Nursing Comprehensive General Core Competencies

Core Competency Inservice
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Abuse, Neglect and Exploitation (Child, Domestic, Elder)

Introduction

Anyone, regardless of age or sex can be a victim of abuse, neglect, and/or assault, but people most vulnerable are the elderly, mentally impaired, children, and women.

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

Neglect is defined as the state or act of being uncared for or failing to provide care for properly.

Assault is defined as making a physical attack.

Forms of Abuse and Neglect

Physical abuse is intentional bodily injury. Examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints. Signs and symptoms of physical abuse include burns, bodily bruises, bone fractures, cuts, wounds, dislocations, sprains, poor hygiene, malnutrition, and behavioral changes.

Sexual abuse is nonconsensual sexual contact (any unwanted sexual contact). Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing. Signs of sexual abuse include bruising or bleeding around private areas such as the breast, anus, and genitalia. Unexplained sexual disease and/or infection can also be a sign of sexual abuse.

Mental mistreatment or emotional abuse is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing, harassment, treating an adult like a child, isolating an adult from family, friends, or regular activity, use of silence to control behavior, and yelling or swearing which results in mental distress. Signs of emotional abuse include low self-esteem, depression, anxiety, fear, hopelessness, insecurity, withdrawal, isolation, weight gain or loss, an elder acting childlike, and refusing to talk.

Financial/Economic Exploitation occurs when a vulnerable adult or his/her resources or income are illegally or improperly used for another person's profit or gain. Examples

include illegally withdrawing money out of another person's account, forging checks, or stealing things out of the vulnerably adult's house. Signs of financial abuse include a sudden inability to pay bills, unexplained decrease in bank accounts, unexplained transfer of possessions, and sudden inability to pay for care needed.

Neglect occurs when a person, either through his/her action or inaction, deprives a vulnerable adult of the care necessary to maintain the vulnerable adult's physical or mental health. Examples include not providing basic items such as food, water, clothing, a safe place to live, medicine, or health care.

Neglect may include withholding adequate meals, hydration, clothing, housing, education, medical treatment, medication, and hygiene. Withholding physical aids such as hearing aids, glasses, ambulating aids (walkers, canes, wheelchairs, etc.), false teeth, or safety precautions (night lights, safety bars, call light etc.) are also neglect. Health care providers can unknowingly neglect patients by leaving a patient on the bedpan for an extended period of time, moving walking aid devises out of reach keeping patients in bed, charting a patient has been repositioned but forgetting to do so, or moving a call button out of reach.

Self-neglect occurs when a vulnerable adult fails to provide for themselves and jeopardizes his/her well-being. Examples include a vulnerable adult living in hazardous, unsafe, or unsanitary living conditions or not having enough food or water.

Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter, or health care. Examples include deserting a vulnerable adult in a public place or leaving a vulnerable adult at home without the means of getting basic life necessities.

Elder

The Centers for Disease Control and prevention defines elder abuse as an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult (An older adult is defined as someone age 60 or older). Forms of Elder abuse include physical, sexual, or abusive sexual contact, emotional or psychological, neglect or financial abuse or exploitation 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?

Research indicates that older adults from all levels of society can be victims of abuse – people from all racial, ethnic, and economic groups.

- Elders aged 80 and older, and those with physical or mental impairments, are more likely to be abused than any other
- Elder abuse, including neglect and exploitation, is experienced by an estimated one out of every ten people ages 60 and older who lives at home

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 and may continue abusing elders even after the person has entered a long-term care facility or a hospital. Patients or residents should be routinely checked for injuries, as this may reveal a pattern of abuse. 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.

Why does Abuse and Neglect Matter

Abuse and neglect can arise from misunderstanding, ignorance, and frustration with the elderly, because they do not really understand the effects of aging. Care givers fail to give elders the extra time the elder may need to process information, respond to questions, or perform tasks. Risk factors that contribute to abuse and neglect include:

- Caregivers with an abusive history may continue that behavior at work
- Caregivers with little or no formal training or support can be overwhelmed by 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

Child

Child abuse is more than bruises or broken bones. While physical abuse often leaves visible scars, not all child abuse is as obvious, but can do just as much harm. It is important that individuals working with and around children be able to know what constitutes child abuse or child neglect and know how to identify potential signs. The U.S. Centers for Disease Control and Prevention links adverse childhood experiences (which include other household dysfunctions along with abuse and neglect) with a range of long-term health impacts.

Child Abuse Statistics

Child abuse is categorized into one of four harm types: emotional abuse, neglect, physical abuse, and sexual abuse. At least 1 in 7 children have experienced child abuse and/or neglect in the past year, and this is an underestimate. In 2019, 1840 children died from abuse or neglect.

Child abuse is defined as any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm. More than 70% of the children who died as a result of child abuse or neglect were two years of age or younger. More than 80% were not yet old enough for kindergarten.

Who are the Abusers

Child abusers include parents, guardians, foster parents, relatives, or other caregivers responsible for the child's welfare. Around 80% of child maltreatment fatalities involve at least one parent as perpetrator.

Warning Signs of Child Abuse

- Excessively withdrawn, fearful or anxious about doing something wrong
- Does not seem attached to the caregiver
- Frequent injuries or unexplained bruises
- Wears inappropriate clothing to cover up injuries
- Hygiene is consistently bad
- Untreated illnesses and physical injuries
- Trouble walking or sitting
- Does not want to change clothes in front of others

- Diagnosed with a sexually transmitted disease or pregnancy

Domestic

Domestic violence (also called intimate partner violence (IPV), domestic abuse or relationship abuse) is a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship.

Who are the Abused

Domestic violence does not discriminate. Anyone of any race, age, sexual orientation, religion, or gender can be a victim – or perpetrator – of domestic violence. It can happen to people who are married, living together or who are dating. It affects people of all socioeconomic backgrounds and education levels.

What is Domestic Abuse

Domestic violence includes behaviors that physically harm, arouse fear, prevent a partner from doing what they wish or force them to behave in ways they do not want. It includes the use of physical and sexual violence, threats and intimidation, emotional abuse, and economic deprivation. Many of these different forms of domestic violence/abuse can occur at any one time within the same intimate relationship.

Human Trafficking

Human trafficking involves the use of force, fraud, or coercion to obtain some type of labor or commercial sex act. Language barriers, fear of their traffickers, and/or fear of law enforcement frequently keep victims from seeking help, making human trafficking a hidden crime.

Traffickers often look for people who are susceptible for a variety of reasons, including psychological or emotional vulnerability, economic hardship, lack of a social safety net, natural disasters, or political instability.

Who are the Trafficked

Human trafficking can happen in any community and victims can be any age, race, gender, or nationality.

In 2019, 11,500 situations of human trafficking were reported to the U.S. National Human Trafficking Hotline.

In 2020, the National Center for Missing and Exploited Children Cyber Tipline received more than 21.7 million reports, most of which related to:

Apparent child sexual abuse material.

- Online enticement, including sextortion.
- Child sex trafficking.
- Child sexual molestation.

Who are the Traffickers

Traffickers can be of any age, race, gender, or nationality and range from small-time solo operators to lose networks of criminals and highly sophisticated criminal organizations.

Most suspects arrested for CSEC crimes were male (97 percent), were U.S. citizens (97 percent), were white (82 percent), had no prior felony convictions (79 percent) and were not married (70 percent).

- CSEC suspects had a median age of 39 years, and more than half (56 percent) had no more than a high school education.

Human trafficking is a major public health problem, both domestically and internationally. Health care providers are often the only professionals to interact with trafficking victims who are still in captivity. The expert assessment and interview skills of providers contribute to their readiness to identify victims of trafficking.

Clinician's Responsibility in Reporting Abuse and Neglect

It is your ethical and legal responsibility to intervene immediately when you see a child, elder, or mentally handicapped person be abused or neglected or when you suspect it.

Anytime abuse is witnessed or suspected, it must be documented and reported to the charge nurse, case manager, or social worker. Child and Elder abuse and neglect are to be reported to Child or Adult Protective Services. Domestic abuse can only be reported if the accuser gives consent.

When child or elder abuse or neglect is suspected, the abused should be assessed without the suspected abuser present. The abused should be asked directly if someone hurt them, threatened them, or took anything without asking, and if yes, who? If your facility has Sexual

Assault Nurse Examiner (SANE) follow your facility's guidelines for engaging the SANE Nurse if sexual abuse is suspected.

Every report can be anonymous, and no one can be charged for falsely reporting an abuse or neglect case, but failure to report can result in a claim of negligence.

Advance Directives

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.

By law, each individual patient has the right to be educated about the nature of their illness, the general nature of proposed treatments, 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 every competent adult of sound mind to decide what type of medical care they want in case they become incompetent and are unable to voice their health care decisions. These preconceived decisions are called advanced directives.

- The PSDA requires any health care facility receiving funding from Medicare or Medicaid to:
- Give patients information on their state laws about their rights to make decisions about their care
- Find out if patients have an advance directive
- Recognize the advance directive and honor the patient's wishes
- Never discriminate against patients based on whether they have filled out an advance directive or not

The PSDA recommends that everyone create an advanced directive, but no person is required to create an advanced directive. In the event that no advanced directive was made, and a patient becomes unable to make health care decisions the family, or next of kin, become the health care proxy.

What are Advance Directives

Advance directives are documents, signed in advance, which state a person's choice about medical treatment, or names someone to make decisions about medical treatment if they cannot make their own decisions.

Types of Advance Directives

The most common types of advance directives are the **Living Will** and the **Durable Power of Attorney for Health Care** (also known as the **Medical Power of Attorney**). There are a number of advanced directive formats. Some follow forms outlined in state laws, others are created by lawyers or even the patients themselves. State laws and courts decide whether these documents are valid.

The Living Will

A living will be a written, legal document that spells out medical treatments you would and would not want to be used to keep you alive, as well as your preferences for other medical decisions.

The Living Will should address a number of possible end-of-life care decisions, such as:

The type of medical treatment a person would accept or refuse

- Under what conditions an attempt to prolong life should begin or end
- Pain management
- Comfort or palliative care
- Dialysis
- Organ and tissue donation
- Donating your body to science
- Feeding tube, IV fluids, and TPN
- Mechanical Ventilation
- Do Not Resuscitate and do not intubate

If a person cannot speak for themselves a living will help the attending physician and family understand what interventions the person does or does not want done to prolong life in the event of a terminal illness. If so, it can allow doctors to discontinue life prolonging treatment in the case of an incurable illness or a permanent vegetative state (permanent brain damage). If a person has hope of recovery, the living will does not apply.

The living will is a formal legal document that must be in writing. Each state has different forms and requirements for creating legal documents. Depending on where the patient lives, the form may need to be signed by a witness or notarized. Spouses, potential heirs, doctors caring for the patient, or employees of the healthcare facility are usually not allowed to witness the living will, check facility policies.

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.

The living will apply only when a person is unable to speak for themselves and is terminally ill or permanently brain dead. It also only gives written instructions about certain things that might happen, but it 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 a legal document, signed by a competent adult (the principal), designating a proxy (agent) to make healthcare decisions for them ONLY if the principal becomes unable to do so. The proxy can speak with doctors and other caregivers on behalf of the patient and make decisions according to what the patient would want if the patient were unable to do so for themselves. The agent chosen would decide which treatments or procedures the patient would want only in the event that the patient becomes unable to do so. If the patient's wishes in a certain situation are not known, the agent will decide based on what they think the patient would want and what they consider to be in line with the patient's wishes.

The agent should be someone knowledgeable about your wishes, values, and religious beliefs, and in whom you have trust and confidence. In the event your agent does not know of your wishes, that agent should be willing to make health care decisions based upon your best interests. The law does not allow the agent to be a doctor, nurse, or other healthcare provider to the patient.

State laws that allow a proxy (agent) to be chosen usually to require that the request be in writing, signed by the person choosing the proxy (the principal), and witnessed. In many cases, the proxy also signs the document. A durable power of attorney will go into effect immediately once the document is signed. The durable power of attorney is effective indefinitely unless it is revoked, or the principal becomes competent. The principal can revoke the durable power of attorney or choose another agent at any time.

Do Not Resuscitate Orders

A hospitalized patient can add a Do Not Resuscitate (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. A hospitalized patient can also add a Do Not Intubate order. This is done when the patient wants cardiopulmonary resuscitation if their heart stops beating but does not want to be intubated and placed on a ventilator. A patient can have a DNR or DNI order without making a living will or appointing a medial power of attorney. Some hospitals require a new DNR/DNI order each time a patient is admitted. An In- patient DNR/DNI order is only good while the patient is in the hospital. A DNR or DNI order can be revoked by the patient at any time. Even if a patient has a living will which includes preferences regarding resuscitation and intubation, it is still a good idea to establish DNR or DNI orders each time patients are admitted to a new hospital or health care facility.

An Out of Hospital Do Not Resuscitate (DNR) order is used outside of the hospital. The Out of Hospital DNR is intended for Emergency Medical Service (EMS) teams who answer 911 calls. 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 which can result in unwanted measures that prolong life. The Out of Hospital DNR must be signed by the patient and physician for it to be valid. The order offers a way for patients to refuse the full resuscitation effort in advance, even if EMS is called.

Age Specific

Birth - 1 Year

Birth - 1 months

Physical Development: Basic reflexes that are present include sucking, rooting, automatic grasp, Moro (Startle), Babinski, swallowing, gagging, blinking, coughing, urine and bowel elimination and startling. At this age infants have no hand eye coordination and mostly maintain their hands in a fist position. Fontanels are soft and flat. Newborn vital signs include HR 100-160, BP systolic 75-100 diastolic 50-70, RR 30-50.

Cognitive Development: At birth infants can see 12 to 15 inches away, and by 1-month infants see about 3 feet away. Infants can differentiate different smells and tastes, communicate with crying, and will turn their head towards familiar sounds.

Psychosocial Development: Infants will sleep a total of 17 – 19 hours a day in short spurts throughout the day. They find comfort in close contact and rocking.

2 months - 4 months

Physical Development: The chest and head can be lifted while lying on the stomach. Infants' hands will remain open longer allowing them to grasp objects that are put in their hands. Arms and legs begin to move in a flailing fashion. Infant will roll over at 2-3 months. Posterior Fontanel closes around the second month. Vital signs include HR 90-150, BP systolic 75-100 diastolic 50-70, RR 25-40.

Cognitive Development: By 2 months infants can follow slow moving objects going side to side (tracking). Infants will look at color contrasts and lights. They will investigate the world by putting objects in their mouth and reach towards the sound of voices and toys. They will cry, coo, laugh, and gurgle.

Psychosocial Development: They are comforted by caregivers and will smile and laugh at games like peekaboo.

4 months - 8 months

Physical Development: Weight should be twice the child's weight at birth. When lying flat, infants can turn over, and while lying on their stomach they can push themselves backwards. At this age teeth start coming in. The infant can stay sitting up with minimal help and bounce when held in a standing position. Hand-eye coordination begins allowing them to hold their own bottle as well as purposefully reach for objects nearby with both hands. Vital signs include HR 80-140, BP systolic 75-100 diastolic 50-70, RR 20-30.

Cognitive Development: Infants will mimic movements, sounds and facial expressions. They begin to look for objects that have been removed from their sight. When food is seen, they will open their mouth to be fed. At this age they know their name, can follow one-word commands like eat, and babble by repeating sounds.

Psychosocial Development: Infants are attached to their parents and become scared of strangers.

18 months - 12 months

Physical Development: At this age infants can crawl and sit up on their own, as well as ambulate with little support. They will reach for objects with one hand, and drink from a cup with minimal help. Infants can feed themselves with finger foods. Vital signs include HR 80-140, BP systolic 75-100 diastolic 50-70, RR 20-30.

Cognitive Development: Infants will form their first word, mimic spoken words and sounds, and see objects far away. They can follow simple sentence commands and abandon a toy if given another. They know their parents' name, can nod their head yes or no, and understand what simple objects are used for such as a brush.

Psychosocial Development: They become attached to certain objects like a favorite blanket. They like to keep their parents close by and become anxious if they leave. Infants begin to share and show assertiveness

Age Specific Interventions: Birth to 1 year

General: Encourage parents to participate in care: bathing, feeding, and holding. Encourage parents to respond to cries and to meet the infant's needs consistently. Teach parents 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. Keep infant warm, take time to comfort.

Ensure safety – protect from fall injuries and ensure small objects are outside of the infant's grasp. Maintain feeding schedule. Place infant on back to sleep.

Common Disease/Death: Sudden infant death syndrome, congenital malformations, unintentional injuries, septicemia, homicide, influenza, and pneumonia.

Toddler: 18 months - 3 Years

12 to 18 Months

Physical Development: The toddler will begin to ambulate without assistance with a wider gait stance, maneuver around obstacles in their path, and begin to climb. At 18 months, toddler develops sphincter control and indicates when diaper needs to be changed. Vital signs include HR 80-130, BP systolic 80-110 diastolic 50- 80, RR 20-30.

Cognitive Development: At this age, the toddler should be speaking about 6 – 12 words clearly.

Psychosocial Development: Temperaments increase as the toddler becomes more independent and develops his or her own personality. The toddler likes routine and will play alone while keeping his or her parents safely in sight.

18 Months

Physical Development: At this age, the toddler can now ambulate backwards and walk upstairs. The toddler will begin to throw overhand, kick a ball, and crouch and stand without assistance or the use of their hands. The 2- year-old will begin to use eating utensils and undress himself or herself. Vital signs include HR 80-130, BP systolic 80-110 diastolic 50-80, RR 20-30.

Cognitive Development: A 2-year old's vocabulary increases to about 50 or more words. Memory increases allowing them to remember and repeat songs and rhymes. At age 2 the toddler's cognitive development increases by engaging in pretend play and having an active imagination. Potty training will begin at this age.

Psychosocial Development: The imagination begins to expand during play. The two-year-old continues to become more independent but still craves attention and affection from the parents. At age 2 temper tantrums are at a peak and they have difficulty sharing possessions.

2-Year-Old

Physical Development: Dexterity increases allowing the three-year-old to wash their hands and dry them with a towel. Balance increases, as well letting the toddler ambulate on the balls of the feet (tiptoe) or stand on one foot. Vital Signs include HR 80-130, BP systolic 80-110 diastolic 50-80, RR 20-30.

Cognitive Development: The toddler will begin to form comprehensive sentences, use less baby talk, and like to make up stories.

Psychosocial Development: Fears will begin to develop such as a fear of the dark. A three-year-old will begin to regulate their urges and emotions which will decrease, but not eliminate, temper tantrums. They will ask many questions due to their increase in curiosity, begin to make up and tell stories and call others by their name.

Age Specific Interventions - Toddler

General: Explain the need for consistency. 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 children with peer companionship.

Clinical: Allow child to perform 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. Use repetition to enhance memory and understanding. Examine while in parent's lap or sitting on the floor.

Common Disease/Death: Unintentional injuries, congenital anomalies, homicide, malignant neoplasms, heart disease, influenza and pneumonia, and septicemia.

Preschooler: 3 - 5 Years

Physical Development: Preschoolers have high energy levels and should enjoy playing with other kids. Their fine motor skills will advance allowing them to hold a pencil, eat using utensil correctly, print letters, start cursive writing, write their first and last name, color neatly, thread beads with string, button buttons, zip zippers, tie their shoes, and use scissors to cut paper shapes. Gross motor skills increase letting them run while changing direction, dodge objects, and make sharp turns quickly. At this age they might start joining sports teams and enroll in dance. A preschooler can Move with speed and agility. They can throw, kick, and catch a ball with accuracy, hit a ball with a bat, swim, walk, and balance on a beam, and jump rope. Nighttime bowel and bladder control should be achieved by age three or four. They will lose their first teeth and grow 2-3.5 inches per year and gain 4.5 lbs. per year. Vital Signs include HR: 70-120, BP: systolic 80-120, diastolic 55-80. RR: 20-30.

Cognitive Development: The preschooler will have a vocabulary from 2,500 – 20,000 words, understand time, speak using complex sentences, and begin to read. The child will understand and recognize the most dangerous situations and will easily adapt to new situations. The attention span increases, and the preschooler is able to understand and control their emotions. They will draw detailed pictures that resemble the intended object like a house or a person and put together larger puzzles (12-20 pieces). The child will daydream frequently and love fantasy. They begin to understand nudity and will frequently want privacy when changing.

Psychosocial Development: The preschooler's most significant relationship will be with their family and enjoy helping with simple chores. They crave the caregivers' affection but might not show it in front of their friends. They will keep eye contact with others, enjoy group play, and initiate play with other children around the same age. They are egocentric in thought and behavior.

Age Specific Interventions - Preschooler

General: Encourage expression of fears. Encourage self-care and decision-making when possible. Teach parents to listen to their child's fears and feelings. Provide simple explanations. Focus on positive behaviors. Practice definite limit-setting behavior. Offer

choices. Allow the 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 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 evaluate the child's sense of reality. Reinforce reality of body image. Involve parents in teaching.

Common Disease/Death: Unintentional injuries, malignant neoplasms, congenital anomalies, homicide, heart disease, benign neoplasms, and septicemia.

School Age: 6 - 12 Years

Physical Development: The school age child becomes more athletic and graceful in their movements and individual abilities. They can complete activities that involve the simultaneous use of two or more complex motor skills, like performing complex styles of jumping rope. The child can completely dress and groom himself or herself without the caregiver's help. An increase in dexterity gives the child the ability to paint, sew, play a musical instrument, peel an apple, and use hand tools like a screwdriver. The ability to ride a bike and rollerblade is mastered. Starts to lose baby teeth and gets first permanent teeth between 6 – 8 years of age. The child will grow an average of 2 inches per year and gain 4-6½ pounds per year. Most girls will start their menstrual cycle. Vital signs include HR 70 – 110, BP: Systolic 85 – 120, Diastolic 55 – 80, RR 12 – 30.

Cognitive Development: The school age child will master symbols, count backwards, and read and write very well. They will understand and know the date, month, and year, and understand the notion of space. They have the ability to care for a pet or garden.

Psychosocial Development: The child will continue to love and value their parents, but peers will become increasingly important to the child influencing the child's identity and values. They love to be a part of a team, club, or any group activity. School age children will start to evaluate their body image and will be modest about their body. Interest in the other sex will begin, and alone time will be important to the child.

Age Specific Interventions - School Age Child

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 part of the child's decision.

Common Disease/Death: Unintentional injuries, malignant neoplasms, suicide, congenital anomalies, homicide, heart disease.

Adolescence: 13 - 18 Years

Physical Development: The adolescent male and female will have rapid growth in skeletal size, muscle mass, adipose tissue, and skin. Due to the rapid change in growth and sexual maturity adolescents will go through a short stage making their appearance and coordination awkward. Sexual development occurs with girls experiencing menarche and boys experiencing testicular growth. Most girls will reach adult height by age 18. Vital Signs include HR 60 – 100, BP systolic 94 – 140, Diastolic 60 – 90, RR 12 – 30.

Cognitive Development: The adolescent will begin to use abstract thinking and understand higher math concepts. They will be interested in political and social issues and show interest in philosophical questions. An adolescent will use long-term thinking and begin to set goals. The adolescent will develop their own identity and grow into their own person. They will develop the ability to maintain a longer romantic commitment (fall in love). Decision-making skills are not fully developed, which could lead to the participation in dangerous activities for peer acceptance.

Psychosocial Development: Adolescents tend to push away and criticize the parents and focus on the influence and acceptance of their peers to gain self-independence. They are critical of their features and appearance and frequently feel self-conscious. The adolescents will spend time together in groups and form romantic relationships.

Experimentation with cigarettes, vaping, alcohol, drugs, and sex may occur.

Age Specific Interventions - Adolescence

General: Supplement explanations with rationale. Provide privacy. Involve the adolescent in planning and decision-making. Provide wheelchair access. Provide handicapped parking. Use a language interpreter as needed.

Clinical: Encourage questions regarding fears. Allow adolescents 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.

Common Disease/Death: Trauma, homicide, suicide.

Early Adulthood: 19 - 35 Years

Physical Development: At this age, the adult is vibrant, active, and healthy. Males usually reach their final height at age 21, and the skeletal system usually continues to grow until age 30. Muscle mass continues to grow throughout early adulthood allowing physical performance and athletic abilities to peak. Skin will begin to lose moisture and the GI system secretions will decrease. Vital Signs include HR 50 – 100, BP systolic 90-120, diastolic 60 – 80, RR 16 – 20.

Cognitive Development: The prefrontal cortex of the brain fully develops by age 25 completing brain growth. The adult will now fully apply their knowledge, decision making skills and analyzing capabilities.

Psychosocial Development: At this stage, the adult is achievement oriented. They are concerned about romantic relationships, marriage, having children, developing friendships, and developing a career. They transition from being dependent to being completely independent and responsible.

Age Specific Interventions – Early Adulthood

General: Involve the individual and significant others 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.

Clinical: Explore the impact of hospitalization/illness on work, job, family, and children. Assess potential stressors 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.

Common Disease/Death: Trauma, HIV, malignancies, and heart disease. Middle Adulthood: 36 – 60 Years

Physical Development: During this period, adults will begin to see signs of aging such as wrinkles, gray hair, thinning hair, loss of skin elasticity, and dry skin. Calcium loss occurs, especially after women go through menopause between ages 40 -50. The middle adult might see a decrease in balance, coordination, bone mass and skeletal height and vision changes. They might have a decrease in muscle strength, muscle mass, reflexes and endurance if not used. Vital Signs include HR 50 – 100, BP systolic 90-120, diastolic 60 – 80, RR 16 – 20.

Cognitive Development: Stored knowledge from education and experience increases as people age (like vocabulary and history dates). There is a decrease in short term memory recall, mental performance speed and new information synthesis. They experience a loss of hearing, especially high frequencies, and experience presbyopia which makes the need for bifocals a necessity.

Psychosocial Development: By middle adulthood, the adult has usually hit the peak of their career. They are future-oriented and understand their limitations. They measure their accomplishments against their set goals. At this age they can experience empty nest

syndrome (expressed positively or negatively). They begin to adjust the possibility of retirement and lifestyle modifications.

Age Specific Interventions – Middle Adulthood

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. 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.

Common Disease/Death: Heart disease, cancer, trauma, cerebrovascular conditions.

Late Adulthood (Geriatric): 61 - 80 Years

Physical Development: Late adulthood will bring more wrinkles and gray hair, spider veins, and fat deposits under the chin and on the abdomen. They will experience a decrease in heat and cold tolerance and decreased peripheral circulation. Major body systems will slow like cardiac, respiratory, and renal function. Ability to perform activities of daily living may be limited by physical changes in vision, hearing, and motor skills. Vital Signs include HR 50 – 100, BP systolic 90-120, diastolic 60 – 80, RR 16 – 20.

Cognitive Development: The late adult will have a decreased tolerance to pain and a notable decrease in memory. There are slight changes in IQ. Skills and abilities tend to become obsolete from disuse rather than from deterioration of mental capacity. May experience short-term memory loss.

Psychosocial Development: The late adult will experience retirement and may start pursuing a second career or a hobby. Community activities and leisure activities will become important. Grandparenthood begins, and they begin to accept their life accomplishments. They develop an acceptance for death and may experience the death of

their spouse and friends. There may be a change in living conditions, such as moving to a congregate living facility.

Age Specific Interventions – Late Adulthood

General: Explore the individual's support system. Explore related existing conditions. Involve 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. 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. Assess 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 adjutant analgesics with caution as it increases side effects. Apply lotion to skin immediately after bathing.

Common Disease/Death: Heart disease, malignancy, cancer, cerebrovascular disease, COPD, and lung disease.

Care Planning

What is a Care Plan

Nursing care plans provide a means of communication among nurses, their patients, and other healthcare providers to achieve healthcare outcomes.

- A care plan outlines an individual plan tailored to address the unique needs of each patient/resident
- It develops a set of actions that clinicians implement to resolve problems that are identified by assessment
- It guides in the ongoing provision of safe quality care and assists in the evaluation of that care
- Care planning documentation is an essential part of patient/resident care and helps keep all heath care staff updated on patient history, data, and decision-making
- The plan of care helps to ensure that important issues and information are not neglected
- To be effective and comprehensive, the care planning process must involve all health care disciplines that participate in the care of the patient/resident.

Developing a Care Plan or Plan of Care

Plans of care are organized by four categories:

- Nursing diagnoses or problem list
- Goals and outcome criteria
- Nursing Orders
- Evaluation

The first step in developing a plan of care is to complete an accurate and comprehensive assessment. Acute care, emergent care, long-term care, skilled care, and home health all have established protocols for initial assessments and ongoing reevaluation.

Once the initial assessment is complete, a problem list should be generated. It is based upon identifiable health and holistic problems. This could include a list of patient medical diagnoses, conditions, disabilities, psychological response to illness, support group information, and sociocultural standing, as well spiritual and family/relationship problems that affect the person's overall well-being.

Patient orders, measurable goals, and expected outcomes will be established so treatment can begin. It focuses on actions which are designed to solve or minimize all the patient's existing problems.

Finally, care plan progress will be evaluated by measuring goal achievement. This will determine if the care plan orders are effective. Once the evaluation is complete, the health care professionals can decide which part of the care plan needs to be continued, changed, or stopped.

Interdisciplinary Plan of Care

The Interdisciplinary Plan of Care (IPC) brings together health care professionals from every discipline (Physician, Nurse, Physical and Occupational Therapist, Speech Pathologist, Psychologist, and Social Workers) to create an individualized plan of care to meet the patient's unique needs and circumstances.

The plan will be formed in the same fashion by bringing together any health care personnel involved with the patient to work together. Each discipline, as warranted, will contribute to the IPC, and will involve the patient and family to the extent possible.

Research shows that interdisciplinary care plans are beneficial not only for each patient, but also for healthcare team members included in planning care.

Increased collaboration among healthcare providers, especially between physicians and nurses, helps patients who have interdisciplinary care plans by:

- Decreasing the overall length of stay, regardless of diagnosis
- Lowering rates of hospital-acquired conditions unrelated to the original diagnosis
- Reducing healthcare-related expenditures

Remember that the ultimate purpose of a care plan is to guide all who participate in the care of a patient, and to provide the appropriate treatment in order to ensure optimal outcomes during his/her stay in a healthcare setting. A caregiver unfamiliar with a patient should be able to find all the information needed to properly care for the patient in the care plan.

Complaints & Grievances

Complaints

A patient complaint is any verbal expression stating services are unsatisfactory. A complaint can be fixed as soon as the complaint is received. A complaint can be made by a patient, patient representative, or patient relative.

Grievances

A Patient Grievance is a written or verbal complaint by a patient, or the patient's representative, regarding the patient's care (when the complaint has not been resolved at that time by staff present), abuse or neglect, or the hospital's compliance with the CMS Hospital Conditions of Participation.

A complaint will become a grievance if it is not resolved at the time of the complaint, is asked to be a formal complaint, requires an action from the hospital, or is written and submitted.

For Medicare beneficiaries a grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. The enrollee must file the grievance either verbally or in writing no later than 60 days after the event or incident precipitating the grievance.

Examples of Complaints and Grievances

Complaint: A patient raises a complaint, and it is fixed on the spot by hospital staff nearby.

Grievance: A patient raises a verbal complaint and cannot be resolved in that moment.

Grievance: A patient's family raises a complaint which requires further action by the nurse manager.

Grievance: A patient submits a written complaint to the nurse.

Complaint: The patient's family writes a complaint concerning the patient's food selections on the patient satisfaction survey upon discharge, however no resolution is requested.

Grievance: A patient tells the morning shift nursing assistant, that she was not turned during the night.

Complaint and Grievance Resolution

General Rules

- Any health care staff that becomes 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
- Meet face-to-face with the patient, patient family, or authorized representative
- Listen to the complaint and give your full attention, then take required action
- Every patient and family member should be educated on how to submit an anonymous formal grievance upon admission and encouraged to voice any complaint
- Notify any service involved in a complaint so they can resolve the complaint (Ex: case management, physician, financial counseling, another nursing unit, housekeeping or food and nutrition)
- The department supervisor or manager should be immediately notified of all conce rns or complaints.
- Complaints and grievances must be documented according to the healthcare facility's policies.

Steps to Resolution

- Immediate attention must be given to situations that place the patient or visitor in danger.
- All situations should be taken care of in a quick and timely manner.
- Documentation of complaints and grievances, including the patient or visitor's name, the date, the complaint occurred, how the concern or complaint was resolved, should be completed using the facility's chosen documentation tool.
- If a complaint cannot be resolved at the time of contact, or serviced within a reasonable timeframe by staff present, the complaint is then considered a grievance and is referred to the Supervisor. If the complaint is still not resolved or is deemed a violation of rights or a breach in patient care, the Quality/Risk Manager will be notified to oversee an investigation and develop a resolution.
- All oral or written grievances are to be reviewed, investigated, and resolved within a reasonable period of time to the nature of the grievance. Written complaints should be initially responded to within 24 hours. Any verbal complaint brought to any employee's attention should be resolved immediately.
- The grievant should be notified in writing of the outcome of the grievance, including the name and contact of the hospital employee overseeing the case, 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 is satisfied with the actions taken on their behalf.
- 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 all circumstances.

Compliance (Fraud, Waste, and Abuse)

Introduction

In a highly regulated, high-risk industry like healthcare, compliance is especially important. Healthcare compliance is the process of following rules, regulations, and laws that relate to healthcare practices.

Compliance in healthcare can cover a wide variety of practices and observe internal and external rules, but most healthcare compliance issues are related to patient safety, the privacy of patient information, and billing practices.

We have all seen examples in the news of a company, or its representatives, misrepresenting the company's assets, making misleading statements about what business the company is in, mishandling client's money, or misrepresenting services provided to clients. To ensure that Medicare/Medicaid providers are upfront, honest, and respectable they are required to have a formal Compliance Program. CMS program is structured on a seven- point plan. Each provider's plan must include:

- A written employee code of conduct to include standard policy and procedure rules and regulations
- The designation of a Compliance Officer and Compliance Committee.
- A staff education plan on compliance programs.
- Effective lines of communication for staff to report compliance issues, or concerns, including a hotline.
- An effective way to audit and monitor the program.
- A consistent enforcement of guidelines for non-compliance.
- A way to enforce policies for investigations of reported non-compliance that include, guidelines for investigations and reporting to CMS.
-

Benefits of a Good Compliance Program

- Complying with industry standards and regulations helps healthcare organizations continue to improve the quality of care.
- Healthcare organizations are also held to strict standards, regulations, and laws from the federal and state levels. Violations of these laws can result in lawsuits, hefty fines, or the loss of licenses.
-
- Having a good compliance program will:

- Convey to staff and clients that the company ethically conducts business 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 can choose to stand against illegal and unethical situations by simply conducting themselves with respect and integrity and following 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.
- Compliance keeps operations running smoothly and makes sure everyone follows proper procedures and understands expectations.
- But compliance in healthcare comes with even higher stakes than in other industries. If a doctor or nurse does not follow proper procedure, they can end up injuring a patient or another staff member. Healthcare compliance is about providing safe, high-quality patient care.

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

Fraud, Waste, and Abuse in the Medicare Program

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare program but do not require the same intent and knowledge.

Fraud

Fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit. The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years and is subject to criminal fines of up to $250.000.

Examples of actions that may constitute Medicare fraud include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

Waste

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is not considered to be caused by criminally negligent actions but by the misuse of resources.

Examples of actions that may constitute Medicare waste include:

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests

Abuse

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of actions that may constitute Medicare abuse include:

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Civil False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Conducts other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

Whistleblowers: A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: A person who brings a successful whistleblower lawsuit receives at least 15 percent, but not more than 30 percent, of the money collected.

Criminal Health Care Fraud: Persons who knowingly make a false claim may be subject to criminal fines and imprisonment.

Exclusion

- No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has the authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and

Entities (LEIE).
- The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.

Summary

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is intent and knowledge. Fraud requires the person to have the intent to obtain payment and knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment but intent to defraud and knowledge of wrongful actions are lacking. Laws and regulations exist that prohibit FWA.

Penalties for violating these laws may include:

- Civil Monetary Penalties
- Civil prosecution
- Criminal conviction, fines, or both
- Exclusion from all Federal health care program participation
- Imprisonment
- Loss of professional license

What do I do when issues arise?

When reporting an issue, stick to the chain of command. If the floor supervisor does not resolve an issue, continue reporting the issue in this order:

- Go to the floor supervisor's supervisor
- Go to the HR director
- Go to the Director of Quality Services
- Go to the 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.

Coronavirus (COVID-19)

Introduction

On February 11, 2020, the World Health Organization reported an official name for the sickness that is causing the 2019 novel Covid flare-up, first distinguished in Wuhan China. The new name of this infection is Covid illness2019, truncated as COVID-19. In COVID-19, 'CO' means 'crown,' 'VI' for 'infection,' and 'D' for sickness.

Previously, this illness was alluded to as "2019 novel Covid" or "2019-nCoV".

There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans.

Patients

The first case of COVID-19 in the United States was reported on January 21, 2020. In early 2021 there had been a reported 2.76 million cases in the US and 124 million cases worldwide during the pandemic which first began in late 2019 in China. Patients have been identified in numerous countries across the globe including the United States, China, Iran, South Korea, Japan, Italy, and others. Older individuals with comorbid conditions are at increased risk for infection.

Symptoms

Patients with COVID-19 primarily have had mild to severe respiratory illness/flu like symptoms of:

- Fever
- Cough
- Shortness of breath

Other signs and symptoms

- GI Distress
- Pneumonia
- Multi-organ Failure

Infection Prevention

Spread of Virus

The virus that causes COVID-19 most commonly spreads between people who are in close contact with one another (within about 6 feet, or 2 arm lengths). It is thought to spread through respiratory droplets or small particles, such as those in aerosols, produced when an infected person coughs, sneezes, sings, talks, or breathes.

- The virus is thought to spread from person-to-person.
- Between people who are in close contact with one another (within about 6 feet).
- Through respiratory droplets produced when an infected person coughs or sneezes.

Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain and airborne transmission over long distances is unlikely.

People are thought to be most contagious when they are most symptomatic (the sickest). Some spread might be possible before people show symptoms; there have been reports of this occurring with this new coronavirus, but this is not thought to be the main way the virus spreads.

It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or their eyes, but this is not thought to be the main way the virus spreads.

How easily a virus spreads from person-to-person can vary. Some viruses are highly contagious (spread easily), like measles, while other viruses do not spread as easily. Another factor is whether the spread is sustained, spreading continually without stopping. The virus that causes COVID-19 seems to be spreading easily and sustainably in the community ("community spread") in some affected geographic areas.

Community spread means people have been infected with the virus in an area, including some who are not sure how or where they became infected.

The public are being encouraged to wash their hands frequently and wear a mask when in public while practicing social distancing.

Infection Control Procedures

Healthcare facilities must focus on identifying, isolating, and informing on new cases of patients known or suspected of having the virus. Many facilities are implementing COVID units where patients with known coronavirus are placed on this unit. There are also cases of hospitals being deemed COVID hospitals.

Healthcare Personnel

Pay close attention to the protection of health care workers on the front lines. Healthcare clinicians are the most valuable resource when it comes to treating and stopping the spread of the virus. As such, make sure they have the personal protective equipment, training and support they need to provide care to patients.

- Screen patients and visitors for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering your healthcare facility. Keep up to date on the recommendations for preventing the spread of COVID-19 on CDC's website.
- Ensure proper use of personal protection equipment (PPE). Healthcare personnel who come in close contact with confirmed or patients with COVID-19 should wear the appropriate personal protective equipment.
- Conduct an inventory of available PPE. Consider conducting an inventory of available PPE supplies. Explore strategies to optimize PPE supplies.
- Encourage sick employees to stay home. Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. Ensure that your sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies

Patients

Handwashing remains the most important step in infection prevention along with increased emphasis on early identification and implementation of source control such as wearing of a mask when in public, practicing social distancing and self-quarantine if suspected infection.

Outpatient Settings

1. When scheduling appointments for routine medical care prescreen patients and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (e.g., cough, sore throat, fever1) on the day they are scheduled to be seen.

2. When scheduling appointments for patients requesting evaluation for a respiratory infection, use nurse-directed triage protocols to determine if an appointment is necessary or if the patient can be managed from home.
3. If the patient with respiratory symptoms must come in for an appointment, instruct them to call beforehand to inform triage personnel that they have symptoms of a respiratory infection and to take appropriate preventive actions (e.g., follow triage procedures, wear a facemask upon entry and throughout their visit or, if a facemask cannot be tolerated, use a tissue to contain respiratory secretions).
4. Upon arrival, isolate the patient in an examination room with the door closed. If an examination room is not readily available ensure the patient is not allowed to wait among other patients seeking care.
5. HCP who enters the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or facemask, gown, gloves, and eye protection.

Hospital and Acute Care Settings

PPE recommendations for the care of patients with known or suspected COVID-19:

1. N 95 Respirators, which filter inspired air, offer respiratory protection.
    a. If there is a limited supply of respirators and lacking a respiratory protection program, facemasks do protect the wearer from splashes and sprays.
    b. Available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to HCP.
2. Eye protection, gown, and gloves.
3. Respiratory Protection Program
    a. Patients with known or suspected COVID-19 should be cared for in a single-person room with the door closed.
    b. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients undergoing aerosol-generating procedures.

Standard and Transmission-Based Precautions

Hand Hygiene

HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

HCP should perform hand hygiene by using Alcohol based hand rinse (ABHR) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water.

Respirator or Facemask

Put on a respirator or facemask (if a respirator is not available) before entry into the patient room or care area.

N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure.

- Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door. Do not reuse disposable facemasks.
- If reusable respirators (e.g., powered air purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- Perform hand hygiene after discarding the respirator or facemask.

Eye Protection

- Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- Remove eye protection before leaving the patient room or care area.
- Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- Disposable eye protection should be discarded after use.

Gloves

- Put on clean, non-sterile gloves upon entry into the patient room or care area.
- Change gloves if they become torn or heavily contaminated.
- Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.

Gowns

- Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled.
- Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area.
    - Disposable gowns should be discarded after use.
    - Cloth gowns should be laundered after each use.

- If there are shortages of gowns, they should be prioritized for:
    - Aerosol-generating procedures
    - Care activities where splashes and sprays are anticipated and for high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
        - Dressing
        - Bathing/showering
        - Transferring
        - Providing hygiene
        - Changing linens
        - Changing briefs or assisting with toileting
        - Device care or use
        - Wound care

Implement Environmental Infection Control

- Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Implement mechanisms and policies that promote situational awareness for facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected COVID-19 patients and facility plans for response.

The Importance of COVID-19 Vaccination for Healthcare Personnel

Based on recommendations from the Advisory Committee on Immunization Practices (ACIP), an independent panel of medical and public health experts, CDC recommends healthcare personnel be among those offered the first doses of COVID-19 vaccines. Healthcare personnel include all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials.

This recommendation pertains to paid and unpaid healthcare personnel working in a variety of healthcare settings—for example, acute care facilities, long-term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home health care, mobile clinics, and outpatient facilities, such as dialysis centers and physicians' offices.

Healthcare personnel who get COVID-19 can also spread the virus to those they are caring for—includinghospitalized patients and residents of long-term care facilities. Many of these individuals may have underlying health conditions that put them at risk for severe COVID-19 illness. Healthcare personnel can also spread the virus to other healthcare personnel.

Post Vaccine Considerations for Healthcare Personnel

Systemic signs and symptoms, such as fever, fatigue, headache, chills, myalgia, and arthralgia, can occur following COVID-19 vaccination. Preliminary data from mRNA COVID-19 vaccine trials indicate that most systemic post-vaccination signs and symptoms are mild to moderate in severity, occur within the first three days of vaccination (the day of vaccination and following two days, with most occurring the day after vaccination), resolve within 1-2 days of onset, and are more frequent and severe following the second dose and among younger persons compared to those who are older (>55 years). Cough, shortness of breath, rhinorrhea, sore throat, or loss of taste or smell are not consistent with post-vaccination symptoms, and instead may be symptoms of SARS-CoV-2 or another infection.

Because systemic post-vaccination signs and symptoms might be challenging to distinguish from signs and symptoms of COVID-19 or other infectious diseases, HCP with postvaccination signs and symptoms could be mistakenly considered infectious and restricted from work unnecessarily; this might have negative consequences for HCP, patients, and long-term care facility residents. Hence, strategies are needed to effectively manage post-vaccination systemic signs and symptoms and limit unnecessary work restrictions.

Resources for Healthcare Facilities and Personnel

The true impact of a COVID-19 outbreak in a U.S. community cannot be predicted. The COVID-19 outbreak is rapidly evolving situation and healthcare personnel should continue to monitor and know where to turn for reliable, up-to-date information in your local

community. Monitor the CDC COVID-19 website and your state and local health department for the latest information.

Cultural Competence

Introduction

Most of us think of culture as a synonym of ethnicity, however, it is much more complex than that. Ethnic groups usually share a common race, language, religion. Yet two people from one ethnic group can believe in different religions and have different values.

A persons' culture is made up of values, beliefs, and practices held by a specific group. Culture is passed down from generation to generation but is subject to change and adaptation throughout the years. Culture determines how a person acts and thinks. A person's culture helps them process the world around them by helping them understand relationships, respond to life experiences, and how to act in various situations. This means that each culture will express and experience sickness, pain, and fear differently. Yet a health care provider should never assume each person from the same culture will react the same or require the same approach to care.

Values

Values are principals that a person deems important. For example, a culture can value family and friends.

Beliefs

A belief is having faith that something is true or right without concrete proof. For example, some cultures believe in one almighty God, while others believe in multiple gods.

Practices

Practices are when a person applies their beliefs into actions. For example, some cultures believe in Karma which is the belief that if you live a good life, you will be reincarnated into something better in the next life, but if you live a bad life, you will be reincarnated into something less fortunate in the next life like an animal. This belief guides the practice of a completely nonviolent life where they practice vegetarianism (not eating meat).

Cultural Competency

Unconscious Bias

To be culturally competent, we must understand ourselves. Each of us has biased thoughts and beliefs that impact the way we perceive others which influences the care we give. It is 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. Health care providers are to educate the patient on all their health care options and respect any decision they choose even if the care provider does not agree.

Culturally Competent Care

Illness and stress can cause patients to lose control over parts of their life. When patients lose control, they tend to cling to their cultural practices and beliefs to maintain control and provide familiar comfort. When health care providers recognize and incorporate cultural values and beliefs into the care plan, patients will be more likely to actively participate and be satisfied with the treatment. When health care professionals ignore cultural values and beliefs conflict tends to arise between the care giver and the patient. Incorporating patients' culture into treatment and providing nonjudgmental care is providing culturally competent care.

Dimensions of Diversity

Understanding diversity and the dimensions of diversity are important in providing culturally competent care. Dimensions of diversity include, but are not limited to, age, race, ethnicity, gender, mental abilities, religious beliefs, education, socio-economic status, geological location, marital status, and parental status. All these factors help develop a patient's culture and how they react to their illness and perceive health care.

Skills and Characteristics of Cultural Competency

The LEARN Model

The following guidelines around mnemonic LEARN may be used to help remember how to deliver culturally competent care. The LEARN model will help open communication between the patient and care giver.

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

Caregivers have a responsibility to get to know their patients and families so that healing can take place in the presence of their cultural values, beliefs, and practices. Cultural assumptions should never occur; therefore, the care giver must take the time to learn about a patient's cultural values, beliefs, and practices. Cultural mistakes made from ignorance or assumptions can be hard to recover from harming the patient and caregiver relationship.

Remember to take the time to listen, observe, and care enough to identify the patient's cultural diversity. This can be identified through the patient and their family.

The skills and characteristics of a culturally competent caregiver are:

- Being respectful of others
- Willingness to explore
- Be open to other's differences
- Understanding of the power of words and actions
- Be able to recognize learning opportunities
- 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 a willingness to learn

If caregivers are to be sensitive to various cultures in the workplace, they must first listen to learn about another's culture. Sensitivity to other cultures will assist caregivers in offering healing to patients, residents, and families.

Religious and Cultural Practices

Here is a list of a few religious and cultural practices and beliefs. Once again, the health care provider should never make religious and cultural assumptions when providing care.

Most religions have a prayer schedule or like to pray with their spiritual leader, Pastor, or Priest. It is important to ask the patient what their spiritual beliefs are and if you can contact their spiritual leader, Pastor, or Priest to come for prayer. Also ask if they have any special cultural or religious items that they want by their side.

Common religious practices include, but are not limited to:

- Catholics like to have their rosary beads for prayer and participate in mass
- Baptist might have a cross they like to wear or hold during prayer, and listen to sermons on Sunday
- Orthodox Jews pray three times a day
- Muslims pray five times a day facing Mecca
- Buddhist like time to meditate and chant

Some religions require followers to adhere to dietary restrictions. Common dietary restrictions include:

- Hindus are often vegetarians
- Jews adhere to a Kosher Diet t
- Muslims will refrain from eating pork and some shellfish, and fast during the month of Ramadan
- Eastern Orthodox will have a yearly 40 day fast when they refrain from eating any meat, dairy, and oil
- Jehovah's Witness will not eat any food that contains blood in it
- Catholics avoid eating meat during Lent
- Mormons might fast every month for 24 hours
- Religions and cultures vary on what is acceptable care. Some examples include:
- Jehovah's Witness will refuse any blood product
- Muslims forbid any contact between the opposite gender therefore require same gender care givers
- Hindus must have a bath every day

Proper social interactions and family dynamics vary between cultures.

Some examples include:

- Members of Hispanic Ethnicity are very modest. The eldest male makes important decisions in the family, and family and extended family like to remain by the patient to support and help.
- Members of African American Ethnicity will make eye contact as a sign of respect, and display silence as a sign of distrust. Matriarchs are the leaders of many African American families.

- Members of Native American Ethnicity usually avoid eye contact as a sign of respect. Individuals will make medical decisions for themselves and speaking loud indicates aggression.
- Members of Chinese ethnicity will avoid eye contact and be silent to show respect. Questions are disrespectful. Involve the eldest male in decisions.

LGBTQ culture

- The LGBTQ culture includes patients that identify themselves as lesbian, bisexual, gay, transgender, and queer.
- It is important to remain professional and unbiased when caring for this culturally vulnerable population.
- Communication is essential and should include a patient's partner if applicable. This can help with proper discission making on a patient's care.

LGBTQ patient have also voiced some areas of opportunity for providers to incorporate holistic care:

- Provide and encourage information on support networks.
- Provide safe environments for disclosure by using inclusive language (on forms, brochures, websites, etc.), asking about LGBTQ identities, and responding to disclosure respectfully.
- Ask about and use patients' correct names and pronouns.
- Intervene when patients are mistreated by colleagues or when you witness lack of LGBTQ competence in care.
- Provide clinical examinations informed by knowledge of patients' sexual histories, gender identities, and anatomies.
- Assess and reinforce self-advocacy, self-protection, and transformative experiences of LGBTQ patients.

Customer Relations and CAHPS

Introduction

Whatever role you have within the facility, you are in the business of customer service. Whether you are a housekeeper, nurse, unit secretary, or dietician, good customer relations are an important part of everyone's job. Who is the customer? A customer is anyone to whom you provide service.

There are 2 basic types of customers

- Internal customer
- External customer

Internal Customers

It may seem strange to think of fellow staff members as customers, but internal customers are other people who work at the facility. They include physicians and other professionals, employees of other departments, and other staff members. They are the other people that you provide service to in your facility. Some employees or departments serve mostly internal customers. Their job is to provide services to other departments or employees, such as Human Resources and Computer Information Systems.

External Customers

External customers are people who come into the facility from the outside. They include patients, visitors, and families. They might also include others, such as outside companies, delivery people, and other community members or organizations.

In your job, you may work with many customers: other employees, patients, families, visitors, physicians, and vendors. It is common to have both internal and external customers. For example, nursing staff follow the directions of physicians to provide patient care. These are just two of the many customers that nursing staff serve.

The Importance of Good Customer Relations

The key to good customer service is to treat other people the way you would like to be treated. In dealing with internal customers, maintaining good customer relations is important. It can help to provide a good working environment and a quality standard of

care. When working with patients and families, maintaining good customer relations is of the utmost importunacy.

Patient choice

Patients have a choice about where they go for healthcare services. Although many health plans limit choices, patients may choose their insurance coverage based on the choice of facility they choose to be treated in. If customer service is not good and if patients do not feel that a facility cares about them, they may take their business elsewhere.

Quality of care

When patients go to a facility to seek health care, they become dependent on someone else. They must trust providers and clinicians to tell them what is wrong with them and to treat their illness. Patients experience a real lack of empowerment. They feel that they are not in control of what is happening to them. They may have questions about what is happening, what will be done, and how long it will take. A vital component of customer service is to answer all their questions and give them confidence that the facility will provide the quality of care they want. Many factors can cause patients to feel a lack of empowerment such as:

- being assigned a room
- being given a number
- being given an ID bracelet and patient number
- asked very personal questions
- being seen by different people who come in and out of the room at various times

Even though these things may be necessary for hospital personnel to care for the patients, these can make patients feel that they have no control. Understanding how a patient may feel in this situation can result in better and more considerate care. It is a critical component of customer relations.

Building Good Customer Relations

The key to good customer service is to treat others the way you would want to be treated or the way you would want your loved ones to be treated in a similar situation. It often means simply being courteous and helpful. Remember that things that may be routine for you are NOT routine for patients or their families.

There are many small things that you can do to make a patient feel more confident and cared for:

- Knock when you enter a room, even if the door is open
- Introduce yourself
- Call the patient by name
- Explain what you are going to do
- Use terms that the patient can understand
- If you do not know the answer to a question, find out
- In reception and/or public areas, there are also steps that you can take to build good customer relations:
    - Always acknowledge a person's presence
    - Keep patients informed if there will be a delay
    - It is important to acknowledge a person's presence. Even if you cannot stop, at least make eye contact and smile so that people know they have been seen. Then return and aid as soon as possible. In some cases, patients may need to wait before being seen. If so, explain why and give a reasonable estimate of how long the wait will be. If the wait is long, keep them informed

Customer Relations on the Telephone

We all use the telephone on a regular basis. Most of us take it for granted. We do not often think about using the telephone as a skill. If using the telephone is a part of your job, however, your telephone skills can be especially important. Good customer service is often a question of courtesy. This is also true when dealing with customers on the telephone.

Remember that the people you speak with on the telephone are your customers. When you use the telephone as a part of your job, you are providing customer service. Your telephone skills reflect your facility. Providing an effective telephone service is a part of building good customer relations. It is your chance to make a good impression on your facility.

Courteous customer service on the phone includes:

- Answering the phone by the third ring whenever possible
- Stating your name and title and the name of your department
- Addressing customers by name
- Listening carefully
- Taking messages courteously
- Transferring calls carefully
- Asking questions tactfully
- Your tone of voice is also an important part of building good customer relations on

the telephone
- Smile (even though it cannot be seen, it will affect how you sound)
- Speak clearly
- Be polite.

Clear communication

When people speak face to face, much of the communication is non-verbal. This includes Facial expressions, gestures, and body language.

Non-verbal communication does not occur in a telephone conversation. This means that there is a greater chance of a failure in communication. There are steps that you can take to make sure telephone communication is clearly understood by both you and the other person.

- If you are giving instructions, ask for feedback to make sure that they are correctly understood
- Repeat any information you are given so that the other person can correct any errors
- Write down any messages you need to pass on to someone else.

Effective Service

The goal of telephone communication is to provide effective customer service.

This means:

- Being sensitive to the customer's needs
- Providing the information, the customer requires
- Telephone communication is part of the customer's relationship with the facility. Your customers include everyone to whom you provide service on the telephone, such as patients, family members, and other employees.

Patients and family members need to feel that they are important and that the facility cares about them. Fellow employees need a courteous and supportive work environment. The service that you provide on the telephone is an important part of building a trusting relationship with your customers.

Effective telephone service also means providing the information customers require, such as:

- Avoiding saying, "I don't know"
- Avoiding putting customers on hold for extended periods
- Avoiding transferring a caller to a string of different departments

- No one expects you to know the answer to every question. If you are asked a question and you do not know the answer, tell the caller that you will find out and return the call. Then do it promptly.
- Do not put customers on hold without asking permission. If there is a long wait, check back frequently to give an update and to ask if they would like to continue holding.

As a customer, it is very frustrating to be transferred to department after department. If you must transfer a caller, be sure that you transfer the call to a department that can provide the information needed. If you are not sure, offer to find out the information and call the customer back. Also, when you do transfer a call to another phone, make sure that the call is connected before you hang up.

Finally, when you take a message for someone else, it is important to get all the necessary information. Record the name of the caller and time of the call, as well as the subject. Be sure to indicate whether a return call is required.

Patient Satisfaction Surveys

The Centers for Medicare & Medicaid Services (CMS) develop, implement, and administer several different patient experience surveys. These surveys ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others. The surveys focus on matters that patients themselves say are important to them and for which patients are the best and/or only source of information. CMS publicly reports the results of its patient experience surveys, and some surveys affect payments to CMS providers.

HCAHPS

The Hospital Consumer Assessment of Healthcare Providers and Systems survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care.

OAS CAHPS

CAHPS Outpatient and Ambulatory Surgery Survey asks adult patients about their experiences receiving care in Medicare-certified hospital outpatient surgery departments (HOPDs) and ambulatory surgery centers (ASCs).

Three broad goals have shaped CAHPS:

1. First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to consumers.
2. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care.
3. Third, public reporting serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

As of July 2007, hospitals receiving Medicare and Medicaid funding must report HCAHPS results or lose up to 2% of that funding. As of October 2012, those hospitals may receive additional incentive funding as a result of HCAHPS performance. The intent is to incentivize improvement in patient satisfaction, and, indirectly, the quality of care. A standardized survey enables between-facility comparisons of patient experiences. In effect, survey results will be used to compare and rate hospitals and other facilities and organizations according to how well they meet their patients' expectations. The results are publicly reported.

Healthcare facilities and organizations now have a dual incentive to address barriers to patient satisfaction: 1. Reimbursement will depend on survey performance, and 2. Knowledgeable consumers will make utilization decisions based on publicly available survey information.

Healthcare facilities may use one or more of the following survey technologies: mail, telephone, mail with telephone follow-up, or active voice recognition (automated phone survey technology). Official language versions include Chinese, English, Russian, Spanish, Vietnamese, and Portuguese. All are available to the public.

Patients are surveyed between 48 hours and six weeks after discharge. A random sample of all adult patients, not just those receiving Medicare, is chosen from a variety of diagnoses.

CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. A downloadable version of HCAHPS results is also available through this website. The survey focuses primarily on critical aspects of patients' healthcare experiences (communication with nurses and doctors, the

responsiveness of staff, the cleanliness and quietness of the environment, pain management, communication about medicines, discharge information, overall rating of hospital, and would they recommend the hospital).

Assuring the Best Possible Survey Responses

You pride yourself on the care you provide. And you want your organization to benefit from the quality of care you provide. The following section explains how to ensure that your patient responds to the CAHPS survey in a way that most positively represents the care you provided.

In some of the survey questions 'Always' is the best only answer. Even though the survey question allows for the following responses: Always, usually, sometimes, never. However, 'Always' is the only answer reported to consumers for those domains. This standard particularly applies to the following situations:

- Meeting patient requests, especially bathroom requests, and answering call lights
- Maintaining room and bathroom cleanliness
- Managing pain
- Providing information about medications
- Providing information about post discharge activities and medications
- Maintaining a comfortable and quiet (especially at night) environment

The challenge, therefore, is to assure that your patient answers 'Always' as often as possible. Keep in mind that these surveys take place well after the hospital stay. The patient's recollection of details of nursing care will be incomplete, and survey responses will be heavily influenced by only a few incidents that may stand out in the patient's memory. The following behavioral techniques will help your patient to remember the good care you provide.

1. Make your good care explicit.
    - Making your care explicit may be the most powerful behavioral technique you can use to reinforce your patient's memory of good care. When performing any care that falls into one of the seven 'Always' categories, announce what you are doing to the patient. In other words, explicitly state to the patient that you are providing care in one of those seven categories. For example:
    - When entering a room to answer a call light, say to the patient, "I am

answering your call light, Mrs. Brown." When leaving the room, make a statement that again reminds the patient of what you have done, such as, "I've answered your call light; is there anything else I can do for you?" If possible, incorporate your 'announcement' into the first and last things you say to the patient.
    - Use this technique in every situation in which you are providing care in those 'Always' categories. Making your care explicit will reinforce your patient's memory and will predispose your patient to recalling your high-quality care much later on when completing the survey.
2. Communicate the right message.
    - Verbal and non-verbal interaction with the patient and family members must always indicate respect and caring. A professional appearance helps meet the patient's expectations for how a professional should look. Confident and open body language and posture will indicate a willingness to listen and respond. Good grammar and word usage reinforces that message.
    - Every now and then, however, it is hard to be nice, yet it is much easier than many other risk management strategies. It is imperative to remember that when you are tired, harassed, or you find yourself in a high-stress situation, stop…… take a deep breath, and simply be cheerful and friendly. You will feel better, and it might keep you out of the courtroom someday. Here are some specific things you can do to show your patients that you care when you are in a high-stress situation.
    - If you have to keep your patients waiting, tell them what to expect. Never leave your patients hanging in limbo.
    - Give the patient your full attention.
    - Do not interrupt. Listen carefully to what your patients have to say, especially when you are in a hurry.
    - Respect your patients' privacy.
    - Treat patients as people, not medical conditions. A patient with potential breast cancer will not appreciate being referred to as 'the breast mass
    - Involve patients in decision making. Do not be a 'care dictator'
    - Do not be critical of other care the patient has received. A nurse's criticism of other nurses who have taken care of the patient can give rise to highly unnecessary game-playing and is in very poor taste. It can also give rise to lawsuits!
    - Make sure your fellow nurses show your patients the same consideration that you do. This is also a part of your role as the patient's advocate
3. Focus on trouble areas.
    - CMS tracks and summarizes HCAHPS results by state. Not surprisingly, certain items always trend lower than others, and these trends are fairly

consistent regardless of the state. Please refer to the following website for a look at these interesting trends:
http://www.hcahpsonline.org/Files/Report_July_2015_States.pdf

- From this information, you can assume, for example, that patients consider hospitals noisy at night, are puzzled about their medications, and do not feel they can reliably get help quickly. Know your facilities results and compare those with the national trends at the site above.
- Bottom line, by focusing on the problem areas, and utilizing the behavioral techniques you have learned, you can strongly influence your patient's recall of the care you provide and impact your organization's survey results.

The CAHPS rating depends, to a large extent, on the patient's relationship with their professional healthcare provider. Hospital reimbursement and consumer choice are dependent upon those ratings. Therefore, the healthcare professional/patient relationship, your relationship with your patient, is critical to the hospital's bottom line.

Dementia Care and Communication

Introduction

Dementia is an umbrella term that describes symptoms associated with a decline in memory and thinking capability that severely reduces a patient's ability to perform activities of daily living.

There are several types of dementia, such as Alzheimer's, Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD). According to the Alzheimer's Association, 60 to 80 percent of dementia cases are caused by Alzheimer's, with post stroke vascular dementia coming in second. The types of dementia are associated with the types of brain cell damage and the regions of the brain that are affected. Reversible conditions such as thyroid problems or vitamin deficiencies can mimic or cause symptoms of dementia.

Providing care to a patient with dementia poses many challenges to families and healthcare providers. Effective communication skills can improve one's ability to deal with the challenging behavior that arises when providing care to a patient with dementia.

Dementia

Dementia is a progressive disease with symptoms presenting slowly and gradually appearing worse. Patients with dementia can have short-term memory loss, trouble keeping track of personal belongings such as keys or wallet, performing activities of daily living such as paying bills or preparing food and performing self-care tasks such as bathing or brushing teeth. Dementia can cause mood swings and changes in personality and

behavior. The presentation of dementia can be varied, however, to be considered dementia, at least two core mental functions must be significantly impaired. These core mental functions include memory, communication and language, ability to focus and pay attention, reasoning and judgment and visual perception.

The numerous regions of the brain are responsible for different emotions and bodily functions such as memory, activity, feelings, and/or judgment. Dementia is caused by damage to brain cells of the different regions of the brain. The damaged brain cells then lose the ability to communicate with each other. Impaired communication between brain cells affects the thinking, behavior, and feelings of the patient. When the brain cells of a

region are damaged, the region cannot perform the essential functions as it normally would.

Alzheimer's Disease

In Alzheimer's disease there are elevated levels of proteins, both inside and outside the brain cells that lead to impaired communication amongst the cells. Alzheimer's kills brain cells which impair the patient's cognitive ability and can lead to personality changes. The hippocampus region of the brain is responsible for learning and memory functions. The brain cells in this region are frequently the first affected by the disease, which is why memory loss is one of the first symptoms noticed in Alzheimer's.

Traumatic Brain Injury

Traumatic brain injuries (TBI) are caused by an impact or indirect pressure that causes the brain to violently shake against the skull. The direct or indirect impact leads to the disruption of normal brain function. Falls are the leading cause of TBI's, especially for those aged 75 and older. The other causes of TBI include car accidents, sports, a penetrating wound to the skull or brain and weapon explosions experienced by soldiers in combat.

A TBI patient can have long-lasting or permanent effects such as unconsciousness, memory loss surrounding the traumatic injury, confusion, lack of coordination, and vision or hearing problems. Patients with a history of a TBI have a more than 2 times increased risk of developing Alzheimer's or dementia later on, even years after the initial injury took place. The patient does not necessarily have to lose consciousness or have lingering symptoms for a TBI to occur.

A TBI can be mild, moderate, or severe. A patient with a mild TBI, sometimes referred to as a concussion, can present with memory loss surrounding the traumatic injury, confusion or disorientation, headache, dizziness, blurry vision and nausea or vomiting. In a mild TBI symptoms frequently appear at the time or near the injury. A moderate TBI patient's experience unconsciousness lasting more than 30 minutes but less than 24hours. Severe TBI leads to unconsciousness greater than 24 hours. The symptoms of both moderate and severe TBI are serious and last longer than those of mild TBI.

Cognitive changes are the most common symptoms of all types of TBI's. The patient's ability to learn and remember new information is affected. A TBI patient can also have difficulty paying attention, organizing thoughts, and making sound judgments.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) occurs after experiencing or witnessing a distressing event. PTSD is common among combat veterans, abuse and rape victims and accident survivors; however, PTSD can develop in anyone who has experienced a traumatic event. Symptoms include manic highs and lows, nightmares or unwanted memories of the traumatic event, and avoidance of situations that might trigger unwanted memories of the event.

About 6 out of every 100 people (or 6% of the population) will have PTSD at some point in their lives. About 15 million adults have PTSD during a given year. This is only a small portion of those who have gone through a trauma. Some estimates have the rate as high as 17% in veterans returning from Afghanistan and Iraq and

20-30% in Vietnam veterans. Patients with PTSD can present with complaints of irritability, memory problems, headaches, difficulty concentrating and trouble sleeping. Indicators show that patients with PTSD were more than twice as likely to develop incident dementia compared with those without PTSD.

The direct link between PTSD, dementia and cognitive impairment has not been found in research. However, PTSD is thought to be associated with accelerated brain aging and higher rates of dementia which could be related to co-morbid conditions such as depression, head injuries and stress. Acute stress increases cortisol levels and studies have shown that increased cortisol levels are associated with increased dementia and chronic stress may damage the brain structure which is crucial for memory and learning.

It is important to monitor patients with PTSD, especially if they are of an advanced age for cognitive impairment. Mechanisms linking PTSD and dementia continue to be researched to identify and with the hope of finding ways to improve the care and outcomes of those patients with PTSD.

Caring for Patients with Dementia

Effective communication skills are imperative for the care providers of dementia patients. The difficult behaviors exhibited by the patient can be challenging but you must remember that the patient is not deliberately trying to be difficult. Try to keep in mind also, that the behaviors are part of the disease and if able the patient would choose to behave differently. A patient with dementia cannot be changed, therefore, the caregiver must deploy strategies to accommodate the difficult behaviors and modify the environment to accommodate the patient's behaviors.

The strategies for treatment of dementia, including dementia caused by TBI or PTSD are the same. Providing care to a patient with dementia requires you, the caregiver, to implement strategies for moving your patient through the episodes of difficult behavior.

One strategy, outlined below, involves atechnique answering "what, when, where why and how" behind the patient's difficult behavior.

What

As the patient's care provider, you need to examine the behavior objectively. The patient may be exhibiting embarrassing, disruptive or uncomfortable behavior. It is your role as the caregiver to ask yourself, can the actions lead to adverse outcomes? Will the patient's behavior lead to self-harm or harm to others? You must be able to know what behaviors to let go of, and should avoid correcting, intervening, or escalating the current situation.

When

Care providers should be aware and continuously assess for patterns or situations, such time of day or certain times of year, which trigger the difficult behavior. If you begin to notice a trigger pattern, make sure to discuss and communicate your findings to the other care team members. You should attempt to avoid topics that can trigger your patient, quickly changing topics when your patient becomes agitated.

Where

The environmental condition or changes to the environment can bring about difficult behavior. Care providers should be aware of what the patient sees in their environment and try to see from the patient's perspective. A new smell or unexpected noise, although not noticeable to you, can increase stress and cause agitation to your patient.

Why

It is important to keep your focus on why the patient is behaving this way and not the actual behavior. Patient behaviors most often are reactions to stressful situations or a sense of loss of control, which as an adult is challenging. Think of yourself in situations where you have no control or lack the ability to communicate or even make your own decisions. How would you react? As humans, regardless of cognitive or physical decline, still have basic needs that need to be met. Remember Maslow's Hierarchy of Needs? Your patient could just be tired, hungry, or thirsty, and is unable to communicate his or her needs to you. Meeting an unmet need can resolve difficult behavior.

Navigating Difficult Behaviors

So now you have learned to focus on the reason behind the patient's behavior and not the actual behavior. What is the next strategic step? As the care provider, you need to ask yourself, "What can I do to potentially prevent the difficult behavior (s) from occurring? How can I get us through the episode?" First you must validate your patient's feelings. The more you try to correct or explain to your patient why he or she is "wrong," the more agitated your patient can become and potentially, the difficult behavior can be exacerbated. Let your patients know that you understand that they are upset and ask them "how can I help you"? Instead of trying to correct the "wrong," attempt to find opportunities for you both to agree. For example, if your patient insists on getting her purse, instead of explaining to her over and over why she cannot have her purse, you can simply say "Yes, absolutely I will make sure you have your purse when it's time to leave."

A key point to remember about effective communication is that we, both patients and care givers, communicate through body language, sometimes even more than our spoken words. Be sure you are aware of your body language, facial expressions, and tone of voice. Always maintain eye contact with your patient. A smile or reassuring touch can go a long way with diffusing a difficult situation. Also, the patient's behavior should never be taken personally, and you should try your best to remain calm.

Engaging your patient and family is integral to quality patient care. Having personal conversations with your patient and their family can yield valuable information about your patient's likes and dislikes such as favorite song, food, or hobbies. Once you have this information, you can introduce the stimuli into the behavior episode to deescalate the

situation by distraction and positive reinforcement. It may be helpful to have a supply or goody bag of favorite pictures or items on hand so that you can quickly access them when the need arises.

Planning your patient's activities around things that they enjoy can help to prevent episodes of difficult behavior. The activities should be at a similar time each. The activity needs to match the cognitive and physical capabilities of your patient. You can help the patient get started and see how much they can do or how much help they may need. If the patient gets frustrated, have a plan to redirect the patient to another activity or pull something out of your goody bag. You want to make sure that your patient is successful, maintains his or her sense of control, and has fun. Some suggested activities include exercising (taking walks), watching a favorite TV program, dancing, and listening to music, pet therapy or gardening. As a care giver of patients with dementia, remember to focus on protecting your patient from harming themselves or others, and allow some sense of control by allowing patients to make their own choices when possible. Give patients some room to breathe and decompress when needed. To provide high quality care to your patients, you have to be able to let things go and should not hold a grudge against the patient. Your patient may not be aware of what they are doing, saying or even remember their behavior. Learn to recognize the signs of frustration in yourself and learn to ask for help. Practice your patience and understanding, it is the disease.

Dementia sometimes is accompanied by aggressive and assaultive behavior that can endanger a caregiver.

Communicating with Patients with Dementia, Cognitive Impairment, and Limited English Proficiency

This is a brief overview of communicating with communication-challenged patients. This is a large topic on its own and this section is a general overview, with some communication tips and techniques.

Firstly, make sure that your patient has all they need in order to communicate with you.

With sensory-impaired patients, those with speech, hearing, and/or vision problems, make sure that they are prepared to understand the messages you are sending and to respond to

those messages. Does she require a hearing aid and is it in place? Glasses? Dentures? A picture/alphabet board?

Ask the patient what she needs that will help you communicate with her.

You will frequently encounter patients who speak a different language. While non-verbal techniques and picture boards may suffice, you may need help from the patient, family, or friends, or from the interpreter services in your organization.

Non-verbal Communication

Non-verbal communication is important, even with vision impaired patients. For example, it is important to approach the patient from the front; a patient may startle if you speak to them when they cannot see you. Once you are in front of the patient, use your body posture, expression, and eye contact to signal that you are ready to communicate. Consider leaning in or sitting so that you are on the same level as the patient. Show by your non-verbal's that the patient has your full attention.

Remember your active listening techniques. Give the patient your complete attention.

When gesturing or pantomiming, keep your gestures slow and away from the patient's personal space and face.

Facial Expression

You communicate a great deal of information to a patient that is entirely separate from the words you use. Referring to the definition of communication as 'transmitting messages,' think about what messages you transmit through expression, body language, and general appearance. Effective non-verbal communication builds trust between you and your patient.

For example, when you respond to a patient's call light, what facial expression will communicate to the patient that you are: Impatient? Annoyed? Indifferent? Concerned? Interested? Alert?

Eye Contact

Eye to eye contact communicates that:

- You are focused on and paying attention to the patient
- If the patient is speaking, you are listening to what they have to say

- You are making a connection with the patient and his/her concerns mean something to you
- You are comfortable talking and communicating with the patient

Avoiding eye to eye contact may convey the following:

- You do not care
- You do not like the person
- You are hiding something
- You are thinking about something else

Cultural and interpersonal exceptions: Some cultures and individuals prefer to avoid eye to eye contact. Be sensitive to the patient's concerns.

If you are uncomfortable making eye contact, try focusing on the bridge of the nose instead; it will appear as if you are making eye contact.

Body Language

Assume a posture that will indicate that you are prepared to listen to the patient and be concerned with what the patient has to say—erect, unhurried, upper body facing toward the patient, arms relaxed at sides, and leaning forward slightly. Avoid postures with the opposite effect such as crossing your arms, fidgeting, checking your watch, acting as if in a hurry.

Good use of body language communicates:

- I am good at my job
- I can manage this situation
- I am here and ready to listen to your concern and take action
- Right now, you are my primary concern

Poor body language may communicate inattention or impatience.

We all have bad days. Be alert to your own emotions and their impact on your body language. Even something as seemingly benign as being in a hurry can alter your body language in a way that could communicate uncaring messages to your patient.

Pace

Pace your communication appropriately. For both cognitive and hearing-impaired individuals, speak slowly and clearly. You may need to speak more loudly with the hearing-impaired.

For all communication-challenged patients, focus on one message at a time or one question at a time. Keep your communication as simple as possible. Repeat or rephrase often. Do not hurry the patient.

Always let the patient know when you do not understand what they are trying to communicate. Try different phrasing or a different method of communicating if the patient does not understand what you are trying to say.

Where possible, use family and friends who can help you interpret what is being said.

Minimize distractions such as noise, poor lighting, too many people around, and television (ask permission to turn the TV off). Do not chew gum.

Nothing will impact your patient's safety and satisfaction more than your close attention to your own communication techniques.

Safety Considerations

Patients with dementia have limited decision-making capacity in the following domains, all with safety implications.

Decision-making

Reasoning and memory impairment, even in mild to moderate dementia will diminish a patient's capacity to make appropriate choices. A critical element of this impairment is the patient's own insight into her memory and judgement capacity. Decreased insight amplifies the impairment in decision making.

Driving

It is difficult for patients to surrender their autonomy and recommending cessation of driving is a delicate subject. However, studies have consistently shown that patients with dementia are poor drivers than their age matched controls. The longer that dementia has been present, the poorer the performance and greater the risk of injury from an accident.

Financial Capacity

Patients with dementia are at serious risk for financial mismanagement and exploitation.

Cooking

Patients with dementia are more easily distracted and forgetful and are at risk for burns and injury. Microwave ovens are a safer alternative to stovetops and ovens.

Wandering and Becoming Lost

Distractibility and restlessness may lead to wandering. Interventions include:

- Signage for patients and staff
- Alarms
- Supervised exercise

Bedrails

You should be careful to use bedrails only as stated in the policy of your facility. Research shows that the improper use of bedrails increases the chance of patients falling because patients climb over them.

Falls

While most falls occur in patients over 65 and the highest number in the 80-89 age group, the risk of falls in those with dementia is doubled over that of their unimpaired cohort.

Fall Prevention

There are evidence-based practices that can help reduce the risk of falls in at-risk patients.

- Maintain a safe environment
- Communicate patient fall risk to teammates and at change of shift
- Orient patients and families to their surroundings
- Show them how to use the call light and explain how and when to get assistance
- Ensure good lighting in rooms and bathrooms
- Keep call bell in reach
- Keep beds at a low height
- Make sure path to bathroom is clear

Fall Protocols

Over the last several years, most healthcare organizations have implemented fall protocols. These combine a variety of approaches, usually including:

- Fall risk assessment, patient classification, and plans of care for at-risk patients
- Team and/or round observation of documentation standards
- Patient education, live and in print
- Room signs and job guides for staff, family, and patients
- Quality management tracking and reporting
- Fall-specific event reporting and documentation

Restraints

Restraint for the prevention of falls is either not allowed as per policy guidelines or is allowed only as a last resort. Sitters are a far more common and far safer alternative. Your facility may have special alarms that can be used to alert staff when patients have gotten out of chairs, wheelchairs, or beds.

Emergency Medical Treatment and Active Labor Act (EMTALA)

Introduction

The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Reconciliation Act (COBRA). This legislation mandates that Medicare-participating hospitals, with emergency centers (ED), perform a medical screening examination (MSE) on any individual who presents to the ED for care. The MSE is performed to determine if an emergency medical condition (EMC) exists.

The MSE must be performed on all patients, within the capability of the hospital's emergency center, in a non- discriminatory manner, regardless of their ability to pay, insurance status, national origin, race, creed, color or immigration status. If the MSE determines that a patient indeed has an EMC, then the hospital is required to treat and stabilize the patient to the extent of their capability or transfer the patient to another facility with the capabilities to treat the patient.

The law also prohibits delaying care so that the patient's payment status or insurance status could be determined.

No Patient Dumping In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA"). The purpose of EMTALA is to prevent 'patient dumping,' i.e., refusing to provide emergency treatment to indigent and uninsured patients, or transferring those patients to other facilities without first ensuring that their medical conditions are stabilized sufficiently for transfer.

EMTALA requires that all hospitals participating in the federal Medicare program, meet the following two conditions when a patient arrives at an ED for treatment:

Determine whether an emergency medical condition exists, and,

If an emergency medical condition exists, stabilize the condition before transferring or discharging the patient.

Location, Patients, Exams, and Conditions

Location

The Centers for Medicare and Medicaid Services (CMS) defines an Emergency Department as "a specially equipped and staffed area of the hospital that used a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions."

By this definition, hospital-based system outpatient clinics, who do not have the capabilities to manage medical or surgical emergencies, would not be included or obligated under EMTALA and can refer patients to the closets or most appropriate emergency center for care.

So, what happens if a patient collapses in the parking lot of the ED or is in an ambulance and has not made it into the ED or presents to an outpatient dialysis clinic with fluid overload and shortness of breath. Patients in these situations would be covered under the EMTALA law.

CMS, the governing body that oversees EMTALA enforcement and subsequent court rulings have expanded the domain acreage of an emergency center to include any area of the hospital or facilities where patients can present for evaluation and potential treatment. A designated physical emergency space is not the only area where patients are present with an emergency condition. Therefore, hospital units, hospital or system-based clinics, freestanding urgent care centers, outpatient surgery centers and even psychiatric facilities may be included.

Patients

What type of patients are covered under EMTALA? Any individual who seeks care for an emergency medical condition, regardless of insurance status, citizenship, race, sexual orientation, etc. Absolutely every individual is covered under the EMTALA law.

When does the law no longer apply to a patient? The law applies to any patient until a qualified medical professional performs an exam and determines that a patient either does not have an emergent medical condition or the patient's condition has stabilized.

Medical Screening Exams

Neither CMS nor court rulings have specifically defined what constitutes an MSE, which leaves room for interpretation. Suffice it to say that an appropriate MSE does not include a brief history and physical and quick triage out the door. The MSE should include a history and physical, triage evaluation along with laboratory test, scans, and consults. The MSE should only conclude when an emergent medical condition has been ruled out or the patient has been stabilized.

- For pregnant women, fetal heart tones and cervical dilation should be included in the MSE.
- Psychiatric patients should have a documented assessment of suicide attempt and risk.

Conditions

EMTALA law defines "stabilized" in the following way:

> To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described as a pregnant woman who is having contraction, to deliver (including the placenta)

Transfers and EMTALA

EMTALA mandates that if an emergent medical condition is present, the hospital is obligated to stabilize the patient, within the staff and available resources at the hospital or transfer the patient to another facility who can meet the patient's needs.

If the condition has not been stabilized, the hospital can only transfer the patient, at the patient's request, after the patient has been informed of the risks of the transfer and the hospital's obligation to stabilize.

Additionally, the transferring provider must sign a certificate that is based on the information available at the time of transfer, that the benefits reasonably outweigh the risks and the transfer meets EMTALA definition of appropriate.

Note that sending a patient to another facility for a test with the intention of accepting the patient back after the test is considered a transfer. Also, transfers do not only include facility

to facility. A discharge home from the ED or any other part of a hospital is considered a transfer.

Finally, a hospital who has specialized services, such as the Interventional Cardiology lab or a Certified Stroke center, cannot refuse to accept a patient needing those specialized services, if they have the capacity to treat the patient. This process is often referred to as "reverse dumping."

Violations of EMTALA usually occur in two instances:

1. The hospital claims capacity but was later found to have an available bed for potential transplant recipients or the ED was not on patient diversion.
2. The transferring hospital ignores the receiving hospital's refusal and sends the patient anyway.

Penalties

An anonymous report of a potential EMTALA violation can be initiated by any patient, physician, or hospital. The complaint is then sent to a regional CMS office and if the office determines that an investigation is warranted, the complaint will be referred to the State's CMS agency.

The State's agency must initiate an investigation within 5 working days, concluding in 15 days. The burden of proof is on the hospital to show that it either did not violate EMTALA or has initiated a corrective action plan. Medicare participating hospitals and physicians, who are proven to have indeed violated EMTALA, can receive fines up to $ 50, 000. The potentially most devastating penalty for an EMTALA violation, to both the provider and the facility is denial of participation in the Medicare program.

End of Life Care

Hospice or Palliative Care

Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice care involves a collaborative approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. At the center of hospice and palliative care is the belief that each of us has the right to die pain- free and with dignity, and that our families will receive the necessary support to allow us to do so.

Palliative care is care given to improve the quality of life of patients who have a serious or life-threatening disease, such as cancer. The goal of palliative care is to address the impact of serious illness by managing symptoms, providing emotional support, and ensuring that the plan of care aligns with the patient and the family's goals. The goal is not to cure. Palliative care is also called comfort care, supportive care, and symptom management.

Hospice care, care at the end of life, focuses on caring, not curing. The goal of hospice is comfort care to include symptom control, pain management, education on what to expect during the dying process, and emotional and spiritual support. Hospice Services can be delivered to patients at home, in a skilled nursing facility, or in a hospital.

Advanced Directives

A living will is a written, legal document that spells out medical treatments you would and would not want to be used to keep you alive, as well as your preferences for other medical decisions, for example, in the event of brain death or terminal illness.

Durable Power of Attorney for healthcare, on the other hand, covers all health care decisions, and lasts only as long as the patient is incapable of making decisions for themselves. However, specific provisions can be declared in the Power of Attorney outlining how the patient wants the agent to act regarding deathbed issues.

End of Life Symptoms

Physical Changes

For most dying persons, activity decreases significantly in the final days and hours of life. You will notice:

- They will speak and move less
- They may not respond to questions or show little interest in their surroundings
- They have little, if any, desire to eat or drink
- Their body temperature can go down by a degree or more, so as you hold his or her hand, they may feel cold
- Their blood pressure will also gradually lower and blood flow to the hands and feet will decrease
- The skin of their knees, feet, and hands may become purplish, pale, grey, and blotchy. These changes usually herald death within hours to days. When death does occur, the skin turns to a waxen pallor as the blood settles
- The sound of noisy breathing

Level of Consciousness

Because the central nervous system is directly impacted by the dying process, your loved one may sometimes be fully awake and other times be unresponsive. **Caregivers, family, and physicians should always function as if the dying person is aware of what is going on and can hear and understand voices.** In fact, hearing is one of the last senses to lapse before death.

Often before death, people will lapse into a coma. A coma is a deep state of unconsciousness in which a person cannot be aroused. People in a coma may still hear what is said even when they no longer respond. They may also feel something that could cause pain, but not respond outwardly.

Sensory Changes

It is not unusual for dying persons to experience sensory changes, which are misperceptions that can be categorized as illusions, hallucinations, or delusions.

Illusions - They may misperceive a sound or get confused about physical objects in the room. They might hear the wind blow but think someone is crying, or they may see the lamp in the corner and think someone is standing there. Illusions are misunderstandings about something that is actually in their surroundings.

Hallucinations - Dying persons may hear voices that you cannot hear, see things that you cannot see, or feel things that you are unable to touch or feel.

Delusions of persecution and delusions of grandeur - Many dying people confuse reality and might think that others are trying to hurt them or cause them harm. Or they can come to believe that they are much more powerful than they really are and think that they can accomplish things that are not possible.

Pain Management

Near the end of life, patients may experience a range of discomforts, including pain, shortness of breath, nausea, anxiety, constipation, swelling, and insomnia, among others. A key goal of hospice care is to reduce these symptoms and increase the patient's comfort level as much as possible.

Holistic Care for the Patient and Family

Compassion is an element of care often referred to as a major indicator of the quality of care that patients receive. The patient and family need to be approached as a UNIT, and their care needs to include physical psychological, social, and spiritual aspects. Patients and their families need compassion, support, and education along the health-illness continuum from a time of wellness to chronic illness to advancing illness and frailty to death. Those facing serious life-threatening illnesses and approaching death deserve to be treated with dignity, respect, and compassion and receive care that is focused on the individual's goals for care.

Studies show patients need compassion, acceptance, to be treated as a whole person and not to be abandoned. They need clear information that enables identification of the person they trust to make decisions when they are unable to do so and help in the determination of goals of care.

Patients and their family want quality end-of-life care that includes:

- Receiving adequate pain and symptom management
- Avoiding inappropriate prolongation of dying
- Achieving a sense of control
- Relieving the burden on loved ones
- Strengthening the relationship with loved ones
- Respecting the uniqueness of the individual
- Providing an appropriate environment
- Addressing spiritual issues
- Recognizing cultural diversity

- Effective communication between the dying person, family, and professionals

Environment of Care

Introduction

The Joint Commission has developed Environment of Care standards to help improve patient safety, decrease risks, and improve quality of care. Joint Commission requires every healthcare organization to create and manage their own personal written Environment of Care Plan. Every healthcare employee needs to know how to access these plans in their work area. The written Environment of Care Plan is made up of eight programs which include:

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

Safety Management

Healthcare facilities are required to develop a Safety Management plan to strive to provide a risk-free healthcare facility for employees, patients, and all who enter the facility. Healthcare facilities must have leaders in safety management who ensure set safety standards are followed, create concise and measurable safety goals, manage safety risks, monitor, and evaluate safety programs, and provide safety training to all healthcare staff, patients, and family members. The leaders should consist of a governing safety committee, comprised of healthcare staff, and a safety leader or officer. These individuals enforce safety rules and regulations and have the authority to act should there be a safety issue or risk. Safety leaders develop, manage, monitor, and enforce safety protocols, but it is the responsibility of all healthcare employees to help maintain a safe environment for everyone.

Employee Responsibilities

- Report unsafe and unhealthy acts/conditions to the supervisor or Safety Officer.
- Correct unsafe or unhealthy acts/conditions.
- Complete mandatory safety training at least annually following new

employee orientation.

- Help prevent and report all accidents and injuries.
- All emergency exits and stairwells must be kept clean and clear.
- Be able to explain the proper use, maintenance, and storage of equipment and Personal Protective Equipment.
- Become familiar with and comply with all Safety and Health regulations, policies, and procedures

The Safety Committee

- The committee must be comprised of multidisciplinary healthcare employees at every level.
- They cover all aspects of Safety including, Occupational Health, Environmental Protection, Fire Protection, Patient Safety, Infection Control, and Radiation Safety drills.
- They review safety program effectiveness, accidents, illnesses, and incidents pertaining to safety.
- They plan and report on fire and disaster drills

Emergency Management

An Emergency Management Program is a comprehensive emergency plan that provides direction in the event of a community or internal disaster that disrupts the facility's ability to provide proper care for patients. This could also hinder their ability to provide emergency medical treatment for casualties resulting from the disaster.

Your Responsibility

- Be familiar with the Emergency Management Plan and know where to find copies.
- Understand your role in an emergency event.
- Perform your normal duties during an emergency until called upon to perform additional duties if needed.
- Know that most facilities in the area are linked to the Hospital Emergency Incident Command System (HEICS), which is a standard for healthcare emergency management.
- Remain calm.
- Know the difference between an internal and external disaster.
- Be prepared to be called upon to assist in the movement of patients, food, and supplies.

Internal versus External Disasters

Internal Emergencies occur within the facility. Examples include:

- Bomb threats
- Fires
- Shootings
- Chemical spills

External Emergencies occur 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
- Natural disasters (tornadoes, floods, ice storms, earthquakes)
- Food and/or chemical poisonings
- Terrorism attacks
- Mass casualties

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 must have routine preventative maintenance performed regularly.
- Employees need to know how to check and operate all equipment used on the unit including all emergency response equipment.
- Know the difference between life support and non-life support equipment.
- Understand how to report biomedical equipment failures.
- Preventive Maintenance (PM) inspection is regularly done every year.
- Properly report, document, and remove any broken equipment from service.
- Safety recalls, hazard alerts, and incident reviews are acted upon appropriately.
- Know that in the event of a utility failure red electrical outlets are supported by Emergency Generators.
- Understand how to read the inspection sticker on all equipment to tell when the last day of use is before another inspection is required.
- 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.

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, 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 chemical's medical surveillance, as well as blood borne pathogen exposure (needle sticks and splashes) is also included in this program area.

What You Need to Know

- All employees have the right to know the hazards and identities of the chemicals they are exposed to in the workplace (the Hazzard Communication Program / "Right to Know Law").
- Training must be provided to each employee for every chemical that is used on the unit.
- Know where to locate the chemical and hazardous material protocols.
- Use proper hand hygiene and personal protective equipment when handling hazardous chemicals or materials.
- Chemicals should be inventoried annually in each work area.
- Understand how to properly label, administer, handle, clean, store, and dispose of any chemical or hazardous material used in the workplace.
- 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.
- Know how to clean up hazardous chemical spills and where to locate the spill cleanup kits on the unit.
- Understand how to wash off any hazardous chemicals on the skin.
- Know where the eye wash station is and how to use it to wash out any chemical, or bodily fluid, which splashes into the eyes.
- Remove any clothing, or personal protective equipment, which has hazardous chemicals on it.
- Know the units needle stick protocol and how to report a needle stick.
- Understand how to report exposure of hazardous chemicals or materials.

Safety Data Sheets

All chemicals are required to have a Safety Data Sheet SDSs (formally known as the Material Safety Data Sheet MSDS) that provides information about the chemical. Employers must

ensure that all SDSs are readily accessible to every employee for all hazardous chemicals in the workplace.

The following information is included on an SDS:

- Section 1: Chemical identification including
- Section 2: Chemical hazard identification and label requirements
- Section 3: Composition of chemical ingredients
- Section 4: First-aid measures including side effects and symptoms.
- Section 5: Fire-fighting and extinguishing measures.
- Section 6: Accidental release measures including proper methods of containment and cleanup.
- Section 7: Handling and storage practices and precautions.
- Section 8: Exposure controls including OSHA's Permissible Exposure Limits (PELs); Threshold Limit Values (TLVs); and personal protective equipment (PPE).
- Section 9: Physical and chemical properties of the substance.
- Section 10: Stability and reactivity lists including hazardous reactions.
- Section 11: Toxicological information including acute and chronic effects.
- 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.

Utility Management

The Utility Management Program involves the operational response to failures of all utility systems that support the patient care environment. It also involves the periodic inspection of utility-related equipment and systems for preventive maintenance.

What You Need to Know

- Know where outlets, zones, pressure alarms, and shut-off valves are located in your area.
- Be able to locate all the red electrical outlets.
- Ensure all life sustaining equipment is plugged into a red back-up generator outlet.
- Understand who is authorized to use the Oxygen Shut-Off Valve.
- Know where the compressed gas cylinders for oxygen administration are located.
- Know the units' policy for an inactive elevator system.

The Utility Management 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 require a primary electrical power source as well as a back-up source, such as an emergency generator. When the primary source fails, the back-up 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
- Designated red outlets for Patient Life Support
- Elevators
- Nurse Call Systems
- Code Blue Systems
- Medical Gas Systems (oxygen, nitrogen, medical air, etc.)

Life Safety Management

The Life Safety Management Program provides instructions on how to react during a fire emergency in order to keep employees and patients safe.

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.
- 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.
- 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 and how to properly operate them.

Interim Life Safety Measures

Interim Life Safe Measures (ILSM) are a series of 12 Administrative Actions required to temporarily compensate for any inactive life safety feature of the building. This would be important anytime the existing life safety features are being compromised in or around immediate work areas during times of construction or remodeling. ILSM are intended to provide and maintain a level of safety for all who enter the facility. 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.

Security Management

Security Management is comprised of security staff, and the police or public safety, to ensure the safety of all who enter the facility.

What You Need to Know

- You should know who is responsible for security, including who secures the opening and closing of doors, parking lot areas, and internal and external security checks.
- Know who monitors vehicular access.
- Know who maintains security in sensitive areas such as the pharmacy.
- Know who is responsible for responding to violence in the facility.
- Know who responds to bomb threats or gun threats.
- Know the Emergency Reporting Phone Number for the facility you are working in, and the police notification procedure.
- Understand your role in bomb threats.
- Understand how to handle telephone threats calmly and quietly and keep

the caller talking as long as possible.

- In case of written threats, preserve the written material and the container it arrived in.
- Know when and how to call the emergency phone number and/or telephone operator.
- Understand the procedure to follow for a missing patient search.
- Understand the procedure to follow and associated roles for a suspected, or actual, infant abduction
- 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, as well as how to manage and prevent workplace violence.

Management of the Social Environment

The Social Environment Program is essential to excellence. The delivery of quality healthcare is enhanced by appropriate physical surroundings and features that contribute to the psychosocial well-being of a patient. 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:

- Providing adequate supplies for patient grooming (personal hygiene).
- Having adequate drawer and closet space.
- Providing suitable clothing.
- Providing telephones (with privacy).
- Doors in sleeping rooms.
- The number of patients per room.
- Space provided according to appropriate age, developmental level, and clinical status.
- Maintaining a smoke-free environment.
- Providing a designated smoking area.

Fall Risk Assessments

Fall risk assessments are evidence-based tools used to assess a patient's risk for falling. These tools are used in every area of healthcare and aid facilities in developing Fall Prevention Programs and individual Fall Prevention Care Plans. There are a variety of Fall Risk Assessments one can use. Typically, these tools use a scoring system that measures the cumulative effect of known risk factors.

The most common Fall Risk Assessment tool used in hospital settings is the Morse Fall Scale (MFS) which is a rapid and simple method of assessing a patient's likelihood of falling. It consists of six variables that are quick and easy to score, and it has been shown to have predictive validity and interrater reliability. The six variables include: the patient's fall history, medical diagnosis history (acute and chronic), ambulatory status (types of ambulatory aids), intravenous therapy, gait pattern, and mental status. This tool is used, along with a physical assessment and review of the patient's current medication list, to obtain a quick and easy fall risk score.

Home Healthcare Providers will perform a thorough examination of the patient's home environment when assessing Fall Risk and developing a Fall Risk Plan of Care.

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.

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 Arm Bands/Socks/Signs

Fall risk patients are assigned special-colored socks and arm bands and have colored signs posted outside their door.

Teach 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.

Safe Environment

Remove excess equipment from rooms and hallways, coil, and secure electrical/phone wires, ensure spills are cleaned immediately, keep call light within reach of patient at all times, ensure appropriate lighting.

Bedrail Use Reduction

Bedrails contribute to patient fall risk because they are barriers when transferring patients in and out of beds. The 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-Fall Protocols

After a patient falls, the staff will conduct a debrief to discuss what happened and identify probable causes of the fall. The nurse responsible for the patient also fills out a questionnaire so the unit continually gathers and analyzes data about patient falls. The patient is included in this debrief.

After a Patient Falls:

- FIRST perform a head-to-toe assessment and assess for injuries (e.g., laceration, fracture, head injury).
- Obtain and record sitting and standing vital signs.
- Assess for any change in range of motion.
- Assess for any cognitive change.
- Assess the patient's level of consciousness.
- Alert the physician.
- Follow organizational policies for patient monitoring, depending on patient condition.
- Document circumstances in the medical record, including patient's appearance at time of discovery, patient's response to the event, evidence of injury, location, time when medical provider was notified, and medical/nursing actions.
- Complete occurrence or incident report.

- Complete a debrief with the patient and care team to evaluate why the fall occurred.
- Review the plan of care and add fall prevention strategies.
- Form an interdisciplinary staff meeting to evaluate why the fall happened and how to prevent future falls.
- Implement other interventions as patient condition indicates.

Fall Prevention

Introduction

Falls are a major health problem among older adults in the United States. One of every three people over the age of 65 years living in the community falls each year, and this proportion increases to one in two by the age of 80 years. The goal of a fall prevention program is to promote patient safety by identifying patients at risk for falls, implementing a fall prevention plan of care, and effectively managing patients who do fall. Finding out the cause of the fall, and treating it properly, increases the chances that the patient will return to their original function and reduces the risk of future falls.

A fall is defined as an unintentional unplanned downward motion to the ground. This is considered a fall regardless of if it caused an injury or not.

Fall Risk Factors

Risk factors associated with falls are categorized into extrinsic factors (hazards found in the environment) and intrinsic factors (patient's age, physiological problems, or medication). Assessment of these risk factors is used when developing the Plan of Care for a high fall risk patient. Previous falls indicate a high risk for future falls.

Examples of Extrinsic Risk Factors

- Hazardous activities
- Living alone
- Poor lighting in the home
- Time of day
- External lighting such as lamps cluttering walkways
- Clutter in the home
- Spills/Wet floors
- Loose electrical cords
- Dependence on walking aids such as a cane or walker

Examples of Intrinsic Risk Factors

- Muscle weakness
- Decreased sensory awareness such as touch
- Diseases causing the patient to be housebound
- Gait and balance disorders
- Visual disturbances
- Decreased hearing
- Cognitive impairment/mental status
- Dizziness/Vertigo
- Postural hypotension
- Incontinence
- Polypharmacy
- Age (75 years and older)
- Chronic diseases, especially COPD, depression, arthritis, and circulatory diseases
- New or Fall Risk Medications

Medications that may increase a patient's risk for fall

CATEGORY	DRUG EXAMPLES	SIDE EFFECTS
1. Antihistamines	**Diphenhydramine, Promethazine**	**Sleepiness, Blurred Vision**
2. Cathartics, Laxatives	Bisacodyl, Fleet Enema	**Increased urgency to get to the rest room**
3. Diuretics	Furosemide, Bumetanide, Indapamide	**Increased urgency to get to the rest room**
4. Opioids	Morphine, Meperidine, Codeine	**Low blood pressure, Dizziness, Drowsiness**
5. Antipsychotics	Haloperidol, Risperidone, Quetiapine	**Dizziness, Drowsiness**

6. Benzodiazepines	Diazepam (Valium), Chlordiazepoxide Clonazepam	**Drowsiness, Lightheadedness**
7. Sedatives-Hypnotics	Zolpidem, Chloral Hydrate, Zaleplon	**Drowsiness, Lightheadedness, Confusion, Delirium**
8. Antidepressants	Trazodone, Sertraline, Escitalopram	**Drowsiness, Blurred Vision**
9. Hypotensive	Beta Blockers, Clonidine, Calcium Blockers	**Low blood pressure, Dizziness**
10. Muscle Relaxants	Carisoprodol, Cyclobenzaprine, Metaxalone,	**Drowsiness, Dizziness, Weakness**
Anticonvulsants	**Levetiracetam, Phenytoin, Zonisamide**	**Unsteady gait, psychomotor impairment, syncope**

Healthcare Ethics

Introduction

What are ethics and what are ethics in health care? Ethics are guiding moral principles that direct an individual's behavior in his or her activities, and the term "ethics" is frequently used in reference to professional conduct.

Ethics is a science that deals with principles of good, bad, 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 parties who are involved.

Function

Healthcare professionals are expected to act in the best interests of the patient and follow the patient's wishes. Ethical issues sometime arise in situations that include a patient's right to die as they choose, a patient's right to their own healthcare information and a patient's right to make choices and decisions surrounding their healthcare needs.

Healthcare ethics represent moral values that are regarded as acceptable by society. Healthcare professions have codes of ethics that are expected to be followed by members of the profession. Hospitals and large healthcare systems often have a code of ethics or code of conduct, which they expect 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 profession. Ethics also set a standard for professionalism in health care.

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 values do 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 engage 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 as well as honoring their written directives, such as living wills, power of attorney, and other advanced planning directives.

Codes of Ethics for Healthcare Professionals

Many Professional Associations for Healthcare Providers and Clinicians have their own Code of Ethics. These Codes of Ethics identify behaviors that clinicians and providers are to abide by. These have some commonality and threads, though in different words, identify the responsibility of practitioners.

General Code of Ethics

- Place the patient's interests first, promoting patients' health, safety, and rights
- Protect the autonomy and dignity of the patient
- Maintain confidentiality
- Practice with honesty and integrity
- Maintain competence
- Respect others, including colleagues, and other professionals
- Practice in a non-discriminatory fashion

Other threads that appear in some but, not all the codes and are important to healthcare ethics, include:

- Report colleagues who practice incompetently, illegally, or fraudulently
- Avoid conflict of interest and of behaving unethically in research
- The Registered Nurses' code specifically mentions safe delegation and the responsibility to promote nursing's values in organizational and social policy

Ethical Principles

Several key principles play a role in solving ethical dilemmas. These principles are Respect for Autonomy, Beneficence, Non-maleficence, Justice, Fidelity, Veracity, Respect for Others, Informed Consent, Confidentiality, Cultural Understanding and Humanitarianism.

Respect for Autonomy

Autonomy is the right of each individual to act for his/herself. 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.

Respect for autonomy requires respect for the decisions of adults who have the ability to make sound decisions (self-determination).

In health care, it is vital for patients to have the right to make their own medical decisions after getting information from their healthcare professional. Providers and clinicians must respect the ability that patients have to learn about their health care and make their own choices about what to do with regards to their l care.

Beneficence

The principle of beneficence embodies the concept of the moral obligation to act in the best interests of others.

- Beneficence is exhibited either by:
  - Providing benefits or
  - Balancing those benefits against potential risks/harms
-
- Beneficence calls for the commitment to:
  - Protect and defend the rights of others
  - Prevent others from harm
  - Remove conditions that might cause harm
  - Help those with disabilities
  - Rescue others in danger

Providers and clinicians must practice this in healthcare every day by making choices and judgment calls about how to benefit their patients.

Providing Optimal Care is an example of beneficence. Healthcare professionals are to strive to protect patient's rights and desires. They must respect the patient's decisions and help maintain the patient's dignity throughout the illness process. It is the healthcare professional's job to advocate for the patients so optimal care can be provided.

Non-maleficence

Non-maleficence means non-harming or inflicting the least harm possible to reach a beneficial outcome. Practicing non-maleficence requires a commitment not to harm others in any way.

Caregivers agree to not:

- Kill
- Cause pain or suffering
- Incapacitate anyone
- Cause anyone offense

The idea of "do no harm" is a vital element of healthcare. Providers and clinicians face the ethical dilemmas of how to avoid doing harm every day as they work. They must rely on resources to help them understand the best way to proceed forward and help patients using their education, and their gut instincts.

Justice

Justice calls on us to fairly distribute benefits, risks, costs, and resources as best we know how.

- To each individual, justice, ideally, should proffer:
- An equal share
- According to need
- According to effort
- According to contribution
- According to merit

The principle of justice means that every single person should be treated in the best possible way by their healthcare team. Advocacy for patients who may have less than others is an important part of justice. Ethical theories about justice in health care help doctors and nurses be prepared for what could await them as they treat patients on a wide scale of wealth, education, and health.

Fidelity

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

Maintaining HIPAA is a practice of fidelity. Patient information is a sacred trust, and healthcare providers should act appropriately to ensure confidentiality, following the guidelines of the Health Insurance Portability and Accountability Act (HIPAA).

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.

Informed Consent

A process for being granted permission before performing any kind of healthcare procedure or intervention on a patient who has been advised of potential consequences.

Everyone has the right to be completely informed of all treatments and healthcare options. This helps the patient make an educated decision on whether to consent or refuse any suggested course of treatment. Respect and honor the patient's decision.

Confidentiality

Maintaining confidentiality regarding patient information is critical in the delivery of healthcare and in developing a relationship with your patients.

Cultural Understanding

The ability of healthcare providers and organizations to understand and consider cultural differences and needs in their delivery of healthcare (e.g., someone from another culture or religion may not believe in a certain procedure being performed).

Humanitarianism

An active belief in the inherent value of human life, leading providers to practice benevolent treatment and aid patients, with an end goal of bettering humanity.

HIPAA

Introduction

HIPAA, which stands for the American Health Insurance Portability and Accountability Act, is a set of rules set forth to regulate and improve healthcare insurance, fraud, and abuse. HIPAA also ensures that every healthcare entity protects patient information. Every healthcare entity is required to create patient privacy policies and procedures that reflect the strict rules that HIPAA has set forth.

HIPAA regulations impact virtually every department of every healthcare entity that has access to confidential healthcare information. These include, but are not limited to, hospital/LTAC/SNF/home health staff (physicians, nurses, social workers, physical therapists, respiratory therapists, occupational therapists, secretaries, billing staff, medical transcriptionists, lab technicians, and radiology technicians involved in the patient's care), private medical practices, free healthcare clinics/community health, billing firms, auditors, lawyers, consultants, insurance companies, medical clearing houses, Medicare, Medicaid, medical device manufacturers, and other healthcare organizations.

Five HIPAA Rules

Privacy Rule

HIPAA created nationwide Privacy Rules to ensure the protection of patients' healthcare information. A patient's private healthcare information would include, but is not limited to, the medical record (health history, diagnosis, and plan of care), personal information (address and social security number), and healthcare payment method (insurance information, Medicare/Medicaid, and credit card/bank account information). The Privacy Rule must be followed by any person dealing with patients' paper or electronic healthcare information.

The HIPAA Privacy Rule created regulations to protect the privacy of personal health information, as well as limit the people who have access to private healthcare information. Only those directly involved in a patient's care, billing, or payment have legal access to his or her healthcare information. Each person involved in the case only has legal access to information needed to complete their job correctly.

The Privacy Rule ensures that patients have certain rights when it comes to their healthcare information. All patients have the right to read their medical record, to correct any false information on their medical record, and to have a copy of their personal health records in their possession if they so choose.

Despite the privacy rule, HIPAA cannot protect all personal healthcare information from the Center for Disease Control (CDC). By law, every healthcare provider must report infectious diseases, such as HIV, Hepatitis A, and Tuberculosis, to the Center for Disease Control (CDC).

Security Rule

The HIPAA Security Rule is designed to protect all electronic healthcare information. The Security Rule helps define policies and procedures that protect all electronic healthcare information by regulating how information is accessed, who is allowed to access the information, how the information is saved, how it is disposed of, how the information is safely transmitted, and how to audit the system safely and effectively.

The HIPAA Security Rule created three ways to improve the security of electronic healthcare information. These include **Technical Safeguards** (which limit computer access to healthcare information through the use of passwords and encryptions), **Physical Safeguards** (which limit access to facility computers by keeping them physically out of reach of people who are not granted access), and **Administrative Safeguards** (which develop a security team and officer to update, enforce, and monitor the HIPAA security plan and complete HIPAA risk analysis).

Transaction and Code Sets Rule

To ensure information remains private, HIPAA requires a Code Set to be used to encode healthcare data such as medical terms, medications, clinical manifestations, what caused the illness or injury, care plan, prevention methods, medical concepts, medical diagnosis, medical equipment/supplies used for treatment, and medical procedure codes.

Covered Transactions

The transaction standards for electronic healthcare enable healthcare providers and insurance companies to communicate more fluidly. The HIPAA transaction codes cover:

- Healthcare claims
- Health plan eligibility
- Enrollment and disenrollment in a health plan
- Healthcare payment
- Health plan premium payments
- Claims, inquiries, and responses
- Referral certification and authorization
- Benefits

Unique Identifier Rule

- The HIPAA Administrative Simplification regulation created three types of identifiers used to simplify and organize administrative and financial healthcare transactions. These identifiers include:
- Standard Unique Employer Identifier.
    - This is the same unique number each employer uses on IRS forms to identify themselves. The same number is used for HIPAA identification.
- National Provider Identifier (NPI).
    - The NPI is a unique number used to identify each healthcare provider.
- National Health Plan Identifier (NHI)
    - The NHI identifies healthcare plans for payment and billing purposes.

Enforcement Rule

The enforcement rule helps establish HIPAA violations and creates criminal and civil penalties for those violations. The HITECH Act created the enforcement rule.

HITECH Act

The HITECH Act gives money, funded by Medicare and Medicaid, to facilities who acquire certain technology that will help improve patient care and help protect patient healthcare information, such as electronic health records (EHRs). The HITECH Act also sets guidelines for punishments for HIPAA violators, in any field of business, who are involved with patient healthcare information.

Other Uses of Protected Health Information

Marketing

A healthcare facility, or entity involved in healthcare information, may not use, or disclose protected healthcare information for purposes other than treatment, payment, and healthcare operations, without the patient's written authorization.

Personal health information cannot be disclosed for marketing purposes without the patient's written authorization. For example, a pharmacist may not provide a pharmaceutical company a list of patients with a particular disease in order for the pharmaceutical company to sell drugs to those patients without their authorization.

Incidental Disclosures

The Privacy Rule allows "incidental" disclosures of personal health information, if the facility uses set safeguards and adheres to the "minimum necessary" standard. For example, doctors' offices may use waiting room sign-in sheets, and medical staff may confer at the nurse's station without violating the Privacy Rule.

Patients' Rights

HIPAA's focus is on the Rights of the Patient and confidentiality of their information. Under HIPAA, patients have the right to several key issues: Right to Request Amendment of their medical record. Right to Request to Inspect and Copy their record. Right to Restrict what information and to whom it can be released. Right to Receive Confidential Communication. Right to Complain about a disclosure of their PHI.

Infection Control

Introduction

Proper infection control and prevention is critical in providing high quality healthcare to patients, as well as providing a safe working environment for healthcare employees. Understanding how infectious organisms are transmitted, knowing how to apply infection prevention, and knowledge of control, is critical to successfully running an infection control program. It is the responsibility of every healthcare employee to adhere to the strict infection control and prevention rules of the healthcare facility.

There are six steps that must be present for an infection to be spread:

- A pathogen
- The reservoir - A person or natural environment who carries the pathogen
- A portal of exit
- A means of transportation
- A portal of entry
- A new host

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

Infection Control Procedures

Hand Hygiene

Proper hand hygiene is the most effective method for preventing the transmission of infectious diseases. Hand washing with soap and water for at least 20 seconds is the preferred primary method of hand hygiene.

Decontamination with alcohol-based hand hygiene products is acceptable if hands are not visibly soiled.

All healthcare workers need to be aware of the situations in which soap and water is the only choice for decontaminating hands:

- Before and after touching a patient and/or their surroundings
- Before and after treating an open wound
- After using the bathroom or changing a soiled diaper

- After blowing your nose, sneezing, or coughing
- Before and after eating or preparing food
- After handling garbage or soiled items
- When hands are visibly soiled
- According to CDC and Joint Commission requirements, caregivers are strongly encouraged to not wear artificial fingernails and to keep natural nails less than ¼ inch long when providing care.

The Handwashing Process

There are several diseases and medical conditions caused by poor hand washing. The CDC recommends specific steps when decontaminating hands, using an alcohol-based hand sanitizer or soap and water.

1. Wet the hands with clean, running warm or cold water
2. Turn off the tap and apply soap
3. Rub the hands together to create a lather with the soap, making sure to clean the back of the hands, between the fingers, nails/cuticles, and under rings (if applicable)
4. Scrub the hands for at least 20 seconds. Hint: sing Happy Birthday twice
5. Rinse hands well under clean, running water
6. Dry hand using a clean towel or air dry

*There are no studies showing using a paper towel to turn off the faucet is required. It would be the choice of the healthcare provider whether or not to use a towel.

Respiratory Hygiene

When an infected person coughs or sneezes, they spread their germs to those around them. Proper respiratory hygiene includes:

- Covering your mouth and nose when you cough and sneeze with a tissue, arm, or hand
- Promptly disposing the tissue, or washing your hand, after a cough or sneeze
- Avoid touching your nose, eyes, and mouth even when hands seem clean
- Stay about three feet away from others when sick
- Wear a face mask if you are coughing or sneezing

Handle Sharps Correctly

Each year more than 600,000 healthcare workers are injured with contaminated needles or other sharps and risk becoming infected with bloodborne pathogens, such as Hepatitis B, C, or HIV (JCAHO, 2019). Some of the injuries occur during the clean-up after a procedure.

You can protect yourself against needlestick injuries by disposing of syringes and other sharps as soon as possible to prevent injuries and risk of spreading infection.

Always use a puncture resistant sharps container.

All Sharp medical equipment must be placed in a designated puncture resistant container. Before using a needle, or sharp medical utensil, locate a sharps container nearby. There is usually a sharps container located in every patient's room, medication cart, and PIXIS/Medication room. Never recap a needle after use or pass an uncapped needle to another person. Place any sharps in the sharp's container immediately after use. Never leave any sharps unattended or unaccounted for. Monitor the sharps containers closely and have them emptied if they are over halfway full. Never attempt to stuff objects into a full sharps' container. Never dispose of any medical sharp objects anywhere except the sharp's container.

Personal Protective Equipment (PPE)

PPE is used to provide a barrier between an infectious agent and healthcare employees and visitors. Healthcare employees must be able to locate personal protective equipment (PPE) and negative pressure rooms on the unit. Gowns, masks, goggles, face shields, respirators, shoe covers, hair covers, and gloves are provided in work areas for employee safety, as well as TB particulate masks and protective barriers for CPR. Every employee must be trained in how to properly don, use, and remove any PPE needed to perform their job, as well as know the facility's isolation and PPE policies and procedures. If there is a question on how to use any of the PPE items, verify the correct use with the supervisor. Private rooms and negative pressure rooms are also used to prevent the spread of infection.

Employees must understand what PPE is needed to prepare for Standard, Contact, Droplet, and Airborne Precautions. Isolation Precautions are based on the mode of transmission.

Infection Control Precautions

Standard Precautions

Standard Precautions are the minimum infection prevention practices that apply to all patient care in any setting where health care is delivered. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and

unrecognized sources of hospital infections. All Healthcare providers must don gloves when handling any bodily fluid, mucous membrane, or skin that is not intact. Goggles, face shield, and a gown can be worn if any splashing of bodily fluid is expected.

Contact Precautions

This protects against the spread of infection through direct physical contact. Contact infections include Clostridium Difficile, RSV, and Viral Conjunctivitis. Infections such as these live on the surface of an infected person and their surroundings. Healthcare workers must don gloves and a gown when coming into contact with an infected patient or any of their surroundings like the patient's bed, clothing, or food tray.

Droplet Precautions

This protects against the spread of infection by blocking any large infections particles that are expelled when an infected person coughs, sneezes, laughs, or talks. Infection occurs when infected droplet splash into mucous membranes of the mouth, nose, and eyes. Droplet infections include Pneumonia, Influenza, and Mumps.

Healthcare workers would need a facemask with an eye shield, gown, and gloves to prevent contaminated droplets from coming into contact with anything on the care giver's body.

Airborne Precautions

This is designed to prevent and contain the spread of infectious airborne particles containing microorganisms that remain suspended in the air and can be dispersed widely by air currents. An infected person can expel microorganisms into the air when they cough, sneeze, laugh, or talk. Examples of airborne infections include Tuberculosis, Measles, and Varicella. Staff members must be fitted with a N95 mask every year and trained to properly wear the N95 mask. When treating Tuberculosis and SARS patients, staff members must always wear an N95 respirator mask and place the patient in a negative pressure room. For chicken pox, shingles, or measles a cone mask should be used, and the patient should be in a private room. Gowns and gloves are worn if soiling is likely.

Cleaning, Disinfecting and Disposal

Cleaning and Disinfecting

Cleaning and disinfecting 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. The use of existing facility detergents and disinfectants, according to the manufacturer's recommendations, is sufficient to remove pathogens from surfaces of rooms where colonized or infected individuals were housed. The cleaning and disinfecting of all patient-care areas is important to prevent the spread of infections. Frequently touched surfaces that are most likely to be contaminated include bedrails, bedside tables, commodes, doorknobs, sinks, surfaces, and equipment. 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 infectious agents such as Clostridium Difficile. All healthcare employees must know and follow the hospital's cleaning policies and procedures.

Disposing Biological Waste

Blood, tissue, body fluids, soiled linen, any pathological cultures/waste, and sharps are all biological waste materials. Sharps containers should be emptied ¾ of the way full. It is important that you know and follow hospital policy when disposing of biohazardous waste. All biological waste is placed in a designated red biohazard bag or red puncture resistant biohazard box. Never place anything containing biological waste in the regular trash.

Infectious Agents in the Healthcare Setting

Infectious agents are organisms that can produce infection or infectious disease. They include bacteria, fungi, viruses, and parasites. Healthcare workers have a high risk of contact with infectious agents due to the various types of activities involved with their jobs and the possibilities of contamination.

COVID-19

There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans. In early 2021 there had been a reported 2.76 million cases in the US and 124 million cases worldwide during the pandemic which first began in late 2019.

The virus that causes COVID-19 most commonly spreads between people who are in close contact with one another (within about 6 feet, or 2 arm lengths). It is thought to spread through respiratory droplets or small particles, such as those in aerosols, produced when an infected person coughs, sneezes, sings, talks, or breathes.

- The virus is thought to spread from person-to-person.
- Between people who are in close contact with one another (within about 6 feet).
- Through respiratory droplets produced when an infected person coughs or sneezes.

Community spread means people have been infected with the virus in an area, including some who are not sure how or where they became infected.

Clostridium Difficile

Clostridium difficile is shed in feces requiring the patient to be on contact precautions. Any surface, device, or material that becomes contaminated with particles of feces will serve as a reservoir for Clostridium difficile spores. Clostridium difficile spores are transferred to patients by the hands of healthcare personnel who have touched a contaminated surface or item.

For patients 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, laugh, or speak. If another person inhales these airborne 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), Airborne Isolation, and the use of an N95 mask. Employees should be tested for TB once a year and anytime they suspect exposure.

HIV/AIDS

Human Immunodeficiency Virus (HIV) is spread through direct contact with blood and bodily fluid. HIV leads to Acquired Immune Deficiency Syndrome (AIDS) which kills CD4+T cells. This infection is spread through needle sticks, sharing needles or unprotected sex.

The average risk for infection after an injury from an HIV-infected needles or sharps is less than 1%. The risk of infection from a bloody splash to mucus membranes or open skin is very low, less than 0.1%.

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 all around you like on hands, desktops, sinks, door handles, and counters. They can live on surfaces and in or on 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 spread through physical contact. They can spread from person to person in 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.

Ebola Virus Disease

Ebola is spread by coming into direct contact with blood and bodily fluids of a symptomatic person infected with Ebola. Ebola does not spread through the air, water, food, or mosquitoes. Healthcare workers must follow strict contact isolation protecting the entire body as well as don an N95 or higher respirator, shoulder length disposable surgical hood, and full disposable face shield. Even though Ebola is not spread through air, respiratory protections are required to protect healthcare workers during an aerosol procedure like intubation. All healthcare workers must be monitored during the donning and doffing of PPE to ensure everything is put on and taken off correctly.

Healthcare-associated Infections

"An infection occurring in a patient during the process of care in a health-care facility which was not present or incubating at the time of admission. This includes infections acquired in the hospital, or healthcare setting but appearing after discharge, and also occupational infections among staff."

Infections can be associated with healthcare 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 surgical sites known as surgical site infections. To prevent infections healthcare workers must:

- Wash their hands thoroughly and don gloves.
- Understand and follow hospital policy and procedure for each device used.
- Perform all sterile procedures with proper sterile technique.
- Change all healthcare devises per hospital policy and procedure.
- Clean all healthcare devise sites and surgical sites per hospital policy.
-

The major risk factors for healthcare-associated infection caused by antimicrobial-resistance are either the transmission of pathogens from person-to-person or the result of resistance after exposure to antimicrobials. Steps to preventing healthcare-associated infections include:

- Preventing infections through the use of vaccines and prophylaxis.
- Reducing the use of invasive devices.
- Understanding and following set guidelines for infection prevention.
- Using antimicrobials judiciously.

Latex Allergy

Introduction

Latex allergy erupted in the United States shortly after the CDC introduced Universal Precautions in 1985 and affects 1 to 8% of the general population. Researchers hypothesize that the latex allergy outbreak is the result of multiple factors, including increased latex exposure and deficiencies in manufacturing, among others. Natural rubber latex allergy is a serious medical problem for a growing number of patients and a disabling occupational disease among healthcare workers affecting 8-17% and diagnosed in up to 68% of children with spina bifida. The use of gloves effectively aids in preventing the transmission of many infectious diseases. Even though latex gloves are now no longer often used, many other products in healthcare contain natural rubber latex and some individuals when exposed, may experience an allergic reaction.

Latex

Latex has been the material of choice for surgical gloves because it is flexible and maintains tactile sensitivity for the wearer. Although natural rubber latex has been a common component in thousands of medical and consumer products for many years, latex sensitivity is a new problem for patients and healthcare staff. Latex products are manufactured from the rubber tree, *Hevea brasiliensis*. Natural rubber latex contains up to 240 potentially allergenic protein fragments, and different people may be sensitized to different combinations of latex allergens. Several chemicals are added to this fluid during the processing and manufacturing of commercial latex. There are some proteins in latex that can cause a range of mild to severe allergic reactions.

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. 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.

Products Containing Latex

A wide variety of products contain latex such as medical supplies, personal protective equipment, and numerous household objects. Most people who encounter latex products only through routine use in society usually 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 some examples of medical products that may contain latex:

- Blood pressure cuffs
- Tourniquets (including pneumatic cuffs used in surgery)
- Masks
- Stethoscopes
- Intravenous tubing
- Disposable gloves
- Oral and nasal airways
- Electrode pads
- Endotracheal tubes
- Personal Protective Equipment
- Rubber catheters
- Foley catheters
- Wound drains
- Syringes

The following are some household items that may contain latex:

- Mattresses
- Rubber sink stoppers and mats
- Electrical cords
- Water hoses
- Toothbrushes
- Tub toys
- Sanitary napkins
- Condoms and diaphragms
- Diapers
- Undergarments and socks
- Toys
- Television remotes

Individuals who already have a latex allergy should be aware of products that contain latex as it may trigger an allergic reaction. Most of the listed products above are available in latex-free forms.

Reactions

Allergic reactions to natural rubber latex range from skin disease to asthma and anaphylaxis, which can result in chronic illness, disability, career loss, and death. Reactions may be mild at first and progress. There are three types of latex reactions that can occur.

Irritant Contact Dermatitis

This is the most common reaction to latex products. Irritant contact dermatitis is a non-allergic reaction caused by frequent contact with chemicals found in latex gloves. Frequent contact with these chemicals causes dry, reddened, itchy, irritated skin. This reaction does not spread but appears only in local areas where skin comes into direct contact with latex. The reaction can also result from repeated hand washing, incomplete hand drying, and the use of repeated cleaners and sanitizers.

Allergic Contact Dermatitis

Allergic contact dermatitis is a delayed hypersensitivity to chemicals found in latex products. These chemicals can cause a skin rash similar to irritant contact dermatitis (i.e., pruritus, edema, erythema, vesicles, drying papules, crusting, and thickening of the skin) yet symptoms become much worse and last longer. The rash usually begins 6 to 48 hours (about 2 days) after contact and may spread away from the area of skin touched by 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 a true latex allergic reaction. Although the amount of exposure needed to cause 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, anaphylaxis, and asthma. Rarely,

shock may occur, but a life-threatening reaction is seldom the first sign of a latex allergy. Such reactions are similar to those seen in a bee sting.

Latex Allergy

Individuals at Risk

People with ongoing latex exposure are at risk for developing a latex allergy. Such people include healthcare workers (e.g., nurses, physicians, physical/occupational therapists, dentists), rubber/latex industry workers, and people who frequently use condoms. Workers who use latex gloves less frequently (law enforcement personnel, funeral-home workers, fire fighters, painters, gardeners, food service workers, and housekeeping personnel) may also develop an allergy to latex.

People who have spina bifida, or multiple allergic conditions, are at an increased risk for developing a latex allergy. Certain foods are potential problems for people with latex allergy and can provide significant assessment trigger questions. Foods of concern are apples, avocadoes, bananas, carrots, celery, chestnuts, kiwi, melons, papaya, raw potato, and tomatoes.

Diagnosis

A Latex allergy should be suspected in anyone who develops latex allergy symptoms after latex exposure. These symptoms include, but are not limited to, eye irritation, skin rash, hives, shortness of breath, coughing, or wheezing. Any exposed worker who experiences these symptoms should be evaluated by a physician. A diagnosis is made by obtaining a detailed medical history (including food allergies), a physical examination, and an allergy skin 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, which involves scratching or pricking the skin and then putting a drop of latex protein liquid 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 manage 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 covers the skin.

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 allergy symptoms; but complete latex avoidance, though quite difficult, is the most effective approach. If one has a latex allergy a medical alert bracelet or tag should be worn.

Prevention

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

- Use non-latex gloves.
- Place all patients with latex allergies on latex precautions (latex free zones).
- 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 as this can cause glove deterioration.
- After removing latex gloves, wash hands with a mild soap and dry them thoroughly.
- Frequently clean work areas contaminated with latex dust (upholstery, carpets, and ventilation ducts).
- Frequently change the ventilation filters and vacuum bags used in latex-contaminated areas.
- Learn to recognize the symptoms of a latex allergy.

Clinicians and Latex

If you develop symptoms of a latex allergy, avoid direct contact with products containing latex until you can see a physician.

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

- Avoid contact with products containing latex.
- Avoid areas where you might inhale the powder from latex gloves worn by others.
- Tell your employers, physicians, nurses, dentists, etc. that you have a latex allergy.
- Wear a medical alert bracelet or tag.
- Carry epinephrine autoinjector for use at first signs of anaphylaxis.
- Take advantage of all latex allergy education and training provided by your employer.

Long Term Care

Long Term Care Final Rule

A new CMS rule overhauling long-term care (LTC) programs has defined requirements that LTC facilities to follow in order to participate in the Medicare and Medicaid programs. These changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These revisions are also an integral part of efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

In the healthcare continuum long term care is the level of care for healthcare clients when they can no longer perform everyday tasks (activities of daily living) by themselves due to a chronic illness, injury, disability, or the aging process. Long term care also includes the supervision that a resident might need due to a severe cognitive impairment (such as dementia and Alzheimer's disease).

This level of care is not intended to cure the resident. It is chronic care which they might need for the rest of their life. Residents can receive long term care in a number of facilities: their own home, continuing care retirement communities, assisted living, or nursing homes.

- People often confuse long term care with disability or short-term medical care. Long term care is not:
- Care that resident receive in the hospital or in doctor's office
- Care that is needed to get well from a sickness or an injury
- Short-term rehabilitation from an accident
- Recuperation from surgery

Residents' Rights

When admitted to a long-term care facility, patients gain a special set of residents' rights, which are mandated by federal and state law.

- The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.
- All residents will be provided equal access to quality care regardless of

diagnosis, severity of condition, or payment source.

- The resident has the right to exercise his or her rights and ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.
- Residents have the right to designate a representative, which can include same-sex spouse. The facility will treat the decisions of a resident representative as the decisions of the resident.
- The residents' wishes should be considered in decisions made by the representative and the resident should be included in the care planning process.

Planning and Implementing Care

The resident has the right to be informed of, and participate in, his or her treatment, including:

- The right to be fully informed in a language that he or she can understand.
- The right to be informed, in advance, of the care to be delivered and of the professional that will furnish care.
- The right to be of the risks and benefits of care, of treatment alternatives or treatment options and to choose the care he or she prefers.
- The right to participate in the development and implementation of his or her plan of care to include revision of the plan of care, right to establish goals and outcomes of care, and right to be notified of changes to the plan of care.
- The resident has the right to choose his or her attending physician.

Respect and Dignity

The resident has a right to be treated with respect and dignity, including:

- The right to retain and use personal possessions, including furnishings, and clothing
- The right to reside and receive services in the facility with reasonable accommodation of resident needs and
- The right to share a room with his or her spouse when married residents live in the same facility
- The right to share a room with his or her roommate of choice when practicable
- The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed
- The right to refuse to transfer to another room in the facility

Self-determination

- The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions.
- The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
- Inform each resident and/or resident representative of visitation rights and any restrictions that apply.
- Inform residents of the right to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.
- Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
- Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.
- The resident has a right to organize and participate in resident groups in the facility.
- The resident has a right to participate in family groups. The resident has a right to choose or refuse to perform services for the facility and the facility may not require a resident to perform services for the facility.
- The resident has a right to manage his or her financial affairs.

Information and Communication

- The facility will provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.
- The resident has the right to access personal and medical records pertaining to him or herself.
- The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the residents own expense.
- The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.
- Immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)

when there is:

- An accident involving the resident which results in injury and has the potential for requiring physician intervention.
- A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).
- A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
- A decision to transfer or discharge the resident from the facility.
- A change in resident rights under Federal or State law or regulations
- The facility will inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services.

Privacy and Confidentiality

The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

Safe Environment

The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely.

Grievances

The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal.

Contact with External Entities

Do not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder

Resident Assessments

The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Complete a comprehensive

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assessment of a resident's functional status strengths, goals, life history and preferences, by using a minimum data set also known as the MDS specified by CMS within 14 calendar days after admission, if the resident improves or declines within 14 a significant change in status assessment should be completed once the IDT determines the decline or improvement is noted.

Resident Assessment Instrument (RAI)

The RAI consists of three basic components:

- The Minimum Data Set (MDS)**:** process for clinical assessment and is a core set of screening, clinical and functional status elements, which forms the foundation of a comprehensive assessment.
- The Care Area Assessment (CAA)**:** process designed to assist the assessor to systematically interpret the information recorded on the MDS. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident.
- The RAI Utilization Guidelines**:** provide instructions for when and how to use the RAI. as well as structured frameworks for synthesizing MDS and other clinical information.

The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. This is what drives the residents individualized care plan.

Quarterly Review Assessment

A registered nurse should assess a resident no less frequently than once every 3 months with participation from the healthcare team, the assessment should be accurate and submitted to CMS in a timely manner.

"Preadmission Screening and Resident Review (PASARR)" is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are appropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered

the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.

Comprehensive Person-Centered Care Planning

Within 24 hours admission residents should have a baseline care plan which outlines person-centered care and should include:

- Initial goals based on admission orders.
- Physician orders.
- Dietary orders.
- Therapy services.
- Social services.
- PASARR recommendation, if applicable.

A comprehensive care plan should be developed within 7 days after completion of the comprehensive assessment and is prepared by an interdisciplinary team, that includes (A) The attending physician, (B) A registered nurse with responsibility for the resident, (C) A nurse aide with responsibility for the resident, (D) A member of food and nutrition services staff, (E) the participation of the resident and the resident's representative(s), (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

Discharge Planning Process

The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post- discharge care, and the reduction of factors leading to preventable readmissions.

Quality of Life

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident will receive, and the facility should provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Residents should be given the appropriate treatment and services to maintain or improve his or her ability to conduct the activities of daily living. A resident who is unable to

conduct activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

Activities of daily living include:

- Hygiene –bathing, dressing, grooming, and oral care
- Mobility—transfer and ambulation, including walking
- Elimination-toileting
- Dining-eating, including meals and snacks
- Communication, including
    - Speech
    - Language
    - Other functional communication systems

The facility should provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Quality of Care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Skin Integrity

Pressure Ulcers

Based on the comprehensive assessment of a resident, ensure that residents receive care to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable.

Foot Care

Ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility will provide foot care and treatment, including to prevent complications from the resident's medical condition(s) and assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.

Mobility

Ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and residents with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Residents with limited mobility receive appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

Accidents

Ensure that the environment remains as free of accident hazards as is possible; and that residents receive adequate supervision and assistance devices to prevent accidents.

Incontinence

Ensure that a resident who is on the continent of bladder and bowel receives services and assistance to maintain continence unless his or her clinical condition is not possible to maintain.

For a resident with urinary incontinence or fecal incontinence Ensure that the resident receives appropriate treatment and services to restore as much normal function.

Colostomy, Urostomy, or Ileostomy Care

Ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

Assisted Nutrition and Hydration

A decision to use a feeding tube has a major impact on a resident and his or her quality of life. It is important that any decision regarding the use of a feeding tube be based on the

resident's clinical condition and wishes, as well as applicable federal and state laws and regulations for decision making about life-sustaining treatments.

Parenteral fluids will be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

Respiratory Care (including tracheostomy care and tracheal suctioning)

Ensure that a resident, who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person- centered care plan, the residents' goals, and preferences.

Prostheses

Ensure that a resident who has prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences, to wear and be able to use the prosthetic device.

Pain Management

Ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Dialysis

Ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Trauma-informed Care

Ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

Bed Rails

The facility should attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, Ensure correct installation, use, and maintenance of bed rails.

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.

Reporting Abuse and Neglect

It is your ethical and legal responsibility to intervene immediately when you see a resident being abused or neglected or when you just suspect it. Anytime abuse is witnessed, or suspected, it should be documented and reported to the charge nurse, case manager, or social worker then reported to Adult Protective Services. When abuse or neglect is suspected, the abused should be assessed without the suspected abuser present. The abused should be asked directly if someone hurt them, threatened them, or took anything without asking, and if yes, who? Every report can be anonymous, and no one can be charged for falsely reporting an abuse or neglect case, but failure to report can result in a claim of negligence.

Dementia Management

The facility should have sufficient staff who provide direct services to residents who display or is diagnosed with dementia, with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population.

These competencies and skills set include, but are not limited to, knowledge of and appropriate training and supervision for caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, which have been identified in the facility assessment

The facility will provide dementia treatment and services which may include but are not limited to the following ensuring adequate medical care, diagnosis, and supports based on diagnosis; ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.

Clinical Services

Physician Services

A physician should personally approve in writing a recommendation that a resident be admitted to a facility. Each resident will remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist should provide orders for the resident's immediate care and needs.

Nursing Services

The facility should have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment.

Before allowing an individual to serve as a nurse aide, verify individual has met registry competency evaluation requirements.

Behavioral Health Services

Each resident will receive, and the facility should provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

Pharmacy Services

Provide routine and emergency drugs and biologicals to its residents. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

Drug Regimen Review (DRR)

- The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist.
- This review should include a review of the resident's medical chart
- The pharmacist is required to report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports should be acted upon.
- The facility will develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist should take when he or she identifies an irregularity that requires urgent action to protect the resident.

Medication Errors

- Ensure that:
    - Medication error rates are not 5 percent or greater
    - Residents are free of any significant medication errors

Laboratory Services

- Provide or obtain laboratory radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

Dental Services

Assist residents in obtaining routine and 24-hour emergency dental care. This service is to ensure that residents obtain needed dental services, including routine dental services, and ensure the facility provides the assistance needed or requested to obtain these services.

Food and Nutrition Services

Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

Menus and Nutritional Adequacy

- Menus:

    - Meet the nutritional needs of residents in accordance with established national guidelines
    - Be prepared in advance and followed
    - Reflect, based on a facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups
    - Be updated periodically
    - Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy
- Provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.

Food Safety Requirements

- Obtain food for resident consumption from sources approved or considered satisfactory by Federal, State, or local authorities.
- Follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. and,
- Ensure food safety is maintained when implementing various culture change initiatives such as when serving buffet style from a portable steam table, or during a potluck.
- Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
- Dispose of garbage and refuse properly.

Specialized Rehabilitative Services

Ensure that every resident receives specialized rehabilitative services as determined by their comprehensive plan of care to assist them to attain, maintain or restore their highest practicable level of physical, mental, functional, and psycho-social well-being. Also, to ensure that residents with a Mental Disorder (MD), Intellectual Disability (ID) or a related condition receive services as determined by their Preadmission Screening and Resident Review (PASARR). Specialized rehabilitative services are to be provided under the written order of a physician by qualified personnel.

Administration

Use resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Be licensed under applicable State and local law.

Facility Assessment

Conduct and document a facility-wide assessment to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require.

Staff Qualifications

Employ on a full-time, part-time or consultant basis those professionals necessary to fulfil the provisions of these requirements. Professional staff should be licensed, certified, or registered in accordance with applicable State laws.

Medical Director

The facility will designate a physician to serve as medical director. The medical director is responsible for– Implementation of resident care policies, and the coordination of medical care in the facility.

Resident-identifiable Information

A facility may not release information that is resident-identifiable to the public but may release information to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

Medical Records

The facility will keep all information contained in the resident's records confidential, regardless of the form or storage method of the records. The facility should safeguard medical record information against loss, destruction, or unauthorized use.

Transfer Agreement

Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with State law.

Quality Assurance and Performance Improvement (QAPI) Program

QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI

takes a systematic, comprehensive, and data- driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving.

QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on- going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.

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

- Each LTC facility, including a facility that is part of a multiunit chain, will develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life.
- Design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility.

Infection Control

- Establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections for all the residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment.
- An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.
- Minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumococcal disease by ensuring that each resident:
- Is informed about the benefits and risks of immunizations; and
- Has the opportunity to receive the influenza and pneumococcal vaccine(s), unless medically contraindicated, refused or was already immunized.

- Ensure documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization and the administration or the refusal of or medical contraindications to the vaccine(s).

Compliance and Ethics Program

- Compliance and ethics program should be reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization.

Physical Environment

- The facility will be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.
- The LTC facility should meet the applicable provisions and should proceed in accordance with the Life Safety Code.

Emergency Power

- When life support systems are used, the facility should provide emergency electrical power with an emergency generator.

Space and Equipment

- The facility should - provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's assessment and plan of care; and maintain all mechanical, electrical, and patient care equipment in safe operating condition. Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of entrapment.

Resident Rooms

- Resident rooms should be designed and equipped for adequate nursing care, comfort, and privacy of residents. Each resident bedroom shall be individually accessible from the corridor without passing through another room. The rooms should be designed or equipped to assure full visual

privacy for each resident and should have a floor at or above grade level.

Bathroom Facilities

- Each resident room should be equipped with or located near toilet and bathing facilities.

Resident Call System

- The facility should be equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.

Dining and Resident Activities

- The facility should provide one or more rooms designated for resident dining and activities, and these rooms must be well lighted, well ventilated, furnished and have sufficient space to accommodate all the activities.

Other Environmental Conditions

- The facility should provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two and Equip corridors with firmly secured handrails on each side. Maintain an effective pest control program so that the facility is free of pests and rodents. Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also consider nonsmoking residents.

Training Requirements

- Develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles.
- Determine the amount and types of training necessary based on a facility assessment.
- Training topics should include but are not limited to:
    - Communication
    - Resident's rights and facility responsibilities
    - Abuse, neglect, and exploitation
    - Quality assurance and performance improvement
    - Infection control
    - Compliance and ethics
- Required in-service training for:
    - Nurses’ Aides

    - Feeding Assistants
    - Behavioral Health Services
- When admitted to a long-term care facility, patients have a right to quality safe care. The new ruling overhauling long-term care focuses on improving both quality and patient safety for patients who often are in the final stages of their lives and need daily chronic care. Staff who are educated in this ruling will be better equipped to deliver improved care.

Medication Safety Nursing

Introduction

For any nurse working in a direct care setting, preparing medications, and administering them to patients is part of the daily routine. Mistakes can happen at any point in the process. Administration errors are one of the most serious and most common mistakes made by nurses. The result may lengthen a hospital stay, increase costs, or have life and death implications for the patient. So, what can you do to safely administer medications?

Start with the basics

Verify any medication order and make sure it is complete. The order should include the drug name, dosage, frequency, and route of administration. If any element is missing, check with the practitioner.

Check the patient's medical record for an allergy or contraindication to the prescribed medication. If an allergy or contraindication exists, do not administer the medication, and notify the practitioner.

Prepare medications for one patient at a time.

Educate patients about their medications. Encourage them to speak up if something seems amiss.

Follow the eight rights of medication administration.

Minimize distractions and interruptions

Know that interruptions and distractions have a marked effect on your performance, causing a lack of attention, forgetfulness, and errors.

Make sure you have all the required supplies and documents available before beginning preparation or administration activities.

Follow your facility's policy related to the use of a "No Interruption Zone" (NIZ), a practice recommended by the Institute for Safe Medication Practices (ISMP) to enhance patient safety. Your NIZ should be a discreet area where medication tasks are performed. It may be a dedicated medication room, or a quiet area sectioned off by visual markers.

If required by your facility, wear a special vest, apron, sash, lighted lanyard, or other item that indicates that you are administering medications and should not be interrupted.

If your facility utilizes mobile devices, temporarily transfer calls and other notifications to another staff member or place the device on pause during the most complex parts of the medication preparation and administration tasks.

Implement these additional safety measures

Be especially alert during high-risk situations, such as when you are stressed, tired, or angry or when supervising inexperienced personnel. Monitor and modify work schedules to minimize work- or fatigue-related medication errors.

Be familiar with all appropriate antidotes, reversal agents, and rescue agents. Know where they are stored in your unit and how to administer them in an emergency situation.

Be familiar with high-alert medication (such as anticoagulants, antidiabetic agents, sedatives, and chemotherapeutic drugs). Ask another nurse to perform an independent double check and rectify any discrepancies BEFORE administering the drug.

Be aware of your facility's list of confused drug names, which includes sound-alike (such as Zocor and Cozaar) and look-alike (such as vinblastine and vincristine) name pairs. Take extra precautions when administering drugs from these lists. Your facility may also have extra safeguards in place, such as requiring both the brand and generic name be recorded, including the purpose of the medication with all orders, or setting up computer selection screens to prevent look-alike names from appearing near each other.

Pay attention to Tall Man lettering, a visual safety feature that highlights a section of a drug's name using capital letters to help distinguish look alike name pairs from each other, such as BuPROPion (an antidepressant) from BusPIRone (an anxiolytic) or glipiZIDE from glyBURIDE (two different antidiabetics).

Measure and document a patient's weight in metric units (grams and kilograms) ONLY to allow for accurate dosage calculations. Also, weigh the patient as soon as possible on admission and do not rely on stated, estimated, or historical weights.

For patients receiving IV opioid medication, frequently monitor respiratory rate, sedation level, and oxygen saturation level or exhaled carbon dioxide to decrease the risk of adverse

reactions associated with IV opioid use. If adverse reactions occur, respond promptly to prevent treatment delays.

Administer high-alert intravenous medication infusions via a programmable infusion device utilizing dose error-reduction software.

Reconcile the patient's medications at each care transition and when a new medication is ordered to reduce the risk for medication errors, including omissions, duplications, dosing errors, and drug interactions.

Educate and provide written instructions to the patient and family (or caregiver) regarding prescribed medications for use when at home and verify their understanding prior to discharge.

By being familiar with medications you administer and following safeguards, you can help protect your patients from medication errors.

The Eight Rights of Medication Administration

Chances are that some of you may not have known that in addition to the well-known 5 rights of medication administration, some experts have added 3 more to the list. When it comes to patient safety, it is never an inconvenient time to review some of the basics and increase your awareness of newer recommendations.

1. Right Patient

- Check the name on the order and the patient
- Use 2 identifiers.
- Ask the patient to identify himself/herself.
- When available, use technology (for example, bar-code systems)

2. Right Medication

- Check the medication label
- Check the order

3. Right Dose

- Check the order
- Confirm appropriateness of the dose using a current drug reference
- If necessary, calculate the dose and have another nurse calculate the dose as well

4. Right Route

- Again, check the order and appropriateness of the route ordered
- Confirm that the patient can take or receive the medication by the ordered route

5. Right Time

- Check the frequency of the ordered medication
- Double-check that you are giving the ordered dose at the correct time
- Confirm when the last dose was given

6. Right Documentation

- Document administration AFTER giving the ordered medication
- Chart the time, route, and any other specific information, as necessary.
- For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug

7. Right Reason

- Confirm the rationale for the ordered medication.
- What is the patient's history?
- Why is he/she taking this medication?
- Revisit the reasons for long-term medication use

8. Right Response

- Make sure that the drug led to the desired effect.
- If an antihypertensive was given, has his/her blood pressure improved?
- Does the patient verbalize improvement in depression while on an antidepressant?
- Be sure to document your monitoring of the patient and any other nursing interventions that are applicable

Classification of Narcotics

In 1970, Congress enacted the Comprehensive Drug Abuse Prevention and Control act, which included the Controlled Substances Act (CSA). The CSA established the current classification system used for Purpose Goals narcotics (Schedule I through IV).

Both the Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA) control the classification of drugs, determining which drugs to add or remove.

The DEA regulates controlled substances. Criteria for classification include an estimation of the potential for abuse, risk to public health, potential for psychic or physiological dependence, as well as the current medical use, and limitations resulting from international treaties. It is important to note that some drug classification systems are not consistent

internationally and some drugs (such as heroin) classified as Schedule I in the United States are used medically in other countries.

- Narcotic (opiate) analgesics may be natural, semisynthetic, or synthetic alkaloid derivatives of opium and are classified as opiate agonists and opiate agonist-antagonists.
- Opiate agonists: These include natural opiate agonists (morphine, codeine), semi-synthetic analogs (hydromorphone, oxycodone), and synthetic opioids (meperidine, fentanyl, methadone). They act by binding opiate receptors in the central nervous system, both interfering with the pain pathway and with the perception of pain.
- Opiate agonist-antagonists: These include pentazocine (Talwin®), nalbuphine HCL (Nubain®), Dezocine (Dalgan®), butorphanol (Stadol®) and buprenorphine (Buprenex®). They act by stimulating some receptor sites and antagonizing (blocking) others, resulting in depression of the CNS and alterations in perception of pain. Controlled substances include those on schedules I through V. The DEA does not regulate substances in Schedule VI although states may regulate these drugs.
- Opiate antagonists: These include naloxone (Narcan) and nalmefene HCL (Revex). They act by competing with narcotics for receptor sites and blocking the action of opiates. Used to treat overdose, they may induce withdrawal symptoms in those who are dependent.

Narcotic Handling, Storage and Disposal

Schedule II through V drugs must be handled as controlled substances and securely locked (usually with double locks or special locks) in a substantially constructed cabinet. Twenty or thirty years ago, most facilities simply kept stock narcotics in a locked cabinet in a locked medicine room, but storage and delivery of medications have changed—and the number of controlled substances has increased. Now, there are many options, and these vary widely from one facility to another.

Locked Medication Cabinets

- Double-locking cabinets (requiring two keys on one door or two keys for double doors) are still used, especially in smaller facilities, such as long-term care facilities.
- Only authorized personnel are allowed access to the keys, and this type of cabinet is usually contained in a locked room to further limit access.
- Note that this type of cabinet is not refrigerated, so some controlled substances will need to be stored in a securely locked refrigerator or refrigerated cabinet or container.

- Controlled substances are now usually provided in individual dose containers rather than bulk (such as 30 mL vials or 100 tablet bottles).
- With this system, some form of record (written, computerized) is kept each time a drug is removed from the storage cabinet because this system requires a manual narcotics count.
- The usual information recorded when medication is removed includes the date, time, drug, patient for whom the drug is intended (name, ID, room number), the name of the prescriber, and the name of the healthcare provider procuring the drug.
- With this type of storage, the traditional end-of-shift narcotics count with the oncoming nurse counting and the outgoing nurse verifying is usually conducted.

Medicine Carts

- There are many types of medicine carts, but most have individual drawers to hold medications for each patient rather than each drug. Some medicine carts have special more secure drawers to hold controlled substances with a double-locking system.
- Depending on the system, controlled substances may be co-mingled or in separate drawers.
- Refrigerated controlled substances are usually kept in a central area under double lock in some type of refrigerator or refrigerated container.
- Controlled substances should not be placed in regular medicine drawers, as these drawers are not secure.
- With this system, as with a medicine cabinet, some form of record should be kept each time a drug is dispensed, as a manual narcotics count must be completed.
- Also, if the patient is wearing a transdermal patch, the two nurses completing the Narcotic count should both witness and document that the patch is in place per the MD order.
- Liquid narcotics should be counted at eye level and not appear watered down or change in color and documented on the narcotic record.
- Then end-of-shift count is also conducted with this type of storage, but because the narcotics may be stored in a number of different carts, different pairs of nurses may be conducting counts at the different carts.

Automated Drug Dispensing Systems

- Most hospitals now utilize some type of automated drug dispensing system with computerized access.
- These systems also vary widely although they all have automated record keeping and require usernames and passwords (and sometimes barcodes) for access.
- Some automated systems have individual drawers for patients and others individual medicine carts or automated drug dispensing systems drawers for medications, like a mini pharmacy.

- Because the automated computerized systems automatically maintain an accurate narcotics count, some facilities have eliminated the narcotics count altogether or left it to pharmacy staff. In some facilities, however, periodic manual counts may be done on some routine schedule, such as once a week or once a month.
- The counts may be blind or verifying:
- Blind: Those counting do not see the actual number of doses remaining but do the count and enter the number into the system.
- Verifying: Those counting see the actual number of doses remaining and count to verify that the number is correct. This system is more prone to counting errors than the blind method.

Documentation

When administering a controlled substance, such as a narcotic, to a patient, the purpose of the drug should be clearly documented. For example, if for dyspnea, the patient's condition should be described and the respiratory rate as well as description of skin color and ventilation (rales, wheezing, decreased ventilation).

When administering controlled substances for pain management, the most common reason, documentation should include:

Reason for the administration (such as pain in left knee) and the degree of pain, utilizing the appropriate pain scale, such as the 1-10 scale, FACES, CRIES, and Pain Assessment in Advanced Dementia (PAINAD), depending on the patient's age and condition.

Patient, medication, dosage, route, time. This information should be recorded immediately after administration and not at a later time or at the end of the shift. In automated systems, this information is recorded when the drugs are removed, so the documentation should be administered promptly so that the recorded time is accurate. If there is a delay between the time the medication is dispensed and given, then the next dose may be given too soon.

Response to medication, including description and degree of pain, utilizing the same pain scale. Evaluating the response to the drug should correspond to the onset of action for the individual drug and its peak performance. For example, relief of pain may occur within 5 to 10 minutes for an IV medication but may be delayed for 20 to 30 minutes or longer for oral medications. Some drugs may peak within 1.5 hours, but others may peak in 4 hours.

Disposal of Narcotics

Hospitals and other facilities utilize a range of different methods to dispose of unused or excess narcotics. When controlled substances must be disposed of, the disposal should be witnessed by two healthcare providers who are licensed to dispense drugs, such as two RNs, and the disposal documented with both healthcare providers signing. This should be done immediately after procuring the drug. The nurse should not carry the excess narcotic on a tray or in a pocket or place it in an unsecured medication drawer for later disposal because this increases the risk of diversion or errors in documentation but should immediately ask for a witness and dispose of the drug according to established protocol.

Under no circumstances should a healthcare provider agree to sign for unwitnessed disposal of narcotics. Doing so could make the healthcare provider complicit in diversion or arouse suspicion of unprofessional conduct. For injectables and liquids, the nurse should draw up into the syringe only the amount to be given to the patient and not draw a greater amount, intending to only inject, for example, half of the drug in the syringe because this poses a risk of overdose. Drawing the full amount and wasting part of it prior to administering the drug may result in contamination of the needle (although if syringes are prefilled and a partial dose is given, this may be necessary). A better practice, when possible, is to use a second syringe to withdraw the remaining drug from a vial to be disposed of or to dispose of the vial with the medication inside depending on the disposal method available.

Because protocols for handling and disposing of controlled substances vary widely from one facility to another, the healthcare provider should have a clear understanding of the policies and protocols in place. In some cases, protocols may need updating as technology is introduced, and nurses should take a proactive role.

Adverse Reactions

Patients should be carefully observed for adverse effects, specific to the drugs taken. While many adverse effects are similar, opiate agonists tend to have more adverse symptoms than opiate agonist-antagonists. Any adverse effects must be documented.

Common Symptoms Include:

- CNS: dizziness, confusion, insomnia, disorientation, and seizures (infants and

children)
- CV: Orthostatic hypotension, bradycardia, palpitations, and cardiac arrest
- Skin: Pruritis, rash, urticaria, flushing, and cold, clammy skin
- EENT: Visual disturbances and pupil constriction
- GI: Nausea, vomiting, constipation, anorexia, dry mouth, and biliary colic
- GU: Urinary retention, urinary urgency, dysuria, and oliguria
- Respiratory: Depression, arrest
- Hypothermia and muscle flaccidity
- CNS: Euphoria, dizziness, drowsiness, change in mood, confusion, and light-headedness
- CV: Tachycardia, palpitations, and hypertension
- Skin: Rash pruritis, local irritation at inject site, and flushing
- EENT: Visual disturbances
- GI: Dry mouth, nausea, vomiting, constipation, and altered sense of taste
- GU: Urinary retention.
- Resp: Depression
- *Allergic reactions and shock*

If severe adverse effects occur, an opiate antagonist may need to be administered to reverse effects. Opiate antagonists are another class of drugs that block the effects of opiates:

Organ and Tissue Donation

Introduction and Background

The United Network for Organ Sharing (UNOS) policies dictate a detailed system for checking and rechecking organs for transplantation to ensure that organs of the donor and recipient are compatible. These policies are strictly followed before any transplantation can take place. The United States is divided into 11 geographical regions with 58 Organ Procurement Organizations (OPOs). All imminent deaths and actual deaths must be reported to the OPOs in a timely fashion for screening purposes. Credentialed healthcare facilities are by law required to work with state and federal agencies to provide screening for organ donors.

Safe practice further requires that hospital policies be consistent with applicable law and organ donation regulations, address patient and family preferences for organ donation, and specify the roles and desired outcomes for every stage of the donation process. Standards, policies, and procedures are specific to each healthcare facility and the OPO region that it presides over.

Organ Procurement Organizations (OPOs) work closely with the hospitals in their service area and by law, hospitals must contact their OPO when a patient is a potential donor. The OPO staff are able to evaluate the patient to see if they meet certain criteria to donate as well as check the registry to see if the patient is a registered donor. Know your local donation service area standards.

Organ Donation

Many organ donors are victims of accidents resulting in fatal head injuries. Other donors are victims of spontaneous bleeding in the brain or lack of oxygen after cardiac arrest. There are three medical situations where a family may donate organs and tissues.

Cardiac Death

Cardiac death is defined as the cessation of all cardiopulmonary functions. Cardiac death patients can donate tissues and eyes and, in some cases, organs.

Potential Donation:

- Arteries

- Bones
- Cornea
- Heart valves
- Skin
- Tendons
- Veins

Non-Recoverable Brain Injury-Brain Death

Brain death is defined as the irreversible cessation of all functions of the entire brain, including the brain stem. with impending withdrawal of life support. A physician, in accordance with accepted medical standards and following the hospital policy, must make the diagnosis of brain death. The time of brain death determination is the legal time of death.

A typical process for the determination of brain death is a clinical exam by a physician with an apnea test, then confirmatory tests of cerebral brain flow, EEG, transcranial doppler and/or an additional exam with an apnea test 6 hours after the initial exam and test.

Potential Donation:

- Bones
- Cartilage
- Cornea
- Heart
- Heart valves
- Kidneys
- Liver
- Lungs
- Pancreas
- Skin
- Small bowel
- Tendons
- Veins

Donation after Circulatory Determination of Death (DCDD)

DCDD is an opportunity for families of patients who do not meet the complete criteria for brain death to donate organs. It is offered as an option for families of patients who have a severe neurological injury and/or irreversible brain damage but still have minimal brain function. They are unable to breathe without the aid of a ventilator. If the family agrees, the patient is moved to an operating room where the patient's physician withdraws ventilation support. In some situations, support may be withdrawn in the intensive care unit.

DCDD donors must cease to have a heartbeat within 60 minutes of withdrawal of care. Once death is pronounced by the attending physician (who is not a part of the transplant team), the organs for transplant are surgically removed by the transplant team. If the patient's heart does not stop beating within 60 minutes, donation is no longer an option, and the organs are not recovered. The patient is taken to another unit and cared for until death occurs.

Potential Donation:

- Lungs
- Liver
- Pancreas
- Kidneys

All patients who meet appropriate criteria for organ and tissue donation (see your local standards) are referred to the appropriate referral network affiliated with your healthcare facility.

Living Donors

There are three types of living donors:

- Living related donors (LRD) are donors who are blood relatives of the recipient
- Living unrelated donors (LURD) are not blood related and are usually spouses or friends of the recipient
- A third type of living donor is called an altruistic donor or non-directed donor

Tissue Donation

Tissue donation is a common lifesaving option for people who wish to be donors, as there are very few medical reasons (other than having a communicable disease, such as HIV or hepatitis) a person would not be eligible to donate tissue.

Corneas or whole eyes, bone, skin, tendons, ligaments, heart valves and other cardiovascular tissues can be transplanted. Great care is taken in the recovery of tissues to ensure presentation of the body for funeral purposes. Donation will not delay funeral arrangements, and tissue donation does not interfere with an open-casket funeral for the donor.

Referral Process

Know your local practice standards. Typically, a healthcare professional contacts a representative of the referral network (OPO) which then conducts a phone evaluation that includes demographics, cause of death, neuro status, medical history, family information, hospitalization, and current medical status. Based on the phone assessment, a transplant coordinator may conduct an onsite evaluation.

Approaching the Family about Organ Donation

Know your local practice standards. An approach is only made in collaboration with the state referral network (OPO). And that approach is typically not made until after medical suitability for referral has been determined by the network. Local standards will determine who can authorize the donation. Once a family decides to donate, the next-of-kin signs an authorization form. Now, the patient is called a "donor." All hospital costs from this point are paid by the organ donation center.

Donor Management, Organ Placement and Recovery

Once the individual is deemed a donor their medical information including blood type, height, weight, and hospital are entered into a national database (UNOS) to find patients awaiting transplants who best match the donor's heart, lungs, liver, kidneys, and pancreas. Recipients for corneas (eyes), skin and bones can be found later.

The donor is kept in the hospital to maintain organ function, oxygenation, and hemodynamic stability recipient(s) are matched. Key parameters include urine output, CVP, systolic BP, pH, electrolytes, and O2 saturation. In addition, there are organ and tissue-specific protocols depending on what will be donated.

A transplant recipient's surgical team then comes to the hospital to remove the donor's organ(s) for the patient. Like other operations, this surgery takes place in an operating room. The organ(s) is then taken to the transplant center where a recipient(s) is waiting.

The Nurse’s Role in Organ and Tissue Donation

- Provides ongoing care to families throughout the donor’s hospitalization
- Coordinates the clinical management of the donor and support for the family
- Makes the referral to the appropriate OPO when there are plans to discuss withdrawal of support with the family
- Partners with the OPO to determine DCDD potential

- Coordinates withdrawal of support in the OR and comfort care measures until death is declared

OSHA Healthcare Safety

Introduction

Congress enacted the Occupational Safety and Health 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

Who is Required to Comply with OSHA

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 as effective as Federal OSHA requirements or better. State plans covering the private sector also must cover state and local government employees. Federal OSHA does not typically cover military personal.

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 each employer to provide a safe place to work without obvious work hazards that cause or could cause death or serious injury to any employee.

OSHA Standards

OSHA standards can be grouped into six areas:

- Administrative Safety
- Exposure Control
- Personal Protection
- Facility Safety
- Tools and Equipment
- Behaviors and Attitudes

Administrative Safety

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

Safety Program Development

How do you set up a safety program and make sure your team participates in 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 hazardous chemicals. 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 needle stick 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 such as chemotherapy?

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 employee's bodies, 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?

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 (PPE)

Teach all employees to properly use, don, and doff PPE. Evaluate all work processes to determine if personal protective equipment is required and what PPE is needed.

Respiratory Protection

Do your employees work in environments requiring respiratory protection? Are your employees 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 place? 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/Tag Out

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?

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 and 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 and 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 been trained to effectively work around forklifts?

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 and 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 distinct 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?

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?

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?

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.

Organizational Safety Culture

Incidences of work-related injuries and illnesses among healthcare workers have a significant impact on the employees, their families, healthcare institutions, and on patient safety. It is not surprising that patient and employee safety often go hand-in-hand.

Hazards to healthcare workers caused by a lapse 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 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 targeted interventions at improving organizational support for employee health and safety.

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.

A basic prerequisite for preventing injuries and illnesses is understanding the type, location, and underlying reason for their occurrence in the workplace. This information can be found documented in 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 who lack commitment and participation prove to be ineffective. Strong and visible management leadership is the most critical element of an effective injury and illness prevention program. Worker participation makes an important contribution to an employer's bottom line.

Reporting Workplace Safety Concerns and Employee's Rights

As you can see, OSHA affects many aspects of the Healthcare worker's 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 safe 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. By law employees have a right to file a complaint or ask a question with OSHA by calling 1-800-321-OSHA (6742), or by printing the complaint form and mailing, or faxing, it to your local OSHA office. Complaints that are signed by an employee are more likely to result in an inspection. Every question or report is completely confidential. Every employee is protected by law to report any complaint without being punished by their employer. OSHA does not give employees the right to leave work. If the employee feels unsafe the employer should be notified immediately. If the employer refuses to fix the problem OSHA should be notified as soon as possible. If there is not enough time to fix the problem, or the employer cannot fix the problem, remain at work until the employer requests you to go home.

For other valuable worker protection information, such as Workers' Rights, Employer Responsibilities, and other services OSHA offers, visit OSHA's Workers' page.

OSHA Violations and Penalties

OSHA completes various inspections to ensure employers and facilities are following OSHA safety and health regulations. OSHA will issue citations for anyone violating OSHA rules and regulations and establish penalties according to the violation.

TYPES OF VIOLATIONS INCLUDE:

- **Non-serious Violation:** This violation effects safety and health but does not result in death or serious injury.
- **SERIOUS VIOLATION:** This violation either causes, or could potentially cause, death or serious injury.
- **Willful Violation:** This violation purposefully and knowingly committed by the employer.
- **Repeated Violation:** Repeated violations of OSHA rules and regulations.
- **Failure to Correct Previous Violations:** Refusing, or failing, to correct any previous violation.

Know your Rights

Under federal law, you are entitled to a safe workplace. Your employer must provide a workplace free of known health and safety hazards. If you have concerns, you have the right to speak up about them without fear of retaliation. You also have the right to:

- Be trained in a language you understand
- Work on machines that are safe

- Be provided required safety gear, such as gloves or a harness and lifeline for falls
- Be protected from toxic chemicals
- Request an OSHA inspection, and speak to the inspector
- Report an injury or illness, and get copies of your medical records
- See copies of the workplace injury and illness log
- Review records of work-related injuries and illnesses
- Get copies of test results done to find hazards in the workplace

Pain Management

Introduction

Pain is sensory discomfort derived from possible, or true, tissue damage that can causes emotional distress. The intention of pain management is to obtain adequate pain relief by creating a pain management plan of care tailored to pain reports given by the patient.

Types of Pain

Pain is categorized as nociceptive or neuropathic, depending on the underlying pathophysiology.

Nociceptive Pain Nociceptive pain is caused by the ongoing activation of nociceptors responding to noxious stimuli (such as inflammation, injury, or disease). Visceral pain arises from visceral organs, while pain coming from tissues is called somatic pain. In nociceptive pain, the central nervous system is functioning appropriately. There is a close association between the intensity of the stimulus and the perception of pain, indicating real or potential tissue damage.

Neuropathic Pain Neuropathic or pathologic pain is caused by abnormal signals in the central or peripheral nervous systems, demonstrating injury or impairment. Causes of neuropathic pain may include inflammation, trauma, infections, tumors, metabolic diseases, toxins, or neurological disease

Classification of Pain

Acute Pain**:** This pain is a warning of a bodily threat. It is brief usually lasting less than 6 months. The Pain occurs with tissue damage and subsides as the cause of pain heals.

Chronic Pain**:** This pain is prolonged, lasting for months to a lifetime. The pain usually occurs with disease processes and worsens over time.

Pain Assessment

Pain is an internal experience that cannot be measured through physiological signs, therefore self- reporting is the gold standard for pain assessment. If a patient is unable to communicate, the family or caregiver can provide input. Use of interpreter services may be necessary.

Pain must be constantly assessed so ongoing treatment can be properly provided. The assessment must identify the intensity of the pain, the location of the pain, if the pain radiates, if the pain is constant, what causes the pain, and what relieves the pain. After the assessment, the patient and healthcare provider can create a comfort goal (pain goal) to help keep the patient at a tolerable pain level throughout their hospital stay.

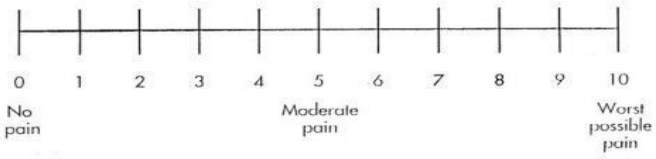
Failure to Report Pain

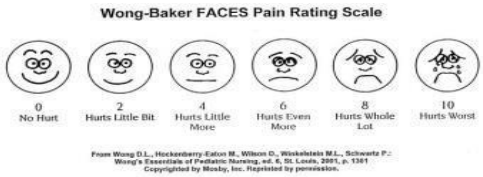
The failure to report pain should not be confused with a lack of pain. Barriers to reporting pain should be assessed during the initial admission assessment. Patients at risk for poor pain management, from a failure to report pain, include:

- Those who fear that pain means the disease is getting worse
- Patient who are non-verbal
- Patients who are mentally impaired
- Patients of a stoic nature
- Patients who do not want to complain or be a bother
- Those who fear addiction or fear being thought of as an addict
- Those who worry about medication side effects (constipation, nausea, etc.)
- Patients concern about distracting the physician from treatment of the underlying disease
- Patients who fear discomfort associated with medication administration (taste/injections)

Pain Assessment Scales

Pain rating scales which are appropriate for the patient population being served, should be used in pain assessment. The following scales are typically utilized:





Numeric Pain Rating Scale

A 1-10 self-reporting pain scale with 1 being no pain and 10 being the worse pain imaginable. This is used for adults of sound mind.

Wong–Baker Face Scale

The faces represent feelings to report pain intensity from no hurt to hurts worst. This scale is used for children and mentally impaired or confused adults.

FLACC Scale

This stands for Face, Leg, Activity, Cry and Consolability. This scale helps discern pain in young children who cannot talk or mentally impaired children.

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

When therapeutic or pharmacological interventions are administered, the nurse should reassess pain and document the effectiveness or ineffectiveness of the intervention. If the patient's comfort goal is not met, the physician should be notified for further orders and interventions. Routine evaluations and systematic reevaluations are performed until pain is controlled. This provides the foundation of appropriate pain management.

Treatment and Interventions

Pain may be managed effectively by using a combination of pharmacological and non-pharmacological approaches. Treatment is based on the patient's report of pain, with consideration given to the 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.

Treatment for Pain

Pharmacological

Initiation of pharmacological interventions must follow hospital policy for prescribing and administering medications. Pain medications will be administered according to the physician's orders.

Non-Pharmacological

Non-pharmacological measures should be considered based on patient preference, type of pain, and degree of pain relief obtained.

These interventions do not need a physician order and 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 and Family Education

The patient and their family have the right to education 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 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
- How to use the pain rating scale being utilized
- Any alternative methods of intervention, which may include non-pharmacological interventions
- All pharmacological interventions
- How and when to report inadequate pain relief
- When to report lethargy, respiratory depression, urinary retention, or constipation
- Discharge instructions (ensure that the patient and family understand the correct dosage and schedule of medication administration before discharge)

Opioid abuse

The Clinician's Responsibility

The assessment of pain is an interdisciplinary responsibility that includes every clinical discipline involved in the patient's care. These responsibilities include:

- Knowing that the patient's self-report is the single most reliable indicator of pain

- Teaching the patient about pain and relief
- Knowing how to use analgesic drugs for optimal safety and efficacy
- Encouraging the use of a wide variety of pain management interventions, including non- pharmacological techniques
- Incorporating what the patient believes will be effective in their plan of care.
- Offering pain medications or interventions frequently or as ordered rather than waiting for the patient to ask for relief
- Discussing the patient's feelings about their pain management interventions
- Requesting further intervention orders if pain management is ineffective
- Incorporating pain into the care planning process by adding it to the interdisciplinary plan of care
- Ensuring that unresolved pain present at discharge or transfer is addressed for continuity of care

Patient's Rights

Patient's Bill of Rights

The patient's bill of rights is a list of reasonable expectations for those receiving medical care. It may take the form of a law or a non-binding declaration either through the federal or state government. The Consumer Bill of Rights was developed by the federal government. This has been used as a foundation for many health plans, including federal government-sponsored health plans.

The Purpose of the Patient's Bill of Rights

- Build up consumer confidence, empowering them to participate actively in their own health care
- Strongly support the importance of a good provider-patient relationship
- Emphasize consumer's rights when it comes to health insurance, privacy, and health improvement

Patients Have the Right to

Information Disclosure

Every person rightfully deserves to receive accurate information about healthcare, health plans, healthcare professionals, and healthcare facilities, in a manner in which they can understand. If they speak another language, have a physical or mental disability, or just do not understand something, appropriate assistance will be provided so they can make informed health care decisions.

Choice of Providers and Plans

Every person deserves the right to choose an appropriate health care provider that will provide appropriate high-quality health care.

Access to Emergency Services

If a person feels that their health is in jeopardy, they have the right to receive emergency healthcare services at any time or place needed.

Participation in Treatment Decisions

Every person has the right to know all their treatment options and participate in decisions about their care. People also have the right to designate a repressive to speak on their behalf if they are unable to make healthcare decisions.

Respect and Nondiscrimination

All people have the right to receive respectful and nondiscriminatory care from every employee in the healthcare setting at all times.

Confidentiality of Health Information

All people have the right to talk privately with their healthcare providers. They are also given the right to keep their personal healthcare information safe and protected. Every patient has the right to review their medical record, correct mistakes, and obtain a copy for their personal use.

Complaints and Appeals

All people have the right to a fair, fast, and objective review of any complaint they have against healthcare plans, personnel, or institutions.

Consumer Responsibilities

In addition to outlining consumer rights for healthcare, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry also outlines guidelines for consumer responsibilities regarding 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.

- Assume responsibility for living a healthy lifestyle. Exercising regularly and eating a healthy diet.
- Be directly involved in decisions about your healthcare.
- Work with health care providers to create and execute treatments.
- Openly give essential information and discuss wants and needs.
- Use the health plan's appropriate complaint and appeal process to deal with problems that come up.
- Avoid spreading the disease to the best of your ability.
- Recognize and understand the reality of human error, medical limitations, and healthcare risks.
- Understand that healthcare providers are obligated to provide care in an efficient, fair, and impartial manner to all.
- Educate yourself on the coverage your healthcare plan offers, and all your healthcare plan options.
- Always show respect to everyone including other patients and the healthcare workers.
- Try to pay all financial obligations with sincere intention.

- Follow all physician and health plan administrative and operational procedures.
- Report all illegal activity including abuse and fraud to the appropriate 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, which include:

- Removing annual and lifetime limits of coverage
- Being able to obtain health insurance despite pre-existing medical conditions
- Having an easy-to-understand summary of benefits and coverage
- Being able to choose a physician
- Keeping young adults on their parent's health insurance policy until age 26, if they meet certain requirements
- Allowing access to certain preventive screenings without paying extra fees or co-pays
- Being informed on how to appeal a decision made by the insurance company (e.g., denying coverage)
- Requiring an insurance company to give 30 days' notice before they cancel an insurance plan
- Requiring premium increases over 10% to be clearly justified

Some existing health plans are "grandfathered," meaning they do not have to follow all of the new rules as long as they keep the old plan in effect. Check each plan to find out exactly what they do and do not follow.

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
- Have their personal healthcare information protected
- Inspect, obtain a copy, and amend their medical records (providers are allowed to charge a reasonable fee for copying expenses).
- Get an account of what protected information was disclosed for the past six years and file a complaint.

Additional Rights Outlined by Joint Commission

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

- Have a language interpreter if needed
- Receive accommodations for disabilities
- Be free from discrimination when receiving care
- Identify a support person to be present during a hospital stay
- The right to a discharge plan.
- Designate a surrogate decision-maker.

Patient Safety

Introduction

Patient safety movements and cultures are designed to help prevent patient harm and reduce incident risks. In November 1999, the Institute of Medicine issued the 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.

Patient Safety Systems

The Joint Commission developed patient safety systems to improve patient safety and quality of care. Healthcare organizations follow the guidelines set forth by Joint Commission to create a safety program tailored to their facility.

An integrated patient safety system includes:

- Creating a culture of safety by having all staff members incorporate safety system rules in everyday work to reduce patient harm
- Implementing ways to improve safety processes and systems, along with implementing safety integrated technologies
- Improving interdisciplinary team communication and collaboration
- Creating proactive safety methods for constant improvement

Safety Culture

One of the most critical responsibilities of healthcare leaders is to establish and maintain a strong safety culture within their facility. A strong safety system creates an integrated patient safety culture that requires administration and staff to work together to create a state of collective mindfulness and respect. The healthcare facility must establish a strong commitment to do no harm.

Proper safety culture is a crucial starting point for hospitals striving to become a learning organization. An effective safety culture helps every employee safely report mistakes,

without judgment, and turn those mistakes into a learning opportunity. This, in turn helps reduce mistakes and correct system failures. To accomplish this, hospitals should provide and encourage the use of a standardized reporting process for staff to safely report patient safety events.

Every healthcare facility must educate each employee on where to find event reporting tools and how to properly report an event.

Types of Safety Events

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

Patient Safety Event: An action, or lack of action, which could have resulted in, or did result in, patient pain or injury.

Adverse Event: A patient safety event that caused pain or injury to a patient.

Sentinel Event: A type of Adverse Events that caused death, permanent damage, or severe temporary pain or injury.

No-harm event: A patient safety event that reaches a patient but does not cause any injury or pain.

Near Miss: A patient safety event that never reaches the patient.

Hazardous conditions: A circumstance, unrelated to the patient's disease, which increases the chance of an adverse event.

All patients have the right to be notified about any safety event that occurred and any outcomes, or potential outcomes, which arise from the event.

Hospital Acquired Conditions

Hospital acquired conditions are safety events that federal legislation has mandated that Center for Medicare & Medicaid Services (CMS) work to improve patient safety and reduce the cost of care. An effective strategy has been to identify the most common and costly hospital acquired conditions, and financially incentivize facilities to provide safer and speedier care that reduces the incidence and severity of these conditions.

Each healthcare facility will have local standards and procedures to address these conditions. Know your facility standards.

If acquired during the hospital stay, CMS may not reimburse the hospital for the care. The conditions are typically associated with infections and injuries acquired during hospital says, the most common are:

- Catheter-associated Urinary Tract Infections (CAUTI)
- Central Line-associated Bloodstream Infection (CLABSI)
- Pressure injury (HAPI)
- Trauma related to a fall in the hospital
- Surgical site infections
- Multi-drug Resistant Organism Infections

System Problems and Errors

Identifying system problems is of key importance. If you know that you have made an error, or if you discover an error made by someone else, it is important to report it. Your facility has a procedure that you should follow for reporting errors.

Most errors are not the fault of one person. There is a combination of factors in the process of delivering a treatment, procedure, or medication. It is important to find out what went wrong, so that the system can be corrected, and future errors of the same type can be avoided.

The goal of reporting and investigating is not to blame someone. The goal is to fix problems in the system so that the same error will not happen again.

The Role of Hospital Leaders in Patient Safety

A learning organization as one in which hospital leaders continuously encourage learning. Learning organizations require employees to conduct team learning, have shared goals, and commit to continuous learning. In a learning organization, patient safety events are seen as opportunities for learning and improvement by analyzing gathered data from every safety event.

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

- Advocate learning

- Maintain an unprejudiced and fair safety culture
- Maintain a truthful environment in which safety events and quality measures are openly shared with all staff members
- Be the role model for professional behavior
- Get rid of any behavior that might stop proper safe behaviors
- Provide any necessary education to employees when implementing improvement initiatives

Just Culture

The goal of safety culture is not to create a blame-free culture, but rather create a Just Culture (nonjudgmental culture) that combines learning with accountability. To achieve this, it is essential that leaders assess staff errors and patterns of behavior to determine whether the mistake is an accidental error that fallible humans make, or an unsafe reckless act where staff members must be held accountable.

Data Use and Reporting Systems

Reporting systems are necessary to complete data measurements for safety improvement. The goal for an event reporting system is that employees will report events to activate collective learning from their mistakes. When continuous reporting of events occurs, the hospital can analyze the reported events and create ways to improve patient safety. Once analysis is complete any changes or lessons derived from the analysis is then shared with the rest of the organization.

The effective use of data allows hospitals to recognize and classify problems, create resolutions, and monitor success. Objective data can be used to defend decisions, influence change, and comply with evidence-based care guidelines.

Effective data analysis can help hospitals find problems within its system. Turning data into information is critical for a learning organization and effective in managing change.

Proactive Risk Assessment

The Patient Safety Program includes an ongoing proactive assessment, using internal and external knowledge, to prevent error occurrence and to maintain and improve patient safety. In a proactive risk assessment process, patients are evaluated to see where they could possibly fail. This identifies parts of the process that needs improvement which prevents failures before they occur.

- Benefits of a proactive approach to patient safety includes:
- Identify common causes
- Avoid unintended consequences
- Identify common aspects across departments
- Identify solutions

Encouraging Patient Engagement

To achieve the best outcome all patients, and families, must be actively engaged in making decisions about their health care. Patients must have broad access to information and support. Patient involvement is directly linked to patient safety. Involved patients are less likely to experience injury. Patients who are less activated suffer poorer health outcomes and are less likely to follow their provider's advice.

Quality Improvement

Quality in Healthcare

Quality programs can be an internal facility-based program that focuses on improvement within the facility, as well as an external private, public, or non-profit agency that monitors quality in healthcare facilities, health plans, and organizations, to determine hospital reimbursement, report findings to the public and to identify common process issues and patient care errors. The common denominator of the internal and external programs is improving the quality of care and patient safety.

Quality Improvement (QI)

The purpose of QI is to use a systematic, data-guided approach to improve processes or outcomes.

QI in healthcare 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, develop a plan, implement the intervention, and collect data before and after the intervention.

Examples of QI projects include implementing a process to remove urinary catheters within a certain period, developing a process to improve wound-care documentation, and improving the process for patient education of a specific chronic disease.

QI Methods

One common QI format is the acronym **FADE:**

F: Focus (Clarify a process/procedure that needs improvement)

A: Analyze (Gather and study collected data to identify the cause of the problem)

D: Develop (Develop a plan to refine and improve the problem)

E: Execute (Set the plan to action) and Evaluate (Closely observe the plan and monitor the progress)

ANOTHER COMMON QI FORMAT IS THE PDSA OR PDCA MODEL.

- The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning

from the consequences (Study), and determining what modifications should be made to the test (Act).
- PDCA (plan-do-check-act, sometimes seen as plan-do-check-adjust) is a repetitive four-stage model for continuous improvement (CI) in business process management.

Quality Assurance and Performance Improvement (QAPI)

The Patient Protection and Affordable Care Act (Affordable Care Act) was passed in March 2010. Section 6102

(c) of the Affordable Care Act states: facilities shall create and execute a QAPI program. The provision ensured that facilities consistently recognize and correct problems as well as maintain performance improvement.

QAPI improves the quality of care and services provided in healthcare facilities by refining problems identified by collected data. QAPI requires every employee to help identify any improvements, find gaps in any processes or procedure, execute a corrective action plan, and constantly monitor the plan's effectiveness. QAPI will help improve patient outcomes and reduce medication errors.

QAPI encompasses two aspects of quality which include Quality Assurance (QA), and Performance Improvement (PI).

- **QA** is a procedure that ensures the facility is meeting quality standards of care that comply with pre-set regulations. QA examines why a facility was unsuccessful at meeting set criteria after failure has already happened. QA procedures improve quality but end as soon as the set standard of care is met.
- **PI** (also called Quality Improvement - QI) is the ongoing study of processes and procedures. PI will help by recognizing areas that need improvement and applying innovative approaches or ideas with the intent to fix or prevent problems.
- **QA+PI** PI goals include the ongoing study of processes and continuously implementing a new process to improve healthcare by preventing problems, while QA goals involve meeting the pre-set standard of care criteria and studying why the criteria was not met. QAPI will identify and verify quality-related problems and their underlying cause, help design, and implement a plan to address deficiencies, follow up on progress to determine if the plan was successful, detect recent problems or opportunities for improvement,

and continuously study and improve healthcare processes to improve services.

Lean Methodology

Lean is a set of operating philosophies and methods that help create maximum value for patients by reducing waste and waits. It emphasizes the consideration of the customer's needs, employee involvement, and continuous improvement. Research on the application and implementation of lean principles in health care has been limited until recently. Many organizations are implementing Lean Methodology in their Quality Improvement Programs to join the evidence-based practice, effectiveness of lean and patient safety. The application of lean management in health care can also be holistic such as the transformation of an overall business strategy.

Quality Tools

Root Cause Analysis

RCA is a structured process used to analyze errors and identify the undisclosed problem that caused the error. This removes the focus from the mistake a person made to what error in the process caused the mistake. RCA helps identify active errors which happen when a human meets a complicated system, and latent errors which are unseen errors in a system. To begin an RCA process, data of the event must be gathered, then a multidisciplinary team breaks down the entire event process to analyze how and why the error happened. The main objective of RCA is to prevent future latent errors from happening thus reducing adverse events.

Failure Mode Effects Analysis (FMEA)

FMEA is a structured, proactive approach for identifying how and why a process or system can fail. The goal of FMEA is to detect system failures and correct the system problems before they occur. This reduces harm to staff and patients and increases hospital safety. FMEA is proven to reduce errors and increase the successful performance of a process.

Quality Occurrences

Sentinel Event

A sentinel event is an occurrence that was unforeseen and that lead to the death or injury of a patient. If death or injury does not occur, but the patient was put at risk for either, it is still

considered a sentinel event. These events require prompt examination after the event happened to determine what happened and why. Sentinel events and any data gathered from the event must be reported, followed by a Root Cause Analysis, and then responded to with an action plan.

Near Miss

A near miss is any unforeseen occurrence or behavior that had a chance to cause an adverse outcome, like injury or illness to a patient or employee, but never did so. A near miss by definition is called a sentinel event and must be reported as well, per policy. A near miss can give insight into process or system weaknesses, providing wonderful opportunities to improve the quality of care.

Quality Measures and Reporting

Healthcare facilities and the organization's National Quality Improvement Goals are displayed in its Quality Report. Quality reports are public information, and data is updated quarterly.

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

The companies 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 Health Grades and U.S. News and World Report

Hospital quality measurements are used for public reporting, provider incentive programs, accreditation and/or certification of providers and health plans.

THIS HELPS TO:

- Make care safer by reducing sentinel events or near misses.
- Promote the most effective prevention and treatment practices for the leading causes of death.

- Promote effective communication about coordination of care and ensure that all individuals and families are engaged as partners in their care.
- Ensure healthcare facilitates work with communities to promote healthy living.
- Make quality care more affordable for individuals, families, employers, by developing new health care delivery models.

Restraints

Introduction

A restraint is anything, such as a device, physical action, or chemical, used to immobilize or restrict a person's movement in any way.

Restraints are used as a last option, after all alternative methods have been unsuccessful, and the patient remains a present danger to themselves or others.

Violent Restraints Versus Non-violent Restraints

Violent Restraints

Restraint for violent or self-destructive behaviors which jeopardizes the immediate physical safety of the patient another person may meet the behavioral health requirements for violent restraints. Placing a patient in violent restraints requires a consultation from the behavioral health team to consider behavioral restraint options.

Non-violent Restraints

Restraint for non-violent non-self-destructive behaviors may be used to promote medical healing, diminish risk of suffering self-harm, to preserve the dignity and integrity of the patient when other less restrictive methods have been determined to be ineffective to protect the patient.

Alternative approaches must be considered prior to the use of restraint.

Types of Restraint

Before using restraints, always explore alternatives for keeping the patient and others safe. When considering such options, discuss with the patient any conditions that may need to be addressed, such as pain, anxiety, fear, or depression. If distraction and other alternatives prove ineffective at calming the patient and he or she continues to pose a risk, restraint usage may be needed. The type of restraint depends on the patient's behavior and condition.

Physical Restraint

A physical restraint is any device, or action, used to physically restrict a person's movement. This includes, but is not limited to, wrist and ankle restraints, holding a patient down, waist

and vest restraints, placing all four bed rails up, or using tightly tucked or tied sheets to prevent movement.

Chemical Restraint

A chemical restraint is a medication, which is not a part of the patient's standard treatment regimen, used to control behavior or to restrict the patient's movement. This includes, but is not limited to, antipsychotics and benzodiazepines.

Seclusion

Seclusion is involuntarily confining a patient to a room and preventing the patient from leaving. Seclusion may only be used for management of violent behavior.

Hand Mitts and Freedom Sleeves

If the patient is confused and impulsive and does not follow directions but can be redirected, consider hand mitts to decrease grabbing ability. Or consider "freedom sleeves" (also called soft splints).

Enclosure bed

An enclosure bed helps prevent patient injury by stopping the patient from getting out of bed unassisted.

Chest Vests and Lap (waist) Belts

Chest vests and lap (waist) belts may be warranted for confused or impulsive patients who are continually trying to get out of bed or a chair after repeated redirection, when it is unsafe for them to get up unaided. Apply the vest or belt according to the manufacturer's instructions. Fasten it securely to an immovable part of the bed or chair. Make sure you can easily slide your fingers underneath the vest or belt, so it is not too tight. It should not press uncomfortably against the skin, which could cause redness or impede expansion of the patient's midsection during respiration. Instruct the patient to call for assistance when he or she needs to get up.

Limb Restraints

Soft bilateral limb holders on both wrists may be appropriate for patients who are becoming increasingly agitated, cannot be redirected with distraction, and keep trying to remove needed medical devices. When device removal would pose serious harm to the patient and cause a significant setback to recovery, or if the patient is a physical threat to

him- or herself or others, limb restraints help protect the patient and staff and remind the patient not to pull on the device.

Restraint Usage

Restraint Orders

A licensed physician must order restraints. If the attending physician did not order the restraint, he/she must be notified immediately. There will be no standing orders, or renewal orders for restraints. After a restraint order has expired, the patient must have another physical and psychological exam to re-evaluate if restraints are still necessary.

Restraint orders must include:

- Date and time of restraint order
- Expiration date and time of order
- What type of restraint
- Circumstances under which a restraint is to be discontinued
- What restraint device should be use

Duration

The following are limitations to the duration of restraint use:

- Time is specified by the physician but is not to exceed 24 hours.
- The patient is to be re-evaluated face-to-face by the physician at least every 24 hours to determine if restraints need to be continued. A new restraint order must be written every 24 hours if restraints are still needed.
- Restraints and seclusion may not be used simultaneously unless the patient is continually monitored face- to-face by an assigned staff member.
- The patient should be frequently evaluated for restraint removal or reduction in the level of restraint used. Restraint removal or reduction should be implemented when the patient demonstrates an improvement or reduction in the behavior that led to restraint use.
- Restraints should be released every 2 hours to perform a skin assessment, and complete range of motion exercises. When done, the restraints should be safely and properly reapplied.

Alternatives to Restraints

Alternative, less restrictive, methods must be explored first before restraints are used.

Examples of less restrictive interventions include:

- Reviewing the patient's medication list for drug interactions and/or polypharmacy
- Speaking with the patient to identify reasons for the behavioral issues.
- Consulting the patient's family about methods of calming the patient
- Consulting the physician about removing tubes, lines, and/or dressings as soon as possible
- Covering IV sites with kerlix for protection
- Covering a PEG tube with an abdominal binder
- Initiating the use of bed alarms
- Increasing rounding times and toileting assessments
- Increasing pain assessments to help increase comfort
- Speaking in soothing tones
- Having family or a sitter in attendance
- Consulting pastoral counseling
- Minimizing environmental clutter
- Reducing stimuli by dimming lights, and reducing noise
- Diversional activities (music, videos, TV, soft objects to handle, etc.)
- Trying relaxation techniques
- Providing exercise/PT/OT
- Providing social activities and snacks

Improper Use of Restraints

Restraints are never to be used as a punishment, threat, or way to convenience healthcare staff. Improper use of restraints could cause serious harm, or even death.

Using restraints incorrectly can result in:

- Mental Distress
- Restrained patients may feel helpless
- Patients may feel like they are being punished
- Lack of control may cause a patient to fight the restraints
- Physical Injury
- Pressure ulcers if not repositioned properly and in a timely manner
- Loss of muscle and bone strength if used for extended periods of time
- Skin tears
- Constipation or incontinence
- Joint problems
- Broken bones, strangulation, and death if restraints are used improperly

Documentation and Assessment

Every episode of restraint use is to be thoroughly assessed and documented. This should include:

- All alternative measures attempted
- Type of restraint used
- Behaviors requiring restraint usage
- Vital signs
- Skin assessment
- 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 and family should include an explanation of the behaviors that caused 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. All education must be documented.

Staff Training Required

Staff members will be trained in proper use of restraints at orientation, before applying restraints, and periodically throughout the year per hospital policy. Training must include, how to recognize and assess situations where restraints are needed, how to implement alternative interventions, how to start with the least restrictive restraints, how to safely use and apply every type of restraint used in the facility, how to implement seclusion, how to assess when restrains are no longer needed, how to properly monitor and assess patients' needs on restraints, how to properly assess patients wellbeing on restraints, and how to provide care for patients in restraints or seclusion.

Risk Management & Legal Issues in Healthcare with Do Not Use Abbreviations

Introduction

In any industry, risk management and legal issues can arise. Risk management addresses liability, both proactively and reactively. Proactive focuses on preventing risk, while reactive focuses on minimizing loss or damage after an adverse event. Risk management is a systematic process aimed at reducing accidents, injuries, and financial risks in the hospital. This helps to prevent, and effectively manage, patient, visitor, and employee adverse events. Risk management cannot eliminate all risk, but it can help increase quality assurance.

The healthcare profession is one of the most legally scrutinized professions and has some of the strongest ethical guidelines where legal issues can arise. 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

Risks to patients, staff, and organizations are prevalent in healthcare. Thus, it is necessary for an organization to have qualified healthcare risk managers to assess, develop, implement, and monitor risk management plans with the goal of minimizing exposure. There are many priorities to a healthcare organization, such as finance, safety and most importantly, patient care.

Risk Management

- Improves quality of care
- Helps respond to unsafe conditions
- Protects employees and patients
- Assures resources are spent to support patient care rather than covering losses
- Reduces cost

Risk Management Plan

Continuous research is needed to identify and measure potential adverse events. Once this is identified a plan is designed and implemented to avoid risk and/or minimize damage or loss. Risk management must be tailored for each individual 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 available practice guidelines and principles. Incident reports, also known as occurrence reports, safety reports or risk reports, also help recognize areas for improvement and become a part of the risk management documentation.

Given that each organization faces unique challenges, there is not a one-model-fits-all risk management solution. Challenges faced by administrators that should be addressed in a risk assessment plan include but are not limited to:

- Patient safety
- Mandatory federal regulations
- Potential medical error
- Existing and future policy
- Legislation impacting the field of healthcare

The hazards of not preparing for potential issues can have significant, long-term effects. Neglecting to have comprehensive risk management plans in place can compromise patient care, increase liability risks, and result in financial losses.

Thus, potential risks have to be evaluated and measured in terms of their potential negative effects. Based on the risk assessment, an organization-specific management plan should be developed, implemented, and monitored.

Risk analysis research to identify potential adverse events should include, but is not limited to:

- Analyzing what could happen
- What is the likelihood of that event occurring
- What would the estimated outcome be if the event occurred
- What can be done to prevent the event from occurring
- What can be done to lessen the potential for the event occurring
- What, if anything, can be done to reduce the impact of the event
- What, if anything, cannot be protected or prevented

Incidents and Reporting Guidelines

Incident, Occurrence, Event Report

Engaging health care professionals and staff in reporting errors to reduce risk and improve the safety culture is a crucial but challenging task for many organizations. Unless staff members are engaged, feel safe speaking up, and are enabled to learn from the occurrence of preventable medical errors, poor patient outcomes will continue to occur. How organizational leaders respond to safety events and communicate to staff, patients, and family members following such events is key to building high reliability organizations and enhancing safety cultures.

An Incident (occurrence or event) Is:

- Any unusual event involving patients, employees, visitors, or contractors.
- Any unexpected medical injury, intervention, or impairment.

An incident (occurrence or event) report helps prevent negative events from reoccurring by helping us to understand the causes and circumstances surrounding the incident. Once an incident is reported and analyzed it can be used to develop educational interventions to train employees to avoid future incidents. Each incident report can also be used to assist with insurance or legal investigations.

Dos of Incident Reporting

- File a report immediately when you identify any incident
- Limit your report to facts, and do not make judgments or report opinions
- The report is, and should remain, confidential
- All information is used to benefit the performance improvement plan

Do Nots of Incident Reporting

- 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 any facts

Safety Events and Root Cause Analysis

Patient Safety Events

Patient Safety Event: An action, or lack of action, which could have resulted in, or did result in, patient pain or injury.

Adverse Event: A patient safety event that caused pain or injury to a patient.

Sentinel Event: A type of Adverse Events that caused death, permanent damage, or severe temporary pain or injury.

No-Harm Event: A patient safety event that actually reaches a patient but does not cause any injury or pain.

Near Miss: A patient safety event that never reaches the patient.

Hazardous conditions: A circumstance unrelated to the patient's disease, which increases the chance of an adverse event.

An incident report is required for every serious adverse event (sentinel event) to help prevent risk and the reoccurrence of risk. Should such an event occur at the health care facility will conduct a thorough investigation (Root Cause Analysis) to establish the cause of the 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.

If in doubt, fill it out! An incident report is not to lay blame for an event that occurred, or almost occurred, but to facilitate learning and performance improvement. Not completing an incident report could cause the facility to miss learning or improvement opportunities. If you are unsure, complete the incident report for any patient safety event and your supervisor will determine whether what happened is an incident or not.

Risk Reduction

Many patient risks can be reduced by training physicians and staff, encouraging effective communication among staff-members, providing counseling services for those working with patients, and conducting competency assessments.

OTHER RISKS POSED TO PATIENT SAFETY CAN BE MITIGATED USING PATIENT-SPECIFIC RISK MANAGEMENT STRATEGIES SUCH AS:

- Encourage reporting and a culture of safety
- Produce a rapid and standardized response to identified concerns
- Empower managers to address issues close to the source
- Promote greater transparency

Sources Used to Interpret the Law

Standards of Care

Standards of care are the level, or quality, of care considered appropriate by a profession, based on the skills, and learning commonly possessed by all members of a profession. Standards of care are the minimal requirements that define an acceptable level of care. All hospital professionals must abide by these regulations to help ensure quality care is given to all patients, and that no unnecessary harm comes to any patient. Failure to meet these requirements is called neglect.

Practice Acts and Standards

Practice acts and standards are created by each state and define healthcare professions' legal scope of practice. These rules and regulations help protect patients from harm by governing health professionals' education standards, licensing requirements, professional duties, professional rights, and disciplinary actions for disobedience. State boards, of every heath profession, publish acceptable standards in practice acts relevant to each individual discipline. These rules and regulations have the force of law because they are met or violated based on evidence presented.

Professional Position Statements

Professional position statements explain, or justify, why a decision was made, or action was done. Professional organizations publish their own position statement to the body of their standards of care.

Policies and Procedures

This is a 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 set forth by the institution.

Negligence vs Malpractice

Negligence

Negligence is a general term that means failing to act as a reasonable prudent person would act. Negligence is when a healthcare professional deviates from the set standards of care in which any reasonable person would use.

Malpractice

Malpractice is a form of negligence when a medical professional, purposefully or accidentally, mistreats a patient. The wrong or injudicious treatment must result in injury, unnecessary suffering, or death to the patient. Malpractice can stem from ignorance, carelessness, lack of proper professional skill, the disregard of established rules, neglect, or a malicious/criminal intent. These purposeful or accidental acts can potentially impact the health, safety, and finances of a patient. When this happens, liability exists which can result in a lawsuit being filed against the healthcare professional whether they acted in good faith or not.

Documentation

Proper documentation can protect healthcare professionals, just as lax documentation can weaken a defense 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 a healthcare professional's ability to defend their answers to these questions. Proper documentation is a healthcare professional's best defense in any

legal issue. **Documentation must be precise and true. Improper or false documentation could lead to a lawsuit.**

The Official Do Not Use Abbreviation List

The Do Not Use Abbreviation List is intended to prevent mistakes by eliminating confusing abbreviations to reduce error and medication mistakes. When a do not use abbreviation is encountered in an order the physician must be called to verify the order then have the order correctly written.

DO NOT USE	USE INSTEAD
U	**Write out "units"**
IU	**Write out "international units"**
Q.D., QD., q.d., qd	**Write out "daily"**
Q.O.D., QOD, qod, q.o.d.	**Write out "every other day"**
Trailing zero (X.0 mg) **Absent leading zero (.X mg)**	**Write "X mg" Write "0.X mg"**
MS	**Write "morphine sulfate"**
MSO4 and MgSO4	**Write "magnesium sulfate"**
< or >	**Write greater or less than**
Abbreviations for drug names	**Write drug names in full**

Apothecary units (Drams, Scruples, Grains)	Use metric units (Meter, Liter, Gram)
@	Write “at”
cc	Write “ml”, “mL” or “milliliters”
ug	Write “mcg” or “micrograms”

Just Culture

To promote effective reporting and achieve quality care, facilities need to adopt what is referred to as a "just culture." The just culture recognizes that it is rare for any single nurse to be the cause of an incident; instead, multiple system factors often combine to create the circumstances. The just culture eliminates punitive action against the person filing out the incident report and encourages looking beyond the incident to determine other factors. These factors may include orientation and training, staffing ratios, and other issues influencing patient safety.

Sexual Harassment

Introduction

Sexual harassment includes any unwanted verbal, physical, sexual behaviors and/or sexual requests. This is a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964. Sexual harassment can be divided into two categories.

1. **Quid Pro Quo sexual harassment** is when work decisions are based on compliance with sexual harassment. Examples include retaining a job, or getting a promotion based on how you respond to sexual harassment.
2. **Hostile work environment sexual harassment** is when the harassment interferes with work and creates a frightening, insulting, and disrespectful environment.

Sexual Harassment Explained

Victims of Sexual Harassment

Anyone, male or female can be victims of sexual harassment. The harm caused by sexual harassment is often extreme including humiliation, loss of dignity, psychological injury, 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 safety.

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

- The victim, as well as the harasser, could be a woman or a man. The victim does not have to be the opposite sex of the harasser.
- The harasser can be the victim's employee, supervisor, customer, co-worker, or a non-employee.
- The victim does not have to be the person directly harassed but could be anyone affected by offensive conduct.
- Unlawful sexual harassment may occur without the harasser withholding money or a job.
- The sexual harasser's conduct must be unwelcomed.

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 sexual objects or photos
- Touching or bodily contact
- Blocking or impeding physical movement

Addressing the Issue

It is helpful for the victim to inform the harasser directly that the conduct is unwanted and must stop. The victim should use any employer complaint mechanism or grievance system available to report the issue.

When investigating allegations of sexual harassment, EEOC looks at all 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 the 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. It is also unlawful to retaliate against an individual for filing a discrimination charge, testifying, or participating in an investigation or proceeding under Title VII.

Substance Abuse Recognition

Introduction

Substance (alcohol and drug) use has reached epidemic proportions in the United States. It is important to understand and recognize signs and symptoms of being under the influence of a substance in order to ensure a safe drug and alcohol-free workplace. No matter what kind of impairing substance someone is affected by– whether it is alcohol, street drugs, prescription medications, or something else–there is a higher risk for workplace accidents, absenteeism, presenteeism, family or social problems, stigmatization, and discrimination, deteriorating physical or mental health, pain, distress, and disability.

Substance Use Disorder

When does drug use become drug abuse or addiction?

Substance Abuse

- using a substance in an unapproved and inappropriate way that hinders a person's ability to perform their daily obligations.

Substance Addiction

- when substance abuse turns into a repeated pattern creating psychological and behavioral symptoms of addiction.

Impairment & Warning Signs

Alcoholism

The warning signs of alcohol abuse include, but are not limited to:

- Impaired motor coordination, slurred speech, flushed face, and bloodshot eyes
- Having problems performing in daily activities such as work and school
- Drinking in dangerous and illegal situations
- Experiencing blackouts
- Hurting oneself or others while drinking
- Smell of alcohol on the breath or excessive use of mouthwash

The warning signs of alcohol addiction include, but are not limited to:

- Drinking in the morning or drinking alone
- Inability to stop, or control, drinking even when it has caused harm to you or others

- Using elaborate excuses to drink
- Experiencing alcohol withdraw symptoms if alcohol is not consumed (perspiring, shaking, nausea, vomiting, anxiety)
- Quitting favorite activities to consume alcohol
- Drinking regardless of the ill effects it has on oneself or their relationships
- Experiencing weight loss and gastritis
- Needing to drink increasingly more to feel "drunk"

Drug Addiction

The warning signs of drug abuse include, but are not limited to:

- Showing signs of being high (appearing abnormally energetic or lethargic)
- Consuming high doses of medications that are not recommended or prescribed
- Experiencing mood swings
- Trying to obtain multiple prescriptions
- Having problems performing in daily activities such as work and school

The warning signs of drug addiction include, but are not limited to:

- Rapid changes in mood and decline in daily performance
- Frequent use of the restroom and absence from work or school
- Inability to care for one's health or appearance
- Frequent complaints of pain that require prescription pain medication
- Spending time and money (even if they cannot afford it) to acquire a drug
- Doing illegal things to acquire a drug

Inability to stop using a drug and experiencing withdrawal symptoms if the drug is not consumed. Withdrawal signs and symptoms include anxiety, fatigue, seizures, vomiting, depression, and hallucinations.

Impaired Practitioners

Clinicians under the influence of drugs, which impact their ability to provide safe and competent care, pose a serious danger to patients. A clinician's first duty is to protect the safety of patients. State Boards of Healthcare Clinicians (e.g., Physicians, Nurses, Physical Therapists, Respiratory Therapists, Pharmacists, etc.) have a responsibility for swift action to remove an impaired practitioner from performing duties, involving direct patient 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 continue practicing under specific guidelines. Many boards will not investigate an impaired practitioner's practice if he or she voluntarily enters and successfully completes a program that establishes recovery.

Healthcare practitioners have easy access to many types of drugs. Practitioners must be aware of any sign indicating a fellow practitioner is abusing his or her access to medications in the hospital. Signs that a practitioner is taking medication from the hospital include, but are not limited to:

- Excessive wasting of drugs
- Patients complaining that pain medication is not effective
- Patients denying that they received pain medication
- Excessive discrepancies in the signing and documentation of controlled substances
- Frequently leaving the nursing unit
- Always asking to medicate other nurses' patients
- Arriving to work late and leaving early
- Changing verbal medication orders

Any sign that indicates a practitioner is under the influence of drugs or alcohol should be reported immediately. Following the chain of command is recommended.

Suicide Prevention

Introduction

In 2019, suicide was the 10th leading cause of death in the US, killing more people than traffic accidents. Every day, approximately 123 Americans die by suicide. Only half of all Americans experiencing an episode of major depression receive treatment. A study found that almost 40 percent of people have a healthcare visit within a week prior to their suicide attempt.

Healthcare professionals are in a unique position to detect depression and suicide warning signs in their patients and intervene early. Suicide is a preventable public health issue. Understanding the stressors and hopelessness that lead people to consider suicide and connecting them to the appropriate resources can help save lives.

Risk factors that help identify the patient at risk for suicide

The following is a list of demographic and behavioral characteristics seen in at-risk patients. This list is meant to help identify these patients but is not inclusive.

- Military service
- Mental or emotional disorders
- Previous attempts
- History of emotional trauma or loss, e.g., abuse
- Serious illness, chronic pain, or impairment
- Substance abuse
- Social isolation
- Pattern of aggressive or antisocial behavior
- Discharge from inpatient psychiatric facility within the last year and particularly within
- The last few weeks or months
- Access to lethal means, e.g., guns, combined with suicide ideation

Joint Commission National Patient Safety Goal for Suicide Prevention

Suicides often occur in patients in around-the-clock care settings/acute care hospitals. The Joint Commission National Patient Safety Goals include recommendations for identifying at-risk patients and preventing suicide. Note even in non-behavioral care environments, the organization must be able to identify and to intervene for at-risk patients. A major difference between non-behavioral and behavioral care environments is that only behavioral care is required to screen ALL patients. However, note the emphasis on identifying at-risk patients as well as the monitoring requirements for ALL patients admitted with a diagnosis that includes emotional and/or substance abuse issues. Remember, the Emergency Department is considered outpatient/ambulatory care and may have different requirements.

Hospitals Must

- Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
- Address the patient's immediate safety needs and most appropriate setting for treatment.
- Provide suicide prevention information (such as a crisis hotline) to the patient and his or her family when a patient at-risk for suicide leaves the care of the hospital.
- Provide a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others, especially if a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse.
- Provide orientation and training to all clinical and nonclinical staff caring for such patients by providing information on effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques).
- Conduct assessments and reassessments and provide care consistent with the patient's identified needs.
- Assess the need of patients who receive treatment for emotional and behavioral disorders.
- Have a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer.

Behavioral Health Facilities must

- Conduct a risk assessment that identifies specific characteristics of the

individual served and environmental features that may increase or decrease the risk for suicide.
- Address the immediate safety needs and most appropriate setting for treatment of the individual served. Provide suicide prevention information (such as a crisis hotline) to the individual and his or her family when an individual at-risk for suicide leaves the care of the organization.
- Collect data to monitor its performance.

Identifying Suicide Ideation

The following steps generically apply to primary, emergency, and behavioral acute and nonacute settings.

- Review patient personal and family history for risk factors
- Screen all patients using a standardized, evidence-based tool (See Appendix)
- For those who screen positive:
    - Refer for assessment and secondary screening (TJC Sentinel Alert #56)

For patients identified in acute suicidal crisis

- Keep patients in acute suicidal crisis in a safe health care environment under one-to-one observation. Do not leave these patients by themselves.
- Provide immediate access to care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources.
- Check patients and their visitors for items that could be used to make a suicide attempt or harm others.
- Keep these patients away from anchor points for hanging and material that can be used for self-injury.
- Specific lethal means that are easily available in general hospitals and that have been used in suicides include: bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing, and oxygen tubing.

For patients at lower risk of suicide

- Make personal and direct referrals and linkages to outpatient behavioral health and other providers for follow-up care within one week of initial assessment, rather than leaving it up to the patient to make the appointment.

For all patients with suicide ideation

Give every patient and his or her family members the number to the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), as well as to local crisis and peer support contacts.

- Conduct safety planning by collaboratively identifying possible coping strategies with the patient and by providing resources for reducing risks.
- A safety plan is not a "no-suicide contract" (or "contract for safety"), which is not recommended by experts in the field of suicide prevention.
- Review and reiterate the patient's safety plan at every interaction until the patient is no longer at risk for suicide.
- Restrict access to lethal means. Assess whether the patient has access to firearms or other lethal means, such as prescription medications and chemicals. Discuss ways of removing or locking up firearms and other weapons during crisis periods. Restricting access is important because many suicides occur with little planning during the short term.

Validated /Evidence Based Suicide Risk Assessment Tools

There are a number of validated evidenced-based suicide risk screening strategies which are available for the identification of both males and females at elevated risk for suicide.

The Joint Commission's recent Sentinel Event Alert identifies several of the most well studied suicide risk screening tools.

- Patient Health Questionnaire-9 (PHQ-9; Spitzer, Kroenke, & Williams, 1999)
- Patient Health Questionnaire-2 (PHQ-2; Löwe, Kroenke, & Gräfe, 2005)
- Suicide Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001)
- Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011); and ED-SAFE Patient Safety Screener (Boudreaux et al., 2013)

Sample Patient Health Questionnaire

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Safety Planning

Developed collaboratively with a provider, safety plans commonly incorporate a list of personalized coping strategies. These can include resources for contacting social and professional support groups and information about restricting access to lethal means. Their primary purpose is to reduce the suicidal individual's imminent suicide risk, by encouraging use of alternative coping strategies during a future crisis.

While empirical evidence for its efficacy to reduce suicidal behavior has not yet been established, safety planning is considered a best practice approach for intervening with suicidal individuals. Emerging evidence has shown that Safety Planning Intervention, in combination with a structured phone follow-up, was associated with increased treatment attendance and decreased risk of hospitalization.

Workplace Violence (Active Shooter, Bleeding Control and Bioterrorism)

Introduction

The Occupational Safety and Health Administration defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers, and visitors. Acts of violence and other injuries is currently the third-leading cause of fatal occupational injuries in the United States.

Factors of Workplace Violence

Workers in hospitals, nursing homes, and other healthcare settings face significant risks of workplace violence. Many factors contribute to this risk, including working directly with people who have a history of violence or who may be delirious or under the influence of drugs. From 2002 to 2013, the rate of serious workplace violence incidents (those requiring days off for an injured worker to recuperate) was more than four times greater in healthcare than in private industry on average. In fact, healthcare accounts for as many serious violent injuries as all other industries combined.

Environmental Factors

Workplace environmental factors that may make workplace violence more likely:

- Contact with the public
- Exchange of money
- Working in high crime areas
- Mobile workplace (e.g., taxi, police, home health professional)
- Working with unstable people
- Working alone or in small numbers or in patients' homes
- 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 Factors

Examples of individual stressors and signs that could lead to workplace violence:

- The death of a family member
- Experiencing marital conflict (Divorce, Adultery)
- Loss of employment
- Moving
- Attendance and discipline problems
- Poor work productivity
- Problems with authority
- Dramatic change in behavior
- Evidence of drug or alcohol abuse
- Depression, low self-esteem
- Withdrawn
- Holds a grudge

Recognizing Levels of Violence & Proper Response

Level 1 (Early Warning Signs)

When a visitor, customer, employee, or employer is verbally abusive, purposefully uncooperative, and/or bullying others.

How to Seek Help

Report the incident to the appropriate supervisor immediately. If the supervisor is the offender, report the incident to the next level of supervision.

Action

Document the event. The supervisor will privately discuss the incident with the offender and listen to their side of the story. The supervisor will then review acceptable behavior per department policy and identify steps to correct the problem. The consequences for duplicating the incident will be thoroughly explained.

Level 2 (Escalation of the Situation)

When a visitor, customer, employee, or employer verbally threatens others, verbally wishes to harm others, and/or steals or sabotages for revenge.

How to Seek Help

First ensure you and others around you are safe. Report the incident to the appropriate supervisor immediately and they will notify the correct authorities. If the supervisor is the offender, report the incident to the next level of supervision. If law enforcement or medical care is needed notify 911 yourself immediately.

Action

Call for help and remain calm. The supervisor, or the authorities, if necessary, will discuss the offenders' concerns and actions. Acceptable behavior per department policy will be discussed and disciplinary actions will take place. Document the event.

Level 3 (Further Escalation)

When a visitor, customer, employee, or employer threatens suicide or physical violence, utilizes weapons, causes physical harm and/or property damage.

How to Seek Help

First ensure your safety then call 911 immediately. Remain calm and contact your supervisor.

Action

Call for help and remain calm. The supervisor, or the authorities, if necessary, will discuss the offenders' concerns and actions. Acceptable behavior per department policy will be discussed and disciplinary actions will take place. Document the event.

Preventing Workplace Violence

OSHA has determined that the best way to reduce violence in the workplace is through a comprehensive workplace violence prevention program that covers four core elements or "building blocks":

1. **Management commitment and employee participation**. Managers demonstrate their commitment to workplace violence prevention, communicate this commitment, and document performance. Employees, with their distinct knowledge of the workplace, ideally engage in all aspects of the program.

2. **Worksite analysis and hazard identification**. Processes and procedures are in place to continually identify workplace hazards and evaluate risks.
3. **Hazard prevention and control**. Processes, procedures, and programs are implemented to eliminate or control workplace hazards and achieve workplace violence prevention goals and objectives.
4. **Safety and health training.** All employees have education or training on hazard recognition and control, and on their responsibilities under the program, including what to do in an emergency.

Creating a Safe Work Environment

Management must create a healthy work environment by promoting open communication, making it easy and safe to submit complaints, listening to and addressing complaints, assessing job satisfaction, promoting employee health and wellbeing, and maintaining consistent disciplinary actions for inappropriate conduct.

Provide Security

Maintaining a secure and physically safe workplace is part of any good strategy for preventing workplace violence. Provide on-site security services, entrance security, identification badges to all staff members, special keys to restricted areas, and security cameras to help ensure safety.

Provide Education

Ensure every staff member knows and understands the workplace violence policies and procedures. Educate every employee on how to recognize early signs of workplace violence and how to implement early intervention techniques.

Active Shooter

All of us are at increasing risk of encountering an active shooter at work and in public spaces. The following information is intended to increase your chances of surviving and of helping others to survive in such situations.

This presentation describes what to do if you find yourself in an active shooting event, how to recognize signs of potential violence around you, and what to expect after an active shooting takes place. Remember during an active shooting to RUN. HIDE. FIGHT.

Be Informed

- Sign up for active shooter training.
- If you see something, say something to an authority right away.
- Sign up to receive local emergency alerts and register your work and personal contact information with any work sponsored alert system.
- Be aware of your environment and any possible dangers.

Make a Plan

- Make a plan with your family and ensure everyone knows what they would do if confronted with an active shooter.
- Look for the two nearest exits everywhere you go and have an escape path in mind & identify places you could hide.
- Understand the plans for individuals with disabilities or other access and functional needs.

During an active shooter incident RUN and escape, if possible.

- Getting away from the shooter(s) is the top priority.
- Leave your belongings behind and get away.
- Help others escape, if possible, but evacuate regardless of whether others agree to follow.
- Warn and prevent individuals from entering an area where the active shooter may be.
- Call 911 when you are safe, and describe the shooter, location, and weapons.

HIDE if escape is not possible

- Get out of the shooter's view and stay incredibly quiet.
- Silence all electronic devices and make sure they will not vibrate.
- Lock and block doors, close blinds, and turn off lights.

- Do not hide in groups- spread out along walls or hide separately to make it more difficult for the shooter.
- Try to communicate with police silently. Use text message or social media to tag your location or put a sign in a window.
- Stay in place until law enforcement gives you all clear.
- Your hiding place should be out of the shooter's view and provide protection if shots are fired in your direction.

FIGHT as an absolute last resort

- Commit to your actions and function as aggressively as possible against the shooter.
- Recruit others to ambush the shooter with makeshift weapons such as chairs, fire extinguishers, scissors, books, etc.
- Be prepared to cause severe or lethal injury to the shooter.
- Throw items and improvise weapons to distract and disarm the shooter.

After an active shooter incident

- Keep hands visible and empty.
- Know that law enforcement's first task is to end the incident, and they may have to pass injured along the way.
- Officers may be armed with rifles, shotguns, and/or handguns and may use pepper spray or tear gas to control the situation.
- Officers will shout commands and may push individuals to the ground for their safety.
- Follow law enforcement instructions and evacuate in the direction they come from, unless otherwise instructed.
- Take care of yourself first, and then you may be able to help the wounded before first responders arrive.
- If the injured are in immediate danger, help get them to safety.
- While you wait for first responders to arrive, provide first aid. Apply direct pressure to wounded areas and use tourniquets if you have been trained to do so.
- Turn wounded people onto their sides if they are unconscious and keep them warm.
- Consider seeking professional help for you and your family to cope with the long-term effects of the trauma.

Please view this excellent video simulation demonstrating the principles presented in the content you have just reviewed. RUN. HIDE. FIGHT. ® Surviving an Active Shooter Event - English - YouTube

Bleeding Control

Traumatic injury results from a wide variety of causes, including accidents or intentional harm, and in a wide variety of locations, such as your home or workplace. Uncontrolled bleeding is the number one cause of preventable death from trauma. The greater the number of people who know how to control bleeding in an injured patient, the greater the chances of surviving that injury. You can help save a life by knowing how to stop bleeding if someone, including yourself, is injured.

The following information will help you learn the numerous ways to control bleeding, whether you only have your two hands to use or whether you have a full trauma first aid kit available to you.

Primary Principles of Trauma Care Response

Ensure your own safety

- Before you offer any help, you must ensure your own safety! If you become injured, you will not be able to help the victim.
- Provide care to the injured person if the scene is safe for you to do so
- If, at any time, your safety is threatened, attempt to remove yourself (and the victim if possible) from danger and find a safe location
- Protect yourself from blood-borne infections by wearing gloves, if available

A–Alert–Call 9-1-1

- Get help
    - Call **9-1-1** yourself, OR have someone call **9-1-1**

B–Bleeding–Find the bleeding injury

- Open or remove the clothing over the wound so you can clearly see it (Removing clothing will enable you to see injuries that may have been hidden or covered.)

C–Compress–Apply pressure to the bleeding

- KEY POINT: There are a number of methods that can be used to stop bleeding and they all have one thing in common – compressing a bleeding blood vessel in order to stop the bleeding.

- If you do not have a trauma first aid kit:
    - Apply Direct Pressure on the wound
    - Cover the wound with a clean cloth and apply pressure by pushing directly on it with both hands

- If you do have a trauma first aid kit:
    - For life-threatening bleeding from an arm or leg and a tourniquet is available:
        - Apply the tourniquet
    - For life-threatening bleeding from an arm or leg and a tourniquet is NOT available OR for bleeding from the neck, shoulder, or groin:
        - Pack (stuff) the wound with a bleeding control (also called a hemostatic) gauze, plain gauze, or a clean cloth and then apply pressure with both hands
    - Look for and identify 'life-threatening' bleeding (See following illustrations.)

Recognizing Life-treatening Injuries

Recognizing Life-threatening injuries

Blood that is spurting out of the wound.

Blood that won't stop coming out of the wound

Blood that is pooling on the ground

Clothing that is soaked with blood

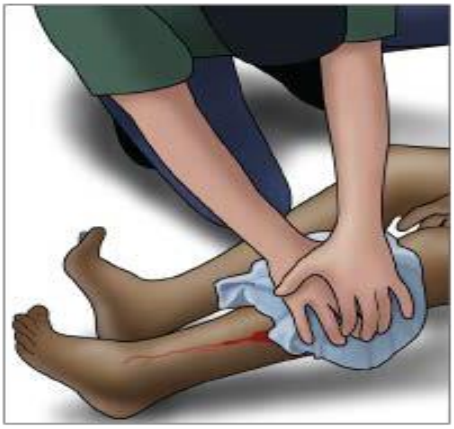
Bandages that are soaked with blood

Loss of all or part of an arm or leg

Bleeding in a victim who is now confused or unconscious

Applying Direct Pressure on a Wound

1. Take any clean cloth (e.g. shirt) and cover the wound
2. If the wound is large and deep, try to "stuff" the cloth down into the wound



3. Apply continuous pressure with both hands directly on top of the bleeding wound
4. Push down as hard as you can
5. Hold pressure to stop bleeding. Continue pressure until relieved by medical responders

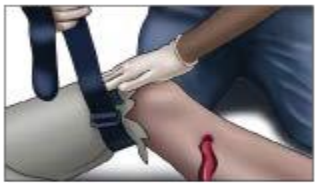
Applying a Tourniquet

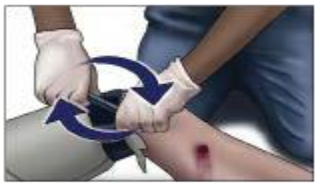
If you do have a trauma first aid kit:

For life-threatening bleeding from an arm or leg and a tourniquet is available:

- Apply the tourniquet

1. Wrap the tourniquet around the bleeding arm or leg about 2 to 3 inches above the bleeding site *(be sure NOT to place the tourniquet onto a joint – go above the joint if necessary)*





2. Pull the free end of the tourniquet to make it as tight as possible and secure the free end
3. Twist or wind the windlass until bleeding stops

4. Secure the windlass to keep the tourniquet tight
5. Note the time the tourniquet was applied

Note: A tourniquet will cause pain but it is necessary to stop life-threatening bleeding.

If you do have a trauma first aid kit:

For life-threatening bleeding from an arm or leg and a tourniquet is **NOT** available

OR

For life-threatening bleeding from the neck, shoulder or groin:

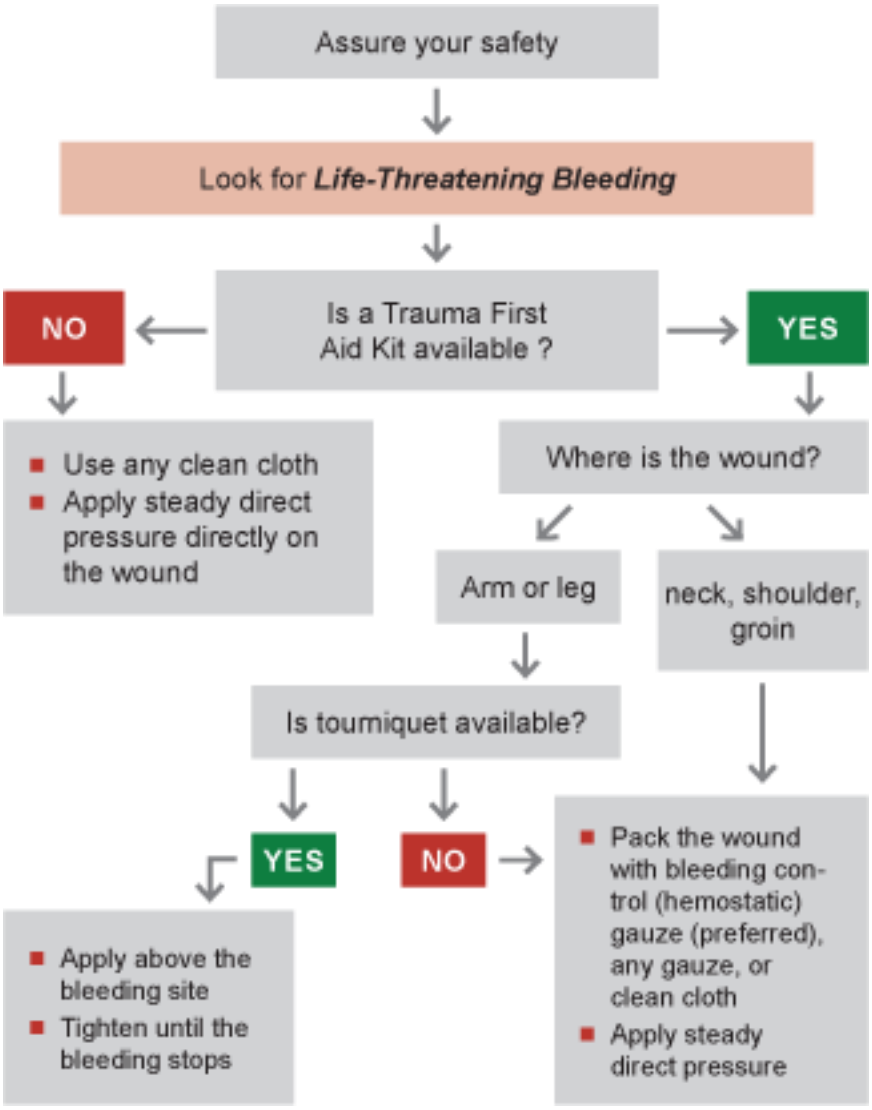
- Pack (stuff) the wound with bleeding control gauze (also called hemostatic gauze), plain gauze, or a clean cloth and then apply pressure with both hands.

1. Open the clothing over the bleeding wound
2. Wipe away any pooled blood

3. Pack (stuff) the wound with bleeding control gauze (preferred), plain gauze, or clean cloth.

4. Apply steady pressure with both hands directly on top of the bleeding wound
5. Push down as hard as you can
6. Hold pressure to stop bleeding. Continue pressure until relieved by medical responders.

Bleeding Control Algorithm



Agents of Bioterrorism

Biological Agents

The U.S. public health system and primary healthcare providers must be prepared to address various biological agents, including pathogens that are rarely seen in the United States.

High-priority agents include organisms that pose a risk to national security because they:

- Can be easily disseminated or transmitted from person to person

- Result in high mortality rates and have the potential for major public health impact
- Might cause public panic and social disruption
- Require special action for public health preparedness

Agents that can only be spread through direct contact with the biological agent and not through contact with the infected person include:

- Anthrax
- Botulism
- Tularemia

Person-to-person contact can also spread to other agents. These include:

- Smallpox
- The Plague (pneumonic form).

Anthrax

Anthrax is caused by bacteria called **Bacillus anthracis**. The bacteria are usually found in hoofed animals and can be spread to humans who are exposed to infected animals. New screening tests for anthrax are being developed. A vaccine has also been developed but is not on the market yet. There are three types of Anthrax:

Cutaneous

- This is the most common form of anthrax. Cutaneous Anthrax is spread by direct contact from an open wound by an infected animal, from inhaling spores or eating infected meat.
- After an incubation period of 2 to 5 days, a large, itchy sore appears on the skin.

Inhalation

- This form is caused by breathing in the anthrax bacteria. In bioterrorism, the bacteria might be carried on a powder or spray. The incubation period can be 60 days or more.
- Inhalation anthrax begins with flu-like symptoms. This makes it difficult to diagnose in the early stages. One suspicious sign to watch for is an elevated white cell blood count, which is not seen in a viral illness like the flu.

- After the initial symptoms, the infected person improves, and then becomes extremely ill with severe respiratory symptoms. Death usually occurs within 24-36 hours.
- The inhalation form of anthrax can be treated but requires early detection and treatment to be effective.
- This is difficult because of the flu-like nature of the early symptoms.

Intestinal

- For purposes of bioterrorism, intestinal anthrax is rare. This would be more difficult than spreading by other means.

Person-to-Person Contact

Some disease-producing agents that may be used in bioterrorism cause illnesses that can also be spread from person to person such as:

- The Plague
- Smallpox

Responding to the Threat of Bioterrorism

People who are injured or become sick as a result of biological or chemical terrorism will come to a medical facility for treatment. Initially, it might be that no one will know that a terrorist attack has occurred--even the victim. ***Healthcare workers in emergency departments and hospitals need to know what to do when faced with a potential bioterrorist situation.***

The hospital, especially the emergency department, may be the first place to identify that an attack has occurred. Hospital and emergency department staff should be alert to possible signs of terrorist activity such as:

- Increase in the incidence of a particular disease
- Disease with unusual geographic or seasonal distribution
- Large numbers of cases of unexplained diseases or deaths
- Large numbers of persons with similar disease or symptoms

If you suspect a problem, you should tell:

- Your supervisor
- Physicians involved
- Infection control practitioner

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