT CARE, June 2014.
http://w3.rn.com/

Age-Specific/Transcultural Competencies for Healthcare Providers. Lee Abramo, MSN, RN Site Update: October 5, 2013.
http://www.agespec.com/
Back Facts

Statistics show that 8 out of 10 people will experience back pain at some time in their lives. 80% of on-the-job injuries are back injuries.

Once you have sustained an injury, your chances of recurrence are much higher.

You perform many tasks every day that could cause back injury. These include repetitive lifting, prolonged standing, bending, reaching, pushing, and pulling. Protect your back by using good body mechanics.

Basic Principles of Good Body Mechanics

1. Maintain a wide base of support.
   You are more stable when you separate your feet or simply turn your toes out. By widening your base of support, you can improve your balance and ability to maintain stability.

2. Lower your center of gravity.
   Your center of gravity is that point about which your weight is centered. You can lower your center of gravity by bending your hips and knees slightly and keeping the load at waist level.

3. Keep the load close to you.
   The work required to hold a three-pound weight out at arm’s length is almost three times as much as holding it close to your body.

Imagine how much more work it is if the weight you are lifting is a 150-pound patient.

Contributing Factors to Back Injuries

Bending or twisting
Reaching out/up
Injury Prevention

<table>
<thead>
<tr>
<th>Injury</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach and Lift</td>
<td>Avoid storing heavy objects above shoulder height. Use step stool or ladder correctly.</td>
</tr>
<tr>
<td>Twist and Bend</td>
<td>Bend at the hips and knees. Do not bend forward and rotate at the waist at the same time.</td>
</tr>
<tr>
<td>Cumulative Trauma</td>
<td>Change position frequently. Space tasks so that you do not have to repeat the same motion over and over for long periods.</td>
</tr>
</tbody>
</table>

**Tools to Help in Moving Patients and Materials**

The following tools are available to assist you in moving patients/residents and materials:

- Gait belts
- Sliding boards
- Mechanical lifts
- Draw sheets
- Carts
- Stretcher

And don’t forget to use common sense: It’s better to ask for help than to risk an injury to yourself or others.

**Injured worker’s responsibilities**

Report the injury or illness to your charge nurse immediately.

*Under all circumstances, the reporting must be made during the shift on which the incident, injury, or illness occurs.*

If necessary, seek medical treatment.

Complete an incident report immediately.
Stay in touch with your supervisor and human resources.

References

www.osha.gov
What is a Care Plan?

A care plan outlines the care to be provided to a patient/resident.
It identifies a set of actions that clinicians implement to resolve problems that are identified by assessment.
It guides in the ongoing provision of care and assists in the evaluation of that care.
Care planning is an essential part of patient/resident care, but is often misunderstood or regarded as a waste of time.
Without a plan of care, important issues are likely to be neglected.
Care planning provides a "road map" of sorts, to guide all who are involved with a patient/resident's care.
The care plan has long been associated with nursing, and many people believe inaccurately, that is the sole domain of nurses. This view is damaging to all members of the interdisciplinary team, as it shortchanges the non-nursing contributors while overloading the nursing staff.
To be effective and comprehensive, the care planning process must involve all disciplines that are involved in the care of the patient/resident.

Developing a Plan of Care

The first step in developing the plan of care is to complete an accurate and comprehensive assessment. In the acute care setting, a thorough admission assessment should be followed by regular reassessments as often as the patient/resident's status demands. In the long-term care setting, the MDS (Minimum Data Set) is the starting point for assessment. Home health utilizes the OASIS assessment. Other settings will have established protocols for initial assessments and ongoing reevaluation.
Once the initial assessment is complete, a problem list should be generated. This may be as simple as a list of medical diagnoses, or may involve working through the RAP (Resident Assessment Protocol) process associated with the MDS. The problem list may actually include patient/resident strengths as well as family/relationship problems which are affecting the person’s overall well-being.

### Interdisciplinary Plan of Care

The Interdisciplinary Plan of Care (IPC) is individualized to meet the patient/resident’s unique needs and circumstances. Initial needs are assessed and care is planned by a registered nurse (RN) and other clinicians from information gathered on the admission assessments. The IPC will be initiated from this assessment and revised or maintained using an interdisciplinary approach based on the patient/resident’s response to the care, treatment, and services provided. Each discipline as warranted will contribute to the IPC and will involve the patient/resident and/or family to the extent possible.

At any time during the process, the plan may be modified or terminated based on: reassessment; the patient/resident’s continued need for care, treatment, and services; or the achievement of goals. This process includes planning for discharge and/or transfer to another care setting.

- It focuses on actions which are designed to solve or minimize the existing problem.
- It is a product of a deliberate systematic process.
- It relates to the future.
- It is based upon identifiable health and nursing problems.
- It focus is holistic.
- It focuses to meet all the needs of the patient.

Remember that the ultimate purpose of the care plan is to guide all who are involved in the care of the person to provide the appropriate treatment in order to ensure the optimal outcome during his/her stay in our healthcare setting. A caregiver unfamiliar with the patient/resident should be able to find all the information needed to care for this person in the care plan.

### References

Care Plans Best Practices for Development and Implementation, January 8, 2013

http://www.pcpcri.org/sites/
COMPLAINTS AND GRIEVANCES

Core Competency Reading Material

December 2014

Complaints vs. Grievances

A patient complaint is any verbal expression of dissatisfaction by a patient/resident, a patient representative, or a relative that relates to patient care, the quality of services, or a violation of hospital policies and procedures which is resolved by staff present. This includes, but is not limited to, confidentiality of protected patient health information.

“Staff present” includes any staff present at the time of the complaint, or those who can quickly be at the patient’s location (i.e. nursing, administration, nursing supervisors, case managers, dietary, RT) to resolve the patient’s complaint.

A patient grievance is a written or verbal complaint that is not resolved at the time of the complaint by staff present that is made by a patient or the patient’s representative, regarding patient care, abuse or neglect, issues related to the hospital’s compliance with the CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

Examples

• If a patient raises a complaint and it is fixed on the spot, it is a complaint and is not necessarily a grievance.

• If a verbal complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance.

• A written complaint is always considered a grievance, whether from an inpatient, outpatient, released/discharged patient, or a patient representative, regarding the patient care provided, abuse and neglect, or the hospital’s compliance with CoPs. An email or fax is considered “written.”
• If an identified patient writes or attaches a written complaint on the patient satisfaction survey and requests resolution, it is a grievance. If the patient has NOT requested resolution, this is not considered a grievance.

All verbal or written complaints regarding abuse, neglect, patient harm, or hospital compliance with requirements are considered a grievance.

Whenever the patient or the patient’s representative requests that his/her complaint be handled as a formal complaint or grievance, or when the patient requests a response from the hospital, it is considered a grievance.

Billing issues are not usually considered grievances; however, a Medicare beneficiary billing complaint related to rights and limitations provided in the CoP and 42 CFR 489 is a grievance.

Resolution

General Rules
Caregivers that become aware of a concern or complaint are encouraged to attempt to resolve it as promptly as the circumstance allows in a courteous and reasonable manner.

The department supervisor or manager should be immediately notified of all concerns or complaints. Complaints must be documented according to the healthcare facility's policies and procedures.

Steps to Resolution
Immediate attention must be given to situations that place the patient/resident or visitor in immediate danger.

Documentation of complaints, including the patient/resident’s or visitor’s name, the date, and all other pertinent information, such as how the concern or complaint was resolved, should be completed using the facility’s chosen document.

In most facilities, if a complaint cannot be resolved at the time of contact or services or within a reasonable timeframe by staff present, the complaint is then considered a grievance and is referred to the Supervisor/Manager, Quality/Risk Manager, or another designated staff member for investigation and resolution.

All oral or written grievances are to be reviewed, investigated, and resolved within a reasonable period of time according to the nature of the grievance. For contacts in person and/or verbally, initial response should be within 72 hours. Written contacts should be initially responded to within seven (7) business days.

The grievant should be notified in writing of the outcome of the grievance, including the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

A complaint or grievance is considered resolved when the patient/resident is satisfied with the actions taken on their behalf.

Approaches to Resolving Complaints or Grievances
The following, as well as any other effective approaches for handling patient grievances, may be used:
Complaints and Grievances

- Listen and then take required action
- Meet face-to-face with the patient/resident or visitor and/or his/her legally authorized representative
- Any staff member, patient/resident, or patient family member/decision maker may refer to a biomedical ethics consultant

Request the following services as needed:

- Case Management
- Financial Counseling
- Housekeeping
- Food and nutrition
- Referral to security
- Referral to a supervisor or manager

Do not ignore what your patients and their families have to say. Address each concern as it is brought to your attention and report to the charge nurse or supervisor immediately. Patient safety is of the utmost importance in this and all circumstances.

References

Medicare Rights & Protections, July 2014
http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf
Why Compliance is Needed

We have all seen examples in the news when a company or representatives of the company have misrepresented the company’s assets, what business the company is in, mishandling of client’s money or misrepresenting services provided to clients. To ensure that Medicare/Medicaid providers are on the up and up they are required to have a formal Compliance Program. Medicare/Medicaid (CMS) believes that the establishment of an effective compliance program will protect the Medicare Trust Fund by significantly reducing the risk of unlawful or improper conduct, and will likely lead to other efficiencies.

The CMS program is structured on a seven point plan. Each provider’s plan must include:

- Written policy and procedures to include a standard of conduct
- Designation of a Compliance Officer and Compliance Committee
- Conduct staff education on compliance program
- Development of effective lines of communication for staff to report compliance issues or concerns including a hotline
- Auditing and monitoring program
- Consistent enforcement of guidelines for non-compliance
- Enforcement policies for investigations of reported non-compliance that include guidelines for investigations and reporting to CMS

Benefits of a Good Compliance Program

Having a good compliance program will
• Convey to staff and clients that the company conducts business in an ethical manner and is committed to quality customer/patient care
• Increase the potential of proper submission and payment of claims;
• Reduce billing mistakes;
• Improve the results of reviews conducted on Medicare claims
• Avoid the potential for fraud, waste and abuse
• Promote patient safety and ensure delivery of high quality patient care.

How are individuals involved?

Individuals make the choice to stand against illegal and unethical situations by simply conducting themselves with respect and integrity and following by the companies Code of Conduct

If the individual feels that the company’s values have been compromised in any way, then he or she takes integrity to a higher level and speaks up to remedy the situation.

What should be reported?

• Theft
• Fraudulent or inaccurate financial reporting
• Abuse of company resources
• Violation of environment, health, or safety laws
• Improper gifts or gratuities
• Alcohol or drug abuse
• Bribery or kickbacks
• Harassment or discrimination
• Threats of violence

What do I do when issues arise?

• Go to your supervisor
• Go to their supervisor
• Go to your HR director
• Go to the Director of Quality Services
• Go to your Administrator
• Call the Compliance Line

If after exhausting all other avenues, you still have concerns about the quality of care or safety, you then have the right to call The Joint Commission, Department of Health, CMS or any other regulatory agency of the facility.
References

CULTURAL DIVERSITY
Core Competency Reading Material
December 2014

Introduction

Most of us think of culture as a synonym of ethnicity. However, it is much more complex than that:

Culture is the values, beliefs, and practices held and carried out by a group.

Culture is dynamic, changing, and complex.

Culture helps members of a group come to understand relationships, how to respond to experiences, and how to think and act in certain situations.

Values

If a person values family, then it will be important to have family members near and part of the comfort and/or care of that patient.

Beliefs

If a patient’s belief is that medicine only refers to those drugs given to you by a doctor, but does not refer to any over-the-counter medicines (e.g., aspirin), then the history that is taken so conscientiously will leave out a whole piece of information that may be critical to the illness or healing.

Practices

If a patient’s practice is to have all medical information told to a specific member of the family and not to the patient, what will happen if we do not do this? How have we cared for this patient by insisting on doing it our way and not abiding by the long-held practice of the family and culture? Also, if a patient’s cultural practice is to have the family present during the illness, then it will promote healing if the family is near when the patient recognizes and adapts to various circumstances. If the patient cannot speak English, it is a comfort to have someone present that can assist the patient in making his or her needs known.
Cultural Competency

Unconscious Bias
In order to be culturally competent, we must understand ourselves. Each of us have unconscious biases, or unconscious decisions and beliefs which impact the way we perceive others and ourselves, and as such, influence the care we give. It is very important that as caregivers we do not “judge” others based on our own values and beliefs. All too often, caregivers allow their unconscious biases to influence the way they listen, treat, and interact with patients.

Dimensions of Diversity
Understanding diversity and the dimensions of diversity is core to becoming culturally competent. The dimensions of diversity are as follows:

- Age
- Mental/physical abilities and characteristics
- Ethnicity
- Gender
- Race
- Sexual orientation
There are also secondary dimensions of diversity, which include:

- Political affiliation
- Socio-economic status
- Communication style
- Work style
- Marital status
- Work background
- Day shift/Night shift
- Function level
- Religious beliefs
- Thinking style
- Geographic location
- Parental status
- Education

Remember that one’s diversity dimensions may influence:

- Health, healing, and wellness belief systems
- Illnesses, diseases, and how causes are perceived
How healthcare treatment is sought
Attitudes toward providers The LEARN Model

To practice culturally sensitive healthcare, the following guidelines around a mnemonic LEARN may be used:

- **Listen** to the patient’s perception of the problem
- **Explain** your perception of the problem
- **Acknowledge** and discuss differences/similarities
- **Recommend** treatment
- **Negotiate** treatment

**Skills and Characteristics of Cultural Competency**

Caregivers have a responsibility to get to know their patients and families so that healing can take place in the presence and congruence of their culture. It is easier to learn about a patient’s cultural values, beliefs, and practices than to undo the mistakes made from ignorance or assumptions.

Remember to take the time to listen, observe, and care enough to identify a patient’s cultural diversity. The skills and characteristics of a culturally competent caregiver are:

- Respectful of others
- Willing to share, risk change, and explore
- Open to other’s differences
- Understanding of the power of words and actions
- Able to recognize learning opportunities
- Has an attitude that says “different is okay and may be interesting”
- Is committed to co-responsibility
- Uses inclusive language
- Makes no assumptions
- Learns about other cultures, generations, and beliefs, especially the patient’s
- Listens actively
- Explains what he/she wants to do and why
- Approaches with engagement, openness, and a willingness to learn

If caregivers are to be sensitive to various cultures in the work place, they must first listen in order to learn about the nuances of another’s culture. The varieties of cultures in the working environment enrich its people. Sensitivity to those cultures will assist caregivers in offering healing to patients/residents and families.
References

Cultural Diversity Training. Updated: July 15, 2014; http://www.ncminorityhealth.org/services/culturaldiversity.html

Ebola Virus Disease (EVD) a Clear Definition

Ebola Virus Disease (EVD) or Ebola (for short), previously known as Ebola hemorrhagic fever, is a rare and deadly disease caused by infection with one of the Ebola virus strains.

Ebola viruses are found in several African countries. Ebola was first discovered in 1976 near the Ebola River in what is now the Democratic Republic of the Congo. Since then, outbreaks have appeared sporadically in Africa.

The natural reservoir host of Ebola virus remains unknown. However, on the basis of evidence and the nature of similar viruses, researchers believe that the virus is animal-borne and that bats are the most likely reservoir. Four of the five virus strains occur in an animal host native to Africa.
Assessment, Signs, and Symptoms

Fever (greater than 38.0°C or 100.4°F)
Severe headache
Muscle and joint pain
Weakness
Diarrhea
Vomiting
Abdominal (stomach) pain
Unexplained hemorrhage (bleeding or bruising)

Symptoms may appear anywhere from 2 to 21 days after exposure to Ebola, but the average is 8 to 10 days.

Recovery from Ebola depends on good supportive clinical care and the patient’s immune response. People who recover from Ebola infection develop antibodies that last for at least 10 years.

Transmission

Ebola is spread through direct contact (through broken skin or mucous membranes in, for example, the eyes, nose, or mouth) with:

- blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) of a person who is sick with Ebola.
- objects (like needles and syringes) that have been contaminated with the virus.
- infected animals.

Ebola is not spread through the air or by water, or in general, by food. However, in Africa, Ebola may be spread as a result of handling bush meat (wild animals hunted for food) and contact with infected bats.

There is no evidence that mosquitoes or other insects can transmit the Ebola virus. Only mammals (for example, humans, bats, monkeys, and apes) have shown the ability to become infected with and spread Ebola virus.

Although coughing and sneezing are not common symptoms of Ebola, if a symptomatic patient with Ebola coughs or sneezes on someone, and saliva or mucus come into contact with that person’s eyes, nose or mouth, these fluids may transmit the disease.

Ebola is killed with hospital-grade disinfectants. Ebola on surfaces such as doorknobs or countertops can survive for several hours; the virus in bodily fluids can survive up to several days at room temperature.
What we do as Health Care Professionals

Identification questions are essential for receiving symptomatic patients; ask about recent travels. An exact location on where they traveled from to pin point origin. I.e. Guinea, Liberia, Nigeria, Senegal, or Sierra Leone within 21 days of symptom onset and/or have they been in contact with anyone diagnosed with Ebola.

If BOTH criteria of travel history and symptoms are met, then the patient should be moved to a private room (containing a private bathroom) with the door closed. Isolation precautions should be initiated to include PPE use as directed by the CDC for EBV. You should immediately call Infection Control or the Nursing Supervisor to assist in assuring that appropriate laboratory specimens are collected and proper isolation precautions for transmission prevention are implemented.

The CDC recommends for Healthcare workers to perform PPE competency testing to include practice putting it on and taking it off in a systemic manner.

The CDC recommends that Personal Protective Equipment (PPE) for healthcare workers providing care to a patient suspected or diagnosed with Ebola should cover all of the provider’s skin and hair to include:

- Double gloves
- Boot covers that are waterproof and go to at least mid-calf or leg covers
- Single-use fluid resistant or impermeable gown that extends to at least mid-calf or coverall without integrated hood.
- Respirators, including either N95 respirators or powered air purifying respirator (PAPR)
- Single-use, full-face shield that is disposable. Goggles are no longer recommended as they may not provide complete skin coverage in comparison to a single-use, disposable full-face shield. Additionally, goggles are not disposable, may fog after extended use, and healthcare workers may be tempted to manipulate them with contaminated gloved hands.
- Surgical hoods to ensure complete coverage of the head and neck
- Apron that is waterproof and covers the torso to the level of the mid-calf (and that covers the top of the boots or boot covers) should be used if Ebola patients have vomiting or diarrhea

Caregivers and visitors should be limited to as small a group of providers as possible and a log of all visitors and caregivers should be kept.

Education to visitors regarding PPE should be conducted. It is highly important to teach visitors about donning and doffing PPE before leaving the patients room and not to wear PPE outside in the hallways.

A trained monitor should observe the providers and visitors while donning and doffing PPE to ensure no cross contamination occurs.

Remember PPE is only one aspect of infection Control. Diligent environment cleaning and disinfection and safe handling of potentially contaminated materials is of paramount importance, as blood, sweat, vomit, feces, urine and other body secretions represent potentially infectious materials and should be done following hospital protocols.

Do not send lab specimens in tube systems or co-mingle with other patient specimens.
Be prepared, be educated, and be proactive.

References

Introduction

The Environment of Care (EC) is a Joint Commission (JC) set of standards including three basic components: the processes, systems, and structures in a healthcare organization that significantly impact the safety and quality of care. These processes, systems, and structures are known as Priority Focus Areas (PFA’s). The EC includes eight programs that the Joint Commission requires facilities to develop written plans for, as well as manage. You need to know how to find the plans in your work area. These programs are as follows:

- Safety Management
- Emergency Management
- Medical Equipment Management
- Hazardous Materials and Wastes Management
- Utilities Management
- Life Safety
- Security Management
- Management of the Social Environment

Safety Management

Healthcare facilities are required to have both a Safety Officer and a Safety Committee. These individuals oversee the Environment of Care plans, preparedness, and policies of the facility and have the authority to take action should there be a safety issue or risk. However, safety is the responsibility of all employees and staff.
**Your Responsibility**

Report unsafe and unhealthy acts/conditions to your supervisor or the Safety Officer.

Correction of unsafe or unhealthy conditions should be given the highest priority.

Complete mandatory safety training, including JC Environment of Care (EC) at least annually following new employee orientation.

All completed safety training is entered into your Employee Training Records. These are used as a part of your competency.

Help prevent and report all accidents and injuries.

Understand that means of egress (ways of escape in event of fire or disaster) must be kept clean and clear, except for very short periods of time (15 minutes), or when the equipment can be rolled into a room in the event of an emergency. Nothing must ever be placed in a stairwell.

Be able to explain the proper use, maintenance, and storage of equipment, including Personal Protective Equipment (PPE), that you may need to use in your job.

Become familiar with and comply with all Safety/Health regulations, policies, and procedures.

Review all policies pertinent to your area and position at least annually.

**The Safety Committee**

Has multidisciplinary membership

Covers all aspects of Safety, Occupational Health, Environmental Protection, Fire Protection, Patient Safety, Infection Control, and Radiation Safety

Reviews safety program effectiveness, Service Subcommittee minutes, and accidents, illnesses, and incidents pertaining to safety

Reports Environment of Care standards, including interpretation and methods of compliance

Plans and reports on fire drills and disasters drills

The Safety Officer is responsible for oversight of the EC

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**Emergency Management**

An Emergency Management Program, formerly called Disaster Preparedness, is a comprehensive emergency plan that provides direction in the event of a community or internal event and/or disaster that may disrupt the system’s ability to provide continued patient care to patients and provide emergency medical treatment for casualties resulting from the event.

**Your Responsibility**

Be familiar with the Emergency Management Plan and know where to find copies.

Understand your role in an emergency, even if it is to “stand by and await further instructions from your supervisor.”

Perform your normal duties during an emergency and know that you could be called upon to perform additional duties if needed.
Know that most facilities are linked to the Hospital Emergency Incident Command System (HEICS), which links hospitals in the area. This is the standard for healthcare emergency management.

The Incident Command Center, if activated, is under the Administrator or Chief of Staff typically.

Remain calm.

Know the difference between an internal and external disaster.

**Internal versus External Disasters**

An internal emergency (disaster) is one that occurs within the facility. Examples include:

- Bomb threats
- Fires
- Shootings
- Chemical spills

An external emergency is an incident that occurs within the community (outside the facility), which may require expansion of services for receiving patients. Examples include:

- Fires/explosions
- Aircraft/vehicle accidents
- Chemical spills
- Releases of toxic gases
- Tornadoes, floods, ice storms, earthquakes or other natural disasters
- Food and/or chemical poisonings
- Terrorism attacks
- Mass casualties

**Emergency Plans**

Emergency Plans include the following.

**Emergency Electrical Plans**

Electrical Power is vital to the life support capability of facilities. Electrical Plans outline actions personnel take in the event of the loss of electrical power. Engineering Service must be fully prepared to maintain and continue electrical power in vital life support areas and functions.

There are both life support and non-life support utilities. Life support and other essential utilities should be on red plugs.
Emergency Heating Ventilation and Air Conditioning (HVAC) and Emergency Sewage Plans

These plans outline actions in the event of a disruption of the system due to internal/external causes. These plans are vital to patient areas such as intensive care, surgery, and bed units. These areas have priority in receiving services when limited.

Building personnel will coordinate with each other to maintain a safe and healthy environment for patients, visitors, and personnel. Temporary systems will be installed, monitored, and maintained as required until systems are back to normal operations.

Emergency Water Plans

Emergency water plans ensure that an adequate supply of water is available for use in the event of an external or internal disruption of water services.

Bottled water should be available for drinking and cooking, and water should be available for cleaning and flushing toilets.

Emergency Elevator Shut-Down Plans

These plans outline actions that are to be taken in the event of a total loss of vertical transport in the building due to internal or external events.

The first concern is for the safety of people (patients, visitors, and employees).

Employees may be called upon to assist in the movement of patients, food, and/or supplies.

Medical Equipment Management

The Medical Equipment Management Program is designed to assess, monitor, and control the clinical and physical risks of equipment used for the diagnosis, treatment, monitoring, and care of patients.

What You Need to Know

All equipment that is used for patient care or called clinical equipment is part of this plan and must have routine preventative maintenance performed regularly.

How to check and operate equipment, including all equipment needed in response to an emergency.

The difference between life support and non-life support equipment.

How to report biomedical equipment failures.

Preventive Maintenance (PM) inspection is regularly done at intervals not to exceed one year.

How equipment is reported, documented, and removed from service.

Safety recalls, hazard alerts, and incident reviews are acted upon appropriately. These are tracked in Quality Management.

In the event of a utility failure, which electrical outlets (red plugs) are supported by the Emergency Generator(s).

How to tell the last day each piece of equipment may be used (from the inspection sticker).

Remember that all patient care equipment and all electrical non-patient equipment, regardless of ownership, should be inspected by Engineering Service prior to initial use. Personal equipment can be
used only if patients have received written authorization. Space heaters are never permitted in hospital divisions.

**Safe Medical Devices Act**

In compliance with the Safe Medical Devices Act, healthcare facilities must report to the FDA and/or the manufacturer any device-related incident that has caused or contributed to the death or serious illness or injury of a patient/resident within the facility.

**Hazardous Materials and Waste Management**

This includes the Hazard Communication Program, the Hazardous Materials and Waste Management Program, as well as the safe obtaining, handling, and disposing of all chemicals (including radioactive materials, asbestos, hazardous energy, chemotherapy, and other pharmaceuticals). Medical surveillance, as well as blood borne pathogen exposure (generally thought of as needle sticks and splashes) is also included in this program area.

**What You Need to Know**

The Hazard Communication Program or “Right to Know Law” states that employees have both a need and a right to know the hazards and identities of the chemicals they are exposed to in the workplace.

Training must be provided when a new chemical is introduced in order to provide information on working safely and reducing the number and severity of accidents, injuries, and illnesses. Any chemical has the potential to be dangerous, even those used at home.

Chemicals should be inventoried annually in each work area or service.

**Safety Data Sheets**

The Hazard Communication Standard was revised in 2012 to require that all chemicals have a Safety Data Sheet, SDSs (formally known as the Material Safety Data Sheet or MSDS) that presents the information about the chemical in a 16 part consistent user-friendly format. Employers must ensure that the SDSs are readily accessible to employees for all hazardous chemicals in their workplace. This can be in a binder or on the computer where the employees can access them without leaving their work area.

The following information is included on an SDS:

Section 1, Identification includes product identifier; manufacturer or distributor name, address, phone number; emergency phone number; recommended use; restrictions on use.

Section 2, Hazard(s) identification includes all hazards regarding the chemical; required label elements.

Section 3, Composition/information on ingredients includes information on chemical ingredients; trade secret claims.

Section 4, First-aid measures includes important symptoms/effects, acute, delayed; required treatment.

Section 5, Fire-fighting measures lists suitable extinguishing techniques, equipment; chemical hazards from fire.
Section 6, Accidental release measures lists emergency procedures; protective equipment; proper methods of containment and cleanup.

Section 7, Handling and storage lists precautions for safe handling and storage, including incompatibilities.

Section 8, Exposure controls/personal protection lists OSHA’s Permissible Exposure Limits (PELs); Threshold Limit Values (TLVs); appropriate engineering controls; personal protective equipment (PPE).

Section 9, Physical and chemical properties lists the chemical’s characteristics.

Section 10, Stability and reactivity lists chemical stability and possibility of hazardous reactions.

Section 11, Toxicological information includes routes of exposure; related symptoms, acute and chronic effects; numerical measures of toxicity.

Section 12, Ecological information

Section 13, Disposal considerations

Section 14, Transport information

Section 15, Regulatory information

Section 16, Other information, includes the date of preparation or last revision.

**Chemical Labeling**

All secondary containers need to be properly labeled and marked legibly and prominently with the identification of the chemical by product name and the appropriate hazard warnings (including target organ).

Flammable chemicals must be stored in flammable storage cabinets. Corrosive chemicals must be stored in corrosive storage cabinets. Never store flammable and corrosive chemicals in the same storage cabinet.

**Chemical Spill Clean-Up**

Users are usually responsible for cleaning up chemical spills with the following exceptions:

- ethylene oxide
- formaldehyde
- mercury
- radioactive agents
- antineoplastic (chemotherapeutic) agents

Spill clean-up kits are to be stocked in each department and at nursing units. Remember, given a large enough quantity any chemical can be a hazard.
Hygiene

Good hygiene (hand washing, use of gloves, not eating in the work area, etc.) is a must to protect yourself from hazardous material.

Wash after handling hazardous materials or whenever you get a chemical on your skin (especially before and after eating, drinking, smoking, or putting on gloves), and after doing each task in patient care settings.

Remove clothing that has been splashed with a hazardous chemical or potential blood borne pathogen. Do not wash contaminated clothing with your family’s laundry.

Wear personal protective equipment (PPE) including gloves, a gown, and eye protection as appropriate.

When to Seek Medical Attention

If you repeatedly experience symptoms such as dizziness, nausea, rashes, eye/nose irritation, etc.

When a hazardous chemical or body fluid is splashed into the eyes or in/on the skin (after you have first flushed with water)

If any dangerous substance is inhaled or ingested

Needle Stick Injuries

Needlestick injuries may occur when staff disposes of needles, collect and dispose of materials used during patient care procedures, administer injections, drawing blood, handling trash or dirty linens where needles have been inappropriately discarded.

Safety needle devices have been shown to significantly reduce needlesticks and exposures. The safety needle devices have built-in safety controls to reduce needlestick injuries before, during and after use and to make needlesticks less likely.

Employers are required to evaluate the effectiveness of the needles used and to establish a written exposure control plan as well as engineering and work practice controls to minimize employee exposure.

Utility Management

The Utility Management Program involves the operational response to failures of utility systems that support the patient care environment, as well as the periodic inspection of utility-related equipment and systems (preventive maintenance). This includes emergency utilities.

This program includes:

- Electrical Distribution and Emergency Power
- Plumbing System
- Medical Gas System
- Medical/Surgical Vacuum System
- Boiler and Steam System
- Heating, Ventilation, and Air Conditioning System (HVAC)
• Communication System
• Vertical Transport Systems (Elevators)
• Electrical Distribution and Emergency Power

All utility systems include a primary source (such as electrical power) and a secondary (back-up) source, such as an emergency generator. When the primary source fails, the secondary source will come on within ten seconds.

The following hospital equipment is on the emergency generators:

• All alarm systems
• Computer mainframe and network hubs
• Emergency lighting system
• Medical Air and Vacuum Systems
• An Emergency Water Distribution System (pumps)
• Pager and communication systems
• Red plugs for Patient Life Support
• Elevators
• Nurse Call Systems
• Code Blue Systems
• Medical Gas Systems (oxygen, nitrogen, medical air, etc.)

Know where outlets, zones, pressure alarms, and shut-off valves are located in your area. Oxygen is supplied by large bulk storage tanks outside of the hospital/facility.

Compressed gas cylinders for short-term outages of the oxygen should be available in departments and nursing units.

Know who is authorized to use the Oxygen Shut-Off Valve.

Isolation rooms are on negative pressure (draw (suck) air from under the door), whereas positive pressure rooms push (blow) air through a filter. Doors must be kept closed in Isolation areas to maintain the negative pressure.

**Communication Systems**

Communication systems are typically on the emergency power generators.

If there is a loss of power, a portion of the Emergency Management Plan may be implemented.

If there is a loss of a specific communication system, the Emergency Management Plan may be implemented if the disruption causes major problems (phone, computer, code blue, etc.)
Vertical Transport Systems (Elevators)

There is a policy to be followed in the event that an elevator is non-functioning and has passengers on board.

All elevators must have intercoms or telephones, an emergency buzzer, and emergency lighting. Selected elevators will continue to operate if there is a loss of power from the primary source.

If a fire detection device is activated in the facility, certain elevators will automatically go to the ground floor for use by the fire department.

Life Safety Management

The Life Safety Management Program provides instructions on how to react to a fire emergency in order to prevent personal injury, impairment of health, and/or property damage.

What You Need to Know

Be alert, using all of your senses (smell, sounds, sight, etc.).

Take time to investigate suspicious smells or smoke immediately.

Close all doors. If you smell smoke behind a door, feel the door with the back of your hand first.

If the door is too hot to touch, do not open it; otherwise, open door slowly.

Call the emergency number for the facility.

Remember the acronym RACE (rescue, alarm, confine and extinguish).

Fire doors are located throughout the facility and must not be blocked.

Know where your two nearest fire exits are.

Many facilities are not fully sprinkled.

Smoke detectors are typically installed 30 feet apart in all corridors and are inspected annually.

Know where the Fire Alarm Pull Stations are located, and where the two nearest to your work area are.

Know the location of the smoke barriers and fire walls closest to your work area.

Know where the two nearest fire extinguishers are.

Fire Extinguishers

Types

Class ABC – “All Purpose;” Dry chemical is used on paper, flammable liquids, and electrical equipment, but DO NOT USE ON METALS.

When and How to Use

Use a fire extinguisher only to fight small fires (nothing larger than a trash can size).

How to Operate

1. Pull the safety pin
2. Aim the nozzle at the base of the fire
3. Squeeze the handle
4. Sweep at the base of the flame

**Interim Life Safety Measures**

Interim Life Safety Measures (ILSM) are a series of 12 Administrative Actions required to temporarily compensate for the significant hazards posed by existing NFPA 101 (1997 Life Safety Code) deficiencies or during construction activities.

ILSM are intended to provide a level of safety comparable to that described in the Life Safety Code and are also important when there is any deficiency in the existing life safety features of the building(s). This would be important anytime the existing life safety features are being compromised in/around immediate work areas during times of construction or remodeling.

Example:

Defective Sprinkler Heads in the Unit: During the period required for retrofit/replacement, ILSM would be put in place. These include such things as adding additional walkthroughs by police and safety staff, conducting extra drills, and/or adding extra fire extinguishers.

Life safety is not to be compromised for any occupants of the building. This includes: construction workers, patients, employees, volunteers, and visitors. Cleanliness of patient care areas and public corridors must be maintained.

The ILSM stays in effect until all work is completed and original conditions are restored.

**Security Management**

You should know who is responsible for security, including the opening and closing of doors; monitoring and securing parking lot areas; internal and external security checks; vehicular access; maintaining security in sensitive areas such as the pharmacy, and who is responsible for responding to violence, bomb threats, and other codes. Some facilities do not have internal security and in this situation typically engineering services will act in this role.

Know the Emergency Reporting Phone Number for the facility you are working in. You must also know your role in:

**Bomb threats**

- Handle telephone threats calmly and quietly.
- Keep the caller talking as long as possible.
- In case of written threats, preserve the written material and the container it arrived in.
- Call the emergency phone number and/or telephone operator.

**Missing patient search procedures**

**Infant abductions**

**Elopement prevention in high-risk patients**
Security in your work area regarding dangerous/deadly weapons or materials

Police notification procedures

Methods for the management and prevention of violence

You are urged and expected to notify security or a supervisor as soon as possible when you become aware of actual or suspected suspicious behavior.

All employees are required to have annual training in workplace violence policies and procedures

Management of the Social Environment

The Social Environment Program is essential to excellence, making possible a sustained high level of care to all patients, especially to those who are disadvantaged. The delivery of quality healthcare is enhanced by appropriate physical surroundings and a psychological sphere for patients. For example, the appearance of the facility’s grounds contributes to the psychological well-being of the patients. Special emphasis is placed on the strategic planning of services, programs, and architectural features that support patient needs.

This program is tailored to the physical, psychological, and social needs of the patient. This is done through:

- adequate supplies for patient grooming (personal hygiene)
- adequate drawer and closet space
- suitable clothing
- telephones (with privacy)
- doors on sleeping rooms
- the number of patients per room
- space provided according appropriate age, developmental level, and clinical status

Maintenance of a No Smoking Environment

Typically, smoking is not permitted in any building or in front of buildings, and is permitted only in designated smoking areas.

There are three reasons for a no smoking policy.

1. To reduce the risks to patients who smoke,
2. To reduce the risks of passive smoking to others, and
3. To reduce the risk of fire.

Maintaining a safe environment reflects a level of compassion and vigilance for patient welfare that is as important as any other aspect of competent health care.
References


Introduction

Ethics is a science that deals with principles of good and bad or right and wrong and governs our relationships with others. Ethics are based on personal values and beliefs that guide the decision-making process. Each ethical dilemma is subject to moral, philosophical, and individual interpretations by all involved parties.

History

Healthcare ethics have been a concern as long as healthcare has been practiced, but they became more prominent in the media in the 1980's and 90's when Dr. Jack Kevorkian publicized his views on the ethics of euthanasia and assisted in the deaths of more than 100 terminally ill patients. Since that time, the sensitive issue of a patient's right to initiate his own death has been one of the central ethical concerns surrounding healthcare, and particularly, hospice care.

Types

In addition to ethical issues surrounding death, other prominent ethical issues in healthcare practice include a patient's right to information and a patient's right to make choices surrounding care.

Physicians are required to take the Hippocratic Oath upon being awarded a medical degree, which states that they will, "First, do no harm." Physicians and clinicians are expected to act in the best interests of the patient.

Function

Healthcare ethics represent moral values that are generally regarded as acceptable by society. Many healthcare professions have a code of ethics that is expected to be followed by every member of the profession. Hospitals and large healthcare systems often have a code of ethics that they expect all members of their staff to follow, relating to the health, safety, and well-being of patients and family members. In general, ethics are standards of behavior.

Benefits
Ethics protect patients and their families from mistreatment, abuse, and neglect by members of the healthcare professions. Ethics also set a standard for professionals in the field, and some professionals are regarded as more ethical than others by the general public. For example, in a local community, a physician may have developed a reputation for being slightly unethical due to rumors that have circulated about his conduct. Another physician in the same community may be highly esteemed due to the community's perception of her ethical principles. Physicians that have a habit of being very upfront and honest with patients about their conditions and treatment options are often touted for their ethics.

**Conduct and Behavior**

**Personal Conduct**

All healthcare team members are expected to extend courtesy and respect to everyone, regardless of position, race, religion, gender, socio-economic standing, or sexual orientation. It is important that the caregiver's value system not keep them from performing their job responsibilities. Each individual is personally responsible for their actions.

**Professional Conduct**

Healthcare professionals who have access to protected medical and financial information must comply with the Health Insurance Portability and Accountability Act (HIPAA) and all other laws protecting privacy rights. Licensed and certified healthcare professionals must abide by the laws governing their professions. Healthcare professionals who are involved in patient care are expected to follow standards of evidence-based care and maintain clear and concise records.

**Ethical Behavior**

Ethical behavior is doing what is right. In healthcare, doing what is right for the patient/client is of the utmost importance. A patient expects healthcare professionals to respect their right to consent or refuse any treatment. The patient must be treated with compassion and sensitivity and their written directives, such as living wills, power of attorney, and other advance planning directives, must be honored.

**Healthcare Provider Code of Ethics**

**Caregiver Rights**

A licensed healthcare professional has the right to relinquish care of a patient due to conflicts of interest, professional bias or relationship, or any other issue that could compromise the care of the patient or violate the ethics or philosophical beliefs of the caregiver. This right does not generally apply to unlicensed professionals such as office staff, who are not entrusted with the care of patients.

**Do No Harm**

In the oath of Hippocrates, a physician will vow: "to use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing." Benefits always should outweigh risks and detrimental side effects.

**Evidence-Based Care and Research**
Care should be backed by a body of evidence-based research that is unbiased and free from conflicts of interest. Take advantage of every opportunity to learn more and provide patients with the best possible care, based on current research.

**Informed Consent and Refusal**

Everyone has the right to consent to or refuse any suggested course of treatment. Respect and honor the patient's decision.

**Integrity, Authenticity, and Accountability**

Honesty and openness are critical to the relationship between caregiver and patient and between caregiver and colleagues.

**Maintain HIPAA**

Patient information is a sacred trust, and healthcare providers should take appropriate measures to ensure confidentiality, following the guidelines of the Health Insurance Portability and Accountability Act (HIPAA).

**Practice Legally**

Maintain a practice that conforms to all local, state, and national legal requirements.

**Principles**

Several key principles play a role in solving ethical dilemmas: autonomy, beneficence and nonmaleficence, justice, fidelity, veracity, and respect for others.

**Autonomy**

Autonomy is the right of each individual to take action for his/her self. It includes respect for individuals and the individual's right to make decisions for and about themselves, even if the healthcare providers do not agree with the decisions made. To respect autonomy is to respect others.

**Beneficence**

Beneficence is the duty to help others by doing what is best for them. This belief also implies the principle of nonmaleficence, or to do no harm. One has the duty not only to do good, but also not to inflict evil or harm or to risk harm to others.

**Justice**

Justice relates to the obligation we have to be fair to all people. This implies that all individuals are treated fairly and equally regardless of age, race, religion, condition, or sexual preference. This principle rises frequently when there is competition for benefits or resources or when supplies are limited.

**Fidelity**

Fidelity refers to the obligation to carry out the agreements and responsibilities one has undertaken. Fidelity is keeping one’s promises or commitments.

**Veracity**

Veracity refers to always telling the truth. This principle also requires that the whole truth be told.
Respect for Others

Respect for others incorporates all other principles. Respect for others acknowledges the right of individuals to make decisions and to live or die by those decisions. Respect for others transcends gender issues, cultural differences, religious differences, and racial concerns. This principle is the core value underlying the Americans with Disabilities Act and several non-discrimination statutes.

References:

FALL PREVENTION
Core Competency Reading Material
December 2014

Introduction

The goal of the fall prevention program is to promote patient/resident safety by identifying patients at risk for falls, implementing a fall prevention plan of care, and effectively managing patients who do fall.

Definitions

Uncontrolled Fall
Loss of upright position that results in landing on the floor, ground, or an object; or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground

Controlled Fall
A controlled, purposeful, downward displacement of a patient’s body from a standing, sitting, or lying position in order to prevent injury from an impending uncontrolled fall

Fall with Injury
While injury is often the result of a fall, injuries do not have equal impact on the patient/resident’s condition or course of treatment. Just because there does not appear to be an injury, does not mean that the patient did not suffer a broken bone, sprain, etc.

Risk Factors

Much work has been done to identify the risk factors associated with the likelihood of a patient/resident falling. These risk factors are generally categorized into extrinsic (factors outside of the patient’s body) and intrinsic (patient’s internal, physiological factors). Assessments of these risk factors are used in the development of the Plan of Care for the patient at risk for falls.

Examples of Extrinsic Factors
• Hazardous activities
• Time of day
• External lighting
• Clutter
• Spills
• Loose electrical cords

Examples of Intrinsic Factors
• Muscle and strength weakness
• Gait and balance disorders
• Visual disturbances
• Cognitive impairment/mental status
• Dizziness/Vertigo
• Postural hypotension
• Incontinence
• Polypharmacy
• Age
• Chronic diseases, especially COPD, depression, arthritis, and circulatory diseases

Fall Risk Assessments
Fall risk assessments are evidence based tools used to assess a patient’s risk for falling. These are used in all areas of healthcare and many facilities develop Fall Programs around these methods. Below are two of the most common

1. Morse Fall Scale (MFS) is a rapid and simple method of assessing a patient’s likelihood of falling. It consists of six variables, which include history of falling and mental status, that are quick and easy to score, and it has been shown to have predictive validity and interrater reliability. The MFS is used widely in acute care settings, both in the hospital and long term care inpatient settings.

2. Medicare OASIS-C Fall Risk Assessment is a fall risk assessment used in home health. The Centers for Medicare and Medicaid Services (CMS) has required Medicare-certified home health agencies to collect and transmit Outcome and Assessment Information Set (OASIS) data for all adult home health patients 18 and older receiving skilled services, whose care is reimbursed by Medicare and Medicaid. The OASIS directs home health agencies to assess fall risk in all patients over the age of 65. The multifactorial assessment includes items such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, and environmental hazards.
## Fall Risk Medications

Medications that may increase a patient’s risk for fall are:

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DRUG EXAMPLES</th>
<th>SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Antihistamines</td>
<td>Diphenhydramine, Promethazine</td>
<td>Sleepiness, Blurred Vision</td>
</tr>
<tr>
<td>2. Cathartics, Laxatives</td>
<td>Bisacodyl, Fleet Enema</td>
<td>Increased urgency to get to the rest room</td>
</tr>
<tr>
<td>3. Diuretics</td>
<td>Furosemide, Bumetanide, Indapamide</td>
<td>Increased urgency to get to the rest room</td>
</tr>
<tr>
<td>4. Narcotics</td>
<td>Morphine, Meperidine, Codeine</td>
<td>Low blood pressure, Dizziness, Drowsiness</td>
</tr>
<tr>
<td>5. Psychotropic Drugs</td>
<td>Haloperidol, Risperidone, Quetiapine</td>
<td>Dizziness, Drowsiness</td>
</tr>
<tr>
<td>6. Benzodiazepines</td>
<td>Diazepam (Valium), Chlordiazepoxide</td>
<td>Drowsiness, Lightheadedness</td>
</tr>
<tr>
<td>7. Hypnotics</td>
<td>Temazepam, Zolpidem, Chloral Hydrate</td>
<td>Drowsiness, Lightheadedness, Confusion, Delirium</td>
</tr>
<tr>
<td>8. Antidepressants</td>
<td>Amitriptyline, Trazodone, Sertraline</td>
<td>Drowsiness, Blurred Vision</td>
</tr>
<tr>
<td>9. Hypotensives</td>
<td>Beta Blockers, Clonidine, Calcium Blockers</td>
<td>Low blood pressure, Dizziness</td>
</tr>
<tr>
<td>10. Muscle Relaxants</td>
<td>Carisoprodol, Cyclobenzaprine, Diazepam, Dantrolene</td>
<td>Drowsiness, Dizziness, Weakness</td>
</tr>
</tbody>
</table>

## Interventions

Programs that focus on fall reduction have shown to be effective. Interventions to prevent falls should be implemented in the patient’s Plan of Care. Some of the most common interventions include:

**Hourly Rounds**

Every patient is seen hourly and assessed for needs, typically need to use the restroom, reposition, need medication, etc.

**Expanding Huddles**

At the beginning of each shift, nurses huddle with unit secretaries, primary care physicians and ancillary staff to go over the fall risk for each patient on the unit.

**Color-Coding**

Patients at risk for fall are assigned colored socks, colored signs are posted outside the patient’s door, or patients are given a color coded arm band.

**Teaching Back**
Using the teach-back method in which the patient demonstrates how to use the call button. That increases the likelihood that patients will call for help rather than trying to get out of bed on their own.

**After-Fall Protocols**

After a patient falls, a staff huddle is convened to discuss what happened and identify possible causes. The nurse responsible for the patient also fills out a questionnaire so the unit continually gathers and analyzes data about patient falls.

**Bedrail Reduction**

Bedrails contribute to patient fall risk because they are barriers when transferring patients/residents in and out of beds. Use of bedrails must be assessed according to each individual patient’s needs. When possible, use alternative positioning devices or pillows to avoid the use of bedrails.

**Post-Fall Management**

After a patient/resident falls:

- Assess for injuries (e.g. laceration, fracture, head injury).
- Obtain and record sitting/standing vital signs.
- Assess for change in range of motion and level of consciousness.
- Alert physician.
- Follow organizational policies for patient monitoring, depending on patient condition.
- Document circumstances in medical record, including patient’s appearance at time of discovery, patient’s response to event, evidence of injury, location, medical provider notification, and medical/nursing actions.
- Complete occurrence or incident report.
- Reassess patient and implement other interventions as patient condition indicates.

**References**


The No-Fall Zone; Nobody can prevent all patient falls, but hospitals are significantly reducing the ones they can; 06.01.13 by Lola Butcher.
http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/

Fall Reduction Program - NPSG - Goal 9 - 09.02.01. Accessed 2014.
http://www.jointcommission.org/standards_information/
Introduction

HIPAA, which stands for the American Health Insurance Portability and Accountability Act of 1996, is a set of rules to be followed by covered entities. HIPAA helps ensure that all medical records, medical billing, and patient accounts meet certain consistent standards with regard to documentation, handling, and privacy.

As you can imagine, the HIPAA regulations impact virtually every department of every entity that has access to confidential health information. Hospitals, medical practices, insurance companies, medical device manufacturers, and other healthcare organizations have undergone major changes in the way they handle patient information in order to be compliant with HIPAA.

Five HIPAA Rules

Privacy Rule

The Privacy Rule establishes national standards to protect individuals’ medical records and other personal health information (PHI). The Privacy Rule applies to health plans, healthcare clearinghouses, and healthcare providers that conduct healthcare transactions electronically.

The HIPAA Privacy Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.

The Privacy Rule also gives patients certain rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

The following HIPAA forms are associated with the Privacy Rule:
• Notice of Privacy Practices (NPP) Form
• Request for Access to Protected Health Information (PHI) Form
• Request for Restriction of Patient Health Care Information Form
• Request for Accounting Disclosures Form
• Authorization for Use or Disclosure Form
• Privacy Complaint Form

Security Rule

The HIPAA Security Rule addresses the privacy protection of electronic protected health information (PHI). Similar to the Privacy Rule, the Security Rule also deals with identifiable health information as defined by 18 HIPAA identifiers. The Security Rule defines standards, procedures, and methods for protecting electronic PHI with attention to how PHI is stored, accessed, transmitted, and audited.

The HIPAA Security Rule addresses three aspects of security:

• Administrative Safeguards - Assignment of a HIPAA security compliance team.
• Physical Safeguards - Protection of electronic systems, equipment, and data.
• Technical Safeguards - Authentication & encryption used to control data access.

Covered entities need to perform a Risk Analysis and utilize Risk Management methodologies in order to reduce vulnerabilities and possible risks. Organizations should assign a security analyst or officer who is responsible for maintaining and enforcing the HIPAA standards within the organization.

Hardware, Software, and Transmission Security Suggested Practices

Organizations should have a hardware firewall in place.

Transmission of personal information should be encrypted and comply with HIPAA rulings.

Operating systems should be hardened and up-to-date.

Policies should cover the updating of hardware, firmware, operating systems, and applications.

Transaction and Code Sets Rule

Per HIPAA regulations, a Code Set is any set of codes used for encoding data elements, such as medical terms, medical concepts, medical diagnosis codes, and medical procedure codes. Code sets for medical data are required for administrative transactions under HIPAA for diagnoses, procedures, and drugs.

Medical data code sets used in the healthcare industry under HIPAA include coding systems for health-related problems and their manifestations; causes of injury, disease or impairment; actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments; and any substances, equipment, supplies, or other items used to perform these actions. Specifically, the following code sets are used in HIPAA transactions:

• ICD-9-CM codes
• ICD-10-CM codes
• HCPCS Codes
• CPT-3 Codes
• CPT-4 Codes
• NDC codes

**Covered Transactions**

HIPAA establishes a single set of transaction standards for electronic healthcare transactions, thus enabling healthcare providers and insurance companies to communicate more fluidly. The Privacy and Security Rules cover the following types of information transactions:

• Healthcare claims (professional, instructional and dental)
• Health plan eligibility inquiries and responses
• Enrollment and disenrollment in a health plan
• Healthcare payment and remittance advice
• Health plan premium payments
• Claim status inquiries and responses
• Referral certification and authorization
• Coordination of benefits

**Unique Identifier Rule**

As part of the HIPAA Administrative Simplification regulation, there are currently three unique identifiers used for covered entities in HIPAA administrative and financial transactions. The use of these unique identifiers will promote standardization, efficiency, and consistency. The unique identifiers under HIPAA regulations are:

• Standard Unique Employer Identifier.
  The same as the Employer Identification Number (EIN) used on an organization's federal IRS Form W-2. This identifies an employer entity in HIPAA transactions.
• National Provider Identifier (NPI).
  NPI is a unique 10-digit number used for covered healthcare providers in all HIPAA administrative and financial transactions.
• National Health Plan Identifier (NHI).
  The NHI is a Centers for Medicare & Medicaid Services (CMS) proposed identifier to identify health plans and payers.

**HITECH Act**

The HITECH Act provides Medicare and Medicaid monetary incentives for hospitals and physicians to adopt electronic health records (EHRs) and also provides grants for the development of a health information exchange (HIE). These incentives and grants were created to stimulate healthcare providers to adopt technology necessary to improve the efficiency of patient healthcare.
The HITECH Act provides over $30 billion for healthcare infrastructure and the adoption of electronic health records (EHR). According to the Act, physicians are eligible to receive up to $44,000 per physician from Medicare for "meaningful use" of a certified EHR system starting in 2012.

The HITECH Act expanded the scope of the HIPAA Privacy and Security Rules and increased the penalties for HIPAA violations to include covered entities, business associates, and others who are subject to more rigorous standards when it comes to protected health information (PHI).

**Covered Entities**

HIPAA is a broad and far-reaching law. Entities covered by the Privacy and Security Rules include:

- Healthcare plans
- Healthcare providers
- Healthcare clearinghouses

The Rule also extends to the business associates of covered entities, which include auditors, consultants, lawyers, data and billing firms, and others with whom the covered entities have agreements involving the use of protected health information. The covered entity must receive satisfactory assurances that the business associate will comply with the Privacy and Security Rules, though the covered entity need not monitor the business associate's work unless it learns of a problem with compliance.

In addition, the Rules apply to any company that offers healthcare and treatment to its employees on-site. Thus, if an employer or school operated an on-site clinic, the clinic would be a covered entity, and its patient information would be subject to the Privacy and Security Rules.

**18 HIPAA Identifiers**

1. Names
2. Address including street, city, county, and zip code
3. Dates directly related to an individual, including birth date, admission date, discharge date, and date of death
4. Phone numbers
5. Fax numbers
6. E-mail addresses
7. Social Security numbers
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet Protocol (IP) address numbers
16. Biometric identifiers, including finger and voice prints
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code

**Other Uses of Protected Health Information**

As a general rule, a covered entity may not use or disclose protected health information for purposes other than treatment, payment, and healthcare operations without the patient's written authorization.

**Marketing**

The Privacy Rule prohibits a covered entity from disclosing PHI to others for marketing purposes without the patient's written authorization. For example, a pharmacy may not provide a pharmaceutical company a list of patients with a particular disease or condition in order for the pharmaceutical company to market drugs to those patients without their authorization.

At the same time, communications regarding treatment, case management, or the recommending of alternative therapies are excluded from the definition of "marketing," as are communications that promote health in a general manner. Thus, for example, a health-related newsletter that a covered entity distributes to patients to inform them about new healthcare developments would not be considered marketing under the Privacy Rule.

**Incidental Disclosures**

The Privacy Rule allows "incidental" disclosures of PHI, as long as the covered entity uses reasonable safeguards and adheres to the "minimum necessary" standard. For example, doctors' offices may use waiting room sign-in sheets, hospitals may keep charts at bedside, doctors may talk to patients in semi-private rooms, and medical staff may confer at the nurse's station without violating the Privacy Rule.

**Compliance**

Failure to comply with the Privacy or Security Rule can lead to significant financial and other penalties:

- Civil monetary penalties for each individual failure to comply with HIPAA provisions include a fine of $100 for each violation with a cap of $25,000 per year for multiple violations of the same provision
- Criminal penalties for a basic offense include fines of up to $50,000 and/or imprisonment for up to one year
- Criminal penalties for an offense committed under false pretenses include fines of up to
- $100,000 and/or imprisonment of up to five years
• Criminal penalties for an offense committed with the intent to use PHI for one's commercial advantage include fines of up to $250,000 and/or imprisonment of up to ten years.

If you suspect noncompliance or violation of HIPAA report it immediately to your supervisor or the facility Privacy Officer.

References


Introduction

Effective infection prevention and control is central to providing high quality health care for patients and a safe working environment for those that work in healthcare settings. Understanding the modes of transmission of infectious organisms and knowing how and when to apply the basic principles of infection prevention and control is critical to the success of an infection control program. This responsibility applies to everybody working and visiting a healthcare facility, including physicians, administrators, staff, patients and visitors.

There are six links in the chain that must be present in order for an infection to be spread:

- A microorganism
- A person who carries the microorganism
- A way out of the carrier
- A method of travel
- A way into another person
- A susceptible person who does not have resistance

Infection control procedures attempt to break the infection chain by removing one of the links:

Medication can break a link in this chain by killing the pathogen.

Workplace practices can help break the chain at other links.

Good hand hygiene is the single most effective way to reduce the spread of infection in the hospital.
Handle biological waste correctly. Blood and other body fluids are potentially infectious materials. It is important that you follow hospital policy in disposing of biohazardous waste. Use red biohazard bags. Never place an article contaminated with blood or body substances in the regular trash.

Other steps health care workers can take include

- Covering coughs and sneezes
- Staying up-to-date with immunizations
- Using gloves, masks and protective clothing
- Making tissues and hand cleaners available
- Following hospital guidelines when dealing with blood or contaminated items

Infection Control Procedures

Hand Hygiene

Proper hand hygiene is the single most effective method for preventing the transmission of infectious diseases.

Hand washing with soap and water is the preferred primary method of hand hygiene. Decontamination with alcohol-based hand hygiene products is acceptable if hands are not visibly soiled. Hand washing with soap and water followed by decontamination with an alcohol-based hand hygiene product is also acceptable.

Always decontaminate hands:

- Before and after any direct contact with patients/residents or their immediate environment.
- Before and after donning gloves, sterile or non-sterile.
- When moving from a contaminated body site to a clean body site during patient/resident care.
- Before eating and after using the restroom.

In compliance with recommendations from the CDC and Joint Commission requirements, caregivers may not wear artificial fingernails or nail extenders when providing care.

Handle Sharps Correctly

Recapping of needles is forbidden. Be careful when drawing blood, collecting trash, or handling soiled bed linens so you do not increase your risk of a needle stick injury.

Sharps containers are typically located in patient/resident rooms, anterooms, and on medication carts. Place sharps in the containers immediately. If a sharps container is 1/2 to 2/3 full, change the container. Never attempt to “stuff” items into the sharps container.
Personal Protective Equipment (PPE)

Verify the locations of the personal protective equipment (PPE). Gowns, masks, goggles, and gloves are provided in most work areas for your safety, as well as TB particulate masks and protective barriers for CPR. If you are unsure of how to use any of the items, verify the correct use with your supervisor. Removing of PPE is as important as donning of the PPE.

Cleaning and Disinfecting

Cleaning and disinfecting of non-critical surfaces in patient-care areas are part of Standard Precautions. In general, these procedures do not need to be changed for patients on Transmission-Based Precautions. In general, use of existing facility detergent/disinfectant according to the manufacturer’s recommendations for amount, dilution, and contact time is sufficient to remove pathogens from surfaces of rooms where colonized or infected individuals were housed. The cleaning and disinfection of all patient-care areas is important for frequently touched surfaces, especially those closest to the patient, that are most likely to be contaminated (e.g., bedrails, bedside tables, commodes, doorknobs, sinks, surfaces and equipment in close proximity to the patient). The frequency or intensity of cleaning may need to change based on the patient’s level of hygiene and the degree of environmental contamination and for certain for infectious agents such as C-diff.

Surveillance

Monitoring the incidence of certain organisms and targeted HAIs that have substantial impact on outcome and for which effective preventive interventions are available; use information collected through surveillance of high-risk populations, procedures, devices and highly transmissible infectious agents to detect transmission of infectious agents in the healthcare facility.

Patient Placement

Place patients who pose a risk for transmissions to others in private rooms when possible. When determining patient placement consider other patient placement, risk factors for transmission and route of transmission of the infectious agent.

Isolation Precautions

Isolation Precautions are based on the mode of transmission.

Standard Precautions

Standard Precautions are used for the care of all patients/residents. The use of Standard Precautions does not negate the need for other isolation precautions, as identified in the hospital’s policies and procedures for caring for patients with infectious diseases. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of hospital infections. The blood and body fluids of all patients should be considered potentially infectious. All healthcare workers should routinely use appropriate barrier precautions to prevent skin and mucous
membrane exposure when contact with blood or other body fluids of any patient is anticipated. It also means correct disposal and handling of sharps that can also contain blood and body fluids.

**Airborne Precautions**

Airborne Precautions are used for patients known or suspected to be infected with microorganisms transmitted by airborne droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance. The patient is placed in a private room with negative airflow. For TB & SARS, all staff entering the room must be fit-tested for an N95 respirator mask. For chicken pox, shingles, or measles, cone masks should be used, but negative airflow is not necessary. Gowns and gloves are worn if soiling is likely.

**Droplet Precautions**

Used for patients known or suspected to be infected with microorganisms transmitted by droplets (large particle droplets [larger than 5 micrograms in size]) that can be generated by the patient during coughing, sneezing, talking, or the performance of procedures. Masks, gowns, and gloves are worn.

**Contact Precautions**

Used for specified patients known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient care activities, that require touching the patient’s dry skin) or indirect contact with environmental surfaces or patient care items in the patient’s environment. Gloves and gowns should be worn. Masks are used, as needed, for dressing changes.

**Infectious Agents of Special Infection Control Interest for Healthcare Settings**

**Clostridium Difficile**

Clostridium difficile is shed in feces. Any surface, device, or material (e.g., commodes, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the Clostridium difficile spores. Clostridium difficile spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item.

For patients/residents in isolation for C. difficile, hand washing with soap and warm water is the only acceptable method of hand hygiene recommended by the CDC. Hand decontamination with an alcohol-based hand hygiene product alone is prohibited.

**Tuberculosis (TB)**

Persons at risk for TB include anyone who has had contact with a person with infectious TB. TB is spread when a person with active TB expels droplets in the air when they cough, sneeze, sing, or speak. If another person inhales these droplets, they may also become infected. The best way to manage TB is to
have a TB Control Plan. The plan outlines TB skin testing (PPD), TB Isolation, and other precautions to take in the healthcare setting.

You should be tested for TB anytime you suspect an exposure and as defined by your healthcare facility.

**Blood Borne Pathogens**

Blood borne pathogens are viruses, bacteria, and other microorganisms that are carried in a person’s bloodstream and body fluids that cause diseases.

**HIV/AIDS**

The highest risk of HIV infection comes from sharing needles.

The average risk from injuries involving HIV-infected needles or sharps is 1 in 300 or 0.33%.

The risk of infection from a bloody splash to mucus membranes or open skin is very low, less than 1 in 3,000.

**Hepatitis B Virus (HBV)**

Risk factors

- Injuries from sharps
- Scratches and cuts on the skin
- Splashes to the eyes
- Bites or wounds

**Hepatitis C Virus (HCV)**

The most common chronic blood borne infection in the United States.

Most of the persons are chronically infected and may not be aware of their infection because they are not clinically ill.

Infected persons serve as a source of transmission to others and are at risk for chronic liver disease.

HCV is transmitted primarily through large or repeated direct percutaneous exposures to blood.

Ways to protect yourself

- Vaccinations are typically offered through employee health. This is a series of three injections over a one year period. These provide immunization from HBV. There is no immunization for HCV
- Follow good standard (universal) precautions.
- Proper hand washing
- Practice good housekeeping – make sure you clean up any spills, keep your work area clean, and make sure you dispose of linens properly. Wash hands after touching soiled linens.
- Dispose of sharps properly – make sure all sharps are placed in a sharps container.
- Dispose of waste properly – make sure any dressings or blood-soaked items are placed in the trash or hazardous waste can.
**Multi-Drug Resistant Organisms (MDROs)**

A multi-drug resistant organism (MDRO) is any kind of bacteria that has become resistant to many different antibiotics. These bacteria can be found in your surroundings, such as a desktop or sink, or they can live on or in your body. These bacteria usually do not make you sick unless they get into your body, such as in a wound, the kidneys, bloodstream, or lungs. Many antibiotics will not treat an MDRO infection.

MDROs are mainly spread through physical contact. They can spread from patient to patient on the hands of hospital staff or from items that are used on or by more than one person. Cultures of body fluids, such as urine, blood, sputum, or fluid from a wound can tell us if patients have a multi-drug resistant organism.

Examples:

- Methicillin-resistant Staphylococcus aureus (MRSA)
- Vancomycin-resistant Enterococcus (VRE)
- Multi-drug resistant Streptococcus pneumoniae (MDRSP)
- Multi-drug resistant Gram-negative bacteria (MDR-GNB) Resistance is increasing in:
  - Streptococcus pneumoniae
  - Klebsiella pneumoniae
  - Pseudomonas aeruginosa
  - Acinetobacter baumannii
  - Escherichia coli
  - Burkholderia cepacia
  - Ralstonia pickettii
  - Stenotrophomonas maltophilia

Risk Factors for MDROs:

- Older patient/resident population
- Long-term care clients
- Intensive care units (adult and pediatric/neonatal)
- Patient transfer among facilities
- Certain patient populations/treatment modalities (e.g., hemodialysis)

Healthcare facilities are stepping up the monitoring of infections and surveillance of patients with MDROs. Many patients that at one time may not have been isolated because they were thought to be colonized are now being isolated and possibly even treated with decolonization.

How to Control Transmission:

- Improved hand hygiene
• Active surveillance of cultures in certain settings
• Preemptive contact isolation on admission to acute care
• Education
• Enhanced environmental cleaning
• Improved communication between facilities

**Ebola Virus Disease**

Ebola is spread through direct contact with blood and body fluids of a person infected by and already showing symptoms of Ebola.

Ebola is not spread through the air, water, food, or mosquitoes.

Strict isolation for contact, airborne, and droplet precautions are to be followed as well as monitoring of staff donning and doffing of PPE.

**Healthcare-associated Infections**

Healthcare employs many types of invasive devices and procedures to treat patients and to help them recover. Infections can be associated with the devices used in medical procedures, such as catheters or ventilators. These healthcare-associated infections (HAIs) include central line-associated bloodstream infections, catheter-associated urinary tract infections, and ventilator-associated pneumonia. Infections may also occur at surgery sites, known as surgical site infections.

The major risk factors for healthcare-associated infection caused by antimicrobial-resistant pathogens are either the transmission of pathogens from person to person (directly or indirectly, usually via the hands of healthcare workers) or the emergence of resistance after exposure to antimicrobials. Preventing healthcare-associated infections caused by antimicrobial-resistant pathogens requires a comprehensive approach that includes:

1) Preventing infections through the use of vaccines and prophylaxis;
2) Minimizing the use of invasive devices;
3) Understanding and fully implementing (and complying with) current guideline recommendations for the prevention of infections;
4) Using antimicrobials judiciously.

Implementing such a comprehensive program will reduce healthcare-associated infections, reduce the prevalence of antimicrobial-resistant pathogens, improve patient outcomes, and reduce health care costs.

**References**


Isolation precautions; Update Date: 2/3/2014
http://www.nlm.nih.gov/medlineplus/ency/patientinstructions
Introduction

Latex gloves have proven effective in preventing the transmission of many infectious diseases to healthcare workers. But for some individuals, exposure to latex may result in allergic reactions. Reports of such reactions have increased in recent years, especially among healthcare workers.

Latex

Latex products are manufactured from a milky fluid derived from the rubber tree, *Hevea brasiliensis*. Several chemicals are added to this fluid during the processing and manufacturing of commercial latex. Some proteins in latex can cause a range of mild to severe allergic reactions. Currently available methods of measurement do not provide easy or consistent identification of allergy-causing proteins (antigens) and their concentrations. Until well-accepted standardized tests are available, total protein serves as a useful indicator of the exposure of concern. The chemicals added during processing may also cause skin rashes. Several types of synthetic rubber are also referred to as "latex," but these do not release the proteins that cause allergic reactions.

Products Containing Latex

A wide variety of products contain latex: medical supplies, personal protective equipment, and numerous household objects. Most people who encounter latex products only through their general use in society have no health problems from the use of these products. Workers who repeatedly use latex products are the individuals likely to develop an allergic reaction. The following are examples of products that may contain latex:
Emergency Equipment

- Blood pressure cuffs
- Intravenous tubing
goggles
- Tourniquets
disposable gloves
- Surgical masks
- Stethoscopes
- Syringes
- Respirators

Oral and nasal airways
Electrode pads
Rubber aprons
Endotracheal tubes

Personal Protective Equipment
Office supplies
Rubber bands

Hospital Supplies

- Anesthesia masks
- Rubber tops of vials
- Injection ports
- Wound drains
- Catheters
- Dental dam

Household Objects

- Automobile tires
- Dishwashing gloves
- Shoe soles
- Pacifiers
- Diaphragms
- Swimming goggles
- Motorcycle and bicycle handgrips
- Hot water bottles
- Expandable fabric (waistbands)
- Baby bottle nipples
- Balloons
- Racquet handles
- Carpeting
- Condoms
Individuals who already have a latex allergy should be aware of products that contain latex that may trigger an allergic reaction. Some of the listed products are available in latex-free forms.

Individuals can also become exposed to latex by inhalation. Latex proteins become fastened to the lubricant powder used in some gloves. When workers change gloves, the protein/powder particles become airborne and can be inhaled.

Reactions

There are three types of reactions that can occur in persons using latex products.

Irritant Contact Dermatitis

The most common reaction to latex products is irritant contact dermatitis—the development of dry, itchy, irritated areas on the skin, usually the hands. This reaction is caused by irritation from wearing gloves and possibly by exposure to other workplace products and chemicals. The reaction can also result from repeated hand washing and drying, incomplete hand drying, use of cleaners and sanitizers, and exposure to powders added to the gloves. Irritant contact dermatitis is not a true allergy.

Allergic Contact Dermatitis

Allergic contact dermatitis (delayed hypersensitivity, also sometimes called chemical sensitivity dermatitis) results from exposure to the chemicals added to latex during harvesting, processing, or manufacturing. These chemicals can cause a skin rash similar to that of poison ivy. As with poison ivy, the rash usually begins 24 to 48 hours after contact and may progress to oozing skin blisters or spread away from the area of skin touched by the latex. Allergic contact dermatitis is also not a true allergy.

Latex Allergy

Latex allergy (immediate hypersensitivity) can be a more serious reaction to latex than irritant contact dermatitis or allergic contact dermatitis. Certain proteins in latex may cause sensitization or an allergic reaction. Although the amount of exposure needed to cause sensitization or symptoms is not known, exposures at even very low levels can trigger allergic reactions in some sensitized individuals. Reactions usually begin within minutes of exposure to latex, but they can occur hours later and can produce various symptoms. Mild reactions to latex involve skin redness, hives, or itching. More severe reactions may involve respiratory symptoms, such as runny nose, sneezing, itchy eyes, scratchy throat, and asthma (difficulty breathing, coughing spells, and wheezing). Rarely, shock may occur, but a life-threatening reaction is seldom the first sign of latex allergy. Such reactions are similar to those seen in some allergic persons after a bee sting.
Latex Allergy

Individuals at Risk

Workers with ongoing latex exposure are at risk for developing latex allergy. Such workers include healthcare workers (physicians, nurses, aides, dentists, dental hygienists, operating room employees, laboratory technicians, and hospital housekeeping personnel) who frequently use latex gloves and other latex-containing medical supplies. Workers who use latex gloves less frequently (law enforcement personnel, ambulance attendants, funeral-home workers, fire fighters, painters, gardeners, food service workers, and housekeeping personnel) may also develop latex allergy.

Workers in factories where latex products are manufactured or used can also be affected.

Atopic individuals (persons with a tendency to have multiple allergic conditions) are at increased risk for developing latex allergy. Latex allergy is also associated with allergies to certain foods, especially avocado, potato, banana, tomato, chestnut, kiwi fruit, and papaya. Individuals with spina bifida are also at increased risk for latex allergy.

Diagnosis

Latex allergy should be suspected in anyone who develops certain symptoms after latex exposure, including nasal, eye, or sinus irritation; hives; shortness of breath; coughing; wheezing; or unexplained shock. Any exposed worker who experiences these symptoms should be evaluated by a physician, since further exposure could result in a serious allergic reaction. A diagnosis is made by using the results of a medical history, physical examination, and tests.

Taking a complete medical history is the first step in diagnosing latex allergy. In addition, blood tests approved by the Food and Drug Administration (FDA) are available to detect latex antibodies. Other diagnostic tools include a standardized glove-use test or skin tests that involve scratching or pricking the skin and then putting a drop of liquid containing latex proteins on the skin. A positive reaction is shown by itching, swelling, or redness at the test site. However, no FDA-approved materials are yet available to use in skin testing for latex allergy. Skin testing and glove-use tests should be performed only at medical centers with staff that are experienced and equipped to handle severe reactions.

Testing is also available to diagnose allergic contact dermatitis. In this FDA-approved test, a special patch containing latex additives is applied to the skin and checked over several days. A positive reaction is shown by itching, redness, swelling, or blistering where the patch covered the skin.

Occasionally, tests might fail to confirm if a worker has a true allergy to latex, or tests might suggest latex allergy in a worker with no clinical symptoms. Therefore, test results must be evaluated by a knowledgeable physician.

Treatment

Detecting symptoms early, reducing exposure to latex, and obtaining medical advice are important to prevent long-term health effects. Once a worker becomes allergic to latex, special precautions are needed to prevent exposures.
Certain medications may reduce the allergy symptoms; but complete latex avoidance, though quite difficult, is the most effective approach.

Prevention

Take the following steps to protect yourself from latex exposure and allergy in the workplace:

- Use non-latex gloves for activities that are not likely to involve contact with infectious materials (food preparation, routine housekeeping, maintenance, etc.).
- Appropriate barrier protection is necessary when handling infectious materials. If you choose latex gloves, use powder-free gloves with reduced protein content.
- When wearing latex gloves, do not use oil-based hand creams or lotions (which can cause glove deterioration), unless they have been shown to reduce latex-related problems and maintain glove barrier protection.
- After removing latex gloves, wash hands with a mild soap and dry thoroughly.
- Frequently clean work areas contaminated with latex dust (upholstery, carpets, ventilation ducts, and plenums).
- Frequently change the ventilation filters and vacuum bags used in latex-contaminated areas.
- Learn to recognize the symptoms of latex allergy: skin rashes; hives; flushing; itching; nasal, eye, or sinus symptoms; asthma; and shock.
- If you develop symptoms of latex allergy, avoid direct contact with latex gloves and products until you can see a physician experienced in treating latex allergy.

If you have latex allergy, consult your physician regarding the following precautions:

- Avoid contact with latex gloves and products.
- Avoid areas where you might inhale the powder from the latex gloves worn by others.
- Tell your employers, physicians, nurses, dentists, etc. that you have latex allergy.
- Wear a medical alert bracelet.
- Take advantage of all latex allergy education and training provided by your employer.

References

Introduction

Healthcare professionals constantly navigate their way through a maze of ethical and legal rules and regulations that govern the profession. The healthcare profession is one of the most legal scrutinized professions and has some of the strongest ethical guidelines. Healthcare requires this type of oversight, not only because the very lives of people are at stake, but also because of the vulnerability of many of the people being cared for within the industry.

Sources Used to Interpret the Law

Standards of Care

Standards of care may be viewed as the level or degree of quality considered adequate by a profession, based on the skills and learning commonly possessed by the members of a profession.

Standards of care describe the minimal requirements that define an acceptable level of care; that is, to exercise ordinary and reasonable care to see that no unnecessary harm comes to the patient.

Practice Acts and Standards

The practice acts and standards are an external standard of care. State boards publish acceptable standards in the practice act relevant to their discipline, or in rules and regulations published to enforce the state practice act. These rules and regulations have the force of law because they are met or violated based on the evidence presented.

Professional Position Statements

Professional organizations add to the body of acceptable standards of care for professional nursing and other disciplinary care by publishing their own position statements.
Policies

This is an internal standard of care, or the standard set forth by an individual institution as the minimal acceptable practice. In court cases, institutional policies and procedures are presented and evaluated to determine if a clinical defendant has met the standard of care for the institution.

Malpractice

The legal issue that healthcare professionals have to concern themselves with most is malpractice. Everyone makes mistakes. However, when a doctor, healthcare professional, hospital, or other organization devoted to patient care makes a mistake, it potentially impacts the health, safety, or finances of a patient. When this happens, a liability exists which can result in a lawsuit being filed against the healthcare professional.

Malpractice vs. Negligence

Negligence is a general term that denotes conduct lacking in due care. It is equated with carelessness; negligence is a deviation from the standard of care that a reasonable person would use in a set of circumstances.

Malpractice is a more specific term that looks at a professional standard of care, as well as the professional status of the caregiver. To be liable for malpractice, the person must be a professional. Malpractice is defined as any professional misconduct or unreasonable lack of skill or fidelity in professional or judiciary duties. The wrong or injudicious treatment must result in injury, unnecessary suffering, or death to the patient, and it proceeds from ignorance, carelessness, the want of proper professional skill, the disregard of established rules and principles, neglect, or a malicious or criminal intent.

Elements of Malpractice

Duty Owed the Patient

Duty of care is owed to others and involves how one conducts oneself. The duty of care owed a patient is usually fairly established, especially if the clinician is employed by a hospital or clinic. A duty is formed not only by employment but also by a relationship where one person depends on another.

In healthcare, the duty is to keep the patient safe.

Breach of the Duty Owed the Patient

A breach of duty is a deviation from the standard of care owed the patient; that is, something was done that should not have been done or nothing was done when something should have been done. For example, an incorrect medication was administered and a correct medication omitted. Another example is failing to report a change in the patient’s condition.
Healthcare Laws

HIPAA

Hospitals and professionals across the healthcare industry are required by law to protect the privacy of their patients. Patients need to provide a great deal of information in order to get healthcare, and much private information about a patient is gathered within a clinic or hospital, such as test results or treatment plans. HIPAA, the Health Insurance Portability and Accountability Act, is a federal regulation that requires healthcare professionals to take all reasonable measures to make sure that patient information is only viewed by those with proper authority and access.

Healthcare Reform

The passage of health insurance reform legislation represents a historic victory for the American people – a victory over the special interests that have fought for decades to prevent families and businesses from having control over their healthcare or the healthcare of their workers.

Fraud and Abuse Laws

In order to adequately address issues of fraud and abuse, responsibility, ownership, and consequences for actions must cross the continuum at the individual physician, healthcare provider, organizational, and federal levels. Providers, as well as consumers, must be committed to providing appropriate documentation in order to address abuse issues, and take a moral and ethical stand against fraud in the healthcare environment. This may mean taking advantage of the FCA whistleblower laws to report fraudulent claims to the appropriate federal authorities. Healthcare providers and organizations must invest in offering education and training programs, creating coding and fraud and abuse committees, and utilizing data mining and modeling software. Finally, the federal government must be diligent in prosecuting providers, healthcare organizations, manufacturers/retailers, and individuals who commit fraud and abuse in an organized and systematic manner.

Consent

In order for treatment to be legal, the patient and or legal guardian must give consent. Failure to obtain basic consent exposes the physician to a claim of medical battery. Getting informed consent is more than simply getting the patient to sign a consent form. Educating the patient so they can make an informed decision either to accept or reject the proposed treatment gives meaning to patient autonomy and ensures the bodily integrity of every patient.

Documentation

Documentation can protect you; lax documentation can weaken your defenses during a lawsuit. What happened, when did it happen, and why did it happen? are fundamental questions that must be answered in every potential claim. Sloppy documentation can hamper your ability to defend your answers to these questions.
The following tips will help you avoid dangerous mistakes.

- Document all informal, "sidewalk" consultations. For example, say a surgeon decided to perform a Caesarian section, and he and the anesthesiologist had an informal conversation in the hallway about the type of anesthetic they would use, but neither provider documented this conversation in the patient's chart. Such an omission could weaken the defense's case. A quick, simple note indicating that the two had spoken would eliminate this liability risk.

- Write down all administered medications. This sounds like common sense, but this information is sometimes omitted from the chart. It is also important to document when and how the drug was administered, such as in a timed sequence.

- Take extensive notes during codes. Timing usually comes into question after a code. A complete code team must include someone who charts accurate times.

- Review all documentation before disclosing information to the patient and the patient’s family. Especially if more than one provider is working on a case, all practitioners should review the case carefully before the meeting with patients or their family members to avoid giving conflicting information.

**Incidence and Occurrence Reporting**

An incidence or occurrence report is a tool used to document potential legal issues, patient harm, losses and opportunities. Incidence reports are meant to be nonjudgmental, factual reports of the problem and its consequences. Filing an incident report is not an admission of negligence; these tools are simply records of all events that are not part of routine medical care.

**References**


Introduction

Congress enacted the Occupational Safety and Health (OSH) Act of 1970, creating the Occupational Safety and Health Administration (OSHA). OSHA’s mission is to help employers and employees reduce on-the-job injuries, illnesses, and deaths.

OSHA directs national compliance initiatives in occupational safety and health. Through the methods described below, OSHA helps businesses protect their workers and reduce the number of workplace deaths, injuries, and illnesses. When employees stay safe and healthy, companies can reduce workers’ compensation insurance costs and medical expenses, decrease payouts for return-to-work programs, reduce faulty products, and lower the costs of job accommodations for injured workers. Indirectly, additional benefits such as increased productivity, lower training costs due to fewer replacement workers, and decreased costs for overtime have also been attributed to OSHA’s research and guidance.

What does OSHA do?

OSHA employs the following strategies in order to fulfill its mission:

- **Enforcement** – making sure OSHA regulations are followed
- **Assistance** – outreach and training to employers and employees
- **Cooperation** – partnerships and alliances through voluntary programs

OSHA promotes workplace safety and health by:

- Implementing new (or improved) safety and health management systems.
- Completing worksite inspections.
- Companies failing to follow OSHA regulations may be cited and/or fined.
• Promoting cooperative programs including Voluntary Protection Programs, OSHA Strategic Partnerships, and other industry alliances.

• Establishing the specific rights and responsibilities of employees and employers.

• Supporting innovation in dealing with workplace hazards.

• Establishing recordkeeping and reporting requirements for employers.

• Developing training programs for occupational safety and health personnel.

• Partnering with states that operate their own occupational safety and health programs.

• Supporting the OSHA Consultation Program.

Who is Required to Comply?

The Occupational Safety and Health Act covers all employers and employees, either directly through Federal OSHA or through an OSHA-approved state program.

Twenty-two states have decided to develop their own safety and health programs. The state plans must be at least as effective as Federal OSHA requirements. State plans covering the private sector also must cover state and local government employees.

OSHA Regulations

In general, OSHA regulations (also referred to as “standards”) require employers:

• To maintain conditions and/or adopt practices necessary and appropriate to protect workers on the job.

• Be familiar with and comply with standards applicable to their establishments.

• Ensure that employees have and use personal protective equipment when required for safety and health.

In addition, the OSH Act instituted a “general duty clause” (Section 5(a)(1)) which requires that each employer “furnish ... a place of employment which [is] free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.”

OSHA standards can be grouped into six areas including: Administrative Safety, Exposure Control, Personal Protection, Facility Safety, Tools and Equipment, and Behaviors and Attitudes.

Administrative Safety

The OSHA regulations regarding administrative safety help employers administer safety and health programs at their workplaces. These standards involve:

Safety Program Development
How do you set up a safety program and make sure your team buys into it?

Accident Investigations
How do you deal with an accident after it has occurred? How do you prevent similar accidents from occurring again?
Emergency Planning
How do you plan for the unexpected? How do you teach your employees how to handle any emergency situation that may arise?

OSHA Recordkeeping
What are OSHA’s recordkeeping requirements, and what must be done to comply?

Safety Audits
How do you regularly review your workplace, equipment, tools, and materials to ensure all hazards have been addressed?

State and Federal Posting Requirements
What are the federal, state, and industry-specific posting requirements that must be met at each work area?

Exposure Control
The exposure control standards prevent exposure to hazards. They regulate areas such as:

Asbestos Safety
How do you protect your employees from asbestos exposure?

Blood Borne Pathogens
How do you protect your employees from blood-related exposure, including needlestick injuries?

Hazardous Materials
How do you teach your employees how to read and understand hazardous material labeling? How do you put preventive measures in place so employees know how to deal with hazardous spills?

Hot and Cold Working Conditions
How do you prevent your employees from having to work in hot or cold work environments?

Lead Safety
How do you mitigate employee exposure to lead?

Right to Know/Hazard Communications
Are your employees and site visitors aware of the hazardous materials in your workplace? Do they understand how to protect themselves from these hazards?

Material Safety Data Sheets (MSDS)
Can your employees read and understand the MSDS forms for the materials they use?

Tuberculosis
Are your employees protected from tuberculosis?

Personal Protection
Regulations in this area deal with equipment that protects employees, including:

Back Safety
How do you protect your employees from normal day-to-day activities that may result in back injury?

Eye Safety
Do you have sufficient protection in place to care for the eye safety of your employees?
Fall Protection
Do you and your employees understand and correctly implement OSHA fall protection standards?

First Aid
What are the requirements as prescribed by OSHA for first aid training and stations?

Hand, Wrist, and Finger Safety
How do you protect your employees from hand, wrist, and finger injuries while on the job?

Hearing Safety
Do you require a hearing conservation program at your workplace?

Personal Protective Equipment
Have you thoroughly reviewed all of your work processes and determined if personal protective equipment is required?

Respiratory Protection
Do your employees work in environments requiring respiratory protection? Are your employees properly trained on the use and maintenance of these protection devices?

Safety Showers and Eyewashes
Do you follow OSHA-specific requirements for safety showers and eyewashes?

Facility Safety
Facility safety regulations ensure that facilities are safe for both employees and visitors.

Confined Spaces
Do you require a confined space program at your workplace?

Electrical Safety
Have you established an electrical safety plan at your workplace and put preventive measures in place?

Ergonomics
Have you addressed ergonomics-related injuries in both your production and office environments?

Fire Safety
Do you have the correct fire extinguishers in your office? Are they properly maintained? Do your employees know what to do in case of a fire?

Indoor Air Quality
Have you monitored your work areas for indoor air quality problems? Do you know what to look for and how to address potential risks?

Lockout/Tagout
Do you have controls in place to protect workers from the accidental exposure to energy sources?

Material Handling
Do your employees know how to handle job-related materials? Do they properly use/understand the tools available to aid in material handling while also reducing the risk of loss or injury?

Office Safety
Do you have an office safety plan in place? Are you sure everything you need is included?

Slips, Trips, and Falls
Do you monitor walking and working surfaces for hazards that may result in slips, trips, or falls?
Tools and Equipment

This category of regulations ensures that employees know how to safely use and maintain tools and equipment in the workplace, such as:

Compressed Gases
Do your employees know/understand how to safely use compressed gas cylinders?

Computer Safety
Do you have protective measures in place to address the repetitive injury issues associated with computers?

Crane Safety
Does your team know/understand how to operate and work around your cranes? Do you have a crane safety program and checklists in place to prevent accidents and injuries?

Driving Safety
Have you adopted a defensive driving program for your drivers?

Forklift Safety
Do you have certified forklift drivers at your workplace? Have other team members that are exposed to forklifts been trained how to effectively work around them?

Hand and Power Tool Safety
Have your employees been trained how to safely use the hand and power tools required for their jobs?

Ladder Safety
Do your employees know how to select the correct ladder for the job?

Machine Guarding
Do you regularly inspect your workplace to ensure all machine guarding is in place and not removed? Do you follow maintenance recommendations on your equipment to ensure guarding is functioning properly?

Rigging Safety
Do your employees know/understand correct rigging procedures?

Scaffolding Safety
Do you have supported/suspended scaffolding procedures in place?

Welding Safety
Are your employees trained on the safety precautions identified by OSHA for the various types of welding activities? Do you feel your employees are safe while working around welders?

Behavior and Attitude

Behavior and attitude regulations answer the question, “How do you address the behaviors of employees and workplace visitors that may have an adverse effect on the safety and health of your team?”

Conflict Resolution
How does your organization deal with conflict? Left to fester, workplace conflict can cause many problems, one of the worst being a lack of focus on the work at hand.

Drug and Alcohol Abuse
Do you have drug and alcohol prevention policies established?
Fitness and Wellness
Do you promote the fitness and health of your employees?

Harassment
How does your firm deal with employee and sexual harassment? Do you have measures in place to help protect employees from harassment?

Safety Housekeeping
Do you have a clean workplace? Have you trained your employees of the hazards of the “work around”?

Safety Orientations
Have you developed a thorough safety orientation program that addresses all the work processes an employee is responsible to perform and the safety precautions they are required to take?

Workplace Stress
Have you addressed issues associated with job stress and provided enough relief to employees to make sure stress does not expose them to other safety hazards?

Workplace Violence
Do you have a violence protection policy in place at your workplace?

How to Comply

Employers have specific responsibilities under OSHA that they must perform to ensure the safety and health of their workers. The following list is a summary of the most important ones:

- Keep your workplace free from serious recognized hazards.
- Monitor your workplace conditions to make sure they conform to OSHA standards.
- Make sure tools and equipment are properly maintained prior to employee use.
- Identify hazards for your employees by using color codes, posters, labels, and signs.
- Develop/maintain safe operating procedures and train employees to follow the requirements.
- Provide medical examinations and training when required by OSHA standards.
- Post the OSHA Poster (or the state-plan equivalent) informing employees of their rights and responsibilities in a prominent location within the workplace.
- Report any fatal accident or one that results in the hospitalization of three or more employees to the nearest OSHA office within 8 hours.
- Keep records of work-related injuries and illnesses and give employees, former employees, and their representative’s access to the OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300).
- Provide employee medical and exposure records to employees or their authorized representatives upon their request.
- Identify authorized employee representatives who may be asked to accompany the OSHA compliance officer during an inspection.
- Do not discriminate against employees who exercise their rights under the Act.
• Post OSHA citations at or near the work area involved until the violation has been corrected, or for three working days, whichever is longer.
• Correct violations by the deadline set in the OSHA citation and submit required verification documentation.

OSHA in the Healthcare Workplace

Healthcare workers face a number of serious safety and health hazards. These include: blood borne pathogens and biological hazards, potential chemical and drug exposures, waste anesthetic gas exposures, respiratory hazards, ergonomic hazards from lifting and repetitive tasks, laser hazards, workplace violence, hazards associated with laboratories, and radioactive material and x-ray hazards. Some of the potential chemical exposures include: formaldehyde, used for preservation of pathology; ethylene oxide, glutaraldehyde and peracetic acid used for sterilization; and numerous other chemicals used in healthcare laboratories.

Organizational Safety Culture – Linking Patient and Worker Safety

The burden and cost of poor patient safety, a leading cause of death in the United States, has been well-documented and is now a major focus of most healthcare institutions. Less well-known is the elevated incidence of work-related injury and illness among healthcare workers (HCWs) that occurs in the work setting, and the impacts these injuries and illnesses have on the workers, their families, healthcare institutions, and ultimately, on patient safety. It is not surprising that patient and worker safety often go hand-in-hand and share organizational safety culture as their foundation.

Hazards to HCWs because of lapses in infection control, fatigue, or faulty equipment may result in injury or illness, not only to workers, but also to patients and others in the institution. Workers who are concerned for their safety or physical or psychological health in a work environment in which their safety and health is not perceived as a priority, will not be able to provide error-free care to patients. Therefore, efforts to reduce the rate of medical errors must be linked with efforts to prevent work-related injury and illness if they are to be successful.

Several studies have found organizational factors to be the most significant predictor of safe work behaviors. Studies have shown compliance with standard precautions increased when workers felt that their institution had a strong commitment to safety and when institutions targeted interventions at improving organizational support for employee health and safety. Also, safety culture has an important influence on implementation of training skills and knowledge.

A safety culture is created through:

1. The actions management takes to improve both patient and worker safety;
2. Worker participation in safety planning;
3. The availability of appropriate protective equipment;
4. The influence of group norms regarding acceptable safety practices; and
5. The organization’s socialization process for new personnel.

Injury and Illness Prevention Programs – Moving Toward Injury-Free Healthcare

An injury and illness prevention program is a proactive process to help employers find and fix workplace hazards before workers are hurt. Such programs have been proven to help employers and society reduce the personal, financial, and societal costs that injuries, illnesses, and fatalities impose. Research demonstrates that such programs are effective at both the establishment and corporate levels in transforming workplace culture; reducing injuries, illnesses, and fatalities; lowering workers’ compensation and other costs; improving morale and communication; enhancing image and reputation; and improving processes, products, and services.

A basic prerequisite for preventing injuries and illnesses is knowledge of the types, location, and underlying reasons for their occurrence in the workplace. A readily available resource to assist in determining this information is the employer’s OSHA 300 log. Through careful review and analysis of the log, the employer can develop a roadmap to prevention and tailor corrective actions specific to the situations found in his or her workplace.

Programs with strong management commitment and active worker participation are effective in reducing injury risk, while "paper" programs are, not surprisingly, ineffective. Strong and visible management leadership is perhaps the most critical element of an effective injury and illness prevention program. Worker participation makes an important contribution to an employer’s bottom line. When workers are encouraged to offer their ideas and they see their contributions being taken seriously, they tend to be more satisfied and more productive.

Despite the value to employers and workers in terms of injuries prevented and dollars saved, many healthcare institutions have not yet adopted injury and illness prevention programs that unite patient and worker safety. Based on the positive experience of employers with existing programs, OSHA believes that injury and illness prevention programs provide the foundation for breakthrough changes in the way employers identify and control hazards, leading to significantly improved overall workplace health and safety environments; improved patient safety; and fewer worker injuries, illnesses, and fatalities.

Infectious Diseases

HCWs are occupationally exposed to a variety of infectious diseases during the performance of their duties. The delivery of healthcare services requires a broad range of workers, such as physicians, nurses, technicians, clinical laboratory workers, first responders, building maintenance, security and administrative personnel, social workers, food service, housekeeping, and mortuary personnel. Moreover, these workers can be found in a variety of workplace settings, including hospitals, nursing care facilities, outpatient clinics (e.g., medical and dental offices, and occupational health clinics), ambulatory care centers, and emergency response settings. The diversity among HCWs and their workplaces makes occupational exposure to infectious diseases especially challenging. For example, not all workers in the same healthcare facility, not all individuals with the same job title, and not all healthcare facilities will be at equal risk of occupational exposure to infectious agents.

The primary routes of infectious disease transmission in US healthcare settings are contact, droplet, and airborne. Contact transmission can be sub-divided into direct and indirect contact. Direct contact
transmission involves the transfer of infectious agents to a susceptible individual through physical contact with an infected individual (i.e., direct skin-to-skin contact). Indirect contact transmission occurs when infectious agents are transferred to a susceptible individual when the individual makes physical contact with contaminated items and surfaces (e.g., door knobs, patient care instruments or equipment, bed rails, examination table, etc.). Two examples of contact transmissible infectious agents are Methicillin-resistant Staphylococcus aureus (MRSA) and Vancomycin-resistant Enterococcus (VRE).

Droplets containing infectious agents are generated when an infected person coughs, sneezes, or talks, or during certain medical procedures, such as suctioning or endotracheal intubation. Transmission occurs when droplets generated in this way come into direct contact with the mucosal surfaces of the eyes, nose, or mouth of a susceptible individual. Droplets are too large to be airborne for long periods of time, and droplet transmission does not occur through the air over long distances. Two examples of droplet transmissible infectious agents are the influenza virus, which causes the seasonal flu, and Bordetella pertussis, which causes pertussis (i.e., whooping cough).

Airborne transmission occurs through very small particles or droplet nuclei that contain infectious agents and can remain suspended in air for extended periods of time. When they are inhaled by a susceptible individual, they enter the respiratory tract and can cause infection. Since air currents can disperse these particles or droplet nuclei over long distances, airborne transmission does not require face-to-face contact with an infected individual. Airborne transmission only occurs with infectious agents that are capable of surviving and retaining infectivity for relatively long periods of time in airborne particles or droplet nuclei. Only a limited number of diseases are transmissible via the airborne route. Two examples of airborne transmissible agents include Mycobacterium tuberculosis, which causes tuberculosis (TB), and the rubella virus, which causes measles.

**Safe Patient Handling**

One major source of injury to healthcare workers is musculoskeletal disorders (MSDs). These injuries are due in large part to overexertion related to repeated manual patient handling activities, often involving heavy manual lifting associated with transferring and repositioning patients and working in extremely awkward postures. Some examples of patient handling tasks that may be identified as high-risk include: transferring from toilet to chair, transferring from chair to bed, transferring from bathtub to chair, repositioning from side to side in bed, lifting a patient in bed, repositioning a patient in chair, or making a bed with a patient in it.

Sprains and strains are the most often reported nature of injuries, and the shoulders and low back are the most affected body parts. The problem of lifting patients is compounded by the increasing weight of patients to be lifted due to the obesity epidemic in the United States, and the rapidly increasing number of older people who require assistance with the activities of daily living.

The consequences of work-related musculoskeletal injuries among nurses are substantial. Along with higher employer costs due to medical expenses, disability compensation, and litigation, nurse injuries are also costly in terms of chronic pain and functional disability, absenteeism, and turnover. As many as 20% of nurses who leave direct patient care positions do so because of risks associated with the work. Direct and indirect costs associated with only back injuries in the healthcare industry are estimated to be $20 billion annually. In addition, healthcare employees who experience pain and fatigue may be less productive, less attentive, more susceptible to further injury, and may be more likely to affect the health and safety of others.
Given the increasingly hazardous biomechanical demands on caregivers today, it is clear the healthcare industry must rely on technology to make patient handling and movement safer. Patient transfer and lifting devices are key components of an effective program to control the risk of injury to patients and staff associated with lifting, transferring, repositioning, or movement of patients. Essential elements of such a program include: management commitment to implement a safe patient handling program and to provide workers with appropriate measures to avoid manual handling; worker participation in the assessment and implementation processes and the evaluation and selection of patient handling devices; a thorough hazard assessment that addresses high risk units or areas; investment in equipment; care planning for patient handling and movement; training for staff; and program review and evaluation processes. The education and training of healthcare employees should be geared towards assessment of hazards in the healthcare work setting, selection and use of the appropriate patient lifting equipment and devices, and review of research-based practices for safe patient handling.

The use of assistive patient handling equipment and devices is beneficial not only for healthcare staff, but also for patients. Explaining planned lifting procedures to patients prior to lifting and enlisting their cooperation and engagement can increase patient safety and comfort and enhance their sense of dignity.

**Workplace Violence**

Workplace violence (WPV) is a recognized hazard in the healthcare industry. WPV is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It can affect and involve workers, clients, customers, and visitors. WPV ranges from threats and verbal abuse to physical assaults and even homicide. In 2010, the Bureau of Labor Statistics (BLS) data reported that healthcare and social assistance workers were the victims of approximately 11,370 assaults by persons; a greater than 13% increase over the number of such assaults reported in 2009. Almost 19% (i.e., 2,130) of these assaults occurred in nursing and residential care facilities alone. Unfortunately, many more incidents probably go unreported.

In most workplaces where risk factors can be identified, the risk of assault can be prevented or minimized if employers take appropriate precautions. One of the best protections healthcare employers can offer their workers is to establish a zero-tolerance policy toward workplace violence. The policy should cover all workers, patients, clients, visitors, contractors, and anyone else who may come in contact with workers of the facility.

By assessing their worksites, employers in the healthcare industry can identify methods for reducing the likelihood of incidents occurring. OSHA believes that a well-written and implemented Workplace Violence Prevention Program, combined with engineering controls, administrative controls, and training can reduce the incidence of workplace violence. It is critical to ensure that all workers know the policy and understand that all claims of workplace violence will be investigated and remedied promptly.

**Other Hazards**

In addition to infectious disease, ergonomic, and workplace violence issues, workers in healthcare settings encounter a number of other workplace hazards. These include chemicals (e.g., sterilants), hazardous drugs (e.g., antineoplastic drugs), materials that cause allergic reactions (e.g., latex), and physical agents (e.g., radiation). Several common examples of these “other hazards” are discussed below.
Chemicals

Safety Data Sheets
The Hazard Communication Standard was revised in 2012 to require that all chemicals have a Safety Data Sheet, SDSs (formally known as the Material Safety Data Sheet or MSDS) that presents the information about the chemical in a 16 part consistent user-friendly format. Employers must ensure that the SDSs are readily accessible to employees for all hazardous chemicals in their workplace. This can be in a binder or on the computer where the employees can access them without leaving their work area. Below are examples of hazardous chemicals frequently found in healthcare facilities.

Ethylene Oxide
Ethylene oxide (EtO) is a flammable, colorless gas at temperatures above 51.3 °F (10.7 °C) that smells like ether at toxic levels. It can be found in fumigants and sterilants and presents an opportunity for healthcare worker exposure during operations such as EtO sterilization of surgical equipment.

Formaldehyde
Formaldehyde can be used as a disinfectant or a sterilant. It is often found mixed in water and referred to as formalin. Formaldehyde can be used to prepare viral vaccines; as an embalming agent; as a tissue fixative; and in the sterilization of medical equipment (e.g., surgical instruments, hemodialyzers). Paraformaldehyde (a solid polymer of formaldehyde) can be heat vaporized for the gaseous decontamination of laminar flow biologic safety cabinets.

Glutaraldehyde
Glutaraldehyde is a colorless, oily liquid with a pungent odor. It is often mixed with water for use. Exposure can occur in healthcare facilities when glutaraldehyde is used in operations, such as cold sterilization/high-level disinfection; tissue fixing/preservation (e.g., for microscopy, histology); and in the processing of x-rays.

Hazardous Drugs
Drugs are classified as hazardous if studies in animals or humans indicate that exposures to them have a potential for causing cancer, developmental or reproductive toxicity, or other organ system damage. Hazardous drugs, such as those used for cancer chemotherapy, antiviral treatments, and hormone regimens, pose a serious hazard to healthcare workers. These effects can be irreversible even with low-level exposures.

Waste Anesthetic Gases
Waste anesthetic gases include nitrous oxide and various halogenated anesthetics (e.g., halothane, enflurane, isoflurane, desflurane). Exposure to these gases can occur through leakage of the patient’s anesthetic breathing circuit during delivery of anesthetic, and through exhalations of patients recovering from anesthesia.

Emergency Response Hazards
During the provision of emergency response care, healthcare workers may be exposed to chemical, biological, physical, or radioactive hazards. These hazards could be encountered singly or in combination with other hazards, could be a hazard that has never been or is rarely seen by the healthcare provider (e.g., anthrax), and could involve a large number of affected individuals, stressing available resources.
Radiation
Ionizing (e.g., x-rays, nuclear medicine)
Ionizing radiation has enough energy to remove an electron from an atom (creating an ion). The main types of ionizing radiation are alpha particles, beta particles, gamma rays, and x-rays. Sources of ionizing radiation in healthcare include: x-ray machines, radioactive isotopes, and radio nucleotides.

Non-Ionizing (e.g., lasers)
Non-ionizing radiation does not have enough energy to remove an electron from an atom, but may cause an atom to vibrate or move around in a molecule. Examples of non-ionizing radiation include: microwaves, infrared radiation, and visible light. A source of non-ionizing radiation in healthcare is a laser.

Lasers produce an intense, highly directional beam of light. In healthcare, lasers may be used as scalpels, probes, or in certain imaging techniques. Hazards may be associated with the laser beam (e.g., burns due to absorption of laser energy), the equipment (e.g., high voltage), or products produced during laser use (e.g., laser plume).

Latex Allergy
Latex, also known as rubber or natural latex, is derived from a milky fluid found in rubber trees. Latex allergy is a reaction to certain proteins found in natural latex. Latex allergy may cause allergic reactions ranging from sneezing or a runny nose to anaphylaxis, a potentially life-threatening condition. Healthcare workers exposed to rubber gloves and other latex-containing medical devices are at risk of developing latex allergy.

Safe Workplace
As you can see, OSHA affects many aspects of the HCWs environment, job, and culture. Many of these standards are common sense and fall under the general duty clause. Remember that employee and patient safety go hand-in-hand. When ensuring patient safety, you are also making your workplace a safer place for you and your peers.

Workers may file a complaint to have OSHA inspect their workplace if they believe that their employer is not following OSHA standards or that there are serious hazards. Employees can file a complaint with OSHA by calling 1-800-321-OSHA (6742), or by printing the complaint form and mailing or faxing it to your local OSHA area office. Complaints that are signed by an employee are more likely to result in an inspection.

If you think your job is unsafe or you have questions, contact OSHA at 1-800-321-OSHA (6742). It is confidential. For other valuable worker protection information, such as Workers’ Rights, Employer Responsibilities, and other services OSHA offers, visit OSHA’s Workers’ page.
Introduction

All patients/residents have the right to have their pain managed. The assessment of pain is an interdisciplinary process including physicians, nurses, physical therapists, and other clinical disciplines involved in the patient’s care.

Treatment is based on the patient’s report of pain, with consideration given to age, culture, gender, cognitive level, type of pain, location, and intensity. Effective pain management is an integral component of patient care and an important indicator of quality of care. Optimal pain management diminishes suffering while minimizing complications, side effects, and cost. Unrelieved pain has adverse physical and psychological effects. Routine evaluation and systematic reevaluation until pain is controlled provide the foundation of appropriate pain management. Patient rights with regard to pain will be respected, including the right to have self-reports of pain accepted and acted on. The intention of pain management in all patients is to obtain adequate pain relief. Members of the healthcare team will encourage the reporting of pain when a patient and/or family member demonstrates reluctance to discuss pain, denies pain when pain is likely to be present, or does not follow through with prescribed treatments. The patient/family has the right to education, when appropriate, regarding their roles in managing pain, as well as the potential limitations and side effects from the treatment of pain. When opportunities present, the staff will provide information and instruction on appropriate ways to manage pain.

The failure to report pain is not to be confused with lack of pain. Mild to moderate pain may not be reported if the patient tends to be stoic. Other patients that might be at risk for poor pain management are non-verbal patients and those with chronic pain. The patient may think that caregivers know that he/she has pain and so do not report it. Thus, there is the need for careful assessment and education of the patient regarding pain management.
Pain Assessment/Reassessment

Pain assessment and intervention are ongoing. Baseline assessment including a pain goal is performed and documented upon admission. Subsequent reassessments are performed and the effectiveness of the interventions is documented per facility policy.

Many facilities have adopted pain assessment as the 5th vital sign (i.e. obtained with routine vital signs).

Pain rating scales that are appropriate for the patient population being served should be used. The following scales may be utilized: the Numeric Pain Rating Scale (1-10 with 10 being the worse pain), the Wong–Baker Face Scale, and the FLACC Scale.

Pain assessment includes the pain rating scale used, the quality/character of pain, the severity of pain, provoking factors (if any), duration of pain, location, and radiation.

Assessment factors in the non-verbal or cognitively-impaired patient include: facial grimacing, writhing, withdrawal of limb(s), moaning, tearing, and guarding.

When pharmacological interventions are administered, the nurse should reassess pain and document the effectiveness/ineffectiveness of the intervention.

If the patient’s comfort goal is not met, the physician should be notified for further orders/interventions.

Barriers to reporting pain from the patient’s perspective should be assessed during the initial admission assessment and may include:

- Fear that pain means that the disease is worse
- Concern about not being a “good” patient and thinking that good patients do not complain
- Fear of addiction or of being thought of as an addict
- Fear of becoming tolerant to pain medications
- Worry about side effects (constipation, nausea, etc.)
- Concern about distracting the physician from treatment of the underlying disease
- Fear of discomfort associated with medication administration (taste/injection)
Interventions

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

Pharmacological

Initiation of interventions must follow hospital policy for prescribing and administering medications and/or treatments. Pain medications will be administered according to the physician order.

Non-Pharmacological

Non-pharmacological measures should be considered based on patient preference, physician order, type of pain, and degree of pain relief obtained. These include, but are not limited to:

- Heat or cold therapies.
- Positioning.
- Massage.
- Distraction techniques, such as music, games, reading material, and television.
- Relaxation techniques, such as meditation and prayers.
- A quiet environment.

Patient/Resident/Family Education

The patient and/or appropriate family members should be educated on:

- Their role in assisting with pain management.
- Interventions used to alleviate patient barriers or fears about participating in effective pain management.
- The limitations and side effects of pain treatments.
- The pain rating scale being utilized.
- Alternative methods of intervention, as appropriate and as employed, which may include non-pharmacological interventions.
- Pharmacological interventions.
- Reporting inadequate pain relief.
- Reporting lethargy, respiratory depression, urinary retention, or constipation.
- Discharge instructions (ensure that the patient/family understands the correct dosage and schedule of medication administration before discharge).

The Clinician’s Responsibility

- Know that the patient’s self-report is the single most reliable indicator of pain.
• Teach the patient about pain and relief.
• Know and use analgesic drugs for optimal safety and efficacy.
• Encourage the use of a wide variety of pain management interventions, including non-pharmacological techniques.
• Include what the patient believes will be effective in the plan of care.
• Offer pain medications or interventions frequently and/or as ordered rather than waiting for the patient to ask for relief.
• Discuss fears and other feelings related to accepting pain management interventions with the patient.
• Request further intervention orders if pain management is ineffective.
• Incorporate pain into the care planning process by adding it to the interdisciplinary plan of care.
• Ensure that unresolved pain present at discharge or transfer is addressed for continuity of care.

Reference

http://www.jointcommission.org/topics/pain_management.aspx

Patient’s Bill of Rights

A patient’s bill of rights is a list of guarantees for those receiving medical care. It may take the form of a law or a non-binding declaration. Typically a patient's bill of rights guarantees patients’ information, fair treatment, and autonomy over medical decisions, among other rights.

The purpose of the bill of rights is to:

- Build up consumer confidence in the healthcare system by making it easy for consumers to participate actively in their own health care.
- Strongly support the importance of a good healthcare provider and that of a good provider-patient relationship.
- Emphasize and support the importance of the consumer’s role in making sure they have rights and responsibilities with regard to health improvement.

Consumer Bill of Rights

The following section, Consumer Bill of Rights, was developed by the federal government. This has been used as a foundation for many health plans, including the federal government-sponsored health plans.

I. Information Disclosure

You have the right to receive accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don’t understand something, assistance will be provided so you can make informed health care decisions.

II. Choice of Providers and Plans
You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality health care.

III. Access to Emergency Services

If you have severe pain, an injury, or sudden illness and you feel that your health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

IV. Participation in Treatment Decisions

You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions.

V. Respect and Nondiscrimination

You have the right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives, and other health care providers.

VI. Confidentiality of Health Information

You have the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.

VII. Complaints and Appeals

You have the right to a fair, fast and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.

**Consumer Responsibilities**

In addition to outlining consumer rights for health care, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry also outlined guidelines for the responsibilities that the consumer has with regard to their own healthcare. The responsibilities outlined are ways that the consumer can work together with the health care provider to achieve the best quality health outcome.

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal process to address concerns that may arise.
- Avoid knowingly spreading disease.
• Recognize the reality of risks and limits of the science of medical care and the human fallibility of
  the health care professional.
• Be aware of a health care provider's obligation to be reasonably efficient and equitable in
  providing care to other patients and the community.
• Become knowledgeable about his or her health plan coverage and health plan options (when
  available) including all covered benefits, limitations and exclusions, rules regarding use of
  information, and the process to appeal coverage decisions.
• Show respect for other patients and health workers.
• Make a good-faith effort to meet financial obligations.
• Abide by administrative and operational procedures of the health plans and health care
  providers.
• Report wrongdoing and fraud to appropriate resources or legal authorities.

Patient Rights and Health Insurance: Affordable Care Act

In 2010, a new Patient’s Bill of Rights was created along with the Affordable Care Act. This bill of rights
was designed to give new patient protections in dealing with insurance companies. Some of the
protections started in 2010, but others were phased in more slowly and take full effect in 2014.

Here are some of the protections that apply to health plans under the new laws:

• Annual and lifetime dollar limits to coverage of essential benefits have been removed.
• People will be able to get health insurance in spite of pre-existing medical conditions.
• You have the right to an easy-to-understand summary of benefits and coverage.
• Young adults are able to stay on a parent’s policy until age 26 if they meet certain requirements.
• You’re entitled to certain preventive screening without paying extra fees or co-pays.
• If your plan denies payment for a medical treatment or service, you must be told why it was
  refused, and how to appeal (fight) that decision.
• You have the right to appeal the payment decisions of private health plans (called an “internal
  appeal”). You also have the right to a review by an independent organization (called an “outside
  review”) if the company still doesn’t want to pay.
• Larger insurance companies must spend 80 to 85% of their premiums on health care and
  improvement of care rather than on salaries, overhead, and marketing.
• If you made an honest mistake on your insurance application, health insurance companies will no
  longer be able to rescind (take back) your health coverage after you get sick. (They can still cancel
  coverage if you don’t pay premiums on time, if you lied on your application form, or if they no
  longer offer plans in your region.)
• If a company does cancel your coverage, they must give you at least 30 days’ notice.
• Premium increases of more than 10% must be explained and clearly justified.

Going into 2014, some existing health plans are still “grandfathered,” meaning they don’t have to follow all of the new rules as long as they keep an old plan in effect.

Besides the grandfathered plans, there are other ways insurance companies can bypass some of the rules. Insurance plans may ask the US Department of Health and Human Services (DHHS) for waivers (exceptions) to some of the new requirements. The DHHS has already granted a number of these exceptions, so you’ll still have to check with each plan to find out exactly what they do and don’t do.

Patient Rights under HIPAA

Under HIPAA, patients have the right to:

• Receive a privacy notice to inform them about how protected information will be used and disclosed.
• Request that uses and disclosure of protected information be restricted (covered entities are not required to always agree to restrictions).
• Inspect, copy and amend their medical records (providers are allowed to charge a reasonable fee for copying expenses).
• Get an accounting of the disclosure of their protected information for the past six years and file a complaint.

Additional RightsOutlined by Joint Commission

Patient rights should address the unique needs of individuals. Patients have the right to:

• Have a language interpreter.
• Receive accommodation for a disability.
• Be free from discrimination when receiving care.
• Identify a support person to be present during the hospital stay.
• Designate a surrogate decision-maker.

References

Patient’s Bill of Rights  What is the Patient’s Bill of Rights? Last Revised: 01/06/2014.
http://www.cancer.org/treatment=findingandpayingfortreatment=understandingfinancialandleegalmatter=s/patients-bill-of-rights

Introduction

In the past fifty years, healthcare has seen many changes. New technology has improved outcomes, and there has been a major push to see that all people have equal access to healthcare. Another trend has been an increased public awareness in the healthcare system and its providers. In November 1999, the Institute of Medicine issued a report, "To Err is Human: Building a Safer Health System." This report emphasized the critical issue of healthcare safety.

The public demands that healthcare organizations be held accountable for their actions. In response to these demands, the Joint Commission began to highlight the need for action in the healthcare industry. Accredited institutions are required to have a patient safety program that addresses patient safety issues in an ongoing, collaborative, proactive approach.

Hospitals are complex environments that depend on strong leadership to support an integrated patient safety system that includes the following:

- Safety culture
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate
- Safely integrated technologies

In an integrated patient safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from their patient safety events, including close calls and other system failures that have not yet led to patient harm.
Safety Culture

A strong safety culture is an essential component of a successful patient safety system and is a crucial starting point for hospitals striving to become learning organizations. In a strong safety culture, the hospital has an unrelenting commitment to safety and to do no harm. Among the most critical responsibilities of hospital leaders is to establish and maintain a strong safety culture within their hospital.

A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively. In order to accomplish this, hospitals should provide and encourage the use of a standardized reporting process for staff to report patient safety events.

Types of Possible Events

The following are types of events that may occur in the healthcare workplace:

- **Patient safety event**: An event, incident, or condition that could have resulted or did result in harm to a patient.

- **Adverse event**: A patient safety event that resulted in harm to a patient.

- **Sentinel event**: A subcategory of Adverse Events, a Sentinel Event is a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following:
  - Death
  - Permanent harm
  - Severe temporary harm

- **No-harm event**: A patient safety event that reaches the patient but does not cause harm.

- **Close call** (or “near miss” or “good catch”): A patient safety event that did not reach the patient.

- **Hazardous** (or “unsafe”) condition(s): A circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event.

The physician is required to inform patients and, when appropriate, their families about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes.

The Role of Hospital Leaders in Patient Safety

Joint Commission defines a learning organization as one in which people continuously learn, and thereby enhance their capabilities to create and innovate. Learning organizations uphold five principles: team learning, shared visions and goals, a shared mental model (that is, similar ways of thinking), individual commitment to life-long learning, and systems thinking. In a learning organization, patient safety events are seen as opportunities for learning and improvement. In order to become a learning organization, a hospital must have a fair and just safety culture, a strong reporting system, and a commitment to put that
data to work by driving improvement. Each of these requires the support and encouragement of hospital leadership.

Hospital leaders provide the foundation for an effective patient safety system by doing the following:

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and patient harms are freely shared with staff
- Modeling professional behavior
- Removing intimidating behavior that might prevent safe behaviors
- Providing the resources and training necessary to take on improvement initiatives

Assessing Staff Accountability

The aim of a safety culture is not a “blame-free” culture but one that balances learning with accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a manner that is applied consistently, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the hospital a clear, equitable and transparent process for recognizing and separating blameless errors that fallible humans make daily, from the unsafe or reckless acts where staff must be held accounted. One tool that facilities can use is the Incident Decision Tree developed by the United Kingdom’s National Patient Safety Agency which can be used to assess the individual’s culpability in the patient safety event. The use of the Incident Decision Tree or other formal decision process can help make determinations of culpability more transparent and fair.

Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When hospitals adopt a transparent, non-punitive approach to reports of patient safety events or other concerns, the hospital begins reporting to learn—and to learn collectively from adverse events, close calls, and hazardous conditions. When there is continuous reporting adverse events, close calls, and hazardous conditions, the hospital can analyze the patient safety events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the organization.

When hospitals collect data or measure staff compliance with evidence-based care processes or patient outcomes, they can manage and improve those processes or outcomes and, ultimately, improve patient safety. The effective use of data enables hospitals to identify problems, prioritize issues, develop solutions, and track success. Objective data can be used to support decisions, influence people to change their behaviors, and to comply with evidence-based care guidelines.

Effective data analysis can enable a hospital to “diagnose” problems within its system similar to the way one would diagnose a patient’s illness based on symptoms, health history, and other factors. Turning data into information is a critical competency of a learning organization and of effective management of change.
Proactive Risk Assessment

The scope of the Patient Safety Program includes an ongoing proactive assessment, using internal and external knowledge and experience to prevent error occurrence and to maintain and improve patient safety. In a proactive risk assessment the hospital evaluates a process to see how it could potentially fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. A proactive risk assessment increases understanding within the organization about the complexities of process design and management—and what could happen if the process fails.

Benefits of a proactive approach to patient safety includes increased likelihood of the following:

- Identification of actionable common causes
- Avoidance of unintended consequences
- Identification of commonalities across departments/services/units
- Identification of system solutions

Encouraging Patient Activation

To achieve the best outcomes, patients and families must be more actively engaged in decisions about their health care and must have broader access to information and support. Patient activation is inextricably intertwined with patient safety. Activated patients are less likely to experience harm and unnecessary hospital readmissions. Patients who are less activated suffer poorer health outcomes and are less likely to follow their provider’s advice.

Reference

http://www.jointcommission.org/topics/patient_safety.aspx
Quality in Healthcare

Quality programs in healthcare vary depending on the setting, region and regulatory requirements. In the past quality was a facility based program that focused on improvement within the facility. Today there are private, public and non-profit agencies monitoring quality in healthcare facilities for purposes of determining reimbursement to reporting findings to the public. The one common thread of the internal and external programs is improving the quality and safety of patient care.

Quality Improvement (QI)

The purpose of QI is to use a systematic, data-guided approach to improve processes or outcomes. Principles and strategies involved in QI have evolved from organizational philosophies of total quality management and continuous quality improvement.

While the concept of quality can be subjective, QI in healthcare typically focuses on improving patient outcomes. So the key is to clearly define the outcome that needs to be improved, identify how the outcome will be measured, and develop a plan for implementing an intervention and collecting data before and after the intervention.

QI methods

Various QI methods are used. A common format uses the acronym FOCUS-PDSA:

- Find a process to improve.
- Organize an effort to work on improvement.
- Clarify current knowledge of the process.
- Understand process variation and performance capability.
- Select changes aimed at performance improvement.
Plan the change; analyze current data and predict the results.
Do it; execute the plan.
Study (analyze) the new data and check the results.
Act; take action to sustain the gains.

What is QI

QI typically doesn't require extensive literature reviews or rigorous critical appraisal
Projects normally are site specific and results aren't intended to provide generalizable knowledge or best evidence.
Examples of QI projects include implementing a process to remove urinary catheters within a certain time frame, developing a process to improve wound-care documentation, and improving the process for patient education for a specific chronic disease.
QI uses systematic processes to improve patient outcomes.

Quality Assurance and Performance Improvement (QAPI)

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions. CMS is requiring that “a long term care QAPI program be an ongoing program that shows measurable improvement in indicators for which there is evidence that they will improve health outcomes and identify and reduce medical errors.”

QAPI encompasses all activities required for measuring quality of care and maintaining it at acceptable levels.

- QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes, skilled facilities typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

- PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

- QA + PI = QAPI:
Identifying and verifying quality related problems and their underlying cause;
Designing and implementing corrective action activities to address deficiencies;
Following up to determine the degree of success of an intervention and to detect new problems and opportunities for improvement; and
Continuously studying and improving the processes of healthcare and the delivery of services

Background

In March 2010, Congress passed the Patient Protection and Affordable Care Act, referred to as the Affordable Care Act. The Provisions set forth at Section 6102 (c) of the Affordable Act provide the opportunity for CMS to mobilize some of the best practices in QAPI and to identify technical assistance needs in advance of a new QAPI regulation. The provision states facilities shall establish and implement a QAPI program. This new provision significantly expands the level and scope of required QAPI activities to ensure that facilities continuously identify and correct quality deficiencies as well as sustain performance improvement.

Other Process Improvement Methods

Many organizations use programs such as Lean Six Sigma, change management process and other change management methodologies and tools for high reliability. One of the important advantages of employing process improvement tools such as DMAIC (define, measure, analyze, improve, control) is that they provide a systematic approach to solving complex problems. Specifically, they guide improvement teams to examine why processes fail to achieve their desired results. It is this systematic search for causes of quality and safety problems and the assessment of the relative contribution of each cause that gives these improvement tools a great deal of their effectiveness.

Change Management

Change Management is a set of principles designed to increase the success and accelerate the implementation of organizational change efforts. It addresses how to create a shared need for the change; understand and deal with resistance from key stakeholders; and build an effective influence strategy and communication plan for the change.

Lean

Lean is a well-defined set of tools that increase customer value by eliminating waste and creating flow throughout the value stream. The following bullets describe lean improvements:

- Inexpensive to implement
- Focus on improving the process, not the people
- Address the batch and queue mentality of silos by following process flow
- Promote simple, error proof systems

Therefore, a Lean process is better (no defects, it is what the customer wants), cheaper (non-value added work is removed, there is no re-work or scrap), and faster (eliminates batch and queue, introduces flow, gets it right the first time).

The Lean Steps:

- Specify Value – from the customer’s perspective
• Map the Process – Process Map or Value Stream Map
• Identify Value Added and Non-Value Added Steps
• Examine Flow – continuous, minimally interrupted flow; single piece vs. batching
• Create Pull – do not produce until the next step downstream is ready for you
• Pursue Perfection – sustain improvement; change culture

Six Sigma

Six Sigma is a statistical model that measures a process in terms of defects. Six Sigma enables an organization to achieve quality by using a set of strategies, tools, and methods designed to improve processes so that less than 3.4 defects (errors) exist per million opportunities and processes are as near to perfect as possible. Sigma, or the Greek letter d, is the symbol for standard deviation in statistics. Standard deviation levels help us understand how much the process deviates from perfection.

Six Sigma is also a philosophy of management that emphasizes:

• The importance of understanding factors critical to quality and customer expectations
• The measurement and analysis of data
• The implementation of solutions designed to improve processes to affect the most statistically significant sources of variation
• Sustaining these solutions

In short, Six Sigma is several things:

• A statistical basis of measurement that strives for reduction of defects to 3.4 defects per million opportunities (DPMO)
• A philosophy or method of management
• A management goal: to perform as perfect as practically possible
• A symbol of quality

Motorola started using Six Sigma in the 1980s to improve its manufacturing processes. General Electric and others expanded its applicability to service processes with great success. Other users and innovators in the late 90s include DuPont, Dow Chemical, 3M, Ford, Amex, Bank of America, JP Morgan Chase, and United Health Care.

Lean Six Sigma

Lean Six Sigma is a business process philosophy that focuses on the customer and increasing value and improving quality, safety and productivity. Both Lean and Six Sigma have their weaknesses and their strengths. For example, Six Sigma will eliminate defects but will not address speed or optimize flow. Lean does not include the advanced statistical tools required to identify the sources of variation necessary to craft an intervention that is as simple and as focused as possible. Recognizing the complementary nature of the two methodologies, many companies have used Lean and Six Sigma concurrently, utilizing different pieces of the tool kit to address specific improvement problems along a value stream. This practice of
combining different tool sets and playing to strengths is sometimes called the "blended approach." The Center for Transforming Healthcare uses the Lean Six Sigma blended approach.

**Quality Tools**

**Root Cause Analysis**

A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. Root cause is the most fundamental reason for the failure or inefficiency of a process.

**Failure Mode Effects Analysis (FMEA)**

Team based, systematic, proactive, and prospective approach for identifying ways that a process or design can fail, why it might fail, and how it can be made safer, in order to prevent process and product problems before they occur.

- Proven to reduce errors and increase successful performance of a process (increase patient safety)
- Can prevent errors and near misses
- Good for new processes and to reevaluate existing processes
- Effective quality improvement tool – narrows gaps in quality and performance
- Can yield significant results without complicated tools and statistical analysis
- Provides data to accurately identify real or potential failure modes and improvement opportunities
- Ensures documentation of procedures – exploring how procedures are performed – critical in reducing variance in how individuals perform the procedure
- If a particular failure cannot be prevented, FMEA focuses on protections that can be put into place to prevent failure from reaching the patient or – in worst case scenario – mitigate its effects if it reaches the patient.

**Quality Occurrences**

**Sentinel Event**

An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

Serious injury specifically includes loss of limb or function. The phrase or risk thereof includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.
Near Miss

Used to describe any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel Event Policy.

Hospital Quality Reports

Your hospital's results on National Quality Improvement Goal measures and measure sets are displayed in its Quality Report. Quality Reports became publicly available in 2004. Data are updated on a quarterly basis.

Your hospital's measure set results (for example heart attack care) are reported with symbols, comparing your hospital's performance with other Joint Commission-accredited hospitals nationwide and statewide.

Your hospital's individual measure results (for example aspirin upon arrival) are reported by using symbols and benchmark scores, comparing your hospital to other Joint Commission-accredited hospitals nationwide and statewide.

The goals track outcomes for common conditions such as heart attack, heart failure, children’s asthma, pneumonia, and surgical care. Health care providers and practitioners recognize these goals as optimal care for treating patients with the identified conditions.

The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) are two distinct organizations that are dedicated to collecting and reporting health care information to the public. The Joint Commission is an independent, not-for-profit organization, and CMS is a federal agency within the U.S. Department of Health and Human Services. CMS reports data on Hospital Compare which is a consumer-oriented website that provides information on how well hospitals provide recommended care to their patients.

Quality Measures

The entities that develop quality measures include:

- Government agencies, such as the Centers for Medicare and Medicaid Services (CMS) and the Agency for Health Care Research and Quality (AHRQ)
- Private nonprofits, such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA)
- For-profit companies, such as Healthgrades and U.S. News and World Report

Currently, the most common uses of quality measurements include public reporting, provider incentive programs, and accreditation and/or certification of providers and health plans.

- Making care safer by reducing the harm that is sometimes caused during the delivery of care
- Promoting the most effective prevention and treatment practices for the leading causes of death
• Promoting effective communication about and coordination of care » Ensuring that all individuals and families are engaged as partners in their care
• Working with communities to promote healthy living
• Making quality care more affordable for individuals, families, employers, and governments by developing and increasing the use of new health care delivery models

**LeapFrog**

Leapfrog’s public reporting initiatives offer valuable benchmarking capabilities to hospitals, as well as provide consumers and purchasers of healthcare with the quality and safety they need to make informed choices.

**Value Based Purchasing**

VBP Program is a novel Medicare payment estimation tool used to encourage clinical care quality improvement as well as improvement of patient experience as a customer of a health care system. The program utilizes well established tools of measuring clinical care quality and patient satisfaction such as the Hospital IQR program and HCAHPS survey to estimate Medicare payments and encourage hospitals to continuously improve the level of care they provide.

**References**


Introduction

A restraint is:

- Any device, manual, physical, mechanical or chemical, used to immobilize or restrict a person’s movement of his or her arms, legs, body or head freely.
- A restraint does not include devices that hold patients during routine physical exam or to protect from falling out of bed, or to permit the patient to participate in physical activities without the risk of physical harm.
- Excludes postural supports

The device is intended to:

- Protect the individual from harming his/herself (e.g., self-injurious behavior or “Sundowner’s Syndrome” [increased confusion, disorientation, and wandering, usually at night]), or
- Protect others from physical abuse or potential harm.

Physical Restraint

A physical restraint is any device used to physically restrict a person’s freedom of movement and physical access to his/her body in order to protect the individual from harming his/herself or others.

Chemical Restraint

A chemical restraint is a medication that is not a standard treatment for the patient’s medical or psychiatric condition, but is used to control behavior or to restrict the patient’s freedom of movement.
## Seclusion

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for management of violent or self-destructive behavior.

## Alternatives to Restraints

A restraint can only be used if needed to protect the patient’s well-being and if less restrictive interventions have been determined and documented to be ineffective. Examples of less restrictive interventions include:

- Speaking with the patient to identify reasons for behavior change
- Review of medications for drug interactions and/or polypharmacy
- Consulting the family about methods of calming the patient
- Consulting with the physician about the removal of tubes, lines, and/or dressings as soon as possible
- Covering IV sites with surginet, stockinet, or kerlix for protection
- Covering PEG with an abdominal binder
- Applying a bed check
- Bowel/bladder assessments
- Pain relief/comfort measures
- Soothing talk
- Providing bathing, a shower, ambulation, and/or a wheelchair ride in hall
- Family/sitter in attendance
- Pastoral counseling
- Modifying the environment to minimize clutter
- Reducing stimuli by dimming lights, reducing noise, etc.
- Diversional activities (music, videos, TV, soft objects to handle, etc.)
- Relaxation techniques
- Exercise/PT/OT
- Social activity
- Snacks
Restraint Use

The use of restraints poses inherent risks to the physical safety and psychological well-being of the patient. Using restraints can result in:

- Mental distress – restrained patients may feel helpless or like they are being punished
- Physical problems – including pressure ulcers if not repositioned properly and/or in a timely manner, loss of muscle and bone strength, skin tears, constipation, incontinence, and joint problems
- Injury – the lack of control may cause a patient to fight the restraints which can cause falls, broken bones, strangulation, and death

A physician must order restraints. Restraint orders must be time-limited and cannot exceed 24 hours. A new order must be obtained each day (24 hours). The order may be a verbal or telephone order in acute care settings.

The following are not acceptable medical orders:

- PRN orders for restraints
- Renewal of Restraint orders
- Standing orders for restraints

Duration

Duration of restraint use is limited to:

- Acute Care Services - Time is specified by the physician, but is not to exceed 24 hours.
- Behavioral Health Management - Time is specified by the physician, but is not to exceed 4 hours for adult patients. This means that if a patient is suicidal, an order needs to be obtained within one hour of application and is valid for only a 4-hour period of time.
- The patient is to be re-evaluated face-to-face by the physician at least every 24 hours to determine the continued need for restraints. A new restraint order must be written.
- Restraints and seclusion may not be used simultaneously unless the patient is continually monitored face-to-face by an assigned staff member.
- Restraint removal or a reduction in the level of restraint use should be implemented when the patient demonstrates a reduction in the behavior that led to restraint use.
- Restraints should be released every 2 hours and safely/properly reapplied

Documentation

Every episode of restraint use is to be documented and should include:

- The alternative measures attempted
- Type of restraint
• Behaviors requiring restraint usage
• Vital signs
• Circulation checks
• Hydration/elimination needs
• Nourishment offered
• Level of distress/agitation, mental status, and cognitive functioning
• Need for continued restraint, if applicable
• Individualized needs assessed

**Patient and Family Education**

Every effort should be made to discuss the issue of restraints with the patient (if practical) and family at the time of use. Education of the patient/family should include an explanation of the behaviors that might cause restraints to be incorporated into the plan of care, why the use of restraints is necessary, and an explanation of available alternatives to the use of restraints. Document all education.

**Type of Restraint**

The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

**Staff Training Required**

Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion (i) before performing [restraint or seclusion], (ii) as part of orientation, and (iii) subsequently on a periodic basis consistent with hospital policy.

**References**


What Is Risk Management?

In any industry, risk management addresses liability, both proactively and reactively. Risk management in health care considers patient safety, quality assurance and patients’ rights. The potential for risk permeates all aspects of health care, including medical mistakes, electronic record keeping, provider organizations and facility management.

Risk management is a systematic process aimed at reducing accidents, injuries, and financial risk to the hospital. Risk management can be proactive or reactive. Proactive focuses on avoiding/preventing risk. Reactive focuses on minimizing loss or damage after an adverse/bad event. Medical care delivery is art based in science. Good results cannot be guaranteed. One example is that every surgery has the potential for an undesirable outcome. Sometimes, regardless of medical intervention, patients die.

Applying common sense can prevent bad results or accidents. For example, slippery floors in high traffic areas can cause accidents. Washing floors at low traffic times and diverting traffic away from wet floors until dry is a proactive means of risk avoidance

Why is Risk Management Important?

Improves quality of care
Helps in responding to unsafe conditions
Protects employees and patients
Assures resources are spent to support patient care rather than cover losses
Reduces cost
Managing Risk

After the potential for adverse events is identified and measured, a plan is designed and implemented to avoid risk(s) and/or minimize damage and loss. Risk management does not have recipes.

Occasionally, a plan to prevent risk can create new risks. For example, the introduction of electronic medical records (EMRs) can make more efficient use of providers’ time and ease access to information about patients’ prescriptions and medical histories. At the same time EMRs can invade patients’ privacy or cause physicians and nurses to rely too much on technology, instead of customizing diagnosis and treatment. Breaches of privacy and diagnostic or treatment mistakes can result in litigation.

Management Plan

Risk management must be designed for each organization. An organization’s purpose, mandate, size, facility construction, nature of business, location, patient populations, demographics, and other factors must be considered.

Health care risk management can benefit from already available practice guidelines and principles. National standards for delivered care also help to prevent medical mistakes.

Making quality of delivered medical care a top priority can avoid unnecessary treatments, undesirable side-effects and unfortunate outcomes.

Incidents and Reporting Guidelines

An Incident Is

- Any unusual event involving patients, employees, physicians, visitors, or contractors
- Any unexpected medical intervention
- Any unexpected intensity of care
- Any unexpected health care impairment

An incident report helps guard against reoccurrences of negative outcomes by helping us to understand the causes and circumstances surrounding the incident, develop educational interventions to train employees to avoid future incidents, and to document the incident in order to assist with insurance or legal investigations.

Employees are cautioned that they have no authority to commit the hospital to liability through their acts or statements in the presence of patients, family members, or visitors.

Do

File a report immediately when you identify an incident (an Incident Report form is included in this section for your review).

Remember that the information is confidential and will be used to benefit our performance improvement plan. Limit your report to facts and do not make judgments.

Do Not

Do NOT place the report on the medical record.
Do NOT make copies of the report.
Do NOT discuss the report with others.
Do NOT state in the chart that the report has been made.
Do NOT hide the facts.

Sentinel Event and Root Cause Analysis

A sentinel event is an unexpected occurrence involving death, serious injury, or the risk thereof. Should such an event occur at health care facility, a thorough investigation (Root Cause Analysis) should take place to establish the cause of the sentinel event. This will help the facility learn how to change the process or system to prevent similar events from occurring in the future. If you were involved in the incident, you may be asked to participate in such an analysis. The findings from this analysis will be reported to the medical staff and to the governing board of the hospital.

What if you are not sure it really is an incident?

When in doubt, fill it out! An incident report is a tool to help determine how to create a safer environment and provides information about the patient and the incident. This helps to improve care and processes. If you are unsure, complete the incident report and your supervisor will determine whether what happened is an incident.

References


Sexual Harassment

Unwelcome verbal or physical conduct, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitutes sexual harassment when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment.

Harassment does not have to be of a sexual nature, however, and can include offensive remarks about a person’s sex. For example, it is illegal to harass a woman by making offensive comments about women in general.

Although the law doesn’t prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as the victim being fired or demoted).

Who are the Victims?

Both victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex.

In Fiscal Year 2007, EEOC received 12,510 charges of sexual harassment. 16.0% of those charges were filed by males. Sexual harassment is a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964. Title VII applies to employers with 15 or more employees, including state and local governments. It also applies to employment agencies and to labor organizations, as well as to the federal government.

Although men face harassment, women are the most likely victims. Harm caused by sexual harassment is often extreme, including humiliation, loss of dignity, psychological (and sometimes physical) injury, and
damage to professional reputation and career. Inevitably, the victims face a choice between their work and their self-esteem. Sometimes, they face a choice between their jobs and their own safety.

**Sexual Harassment Explained**

Federal law recognizes two different sets of legal grounds for claiming sexual harassment under Title VII.38 Quid Pro Quo and Hostile Work Environment.

Under the quid pro quo form of harassment, a person in authority, usually a supervisor, demands sexual favors of a subordinate as a condition of getting or keeping a job benefit.

A hostile work environment arises when a co-worker or supervisor, engaging in unwelcome and inappropriate sexually based behavior, renders the workplace atmosphere intimidating, hostile, or offensive.

Sexual harassment can occur in a variety of circumstances, including but not limited to the following:

- The victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.
- The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee.
- The victim does not have to be the person harassed but could be anyone affected by the offensive conduct.
- Unlawful sexual harassment may occur without economic injury to or discharge of the victim.
- The harasser's conduct must be unwelcome.

To put it more simply, sexual harassment is any offensive, sex-based behavior that no reasonable employee should have to endure. Examples include unwelcome:

- Innuendoes, jokes or gestures of a sexual nature
- Displaying of sexually-suggestive objects, photos or drawings
- Flirting
- Touching or other bodily contact
- Blocking or impeding physical movement

**Addressing the Issue**

Failure to adopt a pro-active and aggressive stance on this issue, however, can result not only in costly lawsuits, but also in a loss of employee morale, decline in productivity, and an erosion of a company's public image.

It is helpful for the victim to inform the harasser directly that the conduct is unwelcome and must stop. The victim should use any employer complaint mechanism or grievance system available.
When investigating allegations of sexual harassment, EEOC looks at the whole record: the circumstances, such as the nature of the sexual advances, and the context in which the alleged incidents occurred. A determination on the allegations is made from the facts on a case-by-case basis.

Prevention is the best tool to eliminate sexual harassment in the workplace. Employers are encouraged to take steps necessary to prevent sexual harassment from occurring. They should clearly communicate to employees that sexual harassment will not be tolerated. They can do so by providing sexual harassment training to their employees and by establishing an effective complaint or grievance process and taking immediate and appropriate action when an employee complains.

It is also unlawful to retaliate against an individual for opposing employment practices that discriminate based on sex or for filing a discrimination charge, testifying, or participating in any way in an investigation, proceeding, or litigation under Title VII.

References


Healthcare Professional Risk Factors

Abuse of alcohol, drugs, and controlled substances has reached epidemic proportions in the United States. It is important to recognize the signs of being “under the influence” in order to ensure a safe, drug-free workplace. “Under the influence” is defined as being unable to perform work in a safe and productive manner, or being in a physical or mental condition which creates a risk to the safety and well-being of the employee, his/her co-workers, and the public.

Healthcare professionals are not immune to the physiologic, behavioral, and genetic risk factors that can predispose one to drug abuse and diversion. In fact, healthcare professionals may be at higher risk because of frequent access and availability of drugs in the workplace. While current literature suggests prevalence rates of substance abuse among health professionals mirrors the general population, these professionals have higher rates of abuse with benzodiazepines and opiates. Nurses who work in high-stress environments with easy access to controlled substances may be particularly vulnerable. Specialties such as anesthesia, emergency medicine, and psychiatry also have an increased incidence

Alcohol Abuse

Some warning signs of alcohol abuse include:

- Impaired motor coordination, slurred speech, flushed face, and bloodshot eyes
- Elaborate excuses for behavior
- Irritability, mood swings
- Isolation from others
- Numerous injuries, burns, and bruises
- Smell of alcohol on breath or excessive use of mouthwash
• Performing poorly at work

**Drug Addiction**

Some warning signs of a drug addiction include:

• Social or professional isolation
• Disorganized schedule
• Frequent absences
• Declining work performance
• Inaccessibility to patients and other staff members
• Heavy drinking at hospital functions
• Changing physical appearance
• Suicide attempt
• Sleeping on the job
• Errors in judgment
• Regularly wearing long sleeves

**Drug Diversion**

• Some warning signs of drug diversion include:
• Overly involved in patients’ pain management
• Volunteering to medicate patients who are assigned to other nurses
• Seeking opportunities to administer controlled substances
• Tendency to administer more narcotics than nurses on other shifts
• Increased wasting of medication related to breakage, contamination, and patient refusal
• Saving controlled substances for administration at a later time
• Frequently asking for additional pain medication orders for patients
• Improper witnessing of waste medication
• Patients complaining that pain medication is not effective or denying that they received the medication
• Excessive discrepancies in the signing and documentation procedures of controlled substances

**Healthcare Provider Diversion**

Physicians, nurses, and other healthcare providers may knowingly or unknowingly be involved in drug diversion by:
• Prescribing controlled substances to patients who have given false information
• Prescribing controlled substances to patients involved in “doctor shopping”
• Prescribing controlled substances to patients who are selling their prescription drugs
• Intentionally prescribing controlled substances for illegal purposes
• Diverting controlled substances for personal use or financial gain

Mental Health Disorders

People have biological and psychological characteristics that can make them vulnerable or resilient to potential behavioral health problems. People with a mental health issue are more likely to use alcohol or drugs than those not affected by a mental illness.

Some warning signs of mental health disorders include:

• Lethargy
• Depression
• Erratic behavior or mood swings
• Inability to focus or concentrate
• Apathy
• Some of the same or similar characteristics as chemical dependency

Impaired Practitioners

Clinicians under the influence of drugs and/or alcohol that impact their ability to provide safe and competent care, pose a danger to patients/residents. A clinician’s first duty is to protect the safety of patients/residents. State Boards of Healthcare Clinicians (e.g., Physicians, Nursing, Physical Therapy, Respiratory Therapy, Pharmacy, etc.) have a responsibility for swift action to remove an impaired practitioner from performing duties involving direct patient/resident care until the practitioner is deemed safe to return to those duties. The board’s primary responsibility is to the public.

Most practitioners do not want to report impaired co-workers because they believe the state board would treat them too harshly by revoking their license to practice. Practitioners should become familiar with how their state board addresses issues of impairment. Practitioners who voluntarily enter peer assistance programs can generally continue practicing under specific guidelines. Many boards will not investigate an impaired practitioner’s practice if he/she voluntarily enters and successfully completes a program that establishes a program of recovery

References

http://www.nursingceu.com/courses/486/index_nceu.html#risk
WORKPLACE VIOLENCE
Core Competency Reading Material
December 2014

Introduction

Workplace violence is any physical assault, threatening behavior, or verbal abuse occurring in the work setting, according to the National Institute for Occupational Safety and Health.

Statistics

Workplace violence is the fastest growing form of murder in the US. Each year, more than 1600 people are murdered at work, 20 million people are assaulted, and more than 6 million are threatened.

Taxi drivers are the most likely victims at 23%, healthcare workers are at 10%, and police at 4%.

Factors

Workplace Environmental Factors

Below are several workplace environmental factors that may make workplace violence more likely:

- Contact with the public
- Exchange of money
- Mobile workplace (e.g., taxi, police)
- Working with unstable or volatile people
- Working alone or in small numbers
- Working at night or early morning
- Chronic labor disputes
• Frequent grievances filed
• Understaffing/excessive demands for overtime
• High number of stressed personnel
• Authoritarian management approach

Individual Stressors

A few examples of individual sources of stress that may lead to workplace violence are:

• The death of a family member
• Divorce or marital conflict
• Loss of employment
• Moving

Profile of the Attacker

Common characteristics of an attacker include:

• Male
• 35 years of age or older
• Owns weapon(s)
• A history of violence
• Withdrawn or a loner
• Job provides self-esteem
• Holds a grudge
• Has a hard time with authority figures
• Intimidates others
• A history of substance abuse or mental health issues
• Externalizes blame (blames others)
• Poor coping skills
• High probability of military service
• Behavioral and/or performance problems
Sources and Prevention

Third Party Intrusion

Third Party Intrusion is an incident caused by someone who is not an employee (e.g., spouses, ex-spouses, customers, clients, etc.)

**Ways to Prevent**

Employees should notify supervisors of domestic conflict.
Utilize codes/alarms.
Have escorts when unsure of situations.

Disgruntled Employees

Violence is directed towards co-workers, supervisors, etc.; employee seeking revenge.

**Ways to Prevent**

- Be aware of non-harassment and ZERO tolerance policies
- Encourage employees to report incidents
- Attend employee training when offered
- Know and follow security procedures
- Evaluate security and emergency procedures and discuss problem areas with your supervisor or safety officer
- Provide a healthy work environment for patients, residents, families, and co-workers

When conflicts occur:

- Do not get physical
- Do not overreact
- Do not take the challenge of another
- Be a good listener
- Find out what is really being said
- Give the other person space
- Watch what you say non-verbally

Miscellaneous

Random acts of violence; i.e., robberies, terrorism, etc.
If a Violent Incident Occurs

Report the incident immediately. Depending on the type of violence (physical, verbal, psychological), call police, report to your supervisor, the human resource department, the safety officer, etc.

Seek medical treatment, if necessary.

Document the incident(s), noting the date, time, etc., and follow through with management, supplying all necessary information and being available if needed.

References
