Comprehensive
Core Competency Pre-Test Reading Material

Abuse and Neglect
Core Competency Pre-Test Reading Material

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

Anyone can be a victim of physical or psychological abuse. Often the signs and symptoms are the same regardless of age; for instance, burns, bruises, fractures, poor hygiene, malnutrition, and behavioral changes. Often injuries are not visible because they are on areas normally covered by clothing. The elderly can also be victims of financial abuse, as evidenced by a sudden inability to pay bills or large decreases in bank accounts.

Healthcare workers' responsibilities for victims of domestic abuse include providing direct medical care as needed, emotional support, and referral services. Victims of sexual assault should be given appropriate medical care at the time of the assault and provided with emotional support.

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

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

- Rushing an elder or pulling him too fast when helping him walk.
- Tying a wandering elder to a chair, so he won't get lost while the healthcare provider is busy.
- Giving an elder too much or too little medication.

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

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

Financial Abuse occurs when people take control of the elder's resources through misrepresentation, coercion, or outright theft for their own gain. Financial abuse may include stealing money or possessions, forcing the elder to sign contracts or assign durable powers of attorney to someone, or charging the older adult for unnecessary services or services never rendered.

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

Psychological Neglect is failure to provide social stimulation. That might mean leaving the older person alone for long periods of time, ignoring him or giving him —the silent treatment,‖ or failing to provide companionship, changes in routine, or links to the outside world.

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

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

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

Why does abuse and neglect occur?

Abuse and neglect can arise from misunderstanding or ignorance. Sometimes people feel frustration with the elderly, because they don't really understand the effects of aging. They fail to give elders the extra time they may need to process information, respond to questions, or perform tasks. Those people may not mean to abuse anyone, but they do.

Several risk factors that have been identified as contributors to abuse and neglect include:

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

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

What are the warning signs?

Many times, the possible victim can't or won't help you uncover the truth. Physical abuse should be suspected when the described cause of injuries is inconsistent with medical finding, or if the elder and caregiver give contradictory accounts. Physical evidence may include bruises, welts, lacerations, fractures, burns, and rope or restraint marks. Genital injuries may be symptomatic of sexual abuse. Signs of neglect may include dehydration, malnutrition, decubitus ulcers, poor personal hygiene, or lack of compliance with medical regimes. You may be encountering psychological abuse or neglect in patients/residents who are extremely withdrawn, depressed or agitated, behaving childishly, or acting indifferently toward others. Financial abuse or neglect should be considered if the senior appears to be receiving inadequate level of care despite adequate financial resources.

What should be done if abuse or neglect is suspected?

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

Domestic Violence: Although domestic violence is usually directed at women, some men have been abused by their wives. Here, we are focusing on wife abuse, since it happens much more frequently.

Wife abuse is an epidemic. According to the Office on Domestic Violence, there are 3 – 6 million case of wife abuse each year. Only 1 in 10 cases are reported. Men of all socio-economic classes and races can abuse their wives.

Violence against women does not usually occur until the man feels some type of OWNERSHIP or POSSESSION of the woman. The violence escalates, becoming more severe and prolonged. Finally it is coupled with psychological terrorism.

Battered women usually do not tell a friend, family member, or police until they feel that their life is threatened. They do not tell others about abuse by their husbands/male friends primarily because of:

- Denial
- Hope for change
- Protection of husband/male friend
- Fear of retaliation from abuser

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

- Denial
- Recognition & Forgiveness Fear
- Guilt and failure Depression
- Anger
- Change in the Relationship

Types of Domestic Violence/Abuse

- Physical Abuse – The man has power and control.
- Emotional Abuse – Puts the woman down. Plays mind games – makes her feel bad about herself. Calls her names
- Economic Abuse – Tries to keep the woman from getting/keeping a job. Gives her an allowance. Makes her ask for money.
- Sexual Abuse – Makes the woman do sexual things against her will. Physically attacks the sexual parts of her body. Treats her like a sex object.
- Using Children – Makes the woman feel guilty about attention given to children. Uses the children to communicate his negative messages to the abused woman.
- Threats – Makes and/or carries out threats to hurt her emotionally. Threatens to take the children, commit suicide, or report her to welfare.
- Uses Dominating Behavior – Treats her like a servant. Makes all the "big" decisions. Acts like the "Master". Isolation – Controls what she does/who she sees/who she talks to/where she goes.

Domestic Violence affects approximately 50% of American families.

Approximately 3.3 million children witness their mothers being beaten. These children who are in violent homes are 15 times more likely to be abused or seriously neglected. Domestic violence is one of the biggest predictors of child abuse. In addition, these children who live in violent homes are more likely to become violent as adults. It is very important that we offer care, support, information, and resources to the domestic violence victim. If the victim chooses to make the decision to return to a violent home, we must not be judgmental.

Advance Directives
Core Competency Pre-Test Reading Material

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

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

What are advance directives?

Advance directives are documents which state a person's choices about medical treatment or name someone to make decisions about their medical treatment, if they cannot make their own decisions. These documents are called advance directives because they are signed in advance to let health care providers know what a person's wishes are concerning medical treatment.

There are several versions of advance directives:
- Living wills
- Directive to physicians and family or surrogate
- Medical power of attorney
- A mental health treatment declaration
- Out of hospital do not resuscitate order

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

Age Specific
Core Competency Pre-Test Reading Material

Newborn/Infant: Birth – 1 Year

PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
Head circumference increases rapidly during the first year of life as the brain increases in size. By the infant's first birthday, the brain is 2/3 of its adult size. Skull fontanels are not usually fused until 16-18 months.

Temp: 97.6°F -98.6°F (oral/tympanic); 99.6°F (rectally)
Heart Rate: newborn rate range of 120-160 bpm to 100-120 bpm by 1 year of age
Respirations: 20 -40 breaths/min (by 1 year of age)
Blood Pressure: 80/40 to 100/60 mmHg Height: Grows about 1-2 inches per month.
Weight: Gains 1-2 lbs per month (21-22 lb by 1 year). Most double their birth weight at 4-6 months, and triple it by 1 year.

Abdomen protrudes.

Physiologic system matures. | Able to recognize faces

Infants respond to light and can see objects at a distance of 20 ft

Near and far distance is blurred. Color vision usually improves at 1-2 months of age.

Hearing is sensitive from birth. Newborns can hear a wide variety of sounds. Prefer complex sounds such as noises and voices.

Develops neck and leg muscle strength.

Develops intentional rather than reflexive muscle movements.

Begins to grasp objects.

Can shake a rattle or other object.

Drops objects when no longer interested in them | Begins to imitate the behavior of others.

Communicates problems by crying or through body posture.

May speak first word by 12 months of age.

Has short attention span.

Ties words to actions and can understand simple directions. | Establishes trust in the caregiver(s) and the world around; that life's essential needs will be provided.

Needs to be held close and to feel secure.

Fear of strangers.

Anxiety in the parents (may be transmitted to the infant.)

Loud noises, bright lights, and sudden environmental changes can trigger the startle response. | Sudden infant death syndrome

Congenital malformations

Unintentional injuries

Septicemia

Homicide

Influenza and pneumonia |

Toddler: 1 – 3 Year

PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
Growth slows considerably. Head circumference is usually equal to chest circumference by 1-2 years. Usual total increase in head circumference during second year is 1 inch. Height: Grows about 3 inches per year and growth occurs mainly in elongation of the legs rather than the trunk. Weight: Gains 4-6 lbs per year. Birth weight is quadrupled by 2 ½ years Temp: 99.0°F – 99.7°F (oral/tympanic); Rectal temperature missing Heart Rate: 80-120 rate Respirations: 20-30 Blood Pressure: 90/50 to 100/60 mmHg	Begins to walk independently at about 15 months and progresses to running, jumping, and climbing at about 18 to 24 months. By end of 2nd year, can stand on one foot, walk on tiptoe, and climb stairs with alternate footing. Able to feed themselves. At 12 months, able to grasp small object, but unable to release it at will. At 15 months, builds tower of two cubes. By 18 months, can throw a ball overhand without losing their balance. Achieves visual acuity of 20/20. Develops taste preferences.	Language development begins with generally a few words and short phrases or sentences. Develops concepts by the use of language. Sees things from their own point of view and can group similar things and shapes. Generally has a short attention span. Concepts with memory begin to develop. Likes to imitate and copy gestures and words. Begins to tie words to actions and begins to understand simple directions and requests.	Identifies parents as the significant persons in their environment. Capable of exploring and manipulating their environment. Asserts independence and control with a sense of will. Expresses temper when they do not get their way. Develops an understanding of their gender. Able to put toys away, play simple games, enjoys being read to and can play alone. A favorite toy or blanket can provide security when stressed, tired, or separated from parents. Toilet training	Unintentional injuries Congenital Anomalies Homicide Malignant neoplasms Heart disease Influenza and pneumonia Septicemia

Preschooler: 4 – 6 Years

PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
Temperature: 97.6°F-98.6°F (oral/tympanic); 99.6°F (rectal) Heart Rate: 70-110 bpm Respirations: 20-25/min. Blood Pressure: 95-105/53-66 mmHg Height: Minimal change (2-3 ½" or 6-8 cm per year) Weight: Weight gain is slight (avg 4.5 lbs/2kg per year) The preschooler becomes thinner and taller during this stage of development.	By age 3, rides a tricycle, walks on tiptoe, balances on one foot for a few seconds, and broad jumps. By age 4, skips and hops proficiently on one foot and catches a ball reliably. By age 5, skips on alternate feet, jumps rope, and begins to skate and swim. Preschool children show rapid gains in eye-hand coordination. Fine motor development is evident in the child's increasingly skillful manipulation, such as drawing and dressing	Language in preschool is of two main types: egocentric and socialized. Egocentric speech fails to take into account the listener's needs and may be used to guide behavior rather than communicate. Socialized speech is intended to communicate. Learns through simple imitation, and that development of language skills requires interaction with adults. 6 years old use complex grammar and have a vocabulary of some 2,500 words. Communication ability improves as egocentrism diminishes.	The important event in this stage is independence. Continues to become more assertive and to take more initiative. The significant relationship is family. Preschoolers harbor the greatest number of new fears. Common fears experienced are: • The unknown • Darkness • Mutilation • Bodily injury • Being left alone	Unintentional injuries Malignant neoplasms Congenital Anomalies Homicide Heart disease Benign neoplasms Septicemia

School Age: 7 – 12 Years

PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
Height: Grows an average of 2 inches per year. Weight: Gains 4 – 6 ½ lbs per year. Boys tend to be slightly taller and heavier than girls. Dental growth is prominent, by 12 years all primary teeth have been shed and the majority of permanent teeth have erupted. Posture is more similar to an adult's Facial bones grow and remodel Girls 10-12 pubescent changes may begin to appear. Able to participate in quiet as well as active games. Has an understanding of the importance of caring for a pet Unintentional injuries Malignant neoplasms Suicide Congenital anomalies	By age 7, able to use eating utensils and some tools; developed skills for drawing and painting; cuts, folds, and pastes paper; colors within line of picture; learns to roller skate, skip rope, and ride bicycle. By ages 8-10, uses knife and fork simultaneously; learns to thread needle and tie knot, becomes proficient at writing cursive; learns to play jacks and marbles; can catch, throw (70 feet), and hit baseball; engages in alternate rhythmic hopping and in complex styles of skipping rope accompanied by verbal jingles. By ages 11-12, learns to peel apples and potatoes; sews simple garments on machine; builds simple objects; learns to play musical instrument; can do standing broad jump of 5 ft.; can do standing high jump of 3 ft., and plays games involving simultaneous use of two or more complex motor skills.	Develops an understanding of relationships between things and ideas. Able to use thought processes to experience events and actions. Able to master symbols and to use their memory store of past experiences in evaluating and interpreting the present. Masters the concept of conservation. Develops classification skills. Acquires the ability to read.	Peer group assumes an increasingly important role. The peer group has a powerful influence on the self-concept of the child and is important in the development of identity and values The peer group is a powerful socializing agent. School-age children can assist in household chores	Unintentional injuries Malignant neoplasms Suicide Congenital Homicide Heart Disease

PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
Rapid growth of skeletal size, muscle mass, adipose, tissue and skin, Maturation of the reproductive system; development of primary and secondary sexual characteristics. Onset of menarche in girls and nocturnal emissions in boys. Vital signs approximate those of the adult	Awkward in gross motor activity. Easily fatigued. Fine motor skills improving. Early Adolescence: may need more rest and sleep	Increased ability to use abstract thought and logic. Able to handle hypothetical situations or thought. Ability to use introspection. Develops more internal growth of self-esteem. Beginning development of occupational identity (what I want to be).	Interested and confused by own development. Often critical of own features and concerned with physical appearance. "Chum" and belonging to peer group are important and valued; may criticize parents. Interested in the opposite sex; achieving female/male social role. Accepts criticism or advice reluctantly. Longs of independence but also desires dependence. Achieves new and more mature relations. Develops physical activities that are socially determined. Identity is threatened by hospitalization, as adolescents are concerned about bodily changes and appearances.	Trauma Homicide Suicide

Early Adulthood: 19 – 45 Years

	PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
	Growth of skeletal system continues until age 30. Skin begins to lose moisture. Muscular efficiency is at its peak between 20-30 years. GI system decreases secretions after age 30.	Visual changes in accommodation and convergence. Some loss in hearing, especially high tones.	Mental abilities reach their peak during the twenties (reasoning, creative imagination, information, information recall and verbal skills).	Searching for and finding a place for self in society. Initiating a career, finding a mate, developing loving relationships, marriage, establishing a family and parenting. Begins to express concerns for health. Achievement-oriented: working up the career ladder Moves from dependency to responsibility. Responsible for children and aging parents.	Trauma HIV Malignancies Heart Disease

Middle Adult: 45 – 59 Years

PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
Bone mass begins to decrease.

Loss of skeletal height; calcium loss especially after menopause.

Decreased muscle strength and mass if not used, endurance declines.

Loss of skin elasticity, dry skin, increased appearance of wrinkles.

Decreased renal functioning metabolic rate, heat/cold tolerance, prone to infection.

Receding hairline in males, more than in females. | Slowing if reflexes.

Muscle activity mar increase or decrease.

Visual changes, especially farsightedness

Noticeable loss of hearing and taste.

Muscles and joints respond more slowly.

Decreased balance and coordination.

More prolonged response to stress. | Mood swings.

Decreased short –term memory or recall.

Re-evaluation of current life-style and value system.

Synthesis of new information is decreased.

Decrease in mental performance speed. | Future-oriented or self-absorbed.

May esperience empty nset syndrome, expressed positively or negatively.

Working way up career ladder.

Adjustment to changes in body image.

Mid-life crisis.

Recognition of limitations.

Adjustments to possibility of retirement and life-style modifications.

Measuring accomplishment against goals. | Malignancy

Heart Disease

Trauma

Cerebrovascular conditions |

Late Adult (Geriatric): 61 – 79 Years

PHYSICAL	MOTOR SENSORY ADAPTATION	COGNITIVE	PSYCHOSOCIAL	COMMON DISEASES / DEATH
Decreased tolerance to heat/cold. Decreased peripheral circulation. Declining cardiac/renal function. Decreased response to stress and sensory stimuli. Atrophy of reproductive organs. Loss of teeth leading changes in food intake. More skeletal changes.	Decreased visual acuity. Hearing loss. Decreased sensitivity of taste buds and smell. Decreased tolerance to pain. Hesitant to respond; skills declining.	Decline depends upon earlier cognitive abilities, general health and involvement in society. Sharing wisdom with others. Decrease in memory, slowing of mental functions.	Retirement. Death of spouse and friends; acceptance of death. Adapting to change of social role. Developing supportive relationships. Pursing second career, interest hobbies, community, activities and leisure activities. Coming to leave home, reestablishes as a couple, grandparenthood. Concern for health increases.	Heart Disease Malignancy Cerebrovascular disease COPC and lung disease

Age Specific Interventions

Newborn/Infant	Toddler
General: • Encourage parent to participate in care: bathing, feeding, and holding. • Encourage parent to respond to cry, meet infant's need consistently. • Teach parent to be aware of rapidly changing locomotive ability **Clinical:** • Handle the infant gently and speak in a soft friendly tone of voice. • Maintain eye contact. • Use a security toy or a pacifier to reduce the infant's anxiety and elicit cooperation. • Do not restrain.	**General:** • Explain need for consistency. • Teach parents' safety measures that guard against child's increased motor ability and curiosity. • Encourage parents to allow for brief periods of separation under familiar surroundings. • Provide child with peer companionship. • Tell the truth. Clinical: • Allow child to perform some self care tasks. • Give the child simple, direct, and honest explanations just before treatment or surgery. • Use puppets or coloring books to explain procedures. • Let the child play with equipment to reduce anxiety. • Give child choices whenever possible. • Allow for expression of fear, pain, or displeasure. • Expect resistant behavior to treatments; reinforce treatments, not punishments.
Preschooler	**School Age**
General • Encourage expression of fears. • Encourage self-care, decision making when possible. • Teach parents to listen to child's fears, feelings. • Provide simple explanations. • Focus on positive behaviors. • Practice definite limit-setting behavior. • Offer choices. • Allow child to express anger verbally but limit motor aggression. • Teach safety precautions about strangers. • Teach parents to be consistent and firm. **Clinical:** • Use simple neutral words to describe procedures and surgery to the child. • Explain when procedure will occur in relation to daily schedule (e.g. after lunch, after bath) • Encourage child to fantasize to help plan his/her responses to possible situations. • Use body outlines or dolls to show anatomic sites and procedures. • Let the child handle equipment before a procedure. • Use play therapy as an emotional outlet and a way to test the child's sense of reality. • Reinforce reality of body image. • Involves parents in teaching.	**General:** • Provide privacy. • Teach injury prevention. • Promote family and peer interactions. • Maintain limit-setting and discipline. • Expect fluctuations between immature and mature behavior. • 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 direction of care the child's decision.

Adolescent	Early Adult
General: • Supplement explanations with rationale. • Provide privacy. • Involve in planning and decision making. • Do not talk about the individual in front of the individual. • Provide wheelchair access. • Provide handicapped parking. • Access language interpreter as needed. • Utilize TTY as needed. **Clinical:** • Encourage questions regarding fears. • Allow adolescent to maintain control. • Provide essential teaching based on how the individual learns best. • Provide information on pain control methods, assessment scale, and schedule for pain management, need to ask for pain medications as soon as pain begins. • Provide information on degree of pain relief, types of pain medications, and methods for pain reduction. • Use visual aids; be concrete and specific. • Relate to child's abilities. • Major fear is loss of control.	**General:** • Involve individual/significant other in 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. • Access language interpreter as needed. • Utilize TTY as needed. **Clinical:** • Explore impact of hospitalization/illness to work/job, family and impact of children. • Assess for potential stresses related to multiple roles of the young adult. • Assess and manage pain based on patient needs and response. • Use a preventative approach. • Titrate to effect and monitor response. • PCA • Provide information on pain control methods, assessment scale, and schedule for pain management, need to ask for pain medication as soon as pain begins, providing information of degree of pain relief, types of pain medications, and methods. • Provide essential teaching based on how the individual leans best.
Middle Adult	Late Adult
General • Allow choices if possible. • Provide decision-making opportunities related to care. • Provide wheelchair access. • Provide handicapped parking. • Access language interpreter as needed. • Adequate lighting for decreasing visual activity • Print in adequate font size for decreasing vision compensation. **Clinical:** • Explore relation of illness/disease to body image and career. • Encourage as much self-care as possible. • Provide information on pain control methods, assessment scale, and schedule for pain management, need to ask for pain medication as soon as pain begins, providing information of degree of pain relief, types of pain medications, and methods. • Provide essential teaching based on how the individual leans best.	**General** • Explore individual's support system. • Explore related existing conditions. • Involve family with care, • Be aware of possible need for a warmer environment (room temperature, need for an extra blanket) **Clinical:** • Provide wheelchair access. • Provide handicapped parking. • Access language interpreter as needed. • Utilize TTY as needed. • Adequate lighting but not too bright (decreasing visual acuity and increasing sensitivity. • Provide written materials as reminders. • Speak slowly, clearly, and of adequate volume for decreasing hearing ability. • Provide adequate nutrition. • Keep environment safe (e.g., BED: Side rails up, wheels locked). • Turn/assist q 2 hrs. • Assess skin integrity frequently. • Monitor bowel elimination q 24 hrs. • Continue with pain assessment & management. Narcotics with long half-life may cause problems with side effects (e.g., confusion, constipation). • Use adjutant analgesics with caution, increases side effects. • Apply lotion to skin immediately after bathing.

Body Mechanics
Core Competency Pre-Test Reading Material

BACK FACTS

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

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

Less than 15% of the money spent on back care is spent on education to prevent injury.

Basic Principles

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

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

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

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

Common Injuries and How to Prevent Them	
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 at the waist** **at the same time.**
Cumulative Trauma	**Change position frequently. Space tasks so that you do not have to repeat the same motion over and over for long periods of time.**

Tools to Help in Moving Patients and Materials

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

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

And don't forget to use common sense:

It's better to ask for help than to risk an injury to yourself or others.

INCIDENT REPORTING

To ensure that proper attention is given and appropriate action taken when an accident involving an employee occurs at work, specific procedures must be followed.

INJURED WORKER'S RESPONSIBILITIES:
- Report the injury or illness to your charge nurse immediately. Under all circumstances, the reporting **MUST** be made during the shift on which the incident, injury, or illness occurs.
- If necessary, seek medical treatment.
- Complete an incident report immediately.
- Stay in touch with your supervisor and human resources.
- Return the physician's initial treatment report to human resources.

If the provider recommends that you do not return to work immediately because of a work-related illness or injury, you must keep human resources and your supervisor apprised of your condition. You are required to cooperate fully with the facility and the provider.

Care Planning
Core Competency Pre-Test Reading Material

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

The first step in care planning is to complete an accurate and comprehensive assessment. In the acute care setting, a thorough admission assessment should be followed by regular reassessments as often as the patient/resident's status demands. In the long-term care setting, the MDS (Minimum Data Set) is the starting point for assessment. Home health utilizes the OASIS assessment. Other settings will have established protocols for initial assessments and ongoing reevaluation.

Once the initial assessment is complete, a problem list should be generated. This may be as simple as a list of medical diagnoses, or may involve working through the RAP (Resident Assessment Protocol) process associated with the MDS. The problem list may actually include patient/resident strengths as well as family/relationship problems which are affecting the person's overall well-being.

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

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

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

Complaints and Grievances
Core Competency Pre-Test Reading Material

What is a Complaint?

A Patient Complaint is any verbal expression of dissatisfaction by a patient/resident, patient representative or relative relating to patient care or the quality of services, or violation of hospital policies and procedures including but not limited to confidentiality of protected patient health information, which are resolved by staff present.

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

In other words if the CEO is walking in the hall and a patient raises a complaint and it is fixed on the spot it is a complaint and therefore is not necessarily a grievance.

What is a Grievance?

Patient Grievance is a written or verbal complaint (when the verbal complaint about patient/resident care is not resolved at the time of the complaint by staff present) by a patient, of the patient's representative, regarding the patient's care; abuse or neglect; issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoP); or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

Examples of Grievances:

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

A written complaint is always considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse and neglect, or the hospital's compliance with CoPs. An email or fax is considered "written".

If an identified patient writes or attaches a written complaint on the patient satisfaction survey and requests resolution, it is a grievance. If the patient has NOT requested resolution, this is not considered a grievance.

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

Whenever the patient or the patient's representative requests their complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital.

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

What Do I Do If Someone Complains?

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

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

Resolution:

1. Immediate attention must be given to situations that place the patient/resident or visitor in immediate danger.
2. Documentation of complaints, including the patient/resident's or visitor's name, the date and all other pertinent information such as how the concern or complaint was resolved, should be completed using the facility's chosen document.
3. If a complaint cannot be resolved at the point of contact or services within a reasonable time frame under the circumstances by staff present, the complaint is then considered a grievance and is referred to the Supervisor/Manager or Quality/Risk Manager.
4. All oral or written grievances are to be reviewed, investigated, and resolved within a reasonable period of time according to the nature of the grievance. For contacts in person and/or verbally, initial response should be within 72 hours. Written contacts should be initially responded to within seven (7) business days.
5. Complaints which have not been resolved at the point of contact will be investigated and resolved by designated staff members in most facilities. .
6. The grievant should be notified in writing of the outcome of the grievance, including the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.
7. A complaint or grievance is considered resolved when the patient/resident is satisfied with the actions taken on their behalf.

Approaches for Resolving Complaints or Grievances:

The following as well as any other additional effective approach for handling patient grievances may be used:
- Listening and then taking required action
- Face-to-face meetings with the patient/resident or visitor and/or their legally authorized representative
- Referral for a biomedical ethics consultation by any staff member, patient/resident, or patient family member or decision-maker
- Request for Case Management services
- Referral for financial counseling
- Request for housekeeping services, food and nutrition services
- Referral to security
- Referral to supervisor or manager

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

Compliance
Core Competency Pre-Test Reading Material

Why do we need compliance?
We have all seen examples of this in the news when a company or representatives of the company misrepresent the company's assets, what business the company may be in, as well as mishandling of clients' money or services provided to clients. Therefore, all healthcare providers that are Medicare/Medicaid providers are required to have a formal Compliance Program. Medicare/Medicaid (CMS) believes that the establishment of an effective compliance program will protect the Medicare Trust Fund by significantly reducing the risk of unlawful or improper conduct, and will likely lead to other efficiencies. The CMS program is structured on a seven point plan. Each provider's plan must include:

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

How are individuals involved?
Individuals make the choice to stand against illegal and unethical situations by simply conducting themselves with respect and integrity.

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

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

What do I do when issues arise?
- Go to your supervisor
- Go to their supervisor
- Go to your HR director
- Go to the Director of Quality Services
- Go to your Administrator
- Call the Compliance Line

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

Remember: Silence never helps and in fact might make things worse. Your voice can make a difference.

Cultural Diversity
Core Competency Pre-Test Reading Material

What is Culture?

Most of us think of Culture as ethnicity. It is much more complex than that.

- Culture is values, beliefs, and practices held by a group.
- Culture is dynamic, changing, and complex.
- Culture helps members of a group come to understand how they think and act in certain situations understand relationships, and respond to experiences.

If we in healthcare are to be sensitive to various Cultures in our work place, we must first listen to learn about the nuances of another's Culture. The varieties of Cultures in our working environment enrich us. Our sensitivity to those Cultures will assist us in offering healing to our patients/residents and families.

Value

If a person's value is family, then it will be important to have the family as part of the comfort and/or care of that patient. If patient's cultural practice is to have the family present during the illness, then it will promote healing when the patient recognizes and adapts to various circumstances. If our patient cannot speak our language, it is a comfort to have someone present that can assist the patient in making his or her needs known.

Belief

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

Practice

If a patient's practice is to have all medical information told to a specific member of the family and not to the patient, what will happen if we do not do this? How have we cared for this patient by insisting on doing it our way and not abiding by the long held practice of the family and the culture?

We have a responsibility to get to know our patients and families well enough so that healing can take place in the presence and congruence of their culture. It is easier to learn about our patient's cultural values, beliefs, and practice, than to undo the mistakes made from ignorance or assumptions. We need to take the time to listen, observe and care enough to identify our patients' cultural diversity.

Environment of Care Core Competency Pre-Test Reading Material

General Safety

Each Healthcare facility has a Safety Officer who oversees the Environment of Care (medical equipment, security, disaster preparedness, utilities, general safety, life safety, patient/resident safety, hazardous materials and waste) and who has authority to take action should there be a safety hazard found that threatens life or property. However, safety is the responsibility of every employee. By being aware of safety issues and risks, we can eliminate most injuries and create a work environment that promotes success for patients/residents and staff.

The Safety Committee of a facility is made up of employees from various departments. The function of the committee is to review incidents, conduct safety surveys and to adopt and monitor a hospital-wide safety program. The Safety Committee also plans disaster drills, reviews fire drills and conducts employee safety in-services.

The Safety Manual should be available at the Nurses' Station at all times.

General Safety Rules
- Report or correct any unsafe condition you see. Fix it if you can or tell your supervisor. Do not assume that someone else will fix it.
- Report defective and broken equipment and remove it from use immediately. Affix a note on the equipment explaining why it is defective.
- If you see foreign matter on the floor, mop or pick it up. Use spill kits for mercury, blood or ―other potentially infectious matter.‖ Use tongs, dust pans or other devices to pick up broken glass.
- Report ALL injuries no matter how slight.
- Walk -don't run, in hallways and on stairs.
- Keep the corridors clear by keeping equipment, carts or other items on one side of the corridor.
- Open swinging doors slowly.
- Avoid horseplay and practical jokes. Injuries are not a laughing matter.
- Know the location of exits and safety equipment.
- Know what you are supposed to do in an emergency.
- Review with your supervisor the specific safety policies for your department.
- Do not reach into waste receptacles with your hands to retrieve garbage or other items.
- Make sure that all equipment is safety checked prior to being put on a patient/resident. Look for the biomedical sticker!

Security
- Always wear your name badge to identify yourself to patients/residents and visitors.
- Store your valuables and purse in your locker during working hours. Do not leave your valuables unattended unless it is in a secure area.
- If you are issued a key by your supervisor, do not lend it to anyone and do not have copies made. Immediately report any key that is lost.
- Firearms are not allowed on the premises. Do not attempt to take a gun from an individual.
- If you are harassed or witness a threatening situation to any patient/resident or employee, call Security immediately.
- Report all incidents (accidents, theft, injury, property damage, etc.) to your supervisor.

- A safe is normally available for patient/resident valuables. However, encourage them to take their valuables home with a family member.

- Fill out an incident report if items are lost or stolen so that a timely investigation can occur.

Electrical Safety

Electrical equipment is essential to the operation of a hospital. Even more essential to the safety of patients/residents is that we use the equipment correctly.

- Frequently check power cords for fraying.

- Pull the plug, not the cord, when removing the plug from a wall outlet.

- If a patient/resident is injured by a piece of electrical equipment, report the incident immediately.

- Anytime a patient/resident is injured by a defective medical device, a report must be made to the FDA, under the Safe Medical Devices Act, detailing the cause and nature of the injury. Immediately notify your supervisor and the biomed department if this occurs.

- Make sure that equipment is safety checked before it is placed on a patient/resident. Biomed will place a sticker with the date of inspection on the equipment alerting that it is safe to use the equipment. As you use equipment, look for this sticker and notify your supervisor if it is not on the equipment. This applies to rental equipment as well.

- Look for the annual safety check performed by the bio-med technician. All patient care equipment is tested at least annually.

- Remove from service and sticker as defective, any equipment that has been dropped, had liquid spilled on it, appears to be overheating or has been physically abused.

- Report to your supervisor any equipment that has knobs that are loose or do not turn smoothly.

- Do a visual check for frayed wires and other obvious defects before the equipment is placed on the patient/resident. Never use —cheaters‖ (the 3 to 2 prong adapters that allow you to plug things into two prong outlets).

- Extension cords may not be used in patient/resident care areas. For use in other areas, the cord must be approved by maintenance.

- Do not stretch cords across walkways.

- Do not operate electrical equipment when there is water nearby.

Utilities Management

Emergency power is provided through diesel powered generators which automatically come on in the event of a disruption of purchased power. This generator will provide power to lighting, alarm systems, red plug electrical outlets, medical air, nurse call and telephone systems. Flashlights and battery powered lanterns should be available for use during power failure. All cardiac monitors, ventilators, BiPAP machines, and other equipment vital to patient/resident survival must be plugged into a red plug.

Fire Safety

Fire Prevention

- Flame retardant materials and construction.
    - Only flame retardant furnishings, carpeting and drapery are allowed in the building. This ensures that smoke and flame spread will be kept to a minimum.
- Fire hazard inspections are performed monthly.
    - Safety surveys are performed by members of the safety committee to discover any fire hazards or malfunctioning fire doors.
- Fire drills are conducted according to the facilities policy with a report and a critique.
    - Make sure you participate in the drill and know your responsibility.
- Fire extinguishers are checked according to the facility policy.

    - Fire extinguishers are checked to ensure they are located where they are supposed to be, that they are properly pressurized and functioning properly.

Fire Partitions

Certain types of doors are rated to resist fire or to keep smoke from migrating from one area to another. These doors are held open by magnetic switches and close when fire or smoke is detected. Do not block these doors or keep them from closing. This creates a —compartment‖ or "zone‖ to increase safety in a fire. Other doors that do not close on their own, such as office or patient/resident room doors must be closed manually during a fire. That is your responsibility!

Doorstops are NEVER to be used in the hospital.   They decrease the effectiveness of the safety plan.

Fire Alarm Response

Any time you hear a Code called, you should assume that it is a real fire and not a drill. It is safe to go back to your work station only after the Code has been cleared. The code is usually cleared by an announcement over the loud speaker, such as — "Code all clear".

Most healthcare facilities use — "RACE" response to fire:

R – Rescue
A – Alarm
C – Confine or Contain
E – Extinguish

If the alarms have been silenced, but there is an actual fire or dangerous situation, you can restart the alarm (horn and strobes) by pulling a manual pull station.

If rescue is needed, be sure you know the compartments and what horizontal areas to which you can move patients/residents. Locate the fire doors that create these compartments. You do not need to evacuate patients outside the building. You simply need to move patients to another compartment on the floor that is separated by the closed fire doors.

Remember, smoke can kill or injure just as easily as flame. That is why it is so important to keep smoke contained!

Fire pull boxes are located at various areas. Please become familiar with the locations of these pull boxes. Pull these alarms if you are aware of a fire and there is not yet an alarm.

Confine fires by closing doors and windows. Close all patient/resident and office doors. Use wet towels at the bottom of doors to keep smoke out.

Extinguishers

Know all locations of fire extinguishers. If a fire extinguisher is used or missing, inform the Supervisor, Plant Operations and/or Safety Officer.

Types of Extinguishers

A – For wood, paper or anything that leaves ashes.
B – For grease, oil or anything that boils.
C – For electrical fires or anything that carries a current.

Most all healthcare facilities have the extinguishers that are multi-use ABC extinguishers.

Use of the Extinguishers

Use the — "PASS" method of remembering how to use a fire extinguisher.

P – Pull the pin.
A – Aim the nozzle.
S – Squeeze the handle.
S – Sweep the base.

In the event a fire extinguisher is used and discharged, it must be immediately removed from service and replaced with a spare of the same type extinguisher. The used extinguisher will be refilled by a licensed fire extinguisher supplier and then returned to service.

Exit Routes and Paths

- In case of fire, do not use the elevators. Always keep corridors clear to enable egress during a fire. Remember; evacuate patients/residents if necessary to the next fire compartment (the other side of the fire doors in the main corridor).
- You will find exit route maps by the elevators and along each hallway. Make sure you know where your exits are located!
- Become familiar with the exit nearest your work area at the beginning of your shift!

General Fire Prevention

- Smoking is permitted only in designated areas.
- Flammable liquids should be ordered only in small quantities and stored in a fireproof cabinet.
- Dispose of trash and rubbish promptly.
- Ensure that a —No Smoking, Oxygen in Use‖ sign is posted wherever oxygen is used or stored.
- Make sure Oxygen cylinders are stored properly in holders or carts specifically designed for cylinders.
- Participate in fire drills when they occur on your shift.
- Know your role in a fire by being familiar with your department's procedure during a fire.
- Make it a habit to watch for fire hazards.

- Be alert for signs of fire and a smoke-like smell. Report any suspicions immediately.

- Do not allow patients/residents or other employees to bring in any items that are an obvious fire hazard.

Disaster Codes and Emergency Preparedness Types of Disasters

- Severe Weather / Tornado
- Fire
- Flooding
- Droughts
- Terrorism Attack
- Hazardous Materials – Spill or Leak
- Radioactive
- Mass Casualties

General Information

During a disaster or emergency situation, you should:

- Remain calm

- Watch for emotional shock, disorganized behavior

- Provide prompt attention and personal reassurance to victims

- Provide psychological first aid, as it is essential in dealing with victims

- Establish treatment priorities

- Recognize panic in victims and act accordingly

KNOW THE CODE! REMEMBER EACH HEALTHCARE FACILITY HAS THEIR OWN ACCRONYMS FOR CODE SITUATIONS. YOU SHOULD BE ORIENTED TO THOSE AT EACH FACILITY. THESE ARE GENERAL GUIDELINES OF WHAT TO DO DURING THESE SITUATIONS.

Chemicals in the Workplace

You might be exposed to a variety of chemicals, some of them dangerous, in the course of your work. OSHA has established guidelines for working with chemicals. OSHA requires that all workplaces handling chemicals have a written plan for their safe handling.

Manufacturers must print the hazards of chemicals and their safe handling on the product label. More detailed information is found on the Material Safety Data Sheet (MSDS).

Hazardous substances are classified into several groups:
- Chemical Disinfectants (e.g., isopropyl alcohol, bleach, iodine, glutaraldehyde)
- Solvents (used to dissolve another substance, e.g. paint thinner, acetone)
- Laboratory Chemicals, e.g. hydrochloric acid, sodium hydroxide)
- Freon (in refrigeration and AC units, also in lab and sterilization procedures)
- Mercury (in glass thermometers and sphygmomanometers)

If you work with or near any of these substances, you need to know how to protect yourself from harm and what to do in case of exposure. The MSDS contains a lot of useful information regarding these issues. Pay particular attention to Section III – Physical Hazards, Section IV – Health Hazards, Section VII-Precautions for Safe Handling, and Section VIII – Control Measures. There is also a section on First Aid. It describes important First Aid treatment steps that could prevent serious or permanent injury.

Other points to remember:

- Chemical spills require special handling and disposal. Chemical Containment Kits are to be used for blood, body fluids, chemo, and chemicals. They are to be disposed of in biohazard waste containers. You must use the proper techniques for your safety and everyone else's.
- The label provides basic information you need to recognize hazardous materials. Every hazardous material has an MSDS.
- MSDS for hazardous materials used in your work area are kept in your work area. You are expected to be able to locate the MSDS in your work area.

Safe Medical Devices Act

- In compliance with the Safe Medical Devices Act, healthcare facilities report to the FDA and/or the manufacturer any device-related incident that has caused or contributed to the death or serious illness or injury to a patient/resident within the facility. This law is one of the FDA's methods of obtaining information on device problems.
- Deaths must be reported directly to the FDA and the manufacturer, if known. Serious injuries must be reported directly to the manufacturer.
- A simplified definition of a device is an item used for diagnosis, treatment or prevention of disease, injury or other condition that is not a drug, biologic or food.
- Any person who uses, discovers, witnesses or is notified of a medical device incident that caused a death, serious illness or injury to a patient should notify the supervisor or charge nurse.
- The device should be removed from service and taken to Biomedical for evaluation. The packaging information should be sent with the device if available. An incident report must also be completed and sent to the Risk Management Department.

Bomb Threats

What should you do if you received a telephone bomb threat? First and foremost, remember do not panic. Second, you want to keep the caller on the phone as long as possible and obtain as much information as you can. Note the time of the call and when the caller hangs up. NEVER hang up first. Try to find out the exact time the bomb is set to go off and the location of the bomb. Think about a description of the caller (voice, age, sex, manner, accent). Did you hear any background noise such as music or a train? Was the phone connection clear or was static present? Jot down your observations while talking.

Infant Abduction

Infant abduction is a growing concern in hospitals. Between 1983-1997, 171 infants (birth to age 6 months) were abducted in the U.S. Seventeen of the abductions took place in locations such as malls, offices, and parking lots; 57 took place in the home; and 97 took place in hospitals. Of the 97 hospital abductions, 55 infants were taken from their mother's rooms, 14 from the nursery, 16 from pediatrics, and 12 from the hospital grounds. At present, 5 of the 97 victims taken from hospitals are still missing.

Who is the Offender.

As a rule, individuals who abduct infants from hospitals are non-family members having the following physical appearance and traits:

- Female of "childbearing" age (12-50), overweight
- Compulsive, relies on manipulation, lying, and deception
- Married or living with a significant other
- Indicates that she has lost a baby or is incapable of having one
- Impersonates a nurse or other healthcare personnel, such as lab technicians; social workers; Women, Infant, and Children (WIC) Program staffers; photographers; etc. to gain access to the infants
- Becomes familiar with healthcare personnel and even with her victim's parents
- Initially visits the nursery and maternity units at more than one hospital before the abduction
- Asks staff detailed questions about procedures and the layout of the maternity unit
- Uses a fire exit stairwell as her escape
- Plans the abduction, but does not necessarily target a specific infant, relies on opportunity
- Demonstrates ability to provide good care to the baby once the abduction occurs
- Lives in the community where the abduction took place
- Has no prior criminal record

Since every offender will not fit this profile, staff should always watch out for and report other unusual behaviors, such as:

- Visiting repeatedly to see or hold the infants
- Asking detailed questions about procedures and the building layout, taking hospital uniforms or other means of hospital identification
- Leaving the hospital on foot with an infant instead of in a wheelchair
- Removing large packages from the maternity ward, particularly if cradling or talking to it
- Transporting an infant in arms instead of in a bassinet

Physical Security Assessment and Use

Physical security safeguards for abduction prevention include:

- Security camera system
- Nursery and staff lounge/locker room doors equipped with self-closing, locking hardware
- Alarms with time-delay locks installed on stairwell and exit doors
- Electronic-asset-surveillance (EAS) detection systems

Establishing Work Practices for Safeguarding Infants and Children

Important work practices for safeguarding infants and children from abduction include:

- Attaching matching identification bands to the infant, mother, and father or the mother's significant other (unused bands should be accounted for)
- Taking footprints, color photographs, and a full physical assessment of the infant within 2 hours after birth or admission and entering the information in the infant's medical records
- Using distinctive photo identification badges and uniforms in maternity, nursery, neonatal intensive care units and pediatric wards
- Keeping infants in direct, line-of-site supervision at all times by a authorized staff member, the mother, or other family member designated by the mother
- Transporting infants by authorized staff in a bassinet only
- Verifying that the persons leaving the hospital with an infant are wearing matching identification bands
- Reporting persons exhibiting behaviors of a potential abductor
- Alerting other hospitals in the area of attempted abductions and of suspicious persons
- Requiring parents to supervise their children at all times when in waiting rooms and outpatient clinics
- Establishing an access control policy for maternity, nursery, neonatal intensive care units and pediatric wards
- Keeping the mother's and infant's full names, address, and telephone number confidential

Incident Response and Reporting

Incident response plans should include procedures for:

- Using a code word, such as Code Pink or Code Stork to alert hospital personnel
- Notifying security/law enforcement
- Securing the facility
- Searching the unit
- Protecting the crime scene
- Notifying other local healthcare facilities
- Holding the shift in the event the incident occurs during shift changes
- Dealing with the media
- Caring for the parents
- Caring for workers suffering from post-traumatic stress disorder

Remember you are responsible for the environment of care to protect your patient/clients and yourself. Always be alert for safety problems and intervene as needed.

The following are some of the key OSHA standards and hazards that apply to health care:

Hazard Communication Standard

This standard is designed to ensure that employers and employees know about hazardous chemicals in the workplace and how to protect themselves. In order to ensure chemical safety in the workplace, information must be available about the identities and hazards of the chemicals.

- Chemical manufacturers and importers are required to evaluate the hazards of the chemicals they produce or import and are required prepare labels and material safety data sheets (MSDSs) to convey the hazard information to consumers.

- All employers with hazardous chemicals in their workplaces must have labels and MSDSs for their exposed workers, and train them to handle the chemicals appropriately.

Bloodborne Pathogens Standard

OSHA issued this standard to protect employees from the health hazards of exposure to bloodborne pathogens.

- Bloodborne pathogens are infectious materials in blood that can cause disease in humans, including hepatitis B and C and human immunodeficiency virus, or HIV.

- An exposure control plan is a written plan to eliminate or minimize employee exposures. Employers must update the plan annually to reflect changes that will help eliminate or reduce exposure to bloodborne pathogens.

- Use devices that isolate or remove the bloodborne pathogen hazard from the workplace. These include sharps disposal containers, self-sheathing needles, and safer medical devices such as needleless systems.

- Enforce practices that reduce the likelihood of exposure by changing the way a task is performed. They include appropriate procedures for hand washing, sharps disposing, lab specimen packaging, laundry handling, and contaminated material cleaning.

- Provide personal protective equipment such as gloves, gowns, and masks. Employers must clean, repair, and replace this equipment as needed.

- Make available Hepatitis B vaccinations to all employees with occupational exposure to blood borne pathogens within 10 days of assignment.

- Provide post-exposure follow up to any worker who experiences an exposure incident, at no cost to the worker.

- Use labels and signs to communicate hazards. The standard requires warning labels affixed to containers of regulated waste, refrigerators and freezers, and other containers used to store or transplant blood or other potentially infectious materials. Facilities may use red bags or containers instead of labels. Employers also must post signs to identify restricted areas.

- Employers must ensure that their workers receive regular training that covers the dangers of bloodborne pathogens, preventive practices, and post-exposure procedures. Employers must offer this training on initial assignment, then at least annually.

- Maintain employee medical and training records.

Ionizing Radiation Standard

This standard applies to facilities that have an x-ray machine.

- Employers should conduct a survey of the types of radiation used in the facility

- Designate restricted areas to limit employee exposure

- Require employees working in designated areas to wear personal radiation monitors

- Radiation areas and equipment must be labeled and equipped with caution signs

Exit Routes Standards

All employers must comply with OSHA's requirements for exit routes in the workplace.

- Knowing the answers to these questions could keep you safe during an emergency.

  o How would you escape from your workplace in an emergency?

  o Do you know where all the exits are in case your first choice is too crowded?

  o Are you sure the doors will be unlocked and that the exit access behind them will not be blocked during a fire, explosion, or other crisis?

  o Keep exit routes free of explosives or highly flammable furnishings and other decorations.

  o Ensure that exit routes are free and unobstructed by materials, equipment, locked doors, or dead-end corridors.

  o Provide lighting for exit routes adequate for employees with normal vision.

  o Keep exit route doors free of decorations or signs that obscure their visibility of exit route doors.

  o Post signs along the exit access indicating the direction of travel to the nearest exit and exit discharge if that direction is not immediately apparent.

  o Mark doors or passages along an exit access that could be mistaken for an exit "Not an Exit" or with a sign identifying its use (such as "Closet").

  o Maintain exit routes during construction, repairs, or alterations.

Electrical Standards

Electrical hazards, such as wiring deficiencies, are one of the hazards most frequently cited by OSHA. OSHA's electrical standards include design requirements for electrical systems and safety-related work practices. ▪ OSHA standards require that medical and electrical equipment is certified before use in the workplace to ensure it is safe.

- Policies, such as lock out tag out, for removal of non-working equipment are developed to ensure electrical safety.

Emergency Action Plan Standard

OSHA recommends that all employers have an Emergency Action Plan.

An Emergency Action Plan describes the actions employees should take to ensure their safety in an emergency situation.

A workplace emergency is an unforeseen situation that threatens employees, customers, or the public; disrupts or shuts down your operations; or causes physical or environmental damage. Emergencies may be natural or manmade and include the following:

- Floods

- Hurricanes

- Tornadoes

- Fires

- Toxic gas releases

- Chemical spills

- Radiological accidents

- Explosions

- Civil disturbances

- Workplace violence resulting in bodily harm and trauma

Emergency action plans must include the following:

- A preferred method for reporting fires and other emergencies

- An evacuation policy and procedure

- Emergency escape procedures and route assignments, such as floor plans, workplace maps, and safe or refuge areas

- Names, titles, departments, and telephone numbers of individuals both within and outside your company to contact for additional information or explanation of duties and responsibilities under the emergency plan;

- Procedures for employees who remain to perform or shut down critical plant operations, operate fire extinguishers, or perform other essential services that cannot be shut down for every emergency alarm before evacuating

- Rescue and medical duties for workers designated to perform them

Fire Safety Standard

OSHA recommends that all employers have a Fire Prevention Plan.

- Every workplace must have enough exits suitably located to enable everyone to get out of the facility quickly

- Fixed extinguishing systems throughout the workplace are among the most reliable fire fighting tools. These systems detect fires, sound an alarm, and send water to the fire and heat.

- Develop an emergency action plan that includes evacuation plans and employee education.

Medical and First Aid Standard

OSHA requires employers to provide medical and first-aid personnel and supplies commensurate with the hazards of the workplace.

- The details of a workplace medical and first-aid program are dependent on the circumstances of each workplace and employer.

Personal Protective Equipment (PPE)

Employers must perform an assessment of each operation in their workplace to determine if their employees are required to wear PPE.

- Personal protective equipment, or PPE, is designed to protect employees from serious workplace injuries or illnesses resulting from contact with chemical, radiological, physical, electrical, mechanical, or other workplace hazards.

- PPE includes a variety of devices and garments such as:

  o face shields

  o safety glasses

  o hard hats

  o safety shoes

  o goggles

  o coveralls

  o gloves

  o vests

  o earplugs

  o respirators

Ergonomic hazards

Some of the major ergonomic stressors at health care facilities include lifting and repositioning patients and lifting materials.

- OSHA recommends that manual lifting of residents be minimized in all cases and eliminated when feasible.

- Employers should implement an effective ergonomics process that: provides management support; involves employees; identifies problems; implements solutions; addresses reports of injuries; provides training; and evaluates ergonomics efforts.

Workplace violence Health care workers face a significant risk of job-related violence. OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults.

- Workplace violence is violence or the threat of violence against workers. It can occur at or outside the workplace and can range from threats and verbal abuse to physical assaults and homicide, one of the leading causes of job-related deaths.

- Nothing can guarantee that an employee will not become a victim of workplace violence. These steps, however, can help reduce the odds:

  o Learn how to recognize, avoid, or diffuse potentially violent situations by attending personal safety training programs.

  o Alert supervisors to any concerns about safety or security and report all incidents immediately in writing.

  o Avoid traveling alone into unfamiliar locations or situations whenever possible.

  o Carry only minimal money and required identification into community settings.

Slips, Trips, and Falls

Slips, trips, and falls are among the leading causes of injuries in health care facilities.
- Identify all potential tripping and fall hazards before work starts.

- Look for fall hazards such as unprotected floor openings/edges, shafts, skylights, stairwells, and roof openings/edges.

- Practice good housekeeping. Keep cords and hoses out of walkways or adjacent work areas.

Influenza

- Healthcare workers are at high risk for contracting influenza

- Get the seasonal influenza vaccine.

- If you develop flu-like symptoms, stay at home except to get medical attention.

Ethics – Core Competency Pre-Test Reading Material

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

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

Autonomy is the right of each individual to take action for themselves. It includes respect for individuals and the right of individuals to make decisions for and about themselves, even if the health care providers do not agree with the decisions made. To respect autonomy is to respect others. It is important that the caregiver's value system not keep them from performing their job responsibilities.

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

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

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

Veracity refers to truth telling and incorporates the concept that individuals should always tell the truth. This principle also requires that the whole truth be told.

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 discrimination statutes.

Ethical behavior is doing what is right.   In healthcare doing what is right for the patient/client is of the utmost importance.

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Falls Prevention
Core Competency Pre-Test Reading Material

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

Definitions

- **Uncontrolled Fall** -Loss of upright position that results in landing on the floor, ground, or an object; or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground.
- **Controlled Fall** -A controlled, purposeful downward displacement of a patient's body from a standing, sitting, or lying position in order to prevent injury from an impending uncontrolled fall.
- **Fall with Injury** -While injury is often the result of a fall, injuries do not have equal impact on the patient/resident's condition or course of treatment.

Risk Factors

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

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

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

Fall Prevention Interventions

Interventions to prevent falls should be implemented on the patient's Plan of Care.

Fall prevention programs emphasize bedrail reduction. Bedrails contribute to patient fall risk by creating barriers to patient/resident transfer in and out of beds. Use of bedrails must be assessed specific to individual patient needs. When possible, use alternative pillows and positioning devices to avoid the use of bedrails.

Hourly rounds have shown to reduce the incidents of falls in facilities.

Post Fall Management

After a patient/resident falls:

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

Fall Risk Medications – Medications that may increase a patient's risk for fall are:

CATEGORY		
1. Antihistamines	Diphenhydramine, Promethazine	Sleepiness, Blurred Vision,
2. Cathartics Laxative	Bisacodyl, Fleet Enema	Increased urgency to get to the rest room
3. Diuretics	Furosemide, Bumetanide, Indapamide	Increased urgency to get to the rest room
4. Narcotics	Morphine, Meperidine, Codeine	Low blood pressure, Dizziness, Drowsiness
5. Psychotropic Drugs	Haloperidol, Risperidone, Quetiapine	Dizziness, Drowsiness
6. Benzodiazepines	Diazepam (Valium), Chlordiazepoxide	Drowsiness, Lightheadedness
7. Hypnotics	Temazepam, Zolpidem, Chloral Hydrate	Drowsiness, Lightheadedness, Confusion, Delirium
8. Antidepressants	Amitriptyline, Trazodone, Sertraline	Drowsiness, Blurred Vision
9. Hypotensives	Beta-blocker, Clonidine, Ca Blocker	Low blood pressure, Dizziness
10. Muscle relaxant	Carisoprodol, Cyclobenzaprine, Diazepam, Dantrolene	Drowsiness, Dizziness, Weakness

Overview

In 1996, Congress enacted the Health Insurance Portability and Accountability Act, also known as HIPAA. The primary purposes' of HIPAA is:

- To protect people from losing their health insurance if they change jobs or have pre-existing health conditions
- To reduce the costs and administrative burdens of healthcare by creating standard electronic formats for many administrative transactions that are currently carried out on paper
- To develop standards and requirements to protect the privacy and security of confidential healthcare information.

    Recently, the Department of Health and Human Services issued new regulations referred to as the Privacy Rule and Security Rule. The regulations require healthcare organizations to adopt processes and procedures to ensure the highest degree of patient confidentiality. These processes include administrative, physical and technical safeguards to ensure that medical information is stored, transmitted and received in a safe and secure manner. As you can imagine, the HIPAA regulations impact virtually every department of every entity that has access to confidential health information. Hospitals, medical practices, insurance companies, medical-device manufacturers and other healthcare organizations have undergone major changes in the way they handle patient information.

    The Privacy and Security Rules provide stiff penalties for those who fail to comply with the requirements or who improperly disclose or misuse protected health information (PHI). It is important that all who may come into contact with PHI understand and carry out their responsibilities under the Rules.

Covered Entities

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

- Healthcare plans

- Healthcare providers

- Healthcare clearinghouses

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

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

When covered entities use or transmit protected health information in any form, they must comply not only with the Privacy and Security Rules, but also with any state laws regarding privacy of medical records. In the event of a conflict between HIPAA and state law, HIPAA *preempts* state law unless the state law is more strict. (In other words, whichever provides greater protection to patients must be followed.)

Covered Transactions

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

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

The Rules also require covered entities to use special coding standards for all transactions involving electronic data interchange (EDI), including the use of "unique identifiers" for providers, health plans, employers and patients. These new coding standards are still being developed and refined by the Department of Health and Human Services.

Protected Health Information

The Privacy and Security Rules protect individually identifiable health information transmitted or maintained by a covered entity, no matter what form it takes.   That means that when a doctor takes notes in a medical chart, when a hospital data-entry clerk types health insurance information into a computer, or when healthcare providers discuss a patient's condition, any identifiable health information becomes protected health information (PHI) under HIPAA.

Education and Employment records are not considered PHI.

Notice of Privacy Practices

The Privacy Rule requires a covered entity to:

- Provide patients with a Notice of Privacy Practices (NPP)
- Make a good-faith effort to obtain a patient's written acknowledgment of receiving the NPP

The NPP must inform patients of:

- the uses and disclosures of PHI that the entity may make
- the patient's right to access and amend their medical information
- the covered entity's responsibilities with respect to PHI

Once it has obtained the acknowledgment or has made a good-faith effort to do so, the entity may:

- Use PHI for its own treatment, payment or healthcare operations
- Disclose PHI to other covered entities for their treatment, payment or certain limited healthcare operations.

When using or disclosing PHI or when requesting PHI from another covered entity, a covered entity must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure.

Other Uses of PHI

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

Marketing

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

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

Incidental Disclosures

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

Administrative Safeguards

Since many of us receive, store and transmit PHI as part of our day-to-day responsibilities, The Privacy Rule requires the following administrative safeguards to ensure that PHI is not compromised:

- Designating a Privacy Officer to be responsible for the development and implementation of privacy policies
- Providing physical safeguards to protect computer systems and related equipment from fire, other environmental hazards and intrusion
- Using technical safeguards like encryption software to transmit health information over the Internet Requiring business associates (lawyers, consultants, auditors, billing companies, pharmacists, etc.) to confirm that they will protect PHI
- Developing a system to track who accessed what information
- Implementing rules for addressing violations of privacy, security and transaction regulations, including establishing a process for making complaints and preventing retaliation against anyone who reports a HIPAA violation
- HIPAA also requires those with access to PHI to undergo periodic training on these and other appropriate privacy procedures, and to keep documented proof that these trainings have been given

The Security Rule also requires that administrative, physical and technical safeguards are in place to prevent the improper use or disclosure of PHI. The required administrative safeguards are as follows:

- Certification Review
  - A technical evaluation to ensure that the computer environment is secure from intrusion
- Chain of Trust Agreements
  - Agreements with external recipients of PHI confirming that they will protect the confidentiality of data exchanged
- Contingency Plan
  - A plan for responding to system emergencies, including the performance of backups, emergency-mode operations, and disaster-recovery procedures.
- Policies & Procedures
  - Policies and procedures for the proper use of healthcare information
- Access Controls
  - A plan for granting different levels of access to healthcare information, including policies that determine each individual's right to access the information Internal
- Audit Procedures
  - An in-house review of system activity records (such as log-ins, file accesses, and security incidents)
- Personnel Security
  - Security checks and special training for all employees with access to sensitive information regarding the proper use and handling of PHI, and documentation to verify that the training has occurred
- Security Configuration Management
  - Procedures for the security of our computer systems, such as virus checking and security testing
- Security Incident Procedures
  - Instructions for reporting security breaches
- Security Management Process
  - A process to ensure that we have the proper infrastructure in place to prevent and detect security breaches
- Termination Procedures
  - Procedures to prevent a terminated employee from having access to confidential information

HIPAA also requires those with access to PHI to undergo periodic training on these and other appropriate security procedures, and to keep documented proof that these trainings have been given.

Physical Safeguards

The Security Rule also requires a number of physical steps to ensure that PHI contained in computers is properly protected from fire and environmental hazards, as well as from intrusion. Physical safeguards include the following:

- **Security Management:** Assignment of responsibility for Security management
- **Media Controls:** A set of procedures that govern the receipt and removal of hardware and software (such as diskettes, tapes, and personal data assistants)
- **Physical Access Controls**: Procedures that deter intruders from accessing environments where sensitive information resides
- **Equipment Controls**: Security policies for bringing hardware and software into and out of offices, including policies on how to dispose of hardware and other storage media
- **Guidelines on Workstation Use**: Procedures describing the proper functions to be performed on computers, and how to handle sensitive information that may be displayed on computer screens.

Technical Safeguards

Finally, the Security Rule requires certain technical safeguards for PHI, including:

- **Access Controls**: Controls to ensure that access to sensitive information is available on a need-to know basis, based on roles and context
- **Audit Controls**: Controls to record and examine system activity, helping to eliminate unnecessary access to sensitive information
- **Authorization Controls**: Controls for obtaining consent for the use and disclosure of health information
- **Data Authentication**: Controls to help ensure that health data has not been altered in an unauthorized manner.

Sending PHI via E-mail and Fax

According to the Security Rule, it is permissible to use the Internet to transmit PHI, as long as (1) an acceptable method of encryption is used to protect confidentiality, and (2) appropriate authentication procedures are followed to ensure correct identification of the sender and receiver. Although faxes are transmitted over telephone lines, they are not considered to be "covered transactions," so they may be sent without additional security precautions.

Compliance and Enforcement

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

- Civil monetary penalties for each individual failure to comply with HIPAA provisions include a fine of $100 for each violation with a cap of $25,000 per year for multiple violations of the same provision
- Criminal penalties for a basic offense include fines of up to $50,000 and/or imprisonment for up to one year
- Criminal penalties for an offense committed under false pretenses include fines of up to $100,000 and/or imprisonment of up to five years
- Criminal penalties for an offense committed with the intent to use PHI for one's commercial advantage include fines of up to $250,000 and/or imprisonment of up to ten years
- If you suspect noncompliance or violation of HIPAA report it immediately to your supervisor or the facility Privacy Officer.   You can also report to the Office for Civil Rights.

Infection Control
Core Competency Pre-Test Reading Material

How do infections spread?

All six links in the chain must be present:

- A microorganism.
- A person who carries the microorganism. A way out of the carrier.
- A method of travel.
- A way into another person.
- A susceptible person who doesn't have resistance.

INFECTION CONTROL PROCEDURES ATTEMPT TO BREAK THE INFECTION CHAIN BY REMOVING ONE OF THE LINKS.

Breaking the Links:

- Medication can break a link in this chain by killing the pathogen.
- Workplace practices can help break the chain at other links.
- Good hand hygiene is the single most effective way to reduce the spread of infection in the hospital.
- Handle biological waste correctly. Blood and other body fluids are potentially infectious materials. It is important that you follow hospital policy in disposing of bio-hazardous waste. Use red biohazard bags. Never place an article contaminated with blood or body substances in the regular trash!

Hand Hygiene

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

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

Always decontaminate hands:

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

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

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

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

Sharps containers are located in patient/resident rooms, in the anterooms and on the medication carts. Place sharps in the containers immediately. If a sharps container is 1/2 to 2/3 full, request that Environmental Services change the container and use another container. Never attempt to "stuff" items into the sharps container.

Personal Protective Equipment (PPE)

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

Tuberculosis

In the US, there are four states that report more than 100 cases of TB per year: California, Texas, Florida and New York.

Why is TB a problem?

We are now faced with multi-drug resistant TB. Since the advent in the 1940's of anti-tubercular medication, we are for the first time ever facing incurable TB.

How does multi-drug resistant TB (MDRTB) start?

Well, nearly everyone has known someone who has done this: you have a bladder infection and take the antibiotics for a few days, feel better and decide to save the rest for next time. This is the problem, the bacteria is not completely killed and have had time to build up resistance to the antibiotic. The treatment for TB can last from three months to a year. So it's not surprising that many individuals will stop taking the medication.

How is TB transmitted?

It is spread when a person with active TB expels the droplets in the air when they cough, sneeze, sing, or speak. If another person inhales these droplet nuclei they may also become infected.

Who is at risk for developing tuberculosis?

Persons at risk for TB include anyone who has had contact with a person with infectious TB. Some people are considered to be at high risk for TB. These groups include foreign born persons from areas with a high prevalence of TB, residents and employees of long-term care institutional settings and medically under-served populations, including the poor, the homeless, those with HIV infection), diabetes, end stage renal disease, the very old and neonates.

Prevention of Tuberculosis in the workplace:

The main purpose of preventative therapy is to prevent latent infection from progressing to active disease. One way to manage this is to have in place a TB Control Plan. The plan outlines TB skin testing (PPD), TB Isolation and other precautions to take in the hospital setting. You should be tested for TB anytime you suspect an exposure and as defined by your healthcare facility.

Treatment of TB:

Tuberculosis IS curable if it is diagnosed early and if effective treatment is instituted without delay. Because of the increase in resistance to TB, all persons with TB should be treated with a four drug regime given daily and lasting for up to six months.

Diagnosis of TB:

The combination of history and symptoms along with AFB sputum smears and a chest x-ray diagnose TB. The definitive diagnosis is the culture, which takes 4-6 weeks to actually grow. Consequently, treatment is begun, and reevaluated when the culture is complete. TB isolation may be discontinued once the patient has had three consecutive negative AFB morning sputum smears. The patient will need to continue treatment, but is no longer infectious.

Blood Borne Pathogens
What are blood borne pathogens?

Blood borne pathogens are viruses, bacteria and other microorganisms that are carried in a person's bloodstream and body fluids that cause disease. HIV and Hepatitis B are blood borne pathogens.

HIV/AIDS
Facts you should know:
- At least every 13 minutes another American is infected with HIV.
- Every 17 minutes someone dies of AIDS.
- AIDS is now the third leading cause of death among all adults between the ages of 25 and 44.
- The fastest growing population of newly diagnosed HIV positive cases is middle aged white, heterosexual females.
- Most US teenagers are practicing behaviors that increase their risk for HIV.

The modes of transmission:
- The highest risk of HIV infection comes from sharing needles.
- What is the risk for getting HIV after a needle stick, an injury with sharps, or a splash? The average risk from injuries involving HIV infected needles or sharps are 1 in 300 or 0.03%. The risk for infection from a bloody splash to mucus membranes or open skin is very low, less than 1 in 3,000.

Hepatitis B

Hepatitis B is transmitted through blood and body fluids.   About 18,000 health care workers are infected with HBV each year.

What are your risk factors for HBV?
- Injuries from sharps.
- Scratches and cuts on your skin.
- Splashes to your eyes.
- Bites or wounds.

How can you protect yourself against Hepatitis B?
- Vaccinations are typically offered through employee health. This is a series of three injections over a one year period. These provide immunization from HBV.
- Follow good standard (universal) precautions.
- Proper hand washing - proper hand washing remains the single most effective means of preventing the transmission of infection!!
- Practice good housekeeping – make sure you clean up any spills, keep your work area clean and, make sure you dispose of linens properly. Wash hands after touching soiled linen.
- Dispose of sharps properly – make sure all sharps are placed in a sharps container.   Empty when ¾ full.
- Dispose of waste properly – make sure any dressings or blood-soaked items are placed in the trash or hazardous waste can.

Hepatitis C
Hepatitis C virus (HCV) infection is the most common chronic blood borne infection in the United States. 1988 to 1994 data suggest that 3.9 million Americans have been infected with HCV.

Most of these persons are chronically infected and might not be aware of their infection because they are not clinically ill. Infected persons serve as a source of transmission to others and are at risk for chronic liver disease.

HCV is transmitted primarily through large or repeated direct percutaneous exposures to blood. In the United States, the two most common exposures associated with transmission of HCV are blood transfusion and injecting- drug use, however improved screening of blood donors has significantly decreased the risk for transfusion-transmitted to almost zero.

At this time there is no vaccine to protect against Hepatitis C. However, you can protect yourself by the same methods listed for Hepatitis B, as listed above items 2-6.

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

Contact: Isolation Precautions are based on the mode of transmission.

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

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

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

Multi-Drug Resistant Organism (MDRO)
A multi-drug resistant organism (MDRO) is any kind of bacteria that has become resistant to many different antibiotics. These bacteria can be found in your surroundings, such as a desktop or sink, or they can live on or in your body. These bacteria usually do not make you sick unless they get into your body, such as a wound, kidneys, bloodstream or lungs. Many antibiotics will not treat a MDRO infection.
MDROs are mainly spread through physical contact. They can spread from patient to patient on the hands of hospital staff or from items that are used on or by more than one person. Cultures of body fluids, such as urine, blood, sputum or fluid from a wound can tell us if patients have a multi-drug resistant organism.

Examples of MDROs are:

--Methicillin methicillin-resistant resistant *Staphylococcus staphylococcus aureus ureus* (MRSA)

- Vancomycin vancomycin-resistant resistant enterococci *enterococci* (VRE)

- Multidrug-resistant *Streptococcus streptococcus pneumoniae pneumoniae* (MDRSP)

- MDR Gram gram-negative negative bacilli (MDR acilli - GNB)

Resistance Increasing in:

Streptococcus pneumoniae	*Klebsiella pneumoniae*	*Pseudomonas aeruginosa*
Acinetobacter baumannii	*Escherichia coli*	*Burkholderia cepacia*
Ralstonia pickettii	*Stenotrophomonas maltophilia*	

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

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

Steps to Control Transmission

Improved hand hygiene

Active surveillance cultures in certain settings

Pre-emptive contact isolation on admission in acute care

Education Enhanced environmental cleaning

Improved communication between facilities

Infection Control is everyone's job. Wash your hands and if in doubt wash your hands.

Latex Allergy

Core Competency Pre-Test Reading Material

Equipment

Latex gloves have proved effective in preventing transmission of many infectious diseases to health care workers. But for some workers, exposures to latex may result in allergic reactions. Reports of such reactions have increased in recent years--especially among health care workers.

What is latex?

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

Products Containing Latex

A wide variety of products contain latex: medical supplies, personal protective equipment, and numerous household objects. Most people who encounter latex products only through their general use in society have no health problems from the use of these products. Workers who repeatedly use latex products are the focus of this Alert. The following are examples of products that may contain latex:

Emergency Equipment			
Blood pressure cuffs	Endotracheal tubes	Electrode pads	Rubber aprons
Stethascopes	Tourniquets	Gloves	Goggles
Disposable gloves	Intravenous tubing	Surgical masks	Respirators
Oral and nasal airways	Syringes	Personal Protective Equipment	

Office Supplies			
Rubber bands	Erasers		

Hospital Supplies			
Anesthesia masks	Wound drains	Rubber tops of vials	
Catheters	Injection ports	Dental dams	

Household Objects			
Automotive tires	Raquet handles	Hot water bottles	Swimming goggles
Diaphragms	Shoe soles	Condoms	Pacifiers
Carpeting		Balloons	Baby bottle nipples
Dishwashing gloves	Motercycle and bycle handgrips	Expandable fabric (wristbands)	

Individuals who already have latex allergy should be aware of latex-containing products that may trigger an allergic reaction. Some of the listed products are available in latex-free forms.

What is latex allergy?

Latex allergy is a reaction to certain proteins in latex rubber. The amount of latex exposure needed to produce sensitization or an allergic reaction is unknown. Increasing the exposure to latex proteins increases the risk of developing allergic symptoms. In sensitized persons, symptoms usually begin within minutes of exposure; but they can occur hours later and can be quite varied. Mild reactions to latex involve skin redness, rash, hives, or itching. More severe reactions may involve respiratory symptoms such as runny nose, sneezing, itchy eyes, scratchy throat, and asthma (difficult breathing, coughing spells, and wheezing). Rarely, shock may occur; however, a life-threatening reaction is seldom the first sign of latex allergy.

Who is at risk of developing latex allergy?

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

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

Latex Allergy

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

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

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

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

Is skin contact the only type of latex exposure?

No. 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.

How is latex allergy treated?

Detecting symptoms early, reducing exposure to latex, and obtaining medical advice are important to prevent long-term health effects. Once a worker becomes allergic to latex, special precautions are needed to prevent exposures.

Certain medications may reduce the allergy symptoms; but complete latex avoidance, though quite difficult, is the most effective approach.

Are there other types of reactions to latex besides latex allergy?

Yes. The most common reaction to latex products is irritant contact dermatitis-the development of dry, itchy, irritated areas on the skin, usually the hands. This reaction is caused by irritation from wearing gloves and by exposure to the powders added to them. Irritant contact dermatitis is not a true allergy. Allergic contact dermatitis (sometimes called chemical sensitivity dermatitis) results from the chemicals added to latex during harvesting, processing, or manufacturing. These chemicals can cause a skin rash similar to that of poison ivy. Neither irritant contact dermatitis nor chemical sensitivity dermatitis is a true allergy.

Three types of reactions can occur in persons using latex products:
- Irritant contact dermatitis
- Allergic contact dermatitis (delayed hypersensitivity) Latex allergy

Irritant Contact Dermatitis

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

Chemical Sensitivity Dermatitis

Allergic contact dermatitis (delayed hypersensitivity, also sometimes called chemical sensitivity dermatitis) results from exposure to chemicals added to latex during harvesting, processing, or manufacturing. These chemicals can cause skin reactions similar to those caused by poison ivy. As with poison ivy, the rash usually begins 24 to 48 hours after contact and may progress to oozing skin blisters or spread away from the area of skin touched by the latex.

Latex Allergy

Latex allergy (immediate hypersensitivity) can be a more serious reaction to latex than irritant contact dermatitis or allergic contact dermatitis. Certain proteins in latex may cause sensitization (positive blood or skin test, with or without symptoms). Although the amount of exposure needed to cause sensitization or symptoms is not known, exposures at even very low levels can trigger allergic reactions in some sensitized individuals. Reactions usually begin within minutes of exposure to latex, but they can occur hours later and can produce various symptoms. Mild reactions to latex involve skin redness, hives, or itching. More severe reactions may involve respiratory symptoms such as runny nose, sneezing, itchy eyes, scratchy throat, and asthma (difficult breathing, coughing spells, and wheezing). Rarely, shock may occur; but a life-threatening reaction is seldom the first sign of latex allergy. Such reactions are similar to those seen in some allergic persons after a bee sting.

How can I protect myself from latex allergy?

Take the following steps to protect yourself from latex exposure and allergy in the workplace:
1. Use non-latex gloves for activities that are not likely to involve contact with infectious materials (food preparation, routine housekeeping, general maintenance, etc.).
2. Appropriate barrier protection is necessary when handling infectious materials. If you choose latex gloves, use powder-free gloves with reduced protein content.
   - Such gloves reduce exposures to latex protein and thus reduce the risk of latex allergy.
   - So-called hypoallergenic latex gloves do not reduce the risk of latex allergy. However, they may reduce reactions to chemical additives in the latex (allergic contact dermatitis).
3. Use appropriate work practices to reduce the chance of reactions to latex.
   - When wearing latex gloves, do not use an oil-based hand creams or lotions (which can cause glove deterioration). After removing latex gloves, wash hands with a mild soap and dry thoroughly.
   - Practice good housekeeping: frequently clean areas and equipment contaminated with latex-containing dust.
4. Take advantage of all latex allergy education and training provided by your employer and become familiar with procedures for preventing latex allergy.
5. Learn to recognize the symptoms of latex allergy: skin rash; hives; flushing; itching; nasal, eye, or sinus symptoms; asthma; and (rarely) shock.

What if I think I have latex allergy?

If you develop symptoms of latex allergy, avoid direct contact with latex gloves and other latex-containing products until you can see a physician experienced in treating latex allergy.

If you have latex allergy, consult your physician regarding the following precautions:
- Avoid contact with latex gloves and products.
- Avoid areas where you might inhale the powder from latex gloves worn by other workers.
- Tell your employer and health care providers (physicians, nurses, dentists, etc.) that you have latex allergy.
- Wear a medical alert bracelet.

Workers with ongoing exposure to natural rubber latex should take the following steps to protect themselves:
1. Use non-latex gloves for activities that are not likely to involve contact with infectious materials (food preparation, routine housekeeping, maintenance, etc.).
2. Appropriate barrier protection is necessary when handling infectious materials. If you choose latex gloves, use powder-free gloves with reduced protein content.
3. When wearing latex gloves, do not use oil-based hand creams or lotions (which can cause glove deterioration) unless they have been shown to reduce latex-related problems and maintain glove barrier protection.
4. Frequently clean work areas contaminated with latex dust (upholstery, carpets, ventilation ducts, and plenums).
5. Frequently change the ventilation filters and vacuum bags used in latex-contaminated areas.
6. Learn to recognize the symptoms of latex allergy: skin rashes; hives; flushing; itching; nasal, eye, or sinus symptoms; asthma; and shock.
7. If you develop symptoms of latex allergy, avoid direct contact with latex gloves and products until you can see a physician experienced in treating latex allergy.
8. If you have latex allergy, consult your physician regarding the following precautions: Avoid contact with latex gloves and products. Avoid areas where you might inhale the powder from the latex gloves worn by others. Tell your employers, physicians, nurses, and dentists that you have latex allergy. Wear a medical alert bracelet.
9. Take advantage of all latex allergy education and training provided by your employer.

Property Legal Issues in Healthcare

Core Competency Pre-Test Reading Material

1. Legal Concepts and the Judicial Process

A) Definitions

    i) The word *law* is derived from the Anglo-Saxon tern *lagu*, meaning that which is fixed or laid down. Law is defined as —that which is laid down, ordained, or established; a body or rules of action or conduct prescribed by controlling authority and having binding legal force; and that which must be obeyed and followed by citizens subject to sanctions or legal consequences.

B) Sources of Law

    i) Constitution

        1) Constitutional law is a system of fundamental laws or principles for the governance of a nation, society, corporation, or other aggregate of individuals.

    ii) Statutes

        1) Statutory laws are those made by the legislative branch of the government. Statutory laws are designed to declare, command, or prohibit. Licensing laws are an example of statutory law.

    iii) Administrative Law

        1) Administrative laws are enacted by means of the decisions and rules of administrative agencies, which are specific governing bodies charged with implementing particular legislation. For example the state boards of nursing implement and enforce the state nurse practice act by writing rules and regulations for the enforcement of the statutory law and by conducting investigations and hearings to ensure the law's continual enforcement.

    iv) Common Law

        1) Common law is derived from principles rather than from rules and regulations. It is based on justice, reason, and common sense.

2. Sources Used in Legal Decision Making

A) Sources Used to Interpret the Law

    i) Standards of Care

        1) Standards of care maybe viewed as the level or degree of quality considered adequate by a profession.

        2) Standards of care are the skills and learning commonly possessed by members of a profession.

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

    ii) Practice Acts and Standards

        1) The practice acts and standards are an external standard of care. State boards publish acceptable standards in the practice act relevant to the discipline, or in rules and regulations promulgated to enforce the state practice act. These rules and regulations have the force of law because they are

met or violated based on the evidence presented.

    iii) Professional Position Statements

       1) Professional organizations add to the body of acceptable standards of care for professional nursing and other disciplinary care.

    iv) Policies

       2) This is an internal standard of care or the standard set forth by an individual institution as the minimal acceptable practice.

       3) In court cases, institutional policies and procedures are presented and evaluated to determine if a clinical defendant has met the standard of care for the institution.

    v) Requirements of Accreditation Bodies

       1) Federal organizations and federal guidelines are other examples of external standards. Their requirements for individualizing care set a standard of care.

          a) Joint Commission

          b) OSHA

          c) CDC

          d) Health Departments

          e) CMS

3. Liabilities

  A) Anatomy of a Lawsuit

    i) Steps in the Trial Process

       1) Initiation of the lawsuit

          a) The plaintiff, who believes he or she may have a valid cause of action against another person, initiates a lawsuit. This is done through a lawyer. The defendant may respond to the lawsuit.

          b) In most cases, it is rare to have a single plaintiff against a single defendant. More commonly there are multiple parties on either or both sides of the lawsuit. In medical malpractice suits a plaintiff sues multiple defendants such as physicians, the hospital's board of directors, and various members of the hospital staff. . If the plaintiff later discovers that a defendant has been named in error, the defendant can be removed from the case.

          c) Once the plaintiff's cause of action has been identified, a complaint is filed in the court. Once the complaint is filed the defendants are served with a summons to appear before the court at a specific time. Once served with a summons, the clinician should seek legal representation but is still re required to appear before the court.

       2) Pleadings and Pretrial Motions

          a) Pleadings are written documents setting forth the statements of fact as perceived by the opposing sides to the lawsuit. Pleadings give the bias of the legal claim to the court and prevent unfair surprise to either side.

          b) The defendant may also file a motion to dismiss, stating that there is no valid cause of action on

which the claim may be made. The judge can either uphold the motion or decline it. If it is declined the defendant must answer the complaint.

 c) The third alternative for the defendant is a counterclaim. A counterclaim states the cause of action that the defendant has against the plaintiff, such as failing to pay for a hospital bill on time or negligence on the part of the injured party (i.e., the plaintiff is alleging improper cast placement but they did not come for return appointments to check for proper cast placement).

 d) Motions can also be filed. These are requests to the court such as a speedy trial date because of the health of an individual or because of extenuating circumstances.

3) Discovery of Evidence

 e) During this step information about the case is sought.   The following are permitted:
  i) Witnesses to be questioned by the opposing side prior to the trial itself;

  ii) The uncovering of relevant written materials; and

  iii) Possible additional examinations by the plaintiff.

 f) Because of the nature of this step it may take up to two to three years to complete.

 g) Interrogatories are written questionnaires sent to a defendant to complete. The defendant's lawyer will word and return the interrogatory.

 h) A deposition is a sworn statement by a witness that is made outside of the court. This statement is admissible in the court at the trial. Depositions are taken of a witness, who is questioned by the opposing attorney. The purpose of the deposition is to assist opposing counsel in preparing for the court case by revealing potential testimony from witnesses before the actual trial.

 i) The final phase of this step is the pretrial conference or pretrial hearing. This is a fairly informal session during which the judge and attorneys agree on the issues to be decided and settle procedural matters.

4) Trial Process

 a) At the trial the evidence is presented, facts are determined by the jury, principles of law are applied to determined facts, and a solution is formally reached.

 b) The opening statement generally indicates for the jury what both sides intend to show by the evidence they will present.

 c) Witnesses are called one by one to answer specific questions. Witnesses are first questioned by the lawyer calling them then by the opposing side. This cross-examination is a period where the attorney tries to discredit or negate the witness's testimony.

 d) The jury then retires to deliberate and to reach a verdict or decision.

5) Appeals

 a) The losing side of the lawsuit may choose to appeal the decision of the jury. An appropriate appellate court then reviews the case based on the trial record, written summaries of the principles of the law applied, and short oral arguments by representing attorneys.

6) Executions of Judgment

a) After all appeals the plaintiff asks that the judgment as provided for by the court be executed. Nothing can return the plaintiff to their original pretrial status so the court attempts to compensate the plaintiff for their loss.

ii) Witnesses

    1) Expert Witnesses

        a) Expert witnesses explain highly specialized technology or skilled care to the jurors, who usually have little or no experience in medicine and healthcare. Expert testimony is admissible when conclusions by a jury depend on factual and scientific information that is more than common knowledge.

        b) The minimum credential for an expert witness is current licensure to practice. Other criteria for selection include the total lack of involvement with the defendants, whether as an employee or consultant, clinical expertise in the area at issue, certification in the clinical area if possible, and recent continuing or formal education relevant to the specialty at issue. If possible, the expert witness should also have earned graduate degrees and authored publications. Some attorneys will substitute a manager, educator, or preceptor for advanced degrees.

        c) Credentials that speak to the highest level of expertise and knowledge of the standards of care weigh favorably with judges and jurors.

    2) Lay Witnesses

        a) These witnesses testify facts at the trial, stating for the judge and jury exactly what transpired. They may not draw conclusions or form opinions; they define for the jury what happened. Both sides may have lay witnesses but these witnesses must have a direct connection with the case in controversy. Lay witnesses may be the patient, the patient's family, clinicians not named in the lawsuit, or other staff members.

B) Elements of Malpractice

  i) Duty owed the patient

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

    2) In healthcare the duty is to keep the patient safe.

  ii) Breach of the duty owed the patient

    1) Breach of duty is a deviation from the standard of care owed the patient, that is, something was done that should not have been done or nothing was done when something should have been done.

    2) Example – an incorrect medication was administered and a correct medication omitted. Another example is failing to report a change in the patient's condition.

iii) Foreseeability

    1) Certain events may reasonable be expected to cause specific results.

    2) For example – omission of an ordered insulin injection to a diabetic patient will foreseeability result in an increased blood sugar level.

iv) Causation

    1) Causation means that the injury must have been incurred directly by the breech of duty owed the patient.

    2) Cause-in-fact denotes that the breach of duty caused the injury. For example, the patient would not have had an allergic reaction if not given the medication they were allergic to.

    3) Proximate cause builds more upon foreseeability. Could one foresee the extent to which consequences will follow a negligent action? For example is it foreseeable that if sharp objects are left in close proximity to a suicidal patient, this would give him the tools for self-harm?

v) Injury

    1) The plaintiff must demonstrate that some type of physical, financial, or emotional injury resulted from the breach of duty owed the patient. Emotional injuries are allowed only when accompanied by physical injuries. Pain and suffering are allowed only when accompanied by physical injury.

vi) Damages

    1) The basic purpose of awarding damages is compensatory; with the law attempting to restore injured parties to their original position as far as is financially possible. The goal of awarding damages is not to punish defendants but to assist the injured parties. There are 4 types of damages:

        a) General damages – inherent to the injury. Included are general damages such as pain and suffering and any permanent disability or disfigurement because of the injury.

        b) Special damages – account for all losses and expenses incurred as a result of the injury. These include medical bills, lost wages, cost of future medical bills, and cost of converting living areas to more easily accessible for the injured party.

        c) Emotional damages – must be accompanied by physical damages.

        d) Punitive or exemplary damages – may be awarded if there is malicious, willful, or wanton misconduct. Plaintiffs must show that the defendant acted with conscious disregard for their safety. In this case damages are usually very high to deter similar conduct in the future.

            i) An example of this is a DNR patient who was being moved to a private room because he was terminal. There was no supplemental oxygen provided for the transport. The family begged the nurse for a portable oxygen tank for the move. The nurse declined and the patient arrested about 15 feet from the original room and was pronounced dead by the attending physician. The court found that punitive damages were appropriate because the nurse's action was an extreme deviation from the standard of care.

4. **Negligence versus Malpractice**

    A) Negligence

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

    B) Malpractice

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

5. Documentation and Lawsuits

    C) Lax documentation can weaken your defenses during a lawsuit: happened, when did it happen, and why did it happen? These are fundamental questions that must be answered in every potential claim for medical negligence. Sloppy documentation can hamper your ability to defend your answers to these questions.

    D) The following tips will help you avoid dangerous mistakes:

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

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

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

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

Pain Management
Core Competency Pre-Test Reading Material

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

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

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

Scope of Pain Assessment/Reassessment

- Pain assessment and intervention is ongoing. Documentation of baseline assessment is performed on admission with subsequent reassessments and documentation of effectiveness of interventions per facility policy.
- Many facilities have adopted pain assessment as 5th vital sign (i.e. obtained with routine vital signs)
- Pain rating scales will be used appropriate to the patient population served. The following scales may be utilized: Numeric Pain Rating Scale (1-10 with 10 being the worse pain, Wong –Baker Face Scale, and the FLACC Scale.
- Pain assessment will include the scale of pain used, quality/character of pain, severity of pain, provoking factors (if any), duration of pain, location, and radiation.
- Assessment factors in the non-verbal or cognitively impaired patient include: facial grimacing, writhing, withdrawal of limb(s), moaning, tearing and guarding.
- When pharmacological interventions are administered the nurse should reassess pain and document the effectiveness / ineffectiveness of the intervention.
- If the patient's comfort goal is not met, the physician should be notified for further orders/interventions.
- Barriers to reporting pain from the patient's perspective will be assessed on the initial admission assessment any may include:
  o Fear that pain means disease is worse
  o Concern about not being a —good‖ patient. Good patients do not complain
  o Fear of addiction or of being though of as an addict
  o Fear of becoming tolerant to pain medications
  o Worry about side effects (constipation, nausea, etc.)
  o Concern about distracting physician from treatment of underlying disease
  o Fear of discomfort associated with medication administration (taste/injection)

Interventions

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

Non-Pharmacological -Pain may be managed effectively by using a combination of pharmacological and non-pharmacological approaches. Non-pharmacological measures should be considered based on patient preference, physician order, type of pain, and degree of pain relief obtained. These include but not limited to:

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

Patient/Resident/Family Education

The patient and/or family members as appropriate will be educated:
- To their role in assisting in pain management
- Interventions toward alleviating patient barriers or fears to participation in effective pain management
- On the limitations and side effects of pain treatments
- The pain rating scale being utilized
- Alternative methods of intervention as appropriate and as employed, which may include the non-pharmacological interventions
- Pharmacological interventions
- Report inadequate pain relief
- Reinforce use of warm compresses, cold compresses, diversion activities, positional comfort measures
- Report lethargy, respiratory depression, urinary retention, or constipation
- Discharge instructions (ensure that patient/family understands correct dosage and schedule for medication administration before discharge

Clinician's Responsibilities in Pain Management

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

Patient Rights Core Competency Pre-Test Reading Material

Patients/Residents Have the Right To:

- Considerate and respectful care Personal and informational privacy

- Know the identity and credentials of caregivers

- Information about diagnosis, treatment and prognosis Participate in decisions involving care

- Refuse treatment

- Be informed and agree to participate in any educational or experimental care

- Participate in decisions about transfer to another facility

- Be informed of continuing healthcare needs following discharge Request and receive an itemized bill for services

- Report and expect resolution of complaints

- Receive care in a safe manner and environment

These rights are typically posted in the patient/resident care areas.

Patients/Residents Have the Responsibility To:

- Provide accurate and complete information about matters related to their health
- Report unexpected changes in their condition
- Inform the provider if they do not understand what is expected of them
- Follow the treatment plan
- Be responsible for their actions if they refuse treatment
- Assure financial obligations
- Follow hospital rules and regulations affecting patient care and conduct.

Complaints and Problem Resolution:

While you should make every attempt to avoid patient or family dissatisfaction, we all know that clinicians are human and that sometimes complaints will arise.

When there is a complaint, the patient or family member should bring the issue to the attention of the staff or a member of management team. The goal is to resolve the complaint in a timely fashion and continue to promote a working relationship with the patient and family. If you become aware of a complaint, you should do your best to resolve the complaint if it is minor, but immediately refer it to the supervisor or charge nurse if it is not easily resolved. Most healthcare facilities have a formal process for resolving complaints or grievances.

A complaint should NEVER have an effect on the positive quality of care provided to the patient.

Patient Safety

Core Competency Pre-Test Reading Material

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

The public demands that health care organizations be held accountable for their actions. In response to these demands, the Joint Commission began to highlight the need for action in the healthcare industry. Accredited institutions are required to have a patient safety plan that addresses patient safety issues in an ongoing, collaborative, proactive approach. In compliance with this standard, an interdisciplinary team develops the plan. Safety of the patient is dependent upon the multidisciplinary, collaborative, communicative approach. An annual patient safety survey of the staff should be conducted in healthcare facilities to ensure everything possible is being done to ensure patient safety.

The scope of the Patient Safety Plan includes an ongoing proactive assessment, using external and internal knowledge and experience, to prevent error occurrence, and to maintain and improve patient safety. Occurrence information will be gathered from reports and will be reviewed by the Safety Committee to prioritize organizational patient safety activity efforts. Types of errors are:

1. No-Harm Errors --unintended act of commission (occurred) or omission (not occurred) that do not achieve an intended outcome
2. Mild-Moderate Adverse Outcome Errors --unintended acts of commission or omission, that do not achieve their intended outcome, that results in mild or moderate physical or psychological adverse outcome to the patient
3. Any Medication Error
4. Any Adverse Drug Reaction
5. Any Transfusion Reaction
6. Hazardous Condition --any set of circumstances which increases the likelihood of a serious physical or psychological adverse patient outcome
7. Sentinel Event --any unexpected occurrence involving death or serious physical or psychological injury or risk, including any process variation, which would carry a chance of serious adverse outcome
8. Near Hits or Near Misses --any process variation which did not affect outcome but with which a recurrence would carry a significant chance of a serious adverse outcome

Strategy to achieve patient safety:

1. Promote a culture of safety
2. Increased reporting of adverse events and error-prone processes
3. Increased communication about safety issues
4. Increased learning from analysis of reported adverse events
5. Focused process redesign
6. Promotion of appropriate application of technology
7. Focused education about new safety activities

Goals:

1. Reduction of adverse events
2. Reduction of unanticipated medical outcomes

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

What happens now?

The Quality or Risk Manager usually reviews incident reports and a patient safety report is forwarded through the Quality Committees up to the Governing Board. The report will contain information on the occurrences of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

Who is required to report errors?

All personnel are required to report suspected medical/health care errors and should do so without the fear of reprisal in relationship to their employment. Most organizations support the concept that errors occur due to a breakdown in systems and processes and will focus on improving systems and processes rather than disciplining those responsible for errors and occurrences.

Quality Improvement

Core Competency Pre-Test Reading Material

What is Continuous Quality Improvement?

It is a structured problem-solving system to analyze a "PROCESS" and reduce unnecessary variations to improve the quality of a product or service. It's a systematic team approach to improving a "PROCESS".

What is the definition of Teamwork?

Everybody looking out for everybody else

Why is teamwork part of quality improvement?
•   None of us is as smart as all of us
•   Better ideas
•   More ideas
•   Involves the people who know the system best
•   Involves employees in the solutions
•   Maintains pride & interest in work

One of the most common process improvement methods used in health care:

F – Find a process to improve
O – Organize (a team or individual) to improve the process
C – Clarify (your or the team's) current knowledge of the process
U – Understand the source of process variations
S – Select the process improvement

P – Plan the improvement
D – Do the improvement to the process
C – Check the results
A – Act to hold the gain and continue to improve the process.

Principles of Good Design

•   Good design has the following characteristics:
•   Is consistent with your organization's mission, values, and goals. Meets the needs of patients.
•   Reflects the use of currently accepted practices (doing the right thing, using resources responsibly, using practice guidelines)
•   Incorporates current safety information and knowledge, such as sentinel event data and Joint Commission National Patient Safety Goals
•   Incorporates relevant performance improvement results

Failure Mode and Effects Analysis (FMEA)

- Techniques have been around since the mid 1960's, originating in industry – industrial engineering design – initially in new product design and development. Use of FMEA techniques reduced or eliminated need for —after-the-factǁ corrective actions following process failure.
- FMEA application in healthcare began in the 1990s.
- Joint Commission Leadership standard beginning in 2002: Proactive risk assessment and risk reduction. Part of the move to patient safety standards.
- Required to do at least one FMEA per year, with completion by July 1.

- FMEA:
  - Proven to reduce errors and increase successful performance of a process (increase patient safety)
  - Can prevent errors and near misses
  - Good for new processes and to reevaluate existing processes
  - Effective quality improvement tool – narrows gaps in quality and performance
  - Can yield significant results without complicated tools and statistical analysis
  - Provides data to accurately identify real or potential failure modes and improvement opportunities
  - Ensures documentation of procedures – exploring how procedures are performed – critical in reducing variance in how individuals perform the procedure
  - Team based, systematic, proactive, and prospective approach for identifying ways that a process or design can fail, why it might fail, and how it can be made safer, in order to prevent process and product problems before they occur.

- If a particular failure cannot be prevented, FMEA focuses on protections that can be put into place to prevent failure from reaching the patient or – in worst case scenario – mitigate its effects if it reaches the patient.

- Components:
  - Failure: lack of success, nonperformance, nonoccurrence, breaking down, or ceasing to function
  - Mode: way of operating, using a system or process, the way in which a failure can happen
  - Failure Mode: manner in which something can fail
  - Effects: Result/consequences of a failure mode
  - Analysis: detailed analysis of a process

- Several sources for FMEA formats – ranging from 4 to 10 steps. Joint Commission uses 8 step processes.

Occurrences

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase or risk thereof includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.

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

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

Medication Errors

Medication Errors can occur in a variety of ways:
- Wrong Patient
- Wrong Dose
- Wrong Drug
- Wrong Route
- Wrong Time
- Omission
- Duplication
- Dispensing Error
- Labeling Error
- Transcription Error
- Allergy/Sensitivity Error

All Medication ERRORS are usually required to be documented on a Occurrence or Incident Report Form (located at the Nurses Station)

The FIVE (5) Rights of medication administration along with the (3) new Rights are:
- Right patient
- Right drug
- Right dose
- Right time
- Right route

The THREE NEW Medication rights are:
- Right documentation
- Right administration/reason (i.e. rate)
- Right preparation

Three people that should be notified when a medication error occurs are:
- Charge Nurse
- Manager
- Attending/House Physician

NEVER DOCUMENT IN THE MEDICAL RECORD THAT AN OCCURRENCE REPORT HAS BEEN COMPLETED --ALWAYS DOCUMENT FACTS OF THE INCIDENT.

Definition of Restraints:

Physical Restraint – any device used to physically restrict a person's freedom of movement and physical access to his/her body in order to protect the individual from harming self or others, yet promotes patient/resident well being. The device is intended to:

- Protect the individual from harming self (self-injurious behavior, —Sundowner Syndromell with increased confusion, disorientation and wandering, usually at night), or;
- Protects others from physical abuse or potential harm.

Drug used as a Restraint – a medication used to control behavior or to restrict the patient's freedom of movement and that is not a standard treatment for the patient's medical or psychiatric condition.

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

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

REMINDER: A restraint can only be used if needed to improve the patient's well being and less restrictive interventions have been determined and documented to be ineffective.

Alternative Measures – must be initiated prior to decision to restrain patient.
Dialogue to identify reasons for behavior change
- Med review for drug interactions and/or polypharmacy Consult family on methods of calming patient
- Consult with physician about removal of tubes, lines, dressings as soon as possible.
- Cover IV sites with surginet, stockinet, or kerlix for protection
- Cover PEG with abdominal binder
- Apply bed check
- Bowel/bladder assessments
- Pain relief/comfort measures
- Soothing talk
- Providing bathing, shower, ambulation, and/or wheelchair ride in hall
- Family/sitter in attendance
- Pastoral Counseling
- Modify environment to minimize clutter
- Reduce stimuli: dimming lights, reducing noise, etc.
- Diversional activities (music videos, TV, soft objects to handle)
- Relaxation techniques
- Exercise/PT/OT
- Social activity
- Snacks

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

THE FOLLOWING ARE NOT ACCEPTABLE MEDICAL ORDERS:

- Restraint PRN
- Renew Restraints
- Standing Orders for restraints

Key Restraint Measures to be followed:
Duration of restraint use is limited to:
- Acute Care Services – time as specified by the physician.   Not to exceed 24 hours.
- Behavior Health Management – time as specified by the physician BUT NOT TO EXCEED 4 hours for adult patients. This means if a patient is suicidal, an order needs to be obtained within one hour of application and is valid for only a 4-hour period of time!
- The patient is to be re-evaluated face-to-face by the physician, minimally every 24 hours, to determine the continued need for restraints. A new restraint order must be written.
- Restraint and seclusion may not be used simultaneously unless the patient is continually monitored face-toface by an assigned staff member.
- Restraint removal or reduction in the level of restraint use should be implemented when the patient demonstrates a reduction in the behavior that led to restraint use.
- Every episode of restraint use is to be documented and should include:
  o Alternative measures attempted
  o Behaviors requiring restraint usage
  o Vital signs
  o Circulation checks
  o Hydration/elimination needs
  o Nourishment offered
  o Level of distress/agitation, mental status, cognitive functioning
  o Need for continued restraint
  o Released every 2 hours and safely/properly reapplied
  o Individualized needs assessed

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

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Risk Management
Core Competency Pre-Test Reading Material

What Is Risk Management?

Risk management is a systematic process aimed at reducing accidents, injuries, and financial risk to the hospital.

Risk management is important to:

• Reduce cost
• Improve quality
• Respond to unsafe conditions Protect employees
• Assure resources are spent to support patient care rather than cover losses

An Incident Is

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

Incident Reporting

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

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

Do's:

• File a report immediately when you identify an incident (an Incident Report form is included in this section for your review).
• Remember that the information is confidential and will be used to benefit our performance improvement plan. Limit your report to facts and do not make judgments.

Don'ts

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

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

When in doubt, fill it out!

An incident report is a tool to help determine how to create a safer environment. If you are unsure, complete the incident report and your supervisor will determine whether what happened is an "incident".

Sentinel Event and Root Cause Analysis

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

Each facility has different policies. Always ask the supervisor, what these policies are.

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

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

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

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

It is helpful for the victim to inform the harasser directly that the conduct is unwelcome and must stop. The victim should use any employer complaint mechanism or grievance system available.

When investigating allegations of sexual harassment, EEOC looks at the whole record: the circumstances, such as the nature of the sexual advances, and the context in which the alleged incidents occurred. A determination on the allegations is made from the facts on a case-by-case basis.

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

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

Substance Abuse Recognition
Core Competency Pre-Test Reading Material

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

Three Recognized Types of Impairment and Warning Sign
  1. Alcoholism
        • Impaired motor coordination, slurred speech, flushed face, bloodshot eyes
        • Elaborate excuses for behavior
        • Irritability, mood swings
        • Isolation from others
        • Numerous injuries, burns, bruises
        • Smell of alcohol on breath or excessive use of mouthwash

  2. Drug Addiction
        • Rapid changes in mood or performance
        • Frequent use of bathroom
        • Frequent absence from unit
        • Work a lot of overtime, arrive early, stay late,
        • Excessive wasting of drugs
        • Patients complaining that pain medication is not effective or deny receiving medication
        • Increased somatic complaints necessitating prescriptions of pain medications
        • Excessive discrepancies in signing and documentation Procedures of controlled substances

  3. Mental Health Disorder
        • Lethargic
        • Depressed
        • Erratic behavior or mood swings
        • Unable to focus or concentrate
        • Apathetic
        • May exhibit some of the same or similar characteristics as chemical dependency

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

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

Workplace Violence
Core Competency Pre-Test Reading Material

Definition
Any physical assault, threatening behavior, or verbal abuse occurring in the work setting (National Institute for Occupational Safety and Health)

Statistics
- The fastest growing form of murder in the US
- Each year, more than 1600 people are murdered at work
- More than 20 million people are assaulted
- More than 6 million are threatened
- Workplace violence is an increasing phenomenon
  - Taxi drivers are the most likely victims at 23%
  - Health Care Workers at 10%
  - Police at 4%

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

Stressors in the Workplace

- Death of family member
- Divorce or other marriage conflicts Loss of employment
- Moving

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

Sources of Workplace Violence

- Third Party Intrusion – Not an employee. Examples: Spouses, ex-spouses, domestic disputes, customer, client
- Disgruntled Employees – Violence directed towards co-workers, supervisors, revenge
- Miscellaneous – Robberies, terrorism, etc.

Ways to Prevent Workplace Violence

- Third Party Intrusion:
  - Employees should notify supervisors of domestic conflict
  - Utilize codes / alarms
  - Have escorts when unsure of situations
- Disgruntled Employees:
  - Be aware of non-harassment policy and ZERO tolerance
  - Encourage employees to report incidents
  - Attend employee training when offered
  - Know and follow security procedures
  - Evaluate security and emergency procedures and discuss problem areas with your supervisor or safety officer
  - Provide a healthy work environment for patients, residents, families, and co-workers

Resolving Workplace Conflicts:

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

IF a Workplace Violence Incident Occurs:

- Report the incident immediately
- Depending on type of violence (physical, verbal, psychological), call police, report to supervisor, human resource department, safety officer, etc.
- Seek medical treatment, if necessary
- Document the incident(s) – date, time, etc
- Follow through with management – supply all necessary information and be available if needed