

## **Annual Mandatory Education: Professional**

### Topics Include:

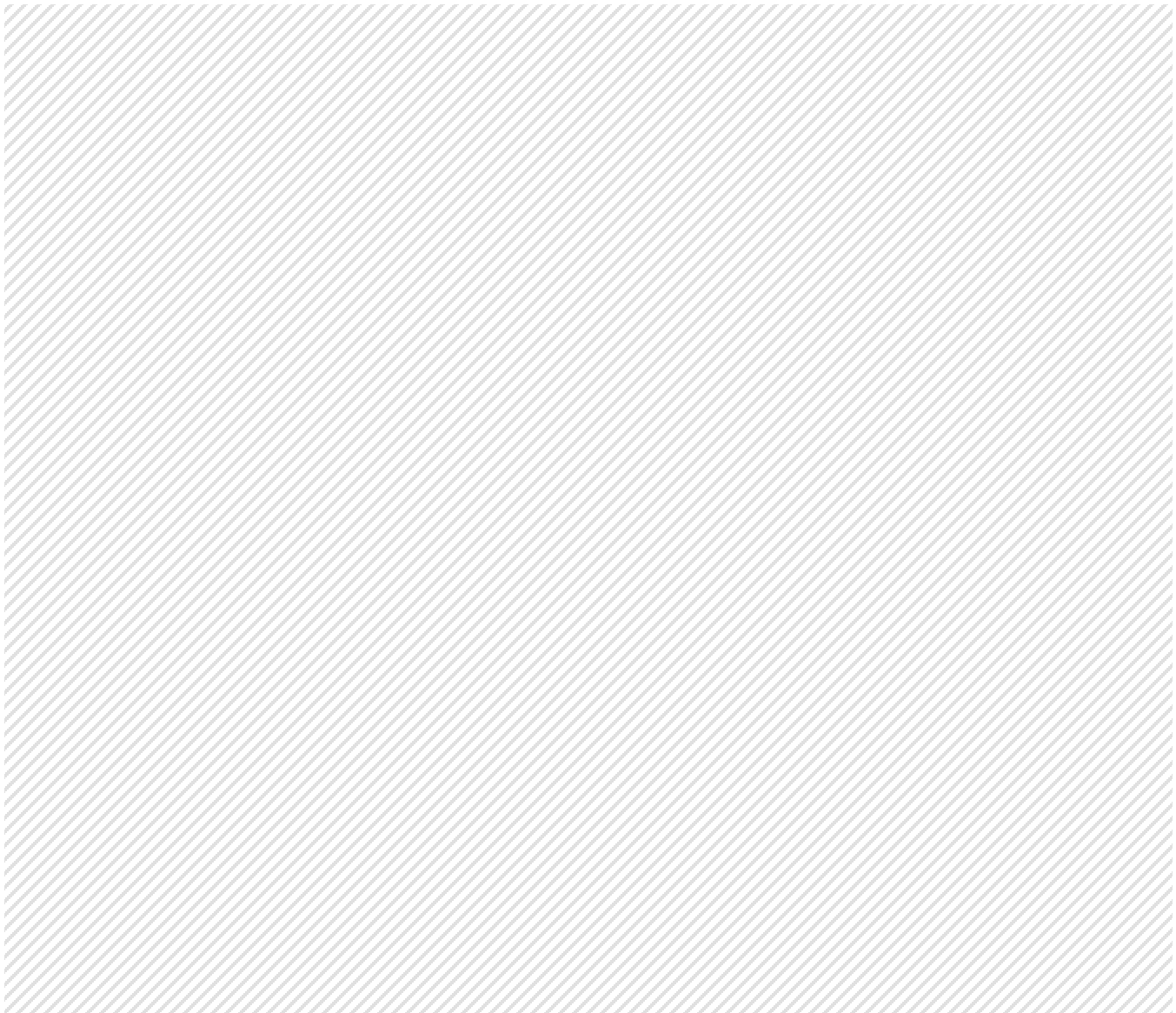
- Abuse and Neglect (Child, Domestic, Elder) and Human Trafficking
- Advanced Directives
- Adverse Drug Reactions and Drug Therapy Monitoring
- Age Specific
- Blood Products Administration
- Body Mechanics
- Care Planning
- Compliance (Fraud, Waste and Abuse)
- Coronavirus COVID-19
- Crisis Intervention and Managing Assaultive Behavior
- Cultural Competence
- Customer Relations and CAHPS
- Dementia Care and Communication
- Documenting Patient Care
- The Joint Commission - Do Not Use Abbreviations
- End of Life Care
- Environment of Care: Safety, Emergency, Equipment, Hazmat, Utilities, Life Safety, and Security Management
- Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather
- Workplace Violence (Active Shooter, Bleeding Control and Bioterrorism)
- Ethics
- Fall Prevention
- HIPAA and HITECH
- Infant Abduction
- Infection Control, Bloodborne Pathogens, C. diff, Cleaning and Disinfection, Ebola, HAIs, Hand Hygiene, HIV, MDROs, PPEs, Sharps, Std. Spec. and Isol. Precautions, TB, and Waste Disposal
- Legal Issues in Healthcare
- Medication Safety
- Moderate Conscious Sedation
- The Joint Commission's National Patient Safety Goals – Nursing
- Organ and Tissue Donation
- OSHA
- Pain Management
- Patient Rights
- Patient Safety
- Quality Improvement
- Restraints
- Risk Management
- Safe Patient Handling
- The SBAR Communication Model
- Sexual Harassment
- Substance Abuse Recognition
- Suicide Prevention
- Workplace Harassment

# Abuse, Neglect and Exploitation (Child, Domestic, Elder)

## Core Competency Inservice

January 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Forms of Abuse and Neglect .....</b>	<b>3</b>
<b>Elder .....</b>	<b>4</b>
<i>Who is Subject to Elder and Abuse.....</i>	<i>4</i>
<i>Who are the Abusers.....</i>	<i>4</i>
<i>Why does Abuse and Neglect Matter .....</i>	<i>4</i>
<b>Child.....</b>	<b>5</b>
<i>Child Abuse Statistics .....</i>	<i>5</i>
<i>Warning Signs of Child Abuse .....</i>	<i>5</i>
<b>Domestic .....</b>	<b>6</b>
<i>Who are the Abused.....</i>	<i>6</i>
<i>What is Domestic Abuse.....</i>	<i>6</i>
<b>Human Trafficking.....</b>	<b>6</b>
<i>Who are the Trafficked.....</i>	<i>6</i>
<i>Who are the Traffickers.....</i>	<i>7</i>
<b>Clinician’s Responsibility in Reporting Abuse and Neglect .....</b>	<b>7</b>
<b>References.....</b>	<b>7</b>

---

## 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. Some 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 vulnerable 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 devices 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 adequately 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 and Abuse

Research indicates that older adults from all walks of life can be victims of abuse – men and women from all racial, ethnic, and economic groups.

- Elders age 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 don't really understand the effects of aging. Care givers fail to give elders the extra time they 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 likely an underestimate. In 2014, state agencies identified an estimated 1,580 children who died as a result of abuse and neglect. This averages between four and five children a day.

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 generally 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
- Doesn't 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
  - Doesn't 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 be occurring 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.

- The Department of Justice has reported that more than half of sex-trafficking victims are 17 years old or younger
- The annual number of persons prosecuted for commercial sexual exploitation of children (CSEC) cases filed in U.S. district court nearly doubled between 2004 and 2013, increasing from 1,405 to 2,776 cases.

---

## Who are the Traffickers

Traffickers can be any age, race, gender, or nationality and range from small-time solo operators to loose 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 then reported to Child or 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. If your facility has Sexual Assault Nurse Examiner (SANE) follow your facility's guidelines for engaging the SANE Nurse.

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.

## References

"Child Abuse and Statistics." Childhelp.org. Accessed June 30, 2019. <https://www.childhelp.org/child-abuse-statistics/>

"Identification and Warning Signs of Child Abuse and Neglect." Mono County California. Accessed June 30, 2019. <https://monocounty.ca.gov/social-services/page/identification-and-warning-signs-child-abuse-and-neglect>

"Human Trafficking: The Role of the Health Care Provider." US National Library of Medicine. NIH. Accessed June 30, 2019. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3125713/>



---

“Preventing Child Abuse and Neglect.” CDC. February 26, 2019.  
<https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html>

“Trafficking Statistics.” NOVA Human Trafficking Initiative. Accessed June 30, 2019.  
<https://www.novahti.com/trafficking-statistics>

“Types and Signs of Abuse.” Washington State Department of Social and Health Studies. Accessed June 30, 2019. <https://www.dshs.wa.gov/altsa/home-and-community-services/types-and-signs-abuse>

“Violence Prevention: Elder Abuse.” CDC. May 28, 2019.  
<https://www.cdc.gov/violenceprevention/elderabuse/index.html>

“What is Domestic Violence.” The National Domestic Violence Hotline. Accessed June 30, 2019.  
<https://www.thehotline.org/is-this-abuse/abuse-defined/>

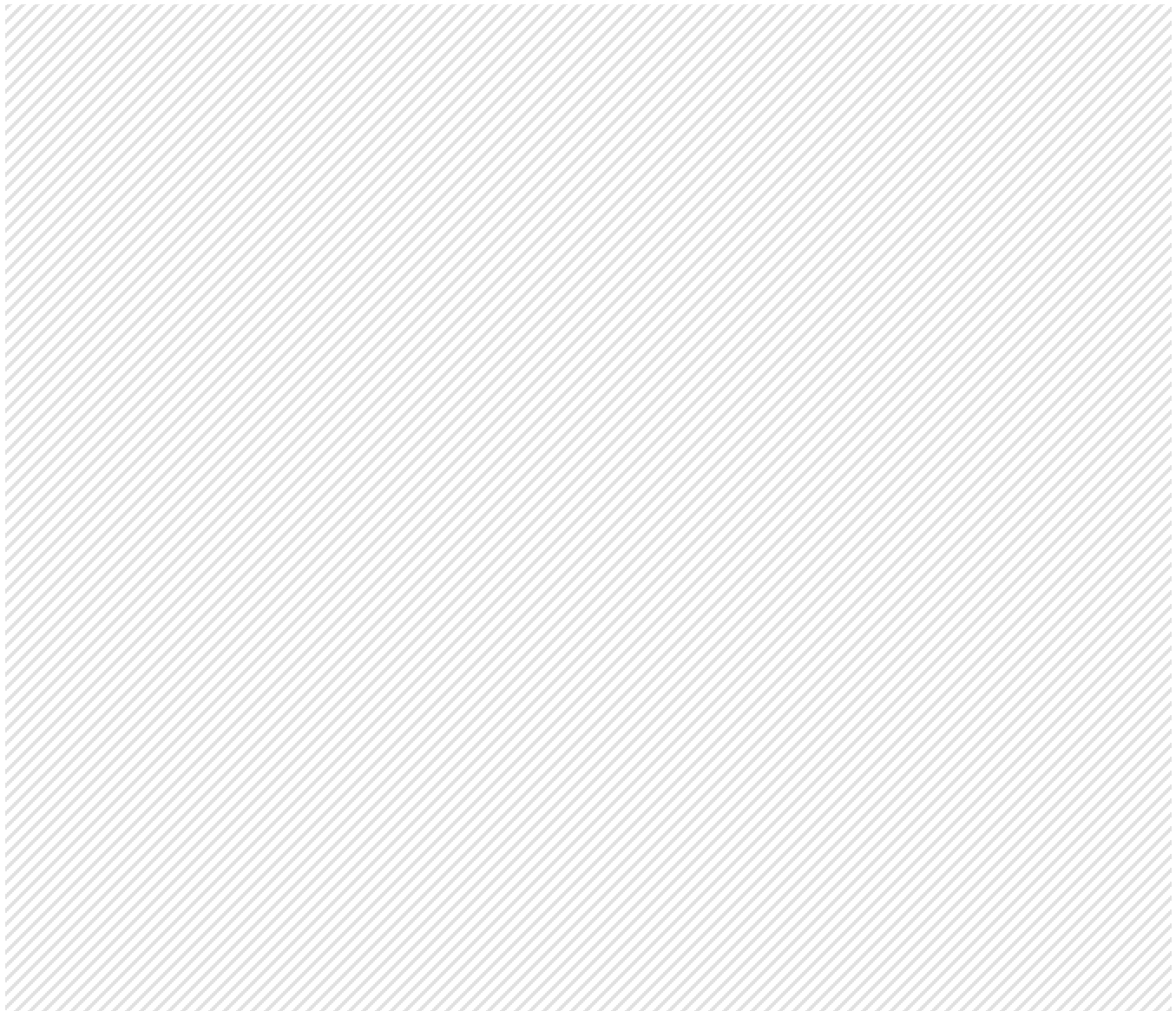
“What is Human Trafficking?” Homeland Security. Accessed June 30, 2019. <https://www.dhs.gov/blue-campaign/what-human-trafficking>

“Who are Human Traffickers?” Human Rights First. Accessed June 30, 2019.  
<https://www.humanrightsfirst.org/resource/who-are-human-traffickers>

# Advance Directives

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

# Table of Contents

<b>Introduction</b> .....	<b>3</b>
<b>The Patient Self-Determination Act (PSDA)</b> .....	<b>3</b>
<b>What are Advance Directives</b> .....	<b>3</b>
<b>Types of Advance Directives</b> .....	<b>3</b>
<i>The Living Will</i> .....	<i>4</i>
<i>Durable Power of Attorney for Healthcare</i> .....	<i>4</i>
<i>“Do Not Resuscitate” Orders</i> .....	<i>5</i>
<b>References</b> .....	<b>5</b>

# 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 in terms they can understand about the nature of their illness, 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 states 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 many advance 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 can't speak for themselves a living will helps the attending physician and family understand what interventions the person does or doesn't want done to prolong life in the event of a terminal illness. If so, stated 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 generally 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.

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 generally applies 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 is 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 cardio pulmonary 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 include preferences regarding resuscitation and intubation, it is still a good idea to establish DNR or DNI orders each time they 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.

## References

“Advanced Directives.” American Cancer Society. May 10, 2019.

<http://www.cancer.org/treatment/findingandpayingfortreatment/understandingfinancialandlegalmatters/advancedirectives/index>

“Living wills and advance directives for medical decisions.” Mayo Clinic, December 15, 2018

<http://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/living-wills/art-20046303?pg=2>

“Medical Power of Attorney. Information for Patients, Physicians, and Providers.” Texas Medical Association. May 06, 2019

<https://www.texmed.org/Template.aspx?id=65#GENERAL>

“Myths and Facts About Health Care Advance Directives.” American Bar Association.

[https://www.americanbar.org/groups/law\\_aging/publications/bifocal/vol\\_37/issue\\_1\\_october2015/myths\\_and\\_facts\\_advance\\_directives/](https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_37/issue_1_october2015/myths_and_facts_advance_directives/). October 15, 2018.



# **ADVERSE DRUG REACTIONS AND DRUG THERAPY MONITORING**

## **CORE COMPETENCY READING MATERIAL**

### Contingent Staffing and Recruiting

Initial Release: January 2008

Revised: April 2013



## Copyright © 2013 API Healthcare Corporation

This guide is copyrighted by API Healthcare Corporation and all rights are reserved. This guide may not, in whole or part, be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, recording, or otherwise, without the prior written consent of API Healthcare Corporation.

Portions of the information contained in this guide, respectively, are: Copyright © 2006 Microsoft Corporation, One Microsoft Way, Redmond, Washington 98052-6399 U.S.A.; Copyright © 2005 Sax Software Corp.; Copyright © 2005 Identify Software, Ltd., All rights reserved; TallPDF.NET and PDFKit.NET are Copyright © 2001-2006 TallComponents BV. All rights reserved; The Desaware Universal .NET StorageTools are Copyright © 2005 Desaware, Inc. All rights reserved; Redistributable DLL files in the NetAdvantage TM .NET Windows Forms Controls are Copyright © 2001-2006 Infragistics, Inc. Windsor Corporate Park, 50 MillStone Rd., Building 200 - Suite 150, East Windsor, NJ 08520. All rights reserved; Copyright © 1999 - 2008 Developer Express Inc., Inc. All rights reserved; Copyright © 2009, Inventive Labs Corporation. All Rights Reserved; Copyright © 2004-2010 Symmetry Software, All Rights Reserved. Portions of the ActiveX controls, respectively, are: Copyright © 2003 Bennet-Tec Information Systems, Inc., All rights reserved; Copyright © 2005 Data Dynamics, Ltd., All rights reserved; Copyright © DL Technology, Ltd.; Copyright © 1991-2005 FarPoint Technologies, Inc.; Copyright © Janus Systems SA de CV; and Copyright © Olympus 2005.

The information in this guide is subject to change without notice. API Healthcare assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide.

Names, data and all other information used in examples herein are fictitious, unless otherwise noted.

### Trademarks

ActiveLink, ActiveRoster, ActiveStaffer, Acuality, API Healthcare, API Healthcare Connect, api LaborWorkx, api software, Applicants Navigator, Attendance+, Benefits Navigator, CalcEngine, Daycare DeductIT, DeductIT, e:HRStats, e:LaborStats, e:SecureStats, e:StafferStats, EdStats, EdTrack, Electronic Employee Record, HR Navigator, HRStats, HRXpress, LaborStats, LaborVision, myHRAccess, Payroll Navigator, Payrollmation, Position Control Navigator, ReportXpress, SecurALL, SecurStats, StafferStats, TimeBack, TimeCall, TimeFax, TimeID, TimePC, TimeStor, TimeView, www.ActiveStaffer, www.ApplicantsNavigator, www.ReportXpress, www.TimePC, WorkAgent, and the API Healthcare Logo and the api software Logo are either registered trademarks or trademarks of API Healthcare Corporation in the United States. The absence of a name or logo in the foregoing list does not constitute a waiver of any and all intellectual property rights that API Healthcare Corporation has established in any of its products, features, or service names or logos.

Trademarks of API Healthcare may be used publicly only with written permission from an authorized representative of API Healthcare. Nothing contained in this document should be construed as granting, by implication, laches, estoppel, or otherwise, any license or right to use, copy, publish, transmit, or modify any trademark of API Healthcare Corporation without such prior written authorization.

Microsoft, Windows, Windows 2008, Windows 2003, Windows 2000, Windows XP, Windows CE, Windows 98, and SQL Server are either registered trademarks or trademarks of Microsoft Corporation in the United States and/or other countries. Oracle is a registered trademark of Oracle Corporation and/or its affiliates. Adobe, the Adobe Logo, Acrobat, Reader, Flash, and Macromedia are either registered trademarks or trademarks of Adobe Systems Incorporated in the United States and/or other countries. Canon is a registered trademark or trademark of Canon Corporation in the United States and/or other countries. Catalyst Systems and EVALISYS are registered trademarks or trademarks of Catalyst Systems, LLC. Patient Care Technologies, PtCT, and well.at.home are registered trademarks of Patient Care Technologies, Inc. PKZIP and PKWARE are trademarks of PKWARE, Inc. Per-Se, ANSOS, and One Staff are registered trademarks or trademarks of Per-Se Technologies, Inc. Res-Q is a registered trademark of Res-Q Healthcare Systems, Inc. Intel and Dialogic are registered trademarks of Intel Corporation. MicroTouch is a trademark of MicroTouch Systems, Inc. Adaptec is a trademark of Adaptec, Inc. Nisca is a trademark of Team Nisca. Sun, Sun Microsystems, the Sun Logo, the Java Coffee Cup Logo, J2RE, J2SE, and Java are trademarks or registered trademarks of Sun Microsystems, Inc. in the U.S. or other countries. The Symmetry Tax Engine is a registered trademark of Tekon Corporation d/b/a Symmetry Software. VMware, Virtual SMP and VMotion are registered trademarks or trademarks of VMware, Inc. in the United States and/or other jurisdictions. Citrix is a trademark of Citrix Systems, Inc. and/or one or more of its subsidiaries, and may be registered in the United States and/or in other countries.

All other company, product, feature, or service names or logos are the registered trademarks or trademarks of their respective companies.



## Table of Contents

<b>Introduction</b>	<b>4</b>
<b>Medication Monitoring Requirements</b>	<b>4</b>
<b>What to Do If the Patient Has an Adverse Drug Reaction</b>	<b>4</b>
<b>Pharmacy Interventions</b>	<b>5</b>

## Introduction

A significant adverse (untoward) drug reaction is any unintended, undesirable, and unexpected effect of prescribed drugs that:

- Requires discontinuing a drug or modifying the dose
- Requires initial or prolonged hospitalization
- Results in disability
- Requires treatment with a prescription drug
- Is life-threatening
- Results in death
- Results in congenital abnormalities

Side effects are a common, unexpected, trivial reaction (e.g., drowsiness due to an antihistamine) and need not be reported unless it is deemed adverse. If in doubt, report it. Side effects, if observed, should be recorded in your documentation.

## Medication Monitoring Requirements

Monitoring requirements for all medications include:

- first dose monitoring
- appropriate drug, dose, and route
- real or potential allergies or sensitivities
- therapeutic duplication
- real or potential interactions between prescriptions and other medications, food, and laboratory values
- other contradictions
- variations from routine use
- current laboratory findings relevant to drug therapy

## What to Do If the Patient Has an Adverse Drug Reaction

If your patient has an adverse drug reaction, you should:

- Monitor and treat the patient as needed.

- Check the patient's vital signs.
- Notify the ordering practitioner.
- Immediately discontinue the drug.
- Report the reaction to the hospital pharmacy or distributing pharmacy.

## Pharmacy Interventions

Drug therapy monitoring is an ongoing process that can be prospective and/or concurrent in order to assure effective, appropriate, and safe drug therapy. The pharmacy reviews orders and prescriptions, monitors the patient's drug regimen, monitors laboratory findings relevant to drug therapy, performs reconciliations of pharmacy and nursing records, and collects patient drug histories. In the event of a drug reaction, the pharmacist will:

- Review the documentation and event,
- Report the event to the Pharmacy and Therapeutics Committee,
- Implement actions to reduce adverse drug reactions, and
- Monitor the effectiveness of these improvements.

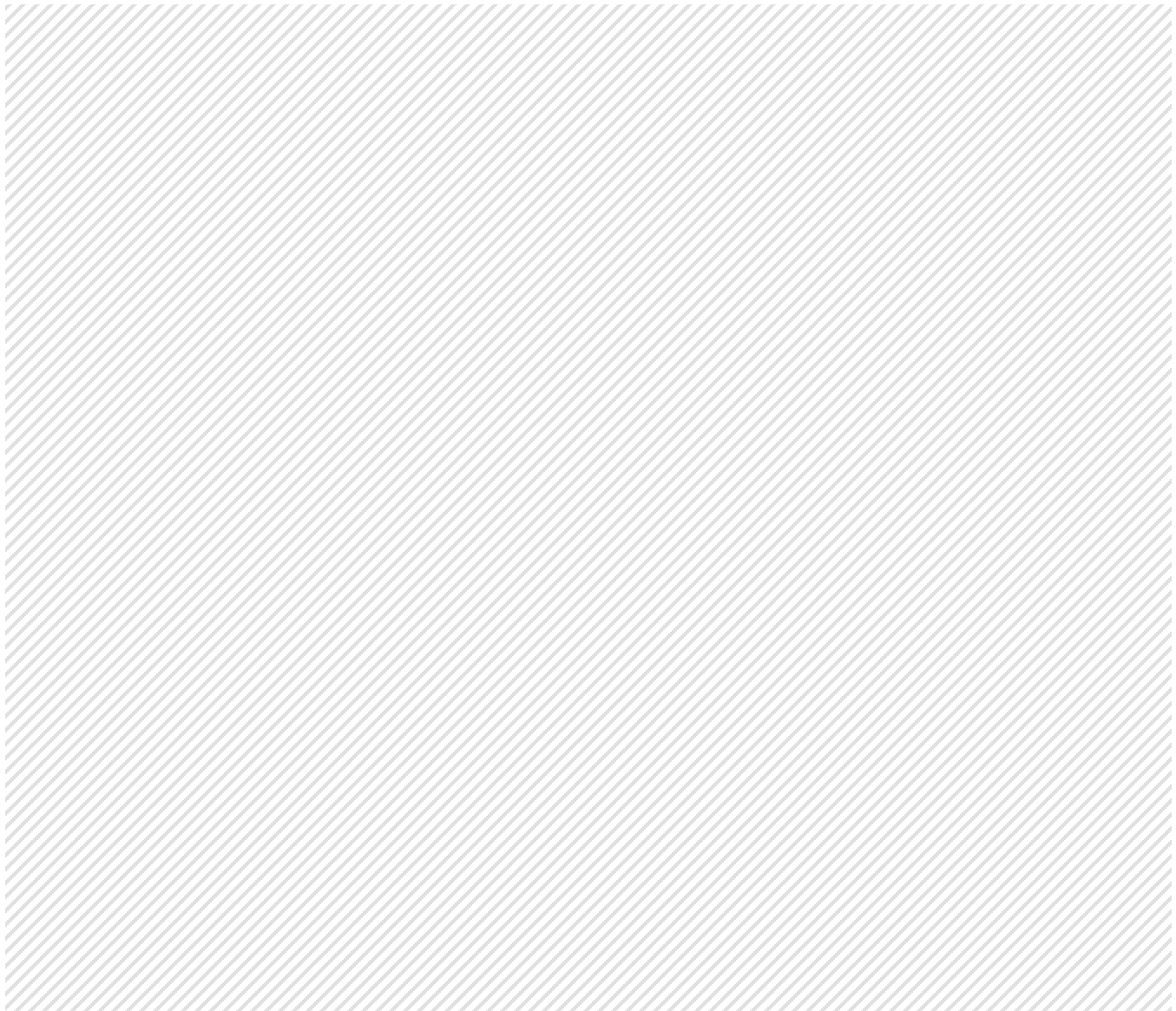
Serious adverse drug reactions, as defined in the Introduction, must be reported to the FDA.

In addition to serious adverse drug reactions, the FDA is interested in events not described in or that are significantly different from the package inserts and reactions to newly marketed products.

Remember medication administration is a multi-disciplinary approach which includes the discipline administering the medication, the practitioner ordering the medication, and the pharmacy.

# Age Specific Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Birth - 1 Year</b> .....	<b>3</b>
<i>Birth - 1 months</i> .....	3
<i>2 months - 4 months</i> .....	3
<i>4 months - 8 months</i> .....	3
<i>8 months - 12 months</i> .....	4
<i>Age Specific Interventions: Birth to 1 year</i> .....	4
<b>Toddler: 18 months - 3 Years</b> .....	<b>4</b>
<i>18 Months</i> .....	4
<i>2-Year-Old</i> .....	5
<i>3-Year-Old</i> .....	5
<i>Age Specific Interventions - Toddler</i> .....	5
<b>Preschooler: 3 - 5 Years</b> .....	<b>6</b>
<i>Age Specific Interventions - Preschooler</i> .....	6
<b>School Age: 6 - 12 Years</b> .....	<b>7</b>
<i>Age Specific Interventions - School Age Child</i> .....	7
<b>Adolescence: 13 - 18 Years</b> .....	<b>7</b>
<i>Age Specific Interventions - Adolescence</i> .....	8
<b>Early Adulthood: 19 - 35 Years</b> .....	<b>8</b>
<i>Age Specific Interventions – Early Adulthood</i> .....	9
<i>Age Specific Interventions – Middle Adulthood</i> .....	9
<b>Late Adulthood (Geriatric): 61 - 80 Years</b> .....	<b>10</b>
<i>Age Specific Interventions – Late Adulthood</i> .....	10
<b>References</b> .....	<b>11</b>

---

# 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 around strangers.

---

## 8 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 parent 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 parent to respond to cries and to meet the infant's needs consistently. Teach parent to be aware of rapidly changing locomotive ability.

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

### 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.



---

## 2-Year-Old

**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 his or her self. 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 some 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

## 3-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 makeup 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 child with peer companionship.

**Clinical:** Allow child to perform some self-care tasks. Give the child simple, direct, and honest explanations just before treatment or surgery. Use puppets or coloring books to explain procedures. Let the child play with equipment to reduce anxiety. Give the child choices whenever possible. Allow for expression of fear, pain, and/or displeasure. Expect resistant behavior to treatments; reinforce treatments, not punishments. 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 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 actually resemble the intended object like a house or a person and put together larger puzzles (12-20 pieces). The child will day dream 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 enjoys 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 thoughts and behavior.

### Age Specific Interventions - Preschooler

**General:** Encourage expression of fears. Encourage self-care and decision-making when possible. Teach parents to listen to child's fears and feelings. Provide simple explanations. Focus on positive behaviors. Practice definite limit-setting behavior. Offer choices. Allow child to express anger verbally, but limit motor aggression. Teach safety precautions about strangers. Teach parents to be consistent and firm.

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

**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 his or her self 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. Some 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. The school age child will start to evaluate their body image and will be modest about their body. Interest in the opposite 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 very critical of their features and appearance and frequently feel self-conscious. The adolescent will hang out 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 adolescent to maintain control; a major fear is the loss of control. Provide essential teaching based on how the individual learns best. Provide information on pain control methods, the assessment scale, the schedule for pain management, and the need to ask for pain medications as soon as pain begins. Provide information on the degree of pain relief, the types of pain medications, and methods for pain reduction. Use visual aids; be concrete and specific. Relate to the adolescent's abilities.

**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 some 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 other in the plan of care. Watch for body language as a cue for feelings. Allow for as much decision-making as possible. Provide wheelchair access. Provide handicapped parking. Use a language interpreter as needed.

**Clinical:** Explore the impact of hospitalization/illness on work, job, family, and children. Assess for 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 a few wrinkles, some 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, and 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 understands 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 make adjustment to the possibility of retirement and life-style 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 a 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 is little change in IQ. Skills and abilities tend to become obsolete from disuse rather than from deterioration of mental capacity. May experience some 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 temperature, 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 adjunct 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.

---

## References

AGE-SPECIFIC CONSIDERATIONS IN PATIENT CARE, June 2014.

Early Adulthood Development Psychology. 2016. <http://www.allpsychologycareers.com/topics/early-adulthood-development.html>

Late Adulthood Developmental Psychology. 2016. <http://www.allpsychologycareers.com/topics/late-adulthood-development.html>

Middle Adulthood Development. 2016. <http://www.allpsychologycareers.com/topics/middle-adulthood-development.html>

Pathways. 4 – 6 Years. 2016. <https://pathways.org/growth-development/4-6-years/>

“Providing Population-Competence Care.” Massachusetts Department of Higher Education. Accessed July 1, 2019. <https://www.mass.edu/mcnpcs/orientation/m1PopSpecificCare.asp>

Stanford Children’s Health. The Growing Child: School-Age (6 to 12 Years). 2016. [http://www.stanfordchildrens.org/en/topic/default%3Fid%3Dthe-growing-child-school-age-6-to-12-years-90-P02278&sa=U&ei=eMq7VNe218\\_4yQsX-oCwAw&ved=0CEIQFjAI&usg=AFQjCNFn5tO-78ISMzUno4\\_7cO4dCvft1Q](http://www.stanfordchildrens.org/en/topic/default%3Fid%3Dthe-growing-child-school-age-6-to-12-years-90-P02278&sa=U&ei=eMq7VNe218_4yQsX-oCwAw&ved=0CEIQFjAI&usg=AFQjCNFn5tO-78ISMzUno4_7cO4dCvft1Q)

Victoria State Government, Education and Training. Child Health and Development > Learning and Development > Toddlers (1-3 Years). Last Update: 03 June 2016. <http://www.education.vic.gov.au/childhood/parents/health/Pages/toddler.aspx>

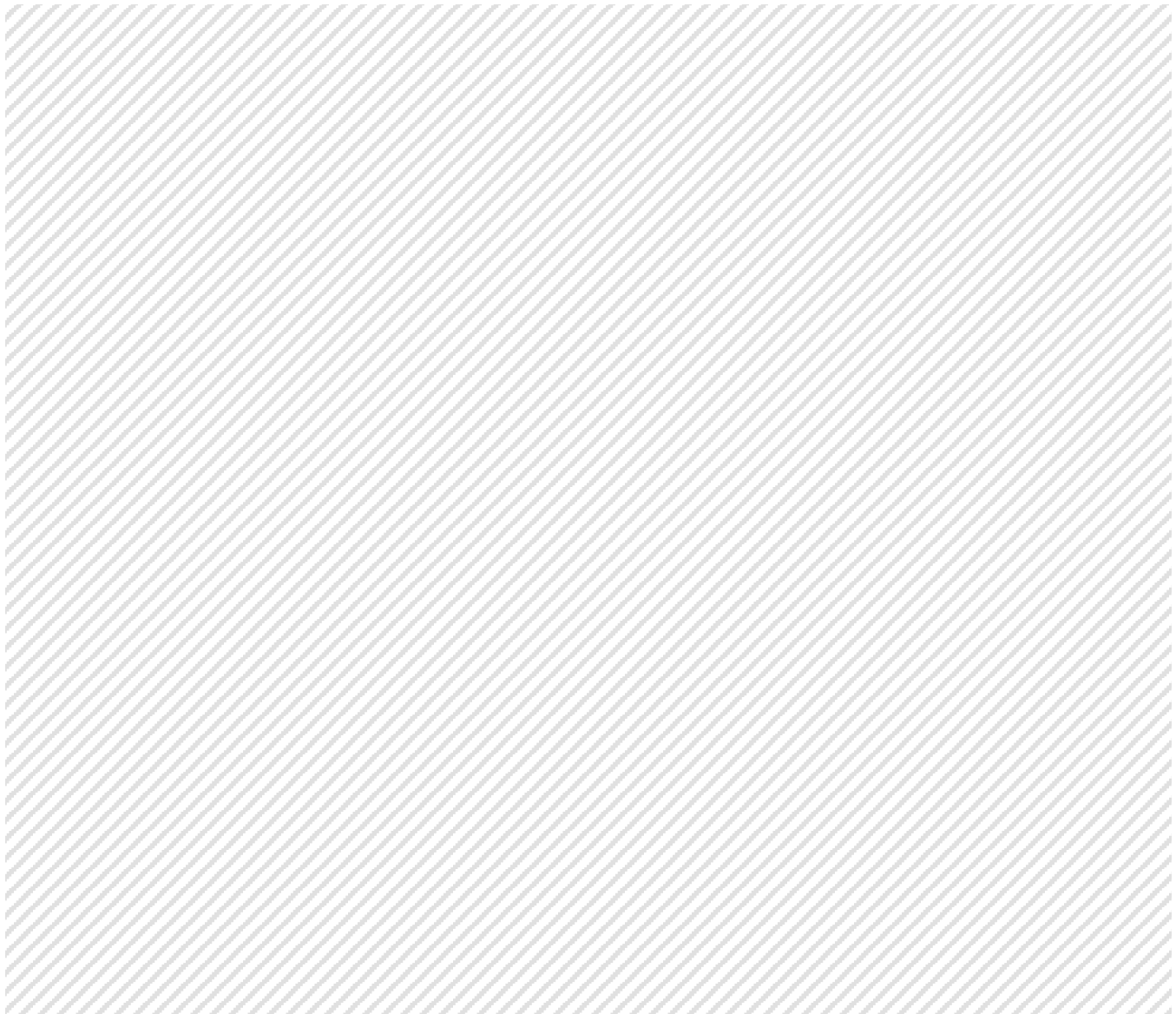
Web MD. 4- to 5-Year-Olds: Developmental Milestones. 2005-2016. <http://www.webmd.com/parenting/guide/4-to-5-year-old-milestones>

Web MD. Childhood milestones age 7. 2009 – 2016. <http://www.webmd.boots.com/children/guide/childhood-milestones-age-7>

# Blood Products Administration

**Inservice**

APRIL 2019



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.



---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Pretreatment Care .....</b>	<b>5</b>
<b>Procedure.....</b>	<b>7</b>
<b>Post-treatment Care.....</b>	<b>9</b>
<b>References .....</b>	<b>13</b>

---

## Introduction

Transfusions of blood and/or blood products can save a patient's life, however there are risks that come with this life-saving measure. Administering an incompatible blood type or administering to the wrong patient can result in long-term complications and potentially lead to death. Understanding both the compatibility and different types of blood and blood products is instrumental in safe transfusion and reducing the risk of harm with incompatibility errors.

### BLOOD TYPE COMPATIBILITY

Donor Blood Type	Recipient Blood type
Blood Type O (universal donor)	Blood Types A, B, AB and O
Blood Type A	Blood Types A and O
Blood Type B	Blood Types B and O
Blood Type AB	Blood Types A, B, AB and O (universal recipient)

Donor RH Group	Recipient RH Group
ONLY Rh-negative RBCs	Rh-negative
Rh-positive or Rh-negative RBCs	Rh-positive

---

## **Blood products that DO require ABO and Rh group crossmatch prior to administering:**

Whole blood is blood with all blood components intact is used to quickly restore or maintain blood volume and oxygen (O<sup>2</sup>) carrying capacity.

Packed red blood cells (RBCs or PRBCs) is whole blood with about 80% of plasma removed; total volume usually 250 milliliters (mL). It is used to sustain or increase O<sup>2</sup> carrying capacity, often as an intervention for blood loss or RBC destruction. Each unit of whole blood or RBCs can raise adult hemoglobin level one gram per deciliter (1 g/dL), equivalent to an increase of 3%. Usually transfused over 1 ½ to 2 hours, as the patient can tolerate, however must complete transfusion within 4 hours.

Leukocyte-poor RBCs is the same as packed RBCs with about 95% of the leukocytes removed; total volume about 200 mL. This product is generally administered to patients who have had a febrile, nonhemolytic transfusion reaction (See Transfusion Reactions) that is caused by the WBC antigens in a transfused blood component reacting with the patient's WBC antibodies or platelets or for treatment of symptomatic anemia in immunocompromised patients

White blood cells (WBCs or leukocytes) is whole blood with both RBCs and 80% of plasma removed; total volume about 150 mL. WBCs are used to treat sepsis unresponsive to antibiotics (especially if the patient has positive blood cultures or a persistent fever exceeding 101° F [38.3° C] and granulocytopenia [granulocyte count usually less than 500/microliters (μl)]). White blood cell transfusions cause febrile transfusion reaction. Due to limited evidence that WBC transfusions are effective, and to the risk of transmission of infectious diseases such as cytomegalovirus (CMV), WBCs are not commonly in use.

Platelets is platelet sediment from RBCs or plasma that has been separated from whole blood or blood during apheresis and can be pooled from multiple donors; total volume 35 to 50 mL/ unit; 1 unit of platelets is expected to increase adult platelet count by 20-40 x 10<sup>9</sup>/Liter (L). Platelets are indicated in thrombocytopenia, high volume transfusion of stored blood, leukemia, and preoperatively in low platelet count. Can transfuse as quickly as the patient tolerates, however must be less than 4 hours.

Plasma (FFP or fresh frozen plasma) is a blood component that is separated and frozen after donation and contains coagulation factors such as factors V, VIII and IX and other proteins. The total volume is 200-250ml Plasma is used to reverse effects of warfarin, treatment of thrombocytopenia and to reverse coagulopathy results on patients prior to an invasive procedure, such as patients with End-stage liver disease requiring dental

---

extractions. The effectiveness on reversing coagulopathy is short-lived and declines by 50% within 2-4 hours of transfusion. Therefore, coordination with the procedure area is important to ensure effectiveness of transfusion and patient safety during the invasive procedure. *Note: It is no longer used for volume expansion, as prophylaxis after cardiac surgery, or with high volume blood transfusions.* Administration is usually over 30 to 60 minutes

## Blood products that DO NOT require type and crossmatch

Cryoprecipitate (Cryo or cryoprecipitated antihemophilic factor) contains concentrated levels of fibrinogen, factor VIII, von Willebrand factor, factor XIII and fibronectin. FFP is thawed, then the precipitate is recovered. Refreezing must occur within 1 hour of collection. Cryo is used in the treatment of patient with either factor or fibrinogen deficiencies, dysfibrinogenemia and Willebrand disease. Administration is usually over 15-30 minutes.

Albumin 5% (buffered saline) and albumin 25% (salt-poor saline) is small plasma protein prepared by fractionating pooled plasma; total volume of 5% product is 12.5 g/250 mL; total volume of 25% product is 12.5 g/50 mL. Albumin is indicated as a volume expander in shock, burns, trauma, and infections; and to treat hypoproteinemia (with or without edema).

Factor VIII is the insoluble portion of plasma recovered from FFP; total volume about 30 ml (freeze-dried). Most recognizable as a treatment for hemophilia A, it is used to control bleeding associated with factor VIII deficiency, and to replace fibrinogen or deficient factor VIII.

Factors II, VII, IX, and X complex (prothrombin complex) is lyophilized (freeze-dried), commercially prepared solutions drawn from pooled plasma. Factors II, VII, IX, and X are indicated for various factor deficiencies that cause bleeding disorders. *Note: These products are contraindicated in patients with fibrinolysis secondary to hepatic disease or in patients with disseminated intravascular coagulation and are not receiving heparin therapy.*

Alternatives volume expanders include normal saline or lactated Ringer's solution, albumin or purified protein fractions, hydroxyethyl starch or dextrans.

## Pretreatment Care

### PATIENT Teaching

One of the hallmarks of safe, effective and high-quality care is patient teaching. Prior to transfusing, the healthcare provider should explain the procedure to ensure that the patient understands the transfusion procedure. This teaching includes risks and benefits of transfusion, signs and symptoms of reaction, including delayed reactions, and when to notify health care provider.

---

**The patient's teaching plan should include:**

- Sequence of expected events: reason for the transfusion, Vital signs and other monitoring, expectations after transfusion
- Benefits of transfusion
- Risks associated with the transfusion
- Signs and Symptoms of Complications: vague, uneasy feeling; chills, flushing, fever, nausea, dizziness, rash, itching, pain (IV site, back or chest)

**Teach the patient to immediately report the following complaints to the nurse:**

- Flushing, feverish feeling, chills, nausea, headache (transfusion reaction)
- Palpitations (with hypotension, arrhythmia, and shaking chills; may be sign of hypothermia)
- Difficulty swallowing or breathing (possible anaphylaxis)
- Tingling in the fingers, muscle cramps, nausea and vomiting, faintness (with hypotension, arrhythmia, and seizures; may signal hypocalcemia from citrate toxicity or liver impairment)
- Intestinal colic, diarrhea, muscle weakness (with irritability, oliguria, T-wave changes on the electrocardiogram, and bradycardia; may signal hyperkalemia from large-volume transfusions).

**Additional teaching and information:**

- Explain to the patient that additional transfusions may be needed and that specimens may be drawn to evaluate the effectiveness of therapy.
- Ensure that informed consent has been given according to your organization's policies.
- Monitor baseline and ongoing vital signs according to policy.
- All Blood products should be transfused within 30 minutes of obtaining the blood product from the lab. Never store blood products at the point of care. Return the blood to the lab for storage if the procedure will be delayed by 30 minutes or more. Blood and blood products transfusions are completed as the patient can tolerate however no longer than 4 hours. There is a risk of bacterial proliferation in the blood component at room temperature, therefore the infusion time should not exceed 4 hours.
- For multiple unit transfusions, the administration set, and filter is changed after each unit or after 4 hours\* Should be changed immediately if there is a suspected contamination or compromise in the product or system.

**The Joint Commission's National Patient Safety Goals require that one of the two following verification systems be used:**

- 2-person process in which one person is qualified to administer the blood product and the other person is qualified to participate in the verification process, as determined by organization standards.

- 
- 1-person process in which the verifier is qualified to administer the blood product and verification includes an automated technology such as bar coding. Note: if using technology as the 2<sup>nd</sup> verifier, understand technology is a tool and should not take the place of what a prudent clinician would do.

### **Before initiating a blood or blood component transfusion:**

- Match the blood or blood component to the order
- Match the patient to the blood or blood component
- Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding
- Check the expiration date
- Examine for anomalous appearance (color, foreign objects, bubbles)
- Match the patient's name and medical record number on the ID band with those on the on the blood product bag label.
- Ensure the appropriate blood product, and if applicable, the ABO blood group, and Rh compatibility.
- Match the patient's blood bank identification number with that on the blood bag.

## Procedure

### ***Setup, verification, and administration***

- Don appropriate personal protective equipment (PPE).
- Verify patient identity using institutionally approved criteria such as name and date of birth. A patient's room number is not acceptable
- Confirm IV patency or start an IV, 20 Gauge (G) or larger and in children or older patients, no larger than 20G.
- Flush IV line with saline before (and after) transfusion and keep the vein open between transfusions. Note: Only isotonic saline is suitable for an IV that will be used to transfuse blood products. Ensure that no additives are present. For example, calcium can cause clotting in the IV tubing, and glucose can hemolyze blood cells.
- An infusion pump and blood warmer may be ordered. Note: Take Caution if administering via gravity, to ensure that the administration rate of the blood component is a within the 2-4 hours.

Verify the appropriate blood or blood component with the doctor's order and verify the patient to the blood component. One verifier must be the appropriately qualified person who will administer the blood component. The second verifier must be appropriately qualified, whether technology or another person to conduct the verification

- Generally, verification of the blood product includes these steps:
  - Match the patient wristband name and identification number to the blood bag label.
  - Confirm the blood bag identification number, ABO blood group, and Rh compatibility.
  - Match the patient's blood bank identification number with the number on the blood bag.

---

*The Joint Commission's National Patient Safety Goals require that one of the two following verification systems be used:*

---

*2-person process in which one person is qualified to administer the blood product and the other person is qualified to participate in the verification process, as determined by organization standards.*

---

*1-person process in which the verifier is qualified to administer the blood product and verification includes an automated technology such as bar coding.*

---

- Obtain a baseline set of vital signs prior to the initiation of the transfusion. Monitor the patient closely and adjust the flow rate to no greater than 2 mL/minute for the first 15 minutes of the transfusion to observe for a possible transfusion reaction. Most reactions occur within the first 15 minutes, therefore, remain with the patient and reassess his vital signs and blood pressure, facial color, and any complaints frequently for the first 15 minutes, according to facility policy.
- If signs of a reaction develop, stop the transfusion and record the patient's vital signs. Infuse normal saline solution through a new I.V. line at a deep-vein-open-rate and notify the physician. Save the blood product bag for return to the blood bank. Obtain a urine and blood sample and send them to the laboratory.
- If no signs of a reaction appear within 15 minutes, adjust the flow to the ordered infusion rate, which should be as rapid as the circulatory system or patient can tolerate.
- After completion, flush the administration set and I.V. catheter with normal saline. Remove and discard the infusion equipment and reconnect the original I.V. fluid if necessary
- Discard the blood bag, tubing, and filter in the appropriate hazardous waste container.
- Monitor and assess the patient for 1 hour after the transfusion for signs and symptoms of delayed transfusion reaction.
- Procedural variations for specific blood products
  - **Whole blood and PRBCs:** Use a Y-type I.V. set with a 170-micron filter. Alternatively, a 20-40-micron filter is sometimes ordered. Tubing may be primed with normal saline per institutional policy or tubing manufacturer recommendations
  - **Leukocyte-poor RBCs:** Use a straight-line or Y-type I.V. set. Infuse blood over 1½ to 4 hours. Use a 40-micron filter suitable for hard-spun, leukocyte-poor RBCs.
  - **WBCs (not commonly in use):** Use a straight-line I.V. set with a standard in-line blood filter. Provide 1 unit daily for 5 days or until the infection resolves. Because a WBC infusion induces fever and chills, administer an antipyretic if fever occurs. Don't discontinue the transfusion; instead, reduce the flow rate, as ordered, for patient comfort. Agitate the WBC container to prevent settling, thus preventing the delivery of a bolus infusion of WBCs. Diphenhydramine (Benadryl) will likely be administered prior to transfusion of WBCs.
  - **Platelets:** Use component drip administration set to infuse 100 mL over 15 minutes. As prescribed, pre-medicate with an antipyretic and an antihistamine if the patient's history includes a platelet

---

transfusion reaction. If the patient has a fever before administration, notify the practitioner for probable delay of the transfusion.

- **FFP:** Use a straight-line I.V. set, and administer the infusion rapidly. Note: Caution if administering several units in fluid compromised patients such as Heart Failure or Liver failure patients. There is an increased potential to exacerbate the volume overload status in these compromised patients. A slower rate of transfusion may be warranted.
- **Albumin:** Use a straight-line I.V. set with rate and volume dictated by the patient's condition and response. Albumin is contraindicated in severe anemia. Keep in mind that albumin is contraindicated in patients with severe anemia. Use caution when administering to patients with liver, cardiac or pulmonary disease due to potential circulatory overload.
- **Factor VIII:** Use the administration set supplied by the manufacturer. Administer with a filter; the standard dose recommended for the treatment of acute bleeding episodes in patients with hemophilia is 15 to 20 units/kg.
- **Factors II, VII, IX, and X complex:** Use a straight-line I.V. set, basing the dose on the desired factor level and the patient's weight. Coagulation assays are drawn prior to administration and at intervals throughout treatment.

## Post-treatment Care

- Change the blood or blood administration set and filter after each unit or as needed to ensure sterility and/or system integrity. If evidence of bleeding or reactivity develops at the I.V. site, discontinue the transfusion and the IV and notify the prescriber. Follow your facility's policy for treatment of the reaction site.
- Monitor I&O, and signs of fluid overload such as lung status and edema.
- After completing the transfusion, adhere to standard precautions and remove and discard the used infusion equipment in the biohazard material receptacle. Reconnect the original I.V. fluid, if necessary, or discontinue the I.V. infusion. Return the empty component bag to the blood bank, if facility policy dictates.
- Record the patient's vital signs.
- Prepare to draw blood for a repeat of blood count p, as ordered, 1 hour after administration of the blood component to determine transfusion increment.

*Keep in mind that large-volume transfusions of FFP may require correction for hypocalcemia because citric acid in FFP binds calcium. If transfusing to correct INR for an invasive procedure, the correction of the coagulation factor is short-lived about 2-4 hours, therefore the procedure and transfusion should be coordinated to ensure patient safety and efficacy of the transfusion.*



---

*The half-life of factor VII is 8 to 10 hours, which necessitates repeated transfusions at specified intervals to maintain normal levels.* Blood transfusion reactions

**Stop the transfusion in the event of a reaction.**

Organization standards differ, but generally, when any evidence of a transfusion reaction occurs, stop the transfusion immediately, and maintain a patent IV access with saline solution. Follow your organization standards for specific practices regarding IV flushing and admin set replacement practices, lab tests, and vital signs. Adverse effects or transfusion reactions occur in an estimated 5%-6% of patients who receive blood or blood products.

**Transfusion reactions occur with a variety of symptoms and severity. Transfusion reactions are grouped as follows:**

- Transfusion-related acute lung injury (TRALI)
- Transfusion Associated Circulatory overload
- Bacterial contamination
- Acute hemolytic transfusion reaction (immune or nonimmune related)
- Nonhemolytic febrile transfusion reaction
- Allergic reactions

## Transfusion-related acute lung injury (TRALI)

Though relatively rare, less than 1 in 5,000, TRALI is the number one cause of death from transfusion reaction. Histamines are released due to the granulocyte antibodies in the donor or recipient causing a reaction that impairs breathing. Male-donated blood reduces the risk of TRALI to some extent.

Patients whose reactions are mild to moderate are treated with O<sub>2</sub> and blood pressure support as prescribed. The healthcare provider should prepare for the possibility of intubation and mechanical ventilation as needed while the lungs recover.

**Symptoms:**

- Shortness of breath of rapid onset
- Hypoxemia
- Rales
- Absence of signs of acute pulmonary edema
- No fever

## Transfusion-associated Circulatory overload(TACO)

---

Many patients, especially those with compromised cardiac, liver or kidney function have difficulty tolerating the additional or rapid infusion of fluid volume of a transfusion. Reactions are similar to those of heart failure, such as edema and/or dyspnea. Cardiac patients are generally transfused more slowly. Patients with evidence of fluid overload reaction are often treated with diuretics.

**Symptoms:**

- Shortness of breath
- Hypoxemia
- Rales
- Orthopnea
- Tachycardia
- Jugular venous distention
- Crackles at lung bases
- Dependent edema

## Bacterial contamination

Though blood products are tested carefully, infections cannot always be detected, especially where the donor was infected shortly before giving blood. Treatment is as for any sepsis.

**Symptoms:**

- High fever (temperature increase of 3.5-degree F or more)
- Chills
- Vomiting
- Diarrhea
- Marked hypotension
- Weak pulse
- Rigors

## Acute Hemolytic reaction

Subtle mismatches between host and donor blood (as well as occasional treatment errors) can result in the destruction of the donor's red blood cells during or after the transfusion. Along with TRALI, this type of reaction has the highest death rate.

The patient may experience vague anxiety or discomfort, dyspnea, flushing, back pain, or chest pressure.

Usually, this reaction starts as general discomfort or anxiety during or immediately after the transfusion. Severe shock can result, and this reaction can be fatal. As soon as this reaction is detected, the transfusion is stopped, and the patient is supported according to the symptoms. A delayed hemolytic reaction usually occurs 5-10 days after transfusion but can occur up to a month after transfusion, though these are usually mild. Delayed hemolytic reactions should be monitored via laboratory tests for anemia and potential for a reduced benefit

**Symptoms**

- 
- Fever
  - Hypotension
  - Flushing
  - Wheezing
  - Anxiety
  - Red-colored urine
  - Disseminated intravascular coagulation (late)

## Nonhemolytic febrile transfusion reaction

Fever is the most common transfusion reaction and is likely a response to transfused WBCs or their metabolic products. Chills, headache, back pain sometimes accompany fever. Generally, acetaminophen is the only treatment needed. For purposes of whether or not stop a transfusion when a patient's temperature elevated, standards vary. Generally, when no other symptoms are present, a transfusion should be stopped when temperature elevates more than 1 degree C or 2 degrees F.

### Symptoms

- Fever ( temperature increase of 2 degrees F or more) that occurs during or shortly after a transfusion
- Chills

## Allergic reactions

Allergic reactions are almost as common as febrile reactions. Some patients react to donor blood with classic allergic reaction symptoms such as itching, swelling, urticaria and other skin rashes, dizziness, and headache. Administering antihistamines and reducing the rate of transfusion can treat mild allergic reactions Allergic reactions may be severe as well and cause breathing problems, hypotension and shock. Epinephrine, as prescribed, should be administered for anaphylactic reactions. In the event of an allergic reaction, whether mild or severe, the transfusion is stopped immediately, and the patient is treated according to symptom presentation.

Washed red blood cells can be given to patients who have a history of allergic reaction to transfusion. Washed RBCs have reduced amounts of WBCs and platelets.

### Symptoms

- Urticaria
- Itching, maculopapular rash
- Flushing
- Asthmatic wheezing
- Anaphylaxis

---

## Posttransfusion purpura

Posttransfusion purpura is a sudden and dramatic thrombocytopenia. The patient is sensitized to blood or blood product transfusions due to pregnancy or previous transfusions. The reaction usually occurs 7- 10 days after the transfusion. The treatment includes administration of high-dose immune globulin IV (IVIG) and monitoring of the patient's platelet count.

## References

American Red Cross. (2013, Jun). *Blood Facts and Statistics*. Retrieved Nov Nov, from American Red Cross:  
<http://www.redcrossblood.org/learn-about-blood/blood-facts-and-statistics>

Nobelprize.org. (2013). *The Blood Typing Game*. Retrieved Nov 2015, from Nobelprize.org:  
<http://www.nobelprize.org/educational/medicine/bloodtypinggame/game/index.html>

UpToDate. (n.d.). *Approach to the patient with a suspected acute transfusion reaction*. Retrieved Apr 2016, from UpToDate.

US Department of Health and Human Services. (n.d.). *Blood transfusion: indications, administration and adverse reactions*. Retrieved Mar 2015, from National Guideline Clearinghouse:  
<https://www.guideline.gov/summaries/summary/34955?>

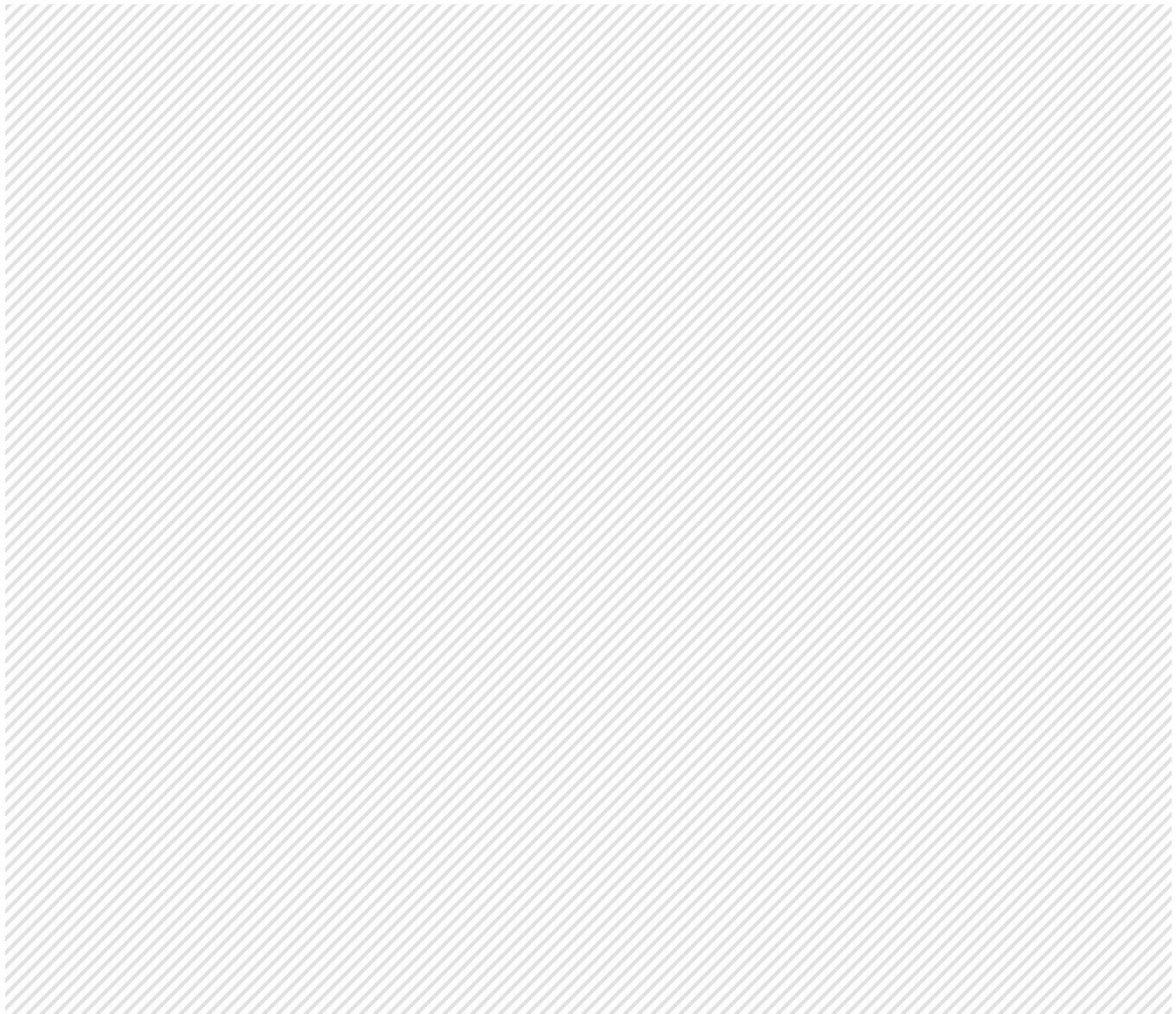
Lippincott Procedures Manual (2018) Blood and blood product transfusion, Retrieved July 2019  
<https://procedures.lww.com/lnp/browse.do?disciplineId=5312#/all>

Lippincott Procedures Manual (2018) Blood and blood product transfusion reaction management, Retrieved July 2019  
<https://procedures.lww.com/lnp/browse.do?disciplineId=5312#/all>

# Body Mechanics

## Core Competency In-service

December 2018



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Body Mechanics.....</b>	<b>3</b>
<b>Contributing Factors to Back Injuries .....</b>	<b>4</b>
<b>Tools to Help in Moving Patients and Materials .....</b>	<b>4</b>
<b>Injured worker’s responsibilities.....</b>	<b>5</b>
<b>References.....</b>	<b>5</b>

---

# Body Mechanics

## Back Facts

- Statistics show that 8 out of 10 people will experience back pain at some time in their lives. 80% of on-the-job injuries are back injuries.
- Once you have sustained an injury, your chances of recurrence are much higher.
- You perform many tasks every day that could cause back injury. These include repetitive lifting, prolonged standing, bending, reaching, pushing, and pulling. Protect your back by using good body mechanics.

## Basic Principles of Good Body Mechanics

- Maintain a wide base of support.
- You are more stable when you separate your feet and simply turn your toes out. By widening your base of support, you can improve your balance and ability to maintain stability.
- Keep your back straight.
- When lifting keep the back straight and bend at the hips and knees. This will place most of the weight force on your legs keeping your back safe from strain.
- Lower your center of gravity.
- Your center of gravity is the point at which your weight is centered. You can lower your center of gravity by bending your hips and knees slightly and keeping the load at waist level.
- Keep the load close to you.
- The work required to hold a three-pound weight out at arm's length is almost three times as much as it is holding it close to your body.
- Pivot the body, never twist the spine.
- When transferring never twist at the waist as this could cause spinal injury. Always pivot the entire body when lifting to transfer a patient.
- Push or pull to slide when possible.
- It is always preferable to slide something heavy by pushing or pulling it rather than lifting something heavy. If you have a choice between the two pushing is preferable because it uses the entire body as opposed to a select group of muscles.

Common Mechanisms of Injury and How to Prevent Them	
MECHANISM OF INJURY	PREVENTION

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

## Contributing Factors to Back Injuries

- Bending or twisting
- Reaching out and/or up
- Prolonged holding, sitting, standing, stooping
- Too much force (e.g., heavy patients)
- Abrupt motions (e.g., stopping falls)

## Tools to Help in Moving Patients and Materials

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

- **Gait belts:** Help the health care provider safely stabilize a patient when ambulating or transferring.
- **Sliding boards:** Will help slide or scoot a patient from one position to another (E.g. From the bed to the chair).
- **Mechanical lifts:** Will lift and transfer a patient from one position to another without requiring the health care provider to lift at all. (E.g. From the chair to the bed).
- **Draw sheets:** Are used to help slide a patient from one position to another. (E.g. Slide up the bed or over to a stretcher).



- 
- **Carts:** Are used to carry and transfer heavy equipment.
  - **Stretchers:** Are used to help move patients from one location to another. (E.g. Transfer from one floor to another).

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

## Injured worker's responsibilities

- Report the injury or illness to your supervisor immediately. Under all circumstances, the reporting **MUST** be made during the shift on which the incident, injury, or illness occurs.
- If necessary, seek medical treatment.
- Complete an incident report immediately.
- Stay in touch with your supervisor and human resources.

## References

Healthcare Wide Hazards, Ergonomics OSHA Safety and Health Topics Page. Accessed Nov. 2014 [WWW.Osha.gov](http://www.Osha.gov)

<https://www.wcf.com/body-mechanics-healthcare-staff> WFC Insurance. Body Mechanics for Healthcare Staff. 2016.

<http://preferredregistry.com/using-good-body-mechanics/> Preferred Health Care Staffing. Using Good Body Mechanics. February 28, 2013.

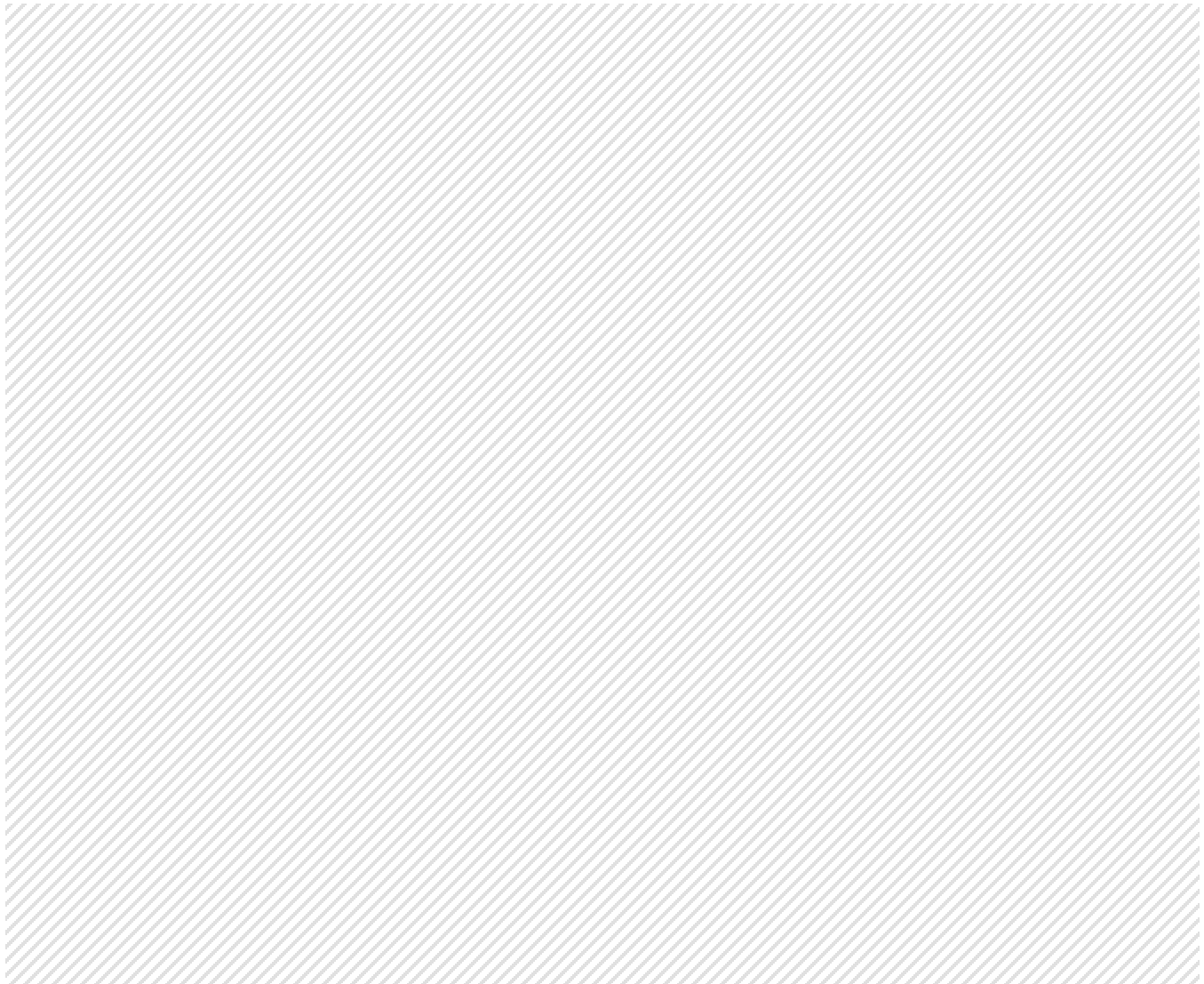
[http://www.mccn.edu/library/patienteducation/duplicatenetip\\_/patienteducatio\\_/safetyandlegal\\_/gaitbeltsafeuse/GaitBelt-SafeUse.pdf](http://www.mccn.edu/library/patienteducation/duplicatenetip_/patienteducatio_/safetyandlegal_/gaitbeltsafeuse/GaitBelt-SafeUse.pdf) Mount Carmel. Gait Belt – Safe Use. 11/2014.

<http://www.vdh.virginia.gov/mrc/WTMRC/documents/pdf/Slide-Board.pdf> Medical Reserve Corps. How to Use a Sliding Board. 2016.

# Care Planning

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

What is a Care Plan .....	3
Developing a Plan of Care.....	3
Interdisciplinary Plan of Care.....	4
Reference .....	4

---

# 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 health 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 are involved in the care of the patient/resident

## Developing a Plan of Care

Plans of care are generally 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 personal 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 are involved 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.

## Reference

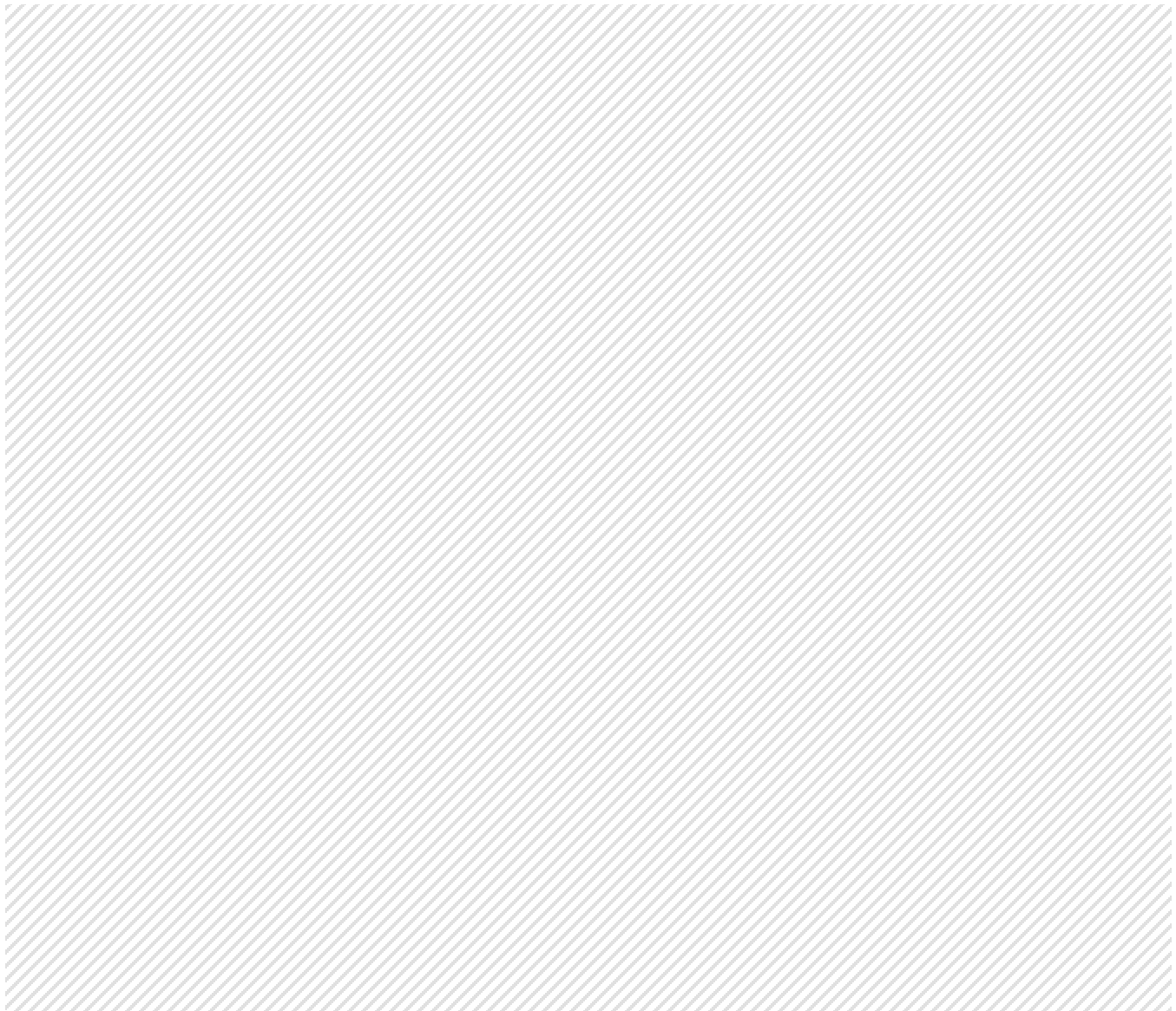
“Interdisciplinary Care Plans: Teamwork Makes the Dream Work.” Lippincott Solutions. September 6, 2018. <http://lippincottsolutions.lww.com/blog.entry.html/2018/09/06/interdisciplinaryca-z601.html>

“Nursing Care Plans: What You Need to Know.” Nurse.org. January 8, 2018. <https://nurse.org/articles/what-are-nursing-care-plans>.

<http://www.rncentral.com/nursing-library/careplans/> RN Central. What Is A Nursing Care Plan and Why is it Needed? 2003 – 2016.

# Compliance (Fraud, Waste and Abuse) Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Benefits of a Good Compliance Program.....</b>	<b>3</b>
<i>How are Individuals Involved .....</i>	<i>4</i>
<i>What Should be Reported .....</i>	<i>4</i>
<b>Fraud, Waste and Abuse in the Medicare Program.....</b>	<b>4</b>
<i>Fraud .....</i>	<i>4</i>
<i>Waste .....</i>	<i>5</i>
<i>Abuse.....</i>	<i>5</i>
<b>Civil False Claims Act (FCA) .....</b>	<b>5</b>
<b>What do I do when issues arise? .....</b>	<b>6</b>
<b>References.....</b>	<b>1</b>

---

# 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 relate 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 up front, honest, and respectable they are required to have a formal Compliance Program. Medicare/Medicaid (CMS) believes that the establishment of an effective compliance program will protect the Medicare Trust Fund by significantly reducing the risk of unlawful or improper conduct and will likely lead to other efficiencies. The CMS program is structured on a seven-point plan. Each provider's plan must include:

- 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 conducts business in an ethical manner and is committed to quality customer/patient care
- Increase the potential of proper submission and payment of claims
- Reduce billing mistakes
- Improve the results of reviews conducted on Medicare claims
- Avoid the potential for fraud, waste and abuse
- Promote patient safety and ensure delivery of high-quality patient care



---

## How are Individuals Involved

Individuals can make the choice 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 doesn't follow proper procedure, they can end up injuring a patient or another staff member. Ultimately, 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 Statue 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 up to 10 years and is subject to criminal fines 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 generally not considered to be caused by criminally negligent actions but rather 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
- Carries out 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:** Person who bring a successful whistleblower lawsuit receive 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 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 have 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 doesn't resolve an issue, continue reporting the issue in this order:**

- Go to the floor supervisor
- 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 quality of care or safety, you then have the right to call The Joint Commission, Department of Health, CMS, or any other regulatory agency of the facility.

## References

Medicare Fraud and Abuse: A Serious Problem that Requires Your Attention, Accessed Nov 2014.

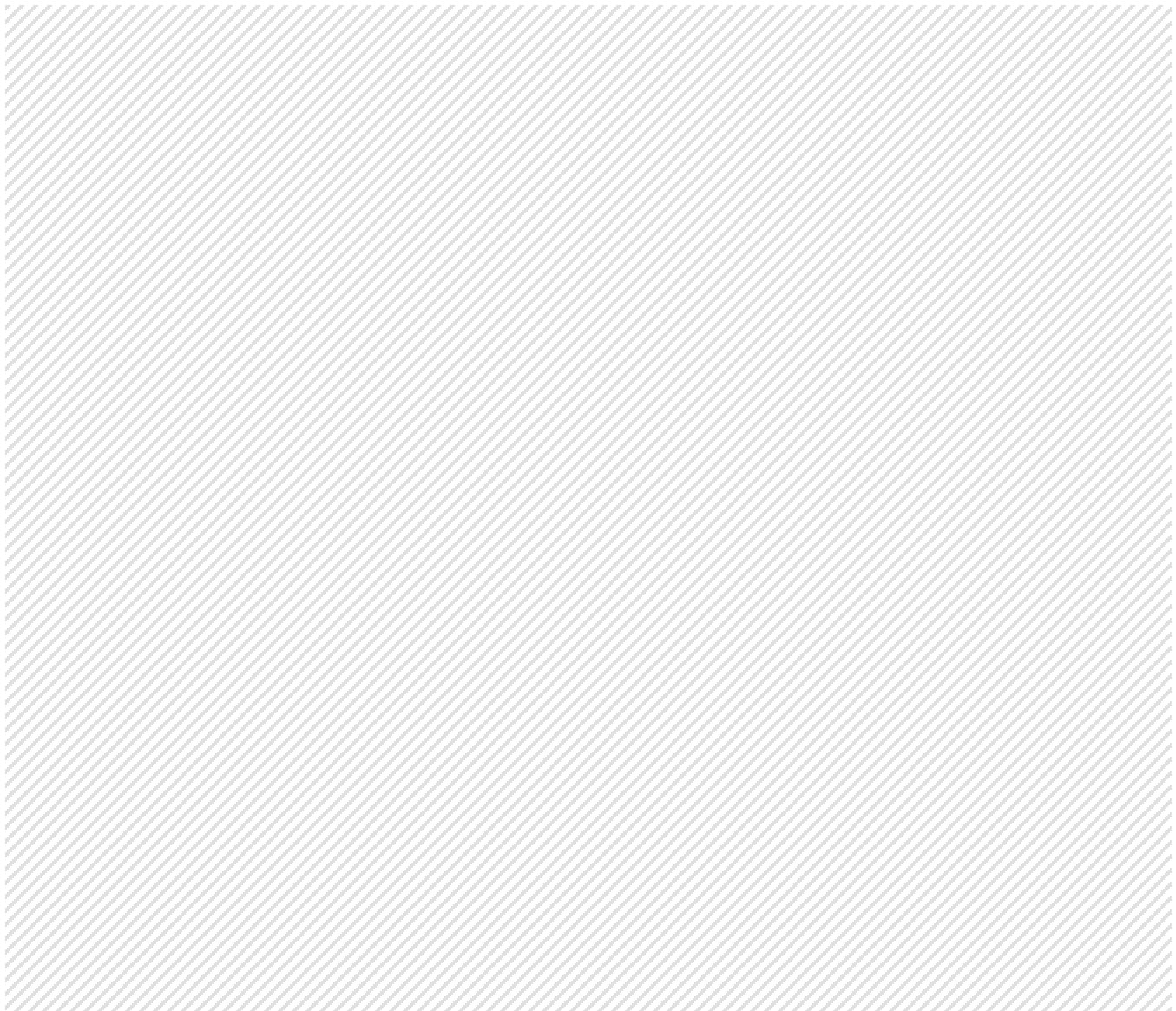
"Medicare Parts C and D General Compliance Training." CMS.Gov. January 2019.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWDownload.pdf>

# Coronavirus (COVID-19)

## Core Competency Inservice

March 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<i>Patients .....</i>	<i>3</i>
<i>Symptoms.....</i>	<i>3</i>
<b>Infection Prevention .....</b>	<b>3</b>
<i>Spread of Virus .....</i>	<i>3</i>
<i>Infection Control Procedures.....</i>	<i>4</i>
<i>Patients .....</i>	<i>4</i>
<i>Standard and Transmission-Based Precautions.....</i>	<i>5</i>
<i>Implement Environmental Infection Control.....</i>	<i>7</i>
<b>Resources for Healthcare Facilities and Personnel.....</b>	<b>7</b>
<b>References.....</b>	<b>7</b>

---

## Introduction

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China. COVID-19 is spreading from person to person across the globe. Risk of infection with COVID-19 is higher for people who are in close contact of someone known to have COVID-19, for example healthcare workers, or household members. Other people at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.

### Patients

The first case of COVID-19 in the United States was reported on January 21, 2020. The current count of cases of COVID-19 in the United States is over 1000. 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 have had mild to severe respiratory illness with symptoms of:**

- Fever
- Cough
- Shortness of breath

Some patients have pneumonia in both lungs, multi-organ failure and in some cases death.

## Infection Prevention

### Spread of Virus

There is currently no vaccine to prevent coronavirus disease 2019 (COVID-19). The best way to prevent illness is to avoid being exposed to this virus.

- The virus is thought to spread mainly 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 possibly 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.

## Infection Control Procedures

Healthcare facilities must focus on identifying, isolating and informing on new cases of patients known or suspected of having the virus.

## 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.

1. 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 spread of COVID-19 on CDC’s website.
2. Ensure proper use of personal protection equipment (PPE). Healthcare personnel who come in close contact with confirmed or possible patients with COVID-19 should wear the appropriate personal protective equipment.
3. Conduct an inventory of available PPE. Consider conducting an inventory of available PPE supplies. Explore strategies to optimize PPE supplies.
4. 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 (i.e., putting a face mask on patients presenting with symptoms of respiratory 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, fever<sup>1</sup>) 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).
  - a. 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.
  - b. HCP who enter 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 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.

## 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 a 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.

## References

About coronavirus disease 2019 (COVID-19). Accessed March 2020. <https://www.cdc.gov/coronavirus/2019-ncov/about/index.html>

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Accessed March 2020  
<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?>

Talking Points: Hospitals and Health Systems – COVID 19 Response. (March 2020).  
<https://www.aha.org/system/files/media/file/2020/03/talking-points-hospitals-and-health-systems-covid-19-response-3-3-2020.pdf>

## How to Use this Syllabus

- Review the entire syllabus, including the Glossary and the linked videos and articles.
- Leave the syllabus open while you answer the test questions.
- Look over the Table of Contents. Note that:
  - Mousing over a Lesson title allows you to left-click and go to that Lesson.
  - The bottom of each page displays the page number and Lesson title.
- Hold down the 'Ctrl' key while pressing the 'F' key to view a 'Find' dialog box.
  - Type in a key word or phrase to find it in the text.
  - Remember that 'Find' will find all instances of the word or phrase in the entire document. Before using 'Find', consider navigating to the proper Lesson first, in order to be as close as possible to the information you want to 'Find'.

**IMPORTANT NOTE on the limitations of this material:** This content is not localized to a particular healthcare environment, system, or entity. Since local system and administrative processes are crucial to patient safety, it is imperative that the learner be familiar with local, facility/entity practices such as: policies and procedures, equipment, patient identification and validation procedures, communication and handoff practices, etc. Adhere to your organization's policies and procedures.

This course contains two sections: Verbal Crisis Management and Managing Assaultive Behavior. Please read material for both sections prior to taking the exam.

## Contents

How to Use this Syllabus .....	1
Crisis Intervention .....	2
Introduction.....	2
Limitations of this course .....	3
Definitions .....	3
Core Precepts of Verbal Crisis Management .....	4
Prepare Yourself to Be a Responder .....	4
Maintain emotional and behavioral control .....	4
Professional distancing.....	6
Prevent, Recognize, and Deescalate Crises.....	6
Crisis stages—from equilibrium to crisis and back again .....	6
Equilibrium .....	7
Tension Building .....	7

## Crisis Intervention and Managing Assaultive Behavior

Crisis 1 .....	8
Crisis 2 .....	9
Release .....	10
Recovery.....	10
Motivating Persons in Crisis and Building Trust/Rapport .....	11
Body language .....	11
Verbal interventions.....	12
Providing choices enabling the learner to control his/her emotional responses and behavior .....	12
De-escalation tactics .....	12
Debriefing.....	13
Conclusion .....	14
References.....	14
Managing Assaultive Behavior .....	15
What is workplace violence?.....	15
Risk factors .....	17
Prevention of Violent Incidents.....	18
Diffusion of Violent Incidents.....	20
Response to Violent Incidents.....	24
Protect yourself!.....	24
Avoiding and escaping common types of physical assault .....	25
After the violent incident .....	26
References.....	26

## Crisis Intervention

### Introduction

This course is intended as an introduction to ‘crisis management’ for professional and paraprofessional healthcare workers. A ‘crisis’ is a situation in which a patient is experiencing a serious emotional and behavioral event that could result in physical and/or psychological harm to themselves or others.

‘Management’ is the tactics discussed in this course for preventing, recognizing, and deescalating those crises.

Though patient crises is the primary focus of this content, these de-escalation tactics can apply as well to crises experienced by co-workers, patient family members, and visitors. The audience for

## Crisis Intervention and Managing Assaultive Behavior

this course includes the broadest range of healthcare roles and potential situations for encountering people in crisis. For these reasons, the term 'individual' is substituted for 'patient' when referring to a person experiencing a crisis.

### Limitations of this course

#### Organizational context

This introductory course addresses content that cannot stand outside the context of the learner's own work role. Much of crisis management in the healthcare setting is based on the organization's policies, plans, and training at all levels and departments. What the healthcare worker can and should do must be determined within the context of work role in that particular situation and department.

#### Personal context

And this content cannot stand outside the context of the learner's own motivation, emotional makeup, and experience. The information presented here will not prepare the learner to function effectively.

Rather, the learner will be able to incorporate the information presented here into their own plan for developing the cognitive and behavioral skills needed to manage crises in their work role. Self-awareness, emotional control, active listening, verbal intervention, and offering choices are skills that are, ideally, learned through mentored experience on the job.

#### No discussion of physical holds, escapes, restraints, etc.

This introduction does not include critical information about what to do when verbal de-escalation fails and when physical intervention may be necessary to the safety and security of individuals and care providers. Physical intervention content is beyond the scope of this course. Generally, physical interventions are best introduced as simulations in a live setting.

### Definitions

The following are operational definitions pertaining to the specific subjects and methods taught in this course.

#### Crisis

A physical and emotional response to a disruptive life event, e.g., anything from a stubbed toe to the death of a spouse. The crises discussed here are those which occur when the individual is overwhelmed, unable to cope, and **responds in a way that is potentially harmful to themselves and others.**

#### Crisis management

The prevention, recognition, and de-escalation of individuals experiencing a crisis.

### Crisis intervention

The Responder's verbal and non-verbal methods discussed here which decrease the individual's risk of harm to self or others. The Responder assesses the situation and offers verbal interventions and choices that mitigate the extreme emotions and behaviors of the person in crisis.

### De-escalation

Verbal and non-verbal methods of interacting with an individual in crisis in order to help that individual manage their own emotions and behavior.

### Responder

The person responsible for deescalating the crisis and ensuring the safety and security of themselves and other.

## Core Precepts of Verbal Crisis Management

The following is a suggested general philosophy of verbal crisis management. Healthcare workers can and should modify and personalize these as they develop their crisis management knowledge and skills.

1. Individuals and responders have the right to safety and autonomy.
2. Responders can prevent and deescalate most crises through verbal intervention.
3. Responders can successfully intervene at any time throughout the crisis trajectory.
4. Responders are effective in de-escalation to the extent that they are able to identify and modulate their own patterns of behavior that impact individuals in crisis.
5. Ultimately, responders' actions are determined by the choices and behaviors of the person in crisis.

## Prepare Yourself to Be a Responder

### Maintain emotional and behavioral control

Your ability to deescalate a crisis is limited to the extent to which you are able to maintain control of your own emotions and patterns of thought and behavior.

### Understand your own response to crisis

Everyone experiences crisis. Feelings of anger, sadness, helplessness, and being generally overwhelmed are typical. Physical symptoms include increased heart rate and breathing, tensed muscles, changes in hearing and sight. Mental effects are confusion, disorientation occur, and poor impulse control.

By becoming familiar with your own response, you gain experience anticipating and lessening that response. Naturally, it is difficult to alter your own emotions and physical symptoms; however, with

## Crisis Intervention and Managing Assaultive Behavior

knowledge and experience, you will learn to alter your behaviors when in crisis. That skill enables you to be more effective in the 'heat of the moment' when responding to an individual in crisis.

The following was a viral YouTube video a few years ago in which a person in authority precipitates a crisis through a lack of self-awareness and poor impulse control. Click the link to watch [this less than 4- minute video](#).

Take some time here to reflect: Think about what attitudes and behaviors the police officer exhibits that makes the situation far worse than it should have been. Think of what he could have done instead.

The Officer was angry; threatening in tone and body language; rude; unable to listen, and unable to respect the teenager's responses, point of view, or even any common humanity. He communicated disrespect and disgust.

Put yourself in the shoes of that teenager, or of any individual in crisis. How would you like to be treated in that situation? The answer is likely a simple list of behaviors that directly contradict those of the Officer in the video. That is, you'd like your responder to be calm, patient, respectful, and non-threatening.

Note the Core Precepts from the Introduction with the added corresponding Officer behavior shown in the video:

1. Individuals and responders have the right to safety and autonomy.  
At no time could the teenager have felt safe or felt that he was treated as an individual.
6. Responders can prevent and deescalate most crises through verbal intervention.  
The Officer was threatening in body language and tone of voice, even to the point of physical assault.
2. Responders can successfully intervene at any time throughout the crisis trajectory.  
The Officer's poor behavior continuously worsens throughout the interaction.
3. Responders are effective in de-escalation to the extent that they are able to identify and modulate their own patterns of behavior that impact individuals in crisis.  
The Officer never seemed to try being patient, calm, and respectful. On the contrary, he seemed entirely driven by his pre-judgements about how the teenager should behave.
4. Ultimately, responders' actions are determined by the choices and behaviors of the person in crisis.  
No real choices were offered. The Officer was simply giving orders, most of which seemed arbitrary. \*

\*Arbitrary, in the sense that the commands had little to do with what the Officer wanted to accomplish, i.e., no skateboarding; and were mostly to do with his personal belief system about how teenagers should talk and behave.



### Identify your triggers

The Officer seemed almost entirely focused on what he perceived to be the disrespect evidenced by the teenager's posture, body language, tone and volume of voice, and non-verbals. The Officer's primary trigger seemed to be his perception of disrespect. We watched as he lost control of his emotions and actions.

The key to identifying your triggers is to develop self-awareness of your attitudes and beliefs about how people should and should not behave. What are your own values regarding sexuality, politics, respect for authority, race, religion, and the whole gamut of differences between people? Know your own beliefs and attitudes and how your responses to those may impact a person in crisis.

Think about your own triggers. What makes it difficult for you to maintain control and act professionally? Keep those in mind when responding to individuals in crisis. Remember the Officer in the video being totally overwhelmed by his own reactions and unable to maintain control.

### Professional distancing

Many healthcare workers rightly consider objectivity as an important element of appropriate care. Becoming too emotionally invested in patients can impair the effectiveness of care and judgement, predispose to professional burnout, and even lead to inappropriate relationships. However, there must be a balance of involvement and distance according to the needs of the patient.

Patients generally expect healthcare workers to care about them. So much of crisis management is based on the Responder's direct and honest interaction with the individual in crisis, some degree of involvement is necessary in order to be authentic and maintain the individual's trust.

The healthcare worker, in entering into an 'emotional' relationship with the individual is offering caring and concern without demanding any gratification. The appropriate relationship is a commitment to help the individual, and does not go beyond.

## Prevent, Recognize, and Deescalate Crises

### Crisis stages—from equilibrium to crisis and back again

In order to recognize impending crises, you will need to understand a general model for how crises begin and proceed. In this section, you'll learn about:

1. Identifying where the individual currently resides on the crisis continuum, and
2. Appropriately intervening according to that location (Crisis stage).

A note on the limitation of the Crisis stages:

There are scores of crisis models and descriptions of stages. Though the differences are to some degree semantic, the main reason for the variety of models is the broad flexibility of human behavior in these circumstances. In reality, there are no discrete stages, but rather a continuum of behavior that varies with each individual and situation. The following descriptions of the

boundaries between stages as well as the progression from one stage to another are far less complex and fluid than the actuality. The model is provided here to assist the learner in conceptualizing these continua in a simple and accessible way.

## Equilibrium

### Description

This is the 'optimum' for that individual in that situation.

### Individual Behaviors

- Calm, rational, and with little or no evidence of tension or anger.
- Able to engage with their care providers.
- Note that Equilibrium varies by individual and a 'calm' state for one person may represent tension for another.

### Interventions

- Therapeutic goals are most achievable.
- Build rapport and earn trust.
- Expand your knowledge of the individual through direct observation and interaction and through peer to peer team communication.
- Identify any potential triggers that could escalate emotions as well as reassuring environmental features that might contribute to de-escalation.

## Tension Building

### Description

This is a low-level stage of crisis. The individual is experiencing a conflict—they are reacting to some trigger such as a personal problem, argument with another patient, disagreement with staff about a restriction, etc.

### Individual Behaviors

- Feels increased tension, i.e., increased heartrate, blood pressure, muscle tension, anxiety
- Changes in body language such as increased or decreased rate and volume of speech, rocking or tapping, withdrawing from others, tics and superfluous gestures (pulling at clothes, rubbing or hiding face, etc.)
- May be rude or argumentative

### Interventions

- Identify and gain control of your own emotions and triggers that may negatively influence your ability to effectively intervene.
- Do not judge or discount the individual's statements and feelings.
- Avoid overreacting; understanding your own emotions will help you maintain your calm and rationality which, in turn, will help the individual to maintain theirs.

## Crisis Intervention and Managing Assaultive Behavior

- Intervene early, “You talk, I’ll listen.”
- Keep your tone of voice and [body language](#)\* (gestures, expressions, movements, posture) neutral and non-threatening.
- Respect personal space; maintaining a distance of 2 arm-lengths will help reassure the individual of your non-threatening intentions.
- Employ [active listening](#)\* and [verbal interventions](#)\*.
- [Provide choices](#) enabling the learner to control his/her emotional responses and behavior.\*
- Maintain environmental awareness, including:
  - Evidence of escalation/de-escalation such as further changes in tone or body language
  - Potential weapons of opportunity such as objects that could be used to throw or strike, or those you could use in defense of thrown or striking objects
  - Other individuals nearby
  - Available resources such as co-workers and security personnel

[View this 4.5 minute video](#) of an individual waiting to see a doctor who is already at the Tension building stage due to his lengthy wait. Both the patient and Responder are physicians. Take some time to review how the Responder skillfully uses active listening and verbal interventions to assist the individual in gaining control of his emotions.

### Crisis 1

#### Description

This is a medium-level stage of crisis. It is characterized by the individual’s increasingly escalating emotions and behaviors as well their decreasing willingness to cooperate.

#### Individual Behaviors

- Strongly elevated signs of physical and emotional distress and anxiousness
- Decreased rationality and ability to interact calmly with others
- Resistance to efforts to intervene or deescalate
- Accelerated body language such as pacing, fist clenching, quick head and body movements, aggressive posturing, changes in eye contact
- Changes in speech volume and pitch
- Threats or actions to damage furniture, break minor rules, picking up objects that could be used as weapons.
- Challenging statements, e.g., “You can’t make me . . .” “I will not . . .”

#### Interventions

- Continue the tactics you employed at the previous level.
- Remain supportive.
- Offer clear choices that enable to the individual to calm themselves, and reinforce behaviors that demonstrates a willingness to listen, discuss the situation, and maintain emotional/behavioral control. For example, the individual has taken an aggressive stance, clenched her fists, and refused to talk or make eye contact. At your request,

## Crisis Intervention and Managing Assaultive Behavior

however, she agrees to sit with you in chairs. You compliment her willingness to sit down, reinforcing her behavior.

- Ignore threats and do not engage in arguments or struggles for dominance. Any arguing will only continue to escalate the crisis.
- \*[Employ appropriate de-escalation tactics.](#)
- Get help. Ensure that team members are present according to organization guidelines.

### Crisis 2

#### Description

This is a high level stage of crisis. The individual is at their maximum physical and emotional tension.

#### Individual Behaviors

- Continued and/or accelerating behaviors from Crisis 1
- Little or no ability to rationally communicate.
- Offensive, personal insults and remarks
- Belligerence and verbal and non-verbal threats of violence are common.
- Shouting, crying, damaging property, climbing on furniture or out of windows, threatening with or using weapons of opportunity, self-harm, threatening or hurting others

Note that Crisis 2 represents the point at which it is less likely that verbal de-escalation will assist the individual to proceed back to Crisis 1, Tension Building, and Equilibrium. Once the individual has committed to Crisis 2, the stages will likely proceed in the same direction on to Release, Recovery, and ultimately Equilibrium. Note that Equilibrium resides at both sides of the Crisis stages:

Equilibrium → ← Tension building → ← Crisis 1 → Crisis  
2 → ← Release → ← Recovery → ← Equilibrium

#### Interventions

At this stage, there is a real threat of violence to you and others. Physical interventions for preventing violence may become necessary. This course does not include discussion of physical interventions.

- Continue the tactics you employed at the previous level.
- Maintain your composure. By remaining calm and confident in your tone and body language, your presence alone can reassure the individual, discourage them from violence, and help them manage their own emotions.
- Remain supportive.
- Make the environment safer, if possible, by removing weapon objects and furniture.
- Maintain a safe distance from the individual in order to convey that you are not a threat and to help assure your own safety from aggression.
- Allow the individual to vent anger and frustration.

## Crisis Intervention and Managing Assaultive Behavior

- Your own safety and that of the individual is your primary concern. Know how to seek help from available resources such as other team members and security personnel. Know your organizations procedures.
- If you have appropriate training: guide assertively, hold or restrain if necessary.
- Get help. Ensure that team members are present according to organization guidelines.
- Follow organization guidelines!

### Release

#### Description

The individual's emotions have peaked and are now decelerating.

#### Individual Behaviors

- Gaining control of their emotions
- No longer any yelling or threatening
- May feel guilty and attempt to rationalize their outburst

Much less resistant to suggestions and to rational discussions

#### Interventions

- Maintain vigilance; the individual is still at risk for escalation. Leave physical restraints in place if they have been used during Crisis 2 stage.
- Reinforce positive behaviors with positive feedback.
- Be reassuring and supportive.
- Offer choices that will demonstrate the individual's rationality and willingness to gain control of their emotions.

### Recovery

#### Description

The individual is far more relaxed, speaks in a normal tone of voice, and has stopped refusing to cooperate. Emotions and behaviors are near Equilibrium level.

#### Individual Behaviors

- Acknowledges their previous behavior in a realistic way
- Ready to respond to suggestions, discussion, and make positive choices
- May apologize without attempting to rationalize their behavior
- May feel tired and wish to be left alone for a while
- May exhibit signs of depression

#### Caregiver behaviors

- Maintain vigilance for signs of reescalation.
- Be alert to any suicidal or self-harm tendencies as guilt and depression are likely to appear.
- Ask the individual to promise not to be a threat to themselves or others.

- Physical restraints can usually be removed.
- Continue to offer choices.
- Begin rebuilding trust with the individual, e.g., “That was a not a very enjoyable experience for either of us. We can work together to prevent it from happening again. Please let me know how you think I could have helped prevent it. You know I want to help.”
- Begin the [Debrief\\*](#) process.

### Motivating Persons in Crisis and Building Trust/Rapport

The following are categories and descriptions of the skills and tactics needed to verbally deescalate crises. All of these categories are pointed toward two overlapping goals:

1. Establishing and reinforcing in the individual’s trust in you, and consequently your rapport with the individual, and
2. Motivating the individual to committing to gaining control of their emotions and behaviors in a crisis

#### Body language

Posture:

Present a calm, confident, non-threatening, and reassuring presence. Your stance should be open (directly facing the individual), erect without being stiff (bend the knees a little), and with arms relaxed at your sides. Move slowly, or at least avoid sudden movements and jerking gestures. Smile naturally if possible, but don’t fake it—a false smile can look threatening.

#### Personal space

Stand no less than 2 arm lengths away, the distance most people can tolerate without feeling increased anxiety, and also far enough so that you cannot be surprised by a blow or kick. Touching, even in a caring manner, can be misinterpreted by an individual experiencing crisis. Never come in close, as in face to face or toe to toe.

In Crisis 1 and Crisis 2 stages, consider placing yourself slightly to the side so that the individual can see a path to get around or away from you. These tactics will help protect you from an attack and help prevent the individual from feeling trapped or confined.

#### Eyes

Eye contact shows that you are listening, however don’t force it if the individual seems uncomfortable. More importantly, try to be at eye level; both sitting or both standing, etc. Don’t widen your eyes, stare, or close your eyes for longer than normal—all of which could convey an unintended message. If you personally have trouble making eye contact, focus instead on the bridge of individual’s nose.

#### Tone of voice

Use a normal speaking volume; neither too loud nor too soft. A slower rate of speech is reassuring, and conveys calm. Don’t over-inflect, i.e., avoid speaking as if to a child or pet. Use a tone of voice that conveys respect. Consider humor if it comes naturally to you, but only if it is directed at

yourself, and only if the individual is known to you and has comfort with humor.

### Active listening

Pay attention to, understand, respond to, and remember what is said and what is conveyed through the individual's behaviors and body language. Ask questions to be sure that you have understood the speaker. In order to enhance the individual's trust in you, restate or paraphrase the individual's words— do not agree or disagree, simply state your understanding of what was said.

Pay close attention to the emotional message conveyed by the speaker. Sometimes we have trouble identifying our own feelings and the feelings of others. Focus on the individual's feelings as much as on the verbal content. Try 'paraphrasing' the individual's emotional content, e.g., "That sounds like you are feeling frustrated about . . ."

### Verbal interventions

- Use statements and questions that demonstrate your interest in helping the individual: "What can I do for you?" "How would you like me to help?" "I want to help."
- Use statements and questions that demonstrate your close attention and empathy: "That must be very [scary, frustrating, sad, etc.] for you."
- Use silence. Don't be afraid to say nothing. Silence reduces stress by allowing both you and the individual time to reflect on a statement that was made or on the situation, and then make a better choice about how to proceed.
- Avoid 'you' statements and threats that place you directly in opposition to the individual: "It's time you started listening to me." "Either you sit down right now, or I'm going to have you removed to the isolation room."

### Providing choices enabling the learner to control his/her emotional responses and behavior

Strive to identify the situation at hand. What is the source of conflict/disagreement? The choices offered to the individual will be made according to the limits required by the organization, the immediate situation, and the leeway you have as a care provider.

[View this 9-minute video](#) that begins with verbal de-escalation techniques and concludes with offering choices (at about the 6-minute mark). Using these two techniques, the Responder (in this admittedly scripted exchange) skillfully helps the individual manage his emotions.

### De-escalation tactics

Your calm and reassuring presence, positive and open communication, and verbal de-escalation are your primary tools for helping the individual return to Equilibrium and helping ensure the safety of the individual and yourself. De-escalation is entirely situational. No recipe is sufficient, and personal experience will be necessary in order to develop a style and method that is effective for you. The

following is a rough guideline that may serve as a starting point:

Verbal de-escalation tactics:

1. Be calm reassuring, open, confident, and non-threatening  
Refer to the descriptions of appropriate Responder body language, tone of voice, and attitude. Avoid common pitfalls that impair trust, prevent an exchange of information, and raise emotional levels, i.e., criticism, judgement, argument, threats, and power struggles.
2. Be supportive  
Offer yourself. "I'm here to help." Recognize the individual's feelings. "I can see how frustrated you are."
3. Look for short-term gains  
Could the individual be isolated from triggers in their immediate environment? Are they thirsty? What action could you take that can improve their current situation? "Would you like some time to yourself right now?"
4. Compromise  
Are there choices you can offer that allow the individual to meet you halfway? "If you stop banging on that window, I'll walk away."

### Debriefing

Debriefing is sometimes referred to "postvention", a term that emphasizes the prevention benefits of the process. Your organization will have a plan for reviewing all aspects of a crisis occurrence with the goal of preventing or lessening the impact in future crises. Each organization will employ a plan best suited for it, but below are some general steps these plans have in common.

Debriefing benefits the organization by enabling participants to see the event from a variety of perspectives and to come to an understanding of what went right, what went wrong, and what can be improved the next time. The process also helps build and/or reestablish relationships and rapport. It is also a chance for participant's to vent in a constructive way and let go of regrets and strong emotions.

#### Document the facts

Include all participants (including patients and family members, of possible). Document the facts as each participant has understood them. Each participant's perspective is unique and therefore can provide new insight.

#### Identify what went badly and what went well

Avoid sessions that devolve to blame and finger pointing. All aspects, good and bad, should be examined and acknowledged. Address deficiencies and celebrate successes.

#### Look for patterns

Are there commonalities evident, e.g., staff members, times of day, tactics employed, etc.? Were there early warning signs and/or escalation triggers?



Gain consensus about a plan for the next similar event

There may be no one 'truth' in this process where different perspectives are shared. But most of the time, participant can achieve a consensus—a compromise conclusion that all can live with.

Counsel

In the aftermath of a serious event, staff may benefit from follow-up counseling services.

**Conclusion**

It bears repeating that the key to effective crisis management is that the Responder is self-aware, in control of their emotions, and approaches the individual with respect and without judgement. This attitude will help ensure the success of de-escalation tactics, and best ensure the safety of all participants.

**References**

- CPI. (2018, August). *Reducing Workplace Violence: Using Postvention for Prevention*. Retrieved from CPI: <https://www.crisisprevention.com/Blog/June-2013/Reducing-Workplace-Violence-Using-Postvention-for>
- Crisis Consulting Group, LLC. (2018, July). *Calm Every Storm*. Retrieved from Crisis Consultant Group, LLC: <https://ccgces.litmos.com> (paywall)
- DBSAlliance. (2018, August). *Understanding Agitation*. Retrieved from Youtube: <https://www.youtube.com/watch?v=6B9Kqg6jFel>
- Gabay Medical Library. (2007). *Handling Aggressive Behaviors*. Retrieved 2017, from YouTube: <https://www.youtube.com/watch?v=yYre7fmdFus&index=2&list=PLP9UOYtwFfpepd5HZxkw-J1GwPEpBDqs5>
- L. Basford, O. S. (2003). *Theory and Practice of Nursing: An Integrated Approach to Caring Practice*. Nelson Thornes.
- NIOSH. (2002, Apr). *Violence Occupational Hazards in Hospitals*. Retrieved No 2015, from Centers for Disease Control and Prevention: <https://www.cdc.gov/niosh/docs/2002-101/>
- OSHA. (2014, Jun). *Workplace Violence in Healthcare*. Retrieved Nov 2015, from Occupational Safety and Health: <https://www.osha.gov/Publications/OSHA3826.pdf>
- OSHA. (2015). *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. Retrieved Nov 2015, from Occupational Safety and Health Administration: <https://www.osha.gov/Publications/osha3148.pdf>
- Papa, A., & Venella, J. (2013, Jan). *Workplace Violence in Healthcare: Strategies for Advocacy*. Retrieved Nov 2015, from Online Journal of Issues in Nursing: <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJI>

N/Ta bleofContents/Vol-18-2013/No1-Jan-2013/Workplace-Violence-Strategies-for-Advocacy.html

State of Kentucky. (2018, August). *Using Verbal De-escalation*. Retrieved from Kentucky Personnel: <https://personnel.ky.gov/KEAP/Verbal%20De-escalation%20presentation.pdf>

Wheeler, A. (2018, August). *De-Escalation and Communication*. Retrieved from TEDEd: <https://ed.ted.com/on/jG9kdPgc#review>

Wikipedia. (2018, August). *Wikipedia*. Retrieved from Active Listening: [https://en.wikipedia.org/wiki/Active\\_listening](https://en.wikipedia.org/wiki/Active_listening)

### End of Crisis Intervention Lesson

## Managing Assaultive Behavior

Workplace violence is four times more common in healthcare than in the average for private industry. From 2012 through 2013, the healthcare sector had 7.8 cases of serious workplace violence per 10,000 FTEs (full time employees). The average for other industries is 4.2 cases per 10,000 FTEs.

### What is workplace violence?

#### Definitions

- **Workplace** is any place where an employee performs job duties.
- **Violence** is any act that causes physical or emotional harm, and includes the threat of being harmed.
- **Workplace violence** is any act or threat that causes physical or emotional harm in a place where an employee performs job duties.

#### Examples of violence that could occur in a hospital

- An employee who is a victim of domestic violence may be stalked and/or assaulted by a partner in the workplace.
- Gang members may attempt to continue violent acts inside the hospital.
- Substance abusers may be violent if they are reacting to drugs or if they are trying to obtain drugs.
- Family members may become violent when treatment that goes against their religious beliefs is ordered (by court) for a child.
- Medical conditions, such as Alzheimer's, sometimes result in violence.

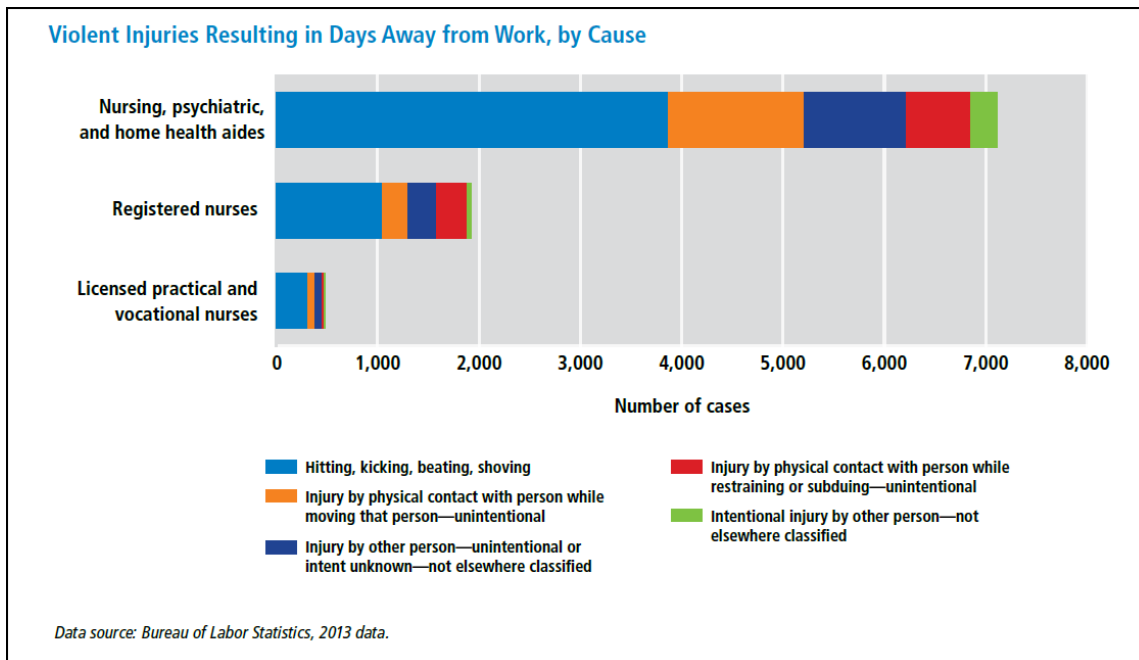
#### Causes and sources of injury to healthcare workers

In 2013, according to the Bureau of Labor Statistics, psychiatric aides experienced the highest rate of violent injuries that resulted in days away from work, at approximately 590 injuries per

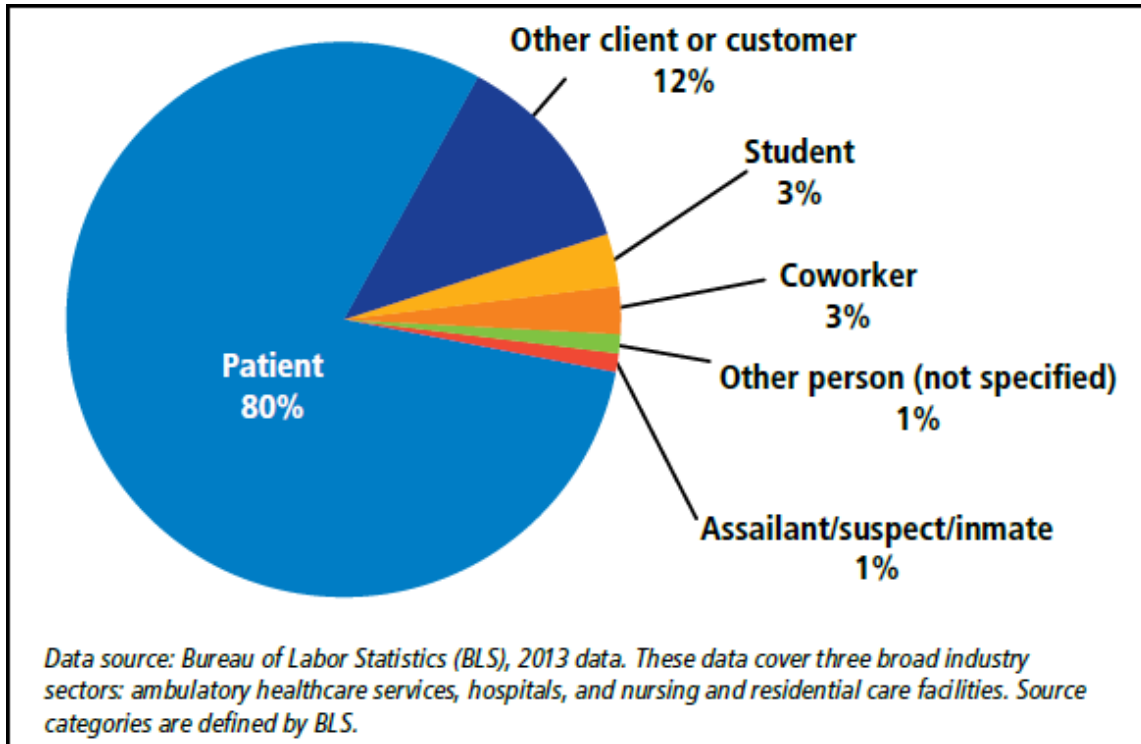
## Crisis Intervention and Managing Assaultive Behavior

10,000 full-time employees. This rate is more than 10 times higher than the next group, nursing assistants, who experienced about 55 such injuries per 10,000 full-time employees. Registered nurses experienced about 14 violent injuries resulting in days away from work per 10,000 full-time employees, compared with a rate of 4.2 in U.S. private industry as a whole. Surveys show that high-risk areas include emergency departments, geriatrics, and behavioral health, among others.

In 2013, the most common causes of violent injuries resulting in days away from work across several healthcare occupations were hitting, kicking, beating, and/or shoving (see graph).



Patients are, by far, the most likely cause of injury



- 85% of non-fatal workplace injuries occurred in healthcare facilities. (Occupational Safety and Health Administration, OSHA)
- One million healthcare workers are injured in violent incidents every year.

A nationwide survey of emergency nurses between May 2009 and February 2010 found that in hospitals:

- 97.1% of physical violence was perpetrated by patients and their relatives.
- 80.6% of physical violence occurred in patients' rooms; 23.2% in corridors, hallways, stairs and elevators; and 14.7% at nurses' stations.
- 38.2% of physical violence against emergency nurses occurred while they were triaging patients, 33.8% while restraining or subduing patients, and 30.9% while they were performing invasive procedures.
- 15% of male nurses reported having been victims of physical violence compared with 10.3% of female nurses.
- 13.4% of violent acts occurred in large urban areas compared with 8.3% in rural areas.

### Risk factors

Your facility has policies for handling violence in the workplace. Do you know what the policies are? Are you aware of risk factors associated with employment in the healthcare field?

Many factors contribute to the risk of violence in a hospital.

## Crisis Intervention and Managing Assaultive Behavior

- Hospitals are open 24 hours a day.
- Employees and patients enter and leave at all times of the day and night.
- There is no way of knowing a person's purpose for being in the hospital.
- There are usually fewer working staff visible or available during times of increased activity, such as meal times and visiting hours.
- At certain hours, especially at night, there are only small numbers of staff working in isolated areas of the building.
- There are a lot of people who are under emotional stress as a result of their illness and/or a long wait to be treated.
- Patients and staff bring money and valuables into the hospital.
- Hospitals are known to have a large supply of drugs, which attracts substance abusers.
- Many hospitals have poorly lighted parking areas.
- Gang members and other violent individuals are treated in the emergency room for injuries sustained in gang violence.
- Weapons, especially handguns, are brought into hospitals by gang members and by other patients who carry weapons for self-defense.

### Prevention of Violent Incidents

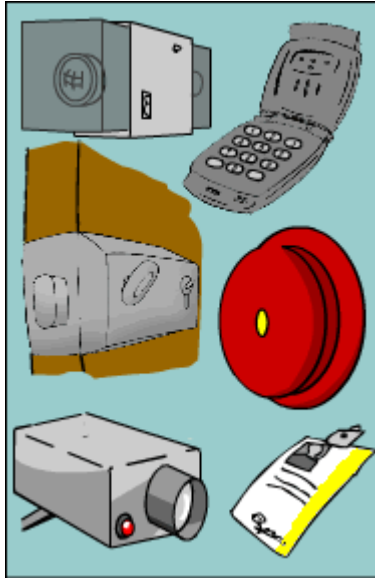
#### **Types and effectiveness of security**

Your facility has security devices you should use and security practices you should follow to help reduce the risk of violence.

Security devices include entrance controls, lighting, surveillance equipment, motion detectors, and other equipment used to monitor traffic in and around the hospital. Be aware of these devices in your facility and learn how to use them correctly. For example, a door may be designed to limit access to a particular area. If you prop that door open, you will be providing an opportunity for an unauthorized person to enter and violence to occur.

Security policies and procedures of your facility are in place for your safety. Keep safety in mind and develop security practices that will help you to reduce the risk of violence. For example, identification (ID) badges may be required for entry to a particular lab. Do not hold the door open to allow someone to enter with you, and question any person who does not have an ID badge, even if that person is wearing the proper uniform or lab coat.

## Security personnel and equipment



Security equipment may include bright lighting, cell phones, automatic locks, alarms, video cameras, and ID badges

Your facility has security personnel, equipment, and devices intended to reduce violence in the workplace. Do you know what they are? Do you know where they are? Do you know how to use them?

Physical security measures at your facility could include:

- **Security personnel** at entrances, to patrol inside and outside buildings, to monitor sensitive areas, and to provide escorts to and from parking lots
- **Access controls** such as ID badges, key codes, and automatic door locks (after hours, people are normally escorted by security personnel) to restricted-access areas such as the pharmacy, laboratories, obstetrics, and pediatrics
- **Security equipment** such as effective lighting (in isolated areas, parking garages and lots, doorways, hallways, and stairways), alarms and emergency call buttons, video cameras (their presence alone is a deterrent), metal detectors, bullet-proof windows, cellular phones, and curved mirrors in hallways (for visibility around corners)
- **Structural planning** such as safe rooms (containing at least **two exits**) and minimal furniture and objects that could be used as weapons in counseling rooms.

Be sure you know about the physical security that is available at your facility. Determine where they are located and learn how to use them properly.

## Security practices

Your facility has security policies and procedures intended to reduce violence in the workplace. Do you know what they are? Do you use security practices to help prevent workplace violence?

Security practices at your facility could include:

- **Access control policies** such as using ID badges for entry, questioning anyone without ID badges, and signing-in all visitors
- **Awareness issues** such as being especially sensitive to patients and families during stressful situations, keeping people informed during long waits to reduce stress and frustration, monitoring gang activity and reporting interference with duties, and developing awareness of items that could be used as weapons (pens, syringes, lamps, books, IV poles, etc.)
- **Sensitivity issues** such as separating persons angry with each other and keeping patients in states of psychiatric crises separated from other patients
- **Personal practices** including wearing minimal jewelry (so it cannot be grabbed), wearing hair short or close to the head (so it cannot be grabbed), avoiding stairways at night or when fewer staff are around, using a buddy system to avoid being alone in areas of potential risk, and withholding personal information (concerning yourself or others) from patients and their families, such as address, phone number, names of family members, etc.
- **Hospital policies** including prosecuting to the full extent of the law for acts of violence, reporting all threats and incidents to supervisors for investigation, providing security and/or escorts when travelling to and from parking areas (especially at night), and using code words to alert others of a problem or when discussing sensitive topics such as drugs or money.

Be sure you know the security policies and procedures of your facility. Use security practices properly to help prevent violence in your workplace.

### Diffusion of Violent Incidents

#### Signs of anger

Violent incidents are often the result of someone's anger.

Anger is a normal, healthy, human emotion. It is a warning sign that something is wrong. Anger varies from mild irritation to intense rage and may result in violence. It may be triggered by the action of a single person or event or it can be caused by stress and worrying too much. When people feel threatened or weak, they react with anger because it makes them feel strong and in control.

## Crisis Intervention and Managing Assaultive Behavior

Everyone gets angry at one time or another. When anger gets out of control, it can lead to problems at work, in personal relationships, and in the quality of a person's life. Anger is a learned behavior. If people have seen their parents use anger to resolve an issue, they are likely to use the same approach.



**A red face, clenched fists, and swearing are signs that indicate a person is angry.**

When people get angry, their heart rate, blood pressure, and adrenaline levels rise. These signs are not visible, but there are other signs that will help you recognize that a person is angry or getting angry.

Signs of anger include:

- Reddening of the face
- Staring eyes
- Rapid breathing
- Shouting (although some people may become quieter)
- Clenching fists
- Swearing
- Pacing



- Challenging behavior.

### **Causes of anger**

Anger can lead to loss of control, which may result in violence. Understanding the causes of anger will prepare you to respond to anger and diffuse a potentially violent incident before it happens.

Causes of violence include:

- Stress
- Frustration
- Feeling that no one is listening
- Feeling of being powerless.

### Stress

Hospitals are stressful places for patients, visitors, and staff. Stress associated with pain and anxiety may lead patients or their family members to become angry. Staff may become angry because of the stress of dealing with irrational behavior by patients.

### Frustration

Patients recovering from illness or injury often become frustrated with the progress of their recuperation. They may direct their frustration at healthcare workers.

### Feeling that no one is listening

Long waits in emergency rooms can cause patients and their family members to become angry, frustrated, and hostile. It is natural for ill or injured patients to want to be seen as soon as possible. When they perceive they are not getting the attention they should, they think that staff are not interested in their problem. This perception can lead to a build-up of anger.

### Feeling of being powerless

Family members who are not allowed into the treatment room and are not kept informed of the condition of the patient may feel powerless. This feeling could lead to anger and violence. For example, they may try to force their way into the treatment room.

### **Responding to anger**

When you notice that someone is angry or getting angry you want to keep the situation from escalating and resulting in harm to people and property.

Follow these steps as you try to calm a person down:

1. Take the person out of the public area.
2. Allow the person to talk about the problem.
3. Listen to what happened.
4. Identify with the person's feelings.

5. Get help.

Take the person out of the public area

Take the angry person out of the public area but avoid isolating yourself. If you go to another room, never let the other person come between you and the exit.

Allow the person to talk

Allow the person to talk about the problem and encourage him or her to say more. Hear the person out and do not try to give any explanation at this point. When people are angry they are unable to reason and will not understand or focus on the explanations. Once they have said everything they want to say, they may be able to listen to you.

You CAN say:

- "This has upset you."
- "Sounds like things are not going as you planned."
- "You felt like no one was listening to you."
- "And then?"
- "Go on ... tell me what happened."

You MUST NOT say:

- "You are wrong."
- "That could not have happened."
- "Just calm down!"
- "Relax ... don't get upset!"

Listen to what happened

Your goal is to listen to what happened, without interrupting, so the person knows that someone is paying attention. It does not matter right now whether the person is right or wrong. This is what he or she thinks happened and it is real to him or her.

Identify with the person's feelings

It is OK to identify with the person's feelings by saying something like, "When you had to wait so long, you felt that you were being forgotten." Once the person is calmer, you may be able to deal with the situation and offer an explanation. If an error has been made, your focus should be on how to correct it.

Get help

If you feel uncomfortable dealing with a situation or if it gets out of hand, call for help or let someone else handle the incident.

## Response to Violent Incidents

### Get help!

When you are confronted by someone who is threatening you, do not try to be a hero. Get help! Your life is priceless.

If you see a co-worker being threatened by another employee, a patient, or a visitor ask them if they need help if the need is not obvious. Then get help!

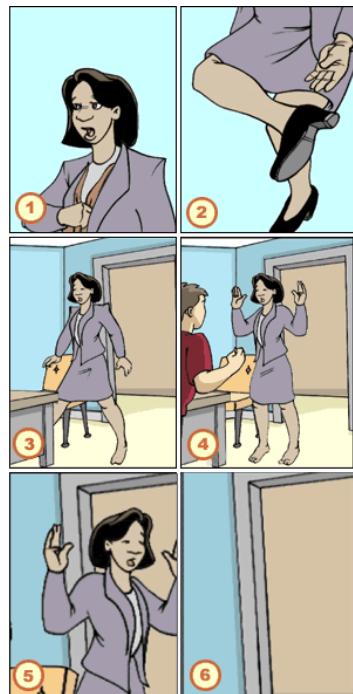
Your facility may have codes to help you and your co-workers in this type of situation. Examples of codes include:

- Code alert that can be broadcast to get help to your area
- Code word(s) such as, "I need Dr. Armstrong."
- Facility alarm codes that you can use to call your supervisor

DO NOT use force in this type of situation especially if you have not been trained how to do so properly. Special programs are used by employees in psychiatric medicine for "taking down" a violent person. If these programs are not used correctly, serious and fatal injuries can occur.

### Protect yourself!

What you should do when a person is angry and out of control depends on the situation and the circumstances.



If you feel that a person is getting out of control and may attack you, take the following precautions to protect yourself:

- Don't try to be a hero..... Get out!
- Loosen or take off items of clothing such as a scarf or necktie that the angry person could grab.
- Remove high heels if you feel you may need to run.
- Move to a place where the furniture in the room is not blocking the exit or the pathway to the door.
- Stay at least six to seven feet away from the angry person.
- If the person comes toward you, hold your arms up with the palms facing outward.
- Trust your instinct; get out if you feel it is necessary.

### Avoiding and escaping common types of physical assault

Please review the following YouTube video (8:05). Click the following link to view the video.

[Avoid and escape video](#)

Several of the concepts and techniques are listed below with a time stamp so you can review each of them more easily. We recommend you view and practice the techniques with a partner.

**IMPORTANT: The notes below are only effective in the context of the video. In order learn the techniques, you must view the video and practice the techniques with a partner.**

- Maintain a safe space and reassuring presence (0:05)
  - At least one leg-length
  - Safe presence off to the side, both you and patient can escape
- Avoid/blocking a hit (1:00)
  - Put arms up to block the hit to the side, move to the side away from the block, get out of the way
- Avoid/blocking a kick (1:30)
  - Step into kick with foot on floor while turning body to the side
- Escape a one-handed wrist grab (2:25)
  - Step in to surprise assailant and gain leverage, then pull out and away from thumb and fingers, pull grabbed hand with other hand to gain extra force
- Escape a two-handed two-wrist grab (3:08)
  - Step in to surprise assailant and gain leverage, then twist wrists outward while pulling out and up
- Escape a two-handed one-wrist grab (3:32)
  - Step in, reach in between assailant's hands and grab own hand, pull out
- Escape a choke hold from behind or from the front (4:15)
  - Shrug shoulders, put arms up, quickly turn and break the hold
- Escape a sidearm choke (5:10)

## Crisis Intervention and Managing Assaultive Behavior

- Put chin inside assailant elbow joint to maintain airway and call for help, place hand closest to assailant elbow under elbow palm inward, place other hand on assailant wrist of choking arm, bend down and to the side closest to assailant wrist, back out
- Safely respond to a Hair pull (6:15)
  - Grab assailant's hands with both of yours, hold hands to your head, call for help
- Safely respond to a Clothes pull (7:15)
  - Grab assailant's hands with both of yours, hold hands to your clothes, call for help
- Safely respond to a Bite (7:20)
  - Do not pull away from bite, push in toward bite to loosen grip, get away

### After the violent incident

Once the violent incident is over, there are three areas of concern:

- Medical help
- Emotional help
- Debriefing

#### Medical help

If you have been injured, you will need immediate medical attention.

#### Emotional help

Even if you have not been physically injured, you have been through a crisis situation and need time to recover. Your facility will have resources available to you to help you through this time. It is normal to need some additional help and counseling. Take advantage of help that is available. If you were not the person involved, be supportive to any co-workers who were involved. Emotional recovery may take some time. Do not make unrealistic expectations for yourself.

#### Debriefing

Your facility will have some specific debriefing procedures once the incident is over. This debriefing typically involves everyone who was involved in the incident. It gives everyone the opportunity to discuss exactly what occurred. The information from the briefing can help prepare you for dealing with future situations.

### References

Gabay Medical Library. (2007). *Handling Aggressive Behaviors*. Retrieved 2017, from YouTube: <https://www.youtube.com/watch?v=yYre7fmdFus&index=2&list=PLP9UOYtwFfpepd5HZxkw-J1GwPEpBDqs5>

## Crisis Intervention and Managing Assaultive Behavior

- NIOSH. (2002, Apr). *Violence Occupational Hazards in Hospitals*. Retrieved Nov 2015, from Centers for Disease Control and Prevention: <https://www.cdc.gov/niosh/docs/2002-101/>
- OSHA. (2014, Jun). *Workplace Violence in Healthcare*. Retrieved Nov 2015, from Occupational Safety and Health: <https://www.osha.gov/Publications/OSHA3826.pdf>
- OSHA. (2015). *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. Retrieved Nov 2015, from Occupational Safety and Health Administration: <https://www.osha.gov/Publications/OSHA3148.pdf>
- Papa, A., & Venella, J. (2013, Jan). *Workplace Violence in Healthcare: Strategies for Advocacy*. Retrieved Nov 2015, from Online Journal of Issues in Nursing: <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Workplace-Violence-Strategies-for-Advocacy.html>

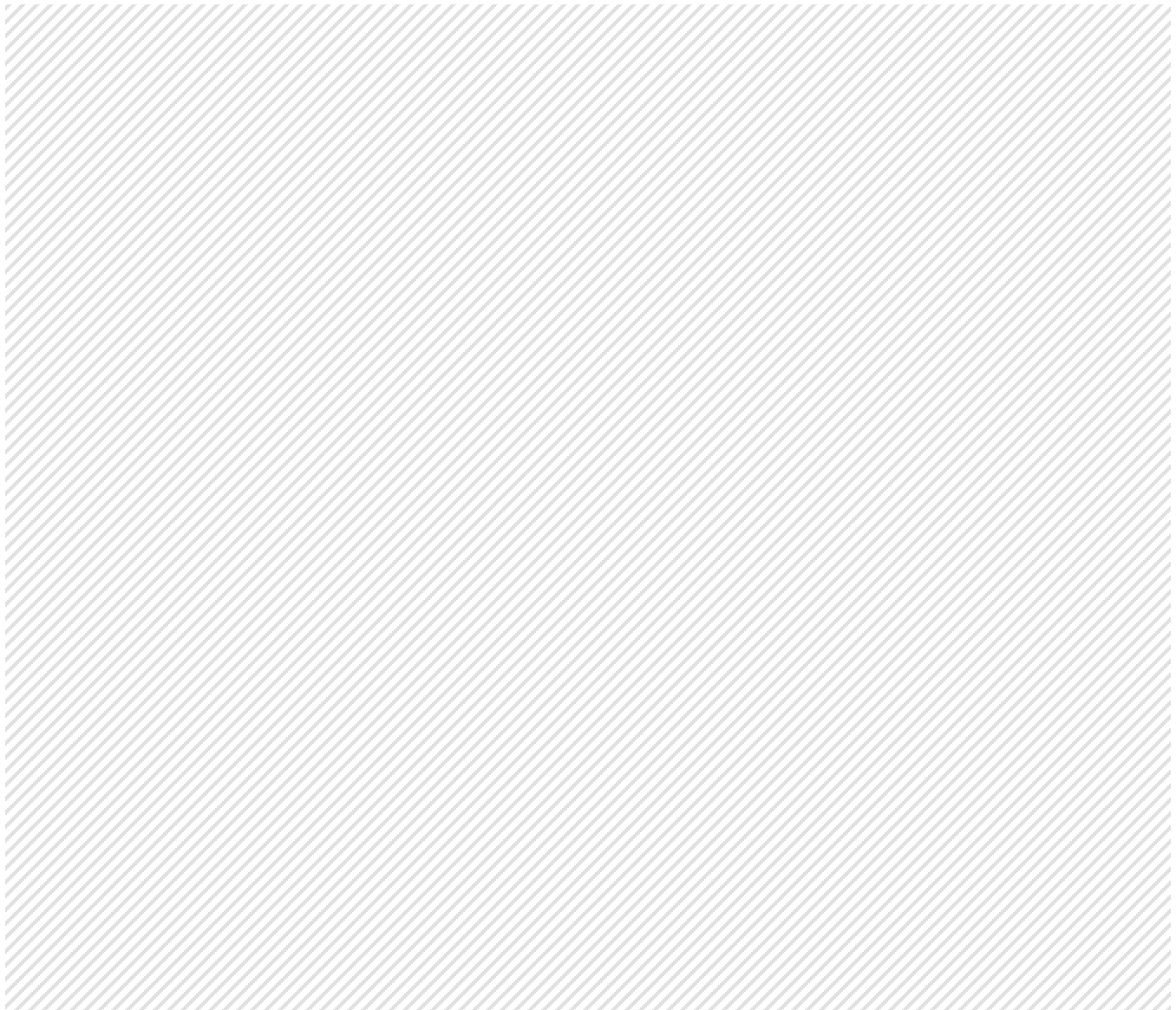
End of Management of Assaultive Behavior Lesson

End of Crisis Intervention and Management of Assaultive Behavior Course

# Cultural Competence

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<i>Values .....</i>	<i>3</i>
<i>Beliefs .....</i>	<i>3</i>
<i>Practices .....</i>	<i>3</i>
<b>Cultural Competency.....</b>	<b>3</b>
<i>Unconscious Bias .....</i>	<i>3</i>
<i>Culturally Competent Care .....</i>	<i>3</i>
<i>Dimensions of Diversity.....</i>	<i>4</i>
<b>Skills and Characteristics of Cultural Competency .....</b>	<b>4</b>
<i>The LEARN Model.....</i>	<i>4</i>
<b>Religious and Cultural Practices.....</b>	<b>5</b>
<b>References.....</b>	<b>6</b>



# 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 adapt 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 complete nonviolent life where they practice vegetarianism (not eating meat).

# Cultural Competency

## Unconscious Bias

In order to be culturally competent, we must understand ourselves. Each of us have bias thoughts and beliefs that impact the way we perceive others which influences the care we give. It is very important that as caregivers we do not judge others based on our own values and beliefs. All too often, caregivers allow their unconscious biases to influence the way they listen, treat, and interact with patients. 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 doesn't 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 a 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 cultural 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 their illness and perceive health care.

# Skills and Characteristics of Cultural Competency

## The LEARN Model

The following guidelines around the 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 work place, 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 you might run into. 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. Some common dietary restrictions include:**

- Hindus are often vegetarians
- Jews adhere to a Kosher Diet
- Muslims will refrain from eating pork and some shell fish, 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 varies 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.

# References

Health Care Chaplaincy. Handbook of Patients' Spiritual and Cultural Values for Health Care Professionals. Updated March 2013.

[http://www.healthcarechlaincy.org/userimages/Cultural%20Sensitivity%20handbook%20from%20HealthCare%20Chaplaincy%20%20\(3-12%202013\).pdf](http://www.healthcarechlaincy.org/userimages/Cultural%20Sensitivity%20handbook%20from%20HealthCare%20Chaplaincy%20%20(3-12%202013).pdf)

Medscape, Nurse. Patient Education: Addressing Cultural Diversity and Health Literacy Issues. Paragraph 1 - 2. Margaret Chang, MN, RN; Ann E. Kelly, MSN, APRN, BC. 2007 – 2016.

[http://www.medscape.com/viewarticle/564667\\_3](http://www.medscape.com/viewarticle/564667_3)

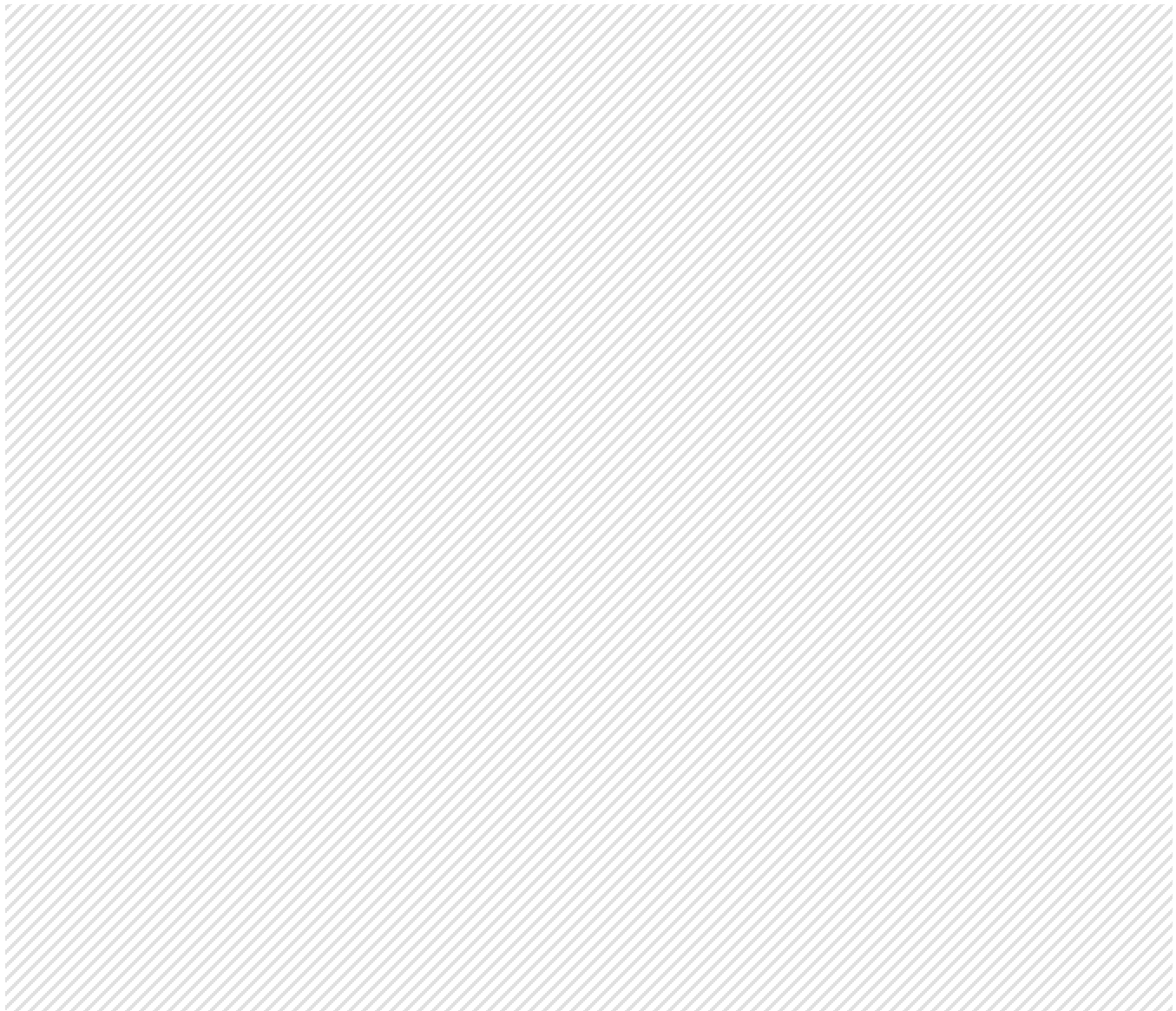
Web Resources from The Provider's Guide to Quality and Culture 3/11/15

# Customer Relations and CAHPS

## Core Competency Inservice

January 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<i>Internal Customers .....</i>	<i>3</i>
<i>External Customers .....</i>	<i>3</i>
<b>The Importance of Good Customer Relations.....</b>	<b>3</b>
<i>Patient choice.....</i>	<i>3</i>
<i>Quality of care.....</i>	<i>4</i>
<b>Building Good Customer Relations .....</b>	<b>4</b>
<b>Customer Relations on the Telephone .....</b>	<b>5</b>
<i>Clear communication .....</i>	<i>5</i>
<i>Effective Service.....</i>	<i>5</i>
<b>Patient Satisfaction Surveys .....</b>	<b>6</b>
<i>HCAHPS .....</i>	<i>7</i>
<i>OAS CAHPS .....</i>	<i>7</i>
<i>Assuring the Best Possible Survey Responses.....</i>	<i>8</i>
<b>References.....</b>	<b>9</b>

---

# 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 a customer? A customer is **anyone to whom you provide service**.

## There are 2 basic types of customer

- 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 service 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 importance.

## 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 personell 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 an important 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. Above all, 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 provide assistance 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 very 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 on your facility. Providing effective telephone service is a part of building good customer relations. It is your chance to make a good impression for 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 can't 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 yourself 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 long 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

- 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, to some extent, 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](http://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 assure 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 likely 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’ve 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 patient waiting, tell them what to expect. Never leave your patients hanging in limbo.
    - Give the patient your full attention.
    - Don't interrupt. Listen carefully to what your patients have to say, especially when you're in a hurry.
    - Respect your patients' privacy.
    - Treat patients as people, not medical conditions. A patient with potential breast cancer won't appreciate being referred to as 'the breast mass
    - Involve patients in decision making. Don't be a 'care dictator'
    - Don't be critical of other care the patient has received. 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 law suits!
    - 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.hcahponline.org/Files/Report\\_July\\_2015\\_States.pdf](http://www.hcahponline.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 don't 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've 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.

## References

CMS. (2010). *HCAHPS Fact Sheet*. Retrieved August 4, 2015, from HCAHPS Online:  
<http://www.hcahponline.org/files/HCAHPS%20Fact%20Sheet%202010.pdf>

CMS. (n.d.). *Hospital Compare*. Retrieved May 15, 2015, from Medicare.gov:  
<https://www.medicare.gov/hospitalcompare/search.html>

---

CMS. (2015, Jun). HCAHPS Fact Sheet. Retrieved Nov 2016, from HCAHPS Online:  
[http://www.hcahpsonline.org/Files/HCAHPS\\_Fact\\_Sheet\\_June\\_2015.pdf](http://www.hcahpsonline.org/Files/HCAHPS_Fact_Sheet_June_2015.pdf) CMS. (2015). Summary of

CMS. (n.d.). *Spring 2015 HCAHPS Executive Insight Letter*. Retrieved May 15, 2015, from HCAHPS Online:  
[http://www.hcahpsonline.org/Executive\\_Insight/Default.aspx](http://www.hcahpsonline.org/Executive_Insight/Default.aspx)

CMS. (n.d.). *Summary of HCAHPS Survey Results*. Retrieved August 2, 2015, from HCAHPS Online:  
[http://www.hcahpsonline.org/Files/Report\\_July\\_2015\\_States.pdf](http://www.hcahpsonline.org/Files/Report_July_2015_States.pdf)

Essentials for Nursing Practice. Elsevier. Schuster, P. (2000). *Communication: The Key to Therapeutic Relationships*. FA Davis

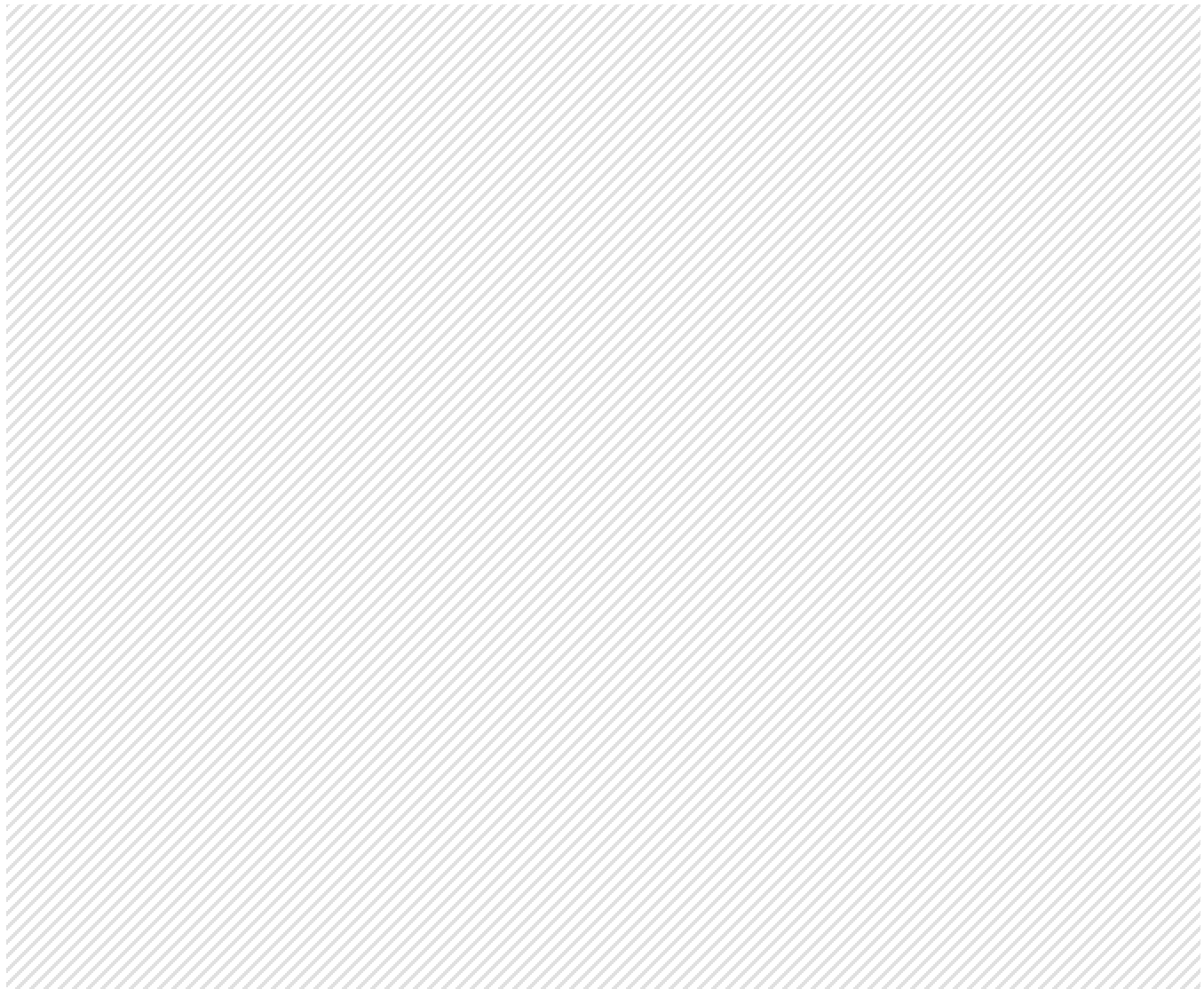
Potter, P., Perry, A., & Stockert, P. (2014). *Essentials for Nursing Practice*. Elsevier. Schuster, P. (2000). *Communication: The Key to Therapeutic Relationships*. FA Davis.

# Dementia Care and Communication

## Core Competency Inservice

January 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Dementia.....</b>	<b>3</b>
<i>Alzheimer’s Disease.....</i>	<i>3</i>
<i>Traumatic Brain Injury.....</i>	<i>4</i>
<i>Post-Traumatic Stress Disorder .....</i>	<i>4</i>
<b>Caring for Patients with Dementia.....</b>	<b>5</b>
<i>What.....</i>	<i>5</i>
<i>When .....</i>	<i>5</i>
<i>Where.....</i>	<i>5</i>
<i>Why .....</i>	<i>5</i>
<b>Navigating Difficult Behaviors .....</b>	<b>6</b>
<i>Communicating with Patients with Dementia, Cognitive Impairment, and Limited English Proficiency.....</i>	<i>7</i>
<i>Non-verbal Communication .....</i>	<i>7</i>
<i>Facial Expression .....</i>	<i>7</i>
<i>Eye Contact.....</i>	<i>7</i>
<i>Body Language.....</i>	<i>8</i>
<i>Pace.....</i>	<i>8</i>
<i>Safety Considerations.....</i>	<i>9</i>
<i>Falls .....</i>	<i>9</i>
<b>References.....</b>	<b>10</b>



---

# 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 different 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 different types of dementia are associated with the types of brain cell damage and the regions of the brain that are affected. Reversible condition 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. Good communication skills can greatly 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 slow and gradually appear 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 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 high levels of proteins, both inside and outside the brain cells that lead to the impaired communication amongst the cells. Alzheimer's kills brain cells which impairs 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 the symptoms frequently appear at the time or near the injury. Moderate TBI patient's experience unconsciousness lasting more than 30 minutes but less than 24 hours. 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) is a common, sometimes chronic, condition in our combat veterans. 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. Soldiers diagnosed with PTSD are at a nearly 2 times increased risk of developing dementia.

The direct link between PTSD and dementia has not been found in research. However, PTSD is thought to be associated with accelerated brain aging and the higher rates of dementia are due to the co-morbid conditions of depression, head injuries and stress. Acute stress increases cortisol levels and there have been studies that have shown that increased cortisol levels are associated with increased dementia.

---

# Caring for Patients with Dementia

Good 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 probably 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 cause by TBI or PTSD are essentially 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 a technique 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 an 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, that 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 the difficult behavior.

## Navigating Difficult Behaviors

So now you've 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 can't 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's 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 by your organization.

## Non-verbal Communication

Non-verbal communication is important, even with vision impaired patients. For example, it important to approach the patient from the front; a patient may startle if you speak to them when they can't 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 don't care
- You don't 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, fidget, checking your watch, acting as if in a hurry.

**Good use of body language communicates:**

- I'm good at my job
- I can handle 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 cognitively 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. Don't hurry the patient.

Always let the patient know when you don't 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). Don't 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 serious risk of 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 patient falls 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

Generally, 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.

## References

Alzheimer's Association [www.alz.org](http://www.alz.org)

Family Caregiver Alliance [www.caregiver.org](http://www.caregiver.org)

Shively, S., Scher, A., Peri, D., Diaz-Arrastia, R. (2012). Dementia resulting from traumatic brain injury: What is the pathology. *Archives Neuro*, 69(10), 1245-1251. Doi 10.1001/archneurol.2011.37. Retrieved from [www.ncbi.nlm.nih.gov/pmc/articles](http://www.ncbi.nlm.nih.gov/pmc/articles)

Yaffe, K., Vittinghoff, E., Lindquist, K., Barnes, D., Covinsky, K., Neylan, T., Kluss, M., Marmar, C. (2010). Post-traumatic stress disorder and risk of dementia among U.S. veterans. *Archives of General Psychiatry*, 67(6). 608-613. Doi 10.1001/archgenpsychiatry.2010.61 Retrieved from [www.ncbi.nlm.nih.gov/pmc/articles](http://www.ncbi.nlm.nih.gov/pmc/articles)

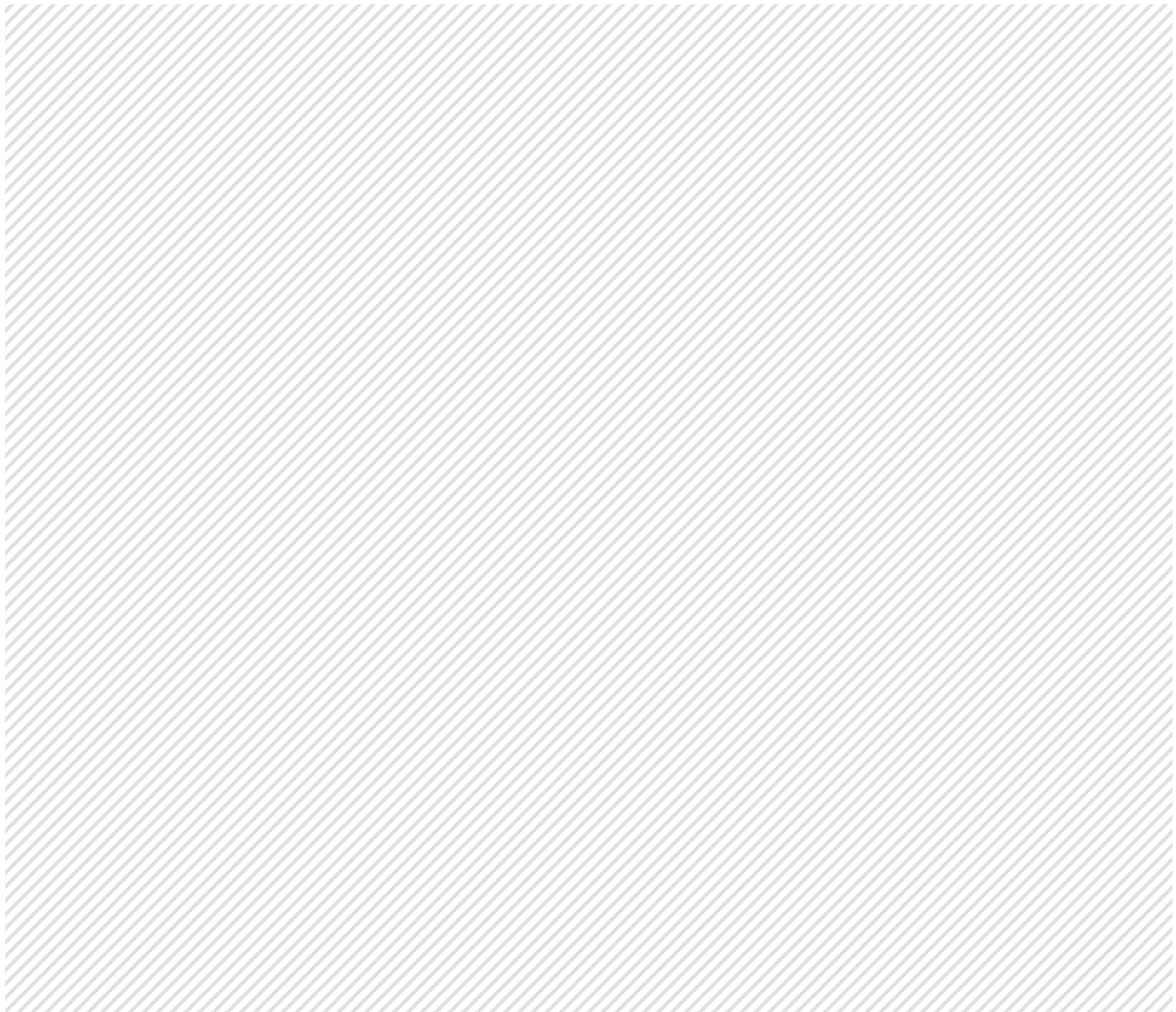




# Documentating Patient Care

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Documetation is a Necessity.....</b>	<b>3</b>
<b>Quality Clinical Records.....</b>	<b>4</b>
<b>Documentation Guidelines.....</b>	<b>4</b>
<i>Documentation Challenges .....</i>	<i>5</i>
<i>Documentation Errors .....</i>	<i>7</i>
<i>Documentation Tools .....</i>	<i>7</i>
<i>Event Reports .....</i>	<i>8</i>
<b>Abbreviations and Official Do Not Use List.....</b>	<b>8</b>
<b>Electronic Medical Records.....</b>	<b>9</b>
<b>References.....</b>	<b>11</b>

---

## Introduction

Clinical record keeping is an integral component in good professional practice and the delivery of quality healthcare. Regardless of the form of the records, electronic or paper, good clinical record keeping should enable continuity of care and enhance communication between healthcare professionals. Consequently, clinical records should be maintained and updated where appropriate, by all members of the multidisciplinary team involved in a patient's care. Should the need arise patients themselves should have access to their records to understand what has been done and what has been considered. Clinical records are valuable as audits tools for quality and risk management and can be used when investigating serious incidents, patient complaints and compensation cases.

The majority of medical errors don't occur as a result of incompetence or recklessness by nurses or healthcare staff. They occur due to faulty systems and fragmented processes – with faulty documentation being a main culprit.

## Documentation is a Necessity

- Serves as a summary of a patient's care, in all settings and across the continuum of care.
- Serves as a communication tool between shifts and disciplines. If you are working the night shift and wonder how far the patient walked in PT, you can go to the chart and find out.
- Used for reimbursement. If a procedure, medication, or care is not documented, then an insurance company is not likely to reimburse for such. As the saying goes, "If it isn't charted, it wasn't done," and isn't reimbursed. Likewise, it is a crime if a record is altered falsely to obtain additional reimbursement.
- Used for quality reviews and determining if standards of care are met. This is an important aspect of continuous quality improvement programs. The intent is to decrease unexpected events, improve outcomes, and improve patient satisfaction.
- In litigation, it is the patient's chart that is used to "tell the story." Therefore, it must reflect accurately the patient situation. A patient's record is generally admissible as evidence. And again, "If it isn't charted, it wasn't done."

State hospital licensing laws and regulations as well as The Joint Commission standards and Centers for Medicare/Medicaid Services specify required documentation in healthcare settings.

### **When documenting, keep in mind:**

- Documentation should be as quantitative, i.e., measurable, and as factual as possible. Don't chart, "Pt. fell out of bed," unless you actually witnessed the event. Instead describe what you observed when you arrived on the scene.
- Avoid stating personal feelings about the patient. Don't say, "Mr. Jones is bullheaded, obnoxious, and a pain in the rear end". Instead describe Mr. Jones' behaviors as factually as possible.

- Documentation should be as timely as possible. Facts are less likely to be omitted when charting is done throughout the shift. This is of particular importance when recording changes in condition, medications, calls to physicians, procedures, etc.
- Your documentation should be legible and accurate. Handwriting that is difficult to read creates a negative impression. It is necessary that the author be able to read what she has written years later. Reflect on what you really mean. Be sure that you use only abbreviations approved by your institution.

**Ultimately, rigorous documentation is for the benefit and protection of your patient, you, and your employer.**

## Quality Clinical Records

Advantages of keeping good clinical records and the disadvantages of poor clinical records

Good clinical records	Poor clinical records
Aid the sharing of relevant information and multidisciplinary team communication	Misinform healthcare professionals and patients
Aid coordination of care	Increase medico-legal risks
Aid continuity of care	Lead to unnecessary repetition of tests or other investigations
Aid informed decision making for patient management	Prolong hospital admission
Improve availability of data for risk assessment	Jeopardise patient care
Improve availability of data for root cause analysis in the investigation of serious incidents	Lead to serious incidents
Improve audit capabilities	
Provide informative evidence in a court of law	
Aid targeting of diagnostics and treatment plans without unnecessary repetition	
Improve time management	

## Documentation Guidelines

The 5 C's of documentation are to be **Correct, Complete, Concise, Consistent, and Cautious**. Here are some specific guidelines to follow:

- Use military time. This eliminates guesswork - is it 7:00 p.m. or a.m.

- 
- Write legibly
  - Use black permanent ink for entries
  - Date and time all entries
  - Don't document a symptom such as shortness of breath without charting what action you took
  - Be as quantitative as possible, e.g., write "400 cc's" instead of "large amount"
  - Allow no blank spaces - draw a line through the space to the end of the page
  - Make no erasures, obliterations, or 'whiting out', on any portion of the medical record
  - Use factual entries only. The medical record is no place for opinions, assumptions, or meaningless statement such as 'had a good day'
  - Use correct spelling, punctuation marks, and grammar. Do not use colloquialisms or slang
  - Ensure that the correct name and other identifying information appear on each page of the medical record
  - Confine abbreviations to those adopted by healthcare delivery system
  - Document as soon as possible after the care is given
  - Document persons in contact with the patient, i.e., physicians, family – including what was discussed, any response, any new orders etc.
  - Never countersign anything unless you can attest to the accuracy of the information e.g. narcotic count
  - Document any unusual incident that occurs, e.g., falls
  - Document whenever a patient leaves the nurses care, e.g., for diagnostic work, off the unit to walk
  - Document patient transfer
  - Document consent for, or refusal of treatment
  - Document patient and/or family teaching/discharge planning
  - Document the existence/disposition of any personal belongings of the patient (dentures, glasses, jewelry, money)
  - Document patient responses to medication, treatments, and procedures
  - Adhere to agency/institution policies regarding documentation
  - Use 'late-entry' or 'addition to nursing note' when it is necessary to add omitted information to an existing entry

## Documentation Challenges

An outside reader should be able to review a patient's record and reconstruct the patient situation, no matter the setting.

### **The following are some common problems encountered in charting**

- Documentation when vital signs or other assessment parameters are abnormal. The nurse must not only document the finding, but his/her actions as well.
  - Did you call the physician or decide to monitor the patient longer?
  - If you contacted the physician, were new orders received or none?
  - Failing to notify the physician or to document such places the responsibility on the nurse.

### **The following is a list of eight documentation mistakes commonly encountered in litigation**

- Failing to record pertinent health or drug information (e.g., allergies and chronic health problems that should be recorded on the admission sheet)
- Failing to record nursing actions
- Failing to record that medications have been given
- Recording on the wrong chart

- 
- Failing to document a discontinued medication
  - Failing to record drug reactions or changes in the patient's condition
  - Transcribing orders improperly or transcribing improper orders
  - Writing illegible or incomplete records

**Thorough documentation** of changes in a patient's condition, physician contacts and subsequent orders, completion of the orders, and evaluation of their effectiveness can keep the physician, nurse and hospital out of legal issues

**Cardiac arrest (codes)** and other emergency changes in patient condition are difficult to document. Events are occurring in rapid sequence and it is difficult to keep track of interventions and the time. Most crash carts have recording sheets that streamline the process. Other emergency situations may be more difficult to reconstruct. Be sure that your notes are later recorded in the chart.

**Transfers** within and between institutions must be recorded. On a related note, communication about such transfers does not tend to be well documented. The verbal transaction often times does not look like the written transfer orders.

**Countersigning or co-signing documentation** implies that you reviewed the entry and agree with the observations. It does not necessarily imply that you personally performed or witnessed the action. It is most desirable that the person making the observation be the one who actually records the event. This is not always possible or realistic, particularly when unlicensed assistive personnel are utilized. However, there is no legal requirement that the person documenting must be a licensed professional. It is often the policy of the organization that documentation be performed by a licensed professional.

**Pre-charting should be avoided.** Documenting something that hasn't taken place yet leaves you legally and professionally liable.

**Confidentiality** issues should be documented carefully. If a patient gives you permission to talk to a family member about her care, document that permission.

**Personalities** should be left out of your documentation. Don't use the chart to express your personal opinions about your patient, the patient's family, or co-workers. Worse, don't express an opinion about the care provided by yourself or your co-workers as these can be red flags for litigation.

**Against Medical Advice (AMA)** is a term used with a patient who checks himself out of the hospital against the advice of his physician. While it may not be medically wise for the person to leave early, in most cases the wishes of the patient are considered first. The patient is usually asked to sign a form stating that he/she is aware that they are leaving the facility against medical advice, and the AMA term is used on reports concerning the patient. The AMA form does not necessarily protect the physician from future legal implications regarding the case. Therefore, documentation must be thorough. Document any patient comments made while leaving AMA or refusing treatments and ensure that AMA and treatment refusal forms are correctly filled out and signed. When

---

a patient refuse to sign an AMA or treatment refusal form, document the patient's statements, describe the patient behavior, any other witnesses to those statements; and have your observations countersigned by a colleague who witnessed the statements and behaviors that you documented.

**Do Not Resuscitate (DNR)** orders must be documented carefully in order to avoid going against a patient or family's wishes for care. Institutional policies and state laws vary so it is your responsibility to know how your institution address the DNR and how it must documented.

## Documentation Errors

Documentation errors are common. It is important to correct errors properly. Proper procedure for written documentation is to draw a single line through the word or phrase and write the correction on the same line, if possible, or above the line. Date, time, and initial any corrections. You may write additional information in a later note and may even refer to the earlier correction.

- Never obliterate an error; use a single line so that even the error remains readable.
- Refer to a documentation error as "an incorrect entry" or "a mistaken documentation" and be careful of words such as "error" or "mistake" in case they could be interpreted as a clinical error, rather than a documentation error
- Use caution whenever you use words such as "error," "by accident," "unsure," and "confused." These words can give the impression that you may have compromised patient safety and can come back to haunt you in a court of law.
- Avoid expressing opinions and stick to a factual description of what occurs

Example: The prescriber has ordered 4 mg. of morphine for cardiac pain. The patient received 8 mg. The following is an appropriate documentation of the occurrence. Patient received 8 mg. morphine IV at 1800 for cardiac pain. Vital signs 100/60, 80, 20. Dr. Jones notified, but gave no orders. Will continue to monitor the patient.

## Documentation Tools

Flowsheets are designed to streamline the documentation process. However, flowsheets are only as good as the information that is input on the flowsheet. These documentation tools should be developed with the staff's involvement and be periodically reviewed and updated to assure that they represent the needs of the unit.

Other documentation systems such as SOAP notes, PIE charting, or charting by exception can be effective. But it is only as good as the information provided. Assuring competency of such systems is important, as implementation of these systems varies widely by institution and by individual staff nurses. Therefore, a huge responsibility is placed on staff development and management for education and assuring that procedures are followed. When using one of these systems ensure that you know the parameters of what should be documented. And always, as a rule of thumb, ask yourself, "Does this document accurately reflect my patient's story?"



---

## Event Reports

Event or Incident reporting is frequently used as a general term for all patient safety event reporting systems. Initial reports often come from the frontline personnel directly involved in an event or the actions leading up to it rather than management or patient safety professionals. Voluntary event reporting is therefore a passive form of surveillance for near misses or unsafe conditions, in contrast to more active methods of surveillance such as direct observation of providers or chart review using trigger tools. Incident reports are used to communicate unusual or unexpected events. Three examples of situations that require an incident report are patient falls, medication errors, and wrong site surgery. The incident form is completed and kept separate from the patient's chart.

### **Incident reports are primarily a risk management tool used for the following purposes:**

- As a non-punitive tool used to identify potential liabilities and correct them before becoming a loss to the organization
- As a tracking tool for trending information to determine the frequency and severity of specific adverse occurrences
- To plan corrective actions to further the improvement of processes and promote safer patient care
- To give Risk Management a head start on claims prevention and claims management
- To meet the requirement for annual reporting of incident reports to specific national regulatory associations
- Incident reports are also used in Peer Review Committee meetings. Peer Review is a process whereby the quality of the services provided by the healthcare staff is evaluated by equivalently trained personnel. In the Peer Review Committee meetings, incident reports are used to determine remediation, counseling, education, and or discipline.

Depending on specific state law, the event report is a confidential document that is protected from discovery in a lawsuit. The incident report should never be copied, placed in the patient chart or referred to in the patient chart.

## Abbreviations and Official Do Not Use List

The issue of approved abbreviations has heated up in the last few years due to the research and intense interest by Joint Commission. Research has shown that confusing abbreviations are a major cause of sentinel events and thus JC published an official "Do Not Use" list of potentially confusing abbreviations. Memorize this list, as JC requires facilities to strictly monitor and enforce the avoidance of the following abbreviations.

---

DO NOT USE	USE INSTEAD
U	Write out "units"

<b>IU</b>	<b>Write out “international units”</b>
<b>Q.D., QD. , q.d.,qd</b>	<b>Write out “daily”</b>
<b>Q.O.D., QOD, qod, q.o.d.</b>	<b>Write out “every other day”</b>
<b>Trailing zero (X.0 mg) Absent leading zero (.X mg)</b>	<b>Write “X mg” Write “0.X mg”</b>
<b>MS</b>	<b>Write “morphine sulfate”</b>
<b>M<sub>SO4</sub> and Mg<sub>SO4</sub></b>	<b>Write “magnesium sulfate”</b>
<b>&lt; or &gt;</b>	<b>Write greater or less than</b>
<b>Abbreviations for drug names</b>	<b>Write drug names in full</b>
<b>Apothecary units (Drams, Scruples, Grains)</b>	<b>Use metric units (Meter, Liter, Gram)</b>
<b>@</b>	<b>Write “at”</b>
<b>cc</b>	<b>Write “ml” , “mL” or “milliliters”</b>
<b>ug</b>	<b>Write “mcg” or “micrograms”</b>

## Electronic Medical Records

Electronic medical records are digital versions of the paper charts in clinician offices, clinics, and hospitals. EMRs contain notes and information collected by and for the clinicians in that office, clinic, or hospital and are used by providers for diagnosis and treatment. EMRs are more valuable than paper records because they enable

---

providers and clinicians to track data over time, identify patients for preventive visits and screenings, monitor patients, and improve health care quality.

U.S. healthcare organizations have been transitioning from paper-based medical records to electronic health records for over a quarter of a century. They allow organizations to minimize the high rate of medical errors occurring throughout the healthcare industry and act as a tool for increasing patient safety and decreasing the overall cost of healthcare. EMRs are easy to search, and update, and provide tools like reminders, alarms, and automated processes that improve clinical accuracy.

Recognizing the role that EMRs can play in transforming health care, in 2003, the Institute of Medicine issued a group of eight key functions for safety, quality, and care efficiency that EMRs should support.

- Physician access to patient information, such as diagnoses, allergies, lab results, and medications.
- Access to new and past test results among providers in multiple care settings.
- Computerized provider order entry.
- Computerized decision-support systems to prevent drug interactions and improve compliance with best practices.
- Secure electronic communication among providers and patients.
- Patient access to health records, disease management tools, and health information resources.
- Computerized administration processes, such as scheduling systems.
- Standards-based electronic data storage and reporting for patient safety and disease surveillance efforts.

Using electronic medical records presents a major change for those who are accustomed to paper records. One issue is that of maintaining confidentiality. Computerized records have extensive systems of checks and balances built in to help assure confidentiality. Methods to protect computerized information may be administrative, technical, or physical.

#### **Administrative Protection of EMRs**

- Policies, procedures, and standards should be in place to protect the records
- Educational programs of an ongoing nature are essential
- Responsibilities should be made explicit, and users held accountable
- Performance appraisal based on use of standards, with opportunities for re-education or discipline as indicated
- Security precautions will not entirely eliminate the risk of corruption. Managers must decide on the level of risk that is acceptable considering time, cost, and manpower
- Ongoing re-evaluation of security measures is necessary

#### **Technical Protection of EMRs**

- Login procedures can deter unwanted access. Users must not share their login names or passwords. Some systems may require a card or utilize fingerprints, retinal patterns, etc.
- Monitors should be programmed to sleep after a period of non-use. Once the screen is blank then a user will need to login again
- Level of access may be based on role or "need-to-know." Users should be assigned a level of access. It is not necessary for a dietary worker to access a patient's lab data, just the type of diet ordered
- Audit trails provide information about who accessed what information and who attempted to access unpermitted information

- 
- Data encryption is a means of protecting data

### Physical Protection of Computerized Information

- Monitors should be placed in locations that the general public will not easily see.
- Theft protection devices (cables, alarms, etc.) should be employed
- Physical access to computers should be limited. A computer with access to an extensive database should not be kept in a remote but easily accessible area. Don't put the computer in a back hallway! Terminals in public areas can be programmed to allow limited access to data
- Disaster preparations are essential. Procedures must be developed to handle all sorts of disasters. Although nurses will not be directly involved, they will need to know of backup procedures.

Healthcare professionals need to be aware of who accesses a patient record (electronically or hard copy).

## References

“Official Do Not Use List.” The Joint Commission. [https://www.jointcommission.org/assets/1/18/dnu\\_list.pdf](https://www.jointcommission.org/assets/1/18/dnu_list.pdf). Accessed December 2019.

“Facts about the Official Do Not Use List.” The Joint Commission. [https://www.jointcommission.org/assets/1/18/Do\\_Not\\_Use\\_List\\_6\\_28\\_19.pdf](https://www.jointcommission.org/assets/1/18/Do_Not_Use_List_6_28_19.pdf). Accessed December 2019.

“Communication and Documentation.” Massachusetts Department of Higher Education. <https://www.mass.edu/mcncps/orientation/m1Documentation.asp>. Assessed January 2020.

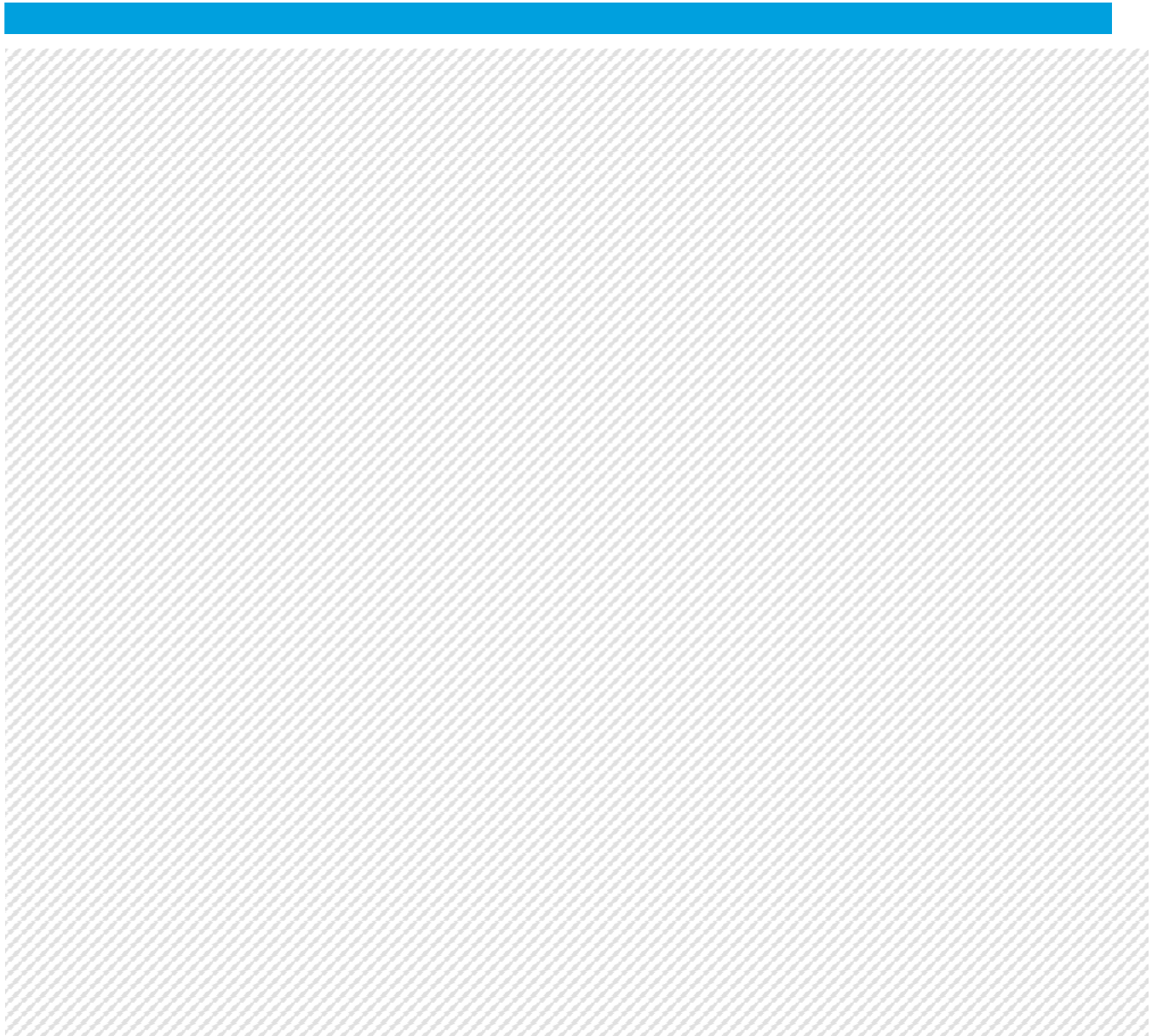
“Reporting Patient Safety Events.” U.S. Department of Health and Human Services. <https://psnet.ahrq.gov/primer/reporting-patient-safety-events>. September 2019.

“How to keep good clinical records.” US National Library of Medicine National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5297955/>. Assessed January 2020.

# Do Not Use Abbreviations

## Core Competency In-service

December 2018



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

Official Do Not Use List.....	3
References.....	4

## Official Do Not Use 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.

<b>DO NOT USE</b>	<b>USE INSTEAD</b>
<b>U</b>	<b>Write out “units”</b>
<b>IU</b>	<b>Write out “international units”</b>
<b>Q.D., QD. , q.d.,qd</b>	<b>Write out “daily”</b>
<b>Q.O.D., QOD, qod, q.o.d.</b>	<b>Write out “every other day”</b>
<b>Trailing zero (X.0 mg) Absent leading zero (.X mg)</b>	<b>Write “X mg” Write “0.X mg”</b>
<b>MS</b>	<b>Write “morphine sulfate”</b>
<b>MSO4 and MgSO4</b>	<b>Write “magnesium sulfate”</b>
<b>&lt; or &gt;</b>	<b>Write greater or less than</b>
<b>Abbreviations for drug names</b>	<b>Write drug names in full</b>
<b>Apothecary units (Drams, Scruples, Grains)</b>	<b>Use metric units (Meter, Liter, Gram)</b>

---

@	Write “at”
cc	Write “ml” , “mL” or “milliliters”
ug	Write “mcg” or “micrograms”

## References

Facts about the Official “Do Not Use” List. June 2014.

[http://www.jointcommission.org/assets/1/18/do\\_not\\_use\\_list.pdf](http://www.jointcommission.org/assets/1/18/do_not_use_list.pdf)

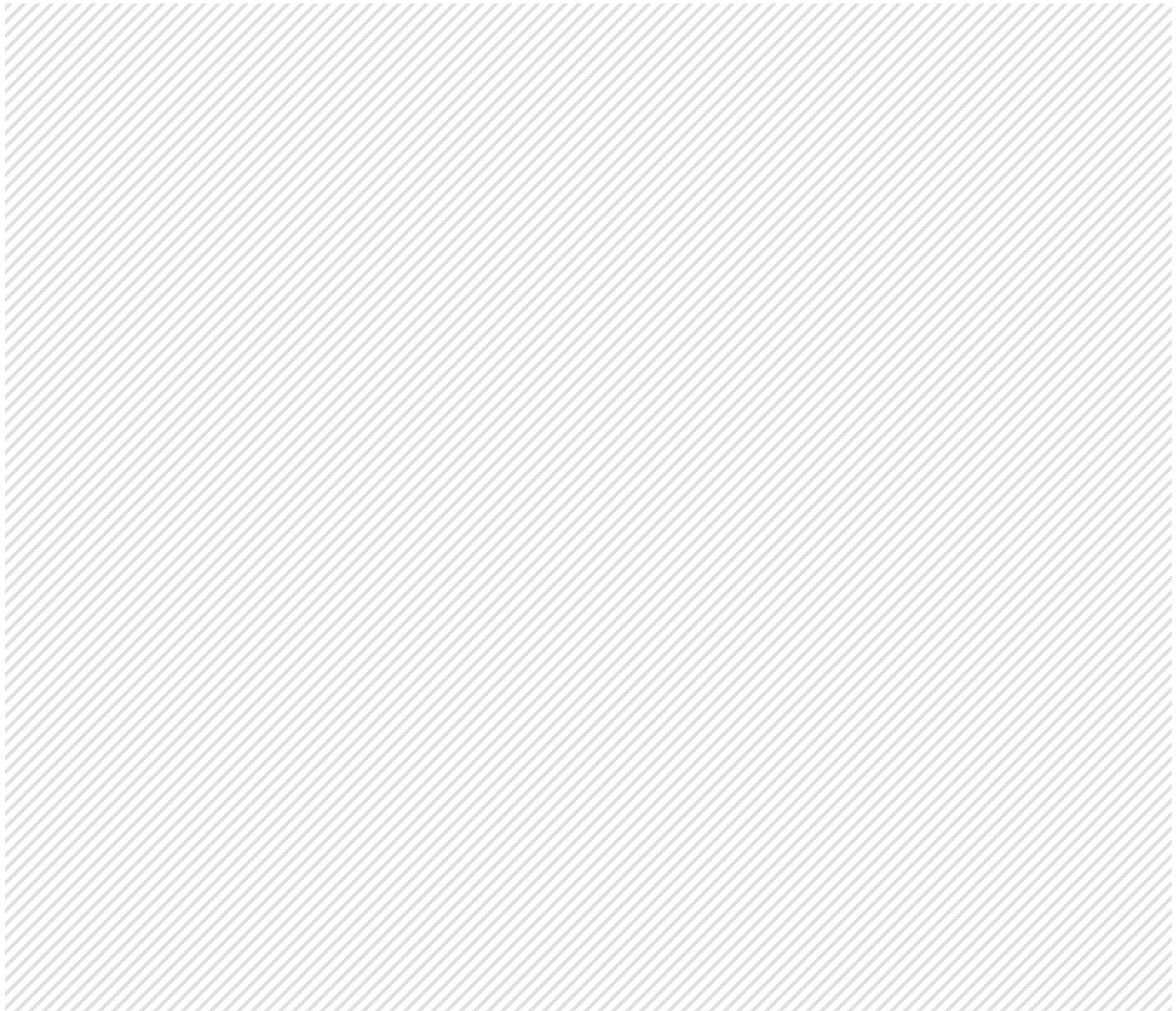
Institute for Safe Medication and Practice (ISMP). ISMP AND FDA CAMPAIGN TO ELIMINATE USE OF ERROR-PRONE ABBREVIATIONS. 2016. <http://www.ismp.org/tools/abbreviations/>



# End of Life Care

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Hospice or Palliative Care</b> .....	<b>3</b>
<b>Advanced Directives</b> .....	<b>3</b>
<b>End of Life Symptoms</b> .....	<b>3</b>
<i>Physical Changes</i> .....	3
<i>Level of Consciousness</i> .....	4
<i>Sensory Changes</i> .....	4
<i>Pain Management</i> .....	4
<b>Holistic Care for the Patient and Family</b> .....	<b>4</b>
<b>References</b> .....	<b>5</b>

---

## 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 team-oriented 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 patient and family 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 waxy 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 act as if the dying person is aware of what is going on and is able to 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. Persons 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 some physical object 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** - Some dying persons 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 on 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 illness 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

## References

Cara Livernois. "Study: Compassion and its importance in healthcare." Health Exec, May 5, 2016  
<https://www.healthexec.com/topics/care-delivery/study-compassion-and-its-importance-healthcare>

Get Palliative Care, Frequent Asked Questions. Accessed March 2015.  
<http://getpalliativecare.org/whatis/faq/>.

"Quality end-of-life care: A global perspective." U.S. National Library of Medicine, National Institutes of Health. Accessed July 15, 2019. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC122082/>.

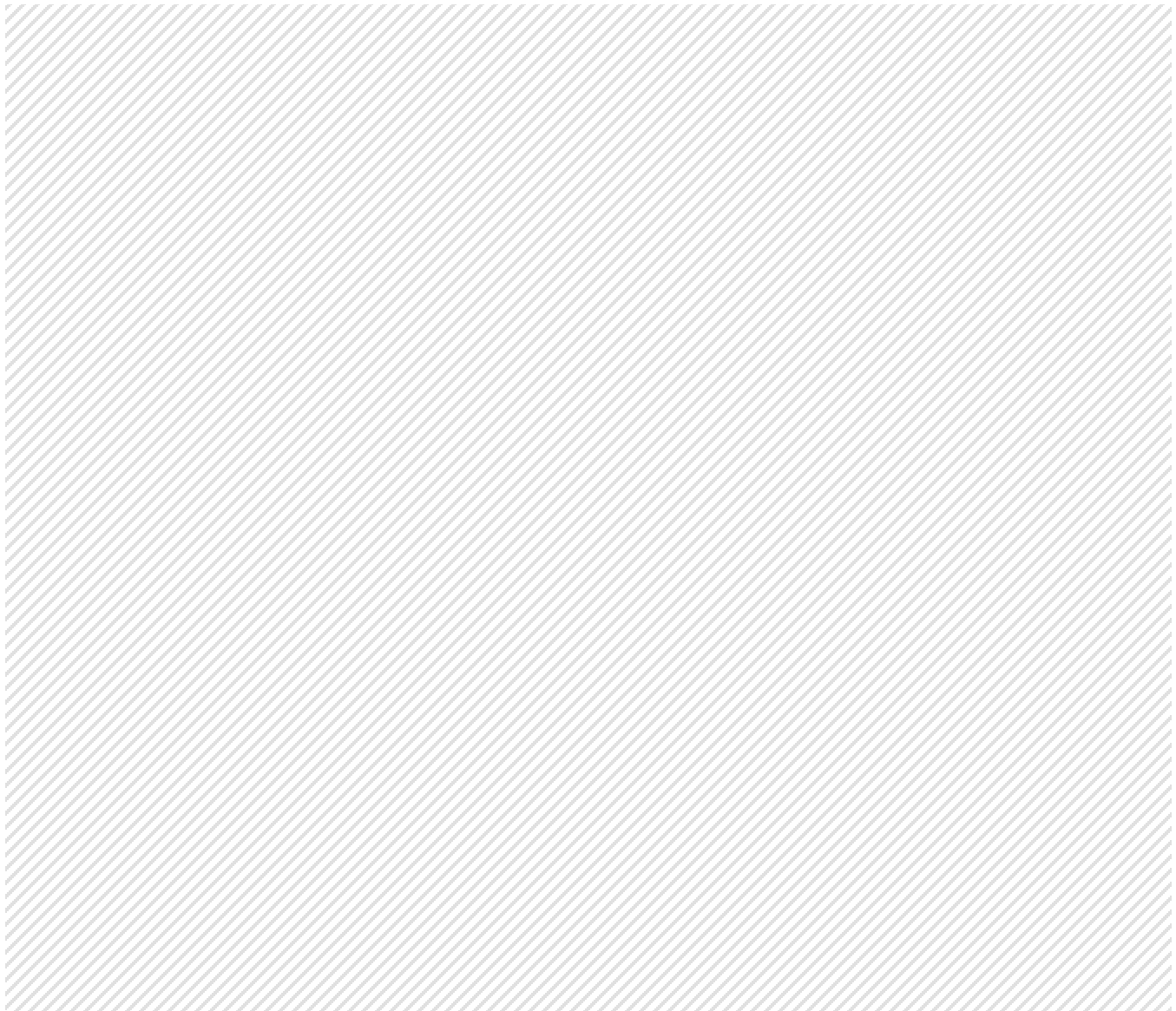
"Resources for Palliative & End-of-Life Care." www.aacn.org. Accessed July 15, 2019.  
<https://www.aacn.org/clinical-resources/palliative-end-of-life>

"Signs of Approaching Death." Hospice Foundation of America. Accessed July 15, 2019.  
<https://hospicefoundation.org/Hospice-Care/Signs-of-Approaching-Death>.

# Environment of Care

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Safety Management.....</b>	<b>3</b>
<i>Employee Responsibilities .....</i>	<i>3</i>
<i>The Safety Committee .....</i>	<i>4</i>
<b>Emergency Management.....</b>	<b>4</b>
<i>Your Responsibility .....</i>	<i>4</i>
<i>Internal versus External Disasters .....</i>	<i>4</i>
<b>Medical Equipment Management.....</b>	<b>5</b>
<i>What You Need to Know .....</i>	<i>5</i>
Safe Medical Devices Act .....	6
<b>Hazardous Materials and Waste Management.....</b>	<b>6</b>
<i>What You Need to Know .....</i>	<i>6</i>
<i>Safety Data Sheets .....</i>	<i>7</i>
<b>Utility Management.....</b>	<b>8</b>
<i>What You Need to Know .....</i>	<i>8</i>
<i>The Utility Management Program includes: .....</i>	<i>8</i>
<b>Life Safety Management .....</b>	<b>9</b>
<i>What You Need to Know .....</i>	<i>9</i>
<i>Interim Life Safety Measures.....</i>	<i>10</i>
<b>Security Management.....</b>	<b>10</b>
<i>What You Need to Know .....</i>	<i>10</i>
<b>Management of the Social Environment .....</b>	<b>11</b>
<b>References.....</b>	<b>12</b>

---

# 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 take action 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 the 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 chemicals. 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 Hazard 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 any chemical or hazardous material used in the work place.
- 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 splashed into the eyes.
  - Remove any clothing, or personal protective equipment, that 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
- 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 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 chemical.
- 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 possibly 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.
  - Know infant abduction policy and procedure
  - 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 handle 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 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 on 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.



---

## References

Clarifications and Expectations. Environment of Care Management Plans. Joint Commission Perspectives. Volume 33, Issue 6. June 2013.

<http://www.jointcommission.org/assets/1/6/EOCManagementPlans.pdf>

Environment of Care Safety Management Plan – 2014. Jefferson University Hospital. Updates 4/18/2014.

<http://www.jefferson.edu/content/dam/tju/facilities/ehs/management-plans/safety-mgt-plan-2014.pdf>

OSHA Safety and Health Topics: HealthCare, Accessed November 2014.

<https://www.osha.gov/SLTC/healthcarefacilities/index.html>

Environment of Care Management Plans; Making Sure Your Plans Get the Job Done. Joint Commission. 2013. <http://www.jointcommission.org/assets/1/6/EOCManagementPlans.pdf>

## How to use these course materials

- Review the entire syllabus, including the Glossary and any linked videos and articles.
- Leave the syllabus open while you answer the test questions.
- Look over the Table of Contents. Note that:
  - Mousing over a Lesson title allows you to left-click and go to that Lesson.
  - The bottom of each page displays the page number and Lesson title.
- Hold down the 'Ctrl' key while pressing the 'F' key to view a 'Find' dialog box.
  - Type in a key word or phrase to find it in the text.
  - Remember that 'Find' will find all instances of the word or phrase in the entire document. Before using 'Find', consider navigating to the proper Lesson first, in order to be as close as possible to the information you want to 'Find'.

**IMPORTANT NOTE on the limitations of this material:** This content is not localized to a particular healthcare environment, system, or entity. Since local system and administrative processes are crucial to patient safety, it is imperative that the learner be familiar with local, facility/entity practices such as: policies and procedures, equipment, patient identification and validation procedures, communication and handoff practices, etc. Adhere to your organization's policies and procedures.

Earthquakes .....	1
Emergency Codes.....	4
Fire Extinguishers.....	5
Radiation Safety .....	9
Weather watches and weather warnings.....	13
References .....	13

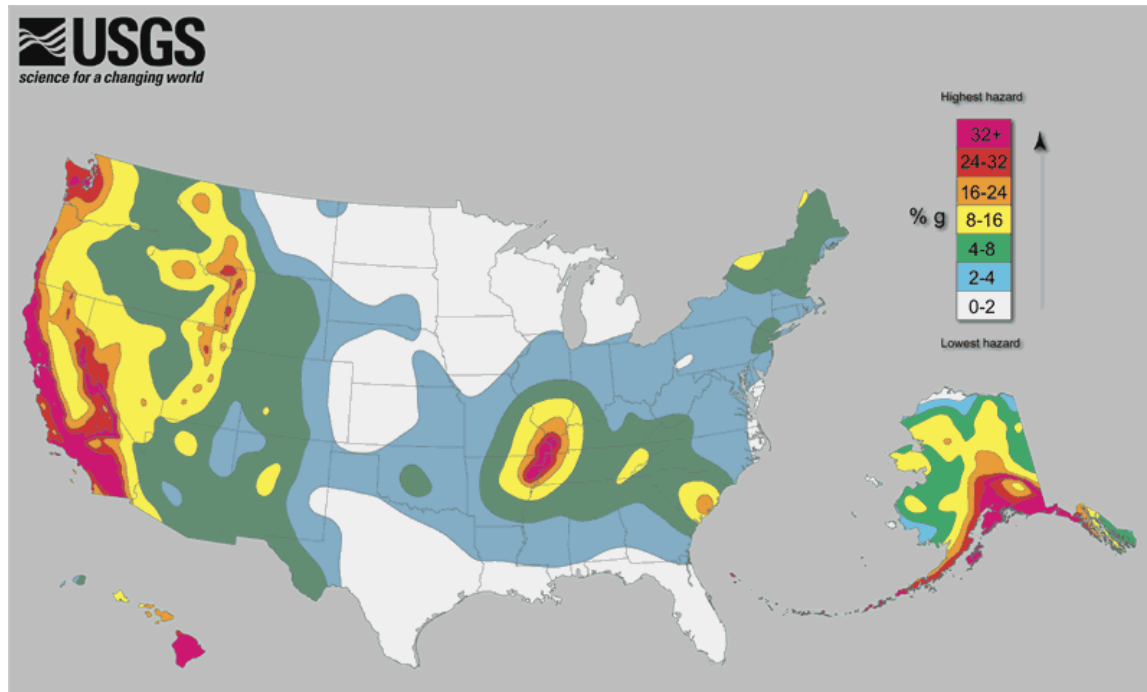
## Earthquakes

In 1994, in Northridge, California, a 6.7 magnitude quake killed 61 people and injured more than 8,000. Several area hospitals were evacuated. *Every healthcare worker must know how to minimize risk to themselves and to their patients during an earthquake.*

### Risk, Magnitude, and Intensity

If you live in California, it's almost a certainty that you've experienced an earthquake. Southern California has an estimated 10,000 earthquakes a year, though only a few will do any damage. The map below shows the relative risk of an earthquake throughout the United States (click on the map to see a full-size version).

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather



[Click here if you'd like to explore more maps and information from the USGS.](#)

The seriousness of an earthquake is dependent upon its magnitude and intensity.

The **magnitude** of an earthquake is a measure of the size of the earthquake and is not dependent on the location or the amount of shaking caused. Seismographs measure magnitude.

The **intensity** of an earthquake is a measure of the amount of shaking caused and is dependent on the location. The effects on people and property determine an earthquake's intensity.

Most earthquakes go unnoticed. However, depending on magnitude and intensity, damage can range from slight to devastating. As a worst case scenario example, it is estimated that an 8.3 magnitude earthquake in Southern California would:

- Cause severe damage as far as hundreds of miles from the center
- Collapse buildings, including tall and modern buildings, and buildings of importance such as schools, hospitals, and municipal services centers (though newer structures are built to withstand earthquakes, many are vulnerable to an earthquake reaching a magnitude of 8 or more)
- Disrupt communication, water, power, and transportation for more than 24 hours
- Cause landslides in vulnerable areas
- Cause tsunamis (tidal waves)

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

- Injure and kill thousands of people as a result of structural collapses (buildings, bridges, tunnels, homes)

### Before the Earthquake

A disaster such as an earthquake, for which there is no early warning system, often causes more casualties because the victims have no time to prepare or to leave the area.

As a result, healthcare workers must **know their facility's disaster plan**. What will you do if an earthquake occurs while you are at work or at home? Disruption of utilities and communications will likely prevent you from using a phone to find out what to do. You must know and prepare in advance.

Healthcare workers in a high-risk earthquake area must also be aware of, and try to correct, any of the following potential hazards in the work area:

- Unanchored furniture and wall fixtures more than 42 inches high
- Stacked furniture
- Tall bookcases
- Unanchored computers and equipment
- Heavy items that are stored above floor level

### During the Earthquake (until shaking stops)

#### Stay Calm

- If you know what to do, you will find it easier to stay calm.

#### Stay Put

- If inside, STAY inside.
- If outside, STAY outside. Most people injured in earthquakes moved more than 10 feet once the earthquake started.

#### Take Cover

- If inside
  - Move the shortest distance possible to a place of safety
  - Take cover under a bed, desk, table, or chair; against a corridor wall; or between seating rows if in a classroom. If you've taken cover under a sturdy piece of furniture, hold on to it.
  - Move away from windows, display shelves, and other falling hazards.
- If no cover is available, drop to the floor.
  - Stay in the building and on the same floor. Do not use the elevators.
- If outside
  - Move away from all falling hazards. The greatest risk of falling hazards is near the entrance and outer walls of buildings.
- If in a car
  - Pull over and stop as soon as you can do so safely

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

- If possible, do not stop on or under a bridge or near power lines
- Stay in your car

### After the Earthquake

- Expect aftershocks of any magnitude and intensity
- Restore calm
- Assist others
- Report injuries
- If you are near the ocean, consider the possibility of a tsunami
- Follow your organizations disaster procedures! (for example, you may be required to proceed to an Emergency Assembly Point).

### For More Information

Here are a few websites you may find interesting:

[USGS Earthquake Preparedness Website](#)

[Wikipedia Earthquake Preparedness Website](#)

## Emergency Codes

Though healthcare organizations universally use emergency codes, there is no universally accepted standard for those codes. The Hospital Association of Southern California has made the following recommendations for standard coding. These may or not be the case at the organization at which you work, but all of most of these are commonly employed at most healthcare entities. Know the codes for your organization.

- RED for fire
- BLUE for adult medical emergency
- WHITE for pediatric medical emergency
- PINK for infant abduction
- PURPLE for child abduction
- GREEN for patient elopement
- YELLOW for bomb threat
- GRAY for a combative person
- SILVER for a person with a weapon and/or hostage situation
- ORANGE for a hazardous material spill/release
- TRIAGE INTERNAL for internal disaster
- TRIAGE EXTERNAL for external disaster

## Fire Extinguishers

### Removing the components of a fire

As already stated above, the three things needed to start a fire are:

- Fuel
- Heat
- Oxygen.

Some examples of fuel include:

- Papers in a wastebasket
- Paint remover
- Bed sheets.

Heat can come from:

- A lit cigarette or match
- A gas or electric burner on a stove
- An electric spark (from a "short" in an electrical wire or plug, for example).

Oxygen is found in the air we breathe, but could also come from an oxygen cylinder.

All three components are needed to keep a fire burning, and a fire can be put out by removing any one of them. It is usually easier to remove the heat or oxygen than to remove the fuel.

### Removing the heat

Cooling the fire by pouring water on it is a good way to put out a wood or paper fire (a fire in a wastebasket, for example).

But **never** use water to put out a chemical fire, a grease fire, or an electrical fire.

- Pouring water on a chemical or grease fire will spread the fire and may cause burning liquid to splash out.
- And pouring water on an electrical fire (a burning plug, wire, or electrical appliance, for example), can cause an electric shock!

### Removing the oxygen

Smothering a fire cuts it off from its oxygen supply. This can be done by putting a blanket or pillow over a fire in a wastebasket, or by covering a grease fire on a stove with a pot lid.

### Removing the fuel

It is often quite difficult to remove the fuel. For example, a wastebasket fire can easily spread to other items in the room that can become fuel for the fire. Curtains, plastic items, carpeting, cushions and other furniture are all combustible, that is, they are able to ignite and burn. If the

Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

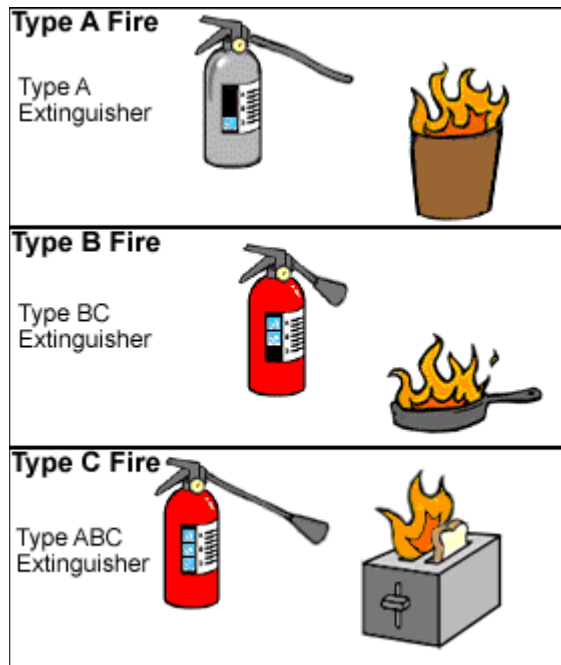
fire can be prevented from spreading and if the wastebasket is made of non-combustible material, the fire will go out when all the paper has burnt.

Most fire extinguishers work by cooling the fire down and smothering it - they remove both the heat and the oxygen supply. Different types of extinguishers use cold water, dry powder, or a cold, dense gas that is sprayed on the fire.

Types of fire extinguishers

Fires are classified according to the **fuel** that is burning.

- In the **Type A** fire, the fuel may be wood, cloth, rubber, and certain types of plastic.
- The **Type B** fire involves burning liquids such as grease, oil, solvents, and other liquid chemicals.
- The **Type C** fire is an electrical fire in which the fuel may be electrical wires, plugs, or appliances.



Fire extinguishers for the three types of fires

The blue symbols below indicate which type or types of fire (A, B, C, or some combination) a particular fire extinguisher is rated for.

Water extinguisher



Type A Fire

A water extinguisher (also known as a Type A extinguisher) can be used on a Type A fire. High pressure water or foam can soak deeply into the fire to cool it down and put it out. Never use a water extinguisher on a Type B or Type C fire.

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

### Carbon dioxide extinguisher



A carbon dioxide extinguisher is one example of a Type BC extinguisher. It can be used on grease, chemical, and electrical fires (Types B and C), which cannot be sprayed with water because of the risk of splashing and electrocution. Carbon dioxide is a compressed, cold gas that cools and smothers the fire.

### Halon extinguisher



Another example of a Type BC extinguisher is a halon extinguisher. It is sometimes used on valuable electrical equipment because it will put out an electrical fire without causing any more damage to the equipment (unlike dry chemical and carbon dioxide extinguishers).

### Multipurpose (dry chemical) extinguisher



A Dry Chemical, multi-purpose type extinguisher extinguishes the fire by coating the fuel and therefore cutting off the oxygen supply to the fuel source. It can be used on most A, B, and C-type fires. It is the most common type of extinguisher found in medical facilities.

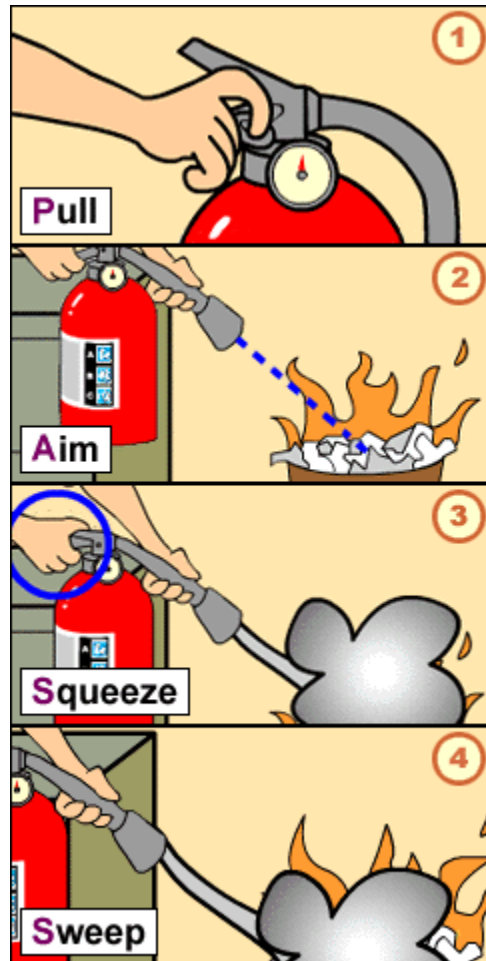
### How to use a fire extinguisher

A fire extinguisher should only be used by someone who has been trained to operate it.

The easiest way to remember all the steps is to memorize the word "**PASS**." The four letters, "P," "A," "S," and "S" stand for of the four steps involved in using a fire extinguisher.



Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather



"P" stands for "PULL" or "PIN." The first step is to pull out the locking pin at the top of the extinguisher.

"A" stands for "AIM." The second step is to aim the nozzle of the extinguisher at the base of the flames. It is important to aim at the base of the flames, because spraying water, foam, or powder at the middle or top of the flames may actually spread the fire.

"S" stands for "SQUEEZE." The next step is to squeeze the handles together to expel the contents of the fire extinguisher. **Do not** touch the nozzle of the extinguisher because it may be very cold and could cause a "freeze" burn.

"S" stands for "SWEEP." The final step is to sweep the contents of the fire extinguisher across the fire. The nozzle should still be aimed at the base of the fire, but a side-to-side sweeping motion should be used so the water, foam, or powder rolls over the fire, forming a thick blanket that cools and smothers the fire.

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

### Know when to leave a fire

If you ever need to use a fire extinguisher, be sure to leave a clear escape route BEHIND you in case you cannot put out the fire. NEVER let the fire get between you and the nearest exit.

Remember it is not your job to fight fires! If you are able to quickly and easily stop a small fire from becoming a large fire, do what you can. Never try to put out a large fire that is spreading - simply leave the area, making sure everyone is out and then closing doors behind you.

Professional fire fighters have the training and equipment to deal with a large, spreading fire. Finally, never try to use a fire hose if there is one in your area - fire hoses are only to be used by professional fire fighters and could cause injury if used by someone who has not been trained.

## Radiation Safety

### **Dangers of Radiation**

Radiation is energy traveling through space. Sunshine is one form of radiation. It provides heat, light, and tans our bodies. Too much sunshine may be harmful so we control our exposure to it with sunglasses, sunscreen, clothing, and shade.

Other types of radiation are infrared and ultraviolet. Some kinds of radiation are known as **ionizing radiation** and they can be harmful to living tissues. Just as we protect ourselves from sunshine, we also must protect ourselves from ionizing radiation.

Controlled amounts of ionizing radiation are used in health care to visualize organs, bones, teeth, etc. These types of ionizing radiation include X-rays, gamma rays, and radiation emitted by radioactive materials. Different types allow us to either see body structures and diagnose disease. Some ionizing radiation is used to treat disease by destroying damaged tissues.

Naturally occurring ionizing radiation provides light and heat and supports life. Artificially produced and controlled radiation can be used to promote health and save lives. Radiation of any kind can cause damage to living tissue so, it is necessary to control the amount of exposure.

### Ionizing radiation in healthcare facilities

Ionizing radiation in hospitals is used for diagnosing and treating patients. Warning signs should be visible in all areas of the hospital where exposure to radiation is possible. Major uses of ionizing radiation include:

- Medical and dental x-rays
- Nuclear medicine testing
- Radiation treatments.

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

### Medical and dental x-rays

Medical and dental x-rays are used to diagnose patient's conditions. X-rays enable specialists to distinguish bones and dense organs like the lungs and heart, from less dense parts of the body such as skin, muscle, and fat. X-rays, along with a "contrast medium" such as a "barium meal," is used to see organs that cannot be seen by x-ray alone, and to see the shape, action, and state of disease or wellness of these organs.

### Nuclear medicine

Nuclear medicine may be used to diagnose patients' conditions. In nuclear medicine, radioactive materials are inserted into the body. The radioactive materials emit radiation and a pattern outside the body is captured as an image on a computer screen. The image along with mathematical imaging techniques, is used to detect disease very early on in the disease.

### Radiation treatment

Radiation treatment, or radiation therapy, is used to kill certain types of cancer cells. Radiation is most harmful to rapidly growing cells, which is what cancer cells are. However, radiation can also be harmful to non-cancer cells. Radiation therapy involves the placement of radioactive implants in the body to kill cancer cells. These implants, sometimes in the form of seeds in a container, may be implanted into a tumor or into a body cavity close to a tumor.

Because of the high energies of different types of ionizing radiation used for medical imaging and radiation therapy, these tests and treatments present risks for patients and healthcare professionals. Knowing the dangers of radiation can help you to avoid them and to minimize your risks.

There are various different ways radiation can be dangerous:

- Radiation can cause cell changes and cancer.
- Radiation can cause birth defects in the fetus of pregnant women.
- Radiation effects are cumulative - they build up in the body with each exposure.

Three ways to minimize exposure and avoid the dangers of radiation:

- Lead shielding, which absorbs most forms of radiation, is built into walls, screens, and patients' gowns.
- Radiation counters monitor the amount of radiation exposure someone experiences, and enable workers to stay within a safety threshold.
- The dose, number of exposures, and a treatment plan must be calculated to insure the patient's risk stays within a suitable safety threshold.

Pause for review

- Radiation is energy traveling through space.

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

- Radiation may be naturally-occurring (such as sunshine) or artificial (such as x-rays used for diagnostic imaging). Natural and artificial radiation have both benefits and risks.
- Ionizing radiation can damage living tissue, but is very useful for the diagnosis and treatment of certain diseases.
- The use of medical x-rays is carefully monitored so that exposure is within acceptable and safe ranges.
- The best safety approach for radiation is to minimize exposure.
- People exposed to radiation in their workplace wear counters to measure the amount of exposure they experience.
- Lead shielding provides protection by absorbing most forms of radiation, so it is built into walls, screens, and gowns worn by workers.

### Radiation Safety Procedures

People are exposed to radiation when they:

- Have an x-ray taken
- Receive radiation treatment
- Stand close to the machine without shielding when an x-ray is taken
- Stand close to someone who has radioactive implants.

People are NOT exposed to radiation when they:

- Visit radiology and nuclear medicine departments. However, employees who work in radiology and nuclear medicine departments expect exposure during their work time and must wear radiation counters that will record their exposure.
- Are in an area where warning signs about radiation are posted. However, all staff must be alert for warning signs and directions, and follow the instructions given in these departments.
- Are near an x-ray machine that is OFF. However, people are exposed to radiation when the x-ray is actually being taken.
- Are near people after those people have received diagnostic x-rays.

### Minimize your exposure to radiation

Everyone must keep exposure to radiation **As Low as Reasonably Achievable** ("ALARA").

To keep your exposure ALARA, remember the following three things:

- Time
- Distance
- Shielding

Time

The less time you are in an area where radiation is present, the less exposure you receive.

## Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

Minimizing exposure time is especially important when caring for someone who has recently received radioactive implants.

- Spend as little time as possible close to the patient, but be careful not to make the patient feel isolated. Talk to the patient from a safe distance.
- Organize your patient care tasks so you minimize the time spent in close proximity with the patient.

### Distance

The further away you are from the radiation source, the less exposure you have.

- Leave the room, or stand behind a shielded wall, when x-rays are being taken (including portable x-ray equipment).
- If you must stay in the room, wear a lead apron if one is available.
- If you must stay in the room, stand at least 6 feet away.
- If distance is not possible try to minimize the length of time you are in contact.

### Shielding

Shielding refers to a barrier between the radiation source and yourself or others. Shielding can be furniture, a wall, or even other people who have not been exposed as much as you have.

- The purpose of lead walls in x-ray rooms is to separate the technician from the patient being x-rayed.
- Technicians and others who need to be close to the patient being x-rayed wear lead aprons.
- Patients should wear lead aprons or other clothing to protect certain areas of the body when another area is being x-rayed.
- Safety features, such as built in lead, are used in the walls of rooms where radioactive implants are given.

### Pause for review

- Identify potential risk situations and be alert and responsive to signs and directions in radiology and nuclear medicine areas so you can minimize your exposure to radiation.
- Exposure to radiation does occur if you have an x-ray, are close to others when they have an x-ray, if you receive radiation treatment, or if you are close to people who have radiation implants.
- Exposure to radiation does NOT occur just because you are in a radiology or nuclear medicine department, near an x-ray machine that is off or not being used, or because you are near people after they have had diagnostic radiation tests.
- To keep exposure to radiation As Low As Reasonably Achievable (ALARA), remember three things: the less time you are in an area where radiation is present, the less your exposure you have; the greater your distance from the radiation source, the less exposure you have; and lead shielding (between the radiation source and yourself or others) minimizes exposure.

## Weather watches and weather warnings

Staff can plan for potential emergencies by responding to weather service forecasts of severe weather. The weather service uses the terms WATCH and WARNING to describe the chance for a particular type of weather hazard to occur in the area. A weather WATCH is a forecast that weather conditions are favorable for a particular type of weather hazard to form. For example, a tornado watch means that the environmental conditions are favorable for the formation of tornados.

The term "WATCH" may also be used to describe severe thunderstorms, winter storms, heavy snow, and flash floods. When used to describe a hurricane or tropical storm, it means that there is a chance that a hurricane or tropical storm could strike the area within 24-36 hours. A tropical storm indicates a storm with sustained winds between 39 and 73 mph and hurricanes involve even stronger sustained winds:

- Tropical storm: sustained winds between 39 and 73 mph
- Category 1 hurricane: sustained winds between 74 and 95 mph
- Category 2 hurricane: sustained winds between 96 and 110 mph
- Category 3 hurricane: sustained winds between 111 and 130 mph
- Category 4 hurricane: sustained winds between 131 and 155 mph
- Category 5 hurricane: sustained winds over 155 mph

A weather WARNING is more serious than a weather WATCH. It means that a particular weather hazard has actually **been observed** and threatens the area over which the warning is issued. For example, a tornado WARNING means that a funnel cloud has actually been spotted. Warnings are used to describe hazards such as tornadoes, severe thunderstorms, winter storms, heavy snow, and flash floods.

When a hurricane or tropical storm warning is issued, it means that the hurricane or tropical storm has been spotted is expected to strike the warning area within 24 hours.

## References

- Agency for Healthcare Research and Quality. (2008). *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Agency for Healthcare Research and Quality.
- American Nurses Association. (2011). *ANA Health and Safety Survey*. ANA.
- Bureau of Labor Statistics. (n.d.). *Nonfatal occupational injuries and illnesses requiring days away from work, 2014*. Retrieved Feb 2015, from Department of Labor.
- CDC. (2014, Feb). *Emergency Preparedness and You*. Retrieved Nov 2015, from Centers for Disease Control and Prevention: <https://emergency.cdc.gov/preparedness/>
- CDC. (n.d.). *Guidance for Donning and Doffing Personal Protective Equipment (PPE) During Management of Patients with Ebola Virus Disease in U.S. Hospitals*. Retrieved May 2016, from Centers for Disease Control and Prevention: <http://www.cdc.gov/vhf/ebola/hcp/ppe-training/index.html>

Environment of Care Supplement: Earthquakes, Emergency Codes, Fire Extinguishers, Radiation, and Weather

CDC. (n.d.). *Guidance on Personal Protective Equipment (PPE) To Be Used By Healthcare Workers during Management of Patients with Confirmed Ebola or Persons under Investigation (PUIs) for Ebola who are Clinically Unstable or Have Bleeding, Vomiting, or Diarrhea in U.S.* Retrieved May 2016, from Centers for Disease Control and Prevention: <http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html>

Centers for Disease Control and Prevention. (n.d.). *Bioterrorism readiness plan: a template for healthcare facilities.* Retrieved Feb 2015, from Centers for Disease Control and Prevention.

CMS. (2016). *CMS Clarifies Compliance Training Requirements.* Health Law News.

EPA. (n.d.). *Radiation Protection.* Retrieved Feb 2016, from EPA, US Environmental Protection Agency.

HHS. (n.d.). *Summary of the HIPAA Security Rule.* Retrieved Feb 2016, from U.S. Department of Health & Human Service: <http://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/>

Ignatavicius, D., & Workman, M. (2015). *Medical-Surgical Nursing: Patient-Centered Collaborative Care.* Elsevier.

NIOSH. (n.d.). *Preventing Allergic Reactions to Natural Rubber Latex in the Workplace.* Retrieved Feb 2015, from Centers for Disease Control and Prevention: <http://www.cdc.gov/niosh/docs/97-135/pdfs/97-135.pdf>

NIOSH. (n.d.). *Violence Occupational Hazards in Hospitals.* Retrieved Apr 2016, from Centers for Disease Control and Prevention: <https://www.cdc.gov/niosh/docs/2002-101/>

Occupational Safety and Health Administration. (n.d.). *Safety and health topics: ergonomics: guidelines for nursing homes.* Retrieved Feb 2015, from Occupational Safety and Health Administration.

The Joint Commission. (2014). *Hospital Accreditation Standards.*

The Joint Commission. (n.d.). *Crosswalk to Performance Improvement.* Retrieved Feb 2015, from The Joint Commission: <http://wonder.cdc.gov/data2010/>

The Joint Commission. (n.d.). *National Patient Safety Goals Effective 2016.* Retrieved April 2016, from The Joint Commission.

The Joint Commission. (n.d.). *Patient Safety Systems Chapter, Sentinel Event Policy and RCA2.* Retrieved Feb 2015, from The Joint Commission.

The Joint Commission. (n.d.). *Radiation risks of diagnostic imaging.* Retrieved Feb 2015, from The Joint Commission: [http://www.jointcommission.org/assets/1/18/sea\\_471.pdf](http://www.jointcommission.org/assets/1/18/sea_471.pdf)

TJC. (2015, Nov). *Emergency Management Resources.* Retrieved Nov 2015, from The Joint Commission: [https://www.jointcommission.org/emergency\\_management.aspx](https://www.jointcommission.org/emergency_management.aspx)

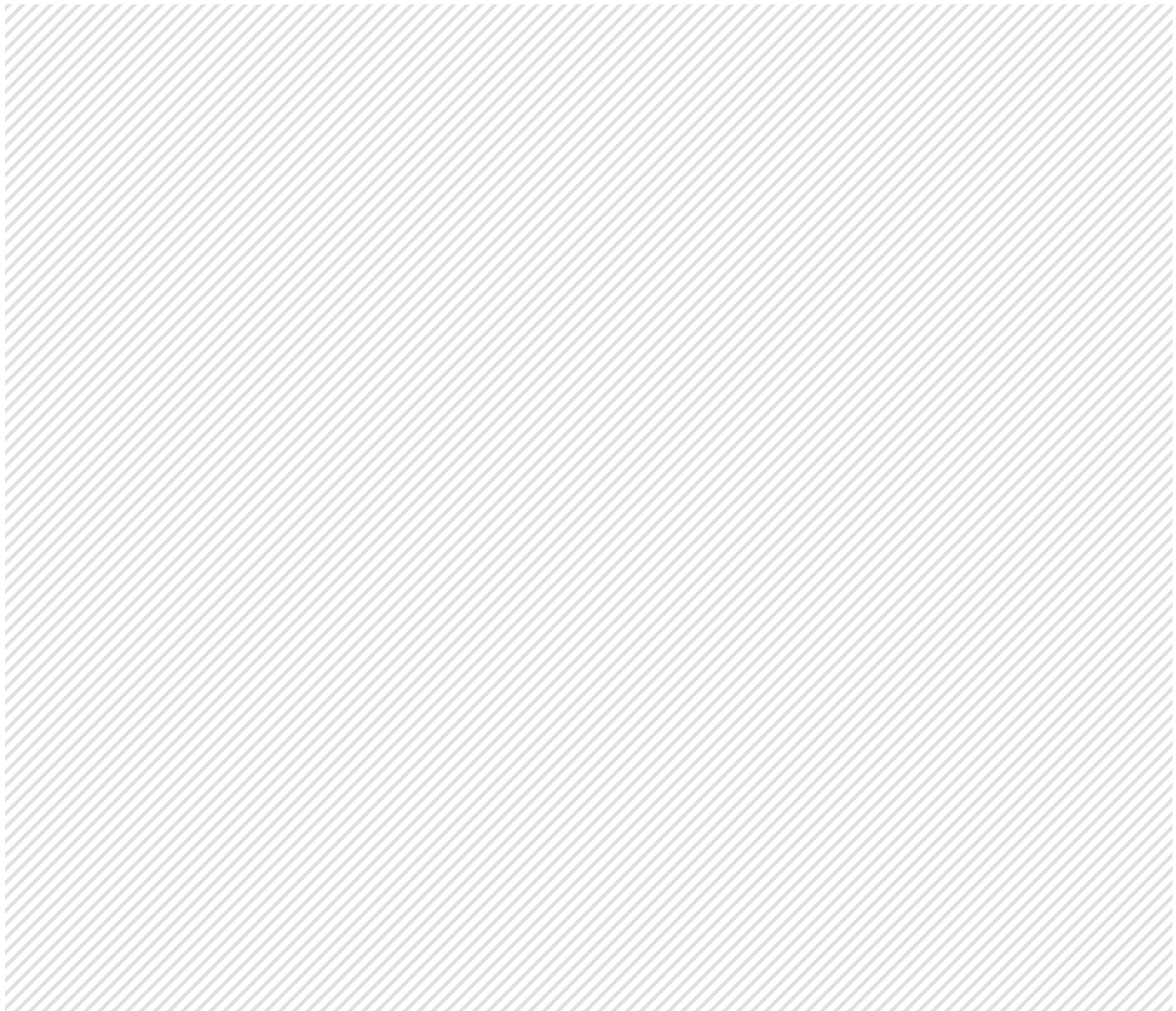
End of Environment Supplement Lesson

# Ethics

## Core Competency Inservice

January 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.



---

# Table of Contents

DECEMBER 2019..... *Error! Bookmark not defined.*

<b>Table of Contents</b> .....	<b>2</b>
<b>Introduction</b> .....	<b>3</b>
<i>Function</i> .....	3
<i>Benefits</i> .....	3
<b>Conduct and Behavior</b> .....	<b>3</b>
<i>Personal Conduct</i> .....	3
<i>Professional Conduct</i> .....	3
<i>Ethical Behavior</i> .....	4
<b>Codes of Ethics for Healthcare Professionals</b> .....	<b>4</b>
<b>Ethical Principles</b> .....	<b>4</b>
<i>Respect for Autonomy</i> .....	4
<i>Beneficence</i> .....	5
<i>Non-maleficence</i> .....	5
<i>Justice</i> .....	6
<i>Fidelity</i> .....	6
<i>Veracity</i> .....	6
<i>Respect for Others</i> .....	6
<i>Informed Consent</i> .....	6
<i>Confidentiality</i> .....	7
<i>Cultural Understanding</i> .....	7
<i>Humanitarianism</i> .....	7
<b>References</b> .....	<b>7</b>

---

# 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 generally regarded as acceptable by society. Healthcare professions have codes of ethics that is expected to be followed by members of the profession. Hospitals and large healthcare systems often have a code of ethics or code of conduct, in 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 don't keep them from performing their job responsibilities. Each individual is personally responsible for their actions.

## Professional Conduct

Healthcare professionals who have access to protected medical and financial information must comply with the Health Insurance Portability and Accountability Act (HIPAA) and all other laws protecting privacy rights. Licensed and certified healthcare professionals must abide by the laws governing their professions.

---

Healthcare professionals who are involved in patient care are expected to follow standards of evidence-based care and maintain clear and concise records.

## Ethical Behavior

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

- Report colleagues who practice incompetently, illegally, or fraudulently
- Avoid conflict of interest and of behaving ethically 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 take action for his/her self. It includes respect for individuals and the individual's right to make decisions for and about themselves, even if the healthcare providers do not agree with the decisions made. To respect autonomy is to respect others.

---

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

In health care, it's 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 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.

Provide Optimal Care is an example of beneficence. Healthcare professionals are to strive to protect patient's rights and desires. They must respect 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 to "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 take appropriate measures 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 take into account 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 provide assistance to patients, with an end goal of bettering humanity.

# References

Advancing High Ethical Standards and Practices. Ethics Toolkit. 2014.

<http://ethics.org/page/ethics-toolkit>

“Code of Ethics for Health Care Compliance Professionals.” HCCA. <https://assets.hcca-info.org/Portals/0/PDFs/Resources/HCCACodeOfEthics.pdf>. Accessed September 1, 2019.

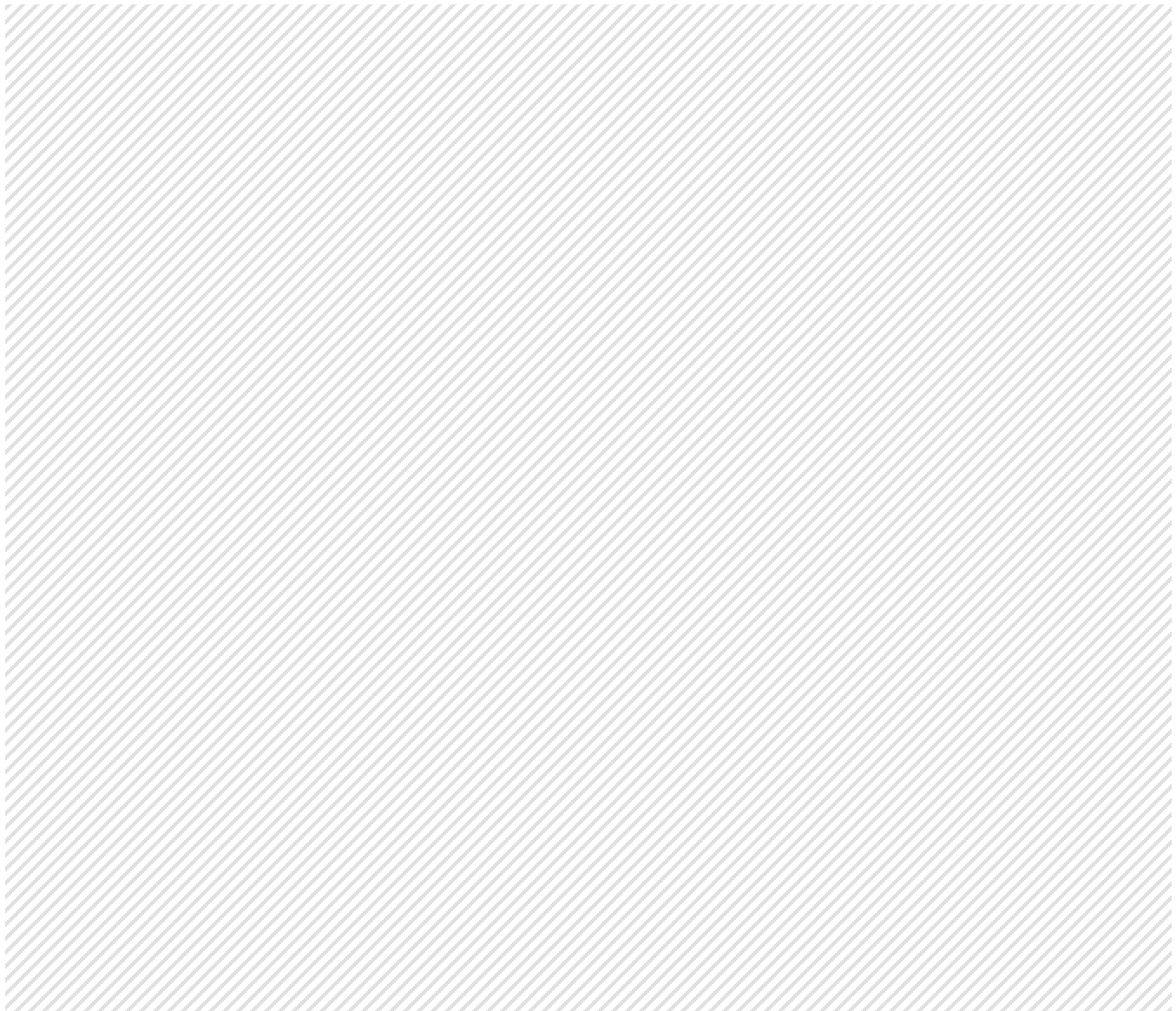
Ethics and the Healthcare Professional. (2012) AMN Healthcare Education Services. RN.Com.

<https://lms.rn.com/getpdf.php/1867.pdf>

# Fall Prevention

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Fall Risk Factors .....</b>	<b>3</b>
<i>Examples of Extrinsic Risk Factors.....</i>	<i>3</i>
<i>Examples of Intrinsic Risk Factors .....</i>	<i>3</i>
<i>Medications that may increase a patient’s risk for fall.....</i>	<i>4</i>
<b>Fall Risk Assessments.....</b>	<b>4</b>
<b>Interventions .....</b>	<b>5</b>
<i>Hourly Rounds .....</i>	<i>5</i>
<i>Huddles.....</i>	<i>5</i>
<i>Color-Coding Arm Bands/Socks/Signs.....</i>	<i>5</i>
<i>Teach Back .....</i>	<i>5</i>
<i>Safe Environment .....</i>	<i>5</i>
<i>Bedrail Reduction .....</i>	<i>5</i>
<b>Post-Fall Management .....</b>	<b>6</b>
<i>After a Patient Falls:.....</i>	<i>6</i>
<b>References.....</b>	<b>6</b>



---

# 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, greatly increases the chances that the patient will return to their original function and greatly reduce the risk of future falls.

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

## Fall Risk Factors

Risk factors associated with falls are generally categorized into extrinsic factors (hazards found in the environment) and intrinsic factors (patient's age, physiological problems, or medication). Assessment of these risk factors are 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 walk ways
- 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. Hypotensives	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

## 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 the 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 add 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 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 possible 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, when the 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.

## References

"Assessing your patients' risk for falling." American Nurse Today.

<https://www.americannursetoday.com/assessing-patients-risk-falling/>. Accessed September 2019.

Falls in the Elderly. American Family Physician. GEORGE F. FULLER, COL, MC, USA, White House Medical Clinic, Washington, D.C. Am Fam Physician. 2000 Apr 1;61(7):2159-2168.

<http://www.aafp.org/afp/2000/0401/p2159.html>

---

“Falls in Older Persons: Risk Factors and Prevention.” National Center for Biotechnology Information, U.S. National Library of Medicine. <https://www.ncbi.nlm.nih.gov/books/NBK235613/>. Accessed September 2019.

“Falls Prevention Interventions in the Medicare Population.” Centers for Medicare and Medicaid Services. <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/Falls-Evidence-Report.pdf>. Accessed September 2019.

“High-Risk Medications Attributed to Falls in Older Adults.” Missouri Pharmacy Association. <https://www.morx.com/assets/docs/FallsAwareness/high%20risk%20med%20list.pdf>. Accessed September 2019.

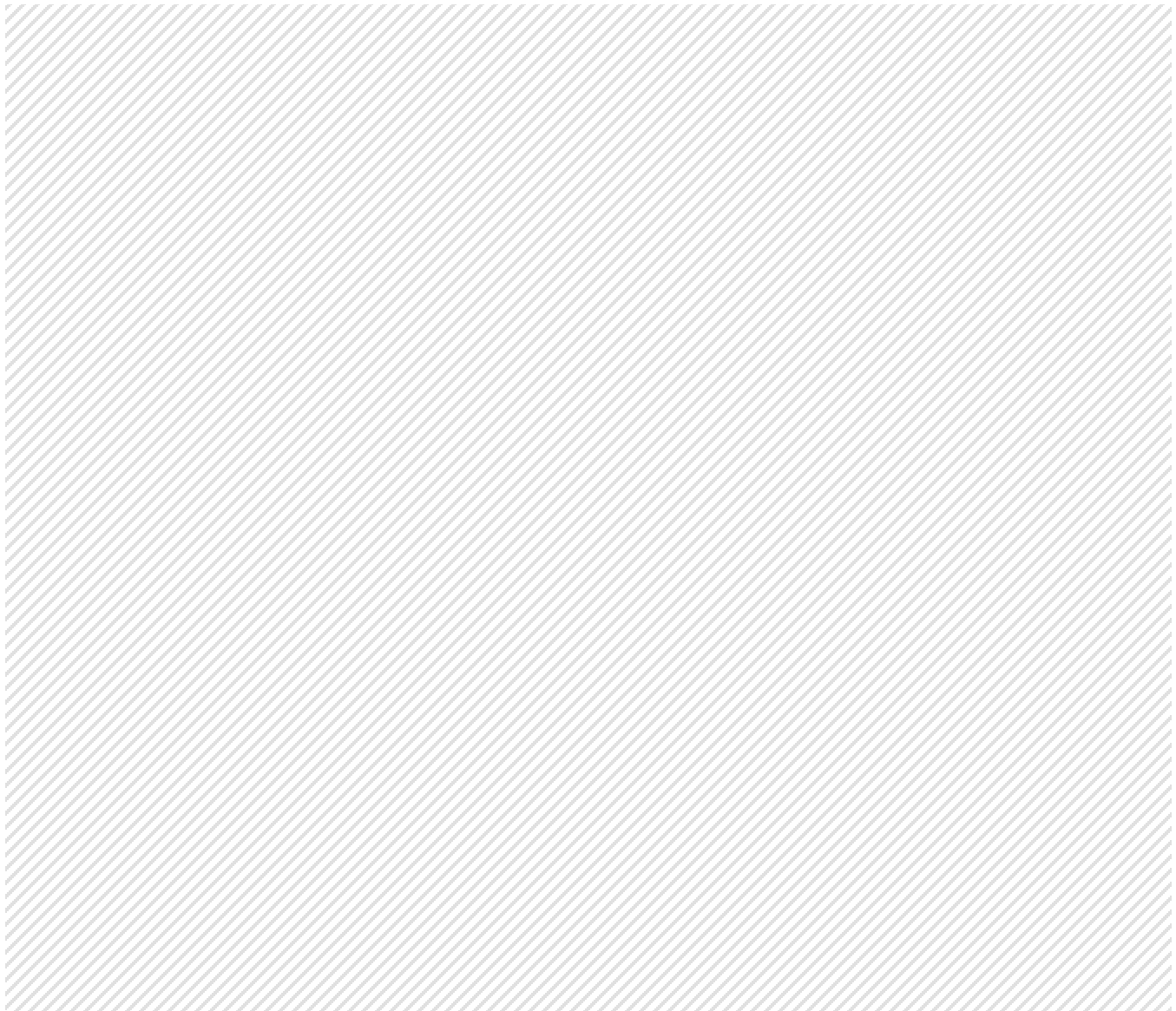
Preventing Falls in Hospitals. Tool 3H: Morse Fall Scale for Identifying Fall Risk Factors. Agency for Healthcare Research and Quality. U.S. Department of Health and Human Services. Page last reviewed January 2013. <http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html>

“Preventing Falls in Inpatient and Outpatient Settings.” Joint commission International. March 2017. <https://www.jointcommissioninternational.org/6th-edition-in-depth-preventing-falls-in-inpatient-and-outpatient-settings/>

# HIPAA

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Five HIPAA Rules.....</b>	<b>3</b>
<i>Privacy Rule .....</i>	<i>3</i>
<i>Security Rule.....</i>	<i>3</i>
<i>Transaction and Code Sets Rule .....</i>	<i>4</i>
<i>Covered Transactions.....</i>	<i>4</i>
<i>Unique Identifier Rule.....</i>	<i>4</i>
<i>Enforcement Rule .....</i>	<i>5</i>
<b>HITECH Act.....</b>	<b>5</b>
<b>Other Uses of Protected Health Information.....</b>	<b>5</b>
<i>Marketing.....</i>	<i>5</i>
<i>Incidental Disclosures.....</i>	<i>5</i>
<i>Patients Rights .....</i>	<i>5</i>
<b>References.....</b>	<b>6</b>

---

# 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 the information is safely transmitted, and how to safely and effectively audit the system.

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, as long as 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 to. Right to Receive Confidential Communication. Right to Complain about a disclosure of their PHI.

---

## References

<http://www.cms.gov/Regulations-and-Guidance/HIPAA-AdministrativeSimplification/HIPAAGenInfo/index.html?redirect=/HIPAAgeninfo/>  
<http://www.hhs.gov/ocr/hipaa> 2019

Center for Disease Control and Prevention. Summary of Notifiable Diseases --- United States, 2009. May 13, 2011, 58(53); 1-100. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5853a1.htm>

Health Information Privacy For Covered Entities and Business Associates, Accessed Nov 2014;  
<http://www.hhs.gov/ocr/privacy/HIPAA/understanding/coveredentities/index.html>

HIPAA 101Guide to Compliance Rules & Laws. HIPAA Security Rule and Compliance. November 1, 2016.  
<http://www.HIPAA-101.com/HIPAA-security.htm>

HIPAA 101Guide to Compliance Rules & Laws. HIPAA and the HITECH Act. November 17, 2016.  
<http://www.HIPAA-101.com/HIPAA-hitech.htm>

HIPAA 101Guide to Compliance Rules & Laws. HIPAA Enforcement Rule and Compliance. November 17, 2016.  
<http://www.HIPAA-101.com/HIPAA-enforcement.htm>

HIPAA 101Guide to Compliance Rules & Laws. Unique Identifiers Rule (Administrative Simplification). November 17, 2016. <http://www.HIPAA-101.com/HIPAA-identifiers.htm>

HIPAA 101Guide to Compliance Rules & Laws. HIPAA Transaction & Code Sets Rule. November 17, 2016.  
<http://www.HIPAA-101.com/HIPAA-transaction.htm>

HIPAA 101Guide to Compliance Rules & Laws. HIPAA Privacy Rule and Compliance. November 17, 2016.  
<http://www.HIPAA-101.com/HIPAA-privacy.htm>

## How to use these course materials

- Review the entire syllabus, including any glossary, linked videos, and articles.
  - Mousing over a Lesson title allows you to left-click and go to that Lesson.
  - The bottom of each page displays the page number and Lesson title.
- Hold down the 'Ctrl' key while pressing the 'F' key to view a 'Find' dialog box.
  - Type in a key word or phrase to find it in the text.
  - Remember that 'Find' will find all instances of the word or phrase in the entire document. Before using 'Find', consider navigating to the proper Lesson first, in order to be as close as possible to the information you want to 'Find'.

**IMPORTANT NOTE on the limitations of this material:** This content is not localized to a particular healthcare environment, system, or entity. Since local system and administrative processes are crucial to patient safety, it is imperative that the learner be familiar with local, facility/entity practices such as: policies and procedures, equipment, patient identification and validation procedures, communication and handoff practices, etc. Adhere to your organization's policies and procedures.

Infant Abduction .....	1
Preventing abduction.....	1
The 'typical' abductor .....	2
General Guidelines.....	4
Proactive Practices.....	4

## Infant Abduction

The standard hospital emergency code for Infant Abduction is Code Pink. Yours may differ, so know your emergency codes.

One of the most serious incidents that can occur in a healthcare facility is the abduction of an infant or child. Between 1965 -may 2019 there were 327 confirmed infant abductions in the United States. Of the 327 cases, 140 were taken from healthcare facilities. There are criteria that can be used to identify a potential abductor.

Remember that a potential kidnapper could be a visitor or an employee. In Pediatrics, the most serious concern is that a child might be taken by a non-custodial parent. Your facility may have policies restricting visitors. In addition, when children are admitted, it is important to find out who is legally allowed to visit.

### Preventing abduction

There are measures that can help to reduce the risk of infant or child abduction:

- Parent education

## Infant Abduction

- Visiting procedures
- Engineering controls.

Teach mothers how to identify nursery and other staff and inform them about usual routines. This is an important step in the protection of newborn and infant children. Your facility may also have visiting procedures stating who can visit and providing methods of identifying visitors. Engineering controls, such as closed-circuit TV cameras, exit-door and wrist-band alarms, and other security devices may also be in place.

One of the most important components in the prevention of infant and child abduction is an alert staff. It is important that staff involved with care of infants and children are aware of security issues and suspicious of anyone who does not belong in the area.

If you discover that an infant is missing, follow your institution's infant abduction procedures. These usually include:

- Securing all exits from the facility
- Inspecting all stairwells, rooms, and other areas where someone might hide.

### **The 'typical' abductor**

(Developed from an analysis of 256 cases)

- Female of "childbearing" age (range now 12 to 53), often overweight or appearing to be pregnant
- Most likely compulsive; most often relies on manipulation, lying, and deception.
- Frequently indicates she has lost a baby or is incapable of having one.
- Often married or cohabitating; companion's desire for a child or the abductor's desire to provide her companion with "his" child may be the motivation for the abduction.
- Usually lives in the community where the abduction takes place.
- Frequently initially visits nursery and maternity units at more than one healthcare facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire-exit stairwell for her escape; and may also try to abduct from the home setting.
- Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes any opportunity present.
- Frequently impersonates a nurse or other allied healthcare personnel.
- Often becomes familiar with healthcare staff members, staff members work routines, and victim parents.
- Demonstrates a capability to provide "good" care to the baby once the abduction occurs. In addition an abductor who abducts from the home setting is more likely to be single while claiming to have a partner.
- Often targets a mother whom she may find by visiting healthcare facilities and tries to meet the target family.

## Infant Abduction

- Often both plans the abduction and brings a weapon, although the weapon may not be used.
- Often impersonates a healthcare or social-services professional when visiting the home.
- More likely to be single while claiming to have a partner

There is no guarantee an infant abductor will fit this description.

The Joint Commission (TJC), an accrediting agency, is a private, not-for-profit organization dedicated to improving the quality and safety of medical care provided to the public. It is an agency that sets the principal standards and evaluations for a variety of healthcare organizations. Infant/pediatric security is an area of concern to TJC as a high-risk security area often referred to as “security-sensitive area.” Such areas require a specific access-control plan, initial and periodic security-related training for staff members working in those designated areas, and a critical-incident response plan. It is common for TJC surveyors to ask in-depth questions regarding the implementation of infant/pediatric security plans. infant/pediatric abductions or discharge to the wrong family are reviewable sentinel events under the sentinel-event standards of TJC.

The typical abduction from a healthcare facility involves an “unknown” abductor impersonating a nurse, healthcare employee, volunteer, or relative in order to gain access to an infant. The obstetrics unit is an open and inviting one where patients’ decreased length of stay, from one to three days, gives them less time to know staff members. In addition it can be filled with medical and nursing staff members, visitors, students, volunteers, and participants in parenting and newborn-care classes.

The number of new and changing faces on the unit is high, thus making the unit an area where a “stranger” is unlikely to be noticed. Because there is generally easier access to a mother’s room than to the newborn nursery and a newborn infant spends increasingly more time with his or her mother rather than in the traditional nursery setting, **most abductors “con” the infant directly from the mother’s arms.**

All healthcare personnel should be alert to any unusual behavior they encounter from individuals such as:

- Repeated visiting or requests “just to see” or “hold” the infants.
- Close questioning about healthcare-facility procedures, security devices, and layout of the floor such as, “When is feeding time?” “When are the babies taken to the mothers?” “Where are the emergency exits?” “Where do the stairwells lead?” “How late are visitors allowed on the floor?” “Do babies stay with their mothers at all times?”
- Taking uniforms or other means of identification within that facility.
- Physically carrying an infant in the facility’s corridor instead of using the bassinet to transport the infant, or leaving the facility with an infant while on foot rather than in a wheelchair.
- Carrying large packages off the maternity unit (e.g., gym bags, suitcases, backpacks), particularly if the person carrying the bag is “cradling” or “talking” to it.

Be aware that a disturbance may occur in another area of the healthcare facility creating a diversion to facilitate an infant abduction (e.g., fire in a closet near the nursery or loud, threatening argument in the

## Infant Abduction

waiting area). Healthcare facilities need to be mindful of the fact that infants can stay in or need to be taken to many areas within the facility. Thus vigilance for infant safety must be maintained in all areas of the facility when infants are present.

**General Guidelines** (You MUST review your facility guidelines; these are non-specific and lack the details necessary for full compliance with your local facility and regional standards.)

- Persons exhibiting the behaviors described above should be immediately asked why they are in that area of the facility. Immediately report the person's behavior and response to the nurse manager/supervisor, security, and administration. The person needs to be positively identified, kept under close observation, and interviewed by the nursing manager/supervisor and security. Remember, caution needs to be exercised when interacting with people who exhibit these behaviors.
- Report and interview records on the incident should be preserved in accordance with the organization's internal procedures. (Many suggest records should be kept from a minimum of seven years up to the child reaching adulthood.)
- Each facility should designate a staff person in their critical-incident response plan who will have the responsibility to alert other birthing facilities in the area when there is an attempted abduction or someone is identified whom demonstrates the behaviors described above, but who has not yet made an attempt to abduct an infant.

**Proactive Practices** (Again, these are general. Know your facilities standards.)

As part of contingency planning, the backbone of prevention, every healthcare facility must develop, test, and critique a written proactive-prevention plan for infant abductions that includes all of the elements listed in this section. In addition measures must be taken to inform new or rotating (temporary) employees of these procedures as they join the staff. This plan needs to be tested, documented, and critiqued at least annually.

Immediately after the birth of the infant and before the mother and infant are separated, attach identically numbered ID bands to both the infant (2 bands) and mother (1 band) and 1 band to the father or mother's significant other when appropriate. Inform parents of the reason or need for the bands. If the fourth band is not used by the father/mother's significant other, that fact must be documented. This band may be stapled to the chart or cut and placed in the "sharps box."

An infant's band needs to be verified with the mother when taking the infant for care as well as upon delivery of the infant to the mother after care has been rendered. The caregiver must examine and verify both the baby and the mother's (or significant other's) identification bands and have the mother (or significant other) do the same.

## Infant Abduction

If an infant band is removed for medical treatment or comes off for any reason, immediately reband the infant after identifying the infant, using objective means such as footprint comparisons or blood testing, and change all bands, mother's, father's/significant other's, and infant's, so once again the bands all have the same number. If the band is cut or entirely removed, parents should be present at the removal and replacement.

Prior to the removal of a newborn from the birthing room or within a maximum of two hours of the birth

- Footprint (with emphasis on the ball and heel of the foot) the infant making sure the print is clear. Repeat if necessary.
- Take a color photograph or color video/digital image of the infant.
- Perform a full, physical assessment of the infant, and record, in the medical chart, the assessment along with a description of the infant.
- Store a sample of the infant's cord blood and any other blood specimens until at least the day after the infant's discharge.
- Place electronic security tags, if such a system is being used.
- The footprints, photograph or video/digital image, physical assessment, and documentation of the placement of the ID bands, including their number, must be noted in the infant's medical chart.
- Require all healthcare-facility personnel to wear, above the waist and "face-side" out, up-to-date, conspicuous, color-photo ID badges. The person's name and title need to be easily identifiable, and the person's photograph needs to be large enough so that he or she is recognizable.
- Update the photograph as the person's appearance changes. These badges need to be returned to Human Resources or the issuing department immediately upon termination of employment.
- Personnel who are permitted to transport infants from the mother's room or nursery, including physicians, should wear a form of unique identification used only by them and known to the parents (e.g., a distinctive and prominent color or marking to designate personnel authorized to transport infants). IDs should be worn above the waist, "face-side" out, on attire that will not be removed or hidden in any way. Paraphernalia should not be worn on name badges (i.e., pins, stickers, and advertisements) that hide name, face, or position. ID systems should include provisions for all personnel, who are permitted to transport infants from the mother's room or nursery including students, "transporters," and temporary staff members, such as the issuance of unique temporary badges that are controlled and assigned each shift (e.g., strict control should be similar to narcotics control). This unique form of identification should be periodically changed.
- Limit infant transportation to an authorized staff member wearing the authorized infant-transportation ID badge.



## Infant Abduction

- Ensure the mother or father/significant other with an identical ID band for that infant are the only others allowed to transport that infant, and educate the mother and father/significant other about the importance of this precaution.
- Prohibit leaving an infant without direct, line-of-sight supervision.
- Require infants to be taken to mothers one at a time. Prohibit “grouping” infants while transporting them to the mother’s room, nursery, or any other location.
- Prohibit “arm carrying” infants, and require all transports to be via a bassinet. Require family members transporting the infant outside the mother’s room, including the mother, father, or significant other, to wear an ID wristband.
- Distribute the guidelines for parents in preventing infant abductions
- Always place infants in direct, line-of-sight supervision either by a responsible staff member, the mother, or other family member/close friend so designated by the mother, and address the procedure to be followed when the infant is with the mother and she needs to go to sleep/the bathroom and/or is sedated. If the mother is asleep when the infant is returned to the room, staff members should be careful to fully awaken her before leaving the room. In rooming-in situations, place the bassinet so the mother’s bed is between the exit door(s) to the room and the bassinet.
- Do not post the mother’s or infant’s full name where it will be visible to visitors. If necessary, use surnames only. Do not publish the mother’s or infant’s full name on bassinet cards, rooms, status or white boards. Do not leave charts, patient index cards, or any other medical information visible to anyone other than medical personnel. Be aware that identifying information in the bassinet such as ID cards with the infant’s photograph and the family’s name, address, and/or telephone number may put the infant and family at risk after discharge. Keep this information confidential and out of sight. Do not provide patient information via the telephone.
- Conform with an access-control policy for the nursing unit, nursery, maternity, neonatal-intensive care, and pediatrics to maximize safety.
- Require a show of the ID wristband for the person taking the infant home from the healthcare facility and be sure to match the numbers on the infant’s bands, as worn on the wrist and ankle, with the bands worn by the mother and father/significant other.

**Know and conform with your facility’s critical-incident-response plan to respond to an infant abduction.**

### References

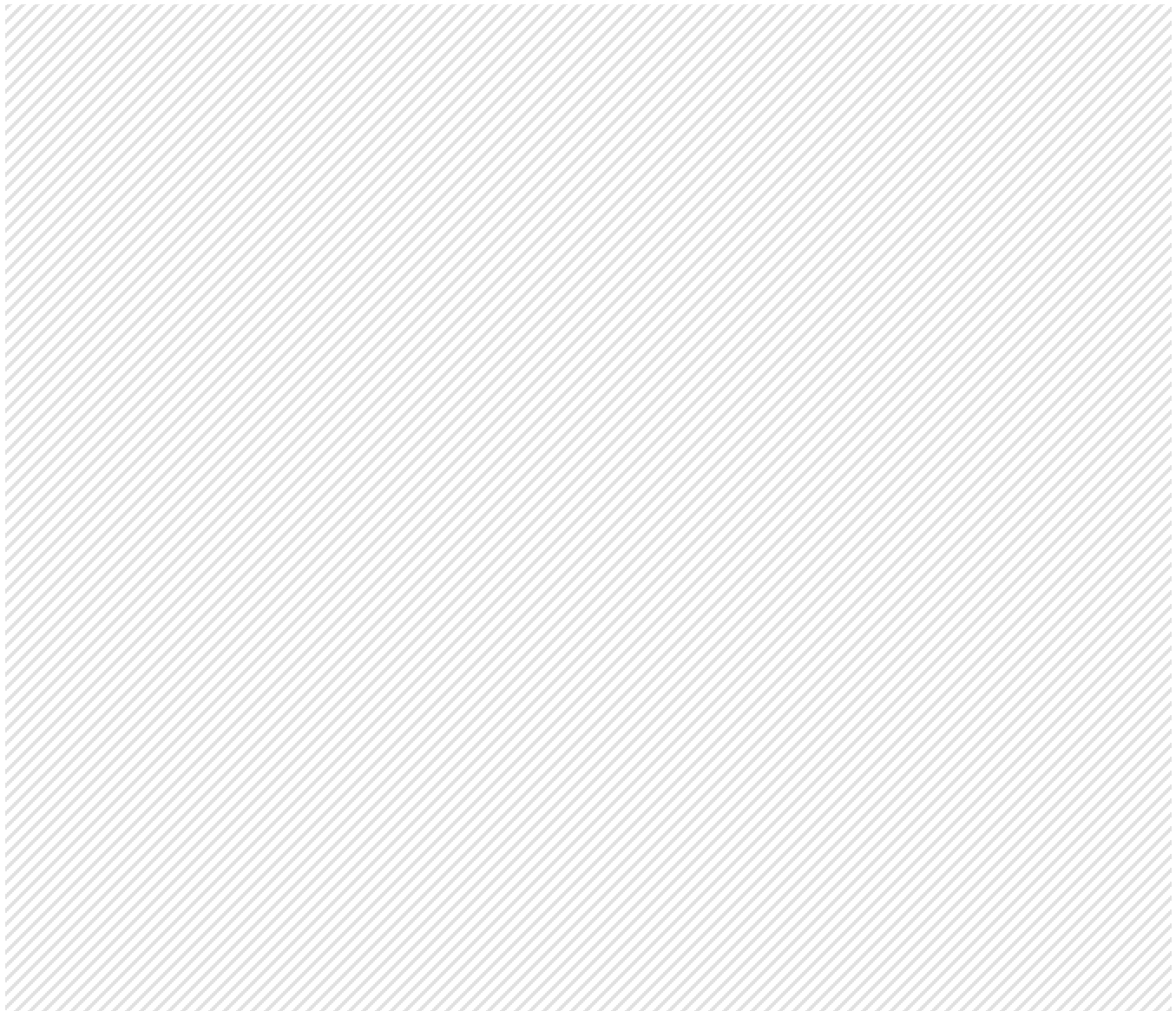
**Infant Abduction. (2019). Retrieved October 8, 2019, from [www.missingkids.org/theissues/infantabductions#bythenumbers](http://www.missingkids.org/theissues/infantabductions#bythenumbers).**

### End of Infant Abduction Lesson

# Infection Control

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

Introduction .....	3
Infection Control Procedures.....	3
Infection Control Precautions .....	4
Cleaning, Disinfecting and Disposal.....	5
Infectious Agents in the Healthcare Setting.....	6
References.....	8

---

# 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 15 seconds is the preferred primary method of hand hygiene. Decontamination with alcohol-based hand hygiene products is acceptable if hands are not visibly soiled.

**Healthcare employees should decontaminate hands:**

- Before and after any direct contact with patients or their immediate environment.
- Before and after donning gloves, sterile or non-sterile.
- When moving from a contaminated body site to a clean body site during patient care.
- After handling any soiled or unclean materials.
- Before eating and after using the restroom.
- After coughing or sneezing on hands.
- 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.

## 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 or 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 patients' 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 sharps 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 object into a full sharps container. Never dispose of any medical sharp objects anywhere except the sharps 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 on 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 infectious 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 for a N95 mask every year and trained to properly wear the N95 mask. When treating Tuberculosis and SARS patient 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 of 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/waist, and sharps are all biological waste materials. 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 are capable of producing 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.

## 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 mainly 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 an 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 most likely spread through needle sticks or sharing needles.

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

## Ebola Virus Disease

Ebola is spread by coming into direct contact with blood and bodily fluids of a symptomatic person infected with Ebola. Ebola is 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 a possible 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 devices per hospital policy and procedure.
- Clean all healthcare device sites and surgical sites per hospital policy.

The major risk factors for healthcare-associated infection caused by antimicrobial-resistant 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.

## References

“Biological Waste.” Boston University Research Compliance Environmental Health and Safety. <http://www.bu.edu/ehs/services/waste/biological-waste/>. Accessed December 2019.

“Chain of Infection: Definition & Example.” Study.com. <https://study.com/academy/lesson/chain-of-infection-definition-example.html>. Accessed December 2019.

“Ebola (Ebola Virus Disease).” Center for Disease Control and Prevention. Page last updated August 28, 2018. <http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html>.

“Hand Hygiene in Healthcare Settings.” Centers for Disease Control and Prevention. Last updated April 29, 2019. <https://www.cdc.gov/handhygiene/providers/index.html>

“Infectious Agents.” Centers for Disease Control and Prevention. Page last reviewed January 13, 2017. <https://www.cdc.gov/niosh/topics/healthcare/infectious.html>.

“Infection Control and Prevention – Standard Precautions.” Wisconsin Department of Health Services. Last Revised December 27, 2018. <https://www.dhs.wisconsin.gov/ic/precautions.htm>.

**“Occupational Exposure to HIV: Advice for Health Care Workers.” FamilyDoctor.org. Last updated July 22, 2019. <https://familydoctor.org/occupational-exposure-to-hiv-advice-for-health-care-workers/>.**

“Personal Protective Equipment.” United States Department of Labor. Occupational Safety Health Administration. <https://www.osha.gov/SLTC/personalprotectiveequipment/>. Accessed December 2019.

“Sharps Safety for Healthcare Settings.” Center for Disease Control and Prevention (CDC). Page last reviewed February 11, 2015. <https://www.cdc.gov/sharpsafety/resources.html>.

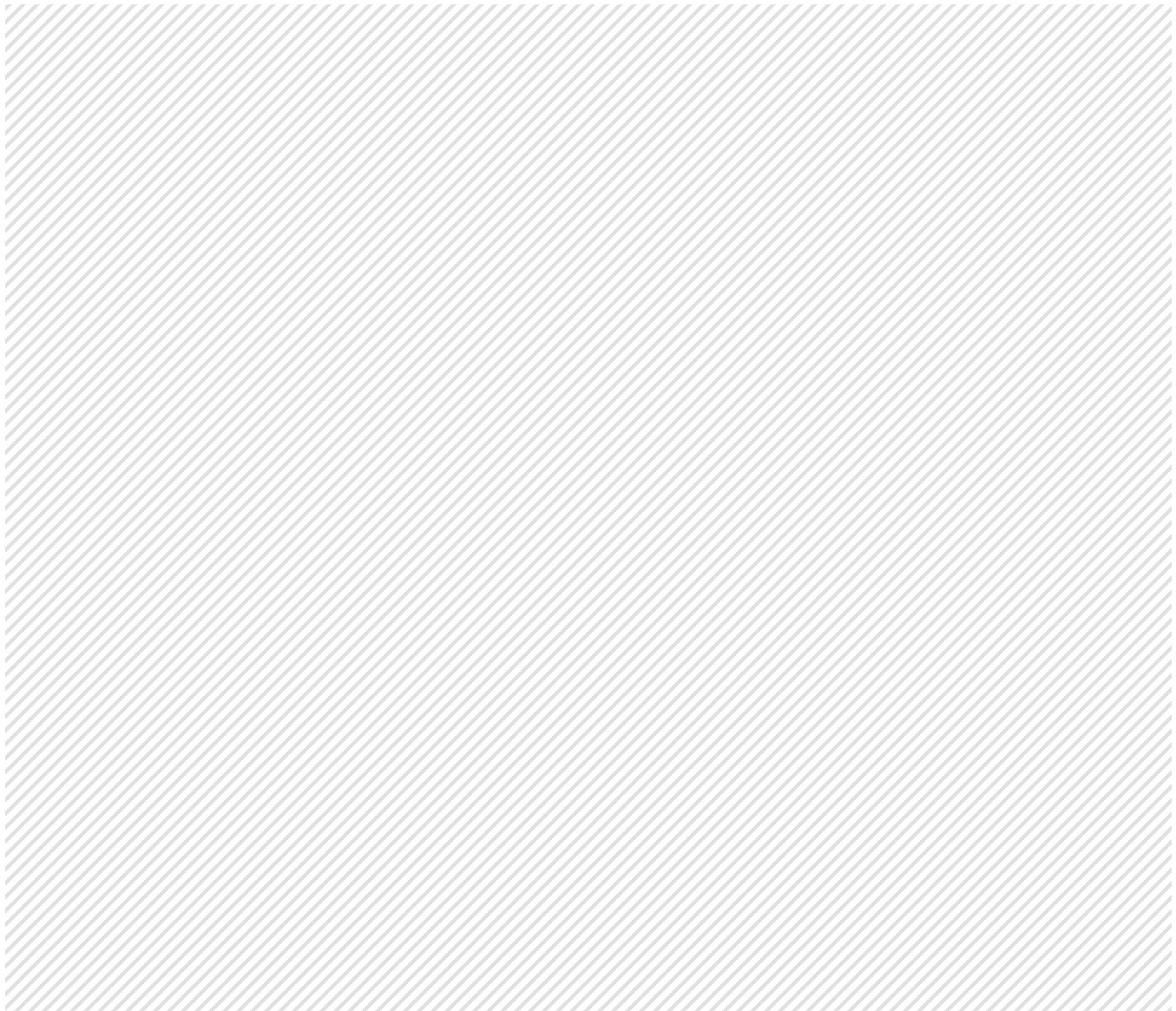
World Health Organization (WHO). (2019). The burden of health care-associated infection worldwide. Retrieved from: [www.who.int/gpsc/country\\_work/burden/hcai/en](http://www.who.int/gpsc/country_work/burden/hcai/en)

# Legal Issues in Healthcare

## Core Competency In-service

December 2018

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of API Healthcare Corporation. Portions of the information contained in this guide may be Copyright © 2006-2016 Microsoft Corporation, One Microsoft Way, Redmond, Washington 98052-6399 U.S.A.

The information in this guide is subject to change without notice. API Healthcare Corporation assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide.

All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

Introduction .....	3
Sources Used to Interpret the Law.....	3
Negligence vs Malpractice.....	4
Healthcare Laws.....	4
Documentation.....	5
Just Culture.....	6
References.....	6

---

# Introduction

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

## Sources Used to Interpret the Law

### Standards of Care

Standards of care 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 health 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, a liability exists which can result in a lawsuit being filed against the healthcare professional whether they acted in good faith or not.

---

# Healthcare Laws

## Health Insurance Portability and Accountability Act (HIPAA): Privacy Rule

All healthcare professionals across the healthcare industry are required by law to protect the privacy of their patients. The HIPAA Privacy Rule is a federal regulation that requires healthcare professionals to take all reasonable measures to make sure that patient information is only viewed by those with proper authority on a need to know basis. Patients also have the right to obtain a copy of their medical chart to have in their possession if they so choose.

## Fraud and Abuse Laws

Fraud is defined as purposefully submitting misinterpreted medical claims for monetary gains. Abuse is, purposefully or accidentally, billing for unnecessary medical services. To help prevent fraud and abuse healthcare professionals must be vigilant in reporting fraudulent claims and abuse to the appropriate federal authorities. Providers, as well as consumers, must be committed to providing appropriate documentation in order to address abuse issues, and take a moral and ethical stand against fraud in the healthcare environment. The federal government has set laws to help reduce fraud and abuse.

- **False Claims Act:** Prevents knowingly submitting claims that are not true.
- **Anti-Kickback Statutes:** Prevents rewards in exchange for referrals.

- 
- **Physicians Self-Referral Law (Stark Law):** Prevents physicians from referring patients to any company they, or their family members, are invested in.
  - **Criminal Healthcare Fraud Statute:** Protects against submitting claims that were not medically necessary.

## Consent

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

## Documentation

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.**

## Incident, Occurrence, Event Report

An incidence report also called an occurrence or event report is a tool used to document near misses, potential legal issue, or patient harm. Occurrence reports should be a nonjudgmental way for healthcare professionals to report facts about a problem and its consequences. Completing an incident report is not admitting to negligence. These tools are simply records of every event that isn't a part of routine medical care.

## The incident report should include:

- A detailed description of how the incident happened.
- Where and at what time the incident happened.
- Who was present to witness the event?
- How the patient was cared for after the event.
- Who was notified?
- Patient's symptoms and activity before the event occurred.
- Post event vital signs.
- Were any injuries sustained during the event?
- Were any environmental hazards involved in the event?
- Corrective actions taken to prevent this from occurring again.

---

## Just Culture

To promote effective reporting and achieve quality care, facilities need to adopt what's referred to as a "just culture." The just culture recognizes that it's 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.

## References

Legal Issues in Health Care. January 2010.

<https://uthsc.edu/Medicine/legaledu/>

Risk Management and Legal Issues. Valorie Dearman, MSN, RN, NEA, BC. Accessed Nov. 2014.

<http://www.jblearning.com/>

National Council of State Board of Nursing. Nurse Practice Act, Rules & Regulations. Nurse Practice Acts Guide and Govern Nursing Practice. Accessed 2016.

<https://www.ncsbn.org/nurse-practice-act.htm>

American Nurses Association. Official ANA Position Statements. 2016.

<http://www.nursingworld.org/positionstatements>

Health Information Privacy (HHS.GOV). U.S. Department of Health and Human services. The HIPAA Privacy Rule. Content created by Office for Civil Rights (OCR). 2016.

<http://www.hhs.gov/hipaa/for-professionals/privacy/index.html>

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services. Medicare Fraud and Abuse. October 2016.

[www.cms.gov/.../MLNProducts/Downloads/Fraud\\_and\\_Abuse.pdf](http://www.cms.gov/.../MLNProducts/Downloads/Fraud_and_Abuse.pdf)

HC Pro. What to include on the incident report. Long-Term Care Nursing Advisor, Barbara Acello, RN, BSN. August 22, 2008 -2016.

<http://www.hcpro.com/HOM-217534-2474/What-to-include-on-the-incident-report.html>

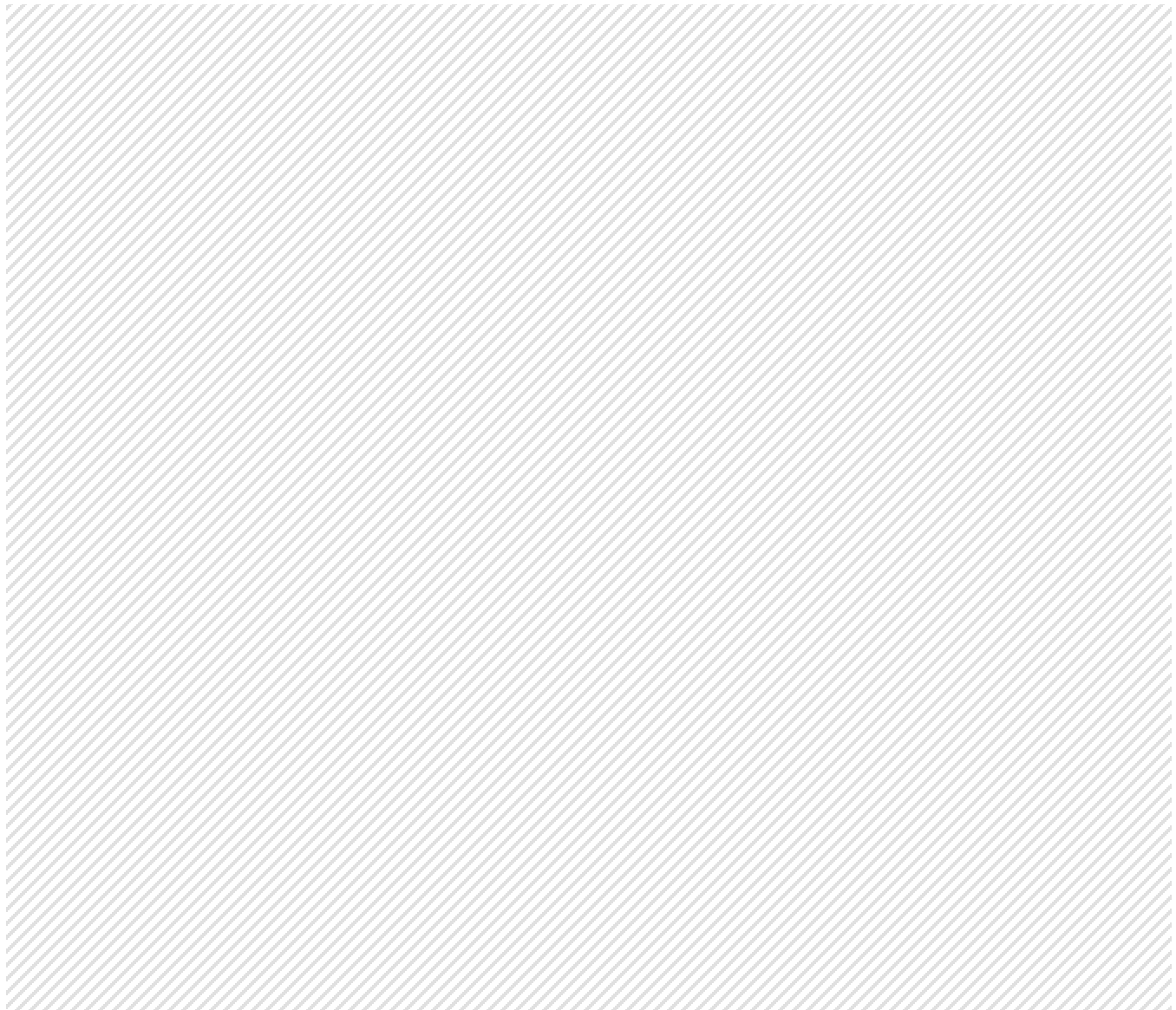
The Law, Science & Public Health Law Site. Incident Reports. Professor Edward P. Richards, III, JD, MPH.

<http://biotech.law.lsu.edu/books/aspen/Aspen-INCIDENT.html>

# Medication Safety Nursing

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.



---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<i>Start with the basics.....</i>	<i>3</i>
<i>Minimize distractions and interruptions .....</i>	<i>3</i>
<i>Implement these additional safety measures: .....</i>	<i>3</i>
<b>The Eight Rights of Medication Administration .....</b>	<b>4</b>
<b>Classification of Narcotics.....</b>	<b>5</b>
<b>Narcotic Handling, Storage and Disposal.....</b>	<b>6</b>
<i>Locked Medication Cabinets .....</i>	<i>6</i>
<i>Medicine Carts.....</i>	<i>6</i>
<i>Automated Drug Dispensing Systems .....</i>	<i>7</i>
<i>Documentation.....</i>	<i>7</i>
<i>Disposal of Narcotics.....</i>	<i>8</i>
<b>Adverse Reactions .....</b>	<b>8</b>
<b>Reference .....</b>	<b>9</b>

---

# 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's 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 contraindications exist, don't 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 shouldn't 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 on 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 don't 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 right of medication administration, some experts have added 3 more to the list. When it comes to patient safety, it's never a bad 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 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's 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 to 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 to some degree.
  - 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 adequately 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 user names 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:**

1. 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.

- 
2. 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.
  3. 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 effect 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:**

## Reference

ASHP guidelines on the safe use of automated dispensing devices. (2019, July 21). ASHP. Retrieved from <http://www.ashp.org/DocLibrary/BestPractices/AutoITGdlADDs.a.spx> • Blackmere, J. et al. (2017). Determining the most efficient controlled substance inventory practice that minimizes discrepancies and maximizes security. • Eckman, M., Labus, D, & Thompson, G., Eds. (2009). Nursing Pharmacology Made Incredibly Easy, 2 nd ed. Amber, PA: Wolter Klower Health/Lippincott Williams & Wilkins. • Gebhart, F. (2016, December 15).

Institute for Safe Medication Practices. (2019). "2018-19 targeted medication safety best practices for hospitals" [Online]. Accessed April 2016 via the Web at <http://www.ismp.org/tools/bestpractices/TMSBP-for-Hospitals.pdf>

Nursing 2019 Drug Handbook. (2019). Wolters Kluwer: Philadelphia, Pennsylvania.

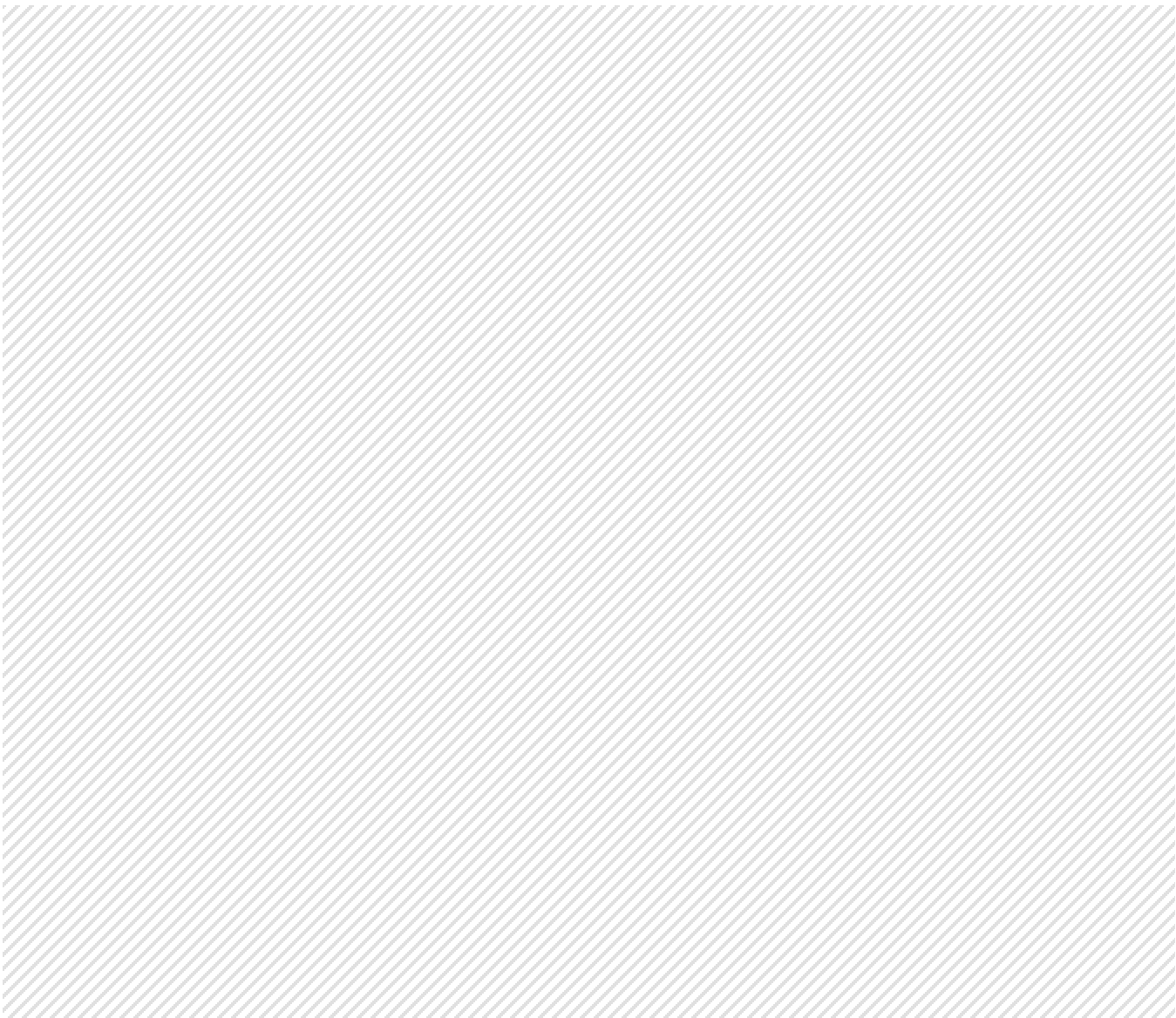
Safe medication administration practices, general. (2019). In Lippincott procedures. Retrieved from <http://procedures.lww.com>.



# Moderate Sedation Core

## Core Competency In-service

December 2018



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

Pre-procedure Phase.....	3
Intra-procedure Phase .....	3
Post-procedure Phase .....	4
Discharge Criteria for Patients Discharged on Day of Procedure .....	4

---

# Moderate Sedation/Analgesia

A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation was be provided by qualified individuals. For all patients receiving IV push sedation, a properly credentialed physician must be present at all times during the administration of the medication and until the conclusion of the procedure.

Intravenous drugs should be given in small, incremental doses that are titrated to the desired end points. Sufficient time must elapse between doses to allow the effect of each dose to be assessed before subsequent drug administration. When drugs are administered by non-intravenous routes, allowance should be made for the time required for drug absorption before supplementation is considered.

The response of patients to commands during procedures performed with moderate sedation serves a guide to their level of consciousness. This, as well as monitoring of respiratory rate and pulse oximetry (by observation and/or auscultation), should be measured and recorded at a frequency determined by the type and amount of medication administered, as well as the length of the procedure.

## Pre-procedure Phase

**All patients receiving moderate sedation will have the following:**

- Vital signs; O2 saturation
- Determination of drug allergies
- Relevant medical/surgical history
- Patent IV access
- Pre-sedation assessment and reassessment just before induction, completed by the physician
- Determination of level of consciousness
- NPO status (no solids 6-8 hours prior to procedure; no clear liquids 2-3 hours prior to procedure)
- ASA classification by the physician
- Cardiac monitoring
- Pre-procedure Aldrete score
- Signed informed consent

## Intra-procedure Phase

- The patient will be monitored throughout the procedure and vital signs will be documented every 5 minutes. This includes blood pressure, heart rate, respiration, and O2 saturation.
- Observe and assess skin color and perfusions, level of consciousness, and patient to the procedure.
- Document all drugs and intravenous fluids administered per policy.

- 
- Use of reversal agents: Specific antagonists should be available whenever opioid analgesics or benzodiazepines are administered for moderate sedation. Following pharmacological reversal, patients should be observed long enough to ensure that cardiorespiratory depression does not occur.

## Post-procedure Phase

- At the completion of the procedure, the patient's status will be evaluated using the Aldrete scoring system.
- The patient will have q 15 minute vital signs monitoring until an Aldrete score of at least 9 and/or a pre-sedation level of consciousness/activity have been achieved. If, after 60 minutes, the patient has not achieved an Aldrete score of 9 or a pre-sedation level of consciousness/activity, the attending physician is to be notified.
- Continuous electrocardiographic monitoring is required for all patients.
- Vital signs will be taken post procedure q 15 minutes x 4, at a minimum.
- Patients may not be discharged for a minimum of 1 hour following the procedure unless specifically ordered by the physician.
- All patients who receive a reversal agent should be monitored an additional 60-90 minutes to ensure that the reversal agent does not wear off before the sedative.

## Discharge Criteria for Patients Discharged on Day of Procedure

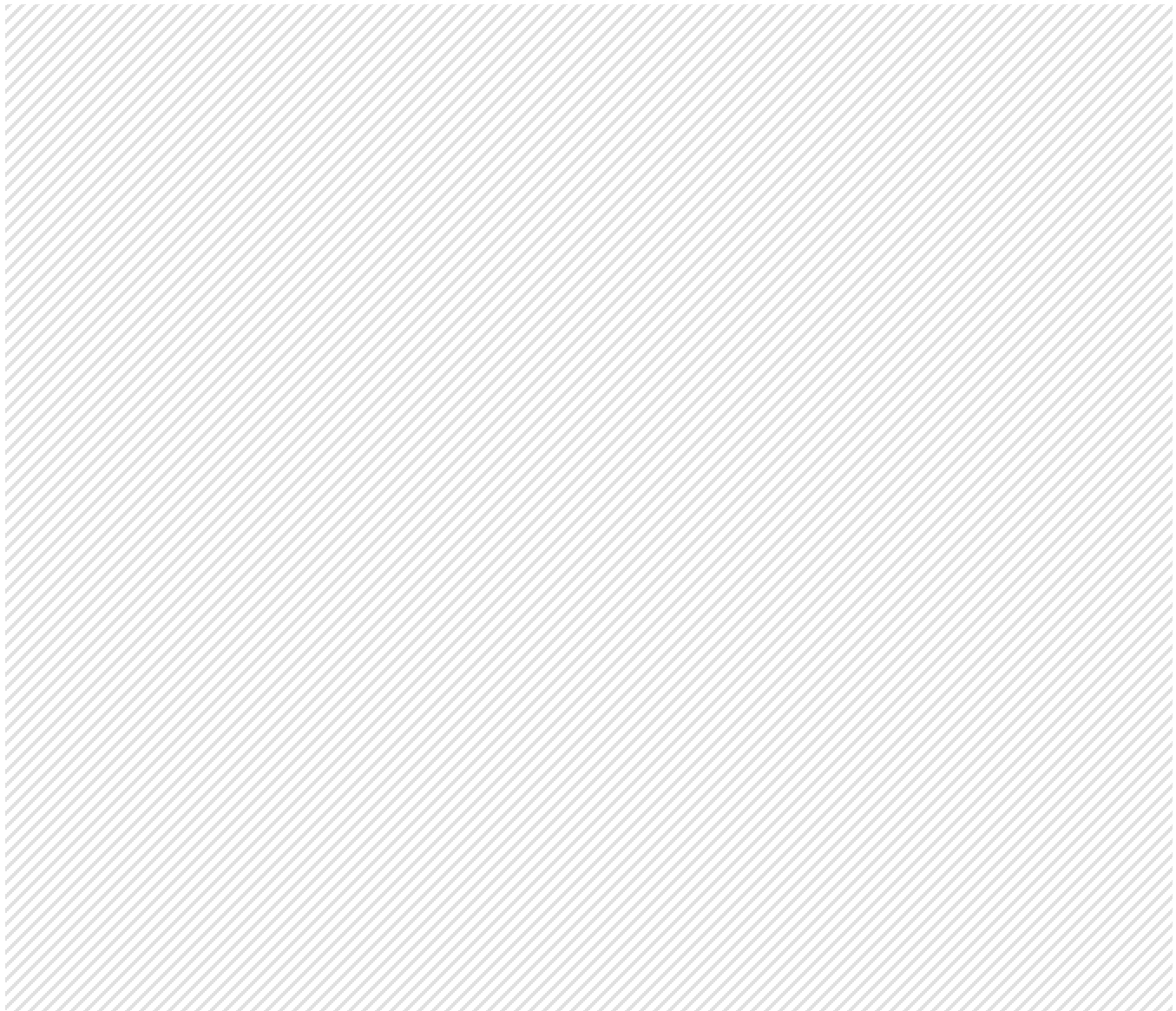
1. Awake, alert, and oriented or at pre-sedation level of consciousness.
2. Vital signs within normal limits for patient. Pulse oximetry reading at pre-procedure levels.
3. Able to drink fluids without nausea/vomiting (if applicable).
4. Must be able to void or have the sensation prior to discharge.
5. Able to move all extremities and ambulate consistent with pre-procedure status, age and procedure.
6. Sufficient time has elapsed following the last administration of reversal agents to ensure that patients do not become re-sedated after reversal effects have worn off.
7. No unusual bleeding and/or discharge.
8. Written physician discharge order.
9. Patient and/or significant other receive written instructions regarding activity, diet, potential side-effects, complications, and post-procedure care.
10. All patient teaching documented per policy.

# National Patient Safety Goals

## Core Competency Inservice

January 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

Identify Patient/Residents Correctly.....	3
Improve Staff Communication .....	3
Use Medicines Safely.....	3
Alarm Management .....	3
Prevent Infection .....	3
Identify Patient/Resident Safety Risks .....	4
Prevent Patient/Residents from Falling .....	4
Prevent Pressure Ulcers .....	4
Prevent Mistakes in Surgery .....	4
References.....	4

---

## Identify Patient/Residents Correctly

- Use at least two ways to identify patient/residents. For example, use the patient/resident's name and date of birth. This is done to make sure that each patient/resident gets the medicine and treatment meant for them.
- Make sure that the correct patient/resident gets the correct blood type when they get a blood transfusion.

## Improve Staff Communication

- Quickly get important test results to the right staff person on time
- Report critical results of tests and diagnostic procedures on a timely basis

## Use Medicines Safely

- Before a procedure, label all medications, medication containers, and other solutions that are not labelled before a procedure. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- Take extra care with patients who take medicines to thin their blood.
- Record and pass along correct information about patient/resident's medications. Find out what medicines each patient/resident is taking at home. Make sure that it is OK for the patient/resident to take any new medicines with their current medicines. Give a list of the patient/resident's medicines to their next caregiver or to their regular doctor before the patient/resident goes home. Give a list of the patient/resident's medicines to the patient/resident and their family before they go home. Explain the medications to the patient and family.

## Alarm Management

- Make improvements to ensure that alarms on medical equipment are heard and responded to in a timely manner to prevent patient injury.

## Prevention of Infection

- Use hand washing guidelines from Center for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
- Use proven guidelines to prevent health care-associated infections due to multidrug-resistant organisms.
- Use proven guidelines to prevent infection of the blood from central lines.
- Use proven guidelines to prevent infection after surgery.
- Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

---

## Identify Patient/Resident Safety Risks

- Identify safety risks inherent in the patient/resident population.
- Find out which patient/residents are most likely to try to commit suicide.
- Find out if there are any risks for patient/residents who are getting oxygen. For example, fires in the patient/resident's home (Home Care).

## Prevent Patient/Residents from Falling

- Reduce the risk of patient harm resulting from falls.
- Find out which patient/residents are most likely to fall (for example, is the patient/resident taking any medicines that might make them weak, dizzy or sleepy) and take appropriate actions to prevent falls.

## Prevention of Pressure Ulcers

- Assess patients/residents for risk for developing pressure injury/ulcers and take actions to address any identified risks. From time to time, re-check residents for pressure ulcers (Long Term Care).
- Find out which patients and residents are most likely to develop or have pressure injury/ulcers.
- Take action to prevent pressure injury in these patients and residents. From time to time, re-check patients and residents for pressure injury/ulcers.

## Prevent Mistakes in Surgery

- Make sure the correct surgery is done on the correct patient and at the correct place on the patient's body.
- Mark the correct place on the patient's body where surgery is to be done.
- Pause before the surgery to make sure that a mistake is not being made.

## References

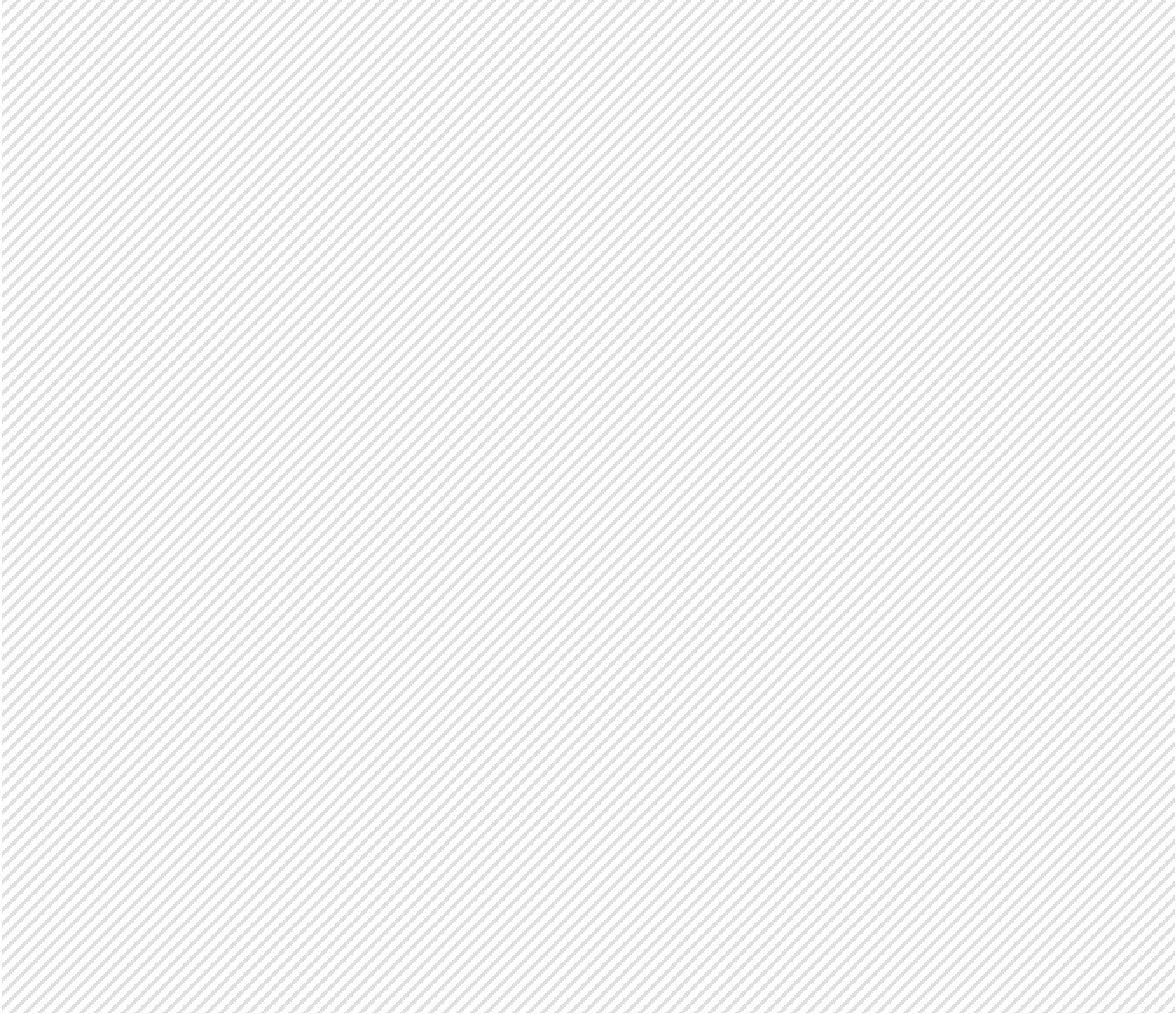

**National Patient Safety Goals: Easy to read versions. November 2020.**  
[http://www.jointcommission.org/standards\\_information/npsgs.aspx](http://www.jointcommission.org/standards_information/npsgs.aspx)



# Organ and Tissue Donation

## Nursing Core Competency Inservice

**JANUARY 2020**



---

# Contents

<b>Introduction and Background .....</b>	<b>3</b>
<b>Organ Donation .....</b>	<b>3</b>
<i>Cardiac Death.....</i>	<i>3</i>
<i>Non-Recoverable Brain Injury-Brain Death .....</i>	<i>4</i>
<i>Donation after Circulatory Determination of Death (DCDD) .....</i>	<i>4</i>
<i>Living Donors.....</i>	<i>5</i>
<b>Tissue Donation .....</b>	<b>5</b>
<b>Referral Process .....</b>	<b>5</b>
<i>Approaching the Family about Organ Donation .....</i>	<i>5</i>
<i>Donor Management, Organ Placement and Recovery .....</i>	<i>5</i>
<i>The Nurse’s Role in Organ and Tissue Donation .....</i>	<i>6</i>
<b>References.....</b>	<b>6</b>

---

# 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 are 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 in.

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 is 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. Generally, 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. Generally, 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, an authorization form is signed by the next-of-kin. 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 a short time 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

## References

Phillips, N. (2017). *Berry & Kohn's Operating Room Technique* (13th ed.). St Louis, Missouri, United States: Elsevier.

Rothrock, J. (2019). *Alexander's Care of the Patient in Surgery* (16th ed.). St Louis, Missouri, United States: Elsevier.

<https://www.tosa1.org/>

<https://unos.org/>

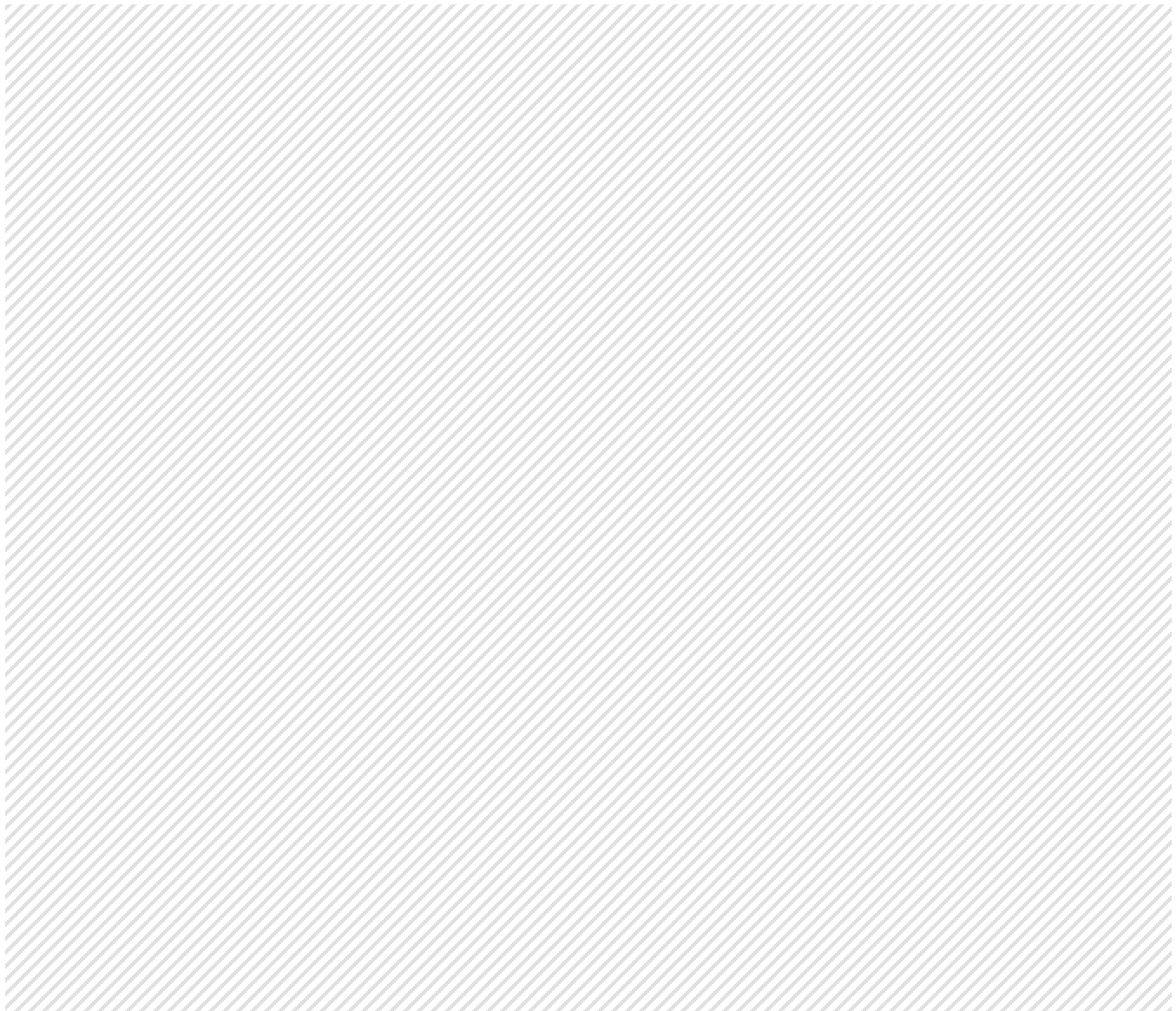
<https://www.lifegift.org/>

<https://www.lifegift.org/sites/default/files/LIF-Organ%20Tissue%20Donation%20Resource%20Manual.pdf>

# OSHA Healthcare Safety

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction</b> .....	<b>3</b>
<b>What does OSHA do?</b> .....	<b>3</b>
<b>Who is Required to Comply with OSHA?</b> .....	<b>3</b>
<b>OSHA Regulations</b> .....	<b>4</b>
<i>Administrative Safety</i> .....	4
<i>Exposure Control</i> .....	5
<i>Personal Protection</i> .....	5
<i>Facility Safety</i> .....	6
<i>Tools and Equipment</i> .....	6
<i>Behavior and Attitude</i> .....	7
<b>OSHA in the Healthcare Workplace</b> .....	<b>8</b>
<i>Organizational Safety Culture</i> .....	8
<i>Injury and Illness Prevention Programs – Moving Toward Injury Free Healthcare</i> .....	9
<i>Reporting Workplace Safety Concerns and Employee’s Rights</i> .....	9
<i>OSHA Violations and Penalties</i> .....	9
<i>Know your Rights</i> .....	10
<b>References</b> .....	<b>10</b>



---

## 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 cover state government employees.

## OSHA Regulations

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

- To maintain conditions and/or adopt practices necessary and appropriate to protect workers on the job
- Be familiar with and comply with standards applicable to their establishments
- Ensure that employees have and use personal protective equipment when required for safety and health

In addition, the OSH Act instituted a “general duty clause” (Section 5(a)(1)) which requires 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 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 properly trained on the use and maintenance of these protection devices?

### **Safety Showers and Eyewashes**

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

## **Facility Safety**

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

### **Confined Spaces**

Do you require a confined space program at your workplace?

### **Electrical Safety**

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

### **Ergonomics**

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

### **Fire Safety**

Do you have the correct fire extinguishers in 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 various types of welding activities? Do you feel your employees are safe while working around welders?

## Behavior and Attitude

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

**Conflict Resolution**

How does your organization deal with conflict?

---

### **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 ultimately 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 perhaps the most critical element of an effective injury and illness prevention program. Worker participation makes an important contribution to an employer's bottom line.

## 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 doesn't 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

## References

All About OSHA. Occupational Safety and Health Administration U.S. Department of Labor. Accessed 2016. [https://osha.gov/Publications/all\\_about\\_OSHA.pdf](https://osha.gov/Publications/all_about_OSHA.pdf)

Occupational Safety and Health Administration. OSHA Law & Regulations. Accessed 2016. <https://www.osha.gov/law-regs.html>

United States Department of Labor. Occupational Safety and Health Administration. Worker Safety in Hospitals. 2016. <https://www.osha.gov/dsg/hospitals/>

United States Department of Labor. Occupational Safety and Health Administration. Workers' Right to Refuse Dangerous Work. Accessed 2016. <https://www.osha.gov/right-to-refuse.html>

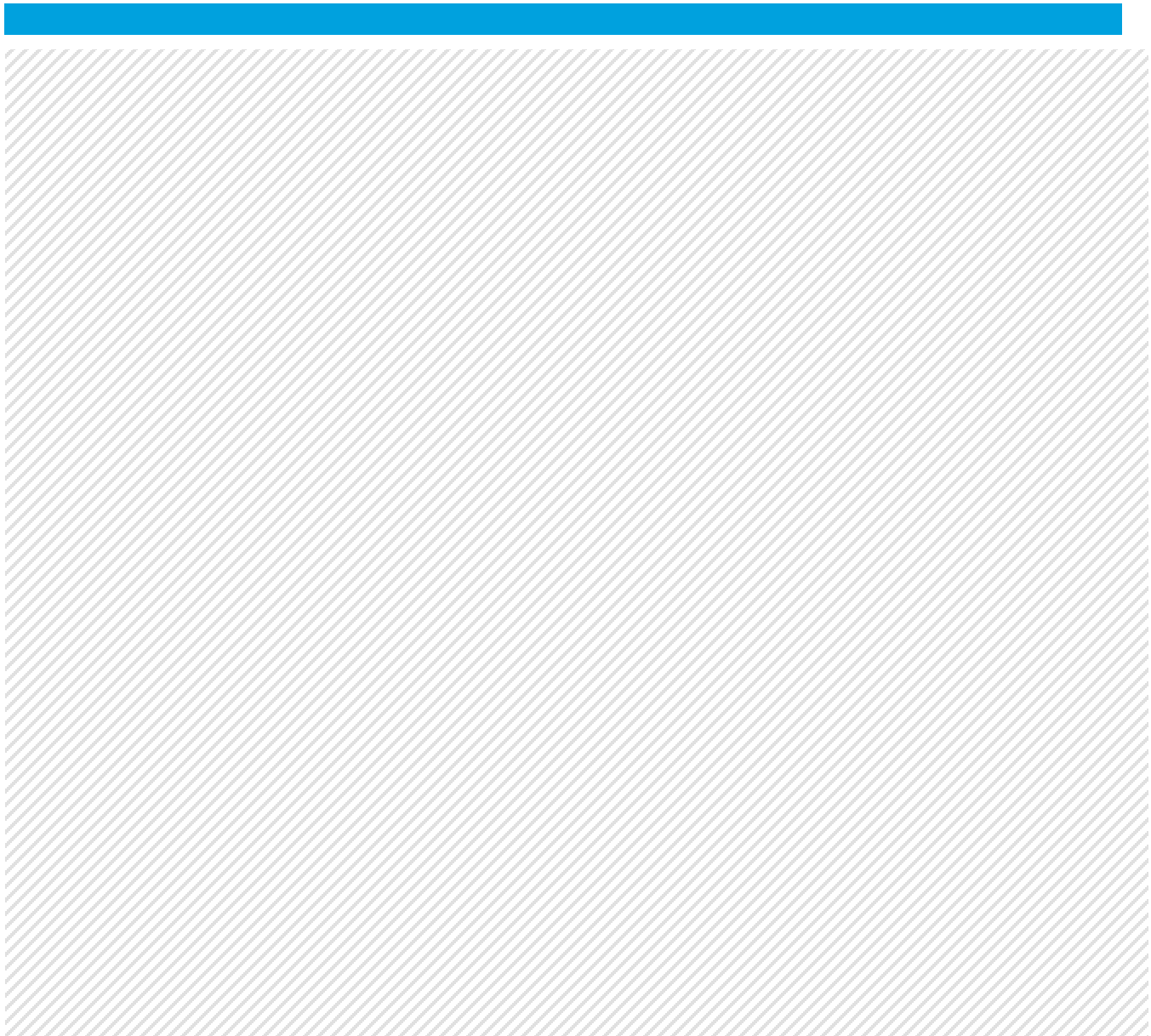
U.S. Department of Labor [www.osha.gov](http://www.osha.gov) 2018



# Pain Management

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<i>Types of Pain .....</i>	<i>3</i>
<b>Pain Assessment .....</b>	<b>3</b>
<i>Failure to Report Pain.....</i>	<i>3</i>
<i>Pain Assessment Scales .....</i>	<i>4</i>
Numeric Pain Rating Scale .....	4
Wong–Baker Face Scale .....	5
FLACC Scale .....	5
<b>Treatment for Pain.....</b>	<b>5</b>
<i>Pharmacological.....</i>	<i>5</i>
<i>Non-Pharmacological.....</i>	<i>5</i>
<b>Patient and Family Education .....</b>	<b>5</b>
<b>The Clinician’s Responsibility.....</b>	<b>6</b>
<b>Reference .....</b>	<b>6</b>

---

## Introduction

Pain is sensory discomfort derived from possible, or true, tissue damage that can cause 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.

Pain can be classified as:

**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 life time. The pain usually occurs with disease processes and worsens over time.

## Pain Assessment

Pain is an internal experience that cannot be properly 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

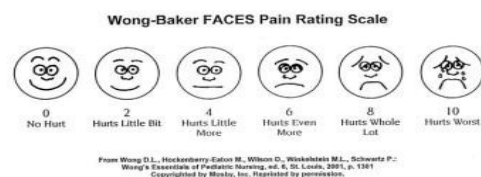
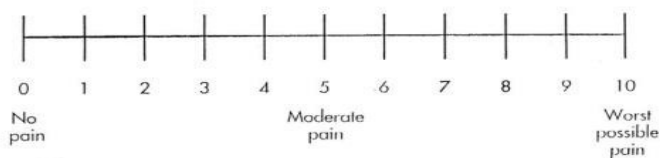
The failure to report pain should not be confused with a lack of pain. Barriers to reporting pain should be assessed during the initial admission assessment. Patients at risk for poor pain management, from a failure to report pain, include:

- 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)
- 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.

## 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 can't 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 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 don't 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

## Reference

The Cleveland Clinic. Acute vs. Chronic Pain. last reviewed on: 7/7/2014.

<http://my.clevelandclinic.org/services/anesthesiology/pain-management/diseases-conditions/hic-acute-vs-chronic-pain>

The Department of Health. Wong Baker FACES Pain rating scale. Page last updated: 21 January 2013.

<http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~trriageqrg-pain~trriageqrg-wong>

---

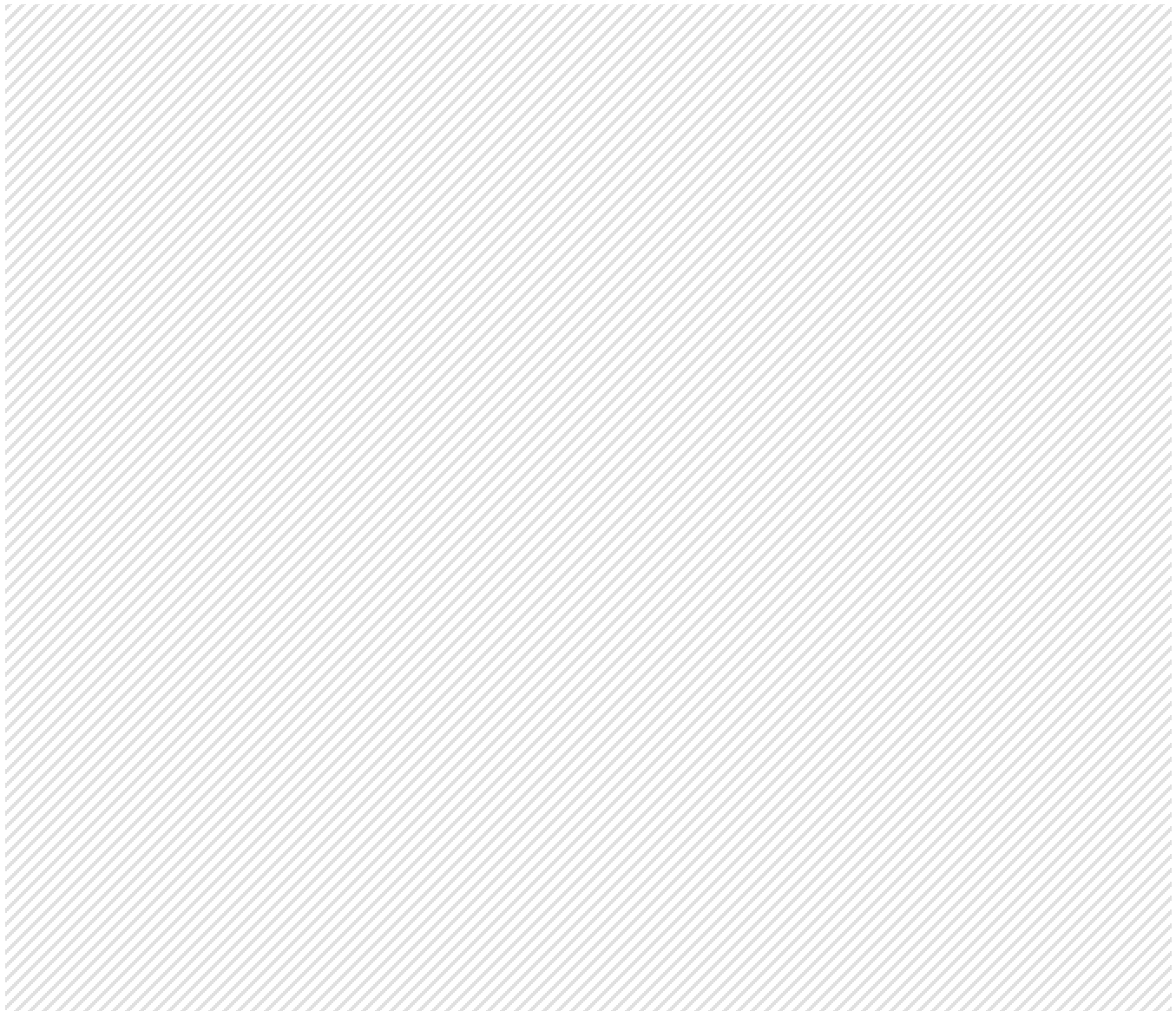
Med Scape. Pain Assessment. Author: Stephen Kishner, MD, MHA; Chief Editor: Erik D Schraga, MD. Updated: Jun 13, 2016. <http://emedicine.medscape.com/article/1948069-overview#a1>  
National Hospice and Palliative Care Organization. FLACC Score. Accessed 2016. <http://www.nhpco.org/flacc-scores>

Pain Management. Facts about Pain Management. February 4, 2014  
[http://www.jointcommission.org/topics/pain\\_management.aspx](http://www.jointcommission.org/topics/pain_management.aspx)

# Patient's Rights

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.



---

# Table of Contents

<b>Patient’s Bill of Rights .....</b>	<b>3</b>
<i>Patients have the right to.....</i>	<i>3</i>
<b>Consumer Responsibilities .....</b>	<b>4</b>
<b>Patient Rights and Health Insurance: Affordable Care Act .....</b>	<b>4</b>
<b>Patient Rights under HIPAA.....</b>	<b>5</b>
<b>Additional Rights Outlined by Joint Commission .....</b>	<b>5</b>
<b>References.....</b>	<b>5</b>

---

# 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 don't 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 representative 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 eat a healthy diet.
- Be directly involved in decisions about your healthcare.
- Work with health care providers to create and execute treatments.
- Openly give important information and discuss wants and needs.
- Use the health plans 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 in spite of 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 don’t 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 don’t 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.

## References

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care. 2010. <http://www.jointcommission.org/assets/1/6/roadmapforhospitalsfinalversion727.pdf>

Consumer Bill of Rights and Responsibilities. Report to the President of the United States, Prepared by Advisory Commission on Consumer Protection and Quality in the Health Care Industry. November 1997. Accessed 2016. <http://www.csun.edu/~hfdss003/atacp/supplements/fph9.html>

Families USA. The Affordable Care Act: Patients' Bill of Rights and Other Protections. January 19, 2019. <http://familiesusa.org/product/affordable-care-act-patients-bill-rights-and-other-protections>

HHS.gov health information Privacy. Your Rights Under HIPAA. 2016. <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

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

---

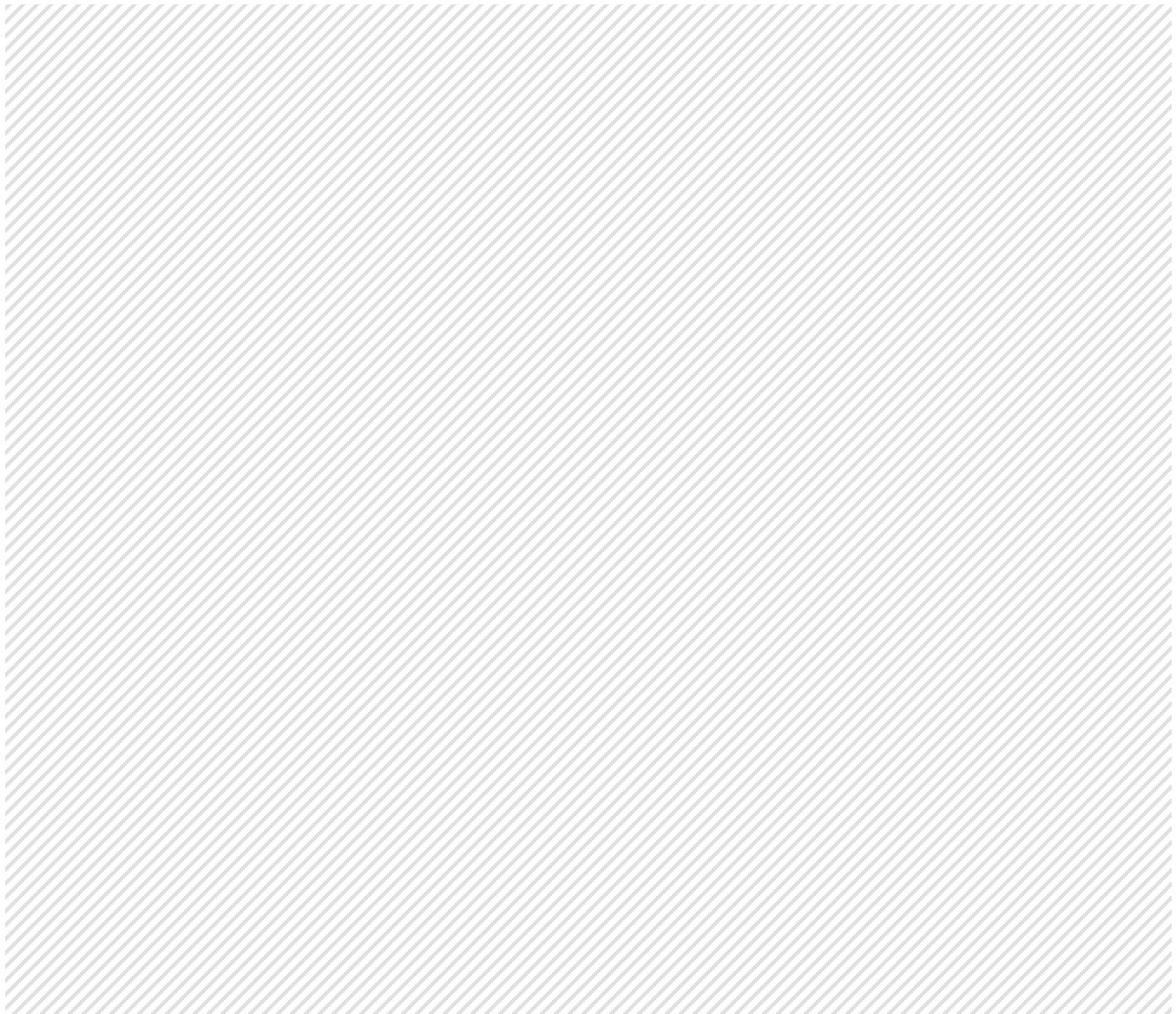
The Patient Care Partnership. Accessed December 2014.

<http://www.aha.org/advocacyissues/communicatingpts/pt-care-partnership.shtml>

# Patient Safety

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Patient Safety Systems.....</b>	<b>3</b>
<b>Safety Culture.....</b>	<b>3</b>
<b>The Role of Hospital Leaders in Patient Safety .....</b>	<b>5</b>
<b>Reference .....</b>	<b>6</b>

---

## 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, that 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, that 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, that 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 stays, the most common are:

- CAUTI
- CLABSI
- Pressure injury
- 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 is 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 processes 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.

## Reference

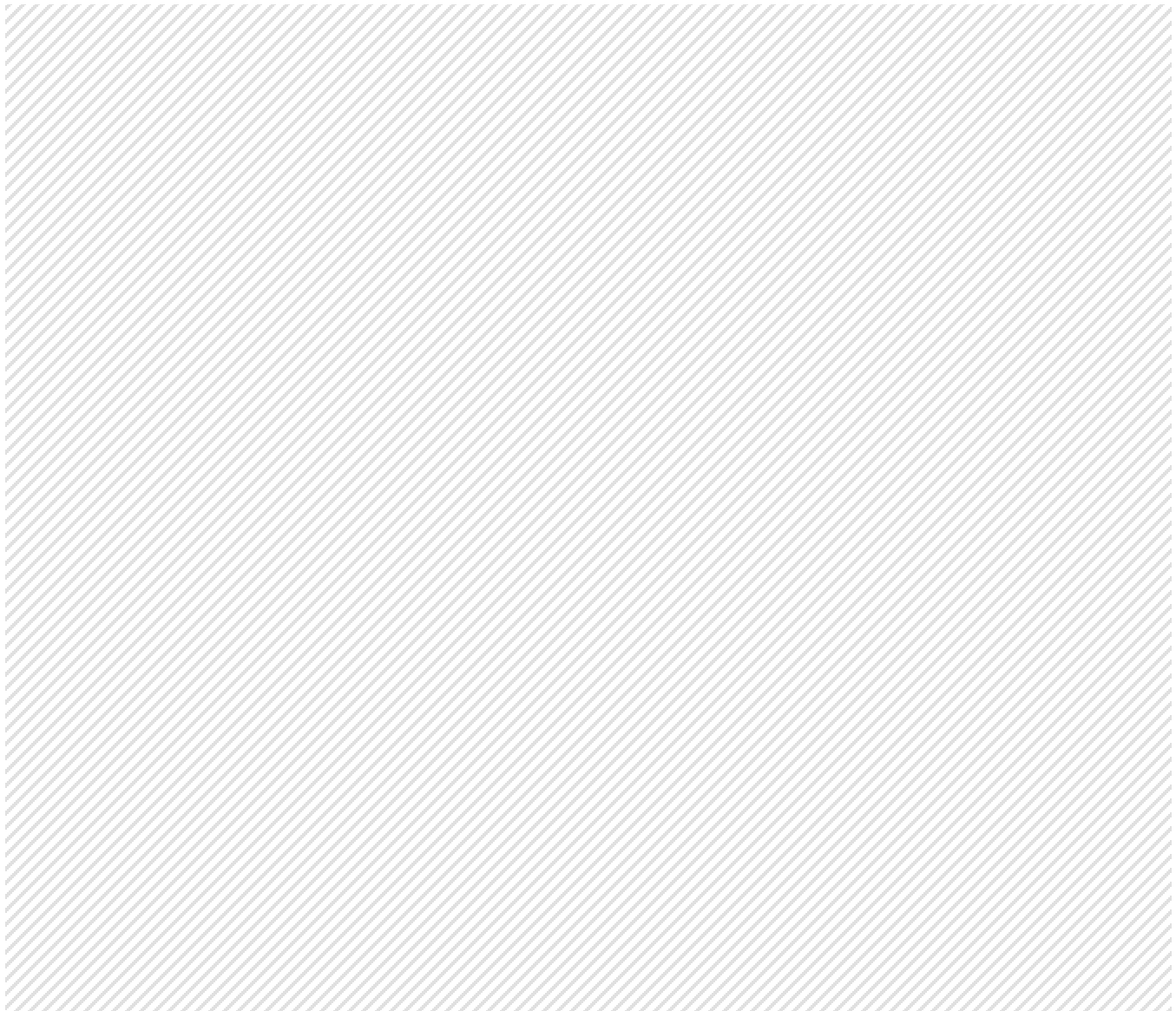
Joint Commission. Patient Safety Systems (PS). January 2019. <https://www.jointcommission.org/>

Patient Safety Systems Chapter for the Hospital Program. December 2019.  
[http://www.jointcommission.org/topics/patient\\_safety.aspx](http://www.jointcommission.org/topics/patient_safety.aspx)

# Quality Improvement

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Quality in Healthcare .....</b>	<b>3</b>
<i>Quality Improvement (QI) .....</i>	<i>3</i>
<i>Quality Assurance and Performance Improvement (QAPI).....</i>	<i>3</i>
<i>Lean Methodology .....</i>	<i>4</i>
<b>Quality Tools .....</b>	<b>4</b>
<i>Root Cause Analysis .....</i>	<i>4</i>
<i>Failure Mode Effects Analysis (FMEA).....</i>	<i>4</i>
<b>Quality Occurrences.....</b>	<b>5</b>
<i>Sentinel Event.....</i>	<i>5</i>
<i>Near Miss .....</i>	<i>5</i>
<b>Quality Measures and Reporting .....</b>	<b>5</b>
<b>References.....</b>	<b>6</b>

---

# 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 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 time frame, 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 possible improvements, find gaps in any

---

processes or procedure, execute a corrective action plan, and constantly monitor the plans effectiveness. QAPI will help improve patient outcomes and reduce medication errors.

### **QAPI encompasses two aspects of quality which includes 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 new approaches or ideas with the intent to fix or prevent problems.
- **QA+PI** PI goals include the ongoing study of processes and continuously implementing new process to improve healthcare by preventing problems, while QA goals involve meeting 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 new 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 a 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 evidence base 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 error 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 happens 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 possible system failures and correct the system problems before they occur. This reduces

---

possible harm to staff and patients and increases hospital safety. FMEA is proven to reduce errors and increase 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 doesn't 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 even must be reported, followed by a Root Cause Analysis, and then respond 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 quality of care.

## Quality Measures and Reporting

Healthcare facilities and organizations National Quality Improvement Goals are displayed in its Quality Report. Quality reports are public information, and data is updated on a quarterly basis.

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, and 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 ensures 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.

## References

CMS.Gov Center for Medicare and Medicaid Services. QAPI Description and Background. 9/20/2016. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition.html>

Duke University School of Medicine. Department of Community and Family Medicine. Patient Safety – quality Improvement. Methods of Quality Improvement. 2016. [http://patientsafetyed.duhs.duke.edu/module\\_a/methods/methods.html](http://patientsafetyed.duhs.duke.edu/module_a/methods/methods.html)

Institute for Health Care Improvement. Tools, Failure Modes and Effects Analysis (FMEA). 2016. <http://www.ihc.org/resources/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx>

Joint Commission. Comprehensive Accreditation Manual for Hospitals. Sentinel Events (SE), I. Sentinel Events, pg. 1. Bullet 1-3. Page 1. CAMH, January 2013. [http://www.jointcommission.org/assets/1/6/CAMH\\_2012\\_Update2\\_24\\_SE.pdf](http://www.jointcommission.org/assets/1/6/CAMH_2012_Update2_24_SE.pdf)

Lawal, A. K., Rotter, T., Kinsman, L., Sari, N., Harrison, L., Jeffery, C., ... Flynn, R. (2014). Lean management in health care: definition, concepts, methodology and effects reported (systematic review protocol). *Systematic reviews*, 3, 103. doi:10.1186/2046-4053-3-103

Safety and Health Magazine, National Safety Council. Near Misses, Near misses as cultural proxies, pg. 1, line 5. August 26, 2013. <http://www.safetyandhealthmagazine.com/articles/9153-near-misses>

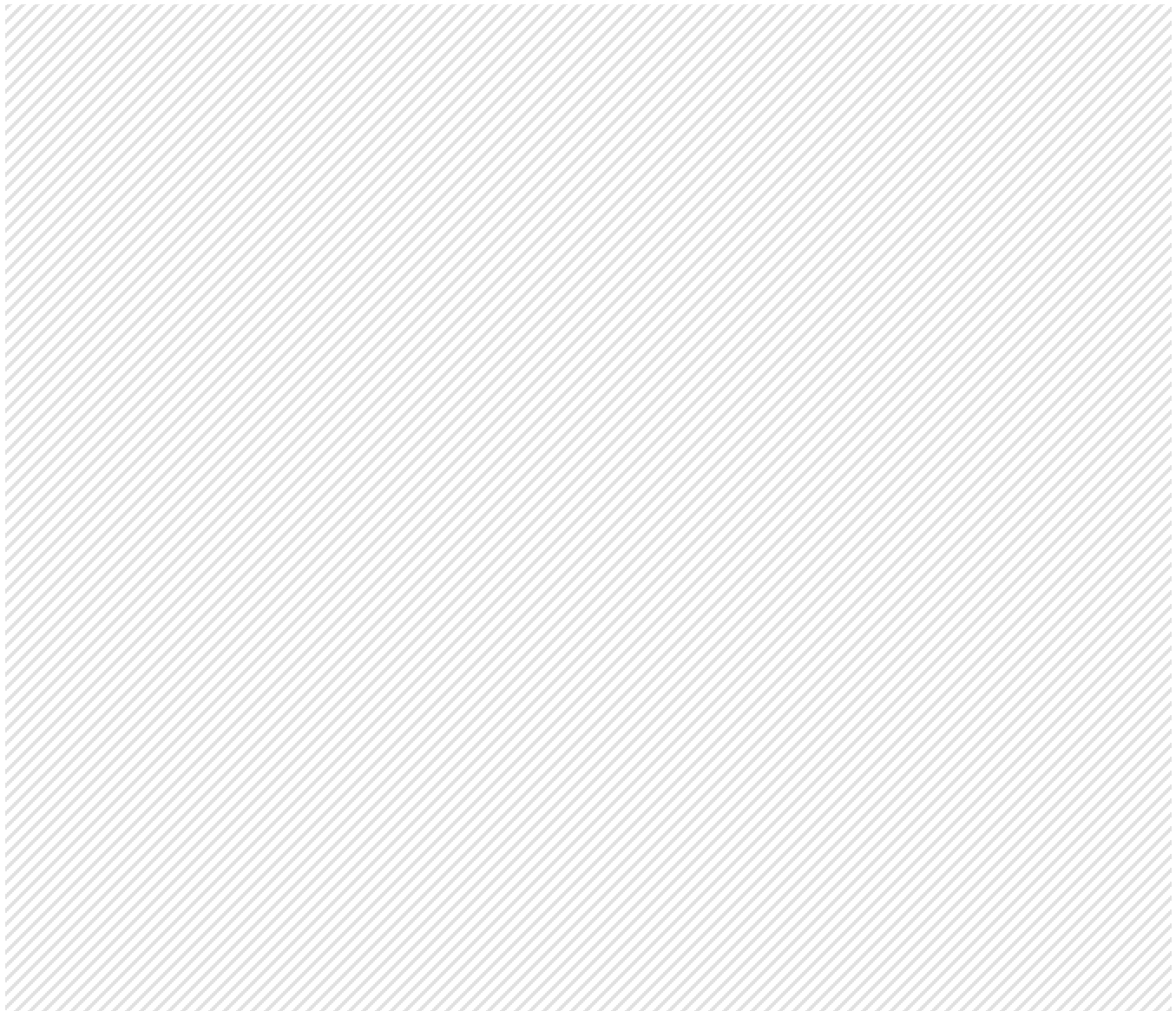
U.S. Department of Health and Human Services. Health Resources and Service Administration. Quality Improvement. Accessed 2016. <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/index.html>

U.S. Department of Health and Human Services. Agency for Healthcare Research and Quality. Patient Safety Network. Root Cause Analysis. July 2016. <https://psnet.ahrq.gov/primers/primer/10/root-cause-analysis>.

# Restraints

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Violent Restraints Versus Non-violent Restraints .....</b>	<b>3</b>
<i>Violent Restraints .....</i>	<i>3</i>
<i>Non-violent Restraints.....</i>	<i>3</i>
<b>Types of Restraint .....</b>	<b>3</b>
<i>Physical Restraint .....</i>	<i>3</i>
<i>Chemical Restraint .....</i>	<i>3</i>
<i>Seclusion.....</i>	<i>4</i>
<i>Hand Mitts and Freedom Sleeves.....</i>	<i>4</i>
<i>Enclosure bed .....</i>	<i>4</i>
<i>Chest Vests and Lap (waist) Belts.....</i>	<i>4</i>
<i>Limb Restraints.....</i>	<i>4</i>
<b>Restraint Usage.....</b>	<b>4</b>
<i>Duration .....</i>	<i>5</i>
<i>Alternatives to Restraints.....</i>	<i>5</i>
<i>Improper Use of Restraints .....</i>	<i>6</i>
<i>Documentation and Assessment.....</i>	<i>6</i>
<b>Patient and Family Education .....</b>	<b>6</b>
<b>Staff Training Required .....</b>	<b>7</b>
<b>References.....</b>	<b>7</b>

---

## Introduction

A restraint is anything, such as a device, physical action, or chemical, used to immobilize or restrict a person's movement in anyway.

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 consult from the behavioral health team to consider behavioral restraint options.

### Non-violent Restraints

Restraint for non-violent non-self-destructive behaviors may be use 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 4 bed rails up, or using tightly tucked or tied sheets to prevent movement.

### Chemical Restraint

---

A chemical restraint is a medication, that 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 doesn’t 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’s 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’s not too tight. It shouldn’t 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, can’t 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 possible restraint removal or possible 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 long 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 on 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 restraints 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.

## References

Centers for Medicare & Medicaid (CMS). (2015). The CMS Interpretive Guidelines for the Hospital Conditions of Participation. Retrieved from: <https://www.cms.gov/Regulations-andGuidance/>

Compilation of Select Laws & Regulations Regarding Behavioral Restraint & Seclusion. February 2014, Pub. #5457.01. <http://www.disabilityrightsca.org/pubs/545701.pdf>

Joint Commission Standards on Restraint and Seclusion/Nonviolent Crisis Intervention, Training Program. [https://www.jointcommission.org/hap\\_2017\\_npsqs](https://www.jointcommission.org/hap_2017_npsqs)

MedScape Nurse. American Nurse Today, When and How to Use Restraints. Gale Springer, RN, MSN, PMHCNS-BC. Am Nurse Today. 2015;10(1). [http://www.medscape.com/viewarticle/838521\\_4](http://www.medscape.com/viewarticle/838521_4)

Restraint or Seclusion: Staff Training Requirements §482.13(g) Standard: Death Reporting Requirements The Joint Commission. Comprehensive Accreditation Manual for Hospitals, Oak Brook, IL: Joint Commission Resources, 2017. Longo, M.A. & Miller-Hoover, S. (2016).

U.S National Library of Medicine. Medline Plus. Use of Restraints. <https://medlineplus.gov/ency/patientinstructions/000450.htm>

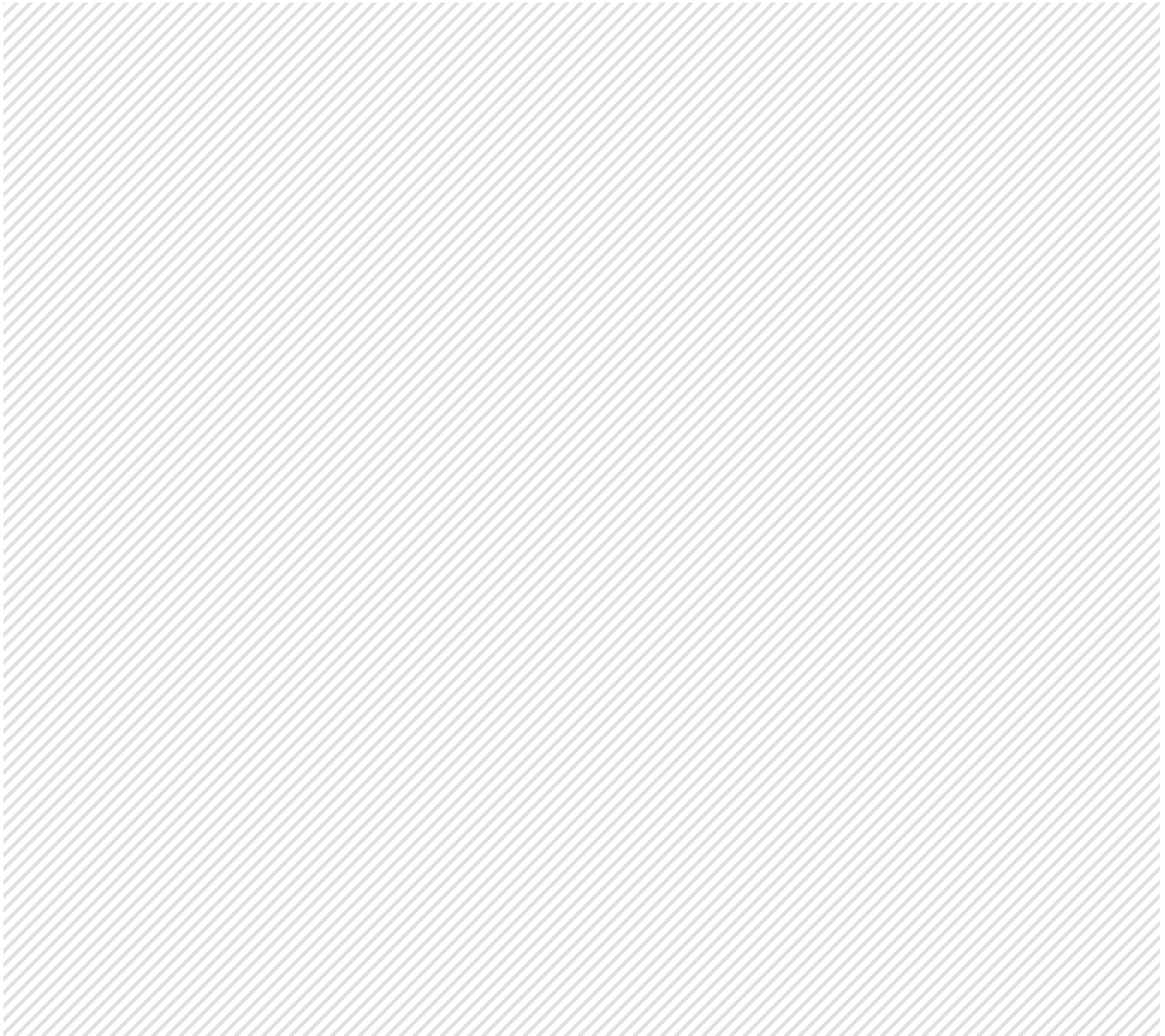


# Risk Management & Legal Issues in Healthcare

## Core Competency Inservice

January 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction</b> .....	<b>3</b>
<b>Risk Management</b> .....	<b>3</b>
<i>Risk Management Plan</i> .....	3
<b>Incidents and Reporting Guidelines</b> .....	<b>4</b>
<i>Incident, Occurrence, Event Report</i> .....	4
<b>Safety Events and Root Cause Analysis</b> .....	<b>5</b>
<i>Patient Safety Events</i> .....	5
<b>Risk Reduction</b> .....	<b>5</b>
<b>Sources Used to Interpret the Law</b> .....	<b>6</b>
<i>Standards of Care</i> .....	6
<i>Practice Acts and Standards</i> .....	6
<i>Professional Position Statements</i> .....	6
<i>Policies and Procedures</i> .....	6
<b>Negligence vs Malpractice</b> .....	<b>6</b>
<i>Negligence</i> .....	6
<i>Malpractice</i> .....	7
<b>Documentation</b> .....	<b>7</b>
<i>The Official Do Not Use Abbreviation List</i> .....	7
<b>Just Culture</b> .....	<b>8</b>
<b>References</b> .....	<b>8</b>

---

# 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 properly handle, patient, visitor, and employee adverse events. Risk management cannot possibly 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 damages 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 possibly 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 around reporting errors to reduce risk and improving the safety culture is a crucial but difficult task for many organizations. Unless staff members are engaged, feel safe to speak up, and are enabled to learn from the occurrence of preventable medical errors, poor patient outcomes will likely 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.

**Do's 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, that 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, that 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 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.

When in doubt, fill it out! An incident report is not to lay blame for an event that occurred, or almost occurred, but rather to facilitate learning and performance improvement. Not completing an incident report could cause the facility to miss out on 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 adequately training physicians and staff, encouraging strong 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 health 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, a 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"

<b>Trailing zero (X.0 mg) Absent leading zero (.X mg)</b>	<b>Write “X mg” Write “0.X mg”</b>
<b>MS</b>	<b>Write “morphine sulfate”</b>
<b>M<sub>2</sub>SO<sub>4</sub> and MgSO<sub>4</sub></b>	<b>Write “magnesium sulfate”</b>
<b>&lt; or &gt;</b>	<b>Write greater or less than</b>
<b>Abbreviations for drug names</b>	<b>Write drug names in full</b>
<b>Apothecary units (Drams, Scruples, Grains)</b>	<b>Use metric units (Meter, Liter, Gram)</b>
<b>@</b>	<b>Write “at”</b>
<b>cc</b>	<b>Write “ml” , “mL” or “milliliters”</b>
<b>ug</b>	<b>Write “mcg” or “micrograms”</b>

## Just Culture

To promote effective reporting and achieve quality care, facilities need to adopt what's referred to as a "just culture." The just culture recognizes that it's 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.

## References

Facts about the Official “Do Not Use” List. June 2014.

[http://www.jointcommission.org/assets/1/18/do\\_not\\_use\\_list.pdf](http://www.jointcommission.org/assets/1/18/do_not_use_list.pdf)



---

HC Pro. What to include on the incident report? Long-Term Care Nursing Advisor, Barbara Acello, RN, BSN. August 22, 2008 -2016.

<http://www.hcpro.com/HOM-217534-2474/What-to-include-on-the-incident-report.html>

Institute for Safe Medication and Practice (ISMP). ISMP AND FDA CAMPAIGN TO ELIMINATE USE OF ERROR-PRONE ABBREVIATIONS. 2016. <http://www.ismp.org/tools/abbreviations/>

The Law, Science & Public Health Law Site. Incident Reports. Professor Edward P. Richards, III, JD, MPH.

<http://biotech.law.lsu.edu/books/aspens/Aspen-INCIDENT.html>

Legal Issues in Health Care. January 2010.

<https://uthsc.edu/Medicine/legaledu/>

Risk Management and Legal Issues. Valorie Dearman, MSN, RN, NEA, BC. Accessed Nov. 2014.

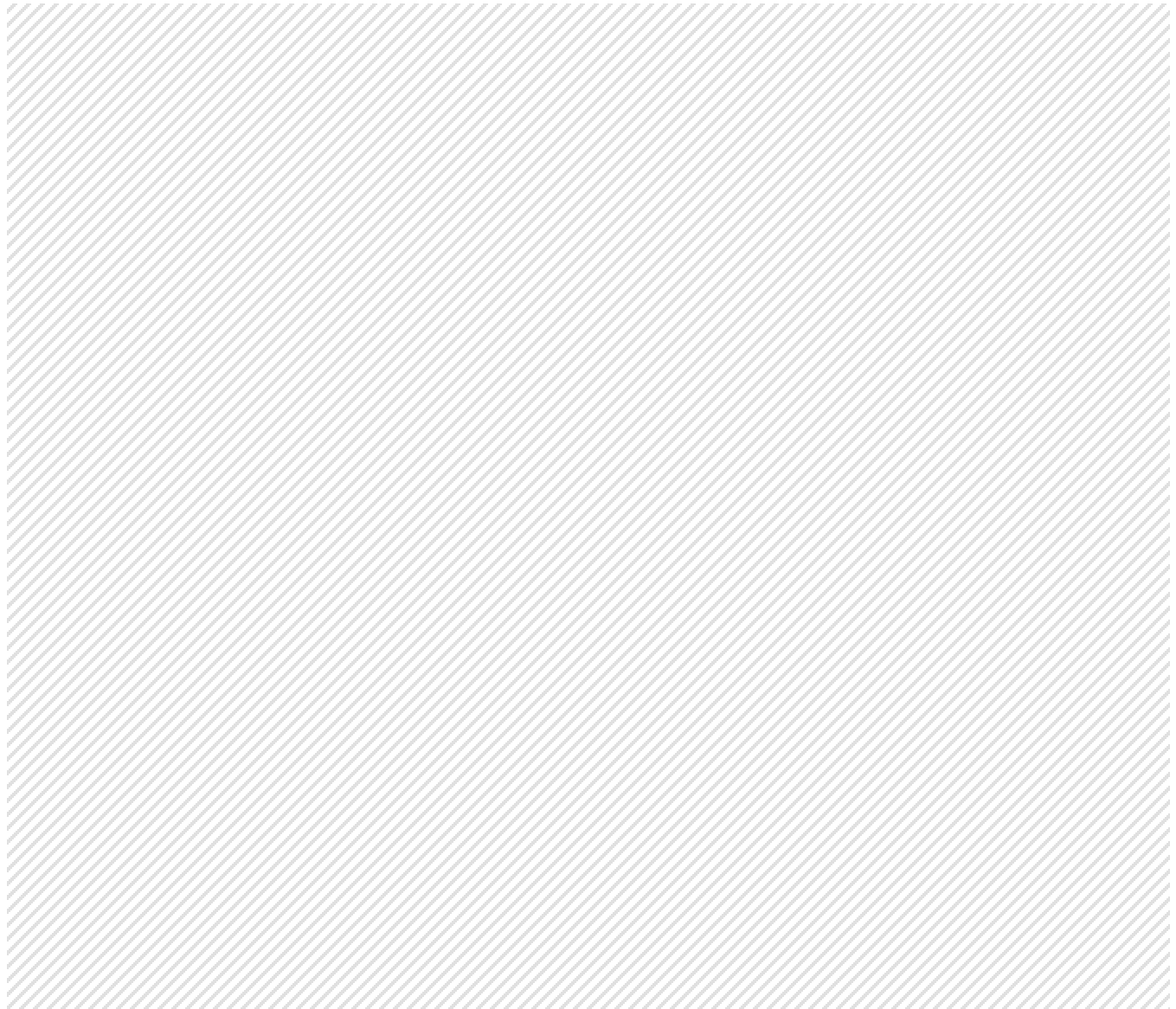
<http://www.jblearning.com/>

U.S Department of Health and Human Services. Agency for healthcare Research and Quality. Root Cause Analysis. Patient Safety Primer Last Updated: July 2016. <https://psnet.ahrq.gov/primers/primer/10/root-cause-analysis>

# Safe Patient Handling

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Body Mechanics</b> .....	<b>3</b>
<i>Back Facts</i> .....	3
<i>Basic Principles of Good Body Mechanics</i> .....	3
<i>Common Mechanisms of Injury and How to Prevent Them</i> .....	4
<i>Contributing Factors to Back Injuries</i> .....	3
<b>Safe Patient Transfers and Body Mechanics</b> .....	<b>4</b>
<i>Safe Practice When Performing Transfers</i> .....	4
<i>Patient Movement Aides</i> .....	6
<b>Mechanical Assist Device</b> .....	<b>8</b>
<i>Transferring from Sitting to Standing Position</i> .....	8
<i>Patient Lifting</i> .....	8
<i>Specialty Chairs</i> .....	8
<i>Ambulation</i> .....	9
<i>Patient Lifting Devices</i> .....	9
<i>Lateral Transfer; Repositioning</i> .....	10
<i>Bed to Stretcher Transfer (Lateral Transfers)</i> .....	11
<i>Lateral Transfer in Sitting Position</i> .....	12
<i>Transfer from Sitting to Standing Position</i> .....	12
<i>Weight Devices</i> .....	13
<i>Transfer from Sitting to Standing Position; Ambulation</i> .....	13
<i>Bathtub, Shower and Toileting Activity Devices</i> .....	16
<b>Safely Ambulating Patients</b> .....	<b>18</b>
<i>Walking with the Patient</i> .....	18
<b>Injured Worker’s Responsibilities</b> .....	<b>19</b>
<b>References</b> .....	<b>19</b>

---

# Body Mechanics

## Back Facts

Statistics show that 8 out of 10 people will experience back pain at some time in their lives. 80% of on-the-job injuries are back injuries. Once you have sustained an injury, your chances of recurrence are much higher. You perform many tasks every day that could cause back injury. These include repetitive lifting, prolonged standing, bending, reaching, pushing, and pulling. Protect your back by using good body mechanics.

### **Other factors that can help to maintain a healthy back include:**

- Exercising regularly
- Reducing Stress
- Eating a healthy diet
- Removing hazards

## Basic Principles of Good Body Mechanics

- Maintain a wide base of support. You are more stable when you separate your feet and simply turn your toes out. By widening your base of support, you can improve your balance and ability to maintain stability.
- Keep your back straight. When lifting keep the back straight and bend at the hips and knees. This will place most of the weight force on your legs keeping your back safe from strain.
- Lower your center of gravity. Your center of gravity is the point at which your weight is centered. You can lower your center of gravity by bending your hips and knees slightly and keeping the load at waist level.
- Keep the load close to you. The work required to hold a three-pound weight out at arm's length is almost three times as much as it is holding it close to your body.
- Pivot the body, never twist the spine. When transferring never twist at the waist as this could cause spinal injury. Always pivot the entire body when lifting to transfer a patient.
- Push or pull to slide when possible. It is always preferable to slide something heavy by pushing or pulling it rather than lifting something heavy. If you have a choice between the two, pushing is preferable because it uses the entire body as opposed to a select group of muscles.

## Contributing Factors to Back Injuries

- Bending or twisting
- Reaching out and/or up
- Prolonged holding, sitting, standing, stooping
- Too much force (e.g., heavy patients)
- Abrupt motions (e.g., stopping falls)

---

## Common Mechanisms of Injury and How to Prevent Them

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

---

## Safe Patient Transfers and Body Mechanics

### Safe Practice When Performing Transfers

Research shows that injuries to healthcare workers happen most often during patient transfers. In fact, more than one third of workplace injuries in hospitals and nursing homes occur when staff try to move patients. Most of these are injuries to the back. The most hazardous types of patient transfers that result in the highest rates of work-related back injuries are: Bed to chair, Bed to stretcher and repositioning in bed.

The back is the main support structure for the body. It carries most of the body's weight, and it is the main pathway for the nervous system. The backbone, or spine, is a column of small bones called "vertebrae." Between each pair of vertebrae is a cushion-like pad called a "disc," which acts as a shock absorber. The vertebrae and discs are supported by ligaments and muscles.

A healthy spine has three natural curves. These natural curves form an S-shape when your back is properly aligned. You know your back is properly aligned when your ears, shoulders, and hips are in a straight line. We often refer to this as good posture. Anything that forces the back out of its natural S-shape can strain muscles and damage discs. Back problems and pain are almost certain to follow.

Healthcare professionals often perform physically demanding tasks with patients. Following proper transfer techniques can help you to maintain a healthy back and to:

- Work more efficiently and comfortably
- Minimize lost time from work with costly and painful injuries
- Increase patient satisfaction by providing good, consistent care.

---

## Patient assessment

Before transferring a patient, it is important to first assess the situation. How much can the patient help? The answers to 3 questions will help you to decide how much the patient can assist and what method of transfer should be used:

1. Is the patient cooperative?

Assessing whether patients are cooperative means deciding if they have the awareness to assist you.

Considerations such as:

- Are they sedated or dizzy?
- Are they weak?
- Are they able to follow simple commands or directions?

2. Can the patient support his or her own weight?

If yes, assistance from an employee may not be needed. The patient may be able transfer without help. The healthcare provider should only stand by for safety as needed.

If patients can partially support their own weight, assistance will be necessary. This may involve a stand and pivot technique and include the use of a transfer belt. Sometimes, patients who cannot bear weight on their legs may have upper body strength. In such cases, transfer may be assisted with a transfer belt until the patient learns to move independently.

Remember that a manual transfer is intended to **assist**, NOT lift a patient. For patients who cannot help support their weight, a mechanical lifting aid is recommended. However, you should not use a mechanical lifting aid unless you have been trained to do so. Improper use or malfunction of a lifting aid can cause serious injury or death. If the patient is not able to understand the process or to cooperate, a lifting aid is recommended.

3. Is the patient too heavy to transfer alone?

Avoid injury to the patient and to yourself. If the patient is heavy, two people should assist in the transfer. This does not mean a patient is overweight. Some sources suggest that a lifting hoist should be used for patients over 154 pounds.

## Preparation

Every time you prepare to move a patient, you should assess the situation and the patient. For example, a patient who has suffered a stroke may be much stronger on one side than the other. In this case, it will be important to support the patient's weak side by standing/walking on that side of the patient. If the patient is unstable, dizzy, or confused, you may need additional assistance. This may include the help of another employee or the use of a transfer belt.

- If patients are not used to getting up, allow them to sit on the side of the bed for a few minutes before standing, this can help to prevent dizziness.
- It is also important to prepare the area before transferring/ambulating the patient. Make sure that the room is not cluttered and remove any obstacles. A cluttered room increases the

chances of trips or falls. You should also be aware that a small room, such as a bathroom, may restrict your movements. Think about how you will deal with such spaces before you get there.

- If the patient begins to fall, DO NOT try to stop the fall. Instead, ease the patient down gently. Provide support, bending your knees not using your back, and guide the patient to the floor. Do not try to get the patient up off the floor by yourself. You are not in a position to maintain good body mechanics and support the patient's entire weight. Trying to hold the patient up could cause serious injury to both the caregiver and the patient.

## Patient Movement Aides

Figure 1: Transfer to and from Bed, Bed to Chair, Chair to Toilet, Chair to Chair or Car to Chair

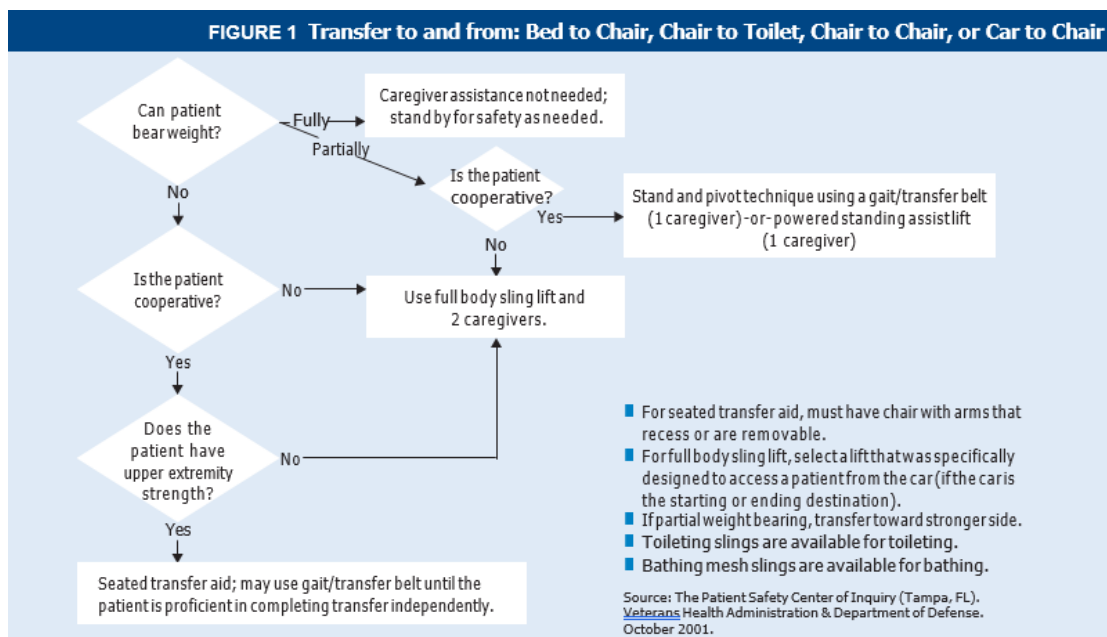


Figure 2: Lateral Transfer to and from: Bed to stretcher or trolley

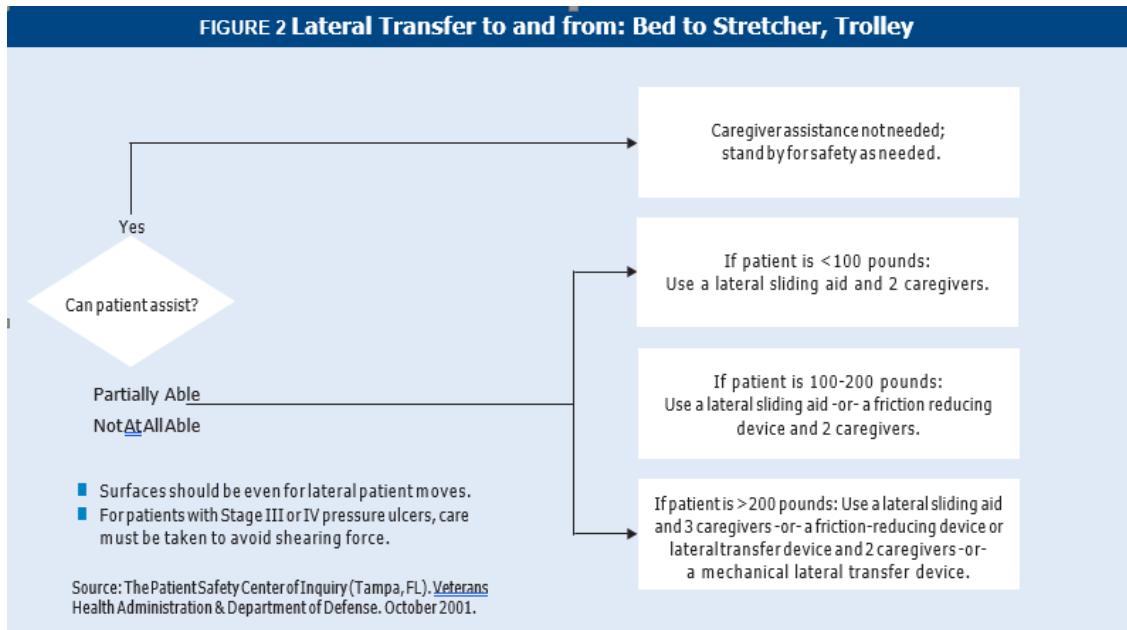
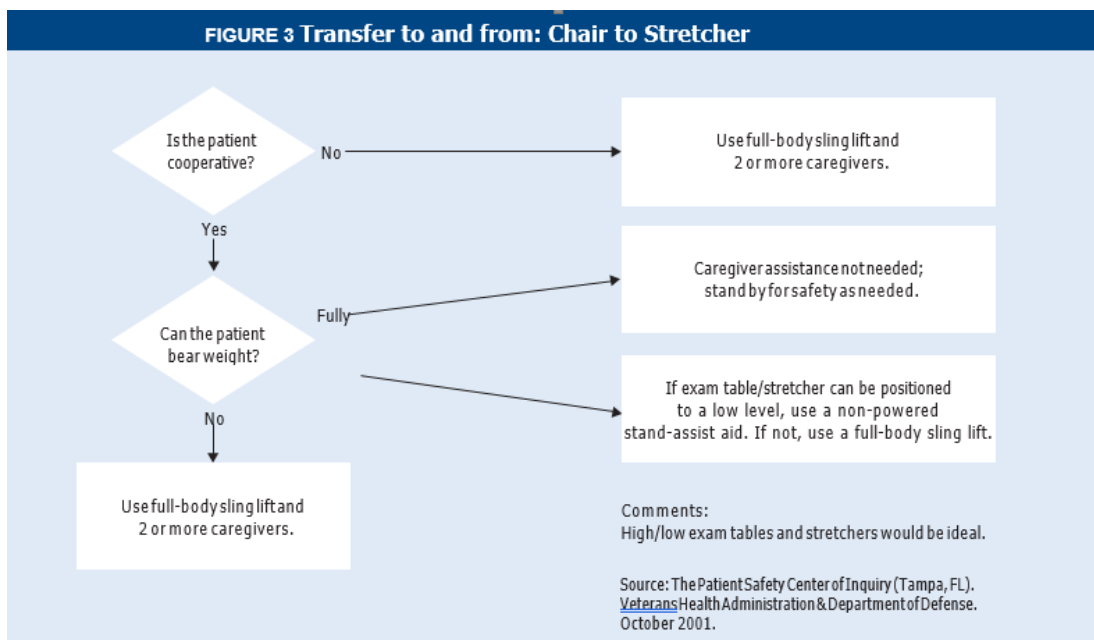


Figure 3: Transfer to and from chair, bed, or stretcher





---

# Mechanical Assist Device

## Transferring from Sitting to Standing Position

### Powered sit-to-stand or standing assist devices

**When to Use:** Transferring patients who are partially dependent, have some weight-bearing capacity, are cooperative, can sit up on the edge of the bed with or without assistance, and can bend hips, knees, and ankles. Transfers from bed to chair (wheel chair, Geri or cardiac chair), or chair to bed, or for bathing and toileting. Can be used for repositioning where space or storage is limited.



**Points to Remember:** Look for a device that has a variety of sling sizes, lift- height range, battery portability, hand-held control, emergency shut-off, and manual override. Ensure device is rated for the patient weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow smoother movement for the patient, and less physical exertion by the caregiver.

## Patient Lifting

### Portable lift device (sling type); can be a universal/ hammock sling or a band/ leg sling

**When to Use:** Lifting patients who are totally dependent, are partial- or non-weight bearing, are very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after patient fall.



**Points to Remember:** More than one caregiver may be needed. Look for a device with a variety of slings, lift-height range, battery portability, hand-held control, emergency shut-off, manual override, boom pressure sensitive switch, that can easily move around equipment, and has a support base that goes under beds. Having multiple slings allows one of them to remain in place while patient is in bed or chair for only a short period, reducing the number of times the caregiver lifts and positions patient. Portable compact lifts may be useful where space or storage is limited. Ensure device is rated for the patient weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow a smoother movement for the resident, and less physical exertion by the caregiver. Enhances patient safety and comfort.

## Specialty Chairs

---

## Variable position Geri and Cardiac chairs

**When to Use:** Repositioning partial- or non- weight-bearing patients who are cooperative.

**Points to Remember:** More than one caregiver is needed and use of a friction- reducing device is needed if patient cannot assist to reposition self in chair. Ensure use of good body mechanics by caregivers. Wheels on chair add versatility. Ensure that chair is easy to adjust, move, and steer. Lock wheels on chair before repositioning. Remove trays, footrests, and seat belts where appropriate. Ensure device is rated for the patient weight.



## Ambulation



### Ambulation assist device

**When to Use:** For patients who are weight bearing and cooperative and who need extra security and assistance when ambulating.

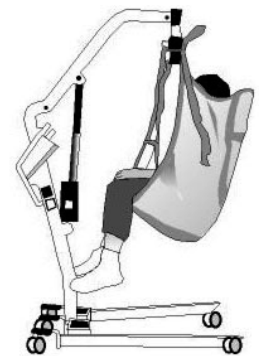
**Points to Remember:** Increases patient safety during ambulation and reduces risk of falls. The device supports patients as they walk and push it along during ambulation. Ensure height adjustment is correct for patient before ambulation. Ensure device is in good working order before use and rated for the patient weight to be lifted. Apply brakes before positioning patient in or releasing patient from device.

## Patient Lifting Devices

### Portable lift device (sling type); universal/hammock sling or a band/leg sling

**When to Use:** Lifting patients who are totally dependent, are partial- or non-weight bearing, are very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a patient fall.

**Points to Remember:** More than one caregiver may be needed. Look for a device with a variety of slings, lift-height range, battery portability, hand-held control, emergency shut-off, manual override, boom pressure sensitive switch, that can easily move around equipment, and has a support base that goes under beds. Having multiple slings allows one of them to remain in place while patient is in bed or chair for only a short period, reducing the number of times the caregiver lifts and positions patient. Portable compact lifts may be



useful where space or storage is limited. Ensure device is rated for the patient weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow a smoother movement for the patient, and less physical exertion by the caregiver. Enhances patient safety and comfort.



### Ceiling mounted lift device

**When to Use:** Lifting patients who are totally dependent, are partial- or non-weight bearing, very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a patient fall. A horizontal frame system or litter attached to the ceiling-mounted device can be used when transferring patients who cannot be transferred safely between 2 horizontal surfaces, such as a bed to a stretcher or gurney while lying on their back, using other devices.

**Points to Remember:** More than one caregiver may be needed.

Some patients can use the device without assistance. May be quicker to use than portable device. Motors can be fixed or portable (lightweight). Device can be operated by hand-held control attached to unit or by infrared remote control. Ensure device is rated for the patient weight. Increases patients' safety and comfort during transfer.

## Lateral Transfer; Repositioning

**Devices to reduce friction force when transferring a patient** such as a draw sheet or transfer cot with handles to be used in combination slippery sheets, low friction mattress covers, or slide boards; boards or mats with vinyl coverings and rollers; gurneys with transfer devices; and air-assist lateral sliding aid or flexible mattress inflated by portable air supply.

**When to Use:** Transferring a partial- or non-weight bearing patient between 2 horizontal surfaces such as a bed to a stretcher or gurney while lying on their back or when repositioning patient in bed.

**Points to Remember:** More than one caregiver is needed to perform this type of transfer or repositioning. Additional assistance may be needed depending upon patient status, e.g., for heavier or non-cooperative patients. Some devices may not be suitable for bariatric patients. When using a draw sheet combination use a good hand-hold by rolling up draw sheets or use other friction-reducing devices with handles such as slippery sheets. Narrower slippery sheets with webbing handles positioned on the long edge of the



---

sheet may be easier to use than wider sheets. When using boards or mats with vinyl coverings and rollers use a gentle push and pull motion to move patient to new surface.

Look for a combination of devices that will increase patient's comfort and minimize risk of skin trauma. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back. Count down and synchronize the transfer motion between caregivers.

## Bed to Stretcher Transfer (Lateral Transfers)

A lateral transfer is the movement of a patient, who is in a laying down position, from one flat surface to another. Before transferring a patient from a bed to a stretcher, it is important to assess the patient to determine how much can the patient help.

- If a patient can move from the bed to stretcher without help, you should only stand by for safety as needed.
- If a patient can assist only partially or not at all, a lateral transfer will need to be done. Two employees should always participate in a lateral transfer and a lateral sliding aid should be used. If the patient is very heavy, three employees should assist, or a mechanical transfer device should be used.

## Convertible wheelchair, Geri or cardiac chair to bed; beds that convert to chairs

**When to Use:** For lateral transfer of patients who are partial or non-weight bearing. Eliminates the need to perform lift transfer in and out of wheelchairs. Can also be used to assist patients who are partially weight bearing from a sit-to-stand position. Beds that convert to chairs can aid repositioning patients who are totally dependent, non-weight bearing, very heavy, or have other physical limitations.

**Points to Remember:** More than one caregiver is needed to perform lateral transfer. Additional assistance for lateral transfer may be needed depending on patient's status, e.g., for heavier or non-cooperative patients. Additional friction-reducing devices may be required to reposition patient. Heavy duty beds are available for bariatric patients. Device should have easy-to-use controls located within easy reach of the caregiver, sufficient foot clearance, and wide range of adjustment. Motorized height adjustable devices are preferred to those adjusted by crank mechanism to minimize physical exertion. Always ensure device is in good working order before use. Ensure wheels on equipment are locked. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back.

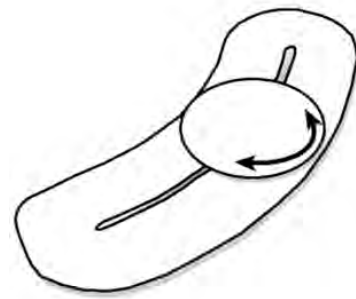


---

## Lateral Transfer in Sitting Position

### Transfer boards – wood or plastic (some with movable seat)

**When to Use:** Transferring (sliding) patients who have good sitting balance and are cooperative from one level surface to another, e.g., bed to wheelchair, wheelchair to car seat or toilet. Can also be used by patients who require limited assistance but need additional safety and support.



**Points to Remember:** Movable seats increase patient comfort and reduce incidence of tissue damage during transfer. More than one caregiver is needed to perform lateral transfer. Ensure clothing is present between the patient's skin and the transfer device. The seat may be cushioned with a small towel for comfort. May be uncomfortable for larger patients. Usually used in conjunction with gait belts for safety depending on patient status. Ensure boards have tapered ends, rounded edges, and appropriate weight capacity. Ensure wheels on bed or chair are locked and transfer surfaces are at same level. Remove lower bedrails from bed and remove arms and footrests from chairs as appropriate.

## Transfer from Sitting to Standing Position

### Lift cushions and lift chairs

**When to Use:** Transferring patients who are weight-bearing and cooperative but need assistance when standing and ambulating. Can be used for independent patients who need an extra boost to stand.

**Points to Remember:** Lift cushions use a lever that activates a spring action to assist patients to rise up. Lift cushions may not be appropriate for heavier patients. Lift chairs are operated via a hand-held control that tilts forward slowly, raising the patient. Patients need to have physical and cognitive capacity to be able to operate lever or controls. Always ensure device is in good working order before use and is rated for the patient weight to be lifted. Can aid patient independence.

**Description:** Stand-assist devices can be fixed to bed or chair or be free-standing.

**When to Use:** Transferring patients who are weight-bearing and cooperative and can pull themselves up from sitting to standing position. Can be used for independent patients who need extra support to stand.



---

**Points to Remember:** Check that device is stable before use and is rated for patient weight to be supported. Ensure frame is firmly attached to bed, or if it relies on mattress support that mattress is heavy enough to hold the frame.

## Weight Devices

### Scales with ramp to accommodate wheelchairs; portable-powered lift devices with built-in scales; beds with built-in scales

**When to Use:** To reduce the need for additional transfer of partial or non-weight-bearing or totally dependent patients to weighing device.

**Points to Remember:** Some wheelchair scales can accommodate larger wheelchairs. Built-in bed scales may increase weight of the bed and prevent it from lowering to appropriate work heights.



## Transfer from Sitting to Standing Position; Ambulation

### Gait belts/transfer belts with handles

**When to Use:** Transferring patients who are partially dependent, have some weight-bearing capacity, and are cooperative. Transfers such as bed to chair, chair to chair, or chair to car; when repositioning patients in chairs; supporting patients during ambulation; and in some cases when guiding and controlling falls or assisting a patient after a fall.



**Points to Remember:** More than one caregiver may be needed. Belts with padded handles are easier to grip and increase security and control. Always transfer to patient's strongest side. Use good body mechanics and a rocking and pulling motion rather than lifting when using a belt. Belts may not be suitable for ambulation of heavy patients or patients with recent abdominal or back surgery, abdominal aneurysm, etc. Should not be used for lifting patients. Ensure belt is securely fastened and cannot be easily undone by the patient during transfer. Ensure a layer of clothing is between patients' skin and the belt to avoid abrasion. Keep patient as close as possible to caregiver during transfer. Lower bedrails, remove arms and foot rests from chairs, and other items that may obstruct the transfer.

For use after a fall, always assess the patient for injury prior to movement. If patient can regain standing position with minimal assistance, use gait or transfer belts with handles to aid patient. Keep back straight, bend legs, and stay as close to patient as possible. If patient cannot stand with minimal assistance, use a powered portable or ceiling-mounted lift device to move patient.

---

A transfer belt is placed around the patient's waist and secured snugly. The belt can be adjusted to fit different patients and usually fastens with Velcro and/or a buckle. If the transfer belt has loops, hold these loops to support the patient more firmly during transfer; if the belt does not have loops, hold onto the belt itself. You should use a transfer belt with patients who can partially support their own weight but need assistance. Remember: Transfer belts are not intended to lift patients.

Studies show that using a transfer belt increases patient satisfaction. Transferring patients manually without a transfer belt may cause the patient discomfort under the arms. Patients also prefer the transfer belt because they feel more secure and the belt gives the employee the ability to better control the patient's movement during a transfer.

A transfer belt should not be used the following:

- Pregnant patients
- Patients who have undergone recent abdominal surgery
- Patients who are experiencing pain in the abdomen
- Patients who have ostomies (such as a colostomy, ureterostomy, ileostomy)
- Patients who are unable to tolerate the pressure of the belt.

## Sit-to-stand pivot transfer Using Transfer Belt

**Before transferring a patient from a bed to a chair or wheelchair:**

- Explain the process to the patient
- Position the chair at the head of the bed on the patient's strong side (if applicable) and remove any obstacles
- Lock the wheels on the chair and bed
- If transferring to a wheelchair, remove the arm nearest the bed and remove the leg rests or swing them out of the way
- Adjust bed height so that the patient's hips will be slightly above the knees with the feet flat on the floor
- Make sure that the floor is dry and that both you and the patient are wearing non-slippery footwear
- Apply a transfer belt to the patient's waist

The transfer itself is a simple process of standing the patient up, pivoting, and sitting the patient down.

**To perform this transfer, carry out the following steps:**

- Stand close to the patient to avoid leaning or over-reaching and place your foot that is closer to the head of the bed on the floor between the patient's legs
- Reach around the patient's waist and grip the transfer belt
- Ask the patient to push against the bed with the arms and to stand with you on the count of 3
- Using a rocking motion, count to 3, and then stand the patient up

- 
- Holding the patient close to your body, pivot on the foot between the patient's legs until the backs of the patients' legs touch the front of the chair
  - With your knees bent, lower the patient into the chair using the transfer belt
  - Throughout the process, ensure that your back is properly aligned with your ears, shoulders, and hips in a vertical line

When performing this transfer, if patients wish to hold on to you for support, instruct them to hold on to your upper arms, forearms, or waist. Never allow a patient to hold on to your neck. If a second employee is available to help with the transfer, the second employee should be behind the patient with one knee on the bed. The second employee grips the transfer belt from the back. The first employee uses a gentle rocking motion to stand the patient

## Repositioning

### Electric powered height adjustable bed

**When to Use:** For all activities involving patient care, transfer, repositioning in bed, etc., to reduce caregiver bending when interacting with patient.

**Points to Remember:** Device should have easy-to-use controls located within easy reach of the caregiver to promote use of the electric adjustment, sufficient foot clearance, and wide range of adjustment. Adjustments must be completed in 20 seconds or less to ensure staff use. For patients that may be at risk of falling from bed some beds that lower closer to the floor may be needed. Heavy duty beds are available for bariatric patients. Beds raised and lowered with an electric motor are preferred over crank-adjust beds to allow a smoother movement for the patient and less physical exertion to the caregiver.



### Trapeze bar; hand blocks and push up bars attached to the bed frame

**When to Use:** Reposition patients that can assist the caregiver during the activity, i.e., patients with upper body strength and use of extremities, who are cooperative and can follow instructions.

**Points to Remember:** Patients use trapeze bar by grasping bar suspended from an overhead frame to raise themselves up and reposition themselves in a bed. Heavy duty trapeze frames are available for bariatric patients. If a caregiver is assisting, ensure that bed wheels are locked, bedrails are lowered, and bed is adjusted to caregiver's waist height. Blocks also enable patients to raise themselves up and reposition themselves in bed. Bars attached to the bed frame serve the same purpose. May not be suitable for heavier patients. Can aid patient independence.





## Pelvic lift devices (hip lifters)

**When to Use:** To assist patients who are cooperative and can sit up to a position on a special bed pan.



**Points to Remember:** Convenience of device may reduce need for patient lifting during toileting. Device is positioned under the pelvis. The part of the device located under the pelvis gets inflated, so the pelvis is raised, and a special bedpan put underneath. The head of the bed is raised slightly during this procedure. Use correct body mechanics, lower bedrails, and adjust bed to caregiver's waist height to reduce bending.

## Bathtub, Shower and Toileting Activity Devices

### Height adjustable bathtub and easy- entry bathtubs

**When to Use:** Bathing patients who sit directly in the bathtub, or to assist ambulatory patients climb more easily into a low tub, or easy access tub. Bathing patients in portable-powered or ceiling mounted lift device using appropriate bathing sling.

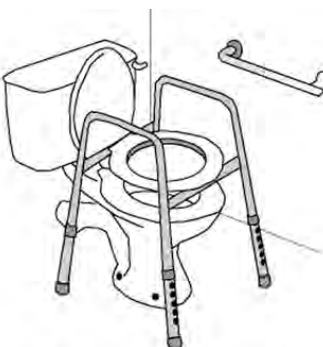


**Points to Remember:** Reduces awkward postures for caregivers and those who clean the tub after use. The tub can be raised to eliminate bending and reaching for the caregiver. Use correct body mechanics and adjust the tub to the caregiver's waist height when performing hygiene activities. Increases patient safety and comfort.

### Shower and toileting chairs

**When to Use:** Showering and toileting patients who are partially dependent, have some weight bearing capacity, can sit up unaided, and are able to bend hips, knees, and ankles.

**Points to Remember:** Ensure that wheels move easily and smoothly; chair is high enough to fit over toilet; chair has removable arms, adjustable footrests, safety belts, and is heavy enough to be stable; and that the seat is comfortable, accommodates larger patients, and has a removable commode bucket for toileting. Ensure that brakes lock and hold effectively and that weight capacity is sufficient.



### Toilet seat risers

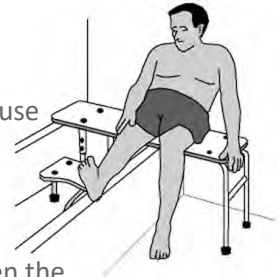
**When to Use:** For toileting partially weight-bearing patients who can sit up unaided, use upper extremities (have upper body strength), are able to

bend hips, knees, and ankles, and are cooperative. Independent patients can also use these devices.

**Points to Remember:** Risers decrease the distance and amount of effort required to lower and raise patients. Grab bars and height-adjustable legs add safety and versatility to the device. Ensure device is stable and can accommodate patient's weight and size.

## Bath boards and transfer benches

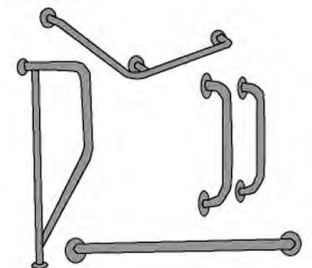
**When to Use:** Bathing patients who are partially weight bearing, have good sitting balance, can use upper extremities (have upper body strength), are cooperative, and can follow instructions. Independent patients can also use these devices.



**Points to Remember:** To reduce friction and possible skin tears, use clothing or material between the patient's skin and the board. Can be used with a gait or transfer belt and/or grab bars to aid transfer. Back support and vinyl padded seats add to bathing comfort. Look for devices that allow for water drainage and have height-adjustable legs. May not be suitable for heavy patients. If wheelchair is used, ensure wheels are locked, the transfer surfaces are at the same level, and device is securely in place and rated for weight to be transferred. Remove arms and foot rests from chairs as appropriate and ensure that floor is dry.

## Grab bars and stand assists; can be fixed or mobile. Long-handled or extended shower heads, or brushes can be used for personal hygiene

**When to Use:** Bars and assists help when toileting, bathing, and/ or showering patients who need extra support and security. Patients must be partially weight bearing, able to use upper extremities (have upper body strength) and be cooperative.



Long-handled devices reduce the amount of bending, reaching, and twisting required by the caregiver when washing feet, legs, and trunk of patients. Independent patients who have difficulty reaching lower extremities can also use these devices.

**Points to Remember:** Movable grab bars on toilets minimize workplace congestion. Ensure bars are securely fastened to wall before use.



## Height adjustable shower gurney or lift bath cart with waterproof top

**When to Use:** For bathing non-weight bearing patients who are unable to sit up. Transfer patient to cart with lift or lateral transfer boards or other friction-reducing devices.

---

**Points to Remember:** The cart can be raised to eliminate bending and reaching to the caregiver. Foot and head supports are available for patient comfort. May not be suitable for bariatric patients. Look for carts that are power-driven to reduce force required to move and position device.

### Built-in or fixed bath lifts



**When to Use:** Bathing patients who are partially weight bearing, have good sitting balance, can use upper extremities (have upper body strength), are cooperative, and can follow instructions. Useful in small bathrooms where space is limited.

**Points to Remember:** Ensure that seat raises so patient's feet clear tub, easily rotates, and lowers patient into water. May not be suitable for heavy patients. Always ensure lifting device is in good working order before use and rated for the patient weight. Choose device with lift mechanism that does not require excessive effort by caregiver when raising and lowering device.

## Safely Ambulating Patients

When ambulating with a patient, you walk beside the patient and provide assistance.

**If you are ambulating with a patient, performing a transfer, or doing any other job that requires lifting, follow these guidelines to help maintain a healthy back:**

- Maintain the back's natural curves by keeping the ears, shoulders, and hips aligned
- Lift and lower with your legs, not your back
- Keep the weight close to your body
- Bend at the hips, not the waist
- Avoid twisting or turning the upper body when carrying or lifting
- Explain what you are doing to patients and other employees who are participating
- Make sure that both you and the patient are wearing non-slip footwear
- Be sure the floor is dry, and obstacles are removed
- Get assistance whenever possible

### Walking with the Patient

When ambulating, or walking, with a patient, you may sometimes wish to use a transfer belt. A transfer belt, or gait belt, is fitted snugly around the patient's waist. The belt is simple to apply and provides a secure grip to assist the employee in transferring or walking with a patient. Some belts have loops that can be used like handles to give a better grip.

One employee may ambulate safely with patients who need some help walking but are reasonably stable. If one side is weaker than the other, support the patient's weak side by walking on that side.

---

### Support the patient by:

- Using one hand to support the patient's elbow
- Placing an arm around the patient's shoulder
- Gripping a transfer belt around the patient's waist

### Two employees should participate if patients are unstable or confused. To ambulate a patient safely with 2 employees:

1. Ask the patient to sit on the side of the bed
2. Apply the transfer belt
3. Stand the patient up (as if starting a sit-to-stand pivot transfer)
4. Two employees stand on either side of the patient
5. Place your arm round the patient's back; hold the transfer belt on the far side of the patient
6. Walk with the patient

## Injured Worker's Responsibilities

- Report the injury or illness to your supervisor immediately. Under all circumstances, the reporting **MUST** be made during the shift on which the incident, injury, or illness occurs
- If necessary, seek medical treatment
- Complete an incident report immediately
- Stay in touch with your supervisor and human resources

## References

"Back Facts – A training workbook to prevent back injuries in nursing homes." US Department of Labor, OSHA. <https://www.osha.gov/SLTC/healthcarefacilities/training/index.html#!intro>. Accessed September 2019.

"Body Mechanics for Healthcare Staff." WCF Insurance. <https://www.wcf.com/body-mechanics-healthcare-staff>. Accessed September 2019.

"Guidelines for Nursing Homes. Ergonomics for the Prevention of Musculoskeletal Disorders." US Department of Labor, OSHA. [https://www.osha.gov/ergonomics/guidelines/nursinghome/final\\_nh\\_guidelines.pdf](https://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.pdf). Accessed September 2019.

"Healthcare Wide Hazards. Ergonomics." US Department of Labor, OSHA. <https://www.osha.gov/SLTC/etools/hospital/hazards/ergo/ergo.html#patienthandlingprogram>. Accessed September 2019.

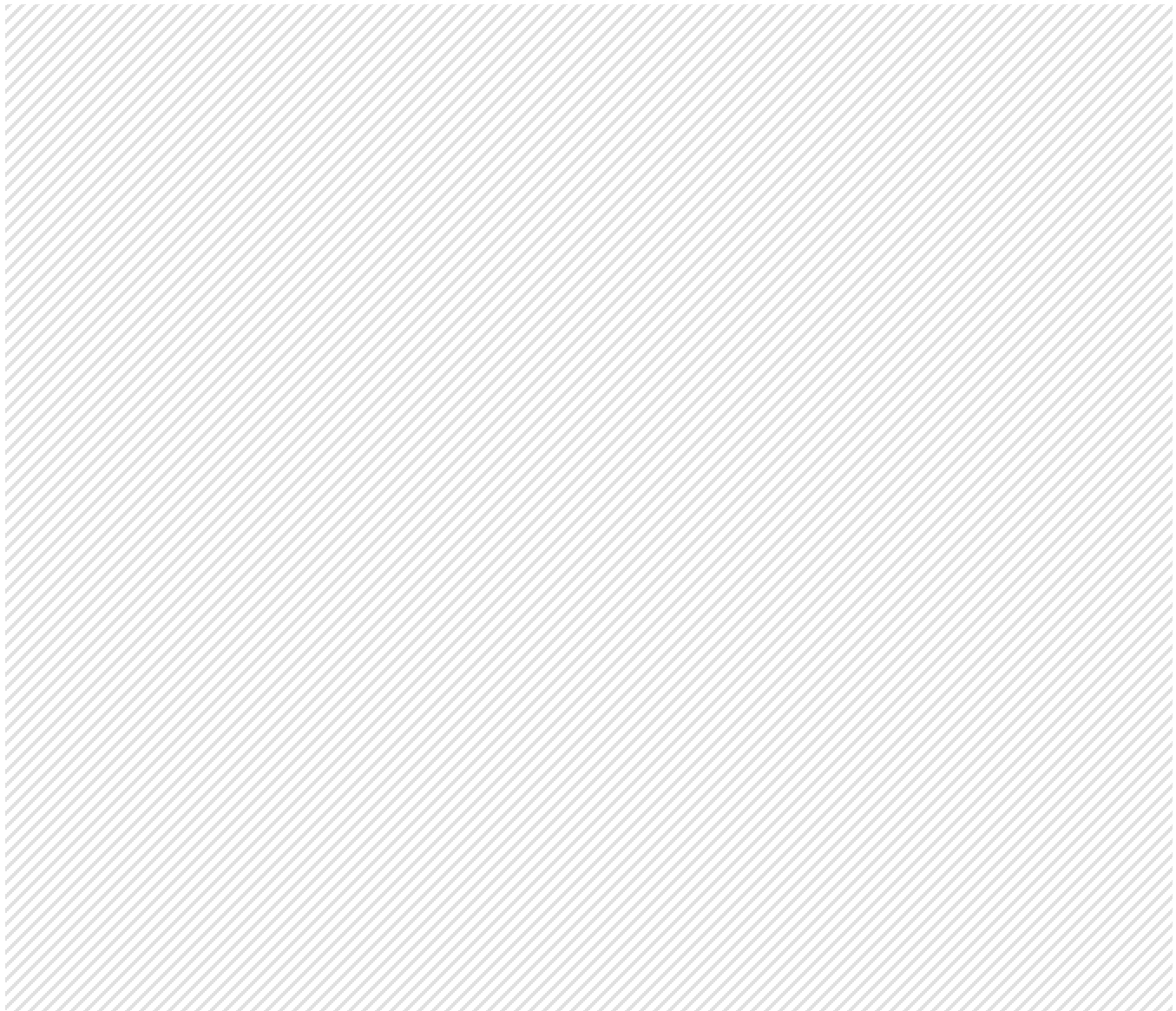
"Safe Patient Handling Among Health Care Workers." US Department of Labor, OSHA. <https://www.osha.gov/harwoodgrants/grantmaterials/fy2011/sh-22316-11>. Accessed September 2019.

# SBAR

## Nursing Core Competency Inservice

JANUARY 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

# Table of Contents

<b>The SBAR Communication Model .....</b>	<b>3</b>
<i>Situation</i> .....	3
<i>Background</i> .....	3
<i>Assessment</i> .....	4
<i>Recommendation</i> .....	4
<b>Scenarios using SBAR .....</b>	<b>4</b>
<b>Hand-off Communication .....</b>	<b>5</b>
<b>References .....</b>	<b>5</b>

# The SBAR Communication Model

The Joint Commission, which accredits the majority of hospitals in the United States analyzes the root causes of sentinel or critical events. Poor communication is the most common cause of patient injury or death in the clinical setting. **SBAR** (Pronounced Ess-Bar) is a formalized method of communicating with other healthcare providers that is becoming increasingly used in many hospitals. SBAR promotes patient safety by helping physicians and nurses communicate with each other. Staff and physicians can use SBAR to share what information is important about a patient. It improves efficiency by way of a standardized form of communication helps caregivers speak about patients in a concise and complete way. SBAR is an acronym for:

- Situation
- Background
- Assessment
- Recommendation

SBAR was developed by Kaiser Permanente of Colorado, and has been increasingly adopted by hospitals throughout the United States. SBAR is used to report to a healthcare provider a situation that requires immediate action, and to define the elements of a hand off of a patient from one caregiver to another (for example, during transfers from one unit to another or during shift report, and in quality improvement reports).

Liability issues may surround the communication that occurred in any clinical situation, particularly when unexpected changes in a patient's condition occur. It is often difficult to determine what the healthcare prescriber (physician, physician assistant, nurse practitioner) was told. An inexperienced or fatigued nurse may omit specific important information. One of the goals of SBAR is to provide a structure for such communication. The elements of SBAR are explained below and applied to contacting a healthcare prescriber.

## Situation

When calling a healthcare provider to report a change in the patient's condition, the nurse identifies his or her name and unit, the name and room number of the patient, and the problem. The nurse describes what is happening at the present time that has warranted the SBAR communication.

## Background

The nurse includes relevant background information specific to the situation. For example, this could include the patient's diagnosis, his mental status, current vital signs, complaints, pain level, and physical assessment findings.

## Assessment

This step of the communication provides the nurse with the opportunity to offer an analysis of the problem. If the situation is unclear, the nurse tries to isolate the problem to the body system that might be involved and describes the seriousness of the problem.

## Recommendation

The nurse states what he or she thinks would help resolve the situation or what is the desired response. This might be phrased in the form of a question: "Do you think we should give him a medication, perform lab work, do an xray, perform cardiac monitoring, or transfer to another unit? Will you come to evaluate him?"

## Scenarios using SBAR

Situation: "Dr. Jones, this is Jane Smith, RN, of 5 West. I am calling you to notify you that your patient, Scott Kelly, in Room 4017-2, fell on the floor today while being transferred out of bed."

Background: "As you know, Mr. Kelly had a laminectomy and bone fusion on January 17. His legs have been weak since surgery. He fell when our aide was helping him get up with a walker. His current vital signs are 145/90, pulse of 88 and respirations of 20. He is able to move all of his extremities, although he is complaining of pain at his incision of 7 on a scale from 1-10."

Assessment: "I see no changes in his neurological status since he fell; neither of his legs is shortened and externally rotated. He is quite anxious now and also worried something in his neck has been injured."

Recommendation: "I believe it would reassure Mr. Kelly if you would examine him. When can we expect you to come?"

Situation: Dr. White, this is Sue Black, RN, I am calling from ABC Hospital about your patient Sophie Brown. Mrs. Brown is having increasing dyspnea and is complaining of chest pain.

Background: The supporting background information is that she had a total knee replacement two days ago. About two hours ago she began complaining of chest pain. Her pulse is 120 and her blood pressure is 128/54. She is restless and short of breath.

Assessment: My assessment of the situation is that she may be having a cardiac event or a pulmonary embolism.

Recommendation: I recommend that you see her immediately and that we start her on O<sub>2</sub> stat.



# Hand-off Communication

The safe and effective care of patients depends on consistent, flawless communication between caregivers. End of shift report, hand-offs or the process of passing on specific information about patients from one caregiver team to another, is an area where the breakdown of communication between caregivers often leads to episodes of avoidable harm to a patient. Using the SBAR: Situation, Background, Assessment and Recommendation model significantly reduces chances of errors in communication.

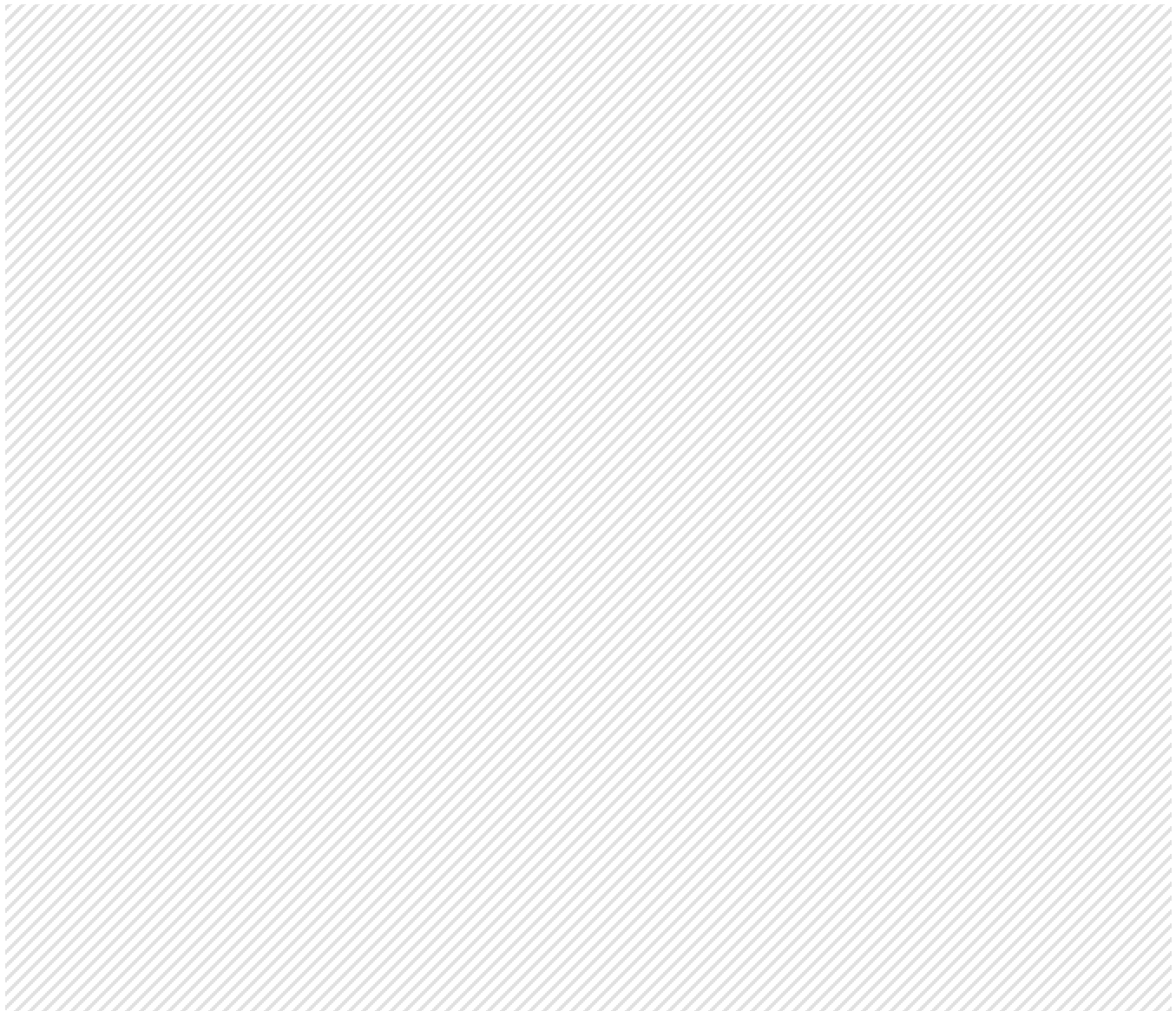
## References

- Aiaya, P. (2014, Jun). *Culture Trumps Policies*. Retrieved Nov 2015, from The Joint Commission, Leadership Blog:  
[https://www.jointcommission.org/jc\\_physician\\_blog/culture\\_trumps\\_policies/](https://www.jointcommission.org/jc_physician_blog/culture_trumps_policies/)
- ANA. (2015). *Code of Ethics for Nurses With Interpretive Statements*. Retrieved Nov 2015, from American Nurses Association: <http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html>
- Beckett, C., & Kipnis, G. (2009). Collaborative Communication: Integrating SBAR to Improve Quality/Patient Safety. *Journal of Healthcare Quality*, September/October.
- Bramhall, E. (2015, December). *Effective communication skills in nursing practice*. Retrieved November 18, 2015, from Continuing Professional Development: <http://journals.rcni.com/doi/pdfplus/10.7748/ns.29.14.53.e9355>
- National Council of State Boards of Nursing. (n.d.). *ANA and NCSBN Joint Statement on Delegation*. Retrieved June 2016, from NCSBN: [https://www.ncsbn.org/Delegation\\_joint\\_statement\\_NCSBN-ANA.pdf](https://www.ncsbn.org/Delegation_joint_statement_NCSBN-ANA.pdf)
- National Council of State Boards of Nursing. (n.d.). *Nurse Practice Act, Rules & Regulations*. Retrieved May 2016, from NCSBN: <https://www.ncsbn.org/nurse-practice-act.htm>
- National Council of State Boards of Nursing. (n.d.). *Working with Others: A Position Paper*. Retrieved June 2016, from NCSBN: [https://www.ncsbn.org/Working\\_with\\_Others.pdf](https://www.ncsbn.org/Working_with_Others.pdf)
- Olson, L., & Stokes, F. (2016, Jul). *The ANA Code of Ethics for Nurses With Interpretive Statements: Resource for Nursing Regulation*. Retrieved Aug 2016, from Journal of Nursing Regulation:  
[http://www.journalofnursingregulation.com/article/S2155-8256\(16\)31073-0/pdf](http://www.journalofnursingregulation.com/article/S2155-8256(16)31073-0/pdf)
- The Joint Commission. (2014). *Hospital Accreditation Standards*.

# Sexual Harassment

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Sexual Harassment Explained .....</b>	<b>3</b>
<i>Victims of Sexual Harassment.....</i>	<i>3</i>
<b>Addressing the Issue .....</b>	<b>4</b>
<b>References.....</b>	<b>4</b>

---

---

# Introduction

Sexual harassment includes any unwanted verbal or 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. 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 own safety.

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

- The victim as well as the harasser may 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 the offensive conduct.
- Unlawful sexual harassment may occur without the harasser withholding money or a job.
- The sexual harasser's conduct must be unwelcome.

**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 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.

## References

AAUW. Know Your Rights: Workplace Sexual Harassment. Accessed 2016.

<http://www.aauw.org/what-we-do/legal-resources/know-your-rights-at-work/workplace-sexual-harassment/>

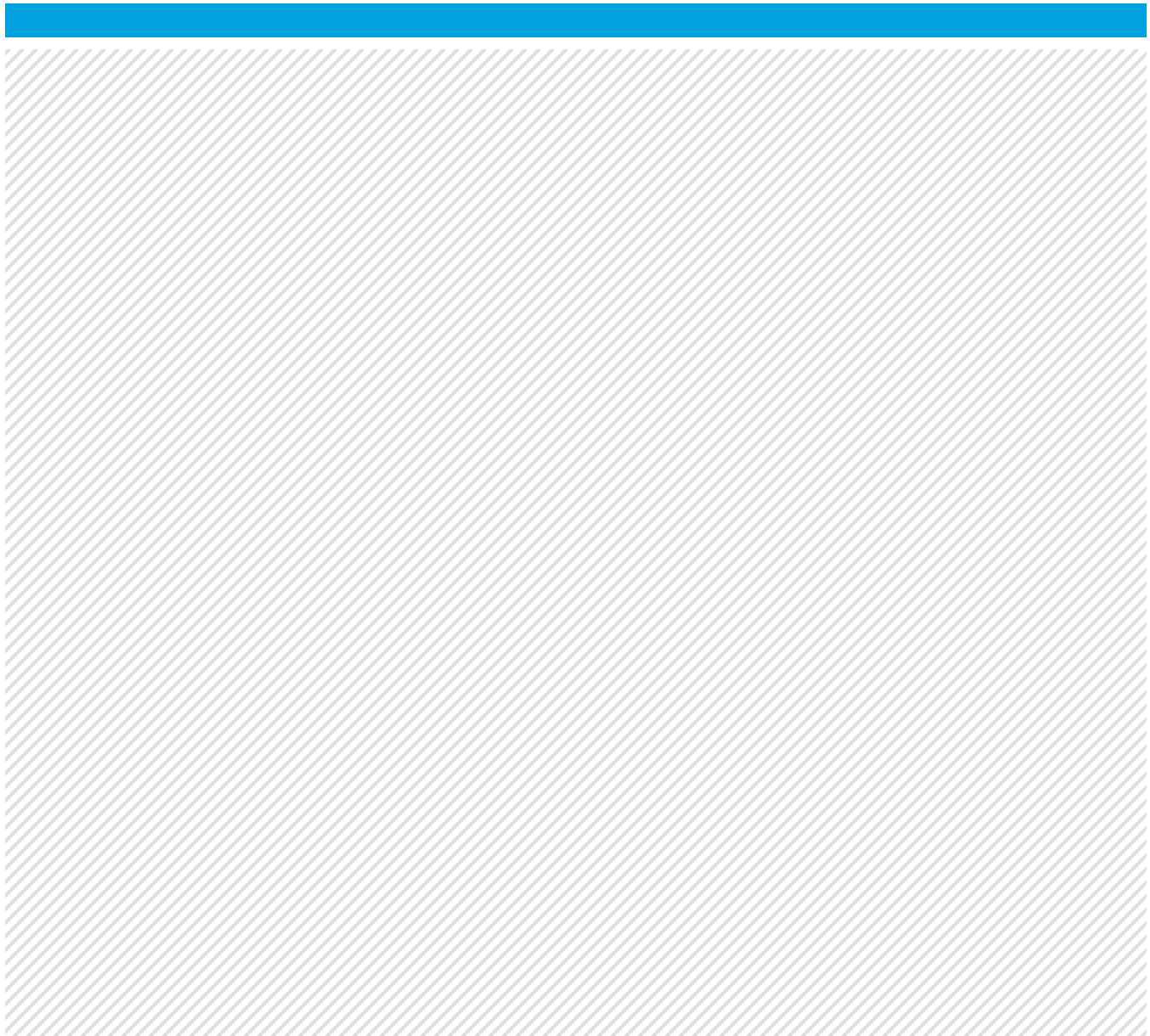
U.S. Equal Employment Opportunity Commission. Harassment. Accessed 2017.

<https://www.eeoc.gov/laws/types/harassment.cfm>

# Substance Abuse Recognition

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Substance Use Disorder.....</b>	<b>3</b>
<i>Substance Abuse .....</i>	<i>3</i>
<i>Substance Addiction .....</i>	<i>3</i>
<b>Impairment &amp; Warning Signs.....</b>	<b>3</b>
<i>Alcoholism .....</i>	<i>3</i>
<i>Drug Addiction .....</i>	<i>4</i>
<b>Impaired Practitioners .....</b>	<b>4</b>
<b>References.....</b>	<b>5</b>

---

# 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's alcohol, street drugs, prescription medications, or something else—there's 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

- is using a substance in an unapproved and inappropriate way that hinders a person's ability to perform their daily obligations.

## Substance Addiction

- is 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 one's self 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
- Needing to drink more and more to feel "drunk"



- 
- Experiencing alcohol withdraw symptoms if alcohol isn't consumed (perspiring, shaking, nausea, vomiting, anxiety)
  - Quitting favorite activities to consume alcohol
  - Drinking regardless of the ill effects it has on one's self or their relationships
  - Experiencing weight loss and gastritis

## 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 can't 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

## Impaired Practitioners

Clinicians under the influence of drugs, that 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 generally 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.

## References

Mayo Clinic. Drug Addiction, Symptoms. Mayo Clinic Staff. Dec. 05, 2014.

<http://www.mayoclinic.org/diseases-conditions/drug-addiction/basics/symptoms/CON-20020970>

Mayo Clinic. Prescription Drug Abuse, Symptoms. Mayo Clinic Staff. May,22, 2018.

<http://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/basics/symptoms/CON-20032471>

PubMed. National Library of Medicine, National Institute of Health. Impaired healthcare professional. Critical Care Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA. 2007 Feb;35 (2 Suppl):S106-16. Accessed 2016.

<https://www.ncbi.nlm.nih.gov/pubmed/17242598>

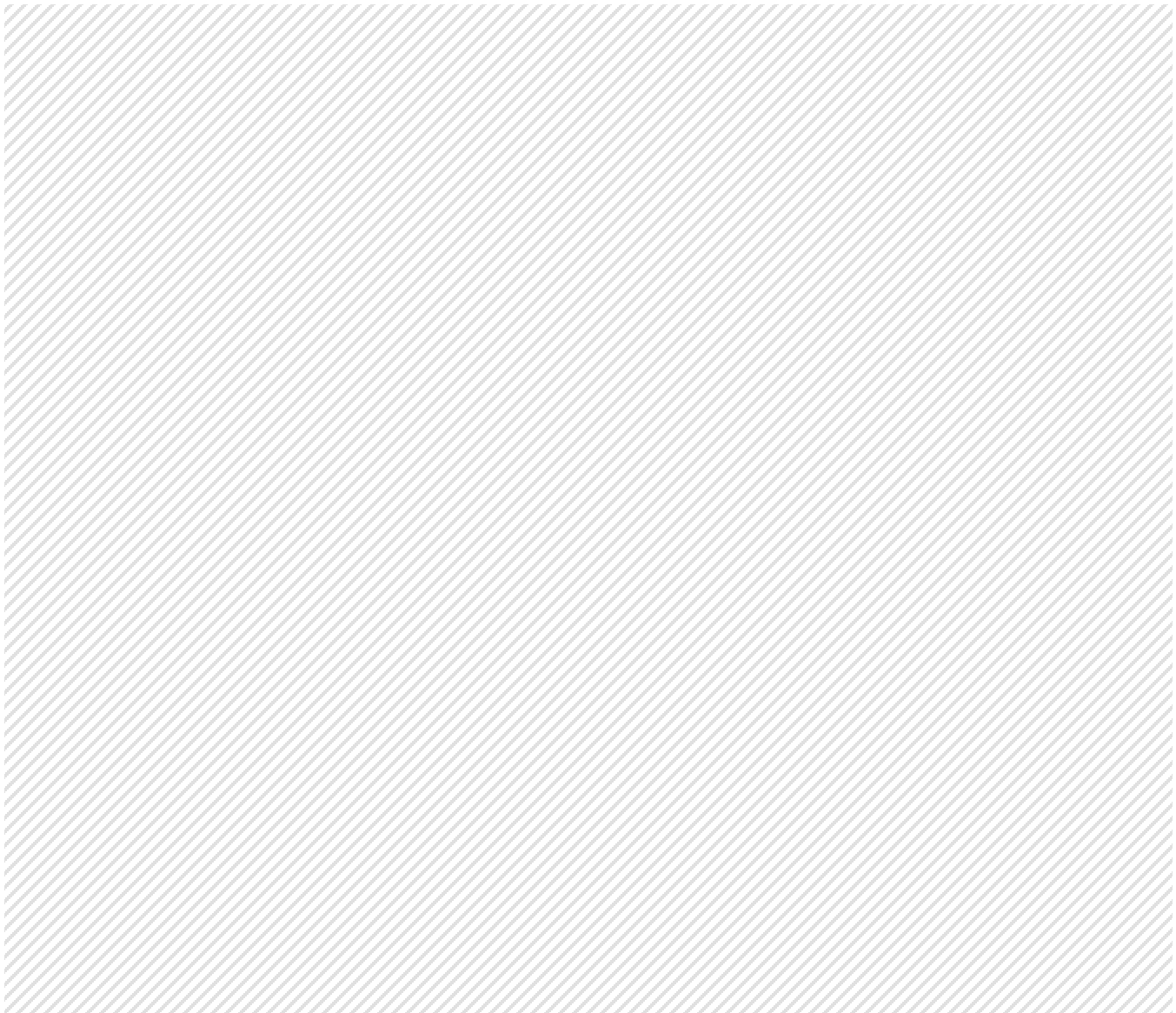
Texas Board of Nursing. Discipline & Complaints - Policies & Guidelines. 2013. Amended July 23, 2015.

[https://www.bon.texas.gov/discipline\\_and\\_complaints\\_policies\\_and\\_guidelines.asp](https://www.bon.texas.gov/discipline_and_complaints_policies_and_guidelines.asp)

# Suicide Prevention

## Core Competency Inservice

January 2020



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>2</b>
<i>Risk factors that help identify the patient at risk for suicide .....</i>	<i>2</i>
<i>Identifying Suicide Ideation .....</i>	<i>4</i>
<i>Validated /Evidence Based Suicide Risk Assessment Tools .....</i>	<i>4</i>
<i>Safety Planning .....</i>	<i>6</i>
<b>References.....</b>	<b>6</b>

## 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 help can save lives.

### Risk factors that help identify the patient at risk for suicide

The following is list of demographic and behavioral characteristics that are often seen in at risk patients. This is meant to help identify at risk patients but, does not encompass all at risk patients.

- 
- Military service
  - Mental or emotional disorders
  - Previous attempts
  - History of emotional trauma or loss, e.g., abuse
  - Serious illness or 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. The Joint Commission National Patient Safety Goals include several recommendations for identifying at risk patients and preventing suicide. The following applies to acute care hospitals. Note that even in non-behavioral care environments, the organization must be able to identify and to intervene for at-risk patients. An important 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 diagnoses that include 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 for 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, 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 any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques).
- Conduct assessments and reassessments and provides 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 patient 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.
- Some 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, and 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 a short-term.

## Validated /Evidence Based Suicide Risk Assessment Tools

There are a number of evidenced based suicide risk screening strategies 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 fidgety 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  +  +

(Health care professional: For interpretation of TOTAL, TOTAL:   
please refer to accompanying scoring card).

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	_____

Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD® is a trademark of Pfizer Inc. A2663B 10-04-2005

---

## Safety Planning

Developed collaboratively with a provider, safety plans commonly incorporate a list of personalized coping strategies that also include resources for contacting social and professional support 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.

## References

- "Suicide Prevention Training for Health Professions." Washington State Department of Health. <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention>. Assessed January 2020.
- "Suicide Facts." Suicide Awareness Voices of Education. <https://save.org/about-suicide/suicide-facts/>. Accessed January 2020.
- "Suicide Risk Screening in Healthcare Setting: Identifying Males and Females at Risk." US National Library of Medicine National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5439267/>. Assessed January 2020.
- "Screening for and Assessing Suicide Risk." Zero Suicide in Health and Behavioral Health Care. <http://zerosuicide.sprc.org/toolkit/identify#quicktabs-identify=1>. Assessed January 2020.



## How to use these course materials

- Review the entire syllabus, including any glossary, linked videos, and articles.
- Leave the syllabus open while you answer the test questions.
- Look over the Table of Contents. Note that:
  - Mousing over a Lesson title allows you to left-click and go to that Lesson.
  - The bottom of each page displays the page number and Lesson title.
- Hold down the 'Ctrl' key while pressing the 'F' key to view a 'Find' dialog box.
  - Type in a key word or phrase to find it in the text.
  - Remember that 'Find' will find all instances of the word or phrase in the entire document. Before using 'Find', consider navigating to the proper Lesson first, in order to be as close as possible to the information you want to 'Find'.

**IMPORTANT NOTE on the limitations of this material:** This content is not localized to a particular healthcare environment, system, or entity. Since local system and administrative processes are crucial to patient safety, it is imperative that the learner be familiar with local, facility/entity practices such as: policies and procedures, equipment, patient identification and validation procedures, communication and handoff practices, etc. Adhere to your organization's policies and procedures.

Workplace Harassment.....	1
What is workplace harassment?.....	1
Types of workplace harassment .....	2
Response to workplace harassment .....	3
Prevention of workplace harassment.....	4
References .....	4

## Workplace Harassment

### What is workplace harassment?

Workplace harassment is unwelcome or unsolicited speech or conduct based upon race, sex, creed, religion, national origin, age, color, or handicapping condition that creates a hostile work environment or circumstances involving quid pro quo. Workplace harassment is a form of discrimination, which is prohibited by law.

Examples of behavior that can constitute unlawful workplace harassment and/or create a hostile work environment include, but are not limited to:

- Making jokes about individuals based on race, sex, creed, religion, national origin, age, color, or handicapping condition
- Making racial or ethnic slurs

## Workplace Harassment

- Forcing employees to segregate based on race, sex, creed, religion, national origin, age, color, or handicapping condition
- Giving a subordinate a degrading or humiliating assignment on the basis of race, sex, creed, religion, national origin, age, color, or handicapping condition
- Displaying offensive literature or posters
- Repeatedly proselytizing fellow employees on the correctness of a particular religion

### **Types of workplace harassment**

Workplace harassment may take many forms. Any harassing activity based on one of the categories listed below that creates a hostile work environment or impairs a person's ability to do their job may be considered workplace harassment. See the previous page for some common examples.

The following categories are known as "Protected Classes." These are categories to which people belong that are specifically protected from discrimination by federal and state laws.

Everyone is a member of at least one of these categories, and therefore anyone can be a victim of workplace harassment based on:

- Age - A person 40 years of age or older
- Color - The complexion or shades of a person's skin
- Creed - A system of beliefs, principles or opinions
- Disability - Any person who has a physical or mental impairment which substantially limits one or more major life activities; one who has a record of such impairment; or one who is regarded as having such an impairment
- National Origin - Characteristic of, or peculiar to, the people of a nation; of or relating to ancestral beginnings, physical, cultural, or linguistic characteristics of a particular national group
- Race - A local geographic or global human population distinguished as a more or less distinct group by certain characteristics such as skin color, hair texture, and facial features. A race may also be any group of people united or classified together on the basis of common history, nationality, or geographical distribution
- Religion - All aspects of religious observance, practice and belief which include moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views
- Gender and Sexual Orientation - The condition or character of being male or female as well as sexual orientation or preference

The harasser may be a person, group of persons, or even an employer or organization that is responsible for creating a hostile work environment for any member of one or more of the above groups.

## Workplace Harassment

### Response to workplace harassment

If you feel that are the victim of workplace harassment, take the following steps:

1. **Collect and preserve evidence**

Take notes as soon as you feel you are being harassed. Record dates, names, and a description of what happened; be as specific as possible. Your written record will help you in when talking with your supervisor and will help both you and any investigators if you need to file a complaint.

2. **Discuss your concerns with the person who is harassing you** (This step may **not** be appropriate depending on the situation; please read the following paragraphs.)

As with sexual harassment, some harassers may not be aware that their behavior is a problem. If you think that the harasser is not intentionally trying to harass you, and that he or she may be willing to listen and correct the behavior, you might consider discussing your concerns with him or her (remember to use your notes and be specific). If the harasser stops the behavior, then no further action on your part may be necessary.

On the other hand, if you feel the harasser is intentionally trying to impair your ability to work and/or create a hostile work environment, then it may not be a good idea to discuss your concerns with him or her. Such an exchange may become confrontational.

3. **Discuss the matter with your supervisor** (or, depending on your own organization policy, another person such as a Human Resources representative)

Naturally, if the harasser *is* your supervisor, you should consider going directly to your Human Resources representative.

4. **Follow your organization's policy**, if necessary, for further action

### Response to an accusation of harassment

If a person tells you that you have harassed him or her, you should do all of the following:

1. **Be a good listener.**

Respect the person's point of view. Try not to become angry or overemotional. Don't treat the situation as a joke or unimportant. He or she is taking a very difficult step in bringing this situation to your attention. Take the person seriously.

2. **Apologize, promise to stop the behavior, and immediately stop the behavior.**

**If you don't feel that you've done anything wrong**, or if you disagree that you have exhibited the behavior in question, you may consider not apologizing since that could be interpreted as an admission of guilt. Instead, say you are sorry that the person has been upset by this behavior, that you will not do it, and that you would appreciate it if he or she immediately brought it to your attention if it occurs. Remember not to become

## Workplace Harassment

angry or defensive.

3. **If a complaint is made against you, cooperate fully with any investigation.**

Your truthful and willing cooperation will assure the best outcome for you, whether or not you have done anything wrong. Don't criticize or otherwise try to retaliate against the person who made the complaint.

4. **If a lawsuit is filed, get an attorney.**

### Prevention of workplace harassment

Everyone can help create an environment of mutual respect and goodwill by following a few simple guidelines:

1. **Apologize.**

We all make mistakes. If you've said or done something that someone finds offensive, apologize. Acknowledging mistakes helps create a climate of trust and prevents small problems from becoming big ones.

2. **Before telling a joke, ask yourself whether it might be offensive to someone.**

"It was just a joke" is not an excuse for harassment.

3. **Take a stand.**

When you see harassment take place even when it is not directed at you, point it out and object.

4. **Respect the differences between people.**

We're all unique. Cherish and respect those differences.

If you are a supervisor or manager, you can further help to prevent harassment by doing the following:

- Treat employees fairly and consistently,
- Display zero tolerance for harassing behaviors.
- Discuss your organization's harassment policies with your employees.
- Ensure that your employees know what to do if they feel they have been harassed.

### References

- ANA. (n.d.). *Position Statement Background Information: Sexual Harassment*. Retrieved Nov 2015, from American Nurses Association: <http://nursingworld.org/harassmentps>
- Baptiste, M. (2015, Sept). *Workplace Discrimination: An Additional Stressor for Internationally Educated Nurses*. Retrieved from Online Journal of Issues in Nursing: <http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/T>

## Workplace Harassment

ableofContents/Vol-20-2015/No3-Sept-2015/Articles-Previous-Topics/Workplace-Discrimination-for-Internationally-Educated-Nurses.html

- Christie, W., & Jones, S. (2014, Jan). *Lateral Violence in Nursing and the Theory of the Nurse as Wounded Healer*. Retrieved Nov 2015, from Online Journal of Issues in Nursing:  
<http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/ableofContents/Vol-19-2014/No1-Jan-2014/Articles-Previous-Topics/Lateral-Violence-and-Theory-of-Wounded-Healer.html>
- EEOC. (n.d.). *EEOC Subregulatory Guidance*. Retrieved Nov 2015, from US Equal Employment Opportunity Commission: <https://www.eeoc.gov/laws/guidance/index.cfm>
- EEOC. (n.d.). *Harassment*. Retrieved Nov 2015, from US Equal Employment Opportunity Commission: <https://www.eeoc.gov/laws/types/harassment.cfm>
- EEOC. (n.d.). *Sexual Harassment*. Retrieved Nov 2015, from US Equal Employment Opportunity Commission: [https://www.eeoc.gov/laws/types/sexual\\_harassment.cfm](https://www.eeoc.gov/laws/types/sexual_harassment.cfm)
- Lockwood, R. (2015, Sept). *Sexual Harassment in Healthcare*. Retrieved Nov 2015, from RN.org:  
<http://www.rn.org/courses/coursematerial-236.pdf>
- Rocker, C. (2012, Sept). *Responsibility of a Frontline Manager Regarding Staff Bullying*. Retrieved Nov 2015, from Online Journal of Issues in Nursing:  
<http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/ableofContents/Vol-17-2012/No3-Sept-2012/Articles-Previous-Topics/Responsibility-of-Manager-Re-Bullying.html>

End of Harassment Lesson

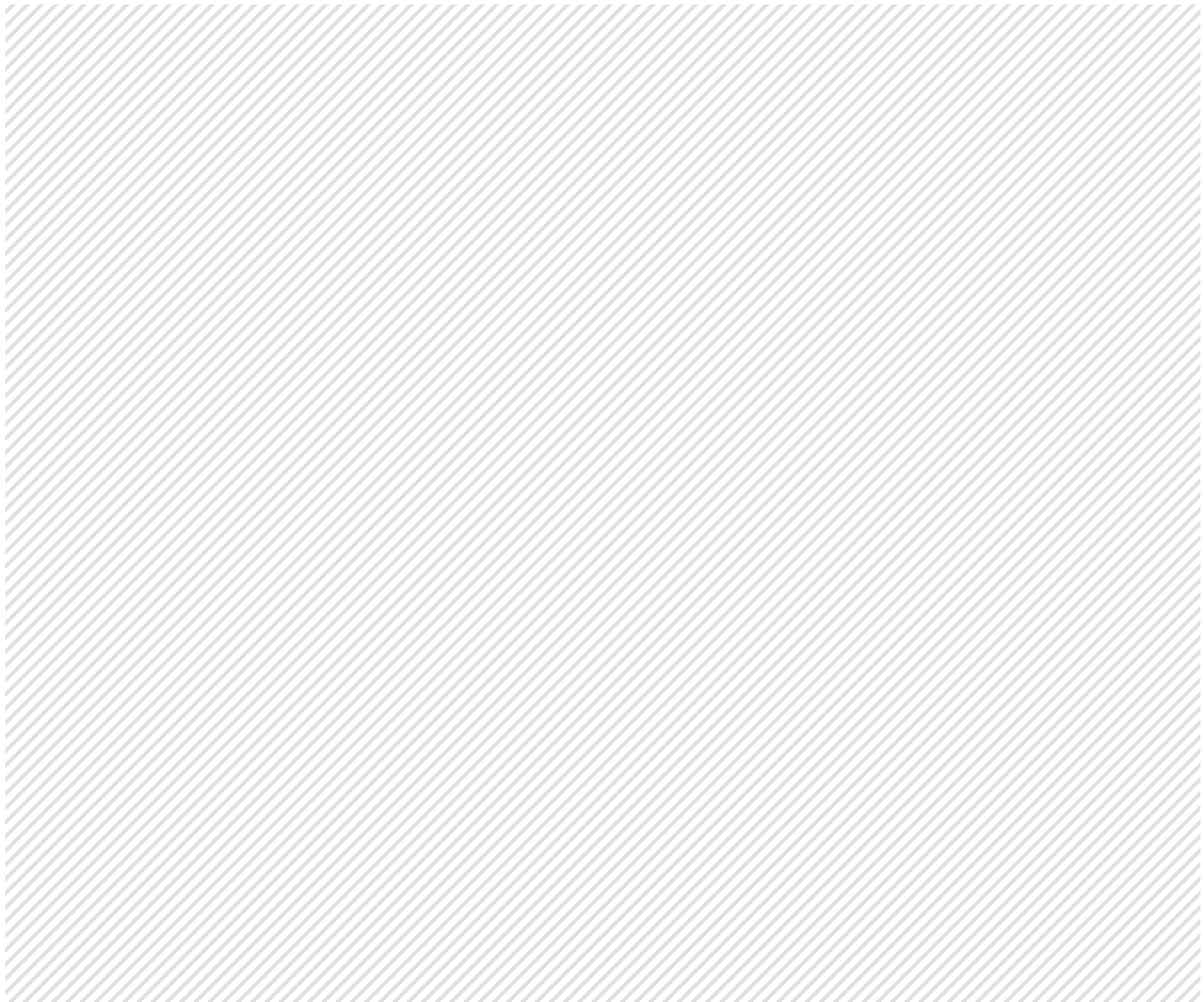
# Workplace Violence

Active Shooter, Bleeding Control and Bioterrorism

## Core Competency Inservice

January 2020

---



This guide may not be reproduced, stored in a retrieval system, or transmitted, in any form, in whole or in part, or by any means, electronic, mechanical, recorded, or otherwise, without the prior written consent of HealthcareSource HR, Inc. The information in this guide is subject to change without notice. HealthcareSource HR, Inc. assumes no responsibility or liability for any errors, omissions, assumptions, or any conclusions drawn from this guide. All other third-party trademarks mentioned in this publication are the property of their respective owner.

---

# Table of Contents

<b>Introduction .....</b>	<b>3</b>
<b>Factors of Workplace Violence .....</b>	<b>3</b>
<i>Environmental Factors .....</i>	<i>3</i>
<i>Individual Factors .....</i>	<i>3</i>
<b>Recognizing Levels of Violence &amp; Proper Response .....</b>	<b>4</b>
<i>Level 1 (Early Warning Signs) .....</i>	<i>4</i>
<i>Level 2 (Escalation of the Situation) .....</i>	<i>4</i>
<i>Level 3 (Further Escalation) .....</i>	<i>5</i>
<b>Preventing Workplace Violence .....</b>	<b>5</b>
<i>Creating a Safe Work Environment .....</i>	<i>5</i>
<i>Provide Security .....</i>	<i>6</i>
<i>Provide Education .....</i>	<i>6</i>
<b>Active Shooter .....</b>	<b>6</b>
<b>Bleeding Control .....</b>	<b>8</b>
<i>Primary Principles of Trauma Care Response .....</i>	<i>8</i>
<i>Applying Direct Pressure on a Wound      Applying a Tourniquet .....</i>	<i>10</i>
<i>Bleeding Control Algorithm .....</i>	<i>11</i>
<b>Agents of Bioterrorism .....</b>	<b>11</b>
<i>Biological Agents .....</i>	<i>11</i>
<i>Anthrax .....</i>	<i>12</i>
<i>Person-to-Person Contact .....</i>	<i>13</i>
<b>Responding to the Threat of Bioterrorism .....</b>	<b>13</b>
<b>References .....</b>	<b>13</b>

---

# 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 nearly 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 possibly 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. 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 are involved 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 anywhere 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 shooter, location, and weapons.

### HIDE if escape is not possible

- Get out of the shooter's view and stay very quiet.
- Silence all electronic devices and make sure they won't vibrate.
- Lock and block doors, close blinds, and turn off lights.
- Don't 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 the 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 act 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 various 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

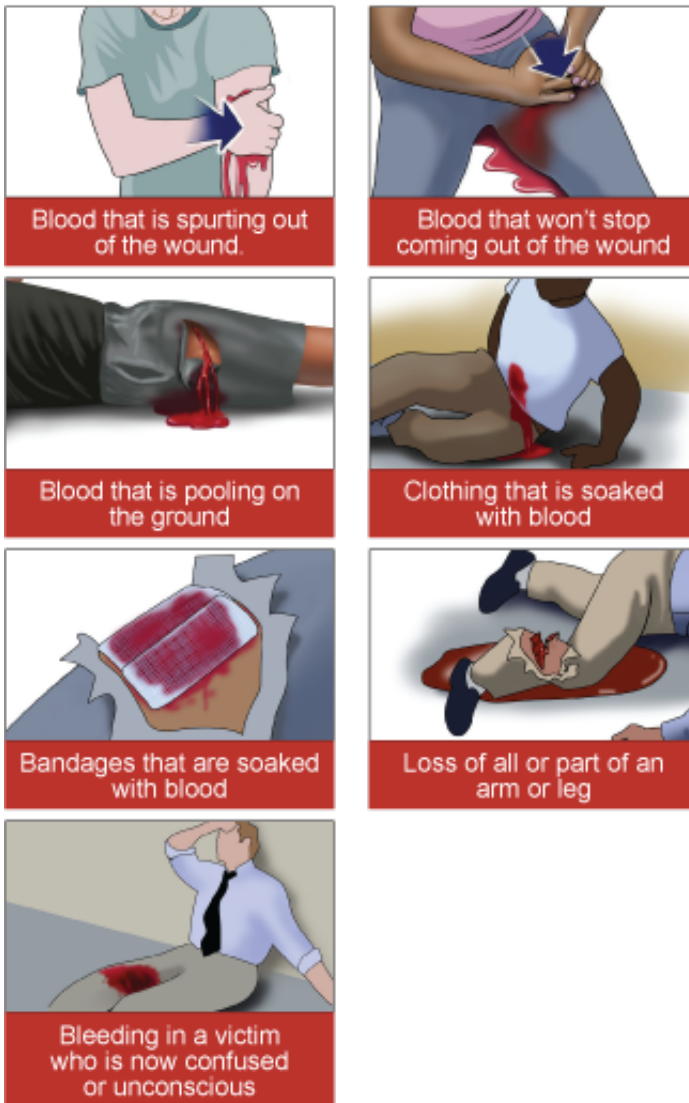
- Open or remove the clothing over the wound so you can clearly see it (Removing clothing will enable you to see injuries that may have been hidden or covered.)

#### 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 don't 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-threatening injuries**



## 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

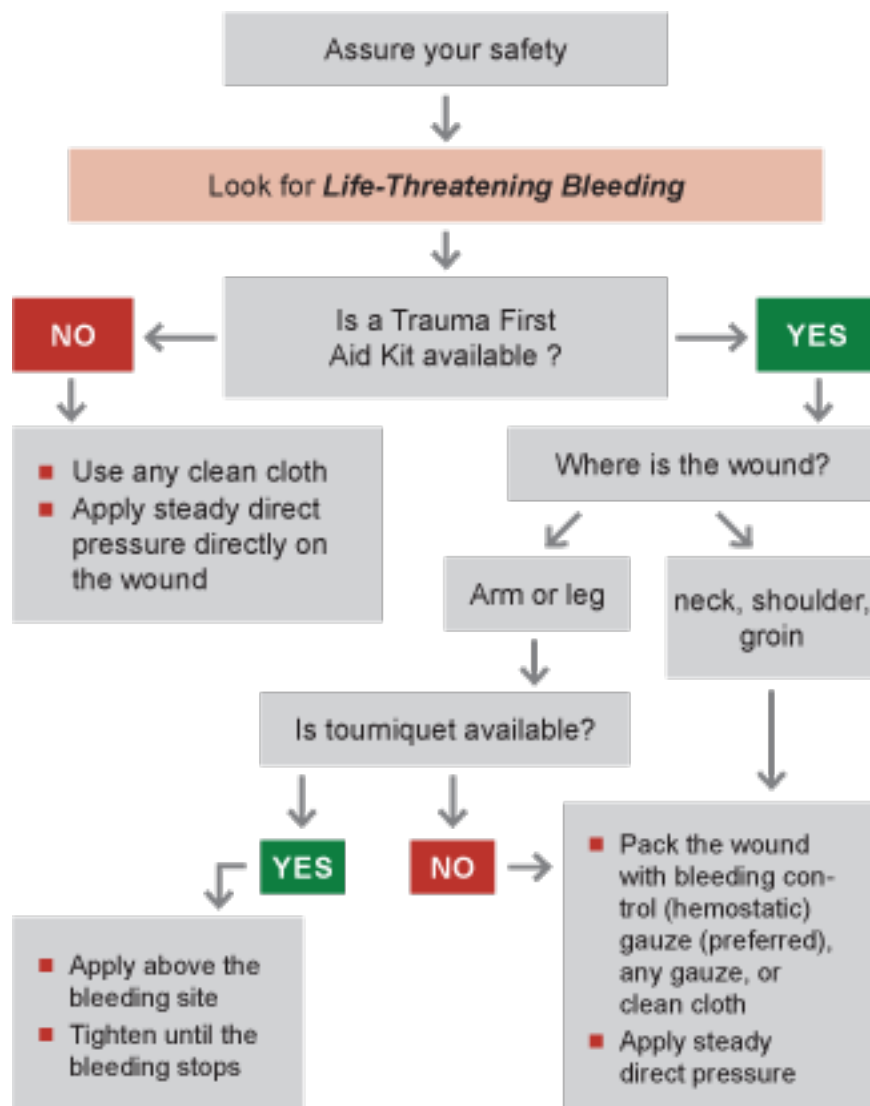


3. Pack (stuff) the wound with bleeding control gauze (preferred), plain gauze, or clean cloth.



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

**Other agents can also be spread by person-to-person contact. These include:**

- Smallpox
- The Plague (pneumonic form).

## Anthrax

Anthrax is caused by bacteria called **Bacillus anthracis**. The bacteria is usually found in hooved 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. Bacteria might be carried on a powder or on an infected animal. The bacteria are spread through contact with broken skin, such as a cut.
- After an incubation period of 2 to 5 days, a papular (raised) lesion appears. After 2 to 2.5 days, this lesion becomes vesicular (filled with fluid). Eventually it becomes blackened and hard. Cutaneous anthrax is curable with antibiotics. If not treated, it can cause death in 5-20% of cases.

### 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 very 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 very 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

## References

“Active Shooter.” Department of Homeland Security. <https://www.ready.gov/active-shooter>. Accessed November 2019.

“Bioterrorism Agents/Diseases.” CDC. <https://emergency.cdc.gov/agent/agentlist-category.asp>. Accessed November 2019

“DOL Workplace Violence Program.” United States Department of Labor . Accessed November 2019. Department of Homeland Security. <https://www.ready.gov/active-shooter>.

“Preventing Workplace Violence in Healthcare.” OSHA. [https://www.osha.gov/dsg/hospitals/workplace\\_violence.html](https://www.osha.gov/dsg/hospitals/workplace_violence.html). Accessed October 2019.

---

“Preventing Workplace Violence: A Road Map for Healthcare Facilities.” OSHA.  
<https://www.osha.gov/Publications/OSHA3827.pdf>. Accessed October 2019.

“Run, Hide, Fight. Surviving and Active Shooter.” City of Houston.  
[https://www.youtube.com/watch?v=5VcSwejU2D0&feature=player\\_embedded](https://www.youtube.com/watch?v=5VcSwejU2D0&feature=player_embedded). Accessed  
November 2019.

“Save a Life: What Everyone Should Know to Stop Bleeding After an Injury.” American College of Surgeons.  
<https://www.bleedingcontrol.org/~media/bleedingcontrol/files/stop%20the%20bleed%20booklet.ashx>.  
Accessed October 2019

“Workplace Violence.” United States Department of Labor.  
<https://www.osha.gov/SLTC/workplaceviolence/>. Accessed November 2019.