Comprehensive Core Competencies

Nursing/Providers/Clinicians

2024

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 Clinical Advisory Team, Inc. The information in this guide is subject to change without notice. Clinical Advisory Team, 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.

Clinical Advisory Team, Inc © 2024 Editor: Tammy McGarity, DNP, MSN, RN, NEA-BC

Symplr 2024

Abuse, Neglect, and Exploitation (Child, Domestic, Elder) 8

Forms of Abuse and Neglect 8
Elder 9
Child 10
Domestic 11
Human Trafficking 12
Clinician's Responsibility in Reporting Abuse and Neglect 13
Mandatory Reporting 13

Advanced Directives 16

What are Advance Directives 16
Types of Advance Directives 16

Age Specific 20

Birth - 1 Year 20
Toddler: 18 months - 3 Years 22
Preschooler: 3 - 5 Years 23
School Age: 6 - 12 Years 25
Adolescence: 13 - 18 Years 26
Early Adulthood: 19 - 35 Years 27
Middle Adulthood (Geriatric): 36 - 60 Years 28
Late Adulthood (Geriatric): 61 - 80 Years 29

Complaints and Grievances 31

Complaint and Grievance Resolution 32

Compliance (Fraud, Waste, and Abuse) 34

Fraud, Waste, and Abuse in the Medicare Program 35
Civil False Claims Act (FCA) 36
What do I do when issues arise? 38

Coronavirus (COVID-19) 39

Infection Prevention 40
Standard and Transmission-Based Precautions 43
COVID-19 Vaccination for Healthcare Personnel 45
Resources for Healthcare Facilities and Personnel 46

Cultural Competence 47

Cultural Competency 47

Skills and Characteristics of Cultural Competency 48
Religious and Cultural Practices 49

Customer Relations and CAHPS 52

The Importance of Good Customer Relations 52
Building Good Customer Relations 53
Customer Relations on the Telephone 54

Dementia Care and Communication 60

Dementia 60
Alzheimer's Disease 61
Traumatic Brain Injury 61
Post-Traumatic Stress Disorder 62
Caring for Patients with Dementia 62
Navigating Difficult Behaviors 64
Communicating with Patients with Dementia, Cognitive Impairment, and Limited English Proficiency 65

End-of-Life Care 72

Hospice or Palliative Care 72
Advanced Directives 73
End of Life Symptoms 73
Holistic Care for the Patient and Family 74

Environment of Care 76

Safety Management 76
Emergency Management 77
Internal versus External Disasters 77
Medical Equipment Management 78
Hazardous Materials and Waste Management 79
Safety Data Sheets 79
Utility Management 80
Life Safety Management (Fire Safety) 81
Security Management 83
Management of the Social Environment 84

Fall Prevention 85

Fall Risk Factors 85
Fall Risk Assessments 87
Interventions 88
Post-Fall Management 88

Healthcare Ethics 90

Conduct and Behavior 91
Codes of Ethics for Healthcare Professionals 91
Ethical Principles 92

HIPAA 96

Five HIPAA Rules 96
HITECH Act 98
Other Uses of Protected Health Information 98

Infection Control and Prevention with Blood-Borne Pathogens 100

Infection Control Procedures 100
Infection Control Precautions 102
Cleaning, Disinfecting and Disposal 103
Infectious Agents in the Healthcare Setting 104

Latex Allergy 109

Reactions 110
Clinicians and Latex 113

Long Term Care 114

Residents' Rights 114
Resident Assessments 117
Quarterly Review Assessment 118
Comprehensive Person-Centered Care Planning 118
Discharge Planning Process 119
Quality of Life 119
Quality of Care 120
Dementia Management 123
Clinical Services 123
Administration 126
Quality Assurance and Performance Improvement (QAPI) Program 127
Infection Control 128
Compliance and Ethics Program 128
Physical Environment 128
Training Requirements 130

Medication Safety Nursing 131

Introduction 131
Start with the basics. 131

The Eight Rights of Medication Administration 133
Classification of Narcotics 134
Narcotic Handling, Storage and Disposal 135
Adverse Reactions 138

Mental Health Training for Caregivers 140

Mental Health Diagnoses, Symptomology, and Treatment 143
Intervention Strategies 146
Psychiatric Medications: Common Medications and Potential Side Effects 150
Substance Use Disorders and Treatment 153
Individual-Person-Centered Service Plan, Crisis Plan, and Behavioral Support Plan Implementation 155

OSHA Healthcare Safety 156

What does OSHA do? 156
OSHA Standards 157
OSHA in the Healthcare Workplace 161
Reporting Workplace Safety Concerns and Employee's Rights 163

Pain Management 165

Pain Assessment 165
Treatment and Interventions 167
Treatment for Pain 167
Opioid abuse 168

Patient Safety and Culture of Safety 170

Patient Safety Systems 170
Safety Culture 170
The Role of Hospital Leaders in Patient Safety 172

Patient's Rights 174

Patient's Bill of Rights 174
Consumer Responsibilities 175
Patient Rights and Health Insurance: Affordable Care Act 176
Patient Rights under HIPAA 176
Additional Rights Outlined by Joint Commission 176

Plan of Care 178

Developing a Care Plan or Plan of Care 178
Interdisciplinary Plan of Care 179

Quality Improvement.....180

Quality Tools.....182
Quality Occurrences.....182
Quality Measures and Reporting.....183

Restraints.....184

Violent Restraints Versus Non-violent Restraints.....184
Types of Restraint.....184
Restraint Usage.....186
Patient and Family Education.....188
Staff Training Required.....188

Risk Management & Legal Issues in Healthcare with Do Not Use Abbreviations.....188

Risk Management.....189
Incidents and Reporting Guidelines.....190
Safety Events and Root Cause Analysis.....191
Risk Reduction.....192
Sources Used to Interpret the Law.....192
Negligence vs Malpractice.....193
Documentation.....193
Just Culture.....195

Safe Patient Handling and Back Safety.....196

Safe Patient Transfers and Body Mechanics.....197

Sexual Harassment.....215

Sexual Harassment Explained.....215
Addressing the Issue.....216

Substance Abuse Recognition.....217

Substance Use Disorder.....217
Impairment & Warning Signs.....217
Impaired Practitioners.....218

Suicide Prevention.....220

Risk Factors.....220
Joint Commission National Patient Safety Goal for Suicide Prevention.....220
Identifying Suicide Ideation.....222
Validated /Evidence-Based Suicide Risk Assessment Tools.....223
Safety Planning.....225

Workplace Violence (Active Shooter, Bleeding Control and Bioterrorism) 226

Workplace Violence in Healthcare 226
Factors of Workplace Violence 227
Recognizing Levels of Violence & Proper Response 228
Preventing Workplace Violence 229
Creating a Safe Work Environment 229
Provide Security 230
Provide Education 230
Active Shooter 230
Bleeding Control 232
Primary Principles of Trauma Care Response 232
Agents of Bioterrorism 236
Responding to the Threat of Bioterrorism 237

References 238

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

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

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

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

Assault is defined as making a physical attack.

Forms of Abuse and Neglect

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

Sexual abuse is nonconsensual sexual contact (any unwanted sexual contact). Examples include unwanted touching, rape, sodomy, coerced nudity, and 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 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 their resources or income are illegally or improperly used for another person's profit or gain. Examples include illegally withdrawing money from another person’s account, forging checks, or stealing things from 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, through their action or inaction, deprives a vulnerable adult or child of the care necessary to maintain the vulnerable adult's or child's physical or mental health. Examples include not providing essential food, water, clothing, a safe living place, 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 lights, etc.) are also neglected. Healthcare providers can unknowingly neglect patients by leaving a patient on the bedpan for an extended period, moving walking aid devices out of reach, keeping patients in bed, charting a patient who has been repositioned but forgetting to do so, or moving a call button out of reach.

Self-neglect occurs when vulnerable people fail to provide for themselves, jeopardizing their 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 person cannot obtain necessary food, clothing, shelter, or health care. Examples include deserting a vulnerable adult or child in a public place or leaving a vulnerable adult or child 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 older adult. It may or may not be intentional, and an older adult will often suffer several forms of abuse and neglect at the same time.

Who is Subject to Elder Abuse?

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

- Elders aged 80 and older and those with physical or mental impairments are more likely to be abused than any other
- Elder abuse, including neglect and exploitation, is experienced by an estimated one out of every ten people ages 60 and older who live 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 older people because they do not understand the effects of aging. Caregivers 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 blatant, but it can do just as much harm. Individuals working with and around children must 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 neglect in the past year, and this is an underestimate. In 2020, 1,750 children died of abuse and neglect in the United States.

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

Who are the Abusers

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

Warning Signs of Child Abuse

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

Domestic

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

Who are the Abused

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

What is Domestic Abuse

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

Human Trafficking

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

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

Who are the Trafficked

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

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

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

Apparent child sexual abuse material.

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

Who are the Traffickers

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

Most suspects arrested for the use of Commercial Sexual Exploitation of Children (CSEC) 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 significant public health problem, both domestically and internationally. Healthcare 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 intellectually disabled person being abused or neglected or when you suspect it.

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

When a child or elder abuse or neglect is suspected, the abuse 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 a Sexual Assault Nurse Examiner (SANE), follow your facility's guidelines for engaging the SANE Nurse if sexual abuse is suspected.

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

Mandatory Reporting

A mandated reporter is recognized as an individual required by law to report known or suspected abuse and neglect of children, dependent adults, and older people. Identifying

mandatory reporters depends on the state. For example, most states identify mandated reporters by their profession, whereas others consider all adults mandated reporters. Always reference your local and state laws for reporting guidelines.

Professionals responsible for reporting abuse and neglect of children, elderly, and dependent adults include, but are not limited to, the following:

- Doctors, nurses, and healthcare workers
- Childcare providers
- Teachers and school personnel
- Law enforcement officers
- Medical examiners or coroners
- Guardian or conservator
- Counselors and other mental health professionals

The Federal Child Abuse Prevention and Treatment Act (CAPTA) implements measures to ensure every state has procedures/provisions in place for mandating reporting of suspected or known child abuse and neglect. Most states have a telephone number utilized for receiving neglect or abuse reports.

Professionals must make reports of their concerns promptly. One of the main reasons timely reporting is imperative is that CPS or APS must conduct an investigation and ensure the child, elder, or dependent adult is protected from harm. When reporting becomes delayed, it becomes harder for the agency to do its job, and the abused individual can become more endangered. It is not required to be able to prove that abuse/neglect is taking place, and professionals must report even just suspected abuse/neglect, as it is in the best interest of the child.

The following breaks down information that should be communicated to CPS/APS and reflected in a report:

Location: Reports should disclose information regarding where to find the endangered individual. For children, the home address, names of child/parents of child/caregiver, school attended by the child, any applicable daycare, and information on any siblings/other children residing in the same space should be provided. For dependent adults and older people, the name of the individual/carer is also helpful to provide an informative home address and any other information to help locate them.

Knowledge: When reporting, the individual should express what they know specifically regarding their condition, age, and status. For children especially, it is helpful when the reporter can provide information regarding the child's date of birth. All individuals provide specifics regarding the individual's condition (such as intellectual development, injuries, behavioral/emotional problems, physical disabilities, and medical problems).

Event: Reports should include information about the specific event, including details answering where, what, who, when, and how. In the event of a witnessed act of abuse/neglect in a public place where details are not able to be provided, make sure to report a description of the individual/abuser and a license plate, if applicable.

Doubt: In situations where an individual is unsure if an event warrants reporting, It is advised that the individual call the agency and discuss the situation with them. It is always better to be safe than sorry. If the agency does not feel an abuse/neglect case is present, the documented call would still be helpful if another case is reported, as they would have a file on them.

Advanced Directives

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

By law, each patient has the right to be educated about the nature of their illness, the general nature of proposed treatments, the risks of failing to undergo these treatments, and any alternative treatments or procedures that may be available.

The Patient Self-Determination Act (PSDA)

The 1990 Patient Self-Determination Act (PSDA) encourages every competent adult of sound mind to decide what type of medical care they want if they become incompetent and cannot voice their health care decisions. These preconceived decisions are called advanced directives.

The PSDA requires any healthcare 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 one. If no advanced directive was made, and a patient cannot make health care decisions, the family or next of kin becomes the health care proxy.

What are Advance Directives

Advance directives are documents, signed in advance, which state a person's choice about medical treatment or name someone to decide 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 several

advanced directive formats. Some follow forms outlined in state laws; lawyers or patients create others. 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 and your preferences for other medical decisions.

The Living Will should address several 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

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

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

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

The living will apply only when a person cannot 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 only covers some healthcare situations 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 cannot do so. The proxy can speak with doctors and other caregivers on behalf of the patient and make decisions according to what the patient would want if the patient were unable to do so for themselves. The chosen agent would only decide which treatments or procedures the patient would want if the patient cannot do so. If the patient's wishes in a particular 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 with whom you have trust and confidence. If your agent does not know your wishes, that agent should be willing to make healthcare decisions based on 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 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 adequate indefinitely unless it is revoked or the principal becomes competent. The principal can revoke the durable power of attorney or choose another agent.

Do Not Resuscitate Orders

A hospitalized patient can add a Do Not Resuscitate (DNR) order to their medical record. This is done when the patient does not want the hospital staff to try to revive them if their heart or breathing stops. A hospitalized patient can also add a Do Not Intubate order. This is done when the patient wants cardiopulmonary resuscitation if their heart stops beating but does not want to be intubated and placed on a ventilator. A patient can have a DNR or DNI order without making a living will or appointing a medical power of attorney. Some hospitals require a new DNR/DNI order each time a patient is admitted. An Inpatient DNR/DNI order is

only good while the patient is in the hospital. The patient can revoke a DNR or DNI order at any time. Even if a patient has a living will that includes resuscitation and intubation preferences, establishing DNR or DNI orders is still a good idea each time patients are admitted to a new hospital or healthcare facility.

An Out of Hospital Do Not Resuscitate (DNR) order is used outside 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 patient and physician must sign the Out of Hospital DNR for it to be valid. The order allows patients to refuse the total resuscitation effort in advance, even if EMS is called.

Age Specific

Birth - 1 Year

Birth - 1 months

Physical Development: Basic reflexes that are present include sucking, rooting, automatic grasp, Moro (Startle), Babinski, swallowing, gagging, blinking, coughing, urine and bowel elimination, and startling. At this age, infants have no hand-eye coordination and 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, and 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 smells and tastes, communicate with crying, and turn their heads toward familiar sounds.

Psychosocial Development: Infants will sleep 17 – 19 hours daily in short spurts. They find comfort in close contact and rocking.

Two 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 put in their hands. Arms and legs begin to move in a flailing fashion. The 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, and 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 reaching toward the sound of voices and toys. They will cry, coo, laugh, and gurgle.

Psychosocial Development: They want caregivers to comfort them and will smile and laugh at games like peekaboo.

Four 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 stomachs, they can push themselves backward.

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 allows them to hold their bottle and reach for objects nearby with both hands. Vital signs include HR 80-140, BP systolic 75-100, diastolic 50-70, and 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. They know their name at this age and can follow one-word commands like eat and babble by repeating sounds.

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

Eight months - 12 months

Physical Development: At this age, infants can crawl, sit up independently, and 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, and 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' names, can nod yes or no, and understand what simple objects are used for, such as a brush.

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

Age-Specific Interventions: Birth to 1 year

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

Clinical: Handle the infant gently and speak softly, friendly. Maintain eye contact. Use a security toy or pacifier to reduce the infant's anxiety and elicit cooperation. Keep the infant warm and take time to comfort them.

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

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

Toddler: 18 months - 3 Years

12 to 18 Months

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

Cognitive Development: The toddler should speak about 6 – 12 words clearly at this age.

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

18 Months

Physical Development: The toddler can ambulate backward and walk upstairs at this age. The toddler will begin to throw overhand, kick a ball, crouch, and stand without assistance or using their hands. Vital signs include HR 80-130, BP systolic 80-110, diastolic 50-80, and RR 20-30.

Cognitive Development: Imitate other people's facial expressions, sounds, and actions. Imitate what they see on TV, even if they do not understand what they are doing. Understand what they hear before they can speak. Make noises to communicate with others and to show satisfaction or displeasure. Recognize their name.

Psychosocial Development: The imagination begins to expand during play. They continue to become more independent but still crave parental attention and affection.

2-Year-Old

Physical Development: Dexterity increases, allowing the three-year-olds to wash and dry their hands with a towel. Balance increases, as well as letting the toddler ambulate on the balls of the feet (tiptoe) or stand on one foot. The 2- 2-year-old will begin to use eating

utensils and undress themself. Vital signs include HR 80-130, BP systolic 80-110, diastolic 50-80, and RR 20-30.

Cognitive Development: A 2-year-old's vocabulary increases to 50 or more words. Memory increases, allowing them to remember and repeat songs and rhymes. At age two, the toddler's cognitive development increases by engaging in pretend play and having an active imagination. Potty training will begin at this age. The toddler will begin to form comprehensive sentences, use less baby talk, and like to make up stories.

Psychosocial Development: Fears, such as fear of the dark, will develop. A three-year-old will begin to regulate their urges and emotions, which will decrease, but not eliminate, temper tantrums. They will ask many questions due to their increase in curiosity, begin to make up and tell stories, and call others by their name. At age 2, temper tantrums peak, and they have difficulty sharing possessions.

Age Specific Interventions - Toddler

General: Explain the need for consistency. Teach parents safety measures that guard against the child's increased motor ability and curiosity. Encourage parents to allow for brief periods of separation under familiar surroundings. Provide children with peer companionship.

Clinical: Allow the child to perform self-care tasks. Give the child simple, direct, and honest explanations 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 displeasure. Expect resistant behavior to treatments; reinforce treatments, not punishments. Use repetition to enhance memory and understanding. Examine while in the 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. They might start joining sports teams and enroll in dance at this age. 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, grow 2-3.5 inches per year, and gain 4.5 lbs. yearly. Vital Signs include HR: 70-120, BP: systolic: 80-120, diastolic: 55-80. RR: 20-30.

Cognitive Development: The preschooler will have a vocabulary of 2,500 – 20,000 words, understand time, speak using complex sentences, and begin to read. The child will recognize the most dangerous situations and quickly adapt to new situations. The attention span increases, and preschoolers can understand and control their emotions. They will draw detailed pictures resembling the intended object, like a house or person, and assemble more giant puzzles (12-20 pieces). The child will daydream frequently and love fantasy. They begin to understand nudity and will frequently want privacy when changing.

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

Age Specific Interventions - Preschooler

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

Clinical: Use simple, neutral words to describe procedures and surgery for the child. Explain when the procedure will occur about the daily schedule (e.g., after lunch, after bath). Encourage the child to fantasize about helping plan their responses to situations. Use body outlines or dolls to show anatomic sites and procedures. Let the child handle equipment before a procedure. Use play therapy as an emotional outlet to evaluate the child's sense of reality. Reinforce the 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: School-age children become 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 themself without the caregiver's help. Increasing dexterity allows the child 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 yearly and gain 4-6½ pounds yearly. Most girls will start their menstrual cycle. Vital signs include HR 70 – 110, BP: Systolic 85 – 120, Diastolic 55 – 80, RR 12 – 30.

Cognitive Development: The school-age child will master symbols, count backward, and read and write well. They will understand the date, month, and year and the notion of space. They can care for a pet or garden.

Psychosocial Development: The child will continue to love and value their parents, but peers will become increasingly important, influencing their identity and values. They love being part of a team, club, or group activity. School-age children will start to evaluate their body image and will be modest about their bodies. Interest in the other sex will begin, and alone time will be necessary for 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: Adolescent males and females will rapidly grow in skeletal size, muscle mass, adipose tissue, and skin. Due to rapid growth and sexual maturity, adolescents undergo 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, and 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 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 person. They will develop the ability to maintain a longer romantic commitment (fall in love). Decision-making skills still need to be fully developed, which could lead to participation in dangerous activities for peer acceptance.

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

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

Age Specific Interventions - Adolescence

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

Clinical: Encourage questions regarding fears. Allow adolescents to maintain control; a significant fear is losing 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 continues growing until age 30. Muscle mass continues to grow throughout early adulthood, allowing physical performance and athletic abilities to peak. Skin will lose moisture, and the GI system secretions will decrease. Vital Signs include HR 50 – 100, BP systolic 90-120, diastolic 60 – 80, and RR 16 – 20.

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

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

Age-Specific Interventions – Early Adulthood

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

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

Common Disease/Death: Trauma, HIV, malignancies, and heart disease.

Middle Adulthood (Geriatric): 36 - 60 Years

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

Psychosocial Development: By middle adulthood, the adult has usually hit the peak of their career. They are future-oriented and understand their limitations. They measure their accomplishments against their set goals. At this age, they can experience empty nest syndrome (expressed positively or negatively). They begin to adjust to the possibility of retirement and lifestyle modifications.

Age-Specific Interventions – Middle Adulthood

General: Allow choices if possible. Provide decision-making opportunities related to care. Provide wheelchair access. Provide handicapped parking. Use a language interpreter as needed. Provide adequate lighting for decreasing visual acuity. Print inadequate 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 decreased heat and cold tolerance and decreased peripheral circulation. Major body systems, like cardiac, respiratory, and renal functions, will slow down. Physical changes in vision, hearing, and motor skills may limit the ability to perform activities of daily living. Vital Signs include HR 50 – 100, BP systolic 90-120, diastolic 60 – 80, and RR 16 – 20.

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

Psychosocial Development: The late adult will experience retirement and may start pursuing a second career or a hobby. Community activities and leisure activities will become necessary. Grandparenthood begins, and they begin to accept their life accomplishments. They develop an acceptance of death and may experience the death of their spouse and friends. There may be a change in living conditions, such as moving to a congregate living facility.

Age-Specific Interventions – Late Adulthood

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

Clinical: Speak slowly, clearly, and of adequate volume for decreasing hearing ability. Provide adequate nutrition. Keep the environment safe (e.g., bed: side rails up, wheels locked, etc.). Turn/assist q 2 hours. Assess skin integrity frequently. Monitor bowel elimination q 24 hours. Continue with pain assessment and management. Narcotics with a long half-life may cause problems with side effects (e.g., confusion, constipation). Use adjutant analgesics with caution as it increases side effects. Apply lotion to the skin immediately after bathing.

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

Complaints and Grievances

Complaints

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

Grievances

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

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

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

Examples of Complaints and Grievances

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

Grievance: A patient raises a verbal complaint that cannot be resolved immediately.

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

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

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

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

Complaint and Grievance Resolution

General Rules

Any healthcare staff member aware of a concern or complaint must attempt to resolve it promptly, courteously, and reasonably.

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

Steps to Resolution

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

case, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

- A complaint or grievance is considered resolved when the patient is satisfied with the actions taken on their behalf.
- Please do not ignore what your patients and their families have to say. Address each concern as it is brought to your attention and report to the charge nurse or supervisor immediately. Patient safety is of the utmost importance in all circumstances.

Compliance (Fraud, Waste, and Abuse)

Compliance is essential in a highly regulated, high-risk industry like healthcare. 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. Still, most healthcare compliance issues are related to patient safety, the privacy of patient information, and billing practices.

We have all seen examples in the news of a company or its representatives misrepresenting its assets, making misleading statements about what business the company is in, mishandling clients' money, or misrepresenting services provided to clients. To ensure that Medicare/Medicaid providers are upfront, honest, and respectable, they must have a formal Compliance Program. Centers for Medicare and Medicaid Service (CMS) programs are 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, including guidelines for investigations and reporting to CMS.

Benefits of a Good Compliance Program

- Complying with industry standards and regulations helps healthcare organizations improve care quality.
- 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.
- Convey to staff and clients that the company ethically conducts business and is committed to quality customer/patient care.
- Increase the potential of proper submission and payment of claims.
- Reduce billing mistakes.
- Improve the results of reviews conducted on Medicare claims.

- Avoid the potential for fraud, waste, and abuse.
- Promote patient safety and ensure delivery of high-quality patient care.

How are Individuals Involved

- Individuals can stand against illegal and unethical situations by simply conducting themselves with respect and integrity and following the companies' Code of Conduct. Suppose the individual feels that the company's values have been compromised in any way. In that case, they take integrity to a higher level and speak up to remedy the situation.
- Compliance keeps operations running smoothly and ensures everyone follows proper procedures and understands expectations. But compliance in healthcare comes with even higher stakes than in other industries. If a doctor or nurse does not follow proper procedure, they can injure a patient or another staff member. Healthcare compliance is about providing safe, high-quality patient care.

What Should Be Reported

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

Fraud, Waste, and Abuse in the Medicare Program

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

Fraud

Fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit. The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program.

Healthcare fraud is punishable by imprisonment for up to 10 years and is subject to criminal fines of up to $250.000.

Examples of actions that may constitute Medicare fraud include:

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

Waste

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

Examples of actions that may constitute Medicare waste include:

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

Abuse

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

Examples of actions that may constitute Medicare abuse include:

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

Civil False Claims Act (FCA)

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

- Conspires to violate the FCA
- Conducts other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the

Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

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

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

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

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

Exclusion

- No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG can exclude individuals and entities from federally funded healthcare programs and maintains the List of Excluded Individuals and Entities (LEIE).
- The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.

Summary

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

Penalties for violating these laws may include:

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

- Loss of professional license

What do I do when issues arise?

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

- Go to the floor supervisor's supervisor
- Go to the HR director
- Go to the Director of Quality Services
- Go to the Administrator
- Call the Compliance Line

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

Coronavirus (COVID-19)

On February 11, 2020, the World Health Organization reported an official name for the sickness responsible for the 2019 novel COVID flare-up, first distinguished in Wuhan, China. This was named Covid illness2019, truncated as COVID-19. In COVID-19, 'CO' means 'crown,' 'VI' for 'infection,' and 'D' for sickness. Previously, this illness was referred to as 2019 novel Covid or 2019-nCoV.

In 2023, guidelines and regulations regarding COVID-19 have changed a bit, and we now know much more about the virus. This knowledge has provided more resources and tools to protect ourselves. According to the Centers for Disease Control and Prevention (CDC), the public health emergency (PHE) ended on May 11th, 2023. Although the PHE declaration officially ended, there is still a continued need to monitor and treat COVID-19. Testing, treatments, and vaccines will continue to be available. Regarding data collection and CDC guidance, certain aspects will change. Despite the change, the CDC maintains that providing information necessary to protect public health is the utmost priority.

As of May 2023, vaccinations are still available to the public. Certain medications, such as Paxlovid, will continue to be used when deemed fit. The CDC will continue collecting data and surveillance on COVID-19 hospital admissions.

Patients

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

Symptoms

According to the World Health Organization (WHO), as of August 2023, Patients with COVID-19 primarily present with the following most common symptoms:

- Fever
- Chills
- Sore throat

Other less common signs and symptoms include:

- Severe fatigue and tiredness
- Shortness of breath
- Headache
- Chest pain or tightness
- Loss/change in taste/smell
- Increased sneezing or nasal congestion

Infection Prevention

Spread of Virus

The virus that causes COVID-19 most commonly spreads from person to person in close contact with one another (within about 6 feet or two arm lengths). It is thought to spread through respiratory droplets or small particles, such as those in aerosols, produced when an infected person coughs, sneezes, sings, talks, or breathes. Droplets can land in the mouths, noses, or eyes of nearby people or possibly be inhaled into the lungs of those within proximity. A person can get COVID-19 by touching a surface or object with the virus and then touching their mouth, nose, or eyes.

How easily a virus spreads from person to person can vary. Some viruses are highly contagious, like measles, while others do not spread as quickly. Another factor is whether the spread is sustained, spreading continually without stopping. The virus that causes COVID-19 spreads efficiently and sustainably in the community (community spread). Community spread means people have been infected with the virus in an area, including some who are unsure how or where they became infected.

According to the Centers for Disease Control and Prevention (CDC), as of 2023, individuals are believed to be the most contagious during the first five days of illness. The CDC recommends isolation from other individuals when diagnosed with COVID-19, regardless of vaccination status. In addition, the CDC advises starting isolation if an individual is sick but has not yet been confirmed to be diagnosed with COVID-19 by test results. Specific isolation guidelines have evolved since the start of the COVID-19 pandemic.

As of May 2023, the CDC is recommending the following isolation guidelines in the event of a positive test result:

- **Individual has no symptoms:** Day 0 is considered the day the individual

was tested, and day one is considered the first full day following the day they were tested. Per the CDC, if the individual develops symptoms within the first ten days of being tested, this time clock will restart to day 0 (on the onset of symptoms).

- Individual has symptoms: Day 0 of isolation is considered the day of symptom onset, and day one is considered the first full day after the day symptoms started.
- **In the event of a negative test:** If testing comes up negative, the individual may end their isolation per the CDC.
- **Ending isolation:** Isolation end is determined by the severity of symptoms. In the event of no symptoms, isolation ends after day 5. If the individual has improving symptoms, isolation ends after day five if the individual is fever-free for 24 hours (without using any fever-reducing medications). In the event of symptoms that are not improving, the CDC recommends isolating them until symptoms start improving and the individual is fever-free for 24 hours (without using fever-reducing medications). In the case of moderate illness (distinguished by shortness of breath) or severe illness (distinguished by hospitalization or a weakened immune system), the CDC recommends isolating through day ten and consulting a doctor before ending isolation.

The CDC has recommendations regardless of isolation status (until at least day 11). These include wearing a mask around others in an indoor space and avoiding contact with individuals more inclined to become extremely ill if diagnosed with COVID-19.

Infection Control Procedures

Healthcare facilities must focus on identifying, isolating, and informing on new cases of patients known or suspected of having the virus. Many facilities once implemented COVID units where patients with known coronavirus were placed. And there are also cases of hospitals being deemed COVID hospitals. Today, hospitals treat COVID patients like other infectious disease patients by placing them in isolation and requiring staff to follow proper droplet precautions, including PPE.

Healthcare Personnel

Healthcare clinicians are the most valuable resource for treating and stopping the spread of the virus. As such, ensure you have the personal protective equipment, training, and support you need to care for patients.

- Screen patients and visitors for symptoms of acute respiratory illness (e.g.,

fever, cough, difficultybreathing) before entering your healthcare facility. Keep current on the CDC's website's recommendations for preventing the spread of COVID-19.

- Ensure proper use of personal protection equipment (PPE). Healthcare personnel who come in close contact with confirmed patients with COVID-19 should wear the appropriate personal protective equipment.
- Conduct an inventory of available PPE. Consider conducting an inventory of available PPE supplies. Explore strategies to optimize PPE supplies.
- Encourage sick employees to stay home. Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. Ensure that your sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies

Patients

Handwashing remains the most critical step in infection prevention. This should be followed by an increased emphasis on early identification and implementation of source controls such as wearing a mask in public, practicing social distancing, and self-quarantine if there is suspected infection.

Outpatient Settings

1. When scheduling appointments for routine medical care, prescreen patients and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (e.g., cough, sore throat, fever1) on the day they are scheduled to be seen.
2. When scheduling appointments for patients requesting evaluation for a respiratory infection, use nurse-directed triage protocols to determine if an appointment is necessary or if the patient can be managed from home.
3. If the patient with respiratory symptoms must come in for an appointment, instruct them to call beforehand to inform triage personnel that they have symptoms of a respiratory infection and to take appropriate preventive actions (e.g., follow triage procedures, wear a facemask upon entry and throughout their visit or, if a facemask cannot be tolerated, use a tissue to contain respiratory secretions).
4. Upon arrival, isolate the patient in an examination room with a closed door. If an examination room is not readily available, ensure the patient can only wait with a mask among other patients seeking care.
5. HCPs who enter a patient's room with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or facemask, gown, gloves, and eye protection.
6. Many patients can be treated at home through telehealth visits.

Hospital and Acute Care Settings

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

1. N 95 Respirators, which filter inspired air, offer respiratory protection.
    a. If there is a limited supply of respirators and a lack of a respiratory protection program, facemasks protect the wearer from splashes and sprays.
    b. Available respirators should be prioritized for procedures likely to generate respiratory aerosols, posing 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 withthe door closed.
    b. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients undergoing aerosol-generating procedures.

Standard and Transmission-Based Precautions

Hand Hygiene

HCPs 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 PPEis essential to remove any pathogens that might have been transferred to bare hands during removal.

HCPs should perform hand hygiene using alcohol-based hand sanitizer (ABHS) 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. Generally speaking, washing hands with soap and water is the best practice when riding the body with chemicals and germs. However, if this is not possible, ABHS consisting of at least 60% alcohol will suffice. While ABHS is an excellent option, hand washing with soap in water is ideal because ABHS only kills the germs on one's hand, as opposed to hand washing, which will remove them. In addition, ABHS cannot kill all germs or remove harmful chemicals such as heavy metals and pesticides.

Respirator or Facemask

Put on a respirator or facemask (if a respirator is unavailable) before entering the patient room or carearea.

N95 respirators or respirators that offer a higher level of protection should be used instead of a facemaskwhen 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 the manufacturer's reprocessing instructions before 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 consideredadequate eye protection.
- Remove eye protection before leaving the patient room or care area.
- Reusable eye protection (e.g., goggles) must be cleaned and disinfected per the manufacturer'sreprocessing instructions before 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 handhygiene.

Gowns

- Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomessoiled.
- Remove and discard the gown in a dedicated container for waste or linen before leaving the patient roomor 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 the 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 the 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 before 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 healthcaresettings, including those patient-care areas in which aerosol-generating procedures are performed.
- Routine procedures should also include the management of laundry, food service utensils, and medical waste.
- Implement mechanisms and policies that promote situational awareness for facility staff, including infectioncontrol, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff, about known or suspected COVID-19 patients and facility plans for response.

COVID-19 Vaccination for Healthcare Personnel

Healthcare personnel who get COVID-19 can also spread the virus to those they are caring for—includinghospitalized patients and residents of long-term care facilities. Many of these individuals may have underlying health conditions that put them at risk for severe COVID-19 illness. Healthcare personnel can also spread the virus to other healthcare personnel. The currently recommended vaccines to protect against COVID-19 include Moderna, Pfizer, and Novavax. Consult with your primary care provider regarding administering these vaccines, if they suit you, and a recommended vaccination schedule.

Post-Vaccine Considerations for Healthcare Personnel

As of 2023, millions of individuals have received the COVID-19 vaccine. As a society, we know much more about COVID-19 and vaccination than ever before. Possible side effects from receiving the vaccination vary from person to person.

Common side effects include but are not limited to:

- Aches
- Tiredness
- Flu-like symptoms
- Headache
- Sore arm from the injection site

Rare side effects include, but are not limited to:

- Allergic reaction
- Myocarditis (heart inflammation)

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

Resources for Healthcare Facilities and Personnel

Healthcare personnel should continue to monitor and know where to turn for reliable, up-to-date information in their local community. Monitor the CDC COVID-19 website and your state and local health department for the latest information.

Cultural Competence

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

A person's culture comprises a specific group's values, beliefs, and practices. Culture is passed down from generation to generation but is subject to change and adaptation. Culture determines how a person acts and thinks. A person's culture helps them process the world by helping them understand relationships, respond to life experiences, and act in various situations. 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 principles that a person deems necessary. For example, a culture can value family and friends.

Beliefs

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

Practices

Practice is when a person applies their beliefs to 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. Still, if you live a terrible life, you will be reincarnated into something less fortunate in the next life, like an animal. This belief guides the practice of a completely nonviolent life where they practice vegetarianism (not eating meat).

Cultural Competency

Unconscious Bias

To be culturally competent, we must understand ourselves. Each of us has biased thoughts and beliefs that impact how we perceive others, influencing the care we give. As caregivers, we must not judge others based on our values and beliefs. All too often, caregivers allow their unconscious biases to influence the way they listen, treat, and interact with patients.

Healthcare providers are to educate the patient on all their healthcare options and respect any decision they choose, even if the care provider disagrees.

Culturally Competent Care

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

Dimensions of Diversity

Understanding diversity and the dimensions of diversity are essential 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. These factors help develop a patient's culture, how they react to their illness, and how they perceive health care.

Skills and Characteristics of Cultural Competency

The LEARN Model

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

- **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 are responsible for getting to know their patients and families so that healing can occur in the presence of their cultural values, beliefs, and practices. Cultural assumptions should never occur, and caregivers must take the time to learn about their patients. 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 they want to do and why
- Approaches with a willingness to learn

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

Religious and Cultural Practices

Most religions have a prayer schedule or like to pray with their spiritual leader, Pastor, or Priest. It is essential 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 particular cultural or religious items that they want by their side.

Standard religious practices include, but are not limited to:

- Catholics like to have their rosary beads for prayer and participate in mass
- Baptists 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
- Buddhists like time to meditate and chant

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

- Hindus are often vegetarians
- Those who practice Judaism adhere to a Kosher Diet
- Muslims will refrain from eating pork and some shellfish, as well as fast during the month of Ramadan
- Eastern Orthodox will have a yearly 40-day fast when they refrain from eating any meat, dairy, or 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 caregivers
- Hindus must have a bath every day

Proper social interactions and family dynamics vary between cultures.

Some examples include:

- Members of Hispanic Ethnicity are very modest. The eldest male makes essential decisions in the family. In addition, the 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 loudly indicates aggression.
- Members of Chinese ethnicity will avoid eye contact and be silent to show respect. Questions are disrespectful. Involve the eldest male in decisions.

LGBTQ culture

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

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

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

Customer Relations and CAHPS

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

There are two basic types of customers

- Internal customer
- External customer

Internal Customers

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

External Customers

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

You may work with many customers: other employees, patients, families, visitors, physicians, and vendors. It is expected to have both internal and external customers. For example, nursing staff follow physicians' directions 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 treating others how you want to be treated. In dealing with internal customers, maintaining good customer relations is essential. It can help provide a good working environment and a high standard of care. Maintaining good customer relations is essential when working with patients and families.

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 in which they choose to be treated. If customer service is not good and 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 illnesses. 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 answering all their questions and giving them confidence that the facility will provide the quality of care they want. Many factors can cause patients to feel a lack of empowerment, such as:

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

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

Building Good Customer Relations

The key to good customer service is to treat others the way you would want to be treated or the way you would want your loved ones to be treated in a similar situation. It often means simply being courteous and helpful. Remember that things that may be routine for you are NOT 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 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 essential to acknowledge a person's presence. Even if you cannot stop, make eye contact and smile so that people know they have been seen. Then, return and aid as soon as possible. In some cases, patients may need to wait before being seen. If so, explain why and give a reasonable estimate of how long the wait will be. If the wait is long, keep them informed

Customer Relations on the Telephone

We all use the telephone regularly. 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, your telephone skills can be critical. 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. You provide customer service when you use the telephone for your job. Your telephone skills reflect your facility. Providing an effective telephone service is a part of building good customer relations. It is your chance to make a good impression on your facility.

Courteous customer service on the phone includes:

- Answering the phone by the third ring whenever possible
- Stating your name and title and the name of your department
- Addressing customers by name
- Listening carefully
- Taking messages courteously
- Transferring calls carefully
- Asking questions tactfully
- Your tone of voice is also an essential part of building good customer relations on the telephone
- Smile (even though it cannot be seen, it will affect how you sound)
- Speak clearly
- Be polite.

Clear communication

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

Non-verbal communication does not occur in a telephone conversation. This means that there is a greater chance of a failure in communication. You can ensure telephone communication is clearly understood by you and the other person.

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

Effective Service

The goal of telephone communication is to provide adequate 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 essential and that the facility cares about them. Fellow employees need a courteous and supportive work environment. Your service on the telephone is integral to building a trusting relationship with your customers.

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

- Avoiding saying, I do not know
- Avoiding putting customers on hold for extended periods
- Avoiding transferring a caller to a string of different departments
- No one expects you to know the answer to every question. If you are asked a question and do not know the answer, tell the caller 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.

It is frustrating to be transferred to department after department as a customer. If you must transfer a caller, be sure that you transfer the call to a department that can provide the information needed. If unsure, 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, getting all the necessary information is essential when you take a message for someone else. 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 patient experience surveys. These surveys ask patients (or, in some cases, their families) about their experiences with and ratings of their healthcare providers and plans, including hospitals, home healthcare agencies, doctors, and health and drug plans. The surveys focus on matters that patients themselves say are important to them and for which patients are the best and only source of information. CMS publicly reports the results of its patient experience surveys, and some surveys affect payments to CMS providers.

HCAHPS

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

OAS CAHPS

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

Three broad goals have shaped CAHPS:

1. First, the survey is designed to produce data about patients' perspectives of care, allowing objective and meaningful comparisons of hospitals on essential topics to consumers.
2. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care.
3. Third, public reporting enhances accountability in health care by increasing transparency of the quality of hospital care provided in return for 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 due to 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 patient's expectations. The results are publicly reported.

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

Healthcare facilities may use one or more 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 various diagnoses.

CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. A downloadable version of HCAHPS results is also available through this website. The survey focuses primarily on critical aspects of patients' healthcare experiences (communication with nurses and doctors, the responsiveness of staff, the cleanliness and quietness of the environment, pain management, communication about medicines, discharge information, overall hospital rating, and whether they recommend the hospital).

Assuring the Best Possible Survey Responses

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

In some survey questions, 'Always' is the best 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 ensure 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 nursing care details will be incomplete, and survey responses will be heavily influenced by only a few incidents that may stand out in the patient's memory. The following behavioral techniques will help your patient remember your excellent care.

1. Make your good care explicit.
    - Making your care explicit may be the most powerful behavioral technique to reinforce your patient's memory of reasonable care. When performing any care that falls into one of the seven 'Always' categories, announce what you do 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, tell the patient, I am answering your call light, Mrs. Brown. When leaving the room, make a statement reminding the patient of what you have done, such as I have 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 where you provide care in those 'Always' categories. Making your care explicit will reinforce your patient's memory and will predispose your patient to recall your high-quality care much later on when completing the survey.
2. Communicate the right message.
    - Verbal and non-verbal interactions with the patient and family must always indicate respect and caring. A professional appearance helps meet the patient's expectations for a professional's appearance. Confident and open body language and posture indicate a willingness to listen and respond. Good grammar and word usage reinforce that message.
    - Now and then, however, it is hard to be friendly, yet it is much easier than many other risk management strategies. It is imperative to remember that when you are tired, harassed, or find yourself in a high-stress situation, stop…… take a deep breath, and simply be cheerful and friendly. You will feel better, which might keep you out of the courtroom someday. Here are some specific things you can do to show your patients you care in high-stress situations.

- Suppose you have to keep your patients waiting, tell them what to expect. Never leave your patients hanging in limbo.
- Give the patient your full attention.
- Do not interrupt. Listen carefully to what your patients say, especially when you are in a hurry.
- Respect your patients' privacy.
- Treat patients as people, not medical conditions. A patient with potential breast cancer will not appreciate being referred to as 'the breast mass.
- Involve patients in decision-making. Do not be a 'care dictator'
- Do not be critical of other care the patient has received. A nurse's criticism of other nurses who have cared for the patient can give rise to highly unnecessary game-playing and is in inferior taste. It can also give rise to lawsuits!
- Ensure your fellow nurses show your patients the same consideration 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 pretty consistent regardless of the state. Please refer to the following website for a look at these interesting trends: http://www.hcahpsonline.org/Files/Report_July_2015_States.pdf
    - From this information, you can assume, for example, that patients consider hospitals noisy at night, are puzzled about their medications, and do not feel they can reliably get help quickly. Know your facility's results and compare those with the national trends at the site above.
    - The bottom line is that by focusing on the problem areas and utilizing the behavioral techniques you have learned, you can strongly influence your patients' recall of the care you provide and impact your organization's survey results.

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

Dementia Care and Communication

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

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

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

Dementia

Dementia is a progressive disease with symptoms presenting slowly and gradually appearing worse. Patients with dementia can have short-term memory loss, trouble keeping track of personal belongings such as keys or wallets, difficulty performing activities of daily living such as paying bills or preparing food, and difficulty 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, the 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 judgment. Dementia is caused by damage to brain cells of the different regions of the brain. The damaged brain cells then lose the ability to communicate with each other. Impaired communication between brain cells affects the patient's thinking, behavior, and feelings. 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, elevated levels of proteins inside and outside the brain cells lead to impaired communication among the cells. Alzheimer's kills brain cells, which impair the patient's cognitive ability and can lead to personality changes. The hippocampus region of the brain is responsible for learning and memory functions. The brain cells in this region are frequently the first affected by the disease, which is why memory loss is one of the first symptoms noticed in Alzheimer's.

Traumatic Brain Injury

Traumatic brain injuries (TBI) are caused by an impact or indirect pressure that causes the brain to shake against the skull violently. 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 twice the 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 traumatic injury, confusion or disorientation, headache, dizziness, blurry vision, and nausea or vomiting. In a mild TBI, symptoms frequently appear at the time or near the injury—a moderate TBI patient experiences 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) occurs after experiencing or witnessing a distressing event. PTSD is common among combat veterans, abuse and rape victims and accident survivors; however, PTSD can develop in anyone who has experienced a traumatic event. Symptoms include manic highs and lows, nightmares or unwanted memories of the traumatic event, and avoidance of situations that might trigger unwanted memories of the event.

About 6 out of every 100 people (or 6% of the population) will have PTSD at some point in their lives. About 15 million adults have PTSD during a given year. This is only a tiny portion of those who have gone through a traumatic event. Some estimates have the rate as high as 17% in veterans returning from Afghanistan and Iraq and 20-30% in Vietnam veterans. Patients with PTSD can present with complaints of irritability, memory problems, headaches, difficulty concentrating, and trouble sleeping. Indicators show that patients with PTSD were more than twice as likely to develop incident dementia compared with those without PTSD.

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

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

Caring for Patients with Dementia

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

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

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

What

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

When

Care providers should be aware of and continuously assess patterns or situations, such as time of day or certain times of year, which trigger problematic behavior. If you begin to notice a trigger pattern, make sure to discuss and communicate your findings to the other care team members. It would be best to 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 tricky behavior. Care providers should be aware of what the patient sees in their environment and try to see from their perspective. A new smell or unexpected noise, although not noticeable to you, can increase stress and cause agitation in your patient.

Why

It is essential to focus on why the patient behaves this way and not the actual behavior. Patient behaviors are often reactions to stressful situations or a sense of loss of control, which, as an adult, is challenging. Think of yourself in situations without control; you cannot communicate or make your own decisions. How would you react? Regardless of cognitive or physical decline, we still have basic needs. Remember Maslow's Hierarchy of Needs? Your

patient could be tired, hungry, or thirsty and not communicate their needs to you. Meeting an unmet need can resolve challenging behavior.

Navigating Difficult Behaviors

So now you have learned to focus on the reason behind the patient's behavior, not the actual behavior. What is the next strategic step? As the care provider, you must ask yourself, "What can I do to prevent 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 they are "wrong," the more agitated your patient can become, potentially exacerbating the problematic behavior. Let your patients know you understand that they are upset and ask them, "How can I help you"? Instead of trying to correct the "wrong," attempt to find opportunities for you both to agree. For example, if your patient insists on getting her purse, instead of explaining to her over and over why she cannot have her purse, you can 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, patients and caregivers, 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 in diffusing a problematic 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. Personal conversations with your patient and their family can yield valuable information about your patient's likes and dislikes, such as favorite songs, food, or hobbies. Once you have this information, distraction and positive reinforcement will better equip you to de-escalate the situation. Having a supply or goody bag of favorite pictures or items on hand may be helpful so you can quickly access them when needed.

Planning your patient's activities around things they enjoy can help prevent episodes of complex behavior. The activities should be scheduled predictably and consistently, matching your patient's cognitive and physical capabilities. 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 ensure that your patient is successful, maintains their sense of control, and has fun. Some suggested activities include exercising (taking walks), watching a favorite TV program, dancing, listening to music, pet therapy, or gardening. As a caregiver 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 know what they are doing, saying, or even remembering their behavior. Learn to recognize the signs of frustration in yourself and learn to ask for help. Practice your patience and understanding; it is the disease.

Dementia is sometimes 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 significant topic, and this section is a general overview with some communication tips and techniques.

Firstly, ensure your patient has all they need to communicate with you.

With sensory-impaired patients, those with speech, hearing, and vision problems, ensure they are prepared to understand the messages you are sending and respond to them. 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, friends, or your organization's interpreter services.

Non-verbal Communication

Non-verbal communication is essential, even with vision-impaired patients. For example, it is crucial to approach the patient from the front; a patient may startle if you speak to them when they cannot see you. Once you are in front of the patient, use your body posture, expression,

and eye contact to signal that you are ready to communicate. Consider leaning in or sitting to be on the same level as the patient. Show by your non-verbal cues 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 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 tell 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 their concerns mean something to you
- You are comfortable talking and communicating with the patient

Avoiding eye-to-eye contact may convey the following:

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

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

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

Body Language

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

Good use of body language communicates:

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

Poor body language may communicate inattention or impatience.

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

Pace

Pace your communication appropriately. For both cognitive and deaf and hard-of-hearing individuals, speak slowly and clearly. You may need to speak more loudly with people who are hard of hearing individuals but not deaf people. For all communication-challenged patients, focus on one message at a time or one question at a time. Keep your communication as simple as possible. Repeat or rephrase often. Do not hurry the patient.

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

Use family and friends to help you interpret what is said where possible.

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

Nothing will impact your patient's safety and satisfaction more than your close attention to 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 insight into her memory and judgment 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 compared to those without dementia of the same age. The longer that dementia has been present, the poorer the performance and the greater the risk of injury from an accident.

Financial Capacity

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

Cooking

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

Wandering and Becoming Lost

Distractibility and restlessness may lead to wandering. Interventions include:

- Signage for patients and staff
- Alarms
- Supervised exercise

Bedrails

It would be best if you were careful to use bedrails only as stated in your facility's policy. Research shows that the improper use of bedrails increases patients' chance of falling because they climb over them.

Falls

While most falls occur in patients over 65, with the highest number being in the 80-89 age group, the risk of falls in those with dementia is twice the amount 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 the path to the 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 round observation of documentation standards
- Patient education, live and in print
- Room signs and job guides for staff, family, and patients
- Quality management tracking and reporting
- Fall-specific event reporting and documentation

Restraints

Restraint for preventing falls is either not allowed per policy guidelines or 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.

End-of-Life Care

End-of-life care involves care that is administered at a time surrounding death. This care is geared towards the personal preferences and needs of the individual. Frequently, these individuals may want to be surrounded by their loved ones. It is imperative that end-of-life wishes are honored and death is as peaceful as possible.

The individual experiencing the dying process should be assessed to ensure their physical comfort, spiritual needs, emotional and mental needs, and practical tasks are met. Physical comfort might refer to relieving physical pain, whereas emotional and mental needs might refer to comforting an anxious individual by holding their hand and being present. Spiritual needs can vary and include respecting and honoring someone’s spiritual beliefs, as well as accommodating them. Practical tasks might involve a friend or family member supporting the individual by taking care of their affairs or chores so that they may let go of the worry they are holding onto about these practical tasks.

Hospice or Palliative Care

Considered to be the quality model, compassionate care for people facing a life-limiting illness or injury, hospice, and palliative care involve a collaborative approach to expert medical care, pain management, and emotional and spiritual support 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 illness or disease, such as heart failure or cancer. The goal of palliative care is to address the impact of serious illness by managing symptoms, providing emotional support, and ensuring that the care plan aligns with the patient's and the family's goals. The goal of palliative is to provide symptom management throughout the care continuum as needed. Palliative care is also called supportive care.

Hospice care is provided near the end of life. Hospice care is not curative; the emphasis is quality of life as defined by the patient and their family. The main components of hospice care are symptom management, pain management, education regarding expectations during the dying process, and emotional and spiritual support. Hospice Services can be delivered to patients at home, in a skilled nursing facility, or 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 healthcare 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 their hand, they may feel cold
- Their blood pressure will also gradually lower, and blood flow to the hands and feet will decrease
- The skin of their knees, feet, and hands may become purplish, pale, grey, and blotchy. These changes usually herald death within hours to days. When death does occur, the skin turns to a waxen pallor as the blood settles
- The sound of noisy breathing

Level of Consciousness

Because the dying process directly impacts the central nervous system, your loved one may sometimes be fully awake and other times be unresponsive. **Caregivers, family, and**

physicians should always function as if the dying person knows what is happening and can hear and understand voices. Hearing is one of the last senses to lapse before death.

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

Sensory Changes

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

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

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

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

Symptom 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 significant indicator of patients' quality of care. The patient and family need to be approached as a UNIT, and their care needs to include physical, psychological, social, and spiritual aspects. Patients and their families need compassion, support, and education along the health-illness continuum from a time of wellness to chronic illness to advancing illness and frailty to death. Those facing

serious life-threatening illnesses and approaching death deserve to be treated with dignity, respect, and compassion and receive care that is focused on the individual's goals for care.

Studies show patients need compassion and acceptance to be treated as a whole people and not to be abandoned. They need precise information that enables identification of the person they trust to make decisions when they cannot do so and help in determining goals of care.

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

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

Environment of Care

The Joint Commission has developed Environment of Care standards to help improve patient safety, decrease risks, and improve quality of care. The Joint Commission requires every healthcare organization to create and manage its written Environment of Care Plan. Every healthcare employee must know how to access these plans in their work areas. 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 must 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 have a governing safety committee comprised of healthcare staff and a safety leader or officer. These individuals enforce safety rules and regulations and have the authority to act should there be a safety issue or risk. Safety leaders develop, manage, monitor, and enforce safety protocols, but it is the responsibility of all healthcare employees to help maintain a safe environment for everyone.

Employee Responsibilities

- Report unsafe and unhealthy acts/conditions to the supervisor or Safety Officer.
- Correct unsafe or unhealthy acts/conditions.
- Complete mandatory safety training at least annually following new employee orientation.
- Help prevent and report all accidents and injuries.
- All emergency exits and stairwells must be kept clean and clear.
- Be able to explain the proper use, maintenance, and storage of equipment and

Personal Protective Equipment.
- Become familiar with and comply with all Safety and Health regulations, policies, and procedures

The Safety Committee

- The committee must be comprised of multidisciplinary healthcare employees at every level.
- They cover all safety aspects, including Occupational Health, Environmental Protection, Fire Protection, Patient Safety, Infection Control, and Radiation Safety drills.
- They review safety program effectiveness, accidents, illnesses, and incidents about 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 a community or internal disaster that disrupts the facility's ability to provide proper patient care or hinders its ability to provide emergency medical treatment for casualties.

Your Responsibility

- Be familiar with the Emergency Management Plan and know where to find copies.
- Understand your role in an emergency event.
- Perform your regular 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), 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 to receive patients. Examples include:

- Fires/explosions
- Aircraft/vehicle accidents
- Chemical spills
- Releases of toxic gases
- Natural disasters (tornadoes, floods, ice storms, earthquakes)
- Food and 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 to diagnose, treat, monitor, and care for patients.

What You Need to Know

- Preventive Maintenance (PM) inspection is regularly done every year.
- How to check and operate all equipment used on the unit, including all emergency response equipment.
- The difference between life support and non-life support equipment.
- How to report biomedical equipment failures.
- How to properly report, document, and remove any broken equipment from service.
- When safety recalls, hazard alerts, and incident reviews, and whether or not they are acted upon appropriately.
- In the event of a utility failure, red electrical outlets are supported by Emergency Generators.
- How to read the inspection sticker on all equipment to tell when the last day of use is before another inspection is required.
- All patient care equipment and all electrical non-patient equipment, regardless of ownership, should be inspected by Engineering Service before 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 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, and the safe obtaining, handling, and disposal of all chemical medical surveillance. Bloodborne pathogen exposure (needle sticks and splashes) is also included in this program area.

What You Need to Know

- Under the Hazzard Communication Program / Right to Know Law, all employees have the right to know the hazards and identities of the chemicals they are exposed to in the workplace.
- Training must be provided to each employee for every chemical used on the unit.
- Employees must know where to locate the chemical and hazardous material protocols.
- Chemicals should be inventoried annually in each work area.
- Understand how to properly label, administer, handle, clean, store, and dispose of any chemical or hazardous material used in the workplace.
- Use proper hand hygiene and personal protective equipment when handling hazardous chemicals or materials.
- 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 that could splash into the eyes.
- Remove any clothing or personal protective equipment with hazardous chemicals on it.
- Know the unit's needle stick protocol and how to report a needle stick.
- Understand how to report exposure to hazardous chemicals or materials.

Safety Data Sheets

All chemicals must have a Safety Data Sheet, SDS (formally known as the Material Safety Data Sheet, MSDS) that provides information about the chemical. Employers must ensure that all SDSs for all hazardous chemicals in the workplace are readily accessible to every employee.

The following information is included in 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 practices and precautions.
- Section 8: Exposure controls, including OSHA's Permissible Exposure Limits (PELs), Threshold Limit Values (TLVs), and personal protective equipment (PPE).
- Section 9: Physical and chemical properties of the substance.
- Section 10: Stability and reactivity lists, including hazardous reactions.
- Section 11: Toxicological information, including acute and chronic effects.
- Section 12: Ecological information
- Section 13: Disposal considerations
- Section 14: Transport information
- Section 15: Regulatory information
- Section 16: Other information includes the date of preparation or last revision.

Utility Management

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

What You Need to Know

- The location of your area's outlets, zones, pressure alarms, and shut-off valves.
- The location of all the red electrical outlets.
- Ensure all life-sustaining equipment is plugged into a red backup generator outlet.
- Understand who is authorized to use the Oxygen Shut-Off Valve.
- The location of compressed gas cylinders for oxygen administration is located.
- 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 and a backup source, such as an emergency generator. The backup source will come on within ten seconds when the primary source fails.

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 (Fire Safety)

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

What You Need to Know

- Be alert, using 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 the two nearest to

your work area.
- 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 operate them properly.

Types of Fire Extinguishers

Types of fire extinguishers can be broken down more specifically by the fire class. Classes of fire range from Class A to Class K and can be differentiated by the following:

- **Class A Fires**: Refers to fires involving combustible materials considered ordinary, such as cloth, paper, wood, plastics, and rubber.
- **Class B Fires**: Refers to fires involving combustible and flammable liquids, petroleum greases, oils, tars, alcohols, flammable gases, solvents, lacquers, and oil-based paints.
- **Class C Fires**: Refers to fires involving energized electrical equipment.
- **Class D Fires**: Refers to fires involving combustible metals, such as titanium, magnesium, sodium, zirconium, lithium, and potassium.
- **Class K Fires**: Refers to fires involving cooking appliances with a combustible cooking media present, such as fats, vegetable oil, or animal oil.

The following list breaks down the types of fire extinguishers, as well as the components in them:

- **Water**: The primary liquid used in these extinguishers is water. However, water is not fit for freezing conditions because the water would freeze. There are water extinguishers in which antifreeze is present, resulting in these extinguishers being able to be used in freezing conditions. This particular fire extinguisher is often used in Class A fires and might be applied in scenarios such as book collections, museums, and operating rooms.
- **Film-forming foam type** refers to FFFP (film-forming fluoroprotein) and AFFF (aqueous film-forming foam) and is often used in Class A and B fires. This extinguisher would not be used in freezing conditions and dispenses a foam material.
- **Carbon Dioxide type**: This extinguisher will not leave residue after use. Due to this, this type of extinguisher is generally preferred in instances involving expensive electronic equipment. Additionally, one might use this type of extinguisher in laboratories, printing areas, and food preparation areas. Instances where this type of extinguisher would not be the most helpful include outdoor areas exhibiting windy conditions, as it would prevent successful extinguishment. These extinguishers are used in Class B and Class C fires.

- **Halogenated agent type**: These extinguishers are used for Class A, B, and C fires. They expel a combination of gas/mist, with a range about double that of carbon dioxide.
- Dry chemical type: Multipurpose dry chemicals are used in Class A and B fires. These agents are known for softening and sticking to hot surfaces, smothering the fuel from the air.
- **Wet chemical type**: These are primarily used in Class A and Class K fires and are generally made up of components such as potassium carbonate, potassium acetate, water, and potassium citrate. When it comes to Class A fires, this type acts as a coolant. Regarding Class K fires (such as cooking oil fires), a foam blanket is formed, ultimately preventing reignition.
- **Dry powder** types are used on Class D fires and fires involving specific metals. This can be expelled from an extinguisher or scoop and shovel.

There are several different options for selecting a specific type of fire extinguisher. Knowing the rating of each extinguisher will aid in matching it with the types of fires it is intended for.

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 compromised in or around immediate work areas during construction or remodeling. ILSM is intended to provide and maintain 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 comprises security staff and the police or public safety to ensure the safety of all who enter the facility.

What You Need to Know

- The staff members who:
    - are responsible for security, including those who secure the opening and closing of doors, parking lot areas, and internal and external security checks
    - monitor vehicular access
    - maintain security in sensitive areas such as the pharmacy
    - are responsible for responding to violence in the facility

    - respond to bomb threats or gun threats
- The Emergency Reporting Phone Number for your facility and the police notification procedure.
- Your role in bomb threats.
- 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.
- When and how to call the emergency phone number and telephone operator.
- Understand the procedure to follow for a missing patient search.
- Understand the procedure to follow and associated roles for a suspected or actual infant abduction
- Notify security or a supervisor as soon as possible when you become aware of actual or suspected suspicious behavior.
- All employees must have annual training in workplace violence policies and procedures and how to manage and prevent workplace violence.

Management of the Social Environment

The Social Environment Program is essential to excellence. The delivery of quality healthcare is enhanced by appropriate physical surroundings and features that contribute to the psychosocial well-being of a patient. Particular emphasis is placed on strategically planning services, programs, and architectural features that support patient needs.

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

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

Fall Prevention

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

A fall is an unintentional, unplanned downward motion to the ground. This is considered a fall regardless of whether it caused an injury.

Fall Risk Factors

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

Examples of Extrinsic Risk Factors

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

Examples of Intrinsic Risk Factors

- Muscle weakness
- Decreased sensory awareness, such as touch
- Diseases causing the patient to be housebound
- Gait and balance disorders
- Visual disturbances
- Decreased hearing

- Cognitive impairment/mental status
- Dizziness/Vertigo
- Postural hypotension
- Incontinence
- Polypharmacy
- Age (75 years and older)
- Chronic diseases, especially COPD, depression, arthritis, and circulatory diseases
- New or Fall Risk Medications
-

Medications that may increase a patient's risk for fall

- CATEGORY DRUG EXAMPLES SIDE EFFECTS

1. Antihistamines	**Diphenhydramine, Promethazine**	**Sleepiness, Blurred Vision**
2. Cathartics, Laxatives	Bisacodyl, Fleet Enema	**Increased urgency to get to the restroom**
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 for assessing a patient's fall risk. These tools are used in every area of healthcare and aid facilities in developing Fall Prevention Programs and individual Fall Prevention Care Plans. There are a variety of Fall Risk Assessments one can use. Typically, these tools use a scoring system that measures the cumulative effect of known risk factors.

The most common Fall Risk Assessment tool used in hospital settings is the Morse Fall Scale (MFS), a rapid and straightforward method of assessing a patient's likelihood of falling. It consists of six quick and easy variables to score and 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 and a physical assessment and review of the patient's current medication list are used to obtain a quick and easy fall risk score.

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

Interventions

Programs that focus on fall reduction are 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 review the fall risk for each patient on the unit.

Color-Coding Arm Bands/Socks/Signs

Fall-risk patients are assigned special-colored socks and armbands with colored signs posted outside their doors.

Teach Back

Using the teach-back method, the patient demonstrates using the call button. That increases the likelihood that patients will call for help rather than trying to get out of bed alone.

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 the patient at all times, and ensure appropriate lighting.

Bedrail Use Reduction

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

Post-Fall Management

After-Fall Protocols

After a patient falls, the staff will conduct a debrief to discuss what happened and identify probable causes. 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 the patient's condition.
- Document circumstances in the medical record, including the patient's appearance at the time of discovery, the patient's response to the event, evidence of injury, location, time 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 the patient's condition indicates.

Healthcare Ethics

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 are based on expected behaviors, personal values, and beliefs guiding decision-making. Each ethical dilemma is subject to moral, philosophical, and individual interpretations by all parties involved.

Ethics is a science that deals with good, bad, right, and wrong principles and governs our relationships with others. Ethical theory analyzes belief systems and philosophies used to decide right and wrong. Ethical principles are standards of right and wrong in the context of social values and norms.

Function

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

Healthcare ethics represent moral values that are regarded as acceptable by society.

Healthcare professionals use standards of care and follow codes of ethics that are expected to be followed by members of the profession. Hospitals and large healthcare systems often have a code of ethics or conduct, which they expect their staff members to follow, relating to the health, safety, and well-being of clients and family members. In general, ethics are standards of behavior.

Benefits

Ethical practice protects clients and their families from mistreatment, abuse, and neglect by members of the healthcare profession. Ethical practice guidelines in conjunction with standards of care support and promote 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. The caregiver's values must not keep them from performing their job responsibilities. Each individual is personally responsible for their actions.

Professional Conduct

Healthcare professionals with 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 in patient care must follow evidence-based care standards and maintain clear and concise records.

Ethical Behavior

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

Codes of Ethics for Healthcare Professionals

Many professional associations for healthcare providers and clinicians have their codes of ethics. These codes of ethics identify behaviors clinicians and providers must abide by. These have some commonalities and threads, though; in other words, they identify the responsibility of practitioners.

General Code of Ethics

- Place the client'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 essential to healthcare ethics include:

- Report colleagues who practice incompetently, illegally, or fraudulently
- Avoid conflict of interest and behaving unethically in research
- The American Nurses Association Code of Ethics for Nurses specifically mentions safe delegation and the responsibility to promote nursing values in organizational and social policy

Ethical Principles

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

Respect for Autonomy

Autonomy is the right of each individual to act for themself. Individuals have the ability and right to make personal decisions even if those decisions are not in their best interest. This includes respect for individuals and their right to make decisions for and about themselves and providing the information needed to make an informed decision. To respect autonomy is to respect others. Respect for autonomy requires respect for the decisions of adults who can make sound decisions (self-determination).

Beneficence

The principle of beneficence embodies the concept of the moral obligation to act in the best interests of others and bring about positive good. Doing good is dependent on the context of the situation and the persons involved

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 daily by making choices, and judgment calls about how to benefit their clients.

Providing optimal care is an example of beneficence (goodwill). Healthcare professionals are to strive to protect patient's rights and desires. It is the healthcare professional's job to advocate for the clients 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 any offense

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 and help patients using their education and gut instincts.

Justice

Justice calls on us to distribute benefits, risks, costs, and resources fairly as best we know how. It implies equal treatment for all clients.

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 everyone should be treated in the best possible way by their healthcare team. Advocacy for patients with less than others is an essential part of justice. Ethical theories about justice in health care help doctors and nurses be prepared for what could await them as they treat patients on a wide scale of wealth, education, and health.

Fidelity

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

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

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 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 client decide whether to consent or refuse any suggested course of treatment. Respect and honor the patient's decision.

Confidentiality

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

Cultural Understanding

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

Humanitarianism

An active belief in the inherent value of human life leads providers to practice benevolent treatment and aid clients, aiming to better humanity.

HIPAA

HIPAA, which stands for the American Health Insurance Portability and Accountability Act, is a set of rules to regulate and improve healthcare insurance, fraud, and abuse. HIPAA also ensures that every healthcare entity protects patient information. Every healthcare entity must 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 protect 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 anyone dealing with patients' paper or electronic healthcare information.

The HIPAA Privacy Rule created regulations to protect the privacy of personal health information and limit the number of people who have access to private healthcare information. Only those directly involved in a patient's care, billing, or payment have legal access to their 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 regarding their healthcare information. All patients have the right to read their medical records, correct any false

information on their medical records, and have a copy of their health records in their possession if they choose.

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

Security Rule

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

The HIPAA Security Rule created three ways to improve electronic healthcare information security. 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 that acquire specific 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 business field involved with patient healthcare information.

Other Uses of Protected Health Information

Marketing

Without the patient's written authorization, 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.

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 with a list of patients with a particular disease for the pharmaceutical company to sell drugs to those patients without their authorization.

Incidental Disclosures

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

Patients' Rights

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

Infection Control and Prevention with Blood-Borne Pathogens

Proper infection control and prevention are critical in providing high-quality healthcare to patients and a safe working environment for healthcare employees. Understanding how infectious organisms are transmitted, applying 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.

Six steps must be present for an infection to be spread:

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

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

Infection Control Procedures

Hand Hygiene

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

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

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

- Before and after touching a patient and their surroundings
- Before and after treating an open wound
- After using the bathroom or changing a soiled diaper
- After blowing your nose, sneezing, or coughing
- Before and after eating or preparing food
- After handling garbage or soiled items
- When hands are visibly soiled

- According to CDC and Joint Commission requirements, caregivers are strongly encouraged not to wear artificial fingernails and to keep natural nails less than ¼ inch long when providing care.

The Handwashing Process

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

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

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

Respiratory Hygiene

When infected people cough or sneeze, 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 of the tissue or washing your hands 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

More than 600,000 healthcare workers are injured yearly with contaminated needles or other sharps and risk becoming infected with bloodborne pathogens, such as Hepatitis B, C, or HIV (JCAHO, 2019). Some of the injuries occur during the clean-up after a procedure. You can protect yourself against needlestick injuries by disposing of syringes and other sharps as soon as possible to prevent injuries and the risk of spreading infection.

Always use a puncture-resistant sharps container.

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

Personal Protective Equipment (PPE)

PPE provides a barrier between an infectious agent and healthcare employees and visitors. Healthcare employees must be able to locate personal protective equipment (PPE) and unfavorable 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. Employees must be trained to properly don, use, and remove any PPE needed to perform their job and know the facility's isolation and PPE policies and procedures. If there is a question about using any PPE items, verify the correct use with the supervisor. Private and unfavorable 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 microorganism transmission from recognized and unrecognized sources of hospital infections. All Healthcare providers must don gloves when handling bodily fluids, mucous membranes, or skin that is not intact. Goggles, a face shield, and a gown can be worn if bodily fluid splashes are 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 gowns when contacting an infected patient or their surroundings, such as the patient's bed, clothing, or food tray.

Droplet Precautions

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

Healthcare workers need a facemask with an eye shield, gown, and gloves to prevent contaminated droplets from touching anything on the caregiver'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. Infected people can expel microorganisms into the air when they cough, sneeze, laugh, or talk. Examples of airborne infections include Tuberculosis, Measles, and Varicella. Staff members must be fitted with an N95 mask every year and trained to wear the N95 mask properly. When treating Tuberculosis and SARS patients, staff must always wear an N95 respirator mask and place the patient in a negative pressure room. A cone mask should be used for chicken pox, shingles, or measles, and the patient should be in a private room. Gowns and gloves are worn if soiling is likely.

Cleaning, Disinfecting and Disposal

Cleaning and Disinfecting

Cleaning and disinfecting surfaces in patient-care areas are part of Standard Precautions. These procedures do not need to be changed for patients on Transmission-Based Precautions. Using 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. Cleaning and disinfecting all patient-care areas is essential 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 specific infectious agents such as Clostridium Difficile. All healthcare employees must know and follow the hospital's cleaning policies and procedures.

Disposing Biological Waste

Biological waste materials include blood, tissue, body fluids, soiled linen, pathological cultures/waste, and sharps. Sharps containers should be emptied ¾ of the way full. You must know and follow hospital policy when disposing of biohazardous waste. All biological waste is placed in a designated red biohazard bag or red puncture-resistant biohazard box. Never place anything containing biological waste in the regular trash.

Infectious Agents in the Healthcare Setting

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

Bloodborne Pathogens

Bloodborne pathogens refer to the microorganisms residing in the bloodstream that cause disease. Some of these diseases include, but are not limited to, hepatitis C virus (HCV), hepatitis B virus (HBV), and human immunodeficiency virus (HIV). These diseases can be acquired from contact with blood and other fluids such as serous fluids, vaginal secretions, saliva, and semen. Transmission can occur via accidental puncture, percutaneous injury, cuts, human bites, abrasions, and mucocutaneous exposure.

Healthcare workers are at exceptionally high risk for exposure to bloodborne pathogens, and an emphasis must be placed not only on the prevention of occupational exposure but on reducing infection when exposure is unavoidable. Healthcare workers in certain specialties and disciplines are most at risk in labor and delivery, surgery, dialysis, critical care, and emergency medicine. The rationale behind these groups being more at risk pertains to the urgency of care, exposure to high volumes of blood, and invasive procedures.

The following list provides a breakdown of some of the more common pathogens of concern, as well as protection methods:

Hepatitis B Virus (HBV): Viable and infectious for up to 1 week on surfaces. HBV is infectious and transmitted via mucosal/percutaneous exposure to the body fluids or blood of those infected. Regarding percutaneous infection, rates vary from 6-30% and depend on the transmitting source's serology. Protection can be obtained from vaccination preventing HBV, which has existed since 1981. Employers must provide employees access to this vaccine.

Hepatitis C Virus (HCV): This virus is a significant public health concern, as it is the most frequently reported bloodborne infection in the United States. The most common form of exposure is via contaminated needles. If exposure to HCV occurs, the risk of transmission is lower than HBV, at about 1.8%. No vaccination or post-exposure prophylaxis currently exists for HCV. However, there are treatments.

Human Immunodeficiency Virus (HIV): HIV acts on the immune system, eventually progressing to AIDS, and is transmitted via blood or body fluids from someone with a detectable viral load. The percutaneous risk of HIV is much smaller than HBV and HCV, at about 0.3%. Currently, there is no cure for HIV. However, there are antiviral medications to slow down the progression of it. When exposure occurs, post-exposure prophylactic (PEP) medications are very effective in preventing HIV when administered within 72 hrs.

COVID-19

Many types of human coronaviruses, including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease caused by a novel (or new) coronavirus that has not previously been seen in humans. In early 2021, there were reported 2.76 million cases in the US and 124 million worldwide during the pandemic, which began in late 2019. The virus that causes COVID-19 most commonly spreads between people in close contact with one another (within about 6 feet or two arm lengths). It is thought to spread through respiratory droplets or small particles, such as those in aerosols, produced when an infected person coughs, sneezes, sings, talks, or breathes.

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

sneezes.

Community spread means people have been infected with the virus in an area, including some who are unsure how or where they became infected.

Clostridium Difficile

Clostridium difficile is shed in feces, requiring the patient to be on contact precautions. Any surface, device, or material that becomes contaminated with particles of feces will serve as a reservoir for Clostridium difficile spores. Clostridium difficile spores are transferred to patients by 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 someone 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 using an N95 mask. Employees should be tested for TB once a year and any time they suspect exposure.

Multi-Drug Resistant Organisms (MDROs)

A multi-drug resistant organism (MDRO) is any bacteria that has become resistant to many different antibiotics. These bacteria can be found around you 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 enter your body, such as in a wound, the kidneys, bloodstream, or lungs. Many antibiotics will not treat an MDRO infection.

MDROs are spread through physical contact. They can spread from person to person in the hands of hospital staff or from items 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 a symptomatic infected person's blood and bodily fluids. Ebola does not spread through the air, water, food, or mosquitoes. Healthcare workers must follow strict contact isolation, protect the entire body, and don an N95 or higher respirator, shoulder-length disposable surgical hood, and full disposable face shield. Even though Ebola is not spread through the air, respiratory protections are required to protect healthcare workers during an aerosol procedure like intubation. All healthcare workers must be monitored during the donning and doffing of PPE to ensure everything is put on and removed correctly.

Healthcare-associated Infections

An infection occurring in a patient during the care process 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, known as surgical site infections, may also occur at surgical sites. 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 significant risk factors for healthcare-associated infection caused by antimicrobial resistance are either the transmission of pathogens from person to person or the result of resistance after exposure to antimicrobials. Steps to preventing healthcare-associated infections include:

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

Using antimicrobials judiciously.

Latex Allergy

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

Latex

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

The chemicals added during processing may also cause skin rashes. Several synthetic rubber types are also called latex, but these do not release the proteins that cause allergic reactions. Individuals can also become exposed to latex by inhalation. Latex proteins become fastened to the lubricant powder used in some gloves. When workers change gloves, the protein powder particles become airborne and can be inhaled.

Products Containing Latex

Various products contain latex, such as medical supplies, personal protective equipment, and numerous household objects. Most people who encounter latex products only through routine use in society usually have no health problems from using these products. Workers who repeatedly use latex products are likely to develop an allergic reaction.

The following are some examples of medical products that may contain latex:

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

The following are some household items that may contain latex:

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

Individuals with a latex allergy should be aware of products containing latex as it may trigger an allergic reaction. Most of the listed products above are available in latex-free forms.

Reactions

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

Irritant Contact Dermatitis

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

Allergic Contact Dermatitis

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

Allergy

Latex allergy (immediate hypersensitivity) can be a more severe reaction to latex than irritant or allergic contact dermatitis. Specific proteins in latex may cause an actual latex allergic reaction. Although the amount of exposure needed to cause symptoms is unknown, exposures at lower levels can trigger allergic reactions in some sensitized individuals. Reactions usually begin within minutes of exposure to latex, but they can occur hours later and produce various symptoms. Mild reactions to latex involve skin redness, hives, or itching. More severe reactions may involve respiratory symptoms, such as runny nose, sneezing, itchy eyes, scratchy throat, anaphylaxis, and asthma. Rarely, shock may occur, but a life-threatening reaction is seldom the first sign of a latex allergy. Such reactions are similar to those seen in a bee sting.

Individuals at Risk

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

People with spina bifida or multiple allergic conditions are more likely to develop a latex allergy. Certain foods are potential problems for people with latex allergies and can provide significant assessment trigger questions. Foods of concern are apples, avocados, bananas, carrots, celery, chestnuts, kiwi, melons, papaya, raw potato, and tomatoes.

Diagnosis

A Latex allergy should be suspected in anyone who develops latex allergy symptoms after latex exposure. These symptoms include, but are not limited to, eye irritation, skin rash, hives, shortness of breath, coughing, or wheezing. A physician should evaluate any exposed worker who experiences these symptoms. A diagnosis is made by obtaining a detailed medical history (including food allergies), a physical examination, and allergy skin tests.

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

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

Treatment

Detecting symptoms early, reducing exposure to latex, and obtaining medical advice are essential to prevent long-term health effects. Special precautions are needed to prevent exposure once a worker becomes allergic to latex.

Certain medications may reduce allergy symptoms, but complete latex avoidance is the most effective approach, though quite tricky. A medical alert bracelet or tag should be worn if one has a latex allergy.

Prevention

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

- Use non-latex gloves.
- Place all patients with latex allergies on latex precautions (latex-free zones).
- If you choose latex gloves, use powder-free gloves with reduced protein content.
- When wearing latex gloves, do not use oil-based hand creams or lotions, as this can cause glove deterioration.
- After removing latex gloves, wash hands with mild soap and dry them thoroughly.
- Frequently clean work areas contaminated with latex dust (upholstery, carpets, and ventilation ducts).
- Frequently change the ventilation filters and vacuum bags used in latex-contaminated areas.
- Learn to recognize the symptoms of a latex allergy.

Clinicians and Latex

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

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

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

Long Term Care

A new CMS rule overhauling long-term care (LTC) programs has defined requirements that LTC facilities must follow to participate in the Medicare and Medicaid programs.

These changes are necessary to reflect the substantial advances made over the past several years in the theory and practice of service delivery and safety. These revisions are also an integral part of efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs and in patient safety while at the same time reducing procedural burdens on providers.

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

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

People often confuse long-term care with disability or short-term medical care. Long-term care is not:

- Care that the resident receives in the hospital or a doctor's office
- Care that is needed to get well from a sickness or an injury
- Short-term rehabilitation from an accident
- Recuperation from surgery

Residents' Rights

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

- The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.
- All residents will be provided equal access to quality care regardless of diagnosis, severity of condition, or payment source.
- The resident has the right to exercise their rights and ensure they can

exercise their rights without interference, coercion, discrimination, or reprisal from the facility.

- Residents have the right to designate a representative, including same-sex spouses. The facility will treat a resident representative's decisions as the resident's decisions.
- The residents' wishes should be considered in decisions made by the representative, and the residents should be included in the care planning process.

Planning and Implementing Care

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

- The right to be fully informed in a language they can understand.
- The right to be informed, in advance, of the care to be delivered and of the professional that will furnish care.
- The right to be made aware of the risks and benefits of care, treatment alternatives, or treatment options and choose the care they prefer.
- The right to participate in developing and implementing their plan of care, including revision of the plan of care, right to establish goals and outcomes of care, and right to be notified of changes to the plan of care.
- The resident has the right to choose their attending physician.

Respect and Dignity

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

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

Self-determination

- The resident has a right to choose activities, schedules (including

sleeping and waking times), **health** care, and providers of health care services consistent with their interests, assessments, plan of care, and other applicable provisions.

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

Information and Communication

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

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

Privacy and Confidentiality

The resident has a right to privacy and confidentiality of their personal and medical records.

Safe Environment

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

Grievances

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

Contact with External Entities

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

Resident Assessments

The facility will initially and periodically conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. Complete a comprehensive assessment of a resident's functional status, strengths, goals, life history, and preferences. This can be done using a minimum data set, also known as the MDS, specified by CMS within 14 calendar days after admission. If the resident improves or declines within 14 days, a significant

change in status assessment should be completed once the IDT determines that the decline or improvement is noted.

Resident Assessment Instrument (RAI)

The RAI consists of three essential components:

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

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

Quarterly Review Assessment

A Registered Nurse should assess a resident at least once every three months with participation from the healthcare team. The assessment should be accurate and submitted to CMS promptly.

Pre-admission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are appropriately placed in nursing homes for long-term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a severe mental disorder and intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.

Comprehensive Person-Centered Care Planning

Within 24 hours of admission, residents should have a baseline care plan that outlines person-centered care and should include the following:

- Initial goals based on admission orders
- Physician orders

- Dietary orders
- Therapy services
- Social services
- PASARR recommendation, if applicable

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

Discharge Planning Process

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

Quality of Life

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident will receive, and the facility should provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This should be consistent with the resident's comprehensive assessment and care plan. Residents should be given the appropriate treatment and services to maintain or improve their ability to conduct daily activities. A resident unable to conduct activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. In addition, personnel provide essential life support, including CPR, to a resident requiring such emergency care before the arrival of emergency medical personnel. They are also subject to related physician orders and the residents' advance directives.

Activities of daily living include:

- Hygiene –bathing, dressing, grooming, and oral care
- Mobility—transfer and ambulation, including walking
- Elimination-toileting

- Dining-eating, including meals and snacks
- Communication, including
    - Speech
    - Language
    - Other functional communication systems

Using each resident's comprehensive assessment, care plan, and preferences, the facility should provide an ongoing program. This program should support residents in their choice of activities to meet their interests and support each resident's physical, mental, and psychosocial well-being. Programs should encourage both independence and interaction in the community.

Quality of Care

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

Skin Integrity

Pressure Ulcers

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

Foot Care

Ensure residents receive proper treatment and care to maintain mobility and good foot health. The facility will provide foot care and treatment, including:

- Preventing complications from the resident's medical condition(s)
- Assisting the resident in making appointments with a qualified person
- Arranging for transportation to/from such appointments

Mobility

Ensure that a resident who enters the facility without a limited range of motion does not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. Residents with a limited range of motion should receive appropriate treatment and services to increase their range of motion and prevent further decreases. Residents with limited mobility should receive appropriate services,

equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

Accidents

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

Incontinence

Ensure that an incontinent resident receives services and assistance to maintain continence unless their clinical condition is not possible to maintain.

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

Colostomy, Urostomy, or Ileostomy Care

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

Assisted Nutrition and Hydration

A decision to use a feeding tube significantly impacts a resident's quality of life. Any decision regarding the use of a feeding tube must be based on the resident's clinical condition and wishes and applicable federal and state laws and regulations for decision-making about life-sustaining treatments.

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

Respiratory Care (including tracheostomy care and tracheal suctioning)

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

Prostheses

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

Pain Management

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

Dialysis

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

Trauma-informed Care

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

Bed Rails

The facility should use appropriate alternatives before installing a side or bed rail. If a bed or side rail is used, ensure correct installation, use, and maintenance of bed rails.

Abuse and Neglect

The American Medical Association defines elder abuse and neglect as physical, psychological, or financial mistreatment of an older adult. It may or may not be intentional, and an older adult will often suffer several forms of abuse and neglect at the same time.

Reporting Abuse and Neglect

It is your ethical and legal responsibility to intervene immediately when you see a resident being abused or neglected or when you just suspect it. Anytime abuse is witnessed or suspected, it should be documented and reported to the charge nurse, case manager, or social

worker, then reported to Adult Protective Services. When abuse or neglect is suspected, the abuse should be assessed without the suspected abuser present. The

abused should be asked directly if someone hurt them, threatened them, or took anything without asking, and if yes, who? Every report can be anonymous, and no one can be charged for falsely reporting an abuse or neglect case, but failure to report can result in a negligence claim.

Dementia Management

The facility should have sufficient staff who provide direct services to residents who display or are diagnosed with dementia. Staff should be competent and skilled to provide nursing and related services. Services should ensure resident safety and attain/ maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This is determined by resident assessments and individual care plans and considering the number, acuity, and diagnoses of the facility's resident population.

Competencies and skill sets include but are not limited to knowledge and training of how to care for residents with mental and psychosocial disorders, as well as residents with a history of trauma and post-traumatic stress disorder, which have been identified in the facility assessment.

The facility will provide dementia treatment and services, which may include, but are not limited to, the following:

- Ensuring adequate medical care, diagnosis, and support based on the diagnosis
- Ensuring that the necessary care and services are person-centered and reflect the resident's goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.

Clinical Services

Physician Services

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

Nursing Services

The facility should have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and to attain/maintain the highest practicable physical, mental, and psychosocial well-being. This is determined by resident assessments and individual plans of care while considering the number, acuity, and diagnoses of the facility's resident population by the facility assessment. Before allowing an individual to serve as a nurse aide, verify that the individual has met registry competency evaluation requirements.

Behavioral Health Services

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

Pharmacy Services

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

Drug Regimen Review (DRR)

- A licensed pharmacist will review each resident's drug regimen at least once a month.
- This review should include a review of the resident's medical chart
- The pharmacist must report any irregularities to the attending physician, the facility's medical director, and the director of nursing, followed by these reports being acted upon.
- The facility will develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, timeframes for the different steps in the process and steps the pharmacist should take when they identify an irregularity that requires urgent action to protect the resident.

Medication Errors

- Ensure that:
- Medication error rates are not 5 percent or greater

- Residents are free of any significant medication errors

Laboratory Services

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

Dental Services

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

Food and Nutrition Services

Provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, considering each resident's preferences.

Menus and Nutritional Adequacy

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

Food Safety Requirements

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

by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
- Dispose of garbage and refuse properly.

Specialized Rehabilitative Services

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

Administration

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

Facility Assessment

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

Staff Qualifications

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

Medical Director

The facility will designate a physician to serve as medical director. The medical director is responsible for implementing resident care policies and coordinating medical care in the facility.

Resident-identifiable Information

A facility may not release resident-identifiable information to the public. Still, it may release information to an agent only by a contract, under which the agent agrees not to use or disclose the information, except to the extent the facility is permitted to do so.

Medical Records

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

Transfer Agreement

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

Quality Assurance and Performance Improvement (QAPI) Program

QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving nursing home safety and quality while involving all caregivers in practical and creative problem-solving.

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

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

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

Infection Control

- Establish an infection prevention and control program (IPCP) to provide a safe, sanitary, and comfortable environment. This should prevent the development and transmission of infectious diseases and infections for all the residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment.
- An antibiotic stewardship program includes antibiotic use protocols and a system to monitor antibiotic use.
- Minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumococcal disease by ensuring that each resident is informed about the benefits and risks of immunizations and
- They can receive the influenza and pneumococcal vaccine(s) unless medically contraindicated, refused, or already immunized.
- Ensure documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization and the administration or the refusal of, or medical contraindications to, the vaccine(s).

Compliance and Ethics Program

- Compliance and ethics programs should be reasonably designed, implemented, and enforced so that they are likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act. It should also promote quality of care and the assignment of high-level personnel within the organization, with the overall responsibility of overseeing compliance to meet organizational standards, policies, and procedures. Examples of this include but are not limited to the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization.

Physical Environment

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

Emergency Power

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

Space and Equipment

The facility should:

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

Resident Rooms

- Resident rooms should be designed and equipped for adequate nursing care, comfort, and residents' privacy. Each resident bedroom shall be individually accessible from the corridor without passing through another room. The rooms should be designed or equipped to assure complete visual privacy for each resident and have a floor at or above grade level.

Bathroom Facilities

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

Resident Call System

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

Dining and Resident Activities

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

Other Environmental Conditions

- The facility should provide residents, staff, and the public with a safe, functional, sanitary, and comfortable environment. The facility must

have adequate outside ventilation using windows, mechanical ventilation, or a combination of the two, and equip corridors with firmly secured handrails on each side. Maintain an effective pest control program so that the facility is free of pests and rodents. Establish policies, by applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also consider nonsmoking residents.

Training Requirements

- Develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles.
- Determine the amount and types of training necessary based on a facility assessment.
- Training topics should include but are not limited to:
- Communication
- Resident's rights and facility responsibilities
- Abuse, neglect, and exploitation
- Quality assurance and performance improvement
- Infection control
- Compliance and ethics
- Required in-service training for:
- Nurses' Aides
- Feeding Assistants
- Behavioral Health Services
- Patients have a right to quality, safe care when admitted to a long-term care facility. The new ruling overhauling long-term care focuses on improving quality and patient safety for patients who are often in the final stages of their lives and need daily chronic care. Staff who are educated in this ruling will be better equipped to deliver improved care.

Medication Safety Nursing

Introduction

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

Start with the basics.

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

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

Prepare medications for one patient at a time.

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

Follow the eight rights of medication administration.

Minimize distractions and interruptions.

Know that interruptions and distractions affect your performance, causing a lack of attention, forgetfulness, and errors.

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

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

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

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

Implement these additional safety measures.

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

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

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

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

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

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

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

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

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

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

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

By being familiar with the 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 five rights of medication administration, some experts have added three more to the list. Regarding patient safety, reviewing some of the basics and increasing your awareness of newer recommendations is never an inconvenient time.

1. Right Patient

- Check the name on the order and the patient
- Use two identifiers.
- Ask the patient to identify themself.
- 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 the 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
- As necessary, chart the time, route, and any other specific information.
- 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 are they taking this medication?
- Revisit the reasons for long-term medication use.

8. Right Response

- Make sure that the drug leads to the desired effect.
- If an antihypertensive was given, has their 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 for Purpose Goals narcotics (Schedule I through IV).

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

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

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

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

Narcotic Handling, Storage and Disposal

Schedule II through V drugs must be handled as controlled substances and securely locked (usually with double locks or special locks) in a substantially constructed cabinet. Twenty or thirty years ago, most facilities kept stock narcotics in a locked cabinet in a locked medicine room. Still, 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, long-term care facilities.
- Only authorized personnel are allowed access to the keys; this type of cabinet is usually locked to further limit access.
- Note that this type of cabinet is not refrigerated, so some controlled substances must be stored in a securely locked refrigerator, 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 medicine carts, but most have individual drawers to hold medications for each patient rather than each drug. Some medicine carts have unique, more secure drawers with a double-locking system to hold controlled substances.
- 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 a double lock in some refrigerators or containers.
- Controlled substances should not be placed in regular medicine drawers, as these drawers are not secure.
- With this system, as with a medicine cabinet, some form of record should be kept each time a drug is dispensed, as a manual narcotics count must be completed.
- Also, if the patient is wearing a transdermal patch, the two nurses completing the Narcotic count should 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 changed 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 automated drug dispensing system with computerized access.
- These systems also vary widely, although they all have automated record-keeping and require access to usernames and passwords (and sometimes barcodes).
- Some automated systems have individual drawers for patients, and others have 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 it 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 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 documented. For example, for dyspnea, the patient's condition should be described as the respiratory rate and a description of skin color and ventilation (rales, wheezing, decreased ventilation).

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

- Reason for the administration (such as pain in left knee) and the degree of pain, utilizing the appropriate pain scale, such as the 1-10 scale, FACES, CRIES, and Pain Assessment in Advanced Dementia (PAINAD), depending on the patient's age and condition.
- Patient, medication, dosage, route, time. This information should be recorded immediately after administration and not later 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, the next dose may be too soon.
- Response to medication, including description and degree of pain, utilizing the same pain scale. Evaluating the response to the drug should correspond to the onset of action for the individual drug and its peak performance. For example, pain relief 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 should be 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 the 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 only to inject, for example, half of the drug in the syringe because this poses a risk of overdose. Drawing the total amount and wasting part of it before 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 clearly understand the policies and protocols in place. In some cases, protocols may need updating as technology is introduced, and nurses should take a proactive role.

Adverse Reactions

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

Common Symptoms Include:

- CNS: dizziness, confusion, insomnia, disorientation, and seizures (infants and children)
- CV: Orthostatic hypotension, bradycardia, palpitations, and cardiac arrest
- Skin: Pruritis, rash, urticaria, flushing, and cold, clammy skin
- EENT: Visual disturbances and pupil constriction
- GI: Nausea, vomiting, constipation, anorexia, dry mouth, and biliary colic
- GU: Urinary retention, urinary urgency, dysuria, and oliguria
- Respiratory: Depression, arrest
- Hypothermia and muscle flaccidity
- CNS: Euphoria, dizziness, drowsiness, change in mood, confusion, and light-headedness
- CV: Tachycardia, palpitations, and hypertension
- Skin: Rash pruritis, local irritation at the 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 the effects. Opiate antagonists are another class of drugs that block the effects of opiates.

Mental Health Training for Caregivers

The World Health Organization (WHO) has deemed mental health part of the global developmental goals. Depression is plaguing the country as one of the leading causes of disability. Individuals with mental health disorders face the unfortunate presence of stigma, discrimination, as well as violations of human rights. This may be the reason that many individuals with mental health do not seek access to care and treatment and often suffer silently from their mental illness until it becomes out of control.

Mental Health in Older Adults

Image obtained from Samvedna Care

Mental health is a striking issue for the adult population. According to The World Health Organization (WHO), 15% of individuals over the age of 60 years experience a mental health disorder. The WHO also estimates that from 2015 to 2050, the population of individuals over the age of 60 years will nearly double, making prioritizing mental health in older adults a global concern. Specifically, older adults are more at risk for developing mental health conditions because they are experiencing so many vast physiological changes, such as osteoarthritis, hearing loss, and diabetes. Among the variety of mental health issues older individuals experience, the most common are depression and dementia. **Risk factors** leading to mental health conditions in the older adult population include but are not limited to, a decline in functional ability, health problems such as chronic pain, declined mobility, and overall frailness. In addition to physiological risk factors, there are emotional and socioeconomic risk factors. As we age, so do our family and friends, and often experiencing bereavement plays a significant role in mental health. Often, with age comes retirement, which can cause older individuals to experience a significant decline in socioeconomic status. Life stressors that naturally come with age may push the

older adult into states of loneliness and isolation. The general public must protect older adults, as they are more vulnerable to elder abuse. **Elder abuse** can take many forms, such as verbal, physical, psychological, sexual, financial, neglect, and abandonment. Abuse leads to a sense of overall loss of dignity. According to the WHO, evidence advises that about 1 out of every six older adults will experience some form of elder abuse. The toll elder abuse has on the individual's mental health is significant, and the general public needs to be educated on the matter so that, as an entity, we may put a stop to the issue.

Dementia

Dementia is a syndrome in which the person experiences a deterioration in thinking, memory, and behavior and ultimately loses the ability to complete activities of daily living. Dementia not only takes a toll on the individual directly suffering from the syndrome but also on the family and caregivers. Both economic and social concerns come into play with dementia, as the costs of medical/care for a person with dementia are a heavy burden. This leaves caregivers and family members with enormous stress.

Family/Caregiver Awareness and Care Planning in Older Adults

Family members and caregivers must appropriately care plan for the older adult and have awareness in terms of their needs and prospective threats to watch out for, including elder abuse and risk factors for developing mental health conditions. For example, it is imperative to provide proper training to any individual or health care professional caring for the older adult population. It is also imperative to manage chronic conditions that often come with age. Implementing policies regarding long-term care and services that cater to older adults is essential to promoting good overall mental health. When providing resources to the older adult, it is essential to ensure they still have security and freedom to make their own choices. Attending educational programs that focus on elder abuse handling and prevention is also essential. Support programs may also focus on social support, especially for individuals who live alone or in a rural community. Supportive housing policy allows older individuals to gain access to adequate housing. Community development programs are also very influential when it comes to health promotion regarding mental health.

Mental Health Interventions in Older Adults

Possibly the most critical intervention when it comes to promoting mental health in older adults is early recognition and treatment of a mental health condition. It is also essential to

promote both physical and mental health well-being and treat any physical illness, as it often affects one's mental health. The caregiver should be educated regarding managing any challenging behaviors. Sometimes, caregivers and individuals may need additional long-term support, and those informational resources should be provided.

Mental Health in the Chronically Ill

Chronic illness is a broad category and can include individuals who have cancer and individuals with heart disease. With chronic conditions comes chronic pain and stress with not only the illness itself but also what the future holds. Sometimes, it can be hard to cope with activities that once brought someone so much joy, such as mountain climbing, are no longer part of their lives. Naturally, being chronically ill comes with sadness; however, when this sadness progresses into weeks or even months, the individual is at risk for developing depression. **Signs of depression** that the caregiver should look for include but are not limited to, consistently feeling anxious/sad, irritability, changes in appetite/weight, problems concentrating, difficulty even thoughts of suicide. Those with chronic illness are considered to be at a higher risk for developing mental illness and depression. **Chronic illnesses at risk for depression** include, but are not limited to, Cancer, Epilepsy, Hypothyroidism, Alzheimer's Disease, Coronary Heart Disease, and Multiple Sclerosis. Per the National Institute of Mental Health, it is also suggested that individuals who experience depression in conjunction with an additional medical illness tend to experience more severe symptoms of both illnesses. A collaborative care approach that addresses mental and physical conditions for optimal outcomes in treating both is also helpful. While managing any chronic illness, it is essential to be aware of signs of depression and risk factors and keep open communication lines with caregivers regarding what the individual is experiencing so that early treatment and intervention can occur.

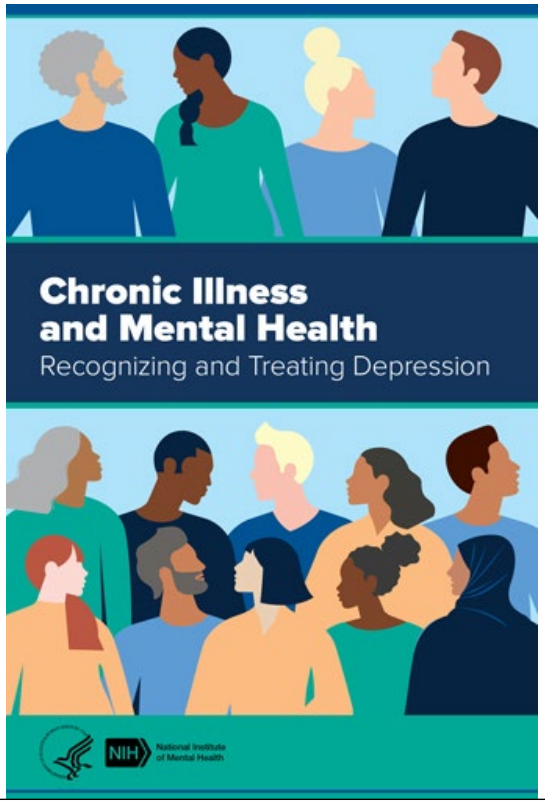


Image Obtained from the National Institute of Mental Health

Mental Health in the Homebound

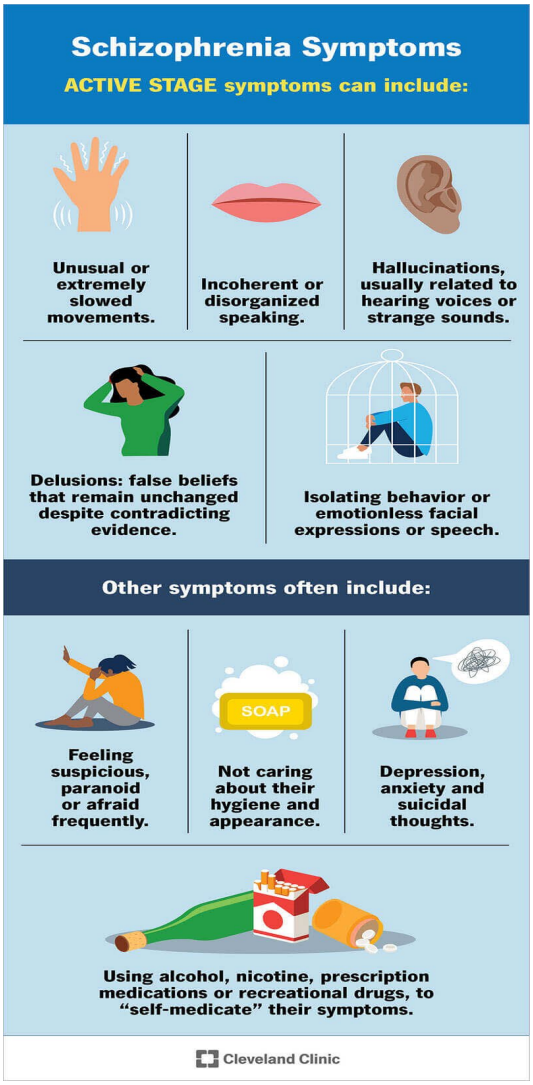
The population of homebound adults receiving home care is a growing group. A large number of these individuals are elderly and managing other comorbidities and require home-based mental health care to help manage any psychiatric conditions they might have. Some of the most common diagnoses that require home-based psychiatric care are depression and anxiety. Often, individuals who are in these homebound positions also have poor support systems and social situations. There are what is known as mobile crisis teams, which provide emergency care to individuals at home, and it is becoming more routine to bring regular mental health services to homebound individuals. Psychiatrists who provide home care give recommendations on medications and implementation of services such as occupational therapy, physical therapy, psychotherapy, and even physical exercise. Sometimes, these homebound adults benefit from socialization and recreation. In older adults, caregivers may consider making referrals to senior centers that coordinate transportation for older adults and allow them to experience daily socialization. So often, the homebound suffering from mental illness also suffers from self-neglect in their depression. Early intervention is critical, such as different therapies (such as cognitive behavioral therapy) and medications (such as antidepressants).

Mental Health Diagnoses, Symptomology, and Treatment

Schizophrenia

Individuals with Schizophrenia often experience a detachment from reality, as well as delusions and hallucinations.

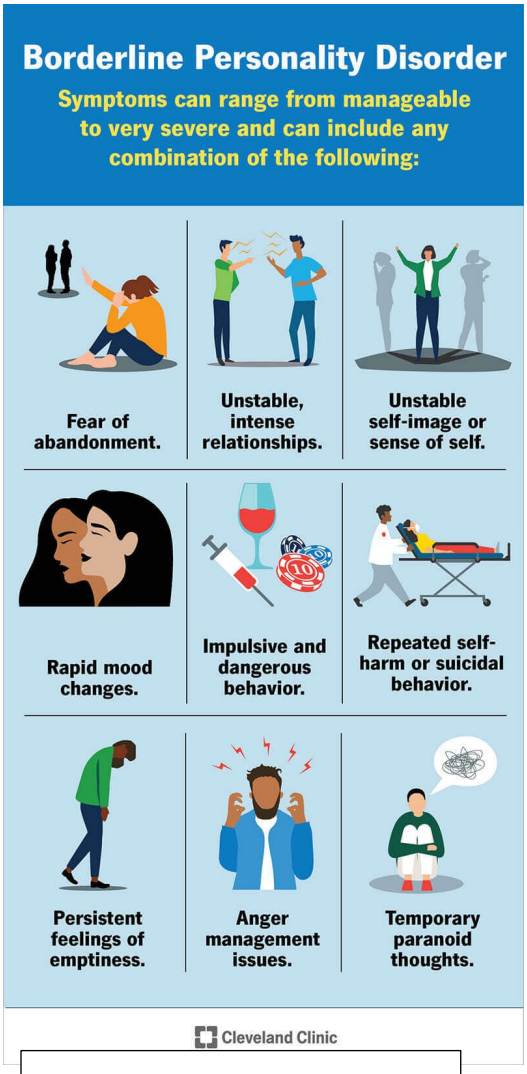
- **Symptoms:** Symptoms of Schizophrenia often occur in stages, which are identified by different symptoms in each stage. The early stage refers to the **onset or prodrome stage**. In this stage, the individual shows a disregard for personal hygiene, anxiety, social withdrawal, as well as a lack of motivation. The **active stage** is differentiated by when the disconnection from reality becomes apparent and psychotic symptoms are more pronounced. The active stage is also differentiated by an individual showing two out of five of the following specific symptoms: delusions, hallucinations, disorganized/Incoherent speaking, disorganized/unusual movements, and negative symptoms. The presence of schizophrenia symptoms classifies the residual stage but is less severe. In this stage, the individual lacks motivation, has odd beliefs, and has limited speaking/emotional expression. This stage is generally fleeting, and individuals will return to the active stage.



- **Treatment:** Unfortunately, there is no cure for Schizophrenia precisely because the probability of having a relapse is entirely unpredictable. Treatment is generally focused on medication management, self-management, and therapy. Medications used are classified as typical antipsychotics, which block how the individual's brain uses dopamine. Treatment may also include the use of atypical antipsychotics, which block both dopamine and serotonin. Clozapine is an atypical antipsychotic medication that is often used for treatment. Types of therapy often recommended in Schizophrenia may include cognitive behavioral therapy (CBT) and electroconvulsive therapy (ECT).

Borderline Personality Disorder (BPD)

Borderline personality disorder (BPD) is a mental health disorder that is characterized by the presence of extreme mood swings, as well as a lack of control over one's emotions.



- **Symptoms:** Symptoms of borderline personality disorder typically present themselves in one's late teens to early adulthood. Commonly, those with BPD experience a fear of abandonment, unstable relationships, unstable self-image, impulsive or even dangerous behavior, self-harm, rapid mood changes, anger management problems, feelings of emptiness, or even paranoid thinking.
- **Treatment:** Treatment for BPD has come a long way with new, evidence-based treatment. Treatment is often focused on medication and psychotherapy. Common effective types of therapy that are used in BPD include dialectical behavioral therapy (DBT), which is centered around helping the individual with BPD to accept the reality of their life, as well as helping the individual learn to change. Additional forms of therapy include cognitive behavioral therapy (CBT) and group therapy. Treatment is heavily targeted around therapy. However, medications are sometimes used to treat specific concerns, such as depression and anxiety. Some medications are also used to help regulate mood swings and impulsive behavior. People with BPD may also find antipsychotic drugs helpful with this disorder.

Dissociative Disorders

A trademark classifier of dissociative disorders is memory loss (amnesia) and feelings of detachment from reality. Dissociative disorders are classified according to three distinct types: dissociative identity disorder, dissociative amnesia, and depersonalization or derealization disorder. **Dissociative identity disorder (DID)** is when the individual has two or more alters or identities. **Dissociative amnesia** is characterized by the lack of ability to

remember fundamental information regarding one's life, such as identity/history.

Depersonalization/derealization disorder is when the individual feels detached from oneself (body/feelings/thoughts), primarily known as depersonalization, Whereas derealization is more focused on the disconnection from one's environment.

- **Symptoms:** Symptoms of dissociative disorders are also classified into three distinct types. Symptoms of **dissociative identity disorder (DID)** are focused on the identities of the individuals. They often shift from their core identity to their altered identities. Accompanying this is often having gaps in memory.

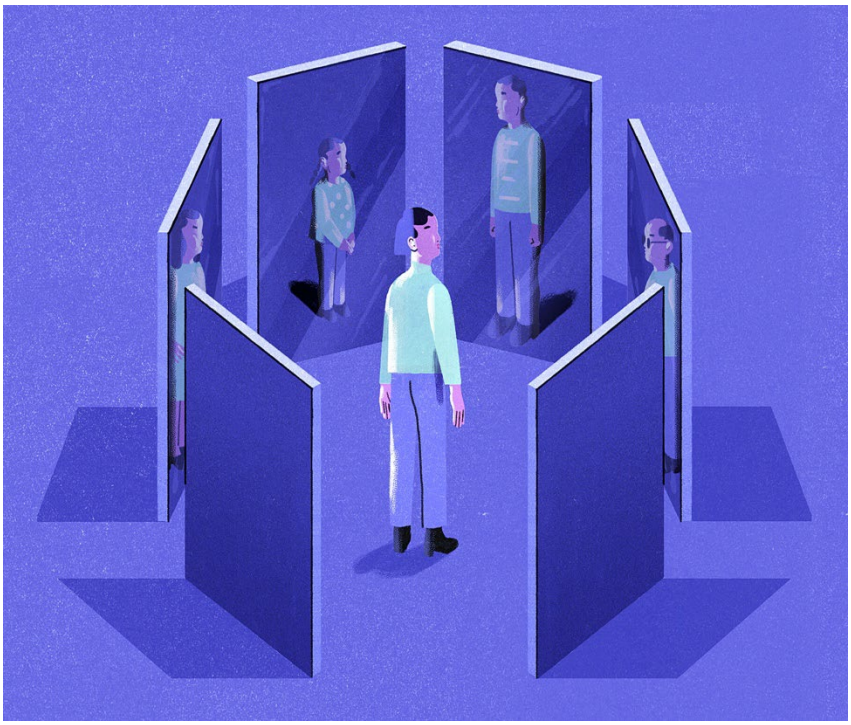


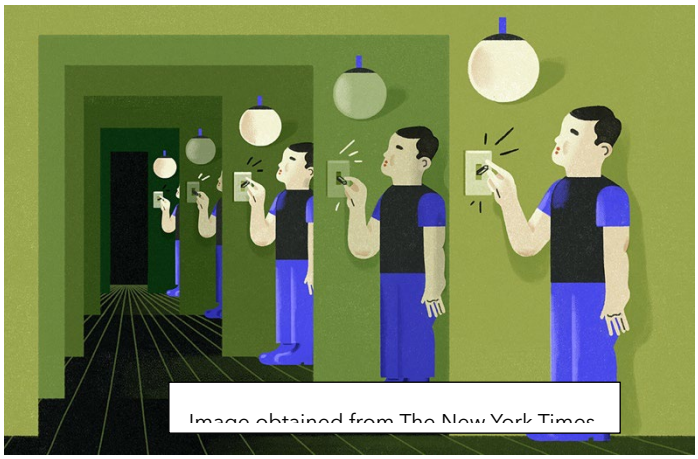
Image obtained from The New York Times

- Symptoms of **dissociative amnesia** are focused on a sudden onset of memory loss, which is either **localized** (inability to remember an event/period), **selective** (inability to remember details of events in a specific timeframe), or **generalized** (ina ut oneself/history).
- **Depersonalization/derealization disorder** involves detachment from one's body/mind/self (depersonalization), detachment from one's surroundings, and thinking that people/things are not real (derealization).
- **Treatment:** Treatment is generally focused on psychotherapy, such as cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), eye movement desensitization and reprocessing (EMDR) therapy, and hypnosis. Medication treatment may include the use of antidepressants as well.

Intervention Strategies

Intervention strategies vary from disorder to disorder and should be client-focused, based on individual needs.

Obsessive-Compulsive Disorder (OCD)



There are several different intervention strategies for OCD. The exposure and response prevention (ERP) technique exposes individuals to the subject matter they fear and implements resistance by performing compulsive rituals. Additionally, individuals with OCD may find utilizing a thought-stopping strategy to discontinue obsessions helpful. Relaxation techniques, such as deep breathing, are also a helpful strategy. Practicing positive self-talk is also beneficial.

Post-Traumatic Stress Disorder (PTSD)

- Intervention strategies for PTSD include increasing awareness of symptoms of PTSD, as well as triggers. Implementation of relaxation skills and anger management skills are also helpful. It is also important to decrease any existing guilt or shame the individual with PTSD might have, as well as work towards improving social and communication skills.

Anxiety

- Intervention strategies for anxiety include cultivating positive coping skills, including exercise, good nutrition, and rest. Using relaxation techniques like deep breathing and replacing negative self-talk with positive self-talk is also beneficial. Acquiring a solid emotional support source and participating in social activities is also recommended.

Major Depression

- When it comes to major depression, there are several different intervention strategies, such as cultivating health, problem-solving, and communication skills. Practicing impulse control and identifying the connections between thoughts, feelings, and actions is essential. Keeping a routine involving physical exercise and social involvement is imperative.

Crisis Management

Both intervention and de-escalation are critical when it comes to crisis management. To understand both of these essential steps, it is crucial to understand what a mental health crisis is. A mental health crisis occurs when there is a disruption in one's normal state, in which their coping methods do not work. An individual experiencing a mental health crisis is at risk of

causing harm to both them and others. Crisis can take many forms and may even present as non-verbal. Often, a crisis comprises body language and tone of voice. This is why it is so important to have good intervention and de-escalation skills in a crisis, as these techniques can make a world of difference.

Intervention

- Intervention techniques in crisis may include assessing the situation to determine if the individual is at risk of causing harm to themselves or others and if emergency assistance is warranted. In crisis management, it is imperative to listen to the individual, refrain from overreacting, maintain a calm voice, express support and concern, move slowly, decrease environmental stimuli, and stay patient. It is also essential to avoid making continuous eye contact to avoid making the individual nervous and not touching them without permission. One should always announce their actions before doing so and give the individual space to avoid making them feel confined.
- **Tips for holding a successful intervention:** Interventions may be necessary in extreme situations, which may involve substance abuse or severe symptoms of an existing mental health illness. There are several tips for holding a successful intervention. First, it is helpful to **involve a professional**. It is essential to have not just the presence of family/friends but also a professional trained to produce productivity and field adverse reactions from the individual in the spotlight of the intervention. Next, it is essential to **be careful when choosing intervention participants**. Participants should have a deep and caring connection to the individual, as well as having good intentions. Sometimes, this might include an individual's children, and in that case, it is essential to keep in mind how intense interventions can get and consider the appropriateness of child involvement. Additionally, participants should **be prepared for the unexpected**. Interventions are entirely unpredictable; however, it is helpful to entertain all the possibilities and conduct a rehearsal before the intervention. If an intervention becomes unsafe, one may need to call 911

for safety. Next, there should always be a **plan for the next step**. For example, if an individual has an alcohol use disorder, there should be a plan for an alcohol rehab center as the next step, as well as the details arranged for that. Lastly, the group holding the intervention should **provide support and accountability** to the individual. For example, if an alcoholic agrees to go to an alcohol rehabilitation center, individuals should already be prepared to hold the individual accountable for completing treatment and holding to their word.

De-escalation

- De-escalation techniques are essential in a crisis. When attempting to de-escalate, they should be empathic and nonjudgmental. Try not to judge odd behavior or discount the individual's feelings. Respecting personal space is also essential, as this will help decrease anxiety. All non-verbal cues should be non-threatening. This includes being mindful of facial expressions and gestures. Avoiding overreacting is critical in a crisis. To accomplish this, the individual should remain calm and professional. If the individual in crisis asks challenging questions, it could potentially lead to a power struggle, so it is essential to avoid this by bringing the focus back to solving the problem at hand and working as a team. One should always focus on the feelings of the individual in crisis. It is also essential to set limits and allow silence for the individual in crisis to reflect, as well as time for them to make decisions.
- **De-escalation techniques in a mental health crisis** can make or break a successful outcome. The following de-escalation techniques are designed to help manage an individual experiencing a mental health crisis:

- **Tone of Voice:** An individual's tone of voice should always be non-threatening. Always be respectful and remain calm.
- **Silence:** It is okay to use silence as a technique, and do not feel the need to fill it with words. Sometimes, it is helpful to utilize silence so the individual can reflect and organize their thoughts.
- **Make empathic responses:** The person de-escalating should work to make the individual feel validated in their feelings. An example of this in a response might be, That must be frustrating for you.
- **Make reflective responses:** Reflective responses, by design, allow the individual to derive emotional insight into what they are saying. Reflective statements are short and show the individual understands what is being said. An example might be, You sound hurt, or You sound discouraged.
- **Facial expressions:** One should always be mindful of their facial expressions to ensure they demonstrate interest and are engaged in the speaker's words.
- **Door openers:** The primary basis of a door opener is to get the individual to elaborate on what they are saying. This may look like saying, Keep going, or

maybe as simple as nodding.

Psychiatric Medications: Common Medications and Potential Side Effects

Antidepressants

Antidepressant medication makes up a substantial portion of the pharmaceutical market today. Antidepressants improve depression, primarily affecting chemicals in the brain such as serotonin, dopamine, and norepinephrine. Selective serotonin reuptake inhibitor (SSRIs) is a specific group of antidepressants and includes main drugs such as Prozac (Fluoxetine) and Zoloft (Sertraline).

Prozac (Fluoxetine)

Prozac (Fluoxetine) is considered an antidepressant medication, specifically a selective serotonin reuptake inhibitor (SSRI). The way Prozac works is that it increases the amount of a neurotransmitter, called serotonin, present in the body, which is known to boost mood. **Common uses** for this medication include depression, OCD, panic attacks, and bulimia nervosa. **Potential side effects** include but are not limited to Hallucinations, seizures, difficulty swallowing/breathing, seizures, or even increased suicidal thoughts/actions (specifically at the start of treatment or with dose changes and in those under the age of 24 years).

Zoloft (Sertraline)

Zoloft (Sertraline) is considered an antidepressant medication, specifically in the SSRI category. **Common uses** for this medication include PTSD, social anxiety, OCD, and depression. **Potential side effects** include but are not limited to Suicidal thoughts, seizures, irregular heart rate, mania, stiff muscles, flu-like symptoms, hallucinations, unclear vision, and abnormal bleeding/bruising.

Antipsychotics

Antipsychotics are categorized as being typical (first generation, developed in the mid-20th century) and atypical (second generation, developed in more recent years). Antipsychotics primarily work by affecting the chemical in the brain known as dopamine to decrease symptoms of psychosis, including hallucinations and delusions. Seroquel (Quetiapine) is a common atypical antipsychotic medication, whereas Thorazine (Chlorpromazine) is a standard typical antipsychotic medication.

Seroquel (Quetiapine)

Seroquel (Quetiapine) is considered an atypical antipsychotic medication. It works by blocking dopaminergic transmissions, which, as a result, decreases excitement in the brain. **Common uses** for this medication include schizophrenia and in individuals with bipolar disorder, specifically to treat episodes of mania, as well as depression. **Potential side effects** include but are not limited to Signs of ketoacidosis (extreme thirst, nausea/vomiting, fruity-smelling breath), confusion, fast/irregular heart rate, drowsiness, and dizziness.

Thorazine (Chlorpromazine)

Thorazine (Chlorpromazine) is considered a typical antipsychotic medication, specifically in the class of phenothiazines. It works by blocking dopaminergic transmissions, which, as a result, decreases excitement in the brain. **Common uses** for this medication include decreasing delusions and hallucinations present in schizophrenia. It is also used to decrease mania symptoms in individuals with bipolar disorder. **Potential side effects** include but are not limited to Irregular heart rate, seizures, flu-like symptoms, yellow eyes/skin, and impaired swallowing/breathing.

Anti-Anxiety Medications

Anti-anxiety medications are medications that decrease symptoms of anxiety. Anxiety can range from general anxiety to social phobias and panic disorders. Frequently, benzodiazepines are used to treat anxiety due to their short-term effectiveness. The downfall of these medications is they are at elevated risk for dependency and substance abuse. Alprazolam (Xanax) is a commonly used anti-anxiety medication.

Alprazolam (Xanax)

Everyday use for Alprazolam (Xanax) is as an anti-anxiety medication, specifically a Benzodiazepine. **Potential side effects** include but are not limited to lack of coordination, depression, low blood pressure, nausea, memory loss, and difficulty thinking.

Member-specific medication protocols

Member-specific medication protocols will vary from person to person, as well as their diagnoses and needs. Support services play a significant role in improving medication adherence in individuals with mental illness. Several interventions may help with medication adherence, including but not limited to motivational and cognitive behavioral strategies and electronic reminders to take medication. Some individuals with mental illness may refuse to take their medications out of denial of acceptance of their illness, or maybe the medications are too much of a financial burden on them. Sometimes, it may be as simple as forgetting to take daily medications.

Research has shown that support from prescribers, such as education regarding the medications and their side effects, is highly valued by patients (National Library of Medicine: National Center for Biotechnology Information).

Image obtained from Extended Care Professional (ECP)

Cognitive behavioral therapy (CBT) is sometimes used with medication adherence because it tackles negative opinions the individual might have regarding the medications and their non-adherence.

Motivational interviewing (MI), more specifically, focuses on how imperative it is to stay compliant with one's medications and motivates the individual to remain compliant with their medications.

Supervision of self-administration of medication

Supervision of self-administration of medication is essential in clients who tend to be non-compliant with their medication regimen. The supervising individual should be trained staff, not the one preparing the dose/handling the medication. For the individual to self-administer their medication, they must be able to recite the following: The name of their medication, the dose, the time they should take the medication, the appearance of the medication, and the side effects of the medication. To supervise self-administration outside of a medical license, such as a registered nurse license, the individual should have proper training, such as a certificate of proof of completing a training program with a registered nurse. Documentation of training must also be completed. When it comes to controlled substances, these medications must be explicitly stored, per state law, and have procedures that limit staff access to medications, such as assigning one person per shift to be granted access.

Documentation

Documentation is an essential step in medication administration and should be done accurately. Documentation should focus on ensuring that the medication is labeled correctly and the individual's use of the medication is documented. Documentation should be done in a Medication Administration Record (MAR). **Documentation should include the following:** Name of medication, the dose, frequency the individual is taking the medication, instructions for taking the medication, the provider who prescribed the medication, and any allergies the patient may have. It is also essential to document any refusals of medications or deviations from medications as ordered by the provider; the provider should also be made aware of these circumstances. Audits should also be done to review any charting mistakes/medication administration mistakes, and these occurrences should be addressed. Competency reviews are imperative to reinforce correct documentation guidelines.

Substance Use Disorders and Treatment

Substance use disorders are treated with a combination of medications, prevention measures, counseling, behavioral therapies, and management of other comorbidities. Substance use disorders can vary from alcohol use disorder to opioid use disorder and beyond. Management is different based on a situational basis.

Image obtained from USC Mann

Alcohol Use Disorder

When dealing with alcohol use disorders, counseling and support groups, such as Alcoholics Anonymous (AA), are crucial to success. There are a few common medications used, such as Acamprosate. **Acamprosate** is used for individuals who are sober and wish to stay that way. Typically, this medication is introduced on the 5th day of sobriety and works efficiently for 5-8 days. **Disulfiram** is a medication used to treat chronic alcoholism, which is found to be effective. However, if the individual taking this medication has even a tiny bit of alcohol, side effects (nausea/vomiting, chest pain, headache, difficulty breathing) may ensue in as little as 10 minutes. **Naltrexone** is a medication that stops the euphoric effects of alcohol, which will ideally limit alcohol use in the individual.

Opioid Use Disorder

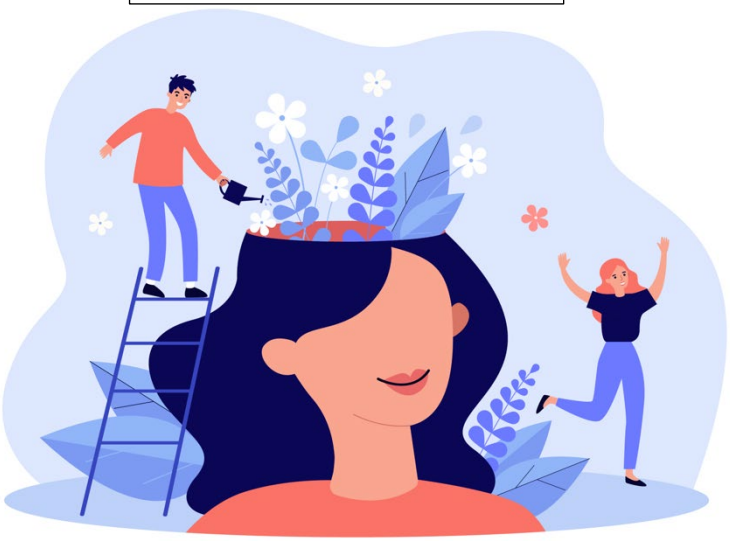
Individuals who are receiving treatment for Opioid use should also be in counseling, attending support groups, and utilizing nonpharmacological resources in addition to pharmacological recourses. There are several medications used for opioid use disorder. Individuals with this disorder are trying to abstain from previous addictions to substances such as heroin, morphine, hydrocodone, and oxycodone. **Buprenorphine** is used to subdue cravings for the drug, whereas Methadone is used not only to subdue cravings but also to reduce withdrawal and prevent the effects of opioids. **Naltrexone** is a drug that blocks feelings of euphoria resulting from using opioids, as well as blocks the sedative effects one derives from opioid use. **Naloxone** is a medication that should be kept on hand for safety measures when dealing with people with a substance use disorder, as it reverses an opioid overdose.

Individual-Person-Centered Service Plan, Crisis Plan, and Behavioral Support Plan Implementation

Person-and Family-Centered Planning

In person-and family-centered treatment planning, the individual being treated makes goals and plans for treatment based on the individual, with family support/involvement. A significant aspect of person-centered planning is empowering the individual and strengthening their voice. The staff must maintain respect for the individual and their needs. A pivotal part of family-centered care is shared decision-making.

Image obtained from Mezzez



There are several resources for achieving a successful support plan for the individual, which include, but are not limited to, peer counseling, recovery coaches, and support systems for the family members themselves. In peer support, an individual who has achieved recovery status from substance abuse or even mental health disorders is the one providing support services. In addition to speaking directly from experience, this peer coach should have formal training, such as a certification, to provide these services.

OSHA Healthcare Safety

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 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 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 directly covers all employers and employees through Federal OSHA or an OSHA-approved state program.

Twenty-two states have decided to develop their own safety and health programs. The state plans must be as effective as Federal OSHA requirements or better. State plans covering the private sector also must cover state and local government employees. Federal OSHA does not typically cover military personnel.

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

- To maintain conditions and 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 severe injury to any employee.

OSHA Standards

OSHA standards can be grouped into the following areas:

- Hazard Communication Standards
- Bloodborne Pathogens Standards
- Person Protective Equipment (PPE)
- Oxygen Training
- Electrical Standards
- Exit Routes Standards
- Ionizing Radiation Standards
- Fire Safety Standard
- Medical and First Aid Standard
- Emergency Action Plan Standard

Hazard Communication Standard

The hazard communication standard is structured to ensure that employees and employers know about identifying hazardous chemicals and protecting themselves. According to this standard, employers must implement a written hazard communication program.

Implementing an Effective Hazard Communication Program

Be knowledgeable about the standard and identify responsible staff: This might look like becoming familiar with OSHA's hazardous communication standards and assigning staff to specific roles, such as training.

Prepare a written hazard communication program and implement it. This would involve listing all hazardous chemicals in a workplace.

Make sure that containers are labeled. Employers should label hazardous containers throughout the workplace when warranted.

Keep safety data sheets (SDSs). Employers should keep these sheets for all hazardous workplace chemicals and ensure they are available to employees.

Train and inform employees. Employees should receive training regarding hazardous chemicals in the workplace, including protective measures.

Continue to evaluate and reassess programs. This would entail reviewing hazard communication programs to ensure objectives are being met.

Bloodborne Pathogens Standard

OSHA implemented the bloodborne pathogens standard to protect employees from health hazards associated with exposure to bloodborne pathogens. Employers must produce a written exposure control plan if their employees are in positions that put them at risk of coming in contact with potentially infectious materials and blood.

Abiding by the bloodborne pathogens standard would include implementing an exposure control plan (ECP). This plan would include the following:

- Hepatitis B vaccination
- Assessment of employee exposure, as well as post-exposure follow-up
- Hazard training for employees
- Recordkeeping
- The procedure used in the event of needing to evaluate exposure incidents and the circumstances surrounding them
- Asserting exposure control via the following methods: PPE, housekeeping, universal precautions, and engineering/work practice controls

Ionizing Radiation Standard

The ionizing radiation standard is specific to facilities with operational X-ray machines. According to this standard, employees must survey the distinct types of radiation used within the facility, implement restricted areas limiting exposure, and ensure employees wear personal radiation monitors. Facilities must also apply caution signs to radiation areas and equipment.

The Nuclear Regulatory Commission (NRC) is the regulating body regarding exposure to radioactive materials. These materials include source material, by-product material, unique nuclear material, accelerator-produced radioactive material, and discrete radium sources. Per OSHA, employers are required to protect employees from exposure to ionizing radiation sources not regulated by the NRC, which includes x-ray equipment.

Exit Routes Standards

According to OSHA, employers are required to adhere to requirements about exit routes in the workplace. OSHA outlines basic requirements for exit routes, which may include:

- A permanent exit route
- Exit route separated by fire-resistant materials
- Openings to exit must be limited

Electrical Standards

OSHA has identified specific electrical hazards, like wiring deficiencies, as one of the most commonly cited hazards. OSHA sets electrical standards, such as safety-related work practices and design requirements for electrical systems. Per OSHA, using flammable gases may require special equipment installation and wiring.

Hospital electrical hazards and considerations as identified by OSHA include, but are not limited to:

- A ground fault circuit interrupter is a fast-acting circuit breaker built to turn off electrical power during a ground fault, preventing potential injury to workers.
- Avoiding electrical equipment with damaged connectors, such as bent blades or a missing ground prong.
- Refraining from hazardous practices, such as pulling equipment by the cord or using wet hands to plug in equipment.
- Avoiding using faulty equipment, such as frayed electric cords

Emergency Action Plan Standard

In the emergency action plan standard, OSHA mandates that employers develop and implement an emergency action plan outlining employee actions during an emergency. This may apply to specific situations, such as fires or other emergencies, and promotes employee safety.

OSHA outlines factors about planning and responding to workplace emergencies, which include:

- Planning: This includes implementing escape procedures and route assignments.
- Chain of Command: There should be an emergency response coordinator and a backup option.
- Emergency Response Teams: Individuals on these teams must be trained for crisis and capable of carrying out their roles.
- Response Activities: It is critical to have adequate emergency communication, such as via communication centers.
- Training: Employers must conduct employee training at least annually.
- Personal Protection: Appropriate personal protective equipment must be made available to employees.
- Medical Assistance: Per OSHA, first aid should be available to employees within 3-4 minutes of an emergency.

Fire Safety Standard

Per OSHA, employers are required to have a fire prevention plan. Factors employers must consider about fire safety include:

- The work environment must have enough exits in appropriate locations so everyone can get out quickly.
- If employers decide to provide portable fire extinguishers, they must also train their employees on how to use them.
- Fire prevention plans should specify handling flammable waste, ensure maintenance and cleaning of heat-producing equipment, and educate employees of potential fire hazards and plan procedures.

Medical and First Aid Standard

According to OSHA standards, employers must provide medical and first-aid to employees consistent with workplace hazards. Specifics regarding workplace medical and first-aid programs are based on individual workplaces and employers.

OSHA standards highlight the need for trained first-aid providers in the workplace if no clinic, infirmary, or hospital is nearby. Part of OSHA requirements for medical and first aid might include cardiopulmonary resuscitation (CPR) training.

Personal Protective Equipment (PPE)

Per OSHA, it is the responsibility of employers to complete operational assessments in the workplace and determine if employees wearing PPE is warranted. OSHA identifies PPE as the last line of defense, placing engineering controls, administrative controls, and work practices as the first line of defense. Administrative controls would include changing how one does

their job, such as rotating workers to reduce exposure. Engineering controls include physically changing a work environment. Work practices include training employees regarding completing tasks, thus reducing the chance of workplace hazards.

PPE should protect workers from injuries and illnesses, including body injury, head injuries, foot/leg/hand injuries, eye/face injuries, and hearing loss, and provide respiratory protection. PPE might include glasses, safety shoes, hard hats, gloves, masks, vests, coveralls, earplugs, respirators, and face shields.

Oxygen Training

OSHA requires facilities to provide proper oxygen training, which includes correct storage of oxygen tanks, by NFPA 99 compliance. In healthcare facilities, oxygen can be found as compressed gas in cylinders or piped inside a closed system. Oxygen itself is categorized as an oxidizer rather than a flammable gas. Due to this, oxygen, when present at an increased content from air at 21%, would act as an accelerator to a fire.

Healthcare facilities must have oxygen cylinder regulations centered around the volume of gas present. The higher the volume of gas is directly correlated to needing more requirements. In healthcare, oxygen cylinders range in size (A, B, D, E, and H-cylinders). For example, an E-cylinder has about 23 cubic feet of oxygen, and an H-cylinder has about 244 cubic feet of oxygen. It is important to remember that NFPA 99 compliance requires a team effort from all healthcare staff. To comply with regulatory standards, policy creation and education of healthcare staff is vital. Healthcare facilities should also complete a risk assessment.

OSHA in the Healthcare Workplace

Healthcare workers face serious safety and health hazards. These include bloodborne 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

Incidents of work-related injuries and illnesses among healthcare workers have a significant impact on the employees, their families, healthcare institutions, and 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 concerned for their safety or health in a work environment where their safety and health are 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 their institution had a solid commitment to safety and targeted interventions to improve 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.

An essential 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 in their workplace.

Programs with strong management commitment and active worker participation effectively reduce injury risk, while paper programs that lack commitment and participation prove ineffective. Strong and visible management leadership is the most critical element of an effective injury and illness prevention program. Worker participation makes an important contribution to an employer's bottom line.

Reporting Workplace Safety Concerns and Employee's Rights

As you can see, OSHA affects many aspects of the Healthcare worker's environment, job, and culture. 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 also make 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 to OSHA by calling 1-800-321-OSHA (6742) or by printing the complaint form and mailing or faxing it to their local OSHA office. Complaints signed by an employee are more likely to result in an inspection. Every question or report is confidential. Every employee is legally protected 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 immediately. 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 affects safety and health but does not result in death or severe injury.

SERIOUS VIOLATION: THIS VIOLATION EITHER CAUSES OR COULD POTENTIALLY CAUSE DEATH OR SEVERE INJURY.

- **Willful Violation:** The employer purposefully and knowingly committed this violation.
- **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 can speak up about them without fear of retaliation. You also have the right to:

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

Pain Management

Pain is sensory discomfort derived from possible or actual tissue damage that can cause emotional distress. Pain management intends 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 actual or potential tissue damage.

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

Classification of Pain

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

Chronic Pain: This pain lasts for months to a lifetime. The pain usually occurs with disease processes and worsens over time.

Pain Assessment

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

Pain must be constantly assessed so ongoing treatment can be appropriately 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.

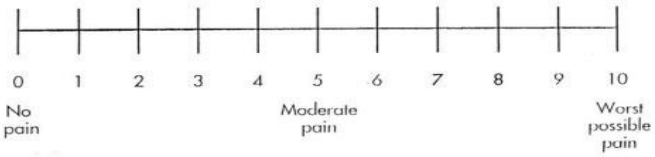
Failure to Report Pain

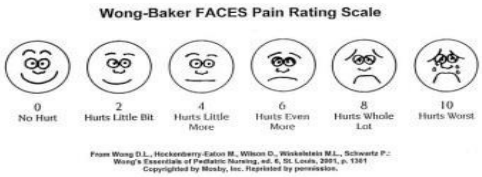
The failure to report pain should not be confused with a lack of pain. Barriers to reporting pain should be assessed during the initial admission assessment. Patients at risk for poor pain management from a failure to report pain include:

- Those who fear that pain means the disease is getting worse
- Patients who are non-verbal
- mentally impaired Patients
- 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 concerned about distracting the physician from the treatment of the underlying disease
- Patients who fear discomfort associated with medication administration (taste/injections)

Pain Assessment Scales

Pain rating scales that 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 worst 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 the worst. This scale is used for children and mentally impaired or confused adults.

FLACC Scale

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

Assessment factors in the non-verbal and 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 has an unmet comfort goal, 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 for appropriate pain management.

Treatment and Interventions

Pain may be managed effectively by using a combination of pharmacological and non-pharmacological approaches. Treatment is based on the patient's pain report, with consideration given to the type of pain, location, and intensity. Effective pain management is an integral component of patient care and an essential indicator of quality of care. Optimal pain management diminishes suffering while minimizing complications, side effects, and cost. Unrelieved pain has adverse physical and psychological effects.

Treatment for Pain

Pharmacological

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

Non-Pharmacological

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

These interventions do not need a physician order and include, but are not limited to:

- Heat or cold therapies
- Positioning
- Massage
- Distraction techniques, such as music, games, reading material, and

television
- Relaxation techniques, such as meditation and prayers
- A quiet environment

Patient and Family Education

The patient and their family have the right to education regarding their roles in managing pain, as well as the potential limitations and side effects of the treatment of pain. When opportunities present, the staff will provide information and instruction on appropriate pain management methods.

The patient and appropriate family members should be educated on the following:

- 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

Pain assessment 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 care plan.
- Offering pain medications or interventions frequently or as ordered rather than waiting for the patient to ask for relief

- Discussing the patient's feelings about their pain management interventions
- Requesting further intervention orders if pain management is ineffective
- Incorporating pain into the care planning process by adding it to the interdisciplinary plan of care
- Ensuring that unresolved pain present at discharge or transfer is addressed for continuity of care

Patient Safety and Culture of Safety

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 highlighted the need for action in the healthcare industry. Accredited institutions must 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 of the 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 robust 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 solid commitment to not 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 learning opportunities. This, in turn, helps reduce mistakes and correct system failures. To accomplish this, hospitals should provide and encourage a standardized reporting process for staff to report patient safety events safely.

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

Types of Safety Events

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

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

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

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

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

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

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

All patients have the right to be notified about any safety event 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 the 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.

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

- Catheter-associated Urinary Tract Infections (CAUTI)
- Central Line-associated Bloodstream Infection (CLABSI)

- Pressure injury (HAPI)
- Trauma related to a fall in the hospital
- Surgical site infections
- Multi-drug Resistant Organism Infections

System Problems and Errors

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

Most errors are not the fault of one person. A combination of factors in delivering a treatment, procedure, or medication exists. It is essential 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 equitable and fair safety culture
- Maintain a truthful environment in which safety events and quality measures are openly shared with all staff members
- Be a 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

Safety culture aims not to create a blame-free culture but rather a Just Culture (nonjudgmental culture) that combines learning with accountability. To achieve this, leaders must 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 for which staff members must be held accountable.

Data Use and Reporting Systems

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

Practical data analysis can help hospitals find problems within their systems. 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 errors and to maintain and improve patient safety. In a proactive risk assessment process, patients are evaluated to see where they could fail. This identifies parts of the process that need improvement, which prevents failures before they occur.

- Benefits of a proactive approach to patient safety include:
- 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 linked to patient safety. Involved patients are less likely to experience injury. Less activated patients suffer poorer health outcomes and are less likely to follow their provider's advice.

Patient's Bill of Rights

The patient's bill of rights lists reasonable expectations for those receiving medical care. It may be a law or a non-binding declaration through the federal or state government. The federal government developed the Consumer Bill of Rights. This has been a foundation for many health plans, including federal government-sponsored ones.

The Purpose of the Patient's Bill of Rights

- Build up consumer confidence, empowering them to participate actively in their healthcare
- 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 they can understand. If they speak another language, have a physical or mental disability, or do not understand something, appropriate assistance will be provided so they can make informed healthcare decisions.

Choice of Providers and Plans

Every person deserves the right to choose an appropriate healthcare provider to provide high-quality healthcare.

Access to Emergency Services

If a person feels their health is in jeopardy, they can receive emergency healthcare services at any time or place.

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 cannot 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 protect their personal healthcare information. Patients have the right to review their medical records, correct mistakes, and obtain a copy for personal use.

Complaints and Appeals

All people have the right to a fair, fast, and objective review of any complaint 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 healthcare. The responsibilities outlined are ways the consumer can work with the health care provider to achieve the best quality health outcome.

- Assume responsibility for living a healthy lifestyle. Exercising regularly and eating a healthy diet.
- Be directly involved in decisions about your healthcare.
- Work with healthcare providers to create and execute treatments.
- Openly give essential information and discuss wants and needs.
- Use the health plan's appropriate complaint and appeal process to deal with problems.
- 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 to all in an efficient, fair, and impartial manner.
- Educate yourself on your healthcare plan's coverage and all your options.
- Always respect 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 to the appropriate authorities, including abuse and fraud.

Patient Rights and Health Insurance: Affordable Care Act

In 2010, a new Patient's Bill of Rights was created along with the Affordable Care Act.

This bill of rights was designed to give new patient protections in dealing with insurance companies, which include:

- Removing annual and lifetime limits of coverage
- Being able to obtain health insurance despite pre-existing medical conditions
- Having an easy-to-understand summary of benefits and coverage
- Being able to choose a physician
- Keeping young adults on their parent's health insurance policy until age 26 if they meet specific 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 justified

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

Patient Rights under HIPAA

Under HIPAA, patients have the right to

- Receive a privacy notice to inform them about how protected information will be used and disclosed
- Have their personal healthcare information protected
- Inspect, obtain a copy, and amend their medical records (providers can 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.

Plan of Care

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 healthcare staff updated on patient history, data, and decision-making
- The plan of care helps to ensure that critical issues and information are not neglected
- To be effective and comprehensive, the care planning process must involve all healthcare disciplines that participate in the care of the patient/resident.

Developing a Care Plan or Plan of Care

Four categories organize plans of care:

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

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

Once the initial assessment is complete, a problem list should be generated. It is based on 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. These, as well as spiritual and family/relationship problems, 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 designed to solve or minimize all the patient's problems.

Finally, the care plan's progress will be evaluated by measuring goal achievement. This will determine if the care plan orders are effective. Once the evaluation is complete, the healthcare 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 healthcare 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 all healthcare personnel involved with the patient to work together. Each discipline, as warranted, will contribute to the IPC and involve the patient and family to the extent possible.

Research shows that interdisciplinary care plans benefit each patient and healthcare team member in planning care.

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

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

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

Quality Improvement

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 standard process issues and patient care errors. The common denominator of the internal and external programs is improving the quality of care and patient safety.

Quality Improvement (QI)

QI aims to use a systematic, data-guided approach to improve processes or outcomes.

QI in healthcare focuses on improving patient outcomes. So, the key is to clearly define the outcome that needs to be improved, identify how the outcome will be measured, develop a plan, implement the intervention, and collect data before and after the intervention.

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

QI Methods

One standard 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 STANDARD 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 that facilities shall create and execute a QAPI program. The provision ensured that facilities consistently recognized and corrected problems and maintained performance improvement.

QAPI improves healthcare facilities' quality of care and services by refining problems identified by collected data. QAPI requires every employee to help identify improvements, find gaps in processes or procedures, execute a corrective action plan, and constantly monitor the plan's effectiveness. QAPI will help improve patient outcomes and reduce medication errors.

QAPI encompasses two aspects of quality: Quality Assurance (QA) and Performance Improvement (PI).

- **QA** is a procedure that ensures the facility meets 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** (called Quality Improvement - QI) is the ongoing study of processes and procedures. PI will help by recognizing areas that need improvement and applying innovative approaches or ideas to fix or prevent problems.
- **QA+PI** PI goals include the ongoing study of processes and continuously implementing a new process to improve healthcare by preventing problems. In contrast, QA goals involve meeting the pre-set standard of care criteria and studying why the criteria were not met. QAPI will identify and verify quality-related problems and their underlying cause, help design and implement a plan to address deficiencies, follow up on progress to determine if the plan was successful, detect recent problems or opportunities for improvement, and continuously study and improve healthcare processes to improve services.

Lean Methodology

Lean is a set of operating philosophies and methods that help create maximum patient value by reducing waste and waits. It emphasizes considering the customer's needs, employee involvement, and continuous improvement. Research on applying and implementing lean principles in health care has been limited until recently. Many organizations are implementing Lean Methodology in their Quality Improvement Programs to join the

evidence-based practice, effectiveness of lean, and patient safety. Implementing lean management in health care can also be holistic, such as transforming an overall business strategy.

Quality Tools

Root Cause Analysis

RCA is a structured process used to analyze errors and identify the undisclosed problem that caused the error. This removes the focus from the mistake a person made to what error in the process caused the mistake. RCA helps identify active errors, which happen when a human meets a complicated system, and latent errors, unseen in a system. To begin an RCA process, data from the event must be gathered; then, a multidisciplinary team will break 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 to identifying how and why a process or system can fail. FMEA aims to detect system failures and correct system problems before they occur. This reduces harm to staff and patients and increases hospital safety. FMEA is proven to reduce errors and increase the successful performance of a process.

Quality Occurrences

Sentinel Event

A sentinel event is an unforeseen occurrence that leads to the death or injury of a patient. If death or injury does not occur, but the patient was put at risk for either, it is still considered a sentinel event. These events require prompt examination after the event happened to determine what happened and why. Sentinel events and any data gathered from the event must be reported, followed by a Root Cause Analysis, and then responded to with an action plan.

Near Miss

A near miss is any unforeseen occurrence or behavior that had a chance to cause an adverse outcome, like injury or illness to a patient or employee, but never did so. A near miss, by definition, is called a sentinel event and must be reported as well, per policy. A near miss can

give insight into process or system weaknesses, providing excellent opportunities to improve the quality of care.

Quality Measures and Reporting

Healthcare facilities and the organization's National Quality Improvement Goals are displayed in its Quality Report. Quality reports are public information, and data is updated quarterly.

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

The companies that develop quality measures include:

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

Hospital quality measurements are used for public reporting, provider incentive programs, accreditation, and 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 care coordination and ensure that all individuals and families are engaged as partners in their care.
- Ensure healthcare facilitates work with communities to promote healthy living.
- Make quality care more affordable for individuals, families, and employers by developing new healthcare delivery models.

Restraints

A restraint is anything, such as a device, physical action, or chemical, used to immobilize or restrict a person's movement in any way.

Restraints are used as a last resort after all alternative methods have been unsuccessful and the patient remains a danger to themselves or others.

Violent Restraints Versus Non-violent Restraints

Violent Restraints

Violent or self-destructive behaviors that jeopardize the immediate physical safety of the patient or another person may meet the behavioral health requirements for violent restraints. Placing a patient in violent restraints requires a consultation from the behavioral health team to consider behavioral restraint options.

Non-violent Restraints

Restraint for non-violent, non-self-destructive behaviors may be used to promote medical healing and diminish the risk of suffering or self-harm. Non-violent restraints preserve the dignity and integrity of the patient when other less restrictive methods have been determined ineffective to protect the patient.

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 are ineffective at calming the patient and continue to pose a risk, restraint usage may be needed. The type of restraint depends on the patient's behavior and condition.

Physical Restraint

Physical restraint is any device or action to physically restrict a person's movement. This includes, but is not limited to, wrist and ankle restraints, holding a patient down, waist and vest restraints, placing all four-bed rails up, or using tightly tucked or tied sheets to prevent movement.

Chemical Restraint

A chemical restraint is a medication that is not a part of the patient's standard treatment regimen and is 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 the management of violent behavior.

Hand Mitts and Freedom Sleeves

Hand mitts should be considered to decrease grabbing ability when patients are confused, impulsive, or do not follow directions but can be redirected. Additional considerations include 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 continually trying to get out of bed or a chair after repeated redirection when it is unsafe 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. Ensure you can easily slide your fingers underneath the vest or belt so it is not too tight. It should not press uncomfortably against the skin, which could cause redness or impede the patient's midsection expansion during respiration. Instruct the patient to call for assistance when they need to get up.

Limb Restraints

Soft bilateral limb holders on both wrists may be appropriate for patients who are becoming increasingly agitated, cannot be redirected with distraction, and keep trying to remove needed medical devices. When device removal poses serious harm to the patient, or if the patient is a physical threat to themselves/others, limb restraints help protect the patient and staff as a reminder to 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, they 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 the following:

- 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 used

Duration

The following are limitations to the duration of restraint use:

- The physician specifies time but should not exceed 24 hours.
- The physician must re-evaluate the patient face-to-face at least every 24 hours to determine if restraints must 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 an assigned staff member continually monitors the patient face-to-face.
- The patient should be frequently evaluated for restraint removal or reduction in the level of restraint used. Restraint removal or reduction should be implemented when the patient demonstrates an improvement or reduction in the behavior that led to restraint use.
- Restraints should be released every 2 hours to perform a skin assessment and complete range of motion exercises. When done, the restraints should be safely and adequately 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 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 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 severe harm or even death.

Misusing restraints can result in the following:

- 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 appropriately repositioned and promptly
- Loss of muscle and bone strength if used for extended periods
- 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 the family at the time of use. Education of the patient and family should include an explanation of the behaviors that caused restraints to be incorporated into the plan of care, why the use of restraints is necessary, and an explanation of available alternatives to the use of restraints. All education must be documented.

Staff Training Required

Staff members will be trained in the 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 and well-being on restraints
- How to provide care for patients in restraints or seclusion

Risk Management & Legal Issues in Healthcare with Do Not Use Abbreviations

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 to reduce hospital accidents, injuries, and financial risks. This helps

prevent and effectively manage patient, visitor, and employee adverse events. Risk management cannot eliminate all risks but can help increase quality assurance.

Healthcare is one of the most legally scrutinized professions and has some vital ethical guidelines where legal issues can arise. Healthcare requires this type of oversight, not only because people's very lives 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, an organization must have qualified healthcare risk managers to assess, develop, implement, and monitor risk management plans to minimize exposure. There are many priorities for 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 to avoid risk and minimize damage or loss. Risk management must be tailored for each organization. An organization’s purpose, mandate, size, facility construction, nature of business, location, patient populations, demographics, and other factors must be considered. Healthcare 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.

Since each organization faces unique challenges, no one-model-fits-all risk management solution exists. 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 regarding their potential adverse effects must be evaluated and measured. An organization-specific management plan should be developed, implemented, and monitored based on the risk assessment.

Risk analysis research to identify potential adverse events should include, but is not limited to:

- Analyzing what could happen
- What is the likelihood of that event occurring
- What would the estimated outcome be if the event occurred
- What can be done to prevent the event from occurring
- What can be done to lessen the potential for the event to occur
- 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 healthcare professionals and staff in reporting errors to reduce risk and improve the safety culture is crucial but challenging for many organizations. Unless staff members are engaged, feel safe speaking up, and are enabled to learn from the occurrence of preventable medical errors, poor patient outcomes will continue to occur. How organizational leaders respond to safety events and communicate to staff, patients, and family members following such events is critical 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 adverse 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 assist with insurance or legal investigations.

Dos of Incident Reporting

- File a report immediately when you identify any incident
- Limit your report to facts, and do not make judgments or report opinions
- The report is, and should remain, confidential
- All information is used to benefit the performance improvement plan

Do Nots of Incident Reporting

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

Safety Events and Root Cause Analysis

Patient Safety Events

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

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

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

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

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

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

An incident report is required for every serious adverse event (sentinel event) to help prevent risk and reoccurrence. Should such an event occur at the health care facility, a thorough investigation (Root Cause Analysis) is needed to establish the event's cause. 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 the hospital's governing board.

If in doubt, fill it out! An incident report is not to lay blame for an event that occurred or almost occurred but to facilitate learning and performance improvement. Not completing an incident report could cause the facility to miss learning or improvement opportunities. If unsure, complete the incident report for any patient safety event, and your supervisor will determine whether what happened is an incident.

Risk Reduction

Many patient risks can be reduced by training physicians and staff, encouraging effective communication among staff members, providing counseling services for those working with patients, and conducting competency assessments.

OTHER RISKS POSED TO PATIENT SAFETY CAN BE MITIGATED USING PATIENT-SPECIFIC RISK MANAGEMENT STRATEGIES SUCH AS:

- Encourage reporting and a culture of safety
- Produce a rapid and standardized response to identified concerns
- Empower managers to address issues close to the source
- Promote greater transparency

Sources Used to Interpret the Law

Standards of Care

Standards of care are the level or quality of care considered appropriate by a profession based on the skills and learning commonly possessed by all members. Standards of care are the minimal requirements defining an acceptable care level. 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

Each state creates practice acts and standards and defines 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 practice standards relevant to each discipline. These rules and

regulations have the force of law because they are met or violated based on the evidence presented.

Professional Position Statements

Professional position statements explain or justify why a decision was made, or an action was made. Professional organizations publish their position statement to the body of their standards of care.

Policies and Procedures

An individual institution sets forth this standard as the minimally acceptable practice. In court cases, institutional policies and procedures are presented and evaluated to determine if a clinical defendant has met the institution's standard of care.

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 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 malicious/criminal intent. These purposeful or accidental acts can impact a patient's health, safety, and finances. When this happens, liability exists, which can result in a lawsuit against the healthcare professional, whether or not they acted in good faith.

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 accurate. 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 errors and medication mistakes. When a do-not-use abbreviation is encountered in an order, the physician must be called to verify the order and then have the order correctly written.

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

cc	**Write ml , mL or milliliters**
ug	**Write mcg or micrograms.**

Just Culture

To promote effective reporting and achieve quality care, facilities need to adopt what is referred to as a just culture. The just culture recognizes that it is rare for any single nurse to be the cause of an incident; instead, multiple system factors often combine to create the circumstances. The just culture eliminates punitive action against the person filing 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.

Safe Patient Handling and Back Safety

Statistics show that 8 out of 10 people will experience back pain at some time. 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 broad base of support. You are more stable when you separate your feet and turn your toes out. By widening your support base, you can improve your balance and ability to maintain stability**.**
- Keep your back straight. Keep the back straight and bend at the hips and knees when lifting. 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 at arm's length is almost three times as much as holding it close to your body.
- Pivot the body; never twist the spine. Never twist at the waist when transferring, as this could cause spinal injury. Always pivot the entire body when lifting to transfer a patient.
- Push or pull to slide when possible. Sliding something heavy by pushing or pulling it is always preferable to lifting something heavy. If you have a choice between the two, pushing is preferable because it uses the entire body instead of a select group of muscles.

Contributing Factors to Back Injuries

- Bending or twisting
- Reaching out and 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

Mechanism of Injury	Prevention
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 prolonged 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. 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 a chair, Bed to a stretcher, and repositioning in bed.

The back is the main support structure for the body. It carries most of the body's weight and 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. Ligaments and muscles support the vertebrae and discs.

A healthy spine has three natural curves. These natural curves form an S-shape when your back is aligned correctly (neutral posture). You know your back is correctly aligned when your ears, shoulders, and hips are straight. 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 sure 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 sound, consistent care.

Patient assessment

Before transferring a patient, it is essential first to 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 their weight?

- If yes, assistance from an employee may not be needed. The patient may be able to transfer without help. The healthcare provider should only stand by for safety as needed.
- If patients can partially support their weight, assistance will be necessary. This may involve a stand and pivot technique and include 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. A mechanical lifting aid is recommended for patients who cannot help support their weight. However, it would be best not to use a mechanical lifting aid unless you have been

trained. Improper use or malfunction of a lifting aid can cause severe 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 yourself. If the patient is heavy, two people should assist in the transfer. This does not mean a patient is overweight. Some sources suggest 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 essential to support the patient's weak side by standing/walking on that side of the patient. You may need additional assistance if the patient is unstable, dizzy, or confused. This may include another employee's help or using 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, which can help prevent dizziness.
- Preparing the area before transferring/ambulating the patient is also essential. 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 like 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 without using your back and guiding 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 severe 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

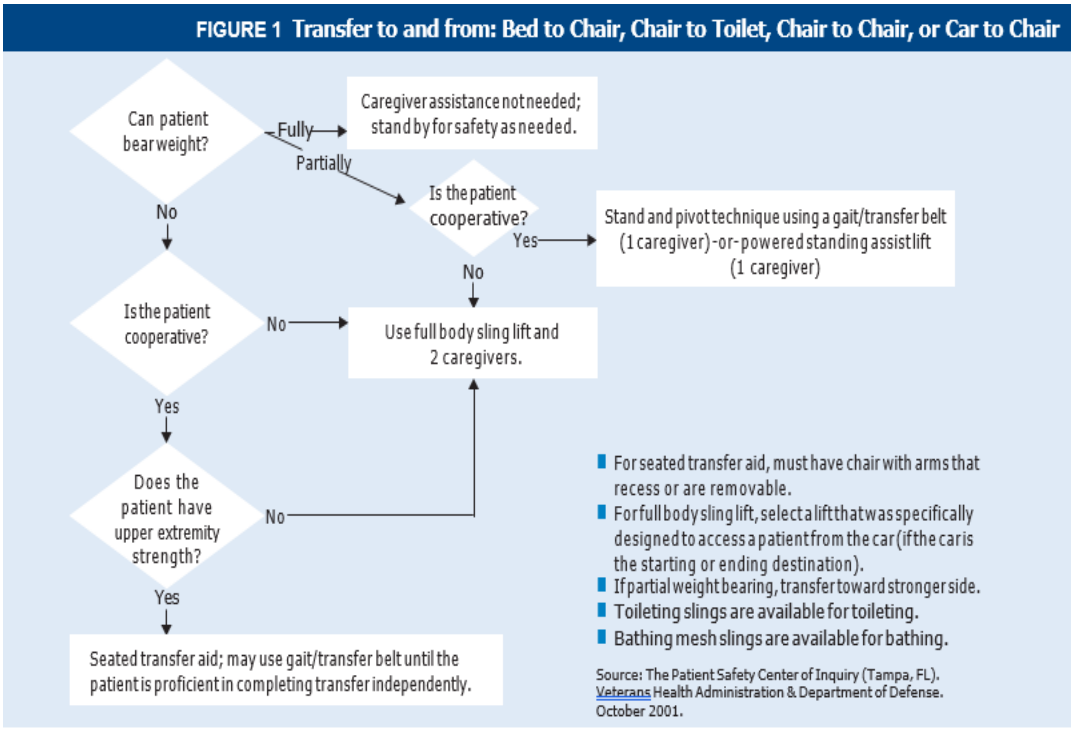


Figure 2: Lateral Transfer to and from Bed to stretcher or trolley

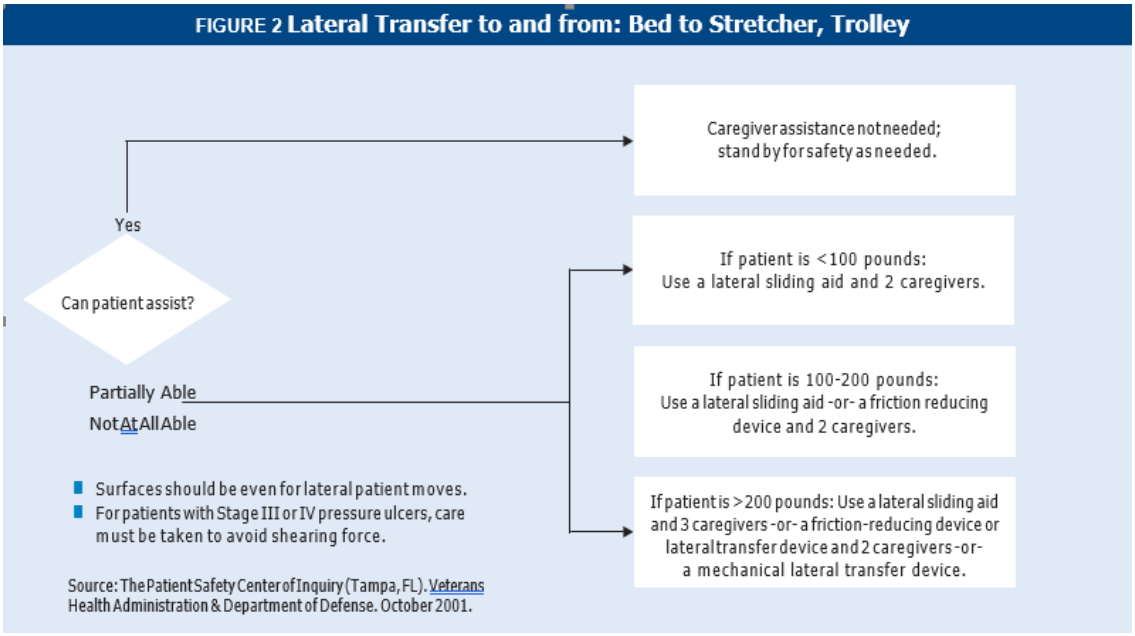
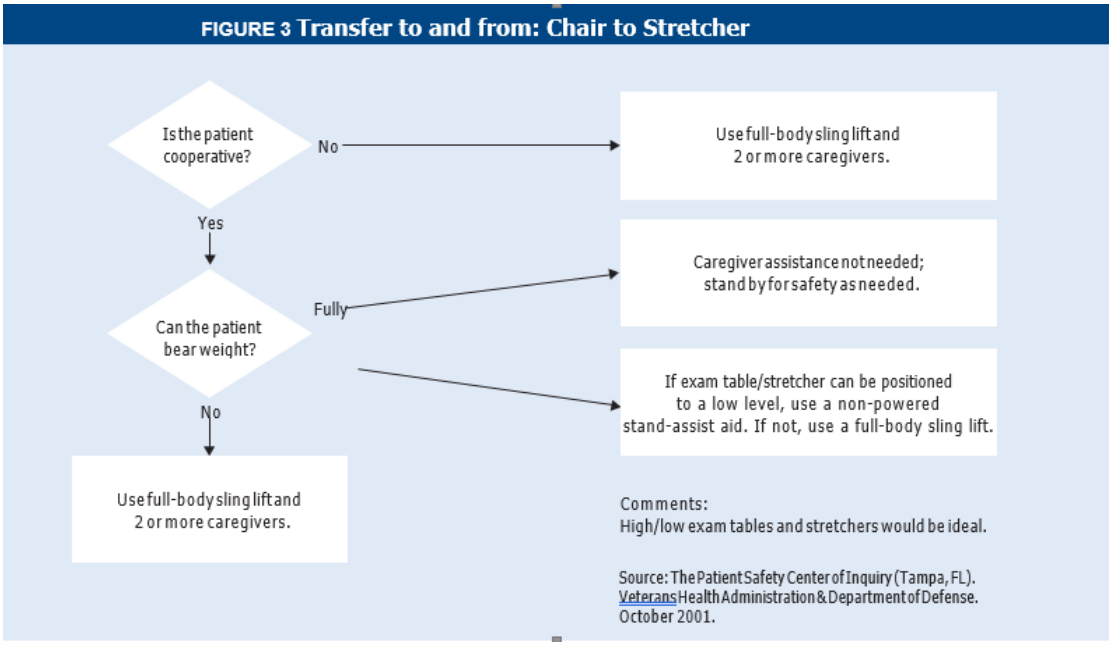


Figure 3: Transfer to and from chair, bed, or stretcher



Mechanical Assist Device

Transferring from Sitting to Standing Position

Powered sit-to-stand or standing assist devices

When to Use: Transferring partially dependent patients, have some weight-bearing capacity, are cooperative, and 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 (wheelchair, 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 the device is rated for the patient's 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-dependent patients are partial- or non-weight bearing, heavy, or have other physical limitations. Transfers from bed to chair (wheelchair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a patient falls.

Points to Remember: More than one caregiver may be needed. Look for a device with various slings, lift-height range, battery portability, hand-held control, emergency shut-off, manual override, boom pressure sensitive switch that can quickly move around equipment, and a support base that goes under beds. Having multiple slings allows one of them to remain in place while the patient is in bed or chair for only a short period, reducing the number of times the caregiver lifts and positions the patient. Portable compact lifts may be helpful where space or storage is limited. Ensure the device is rated for the patient's weight. Electric/battery-powered lifts are preferred to crank or pump-type devices to allow 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 cooperative partial- or non-weight-bearing patients.

Points to Remember: More than one caregiver and a friction-reducing device are needed if the patient cannot assist in repositioning themselves in the chair. Ensure the use of good body mechanics by caregivers. Wheels on the chair add versatility. Ensure that the chair is easy to adjust, move, and steer. Lock the wheels on the chair before repositioning. Remove trays, footrests, and seat belts where appropriate. Ensure the device is rated for the patient's weight.

Ambulation

Ambulation assist device

When to Use: For weight-bearing and cooperative patients who need extra security and assistance when ambulating.

Points to Remember: Increases patient safety during ambulation and reduces the risk of falls. The device supports patients as they walk and push it along during ambulation. Ensure height adjustment is correct for the patient before ambulation. Ensure the device is in good working order and rated for lifting the patient's weight. Apply brakes before positioning the patient in or releasing the patient from the device.

Patient Lifting Devices

Portable lift device (sling type): universal/hammock sling or a band/leg sling

When to Use: Lifting-dependent patients are partial- or non-weight bearing, heavy, or have other physical limitations. Transfers from bed to chair (wheelchair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a patient falls.

Points to Remember: More than one caregiver may be needed. Look for a device with various slings, lift-height range, battery portability, hand-held control, emergency shut-off, manual override, boom pressure sensitive switch that can quickly move around equipment, and a support base that goes under beds. Having multiple slings allows one of them to remain in place while the patient is in bed or chair for only a short period, reducing the number of times the caregiver lifts and positions the patient. Portable compact lifts may be useful where space or storage is limited. Ensure the device is rated for the patient's 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. Enhances patient safety and comfort.

Ceiling-mounted lift device.

When to Use: Lifting-dependent patients are partial- or non-weight-bearing, weighty, or have other physical limitations. Transfers from bed to chair (wheelchair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a patient falls. A horizontal frame system or litter attached to the ceiling-mounted device can be used when transferring patients who cannot safely transfer 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. It may be quicker to use than a portable device. Motors can be fixed or portable (lightweight). The device can be operated by a hand-held control attached to the unit or by an infrared remote. Ensure the device is rated for the patient's 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 with 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 the 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 need to be more suitable for bariatric patients. When using a draw sheet combination, use a good handhold 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, gently push and pull to move the patient to the new surface.

Look for a combination of devices to increase patient comfort and minimize skin trauma risk. Ensure transfer surfaces are at the same level and height, allowing caregivers to work at waist level to avoid extended reaches and back bending. Count down and synchronize the transfer motion between caregivers.

Bed to Stretcher Transfer (Lateral Transfers)

Lateral transfer is a patient's movement from one flat surface to another in a lying down position. Before transferring a patient from a bed to a stretcher, it is essential to assess the patient to determine how much the patient can help.

- If a patient can move from the bed to the 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 must 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 partial or non-weight bearing patients. Eliminates the need to perform lift transfers in and out of wheelchairs. It can also assist patients who are partially weight-bearing from a sit-to-stand position. Beds that convert to chairs can aid dependent repositioning patients, are 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 the patient's status, e.g., for heavier or non-cooperative patients. Additional friction-reducing devices may be required to reposition the patient. Heavy-duty beds are available for bariatric patients. The device should have easy-to-use controls within easy reach of the caregiver, sufficient foot

clearance, and a wide range of adjustments. Motorized height adjustable devices are preferred to those adjusted by crank mechanism to minimize physical exertion. Always ensure the device is in good working order before use. Ensure the wheels on the equipment are locked. Ensure transfer surfaces are at the same level and height, allowing caregivers to work at waist level to avoid extended reaches and back bending.

Lateral Transfer in Sitting Position

Transfer boards – wood or plastic (some with movable seats)

When to Use: Transferring (sliding) patients who have good sitting balance and are cooperative from one level surface to another, e.g., a bed to a wheelchair, wheelchair to car seat, or toilet. It 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 the 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. It may be uncomfortable for larger patients. Depending on patient status, they are usually used with gait belts for safety. Ensure boards have tapered ends, rounded edges, and appropriate weight capacity. Ensure wheels on the bed or chair are locked, and transfer surfaces are at the same level. Remove lower bedrails from bed and arm 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. It 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. 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 operate levers or controls. Always ensure the device is in good working order before use and is rated for lifting the patient's weight. It can aid patient independence.

Description: Stand-assist devices can be fixed to a 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. It can be used for independent patients who need extra support to stand.

Points to Remember: Check that the device is stable before use and is rated for supporting patient weight. Ensure the frame is attached to the bed, or if it relies on mattress support, it is heavy enough to hold the frame.

Weight Devices

Scales with ramps to accommodate wheelchairs; portable-powered lift devices with built-in scales; beds with built-in scales

When to Use: To reduce the need to transfer partial or non-weight-bearing or dependent patients to weighing devices.

Points to Remember: Some wheelchair scales can accommodate larger wheelchairs. Built-in bed scales may increase the 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 partially dependent patients 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 sometimes 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 more accessible to grip and increase security and control. Always transfer to the patient's strongest side. Use good body mechanics and rocking and pulling motion rather than lifting

when using a belt. Belts may not be suitable for ambulating heavy patients or patients with recent abdominal or back surgery, abdominal aneurysms, etc. It should not be used for lifting patients. Ensure the belt is securely fastened and cannot be easily undone by the patient during transfer. Ensure a layer of clothing is between the patient's skin and the belt to avoid abrasion. Keep the patient as close as possible to the caregiver during transfer. Lower bedrails, remove arms and footrests from chairs and other items that may obstruct the transfer.

For use after a fall, always assess the patient for injury before movement. If the patient can regain standing with minimal assistance, use gait or transfer belts with handles to aid the patient. Keep your back straight, bend your legs, and stay as close to the patient as possible. If the patient cannot stand with minimal assistance, use a powered portable or ceiling-mounted lift device to move the patient.

A transfer belt is placed around the patient's waist and secured snugly. The belt can be adjusted to fit different patients and fastens with Velcro and a buckle. If the transfer belt has loops, hold them to support the patient more firmly during transfer; if the belt does not have loops, hold onto the belt itself. It would be best to use a transfer belt with patients who can partially support their 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 discomfort under the arms. Patients also prefer the transfer belt because they feel more secure, allowing the employee to control their movement during a transfer.

A transfer belt should not be used for 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 to the bed and remove the legrests 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 is a straightforward process of standing the patient up, pivoting, and sitting 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 patient's 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 correctly 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 patients.

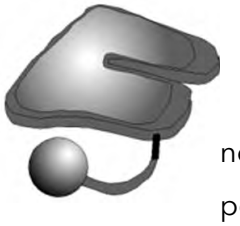
Points to Remember: The device should have easy-to-use controls within easy reach of the caregiver to promote the use of the electric adjustment, sufficient foot clearance, and a wide range of adjustments. Adjustments must be completed in 20 seconds or less to ensure staff use; some beds closer to the floor may be needed for patients at risk of falling from bed. Heavy-duty beds are available for bariatric patients. Beds raised and lowered with an electric motor are preferred over crank-adjust beds to allow smoother movement for the patient and less physical exertion for the caregiver.

Trapeze bar; hand blocks and push-up bars attached to the bed frame

When to Use: Reposition patients who 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 a trapeze bar by grasping a bar suspended from an overhead frame to raise themselves 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 the bed is adjusted to the caregiver's waist height. Blocks also enable patients to raise themselves and reposition themselves in bed. Bars attached to the bed frame serve the same purpose. It may not be suitable for heavier patients. It can aid patient independence.

Pelvic lift devices (hip lifters)



When to Use: To assist cooperative patients who can sit up to a position on a special bedpan.

Points to Remember: Convenience of the device may reduce the need for patient lifting during toileting. The device is positioned under the pelvis. The part of the device under the pelvis gets inflated, so the pelvis is raised, and a special

bedpan is put underneath. The head of the bed is raised slightly during this procedure. Use correct body mechanics, lower bed rails, and adjust the bed to the caregiver's waist height to reduce bending.

Bathtub, Shower and Toileting Activity Devices

Height-adjustable bathtubs and easy-entry bathtubs

When to Use: Bathing patients who sit directly in the bathtub or assisting ambulatory patients climb more readily into a low tub or accessible access tub—bathing patients in portable-powered or ceiling-mounted lift devices using appropriate bathing slings.

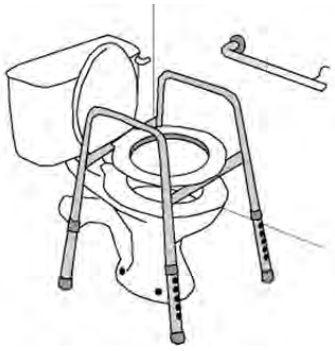
Points to Remember: Reduces awkward postures for caregivers and those who clean the tub after use. The tub can be raised to eliminate bending and reach for the caregiver. Use correct body mechanics and adjust the tub to the caregiver's waist height when performing hygiene activities. Increases patient safety and comfort.

Shower and toileting chairs

When to Use: Showering and toileting partially dependent patients have some weight-bearing capacity, can sit up unaided, and can bend hips, knees, and ankles.

Points to Remember: Ensure that wheels move quickly and smoothly; the chair is high enough to fit over the toilet; the chair has removable arms, adjustable footrests, and 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.

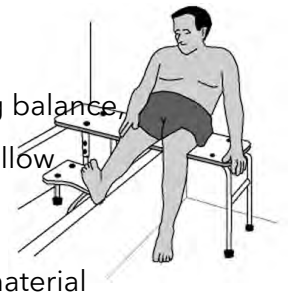
Toilet seat risers



When to Use: For toileting partially weight-bearing patients who can sit up unaided, use upper extremities (have upper body strength), can bend hips, knees, and ankles, and are cooperative. Independent patients can also use these devices.

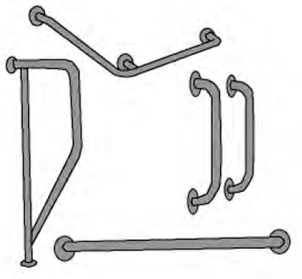
Points to Remember: Risers decrease the distance and effort required to lower and raise patients. Grab bars and height-adjustable legs add safety and versatility to the device. Ensure the device is stable and can accommodate the patient's weight and size.

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. It can be used with a gait or transfer belt and 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. It may not be suitable for heavy patients. If a wheelchair is used, ensure wheels are locked, the transfer surfaces are at the same level, and the device is securely in place and rated for weight transfer. Remove arms and footrests from chairs as appropriate and ensure the floor is dry.



Grab bars and stand assists; they 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 showering patients who need extra support and security. Patients must be partially weight-bearing, able to use upper extremities (have upper body strength), and cooperative.

Long-handled devices reduce the amount of bending, reaching, and twisting the caregiver requires when washing patients' feet, legs, and trunk. Independent patients with difficulty reaching their lower extremities can also use these devices.

Points to Remember: Movable grab bars on toilets minimize workplace congestion. Ensure bars are securely fastened to the wall before use.

Height adjustable shower gurney or lift bath cart with waterproof top

When to Use: For bathing non-weight-bearing patients who cannot 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 the caregiver. Foot and head supports are available for patient comfort. It may not be suitable for bariatric patients. Look for power-driven carts to reduce the force required to move and position the 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. It is helpful in small bathrooms where space is limited.

Points to Remember: Ensure that the seat raises so the patient's feet clear the tub, easily rotates, and lowers the patient into water. It may not be suitable for heavy patients. Always ensure the lifting device is in good working order before use and rated for the patient's weight. Choose a device with a lift mechanism that does not require excessive effort by the caregiver when raising and lowering the device.

Safely Ambulating Patients

When ambulating with a patient, you walk beside the patient and assist.

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

You may sometimes wish to use a transfer belt when ambulating or walking with a patient. A transfer 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, for a better grip.

One employee may ambulate safely with patients who need help walking but are reasonably stable. If one side is weaker, 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 two employees:

- Ask the patient to sit on the side of the bed
- Apply the transfer belt
- Stand the patient up (as if starting a sit-to-stand pivot transfer)
- Two employees stand on either side of the patient
- Place your arm around the patient's back; hold the transfer belt on the far side of the patient
- 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

Sexual Harassment

Sexual harassment includes any unwanted verbal, physical, sexual behaviors and 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 a victim of sexual harassment. The harm caused by sexual harassment is often extreme, including humiliation, loss of dignity, psychological injury, physical injury, and damage to professional reputation and career. Inevitably, the victims face a choice between their work and their self-esteem.

Sometimes, they face a choice between their jobs and their safety.

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

- The victim, as well as the harasser, could be a woman or a man. The victim does not have to be the opposite sex of the harasser.
- The harasser can be the victim's employee, supervisor, customer, co-worker, or a non-employee.
- The victim does not have to be the person directly harassed but could be anyone affected by offensive conduct.
- Unlawful sexual harassment may occur without the harasser withholding money or a job.
- The sexual harasser's conduct must be 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 to report the issue.

When investigating allegations of sexual harassment, the EEOC looks at all the circumstances, such as the nature of the sexual advances and the context in which the alleged incidents occurred. A determination on the allegations is made from the facts on a case-by-case basis.

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

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

Substance Abuse Recognition

Substance (alcohol and drug) use has reached epidemic proportions in the United States. It is essential to understand and recognize signs and symptoms of being under the influence of a substance to ensure a safe drug and alcohol-free workplace. No matter what kind of impairing substance someone is affected by– whether it is alcohol, street drugs, prescription medications, or something else–there is a higher risk for workplace accidents, absenteeism, presenteeism, family or social problems, stigmatization, discrimination, deteriorating physical or mental health, pain, distress, and disability.

Substance Use Disorder

When does drug use become drug abuse or addiction?

Substance Abuse

using a substance in an unapproved and inappropriate way hinders a person's ability to perform their daily obligations.

Substance Addiction

when substance abuse turns into a repeated pattern, creating psychological and behavioral symptoms of addiction.

Impairment & Warning Signs

Alcoholism

The warning signs of alcohol abuse include, but are not limited to:

- Impaired motor coordination, slurred speech, flushed face, and bloodshot eyes
- Having problems performing in daily activities such as work and school
- Drinking in dangerous and illegal situations
- Experiencing blackouts
- Hurting oneself or others while drinking
- Smell of alcohol on the breath or excessive use of mouthwash

The warning signs of alcohol addiction include, but are not limited to:

- Drinking in the morning or drinking alone
- Inability to stop or control, drinking, even when it has caused harm to you or others
- Using elaborate excuses to drink

- Experiencing alcohol withdrawal symptoms if alcohol is not consumed (sweating, shaking, nausea, vomiting, anxiety)
- Quitting favorite activities to consume alcohol
- Drinking, regardless of the ill effects it has on oneself or their relationships
- Experiencing weight loss and gastritis
- Needing to drink increasingly more to feel drunk

Drug Addiction

The warning signs of drug abuse include, but are not limited to:

- Showing signs of being high (appearing abnormally energetic or lethargic)
- Consuming high doses of medications that are not recommended or prescribed
- Experiencing mood swings
- Trying to obtain multiple prescriptions
- Having problems performing in daily activities such as work and school

The warning signs of drug addiction include, but are not limited to:

- Rapid changes in mood and decline in daily performance
- Frequent use of the restroom and absence from work or school
- Inability to care for one's health or appearance
- Frequent complaints of pain that require prescription pain medication
- Spending time and money (even if they cannot afford it) to acquire a drug
- Doing illegal things to acquire a drug

Inability to stop using a drug and experiencing withdrawal symptoms if the drug is not consumed. Withdrawal signs and symptoms include anxiety, fatigue, seizures, vomiting, depression, and hallucinations.

Impaired Practitioners

Clinicians under the influence of drugs, which impact their ability to provide safe and competent care, pose a severe danger to patients. A clinician's first duty is to protect the safety of patients. State Boards of Healthcare Clinicians (e.g., Physicians, Nurses, Physical Therapists, Respiratory Therapists, Pharmacists, etc.) have a responsibility for swift action to remove an impaired practitioner from performing duties involving direct patient care until the practitioner is deemed safe to return to those duties. The board's primary responsibility is to the public.

Most practitioners do not want to report impaired co-workers because they believe the state board would treat them too harshly by revoking their license to practice. Practitioners should

become familiar with how their state board addresses issues of impairment. Practitioners who voluntarily enter peer assistance programs can continue practicing under specific guidelines. Many boards will not investigate impaired practitioners' practice if they voluntarily enter and successfully complete 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 their access to medications in the hospital. Signs that a practitioner is taking medication from the hospital include, but are not limited to:

- Excessive wasting of drugs
- Patients complaining that pain medication is not effective
- Patients denying that they received pain medication
- Excessive discrepancies in the signing and documentation of controlled substances
- Frequently leaving the nursing unit
- Always asking to medicate other nurses' patients
- Arriving to work late and leaving early
- Changing verbal medication orders

Any sign that indicates a practitioner is under the influence of drugs or alcohol should be reported immediately. Following the chain of command is recommended.

Suicide Prevention

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 before their suicide attempt.

Healthcare professionals are in a unique position to detect depression and suicide warning signs in their patients and intervene early. Suicide is a preventable public health issue. Understanding the stressors and hopelessness that lead people to consider suicide and connecting them to the appropriate resources can help save lives.

Risk Factors

The following is a list of demographic and behavioral characteristics seen in at-risk patients. This list is meant to help identify these patients, but it needs to be more inclusive.

- Military service
- Mental or emotional disorders
- Previous attempts
- History of emotional trauma or loss
- Serious illness, chronic pain, or impairment
- Substance abuse
- Social isolation
- Pattern of aggressive or antisocial behavior
- Discharge from an inpatient psychiatric facility within the last year and particularly within the last few weeks or months
- Access to lethal means (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, as well as acute care hospitals. The Joint Commission National Patient Safety Goals include recommendations for identifying at-risk patients and preventing suicide. Not even in non-behavioral care environments, the organization must be able to identify and intervene in at-risk patients. A significant difference between non-behavioral and behavioral care environments is that only

behavioral care is required to screen ALL patients. However, note the emphasis on identifying at-risk patients, as well as the monitoring requirements for ALL patients admitted with a diagnosis that includes emotional and substance abuse issues. Remember, the Emergency Department is 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 of suicide.
- Address the patient's immediate safety needs and the most appropriate treatment setting.
- Provide suicide prevention information (such as a crisis hotline) to the patient and their family when a patient at risk for suicide leaves the care of the hospital.
- Provide a location for the patient that is safe, monitored, and clear of items that the patient could use to harm themself or others, especially if a patient is boarded while awaiting care for emotional illness and the effects of alcoholism or substance abuse.
- Provide orientation and training to all clinical and nonclinical staff caring for such patients by providing information on effective and safe care, treatment, and services (medication protocols and de-escalation techniques).
- Conduct assessments and reassessments and provide care consistent with the patient's identified needs.
- Assess the needs 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 of 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 their 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 apply to primary, emergency, and behavioral acute and nonacute settings.

- Review the 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 with acute suicidal crisis

- Keep patients in acute suicidal crises in a safe healthcare environment under one-to-one observation. Do not leave these patients by themselves.
- Provide immediate access to care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources.
- Check patients and their visitors for items that could be used to make a suicide attempt or harm others.
- Keep these patients away from anchor points for hanging and material that can be used for self-injury.
- Specific lethal means that are readily 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 the initial assessment, rather than leaving it up to the patient to make the appointment.

For all patients with suicidal ideation

Give every patient and their 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 experts in the field of suicide prevention do not recommend.
- Review and reiterate the patient's safety plan at every interaction until the patient is no longer at risk for suicide.
- Restrict access to lethal means. Assess whether the patient has access to

firearms or other lethal means, such as prescription medications and chemicals. Discuss ways to remove or lock up firearms and other weapons during crises. Restricting access is essential because many suicides occur with little planning during the short term.

Validated /Evidence-Based Suicide Risk Assessment Tools

There are a number of validated evidenced-based suicide risk screening strategies that are available for the identification of both males and females at elevated risk for suicide.

The Joint Commission's recent Sentinel Event Alert identifies several of the most well-studied suicide risk screening tools.

- Patient Health Questionnaire-9 (PHQ-9; Spitzer, Kroenke, & Williams, 1999)
- Patient Health Questionnaire-2 (PHQ-2; Löwe, Kroenke, & Gräfe, 2005)
- Suicide Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001)
- Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011); and ED-SAFE Patient Safety Screener (Boudreaux et al., 2013)

Sample Patient Health Questionnaire

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD© is a trademark of Pfizer Inc.

A 2663B 10-04-2005

Safety Planning

Developed collaboratively with a provider, safety plans commonly incorporate a list of personalized coping strategies. These can include resources for contacting social and professional support groups and information about restricting access to lethal means. Their primary purpose is to reduce the suicidal individual's imminent suicide risk by encouraging the use of alternative coping strategies during a future crisis.

While empirical evidence for its efficacy in reducing suicidal behavior has not yet been established, safety planning is considered a best practice approach for intervening with suicidal individuals. Emerging evidence has shown that safety planning intervention, in combination with a structured phone follow-up, was associated with increased treatment attendance and decreased risk of hospitalization.

Workplace Violence (Active Shooter, Bleeding Control and Bioterrorism)

The Occupational Safety and Health Administration defines workplace violence (WPV) as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive workplace behavior. 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 are currently the third-leading cause of fatal occupational injuries in the United States.

Workplace Violence in Healthcare

In 2023, the United States Congress passed The Safety From Violence for Healthcare Employees Act (SAVE). Findings during the hearings related to this bill found that the severity of incidents can increase staffing deficiencies. Healthcare costs affect the quality of patient care and have shown an increase in employee insurance claims and payouts. This bill provides federal protection for healthcare workers who experience violence and intimidation in their workplace settings. Some states have enacted or increased penalties for attacks on health care employees and this national legislation is meant to protect health care employees from workplace violence by:

- requiring employers in health care and social service industries to develop and implement comprehensive workplace violence plans
- prohibiting anyone from interfering with hospital personnel performing their jobs
- enacting penalties and a term of imprisonment for an assault of a hospital employee, of fines and up to 10 years in prison, and if dangerous weapons are involved or if there is bodily injury, the term of imprisonment can be up to 20 years

OSHA has also published guidelines for developing written programs for WPV and lists five building blocks to include in the plan:

- management commitment and employee participation
- worksite analysis
- hazard prevention and control
- safety and health training
- recordkeeping and program evaluation.

Factors of Workplace Violence

Workers in hospitals, nursing homes, and other healthcare settings face significant risks of WPV. Many factors contribute to this risk, including working directly with people with a history of violence or who may be delirious or under the influence of drugs. According to a recent survey, 40% of healthcare workers have reported WPV incidences, and more than half of these reported incidences, 50%, are at the hands of a combative patient. The rate of serious WPV 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. Healthcare accounts for as many serious violent injuries as all other industries combined.

Environmental Factors

Workplace environmental factors that may make WPV 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 patients' homes
- Working at night or early morning
- Chronic labor disputes
- Frequent grievances filed
- Understaffing (excessive demands for overtime)
- High number of stressed personnel
- Authoritarian management approach

Individual Factors

Examples of individual stressors and signs that could lead to WPV:

- 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 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. The supervisor will then review acceptable behavior per department policy and identify steps to correct the problem. The consequences of 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 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. If necessary, the supervisor or the authorities will discuss the offenders' concerns and actions. Acceptable behavior per department policy will be discussed, and disciplinary actions will occur. Document the event.

Level 3 (Further Escalation)

When a visitor, customer, employee, or employer threatens suicide or physical violence, utilizes weapons, or causes physical harm and 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. If necessary, the supervisor or the authorities will discuss the offenders' concerns and actions. Acceptable behavior per department policy will be discussed, and disciplinary actions will occur. Document the event.

Preventing Workplace Violence

OSHA has determined that the best way to reduce violence in the workplace is through a comprehensive WPV prevention program that covers four core elements or building blocks:

1. **Management commitment and employee participation**. Managers demonstrate their commitment to WPV prevention, communicate this commitment, and document performance. With their distinct knowledge of the workplace, employees ideally engage in all aspects of the program.
2. **Worksite analysis and hazard identification**. Processes and procedures are in place to continually identify workplace hazards and evaluate risks.
3. **Hazard prevention and control**. Processes, procedures, and programs are implemented to eliminate or control workplace hazards and achieve WPV prevention goals and objectives.
4. **Safety and health training.** All employees have education or training on hazard recognition and control and 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 WPV. 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 WPV policies and procedures. Educate employees on recognizing signs of WPV and implementing 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 increases your chances of surviving and helping others survive.

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. 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 for local emergency alerts and register your work and personal contact information with any work-sponsored alert system.
- Be aware of your environment and any possible dangers.

Make a Plan

- Make a plan with your family and ensure everyone knows what they would do if confronted with an active shooter.
- Look for the two nearest exits everywhere you go, 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 safe and describe the shooter, location, and weapons.

HIDE if escape is not possible

- Get out of the shooter's view and stay incredibly quiet.
- Silence all electronic devices and make sure they will not vibrate.
- Lock and block doors, close blinds, and turn off lights.
- Do not hide in groups- spread out along walls or hide separately to make it more difficult for the shooter.
- Try to communicate with the police silently. Use text or social media to tag your location or put a sign in a window.
- Stay in place until law enforcement gives you all clear.
- Your hiding place should be out of the shooter's view and protected if shots are fired in your direction.

FIGHT as an absolute last resort

- Commit to your actions and function as aggressively as possible against the shooter.
- Recruit others to ambush the shooter with makeshift weapons such as chairs, fire extinguishers, scissors, books, etc.
- Be prepared to cause severe or lethal injury to the shooter.
- Throw items and improvise weapons to distract and disarm the shooter.

After an active shooter incident

- Keep hands visible and empty.
- Know that law enforcement's first task is to end the incident, and they may have to get injured along the way.
- Officers may be armed with rifles, shotguns, and handguns and 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 protect them.
- 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.
- 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 reviewed. RUN. HIDE. FIGHT. ® Surviving an Active Shooter Event - English - YouTube

Bleeding Control

Traumatic injury results from various causes, including accidents or intentional harm, and in various 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 how to control bleeding, whether you only have two hands or a complete trauma first aid kit.

Primary Principles of Trauma Care Response

Ensure your safety

- Before you offer any help, you must ensure your safety! If you become injured, you cannot 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 to 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: Several methods can be used to stop bleeding, and they all have one thing in common – compressing a bleeding blood vessel to stop the bleeding.
- If you do not have a trauma first aid kit:
    - Apply Direct Pressure on the wound
    - Cover the wound with a clean cloth and apply pressure by pushing directly on it with both hands
- If you <u>do</u> have a trauma first aid kit:
    - For life-threatening bleeding from an arm or leg, 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 Bleeding Control Algorithm

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

Look for *Life-Threatening Bleeding*

Is a Trauma First Aid Kit available?

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

Is tourniquet available?

YES

- Apply above the bleeding site
- Tighten until the bleeding stops

NO

- Pack the wound with bleeding control (hemostatic) gauze (preferred), any gauze, or clean cloth
- Apply steady direct pressure

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

Where is the wound?

Arm

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.

rst aid kit:

g from an arm or leg and a

from the neck, shoulder or groin:

with bleeding control gauze (also), plain gauze, or a clean cloth 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.

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 rarely seen in the United States.

High-priority agents include organisms that pose a risk to national security because they:

- Can be quickly disseminated or transmitted from person to person
- Result in high mortality rates and have the potential for significant public health impact
- Might cause public panic and social disruption
- Require particular action for public health preparedness

Agents that can only be spread through direct contact with the biological agent and not through contact with the infected person include:

- Anthrax
- Botulism
- Tularemia

Person-to-person contact can also spread to other agents. These include:

- Smallpox
- The Plague (pneumonic form).

Anthrax

Anthrax is caused by a bacteria called **Bacillus anthracis**. The bacteria are usually found in hoofed animals and can be spread to humans exposed to infected animals. New screening tests for anthrax are being developed. A vaccine has also been developed but is not on the market yet. There are three types of Anthrax:

Cutaneous

- This is the most common form of anthrax. Cutaneous anthrax is spread by direct contact with an open wound by an infected animal, inhaling spores, or eating infected meat.
- After an incubation period of 2 to 5 days, a large, itchy sore appears on the skin.

Inhalation

- This form is caused by breathing in the anthrax bacteria. In bioterrorism, the bacteria might be carried on a powder or spray. The incubation period can be 60 days or more.

- Inhalation anthrax begins with flu-like symptoms. This makes it difficult to diagnose in the early stages. One suspicious sign is an elevated white cell blood count, not seen in viral illnesses like the flu.
- After the initial symptoms, the infected person improves and becomes highly ill with severe respiratory symptoms. Death usually occurs within 24-36 hours.
- The inhalation form of anthrax can be treated but requires early detection and treatment to be effective.
- This is difficult because of the flu-like nature of the early symptoms.

Intestinal

- For purposes of bioterrorism, intestinal anthrax is rare. This would be more difficult than spreading by other means.

Person-to-Person Contact

Some disease-producing agents that may be used in bioterrorism cause illnesses that can also be spread from person to person, such as:

- The Plague
- Smallpox

Responding to the Threat of Bioterrorism

People injured or become sick due to 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.***

Hospitals, especially the emergency department, maybe 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

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/

About coronavirus disease 2019 (COVID-19). Accessed March 2020. https://www.cdc.gov/coronavirus 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

Active Shooter. Department of Homeland Security. https://www.ready.gov/active-shooter. Accessed. September 2023.

Advanced Directives. American Cancer Society. May 10, 2019. https://www.cancer.org/treatment/finding-and-paying-for-treatment.html

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care. 2010. http://www.jointcommission.org/assets/1/6/aroadmapforhospitalsfinalversion727.pdf

Aetna. Intervention Strategies for Behavioral Health Disorders. https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/Aetna-IL_Intervention%20Strategies%20for%20Behavioral%20Health%20Disorders%20brochure.pdf. Accessed February 2023.

AGE-SPECIFIC CONSIDERATIONS IN PATIENT CARE, June 2014. https://lms.rn.com/getpdf.php/2019.pdf

All About OSHA. Occupational Safety and Health Administration U.S. Department of Labor. Accessed 2016. https://osha.gov/Publications/all_about_OSHA.pdf

Allergy & Asthma Network, Latex Allergy Toolbox Accessed December 2019. https://www.allergyasthmanetwork.org/education/allergies/latex-allergy/

Allergy Associates of Palm Beaches. Latex Allergy. https://www.pballergy.com/latex-allergy. Accessed June 2023.

Alzheimer's Association www.alz.org

American Academy of Allergy Asthma & Immunology (AAAAI). Latex Allergy Video. https://www.aaaai.org/tools-for-the-public/video-library/allergy-videos/latex-allergy-video. Accessed June 2023.

American Hospital Association. Put it in Writing. https://www.aha.org/system/files/2018-01/putitinwriting.pdf. Accessed September 2023.

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

Assessing your patients' risk for falling. American Nurse Today. https://www.americannursetoday.com/assessing-patients-risk-falling/. Accessed September 2019.

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.

Back Injury Prevention Safety Training Program for the Health Care Industry. Texas Department of Insurance, Division of Workers' Compensation. https://www.tdi.texas.gov/pubs/videoresource/stpbkinjhc.pdf. Accessed January 2023.

Banyan Treatment Centers. Crisis Intervention Techniques for Mental Health. https://www.banyantreatmentcenter.com/2022/06/20/crisis-intervention-techniques-for-mental-health-boca/. Accessed February 2023.

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

Bioterrorism Agents/Diseases. CDC. https://emergency.cdc.gov/agent/agentlist-category.asp. Accessed September 2023.

Blackmere, J. et al. (2017). Determining the most efficient controlled substance inventory practice that minimizes discrepancies and maximizes security https://www.bd.com/documents/case-studies/medication-supply-management/DI_Managing-Controlled-Substances_CS_EN.pdf

Body Mechanics for Healthcare Staff. WCF Insurance. https://www.wcf.com/body-mechanics-healthcare-staff. Accessed September 2019.

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

CDC. Bloodborne Infectious Diseases. https://www.cdc.gov/niosh/topics/bbp/default.html. Accessed October 2023.

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

Center for Medicare and Medicaid Services. http://www.cms.gov/Regulations-and-Guidance/HIPAA-AdministrativeSimplification/HIPAAGenInfo/index.html?redirect=/HIPAAgeninfo/
Code Sets Overview. 07 May 2023. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets.

Centers for Disease Control and Prevention (CDC). Hand Hygiene FAQs. https://www.cdc.gov/handwashing/faqs.html. Accessed October 2023.

Centers for Disease Control and Prevention (CDC). Isolation and Precautions for People with COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/your-health/isolation.html. Accessed October 2023.

Centers for Disease Control and Prevention (CDC). Stay Up to Date with Vaccines. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html. Accessed October 2023.

Centers for Medicare & Medicaid (CMS). (2015). The CMS Interpretive Guidelines for the Hospital Conditions of Participation. Retrieved from: https://www.cms.gov/Regulations-andGuidance/

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

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

Child Maltreatment 2019. https://www.acf.hhs.gov/cb/report/child-maltreatment-2019

Child Welfare Information Gateway. (2019). Mandatory reporters of child abuse and neglect. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/topics/systemwide/lawspolicies/statutes/manda/. Accessed October 2023.

Chronic Illness and Mental Health: Recognizing and Treating Depression. https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health. Accessed February 2023.

Cleveland Clinic. Acute vs. Chronic Pain. https://my.clevelandclinic.org/health/articles/12051-acute-vs-chronic-pain. Accessed December 2023.

Cleveland Clinic. Borderline Personality Disorder (BPD). https://my.clevelandclinic.org/health/diseases/9762-borderline-personality-disorder-bpd#symptoms-and-causes. Accessed February 2023.

Cleveland Clinic. Dissociative Disorders. https://my.clevelandclinic.org/health/diseases/17749-dissociative-disorders. Accessed February 2023.

Cleveland Clinic. Schizophrenia. https://my.clevelandclinic.org/health/diseases/4568-schizophrenia#management-and-treatment. Accessed February 2023.

CMS Appeals and Grievances. https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Grievances 03/07/2019

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

CMS. (2015, Jun). HCAHPS Fact Sheet. Retrieved Nov 2016, from HCAHPS Online: http://www.hcahpsonline.org/Files/HCAHPS_Fact_Sheet_June_2015.pdf CMS. (2015). Summary of

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

CMS. (n.d.). *Spring 2015 HCAHPS Executive Insight Letter*. Retrieved May 15, 2015, from HCAHPS Online: 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

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

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

Compilation of Select Laws & Regulations Regarding Behavioral Restraint & Seclusion. February 2014, Pub. #5457.01. http://www.disabilityrightsca.org/pubs/545701.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

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

Coronavirus Education https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/education/ana-covid-19-video-

Coronavirus Vaccines https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/hcp.html/2019-ncov/about/index.html.

Crisis Prevention Institute, Inc. De-Escalation Tips. https://www.jointcommission.org/-/media/tjc/documents/resources/workplace-violence/cpi-s-top-10-de-escalation-tips_revised-01-18-17.pdf. Accessed February 2023.

Cultural Competence Center. Our Mission. https://culturalcompetencecenter.com/. Accessed August 2023.

Culture of Safety. Patient Safety Network. 2019. Accessed 2023 Jul 16. https://psnet.ahrq.gov/primer/culture-safety

Culture of Safety. Patient Safety Network. 2019. Accessed 2023 Jul 16.

Department of Health and Human Services: Centers for Medicare and Medicaid Services. Medicare Fraud & Abuse: Prevention, Detection, and Reporting. https://capitalhealth.com/sites/default/files/uploaded-

documents/Medicare%20Fraud%20and%20Abuse%20102016.pdf. Accessed June 2023.

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

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

Ebola (Ebola Virus Disease). Center for Disease Control and Prevention. Page last updated August 28, 2018.

Eckman, M., Labus, D., & Thompson, G., Eds. (2022). Nursing Pharmacology Made Incredibly Easy, 5th ed. Amber, PA: Wolter Klower Health/Lippincott

End of Public Health Emergency. https://www.cdc.gov/coronavirus/2019-ncov/your-health/end-of-phe.html. Accessed October 2023.

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

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

Extended Care Professional (ECP). How to Identify 8 Rights of Medication Administration with an eMAR. https://www.ecp123.com/blog/how-to-identify-8-rights-of-medication-administration-with-an-emar. Accessed February 2023.

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

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 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 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.

Families USA. The Affordable Care Act: Patients' Bill of Rights and Other Protections. January 19, 2019. https://familiesusa.org/wp-content/uploads/2019/09/Patients-Bill-of-Rights.pdf

Families USA. The Affordable Care Act: Patients' Bill of Rights and Other Protections. January 19, 2019.

Family Caregiver Alliance www.caregiver.org

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

GoodTherapy. https://www.goodtherapy.org/drugs. Accessed February 2023.

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. Accessed September 2019.

Hand Hygiene in Healthcare Settings. Centers for Disease Control and Prevention. Last updated April 29, 2019.

Hazard Communication Standard: Safety Data Sheets. OSHA Brief. Accessed December 2019. https://www.osha.gov/Publications/OSHA3514.html

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

Health Care Chaplaincy. Handbook of Patients' Spiritual and Cultural Values for Health Care Professionals. Updated March 2013. http://www.healthcarechaplaincy.org/userimages/Cultural%20Sensitivity%20handbook%20from%20Hea lthCare%20Chaplaincy%20%20(3-12%202013).pdf

Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards. https://ifdhe.aha.org/system/files/media/file/2020/12/ifdhe_inclusion_dashboard.pdf

Health Facilities Management. Oxygen tank storage regulations. https://www.hfmmagazine.com/articles/4002-oxygen-tank-storage-regulations. Accessed October 2023.

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

Health Insurance Portability and Accountability Act of 1996. 07 May 2023. https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient%27s%20consent%20or%20knowledge
HIPAA PHI: Definition of Phi and List of 18 Identifiers. 07 May 2023. https://cphs.berkeley.edu/hipaa/hipaa18.html#:~:text=What%20is%20PHI%3F,such%20as%20diagnosis%20or%20treatment

Healthcare Wide Hazards. Ergonomics. US Department of Labor, OSHA. https://www.osha.gov/SLTC/etools/hospital/hazards/ergo/ergo.html#patienthandling program. Accessed September 2019.

Herzing University. Cultural Competence in Healthcare. https://www.herzing.edu/blog/cultural-competence-healthcare. Accessed August 2023.

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

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

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.

http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html.

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

http://www.ismp.org/tools/bestpractices/TMSBP-for-Hospitals.pdf
Nursing 2019 Drug Handbook. (2019). Wolters Kluwer: Philadelphia, Pennsylvania.

http://www.jointcommission.org/assets/1/18/do_not_use_list.pdf

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

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

http://www.webmd.boots.com/children/guide/childhood-milestones-age-7

http://www.webmd.com/parenting/guide/4-to-5-year-old-milestones

https://familiesusa.org/wp-content/uploads/2019/09/Patients-Bill-of-Rights.pdf

https://psnet.ahrq.gov/primer/culture-safety

https://www.aha.org/other-resources/patient-care-partnership

https://www.cdc.gov/handhygiene/providers/index.html

https://www.eeoc.gov/laws/types/harassment.cfm

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

https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf May, 2023

https://www.osha.gov/SLTC/personalprotectiveequipment/. Accessed December 2019.

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/

Humanium. How can we help the youth in need on World Suicide Prevention Day?. https://www.humanium.org/en/how-can-we-help-the-youth-in-need-on-world-suicide-prevention-day/. Accessed September 2023.

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

Illinois Leadership Center. Becoming a Culturally Competent Leader. https://blogs.illinois.edu/view/8605/1547105412. Accessed August 2023.

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

Infection control recommendations. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations

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

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

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/

Institute for Safe Medication Practices. (2019). 2018-19 targeted medication safety best practices for hospitals [Online]. Accessed April 2016

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

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

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

International Academy of Cosmetic Dermatology. LATEX GLOVE ALLERGY. https://iacdworld.org/latex-glove-allergy/. Accessed June 2023.

Joint Commission Standards on Restraint and Seclusion/Nonviolent Crisis Intervention, Training Program. https://www.jointcommission.org › hap_2017_npsgs

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

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

Keystone Health. Health services for Homebound Adults. https://keystone.health/homebound-adult-health-services. Accessed February 2023.

Kuechenmeister M. Quality improvement for utilities management. Healthc Facil Manag Ser. 1993 Aug:1-9. PMID: 10132473.

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

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

Legal Issues in Health Care. January 2010. https://uthsc.edu/Medicine/legaledu/

Lifeskills South Florida. Why Do People Self-Harm?. https://www.lifeskillssouthflorida.com/mental-health-blog/why-do-people-self-harm/. Accessed August 2023.

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

Maison Dunham House. 5 Tips for Staging a Successful Mental Health Intervention. https://www.dunhamhouse.ca/5-tips-for-staging-a-successful-mental-health-intervention. Accessed February 2023.

Mayo Clinic https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes

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. Living wills and advance directives for medical decisions. https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/living-wills/art-20046303. Accessed September 2023.

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

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

Medical Device Reporting Regulation History. 3/22/2018. Retrieved from Medical Device Reporting Regulation History | FDA

Medical Power of Attorney. Information for Patients, Physicians, and Providers. Texas Medical Association. May 06, 2019. https://www.texmed.org/endoflife/

Medicare and Medicaid Programs Reform of Requirements for Long Term Care Facilities. https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-Medicaid programs-reform-of-requirements-for-long-term-care-facilities

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/CombMedCandDFWAdownload.pdf

Medicare Rights and Protections.

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

Medscape, Nurse. Patient Education: Addressing Cultural Diversity and Health Literacy Issues. Paragraphs 1 - 2. Margaret Chang, MN, RN; Ann E. Kelly, MSN, APRN, BC. 2007 – 2016. http://www.medscape.com/viewarticle/564667_3

MidCity TMS. How Effective Are Antidepressants. https://www.midcitytms.com/how-effective-are-antidepressants/. Accessed February 2023.

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

Mozzaz. Mental Health and Virtual Care: How Mental Health Awareness Month Drives Actionable Steps Forward. https://www.mozzaz.com/blog/mental-health-and-virtual-care. Accessed February 2023.

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/. October 15, 2018.

NAMR. National Association of Mandated Reporters. https://namr.org/news/what-is-a-mandated-reporter#:~:text=Mandated%20reporters%20are%20people%20required,adults%20are%20considered%20mandated%20reporters. Accessed October 2023.

National Alliance of Mental Illness (NAMI). Types of Medication. https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication. Accessed February 2023.

National Fire Protection Association. Fire Extinguisher Types. https://www.nfpa.org/News-and-Research/Publications-and-media/Blogs-Landing-Page/NFPA-Today/Blog-Posts/2021/07/16/Fire-Extinguisher-Types. Accessed October 2023.

National Hospice and Palliative Care Organization. FLACC Score. Accessed 2016. http://www.nhpco.org/flacc- scores

National Institute on Aging. Advance Care Planning: Advance Directives for Health Care. https://www.nia.nih.gov/health/advance-care-planning-advance-directives-health-care#:~:text=Advance%20directives%20are%20legal%20documents,of%20attorney%20for%20health%20care. Accessed September 2023.

National Institutes of Health. Evaluation of STAT medication ordering process in a community hospital. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4930852/. Accessed December 2023.

National Institutes of Health. Nonpharmacological Interventions for Pain Management in Paramedicine and the Emergency Setting: A Review of the Literature. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4396997/. Accessed December 2023.

National Institutes of Health. Patient Self-Determination Act. https://www.ncbi.nlm.nih.gov/books/NBK538297/. Accessed September 2023.

National Institutes of Health. Refusal of Care. https://www.ncbi.nlm.nih.gov/books/NBK560886/. Accessed September 2023.

National Institutes of Health. Visceral pain: the importance of pain management services. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4590154/. Accessed December 2023.

National Library of Medicine. OSHA Bloodborne Pathogen Standards. https://pubmed.ncbi.nlm.nih.gov/34033323/. Accessed October 2023.

National Library of Medicine: National Center for Biotechnology Information. Strategies to improve medication adherence in patients with schizophrenia: the role of support services. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4404876/. Accessed February 2023.

National Library of Medicine: National Center for Biotechnology Information. Meeting the mental health needs of the homebound: A psychiatric consult service within a home-

based primary care program. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4587535/. Accessed February 2023.

Nationwide. Advance directive vs. living will: What is the difference?. https://www.nationwide.com/lc/resources/investing-and-retirement/articles/advance-directive-vs-living-will. Accessed September 2023.

News Medical & Life Sciences. The Role of Crisis Teams in Mental Health Management. https://www.news-medical.net/health/The-Role-of-Crisis-Teams-in-Mental-Health-Management.aspx. Accessed February 2023.

NHS. COVID-19 vaccines side effects and safety. https://www.nhs.uk/conditions/covid-19/covid-19-vaccination/covid-19-vaccines-side-effects-and-safety/. Accessed October 2023.

NIH. National Institute on Aging. Providing Care and Comfort at the End of Life. https://www.nia.nih.gov/health/providing-comfort-end-life#:~:text=End%2Dof%2Dlife%20care%20is,and%20the%20heart%20stops%20beating. Accessed July 2023.

Noritsu Pharmacy Automation. What is a Long-Term Care Pharmacy?. https://noritsu-rx.com/2021/08/23/what-is-a-long-term-care-pharmacy/. Accessed September 2023.

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

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

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

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

Office of Addiction Services and Supports (OASAS). LSB 2022-01: Policies for Self-Administration of Medication in OASAS Programs. https://oasas.ny.gov/policies-self-administration-medication-oasas-programs-0. Accessed February 2023.

OSHA Safety and Health Topics: HealthCare, Accessed December 2019. https://www.osha.gov/SLTC/healthcarefacilities/index.html

OSHA. Best Practices Guide: Fundamentals of a Workplace First-Aid Program. https://www.osha.gov/sites/default/files/publications/OSHA3317first-aid.pdf. Accessed November 2023.

OSHA. Evacuation Plans and Procedures eTool. https://www.osha.gov/etools/evacuation-plans-procedures/emergency-standards/design-construction. Accessed November 2023.

OSHA. Fire Safety. https://www.osha.gov/sites/default/files/publications/OSHA3527.pdf. Accessed November 2023.

OSHA. Hospital-wide Hazards-Electrical Safety. https://www.osha.gov/etools/hospitals/hospital-wide-hazards/electrical-safety. Accessed November 2023.

OSHA. Ionizing Radiation. https://www.osha.gov/ionizing-radiation/standards. Accessed November 2023.

OSHA. Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard Communications Standards. https://www.osha.gov/sites/default/files/publications/osha3186.pdf. Accessed November 2023.

OSHA. Personal Protective Equipment. https://www.osha.gov/sites/default/files/publications/ppe-factsheet.pdf. Accessed November 2023.

OSHA. Planning and Responding to Workplace Emergencies. https://www.osha.gov/sites/default/files/publications/factsheet-workplaceevergencies.pdf. Accessed November 2023.

OSHA. Steps to an Effective Hazard Communication Program for Employers That Use Hazardous Chemicals. https://www.osha.gov/sites/default/files/publications/OSHA3696.pdf. Accessed November 2023.

Pain Management. Facts about Pain Management. February 4, 2014. http://www.jointcommission.org/topics/pain_management.aspx

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

Patient Safety Systems Chapter for the Hospital Program. December 2019.

Patient's Bill of Rights What is the Patient's Bill of Rights? Last Revised: 01/06/2014. https://www.cancer.org/cancer/financial-insurance-matters/managing-health-insurance/patients-bill-of-rights.html

Patient's Bill of Rights What is the Patient's Bill of Rights? Last Revised: 01/06/2014. https://www.cancer.org/cancer/financial-insurance-matters/managing-health-insurance/patients-bill-of-rights.html

Personal Protective Equipment. United States Department of Labor. Occupational Safety Health Administration.

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

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

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

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/

Preventing Violence: A Road Map for Healthcare Facilities. OSHA. https://www.osha.gov/sites/default/files/OSHA3827.pdf Accessed September 2023.

Provider Enrollment and Certification. https://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

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

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

Puryear B, Gnugnoli DM. Emergency Preparedness. [Updated 2023 Jul 25]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK537042/

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/.

QuoteWizard. Best States for Mental Health Care. https://quotewizard.com/news/best-states-for-mental-healthcare. Accessed August 2023.

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

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).

Risk Management and Legal Issues. Valorie Dearman, MSN, RN, NEA, BC. Accessed Nov. 2014. http://www.jblearning.com/

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

Run, Hide, Fight. Surviving and Active Shooter. The city of Houston. https://youtu.be/5VcSwejU2D0. Accessed September 2023.

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

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

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.

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

Safety From Violence for Healthcare Employees Act. The SAVE Act. Accessed December 2023. /https://www.govinfo.gov/content/pkg/BILLS-118hr2584ih/pdf/BILLS-118hr2584ih.pdf

Samvedna Care. How important is it to raise mental health awareness among older adults? https://www.samvednacare.com/blog/how-important-is-it-to-raise-mental-health-awareness-among-older-adults/. Accessed February 2023.

Save a Life: What Everyone Should Know to Stop Bleeding After an Injury. American College of Surgeons. https://www.traumanurses.org/_resources/online_webinars/STNWebinar-StopTheBleed.pdf. Accessed September 2023

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.

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

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

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

SMI Adviser. How can I use de-escalation techniques to manage a person in a mental health crisis? https://smiadviser.org/knowledge-base-fp Accessed February 2023.

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=eMq7VNe2I8_4yQSX-oCwAw&ved=0CEIQFjAI&usg=AFQjCNFn5tO- 78ISMzUno4_7cO4dCvft1Q

Substance Abuse and Mental Health Services Administration. A Practical Guide To Psychiatric Advance Directives. https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf. Accessed September 2023.

Substance Abuse and Mental Health Services Administration. Medications, Counseling, and Related Conditions. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions. Accessed February 2023.

Substance Abuse and Mental Health Services Administration. Person-and Family-centered Care and Peer Support. https://www.samhsa.gov/section-223/care-coordination/person-family-centered. Accessed February 2023.

Suicide Facts. Suicide Awareness Voices of Education. https://save.org/about-suicide/suicide-facts/. Accessed January 2020.

Suicide Prevention Training for Health Professions. Washington State Department of Health. https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention. Assessed 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.

Ten Things to Know About the CMS Long-Term Care Requirements Final Rule https://www.lexology.com/library/detail.aspx?g=abdcd997-c49e-4629-a87d-8a3a968f3ce3

Texas Board of Nursing. Discipline & Complaints - Policies & Guidelines. 2013. Amended July 23, 2015. ttps://www.bon.texas.gov/discipline_and_complaints_policies_and_guidelines.asp

Texas Department of Family and Protective Services. When and How to Report Child Abuse. https://www.dfps.texas.gov/Child_Protection/Child_Safety/report_abuse.asp#:~:text=Texas%20law%20requires%20that%20any,%2D800%2D252%2D5400. Accessed October 2023.

The American Latex Allergy Association, what is Latex Allergy? Accessed December 2019. https://www.allergyhome.org/blogger/the-american-latex-allergy-association-and-latex-allergy/

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~triageqrg-pain~triageqrg- wong

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

The National Institute on Aging. What Are Palliative Care and Hospice Care? https://youtu.be/rymZI7Vo8kU. Accessed July 2023.

The New York Times. A Documentary Explores Dissociative Identity Disorder. https://www.nytimes.com/2021/03/22/well/mind/dissociative-identity-disorder-busy-inside.html. Accessed February 2023.

The New York Times. Living With O.C.D. in a Pandemic. https://www.nytimes.com/2021/08/16/well/mind/ocd-pandemic.html. Accessed February 2023.

The Patient Care Partnership. 2018.

The Patient Care Partnership. 2018. https://www.aha.org/other-resources/patient-care-partnership

The Royal Children's Hospital Melbourne. Pain assessment and measurement. https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Pain_assessment_and_measurement/#Pain%20Assessment%20Tool. Accessed December 2023.

Thinking, doing, and caring. F. A. Davis Company. https://lms.rn.com/getpdf.php/1867.pdf

TIDI. A PORTFOLIO YOU CAN TAILOR TO SPECIFIC PATIENT NEEDS. https://www.tidiproducts.com/restraints-and-restraints-alternatives. Accessed August 2023.

TIDI. Enclosure Bed. https://www.tidiproducts.com/product-listing/posey-enclosure-bed. Accessed August 2023.

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

Treas, L. S., Barnett, K. L., & Smith, M. H. (2022). *Davis advantage for basic nursing:*

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

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

U.S National Library of Medicine. Medline Plus. Use of Restraints. https://medlineplus.gov/ency/patientinstructions/000450.htm

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.

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 Labor www.osha.gov 2018

U.S. Department of Labor. OSHA. Compliance Assistance Quick Start. https://www.osha.gov/complianceassistance/quickstarts/health-care. Accessed November 2023.

U.S. Equal Employment Opportunity Commission. Harassment. Accessed 2017.

Unique Identifiers Overview. 07 May 2023. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Unique-Identifier/UniqueIdentifiersOverview
Uses and Disclosures for Treatment, Payment, and Health Care Operations. 07 May 2023. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html
187-What Does the HIPAA Privacy Rule Do? 07 May 2023. https://www.hhs.gov/hipaa/for-individuals/faq/187/what-does-the-hipaa-privacy-rule-do/index.html
Code of Ethics for Nurses. ANA. (2017, October 26). https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

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

USC Mann. USC Receives $1.3 Million NIH Training Grant to Enhance Diversity in Addiction Science. https://pharmacyschool.usc.edu/news/usc-receives-1-3-million-nih-training-grant-to-enhance-diversity-in-addiction-science/. Accessed February 2023.

Varkey B. Principles of Clinical Ethics and Their Application to Practice. Med Princ Pract. 2021;30(1):17-28. do: 10.1159/000509119. Epub 2020 Jun 4. PMID: 32498071; PMCID: PMC7923912.

Verywellhealth. How Different Stages of Pressure Ulcers Look. https://www.verywellhealth.com/pressure-ulcer-7549469. Accessed September 2023.

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

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

Web MD, Are You Allergic to Latex? Accessed December 2019 https://www.webmd.com/allergies/latex-allergies#2

Web MD. Childhood milestones age 7. 2009 – 2016.

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

Wed MD. 4- to 5-Year-Olds: Developmental Milestones. 2005-2016.

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

WHRO. Seclusion & Restraint: Behind The Numbers. https://whro.org/news/local-news/5432-seclusion-restraint-behind-the-numbers-seclusion-restraint-in-virginia-private-schools-serving-students-with-disabilities. Accessed August 2023.

Wisconsin Department of Health Services. Infection Control and Prevention: Bloodborne pathogens and exposure control. https://www.dhs.wisconsin.gov/ic/bloodborne.htm. Accessed October 2023.

Workplace Violence in Healthcare. OSHA. https://www.osha.gov/hospitals. Accessed September 2023.

Workplace Violence. United States Department of Labor. https://www.osha.gov/https://www.osha.gov/workplace-violence. Accessed September 2023.

World Health Organization (WHO). (2019). The burden of health care-associated infection worldwide. Retrieved from: www.wholint/gpsc/country_work/burden/hcai/en

World Health Organization (WHO). Coronavirus disease (COVID-19). https://www.who.int/news-room/fact-sheets/detail/coronavirus-disease-(covid-19). Accessed October 2023.

World Health Organization (WHO). Mental health of older adults. https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults. Accessed February 2023.

World Health Organization (WHO). Mental Health. https://www.who.int/health-topics/mental-health#tab=tab_2. Accessed February 2023.

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

Yale News. Yale-led surgical innovation promises better dialysis outcomes. https://news.yale.edu/2020/08/19/yale-led-surgical-innovation-promises-better-dialysis-outcomes. Accessed September 2023.