

ABUSE: Child, Elder, Intimate Partner

Three types of abuse that may be seen in the healthcare setting are child abuse, elder abuse, and intimate partner violence, also known as domestic violence. The abuse of one person by another can take many forms – physical, emotional, psychological, sexual, and more. The statistics regarding abuse are disturbing:

- In 2014, more than 700,000 children were abused and/or neglected in the U.S.
- In 2015, more than 2.1 million cases of elder abuse were reported in the U.S.
- On average, nearly 20 people per minute are physically abused by an intimate partner in the U.S. Many victims end up seeking medical care at hospitals, physician offices, and clinics. Healthcare providers are likely to encounter victims of abuse from time to time, and they can play a critical role in recognizing, reporting, and helping victims of abuse.

CHILD ABUSE

The federal Child Abuse and Prevention Treatment Act (CAPTA) defines child abuse and neglect as:

- Any recent act or failure to act on the part of a parent, caretaker, or other person who has responsibility for a child which results in the child's death, serious physical or emotional harm, sexual abuse or exploitation, or
- An act or failure to act which presents an imminent risk of serious harm to the child A child is:
 - Someone who is less than 18 years old, or
 - The age defined by the Child Protection Act of the state in which the child resides (except in the case of sexual abuse) The U.S. Centers for Disease Control and Prevention (CDC) defines two categories of child maltreatment (abuse and neglect):
 1. Acts of commission (child abuse): o Physical abuse o Sexual abuse o Emotional abuse
 2. Acts of omission (child neglect):
 - Failure to provide, such as physical, emotional, medical, or educational neglect
 - Failure to supervise, such as inadequate supervision and exposure to violent environment

Physical abuse is any action that causes physical harm to a child, even if the harm is not intentional, as in over-punishment. It includes:

- Kicking, punching, hitting or biting
- Burning
- Shaking

Sexual abuse is inappropriate sexual behavior with a child. It includes:

- Fondling a child's genitals or making the child fondle the adult's genitals
- Intercourse or rape
- Incest
- Sexual exploitation

To be considered child abuse, these acts have to be committed by a person responsible for the care of a child (such as a parent, baby-sitter, or daycare provider), or someone related to the child. If a stranger commits these acts, it would be considered sexual assault.

Emotional/Psychological Abuse Emotional abuse is an act, by parents or caregivers that could cause behavioral, cognitive, emotional, or mental disorders. Examples of this type of abuse include:

- Bizarre forms of punishment such as locking a child in a dark closet, basement, or attic
- Constant criticism, threats, or rejection
- Withholding love, support, or guidance Emotional abuse is generally present with most other forms of abuse and is often hard to prove.

Abandonment of a child is when:

- A parent's identity or whereabouts are unknown
- The child has been left alone in circumstances where the child suffers serious harm
- The parent has failed to maintain contact with the child or provide reasonable support for a specified period of time

Neglect is the failure to provide for a child's basic physical, medical, educational, or emotional needs. It is important to note that allowances must be made for cultural values, poverty, and other factors that might be part of the reason for neglect.

- Physical neglect includes the failure to provide food, not allowing a runaway to come home, or inadequate supervision so that the child is endangered.
- Medical neglect includes failure to provide or withholding medical treatment or other life sustaining treatments including water and nutrition, when the treatment would most likely result in correction of a medical condition.
- Emotional neglect includes not responding to the emotional needs of a child, exposing a child to domestic violence, allowing a child to use drugs and/or alcohol, and the failure to provide the necessary psychological care.
- Educational neglect includes failure to educate a child or attend to special educational needs.

Substance Abuse in many states is considered a form of child abuse and neglect. It may include the following circumstances:

- Prenatal exposure of a child due to the mother's use of an illegal drug or other substance
- Manufacture of methamphetamine in the presence of a child
- Selling, distributing, or giving illegal drugs or alcohol to a child
- Use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child

SIGNS OF CHILD ABUSE

Child abuse is often hard to recognize unless it is very obvious. Knowing the signs of different types of abuse can help you recognize possible cases. Signs of physical abuse include:

- Injuries inconsistent with the explanation of the injury (for example, an infant who is not yet walking or crawling with a broken leg, or injuries on both sides of the body because of a fall, since injuries due to a fall are usually found on one side only)
 - Injuries in several stages of healing, such as old bruises and new bruises
 - Evidence of old fractures
 - Injuries such as rope burns, scalding, and cigarette burns
- Signs of sexual abuse include:
- Provocative behavior or knowledge of sexual matters inconsistent with child's age
 - Suicidal gestures
 - Behavior problems
 - Diagnosis of sexually transmitted disease in a child

Signs of emotional/psychological abuse include:

- Poor development of basic skills
 - Anxiety or insecurity
 - Withdrawal
 - Destructive behavior
 - Aggression or angry outbursts
- Signs of neglect include:
- Malnutrition
 - Failure to keep medical appointments or prescribed treatment
 - Child not dressed for the weather
 - Child not taking medicine as prescribed
- Be mindful that factors such as poverty may appear as neglect

REPORTING CHILD ABUSE

In all states, it is MANDATORY that healthcare professionals report suspected cases of child abuse. Your facility may have its own policies about who files the actual report. As a healthcare worker, you should become familiar with your facility's policies in this regard. If a child tells you he or she was abused, or if you suspect abuse:

1. Notify the appropriate state agency as per your facility's policy
2. DO NOT interview the child; studies show that the testimony of children is less accurate when they are asked to repeat it.
3. DO NOT allow the child to leave with the caregiver until the state agency is contacted and you have their permission to allow the child to leave with the parent/caregiver.

Each state has its own statutes defining:

- The procedure for reporting suspected cases of child abuse to Child Protective Services
- Who must file the report
- Other factors such as criminal punishment for abuse

ELDER ABUSE

Elder abuse is:

- The physical, emotional, or financial mistreatment, neglect, or exploitation of a person age 60 or older by another person or
- The self-neglect of an individual in this age range

According to the National Center on Elder Abuse, each state defines elder abuse according to its unique statutes and regulations, and definitions vary from state to state.

Elder abuse can occur in these settings:

1. Domestic elder abuse is abuse of an older person by someone who has a special relationship with the elder, such as an intimate partner, spouse, sibling, child, friend, or caregiver. The abuse occurs in the older person's home or in the home of the caregiver.
2. Institutional elder abuse is abuse of an older person that occurs in a residential facility for older persons such as a nursing home, foster home, group home, or boarding house. In institutions, the persons who are the abusers have been hired to provide care and protection for elders.

TYPES OF ELDER ABUSE

1. Physical Abuse

Physical abuse is intentional physical pain or injury inflicted on an elder by a person who is responsible for his or her care. Examples include:

- Slapping and/or Bruising
- Use of unreasonable physical restraint
- Deprivation of food or water
- Over-medicating or under-medicating

Signs of physical abuse include:

- Elder's report of being hurt
- Injury inconsistent with the story of how it was received
- Injuries in various stages of healing
- Observed actions of caretaker, such as hitting, slapping, or burning
- Caretaker's refusal to allow anyone to see an elder alone

2. Sexual Abuse

Sexual abuse (a type of physical abuse) is any nonconsensual sexual contact or sexual act with any person incapable of giving consent. This includes, but is not limited to:

- Unwanted touching

- Sexually explicit photographing
- All types of sexual assault or battery, such as rape, sodomy, or coerced nudity Signs of sexual abuse include:
 - Elder's report of being sexually abused
 - Torn, stained or bloody underclothing
 - Bruises or other injuries around breasts or genitals
 - Unexplained vaginal or rectal bleeding
 - Unexplained sexually transmitted disease (STDs) such as gonorrhea or syphilis

3. Emotional or Psychological Abuse

Emotional or psychological abuse is the infliction of mental or emotional suffering (anguish, pain, or distress) through verbal or nonverbal acts by a person who is in a position of trust. Examples include:

- Verbal assault
- Humiliation
- Intimidation or threats
- Isolation from family and/or friends

Signs of psychological abuse include:

- Elder report of psychological abuse
- Elder being very agitated and upset
- Elder being withdrawn and uncommunicative or nonresponsive
- Unusual behavior often attributed to dementia (hitting, biting)

4. Neglect

Neglect is the failure of a caretaker to provide adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision to avoid physical harm, mental anguish, or mental illness to the elder. Examples include:

- Failure to assist with personal hygiene or the provision of clothes
- Failure to protect an elder from health and safety hazards

Signs of neglect include:

- Dehydration, malnutrition, untreated bed sores, and poor personal hygiene
- Unattended or untreated health problems
- Unsafe living conditions
- Unsanitary appearance such as dirty clothes
- Elder report of being mistreated

5. Abandonment

Abandonment is the desertion by an individual who has assumed responsibility for providing care for an elder or by a person with physical custody of an elder. This includes:

- The desertion of an elder at a clinical facility, shopping mall, or other public location
- Elder report of being abandoned

6. Financial or Material Exploitation

Financial or material exploitation is the theft or improper use of an elder's money or property, without his or her consent, for someone else's benefit. Examples include:

- Forcing or tricking the elder into selling his or her home
- Forging a signature on pension checks, wills, or financial documents
- Misusing "power of attorney"
- Not allowing the older person to buy needed items such as clothes
- Using the elder's ATM without permission or taking over bank accounts without permission
- Making changes to the elder's will without approval
- Providing substandard care despite an elder's ability to pay
- Unexplained disappearance of funds or valuable possessions

- Elder report of financial exploitation

7. Self-Neglect

Self-neglect (also known as self-abuse) is the behavior of an elderly person that threatens his or her own health or safety, such as not providing himself/herself with enough food or water, clothing, shelter, safety, personal hygiene, and/or medication. Self-neglect usually occurs when an elder lives alone. This excludes any competent older people who make a conscious and voluntary decision to engage in acts that threaten their health or safety and who understand the consequences of those decisions.

Signs of self-neglect include:

- Grossly inadequate housing or homelessness
- Lack of the necessary medical aids
- Hazardous, unsafe, or unclean living conditions
- Dehydration, malnutrition, poor personal hygiene, improperly treated medical conditions

REPORTING ELDER ABUSE

Healthcare professionals in all states are required by law to report any suspected cases of elder abuse. Your facility may direct the procedure for reporting. All calls are confidential and must be made to your state's hotline. The investigation will be carried out by the state's Adult Protective Services. If abuse is suspected or an elder tells you he or she was abused:

- Document all findings, including any statements the victim and caretaker make
- DO NOT allow the elder to leave without permission from the state Adult Protective Services

Your community should also have an Area Agency on Aging that provides services for the elderly. If a caretaker expresses any concerns or clearly needs help, you can either call or refer the person to this agency.

INTIMATE PARTNER VIOLENCE

Intimate Partner Violence is a pattern of threatening or violent behavior used to establish power and control over an intimate partner. It involves emotional, financial, physical, sexual, or social abuse. Intimate Partner Violence is also known as:

- Domestic violence
- Domestic abuse
- Intimate partner abuse

Intimate Partner Violence happens between married couples, unmarried couples, same-sex couples, and couples living together or apart. In a relationship where Intimate Partner Violence exists, one person is forced to change his or her behavior because of abuse or the perceived threat of abuse. Some facts about Intimate Partner Violence:

- People of different races, income levels, and education are potential abusers or victims.
- One in four women will experience this type of violence in her lifetime.
- Children who witness family violence in their home are more likely to grow up to be Intimate Partner abusers or victims.
- Husband abuse represents about 5% of Intimate Partner Violence cases

TYPES OF INTIMATE PARTNER VIOLENCE

1. Physical Abuse

Physical abuse is the infliction of pain or physical injury by the victim's partner. A physical abuser may:

- Hit, push, kick, slap, hold down, or throw things at the victim
- Harm a victim's children, pets, or property

- Commit battery (a threat of violence accompanied by the ability to carry out the threat)

2. Sexual Abuse

Sexual abuse is violence by the victim's partner in which sex is used to hurt, degrade, dominate, humiliate, or gain power over the victim. It is an act of aggression. The abuse may involve force, coercion, bribes, threats, or corruption, and may include prostitution or money. Abusers may brag or boast to the victim about sexual activities with another person, or compare the victim's sex actions to those of other persons. A victim of sexual abuse may:

- Be treated as a sex object, be called sexual names and /or be forced into sexual activities by the abuser
- Develop an inability to trust, which leads to secrecy and nondisclosure

3. Psychological Abuse

Psychological abuse includes:

- Intimidation
- Degradation
- Coercion
- False accusations
- Humiliation
- Ridicule
- Threats of physical harm

4. Financial Abuse

Financial abuse of an intimate partner is the misuse or exertion of control over money, access to money, or possessions. It includes stealing and lying about money. A financial abuser may:

- Remove large sums of money from the victim's bank account
- Deny the victim the ability to pay bills or buy necessities
- Deprive the victim of money or access to money
- Deny the victim job freedom

5. Emotional Abuse

Emotional abuse is behavior that causes feelings of unworthiness. An emotional abuser may withhold affection from the victim, or use jealousy, passion, or anger to justify actions. Victims of emotional abuse may be:

- Put down by their partner
- Told no one else will want them if the partner leaves
- Ignored or isolated

Emotional abuse is cruel and destructive. It is almost always present in situations where other forms of Intimate Partner Violence occur.

THE CYCLE OF INTIMATE PARTNER VIOLENCE

The cycle of abuse is common in many cases of Intimate Partner Violence. It results in the abused person living in fear with the belief that there is no escape. The three phases of the cycle of Intimate Partner Violence are:

1. Tension-building phase
2. Crisis phase
3. Honeymoon phase

Phase 1:

Tension-Building Phase The tension-building phase is characterized by stress.

- The abuser shows signs of increasing irritation with the victim, often finding fault with everything he or she does.
- The victim becomes fearful and tries to find ways to appease the abuser.

Phase 2:

Crisis Phase The crisis phase is characterized by violence.

- The abuser's anger reaches a critical point and is released in the form of verbal or physical violence.
- The abuser may shout and scream at the victim, threaten him or her, and damage the victim's property.
- Physical assaults such as punching, kicking, or slapping hard enough to bruise, break bones, and draw blood may also occur.
- The police or neighbors may be called, or the violence may be unknown to people outside.
- The victim may be made to feel that he or she provoked the escalation from phase 1 to phase 2.

Phase 3:

Honeymoon Phase The honeymoon phase is characterized by a return to calmer behavior.

- The abuser is sorry and promises to get help and never do this again.
- The abuser may offer affection to the victim.

IDENTIFYING INTIMATE PARTNER VIOLENCE

Victims of Intimate Partner Violence often have obvious physical injuries. Others may have vague complaints and deny abuse. When a patient denies Intimate Partner Violence, the following signs may alert healthcare workers to suspect abuse:

- A pattern of missed appointments
- Delays in seeking treatment
- Frequent medical visits for vague complaints with lack of evidence of physical causes
- Injuries in several stages of healing, such as old bruises, and evidence of old fractures
- Injuries during pregnancy (because pregnancy is a high-risk situation for abuse)
- Injuries inconsistent with the explanation of the injury Examples of situations in which the explanation of the injuries are inconsistent with the injuries: • Someone states that the injuries are caused by a fall, and yet the bruises and cuts, on the hands and arms, are consistent with self-defense injuries

REPORTING INTIMATE PARTNER VIOLENCE

If you suspect Intimate Partner Violence:

- Provide privacy and the opportunity for the person to talk. Privacy also means privacy from partner, family members, or acquaintances.
- Assure the person of confidentiality.
- Be nonjudgmental and caring.
- Ask if the partner has ever harmed or threatened to harm the person or his or her children.
- Let the person know that there are options. Reinforce the idea that victims do not cause nor deserve the abuse.
- DO NOT ask the person why he or she does not leave the abuser.
- DO NOT change your course of action because the person does not admit to abuse.

As a healthcare worker, your responsibilities include:

- Screening patients for signs of abuse
- Documenting all findings including the victim's statements
- Ensuring domestic violence information is available in waiting areas and restrooms
- Knowing the options and inform the person about options
- Making referrals, as indicated

Use the acronym RADAR as a guide:

- R = Routinely screen patients
- A = Ask direct questions so the person can answer "yes" or "no"
- D = Document your findings
- A = Assess the person's safety
- R = Review options and referrals

Options for victims include:

- Pressing charges to have the abuser arrested
- Obtaining an injunction or restraining order against abuser (the purpose of the restraining order is to prevent the abuser from communication or associating with the victim)
- Going to a safe house or shelter for protection and accommodations
- Going back home
- Getting help when ready BE CAUTIOUS about giving victims a phone number to call for help. The abuser may find it and respond abusively. Instead:
- Help victims memorize the number.
- Tell them how to find the numbers for help.
- Tell them the names of organizations or websites they can look up when it is safe.

If an abuser seeks help, follow the hospital policy on Intimate Partner Violence and refer him or her to treatment centers for help.

There is also help for substance abuse.

Where to get help: www.thehotline.org

CONCLUSION

Healthcare providers are in a powerful position to help victims of abuse. You do not need to be an expert on interpersonal relationships and domestic violence to do this. But you should know the risk factors and signs of abuse, and how to report it. Healthcare providers can take advantage of their unique roles to assess patients of all ages for mistreatment. Knowing what to do if abuse is suspected is critical. Your role as a provider can make a difference.

ADVANCE HEALTHCARE DIRECTIVES

Many people plan and prepare for many major life events, but few plan for unexpected medical events or health issues if they become very ill, such as:

- The type and length of treatment they wish to receive
- Artificial pulmonary support (ventilator use)
- The administration of chemotherapy and/or immunosuppressants
- Organ transplantation
- Nutrition and hydration
- And more

Addressing these issues when healthy can help family members and healthcare providers understand the wishes of patients in the event they become incapacitated when injured or ill.

The National Institute on Aging states that advance care planning involves:

- Learning about the types of care-related decisions that might need to be made
- Considering those decisions ahead of time
- Letting others know your preferences, often by putting them into an advance healthcare directive (AHD)

Such decisions are based on each person's:

- Personal values
- Preferences
- Discussions with loved ones

BENEFITS OF ADVANCE HEALTHCARE DIRECTIVES

Every adult can benefit from having advance healthcare directives (AHDs).

- Planning is particularly important for those who are terminally ill.
- Research shows that people suffering from chronic illness also benefit from advance care planning.
- Because an accident or serious illness can happen suddenly, and at any time, even healthy people should consider their wishes for end-of-life care.

Studies funded by the Agency for Healthcare Research and Quality (AHRQ) have shown that people who talked with their family, physician, or others about their preferences for end-of-life care:

- Had less fear and anxiety
- Felt more in control of their own medical care
- Believed their doctor had a better understanding of their wishes

Other potential benefits of advance care planning, according to the National Institutes of Health, include:

- Decreased personal worry
- Decreased feelings of helplessness and guilt for the family
- Decreased implementation of costly, specialized medical interventions
- Decreased overall healthcare costs

VALUE OF ADVANCE HEALTHCARE DIRECTIVES

Advance healthcare directives (AHDs) are legal documents that address a person's wishes concerning medical treatments in the event they are incapacitated or unable to speak for themselves. An AHD is an umbrella term that encompasses all forms of written documents in which a person indicates his or her healthcare preferences while cognitively and physically able to make these decisions. AHDs are a required component of the Patient Self-Determination Act (PSDA), legislation enacted by the U.S. Congress in 1990 that obligates healthcare institutions to do the following:

- To inquire about a person's AHD status when he or she is admitted to a healthcare facility
- If the person has an AHD, to incorporate it into his or her medical records Hospitals and healthcare facilities may offer patients the opportunity to complete an AHD if they do not already have one – but they are not required by the PSDA to do so.

AHDs are important because they:

- Give patients control of their medical care when they become incapacitated
- Provide guidance to healthcare professionals and families so that care decisions are consistent with the patient's values and preferences
- Afford legal immunity for healthcare professionals and family members from civil and criminal liability when AHDs are followed in good faith AHDs can be completed by adults age 18 and older and emancipated minors who are of sound mind and acting without undue influence

BARRIERS TO ADVANCE HEALTHCARE DIRECTIVES

Barriers that inhibit individuals from completing and implementing advance healthcare directives (AHDs) include:

- An individual's culture, ethnic, or racial background
- The notion that certain patients, especially those from lower income populations, may experience lower quality healthcare and are less likely to receive assistance in creating AHDs
- Language barriers, if translation services are limited or unavailable
- Lack of physician training regarding AHDs
- Discomfort on the part of the patient and/or physician to discuss AHDs
- Fear that anxiety or hopelessness may result from the discussion
- Time constraints faced by healthcare providers

TYPES OF ADVANCE HEALTHCARE DIRECTIVES

Advance healthcare directives (AHDs) commonly cover:

- What types of medical conditions the person would or would not want treated (such as a terminal illness)
- What types of medical interventions the person would or would not want (such as a feeding tube or ventilator)
- Under what conditions the person would or would not want life prolonged (such as a persistent vegetative state)
- Organ donation decisions
- Whom the person designates as decision-making healthcare agent or proxy should he or she be unable to make decisions independently
- What the individual values most (such as time spent with family, mental competence, pain relief) Types of advance healthcare directives include:
 - A living will or a Natural Death Act Declaration, which usually states the person's desire to not receive life-sustaining treatment in the event of terminal illness or permanent unconsciousness
 - A medical or treatment directive, which is a written directive that describes the patient's wishes in certain situations
 - A durable power of attorney for health care, which identifies one individual (and an alternate, if desired) as a decision maker for the person. The person does not have to be a relative. It does not appoint anyone to make legal or financial decisions – only those related to healthcare
 - A combination AHD, which is a document that includes both a living will and a durable power of attorney or other healthcare-related directives
 - Do-not-resuscitate (DNR) directives, which prohibit the use of CPR in the event of cardiac or pulmonary arrest. AHDs do not necessarily include a DNR. A DNR can be in place without an AHD
 - A values history, which present a patient's values about healthcare and quality of life, and is intended to help providers and family members in end-of-life planning o It often includes treatment preferences. It can also include the appointment of a healthcare agent or proxy
 - Organ and tissue donation wishes, which also can be specified as part of an AHD o Common organ and tissue donations include the heart, lungs, pancreas, kidneys, corneas, liver, skin. There is no age limit for donating. In some states, this information is on a donation card that is carried or noted on a driver's license

IMPORTANT CONSIDERATIONS

It is important to know these aspects of AHDs:

- Emergency medical technicians cannot honor the AHD and are required to stabilize a person during transfer to a hospital. Once there and evaluated by a physician, an AHD can be put into place.
- AHDs do not expire but can be changed as often as desired. Once a new AHD is written, it invalidates the previous one.
- An AHD does not go into effect while a person is mentally and physically able to make decisions; it only goes into effect when the person becomes incapable of doing so.
- Even in cases where an AHD is in place, family members and/or providers may disagree on the type and course of care for a person. In this case, you should be aware of your institution's policies and procedures for resolving these types of conflicts. The portability of advance healthcare directives is also important to understand.
- Every state has its own laws regarding AHDs.
- Not all states recognize AHDs from another state. • In some cases, if the laws are similar, a state will accept the AHDs.
- Knowing state-specific statutes is important for all healthcare professionals.

Aging with Dignity has developed a helpful planning tool, called Five Wishes, for thoughtfully making these types of decisions. Five Wishes is a popular living will because it is written in everyday language and helps people express their wishes in personal and spiritual areas in addition to medical and legal. This tool is available at <https://agingwithdignity.org/five-wishes/about-five-wishes>.

AGE SPECIFIC : PATIENT CARE CONCERNS

Every patient is different. This can be said for their age group, too, because with each comes different medical needs. While any patient can experience general ailments, such as a broken arm or nervous stomach, each age group brings its own specific conditions that you as the caregiver must be aware of. Also in order to accurately assess patients across all age groups, you must effectively communicate with them. You must understand their needs and what they might be facing at their time of life.

In assessing all patients you must be aware of the primary language, whether they have a speech or hearing impediment or if their mental state is confused or depressed under stress or illness. Learning disabilities and cultural differences may keep the caregiver from fully understanding the whole picture in communicating with the patient.

There are additional factors in assessing very young patients. IN infants, vital signs must be checked carefully in addition to growth and development, eating and parental bonds. With older children, there are other factors such as peer pressure, privacy issues, and puberty considerations.

In adult patients there are other things to consider in assessment. Each age group has its own set of factors. It is critical that you educate yourself about these factors and learn to communicate effectively with your patients of any age.

For every patient across all age groups you should:

- Assess primary language
- Check for speech or hearing impairments
- Check for confusion /depression /signs of illness or stress
- Be aware of learning disabilities
- Be aware of cultural differences
- Understand family structure

NEONATES: Birth – 28 Days

In the first 28 days of life, neonates are totally dependent and basic body functions are being established. These are the tests for neonates:

- Reflexes (grasping, gagging and startling are key)
- Good APGAR scores (immediately after birth to evaluate appearance, pulse, grimace, activity and respiration))
- Vital signs
- Weight gain
- Blood glucose levels

INFANTS AND TODDLERS: 0-3 YRS

Rapid growth occurs during period. They are totally dependent but are developing a separate self and personality. Immunizations, check-ups and parental bonds are the checklist for this age group.

YOUNG CHILDREN: 4-6 YRS

Children this age need rules and structure, feedback and praise. You must explain procedures to both child and parents. Never lie to a child about whether something will hurt but reassure them that it will not hurt for long.

OLDER CHILDREN: 7-12 YRS

Use of toys and games is helpful to reduce the fear of health issues. Divert the attention from procedures that may be frightening and always encourage the child to ask questions they may have about those

procedures. During this period, growth continues slowly until there is a “spurt” at puberty. More mental activity and sense of self will also grow. At this age, vital signs approach those of the normal adult patient.

ADOLESCENTS: 13-20 YRS

During these years, the adolescent becomes an adult, mature of body and more complex thinking develops. During this time period the following issues should be considered:

- Privacy and respect
- Checkups
- Sexual responsibility and substance abuse
- Risk taking and handling violence

Nutritional disorders, obesity, anorexia and bulimia are common health problems. However other problems like acne, STDs and pregnancy cannot be ignored. Physical changes can produce stress as well. You must speak to the adolescents as an adult instead of talking to the parents, explaining procedures and encouraging questions.

YOUNG ADULTS: 21-39 YRS

This group has reached mental, physical and sexual maturity. Regular health check ups and immunizations continue to be important. An emphasis on a healthy physical workout and proper nutrition as well as risks such as heart disease and cancer should be part of their education.

MIDDLE ADULTS: 40-64 YRS

A decrease in bone density/mass causes a decrease in height during these years. Muscle tone also decreases, and visual acuity often diminishes necessitating eyeglasses. There is an awareness that one is becoming “old”.

OLDER ADULTS: 65-79 YRS

Although there is a decline in physical ability and sensory perception, older adults continue to learn and think. Aspects of aging need to be accepted with extra effort made to remain active. The more chronic conditions at this age are arthritis, hypertension, hearing impairment and heart disease. Also common are digestive problems such as reflux, and bladder/lowel problems. Use of medications can grow to include multiple medications. It is important to help older adult patients work out a manageable medication schedule. Explain all procedures using appropriate terms. Bel alerto to any issues with mobility or daily activities.

ADULTS 80 AND OLDER

Be on the alert for chronic illnesses and major health problems in patients 80 and older. Medications can become even more complicated and may require you to work out detailed plans and reminders to help the patient follow a schedule. Update immunizations (especially influenza and pneumonia which can be life threatening). Check the living environment for hazards and use aides such as safety grips and ramps to prevent falls. Encourage adequate fluid intake and healthy eating. Taste, chewing and bowel functions should be monitored. Do not treat older adults like children.

CONCLUSION

Every patient has a different set of age-related medical and psychological factors that may affect their health. An efficient caretaker knows the differences and how to communicate effectively in order to provide the best assessment and highest level of care.

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ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is *not* normal aging and is *not* dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitably need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment

- Trouble with routines
- Lessening of initiative
- Disorientation of time and places
- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings

People are "out to get them"

Fear that caregiver is going to abandon (results in AD person never leaving caregiver's side)

Current living space is not "home"

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question

Repetitive action such as wringing a towel

Wandering

Pacing

Sundowning: trying to get "home" Generally feeling uncomfortable or restless Increased agitation at night

Losing things / Hiding things

Simply do not remember where items are

Might hide things so that people don't "steal" them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked too many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract instead
9. Be reassuring with touch, eye contact and tone of voice

10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification

Alzheimer Resource Center of Tallahassee: (850) 561-6869 Website: www.arc-tallahassee.org Alzheimer's Foundation of America Website: <http://www.alzfdn.org>

BODY MECHANICS \ ERGONOMICS

PROPER BODY MECHANICS

Using the safest and most efficient methods of moving and lifting is known as body mechanics. Body mechanics is a term that describes the coordinated effort of the muscles, bones, and nervous system in accomplishing certain tasks.

It is important to understand how the body's mechanical forces work together, in order to avoid musculoskeletal injuries as well as injury to the patient. Your physical strength is not as important as how efficiently you use your body.

When moving a patient, keep in mind these general rules of good body mechanics:

1. Move as close as possible to the patient's bed.
2. Keep your abdominal muscles contracted and your lower back in its normal position.
3. Keep your head upright and hold your shoulders up.
4. Bow slightly using your hips and squat.
5. Don't twist your body; always do a side-step or pivot on the balls of your feet.
6. Push up from your knees and use your own momentum to help move the patient.

Focus on these three concepts:

- Maintain a stable center of gravity to evenly distribute your body weight, and keep your center low for better balance. Rather than bending, flex your knees and keep your torso straight.
- 2. Maintain a wide base of support and greater stability by spreading your feet apart to a reasonable distance and flexing your knees.
- 3. Maintain proper body alignment by keeping your back upright when performing maneuvers. Equal activity balance in the upper and lower parts of your body can reduce your risk of a back injury.
-

In addition to our muscles and tendons, we have added factors that assist with moving those awkward, cumbersome heavy objects. These are:

- The *center of gravity* is the point in a body where weight is equally distributed on all sides. In most people this is located in the pelvis about level with the 2nd sacral vertebra.
- The *line of gravity* (or plumb line) runs behind the ear, through the 2nd sacral vertebra and pelvis, through the knee and just in front of the ankle. Your body is in balance when your posture corresponds to this alignment.
- The *base of support* is the width of your stance. Widening your stance and lowering your center of gravity will increase your base of support. By changing either of these factors, you can maintain your balance and this will help when lifting heavy objects.

POSTURE

Standing:

1. Hold your head straight and centered, not tilted to any one side.
2. Maintain the natural curves of your spine and keep your shoulders straight, not slumped forward.
3. Your abdomen should be held up and in to help support your back, with your hips straight.
4. Each leg should support an equal amount of body weight, with your knees forward and slightly flexed.
5. Your feet should be about shoulder-width apart, with your toes pointed forward.

Sitting:

1. Hold your head straight and centered, with your spine straight. Your body weight should be evenly distributed on your buttocks and thighs.
2. Keep your hips and your knees flexed at 90-degree angles.
3. Your knees should be either level with your hips or slightly above them, and they should be clear of your chair so that there is no pressure on the nerves and blood vessels behind your knees.
4. Keep your feet flat on the floor to help support the weight of your legs; use a footrest if needed.
5. Sit back in your chair and let it support the lumbar region of your back.
6. To avoid bending forward, position your work closer to you. To take additional pressure off your back, support your forearms on a desk, chair armrests, or in your lap whenever possible.

Lifting:

1. If you need to lift an object off the ground, widen your stance and squat down to lower your center of gravity.
2. Keep your back straight and tighten your abdominal muscles.
3. Grasp the object and bring it as close to you as possible.
4. Then, use the power of your quadriceps and gluteal muscles to extend your legs to lift. Always lift with your legs and never with your back muscles, as this can overstress your back and lead to disc injury.

TRANSFERRING AND AMBULATING PATIENTS

In the course of patient care, you may be required to turn and move patients on a regular basis. It is important to do so without endangering either the patient or yourself. Practicing good body mechanics when lifting and moving patients is vital.

Always use patient transfer techniques that apply proper body mechanics.

- Wear comfortable clothes with a loose fit and footwear that will not slip.
- Be sure that the floor is dry and the area is clear of obstacles.
- Explain to the patient how you will make the transfer, and have the patient assist you as much as possible.
- Whenever necessary, have someone help you in the transfer.

Transfer aids can play an important role in avoiding injury. The time it takes to use these devices is greatly offset by the time it would take to recover from an injury.

- You can provide support to a weak or unsteady person by using a transfer belt (also called a gait belt), a sturdy webbed belt with a buckle that easily secures around the patient's waist.
- In addition, mechanical lifts, roller boards, sliding boards, flexible patient movers and slings, and pivoting turntables can facilitate patient transfers and greatly reduce the level of manual effort required to move a patient.

To accomplish bed-to-chair transfers:

1. Position the wheelchair close to the bed, on the patient's strongest side, and lock it at a slight angle.
2. Have the patient sit on the edge of the bed with feet shoulder-width apart and flat on the floor. The patient should wear nonslip footwear.
3. Explain what you are about to do and secure a transfer belt around the patient's waist.
4. Place yourself in front of the patient and block the patient's leg closest to the chair with your foot and leg.
5. Your other leg should be slightly behind and spread in a stance that provides a solid base of support and control of the lift.
6. Grasp the sides of the transfer belt and keep your head and back straight while bending at the knees
7. The patient should lean toward you, and hold your forearms if possible. Do not allow the patient to hold onto your neck or shoulders.
8. With your back straight, lift with your legs to bring the patient to a standing position. Keep the patient as close to you as possible.
9. Pivot on the balls of your feet or side-step and position the patient to the chair.
10. Gently lower the patient into the chair, bending at your knees, not your back. This basic technique can also be used for chair-to-chair, chair-to-commode and chair-to-bed transfers.

To accomplish bed-to-stretcher transfers:

1. Bed-to-stretcher transfers require the assistance of another person and are best done with a lift or draw sheet. If a lift sheet is not available, using the actual bed sheet is safer than attempting to lift the patient without a sheet.
2. Begin by positioning the patient on the lift sheet and as close to the edge of the bed as possible.
3. Raise or lower the bed and stretcher to equal heights. Position the stretcher against the side of the bed and lock the wheels.
4. While keeping your back as straight as possible, reach over the stretcher and grasp the lift sheet.
5. Be sure to hold the corner of the pillow as well as the lift sheet to support the patient's head during the move.
6. Your assistant should grasp the sheet in the same manner and be prepared to push as you pull.
7. The assistant may find it easier to place one or both knees on the patient's bed to avoid leaning over excessively.
8. Using a three count, lift and pull the patient onto the stretcher while your assistant lifts and pushes.
9. Several short lifts may be preferable to attempting one large movement.

To assist a patient with ambulation:

1. Allow the person to sit up in the bed for a few minutes before helping him or her out of bed.
2. Have the patient wear nonslip footwear.
3. Use a transfer belt for safety.
4. Position yourself to the side and slightly behind the patient.
5. If the patient is unsteady, two assistants are required (one may be a family member). Hold the patient's upper arms and support the lower arms and hands.
6. If the patient needs firm support, two assistants are required. The assistants grasp each other's arms behind the patient's back, and the patient puts his or her arms around the shoulders of the assistants.
7. Remember, if the patient becomes faint and is going to fall, you can avoid injury by safely easing him or her to the floor.

EXERCISING

Because working in a healthcare environment can be physically demanding, it is a good idea to stay in good physical shape. Exercising at home at least three times a week can help you avoid injury and increase your flexibility, strength, and stamina. Certain stretches and exercises are especially helpful for healthcare workers. Just be sure that all exercises are "pain free." If you feel discomfort, you may not be ready to do that specific exercise.

Flexibility Exercises:

- Quadriceps Stretch – Using a towel or band, lie on your stomach, attach the band to your foot, and pull your heel to your buttocks. Hold this stretch for 1 minute. Repeat three times for each leg.
- Hip Flexor Stretch – Kneel with one knee on the ground. Raise your same-side arm up and backward to cause your hips to shift forward and your back to extend. Hold for 20-30 seconds. Repeat three times for each leg.
- Adductor Stretch – Prop up the inside of your ankle on a table about the height of your upper thigh, raise your opposite arm over your head, and lean sideways toward the table. Hold for 20- 30 seconds. Repeat three times for each leg.
- Hamstring Stretch – Prop the back of your heel on a table about the height of your upper thigh, keep your back straight, and lean forward at the hips. Hold for 20-30 seconds. Repeat three times for each leg.

Strength Exercises:

- Supine Abdominal Draw-In – Lie on your back on a mat with your knees up and feet flat on the floor. Pull your abs in and push your lower back to the mat. Repeat 20 times.
- Abdominal Draw-In With Knee to Chest—Lie on your back on a mat and maintain the abdominal draw-in as you bring one knee to your chest and back out again. Don't grab your knee with your hand. Repeat 10-20 times with each leg.
- Abdominal Draw-In With Heel Slide – Lie on your back on a mat and maintain the abdominal draw-in as you bend your knee and slide your heel toward your buttocks and back out again. Repeat 10-20 times with each leg.
- Abdominal Draw-In With Double Knee to Chest – Lie on your back on a mat and maintain the abdominal draw-in

as you bring both knees to your chest at the same time, then back out. Repeat 10-20 times.

In conclusion, injury on the job can be a traumatic and debilitating experience. It may result in loss of work and the need for ongoing medical treatment. Work time lost due to injury can also be detrimental to the facility where you work and can put additional pressure on your coworkers. Using proper body mechanics can greatly reduce the risk of injury to both you and your patients. Because you are working with your body's natural design, you will improve your ability to work safely and efficiently.

CULTURAL DIVERSITY IN THE HEALTH CARE SETTING

Competency in cultural diversity is a set of attitudes, skills, behavior and policies that enable you to work effectively in a multi-cultural environment. The following are specific areas that focus on cultural competency in the health care setting:

- Health-related beliefs and values
- Disease prevalence
- Treatment efficacy

Effective communication and incorporating cultural concepts throughout the entire encounter, from admission to discharge, can increase patient satisfaction and treatment.

1. Value Diversity

Caregivers need to become aware of personal beliefs, prejudices and behaviors that may influence our care of patients as well as our interactions with colleagues and staff from diverse racial, ethnic and sociocultural backgrounds.

Cultivating partnerships with our patients and maintaining “cultural humility” can help us to better understand the environmental contexts in which our patients live. It is important to understand patient/community barriers to care but also the physician/health care system barriers. Through collaboration and better understanding, caregivers can work together with other to eliminate racial and ethnic disparities in healthcare.

2. Assess Themselves

Learning to evaluate our own level of cultural competency must be part of the ongoing effort to provide better healthcare. This includes honest assessment of our assumptions about others. Practice examining these assumptions and prejudices. It will help providers understand the impact of unconscious thinking and applying those thought in providing health care.

3. Manage Dynamics of Difference

Adherence to treatment can be a challenge for any patient, no matter his/her culture. When the caregiver and patient come from different cultures and speak different languages, effective communication and the patient’s ability to communicate decrease. The key to adherence (patient’s adherence to medical advice and to take medicine as directed) is the effective communication between provider and patient.

These activities can contribute greatly to this communication:

- 1) Ask non-judgmental questions (what remedies have you tried, what caused your illness)
- 2) Listen carefully (Don’t interrupt, fidget, do take notes, don’t doodle)
- 3) Set realistic goals for behavior change (Pregnant women are not allowed to eat certain foods, certain religions disallow certain foods)
- (4) Solve problems together
- (5) Working with a qualified, professional interpreter

4. Acquire and Institutionalize Cultural Knowledge

Non-verbal communication can be divided into several categories:

- Facial expressions
In some cultures, smiling expresses happiness, but some Chinese, for example smile when discussing something sad or uncomfortable. Other facial expressions that have multiple meanings are winking, blinking one’s eyes, shifting the eyes in the direction of something, using lips to point to an object or person.
- Head Movements
Nodding the head for “yes” in one country, pointing the head sharply upward may mean “no”
- Hand and Arm Gestures
The “OK” sign in Japan signifies money, but in other countries it means “zero”. In other countries the sign can be highly offensive.

Holding up crossed fingers can mean good luck to some, but to hold crossed fingers behind the back negates what was just spoken. In Russia this is a way of rejecting or denying something. In yet another country, this sign is to ward off bad luck and in China it signifies the number 10.

The “thumbs up” gesture has a vulgar connotation in Iran

Some cultures use the whole hand to point because to use one finger is very rude

- **Personal Space**
In some cultures, for a man to stand too close to a woman is not acceptable and in others they are quite used to standing, sitting and talking in close proximity.
- **Touching**
In some cultures, light touching or a light kiss to the cheek is very common but in Asian countries, people may prefer less physical contact with people who are acquaintances.

Touching another person’s head is considered offensive in some cultures, though handshakes are allowed, any other contact may be inappropriate. Many latin americans will embrace upon meeting in Latin America but in the middle east, only the right hand is used to shake hands or accept a gift. Western women should never shake hands with a man from India. Stepping on someone’s foot in India is very offensive and one should apologize immediately.
- **Eye Contact**
To make direct eye contact in some cultures is very disrespectful but in others making good eye contact is important socially and in business.

Family interaction is very important in the context of the patients complete treatment and medical care. Family members can shed light on various cultural factors such as alternative medications, diet, health behavior and daily activities. The family’s involvement can be vital to a patient’s ability to adhere to a plan of treatment.

5. Adapt to diversity and the cultural contexts of individuals and communities served.

- There are roles of men and women, in various cultures that will dictate what is able to be discussed openly. Care should be given to using a family member as interpreter when a professional is not available for this reason.
- Diet and food that is provided to a patient may be very bland compared to what they are used to. It should be discussed what can and cannot be brought from home for the patient. Not all foods are beneficial.
- The family can be invaluable in explaining what other medications the patient is prescribed as well as alternative or cultural treatments that are being used.

Keeping the lines of communication open to the family members will only benefit the patient.

Cultural competence can have a real impact on the clinical outcome for a patient. If it is ignored, it can lead to negative consequences. Culturally competent healthcare can greatly increase the successful treatment of those who do not speak English well and who have their own cultural practices, beliefs and lifestyles. It opens the door to a larger pool of clinicians who can provide a different level of treatment.

EMERGENCY MANAGEMENT PREPAREDNESS

When a disaster strikes, public service agencies, emergency response agencies, and other officials will rapidly mobilize to help the injured and the broader community in general. Because saving lives in a disaster is paramount, medical professionals must be included in all phases of disaster planning as well as in the immediate response to these events.

While there may be different definitions, healthcare workers must be prepared to handle a disaster and other problematic events occurring inside or outside their walls.

- An external disaster is an event that impacts a facility when the demand for services goes beyond the available resources.
- An internal disaster is an event that happens within the facility that poses a threat to interrupt the environment of care.

Disaster events may be categorized as Class A, Class B, and Class C, according to type and severity.

Class A: Natural Disasters

- Earthquakes
- Floods
- Tornadoes
- Hurricanes
- Blizzards
- Other serious weather conditions

Class A: External Disasters/Medical Emergencies

- Chemical exposure
- Epidemic of disease (biological)
- Explosions
- Fire
- Large-scale poisoning
- Multiple-victim accidents (car, bus, train, plane crashes)
- Terrorism
- Nuclear fallout
- Riots and other civil disturbances
- Structural collapse
- Toxic radiation

Class B: Internal Disasters/Medical Emergencies

- Disease epidemics
- Large-scale food poisoning • Large-scale infections

Class C: Internal Disasters/Non-Medical Emergencies

- Explosions
- Fire
- Multi-administrator deaths
- Terrorist threats • Bomb threats
- State Board of Health declared emergency
- Strikes
- Union activity
- Malpractice suit or accusation against facility or physician on staff
- Power failure
- Major mechanical failure
- Internet- or computer-related issues involving patient records

EMERGENCY MANAGEMENT PREPARATION When a disaster occurs, you will be challenged to provide care in difficult situations including:

1. Loss of essential services, such as electricity, water, or the supply chain
2. Loss of infrastructure, including damage to facilities or electronic information
3. Shortage of workers due to transportation loss, worker or worker family illness/injury, or unwillingness to report to work
4. Size of the affected population, requiring triage at a community level
5. Sudden increase in the number of patients, significantly over your facility's capacity and/or with serious injuries or other extreme patient conditions
6. The need to perform patient care at an alternate facility not equipped for patient care

In situations such as these, there can be severe consequences if changes are not made in care practices. Essential decisions about allocation of resources should be made at a system level, by the facility in which you work or the community-wide incident command structure. As a healthcare worker, you are responsible for giving the best possible care to patients within the available resources. Understanding the latest standards, and the role you play, is vital.

THE JOINT COMMISSION STANDARDS The Joint Commission's elements of performance require the organization to:

- Identify a leader to oversee emergency management
- Consider input from staff at different levels when evaluating exercises and responses to events
- Review of the organization's emergency management plan, performance, and responses to actual events by the facility's senior leaders to facilitate improvement

According to The Joint Commission (TJC), an effective emergency management plan includes four key principles:

- Mitigation- plan ahead to lessen the severity and impact of an emergency
- Preparation- build needed resources such as supplies/equipment, training and orientation for staff, outside service agreements to assist, and periodic drills
- Response-define prearranged locations to report to and other organizational steps staff can take to lessen confusion and ensure a more orderly response
- Recovery- restoring and resuming services and normal operations will take community response and staff coordination and support

There are 11 core competencies for healthcare workers in the event of a disaster. As a healthcare worker, you should be able to:

1. Describe your expected role in an emergency response in the specific practice setting as part of the institution or community response.
2. Respond to an emergency event within the incident or emergency management system of the practice, institution and community.
3. Recognize an illness or injury as potentially resulting from exposure to a biologic, chemical, or radiologic agent possibly associated with a terrorist event.
 - Recognize uncommon presentations of common diseases and distinguish these from common presentations of uncommon diseases that may be related to a terrorist event or emerging infectious disease.
 - Recognize emerging patterns or clusters of unusual presentations.
4. Institute appropriate steps to limit spread, including infection control measures, decontamination techniques and use of appropriate personal protective equipment.
5. Report identified cases or events to the public health system to facilitate surveillance and investigation using the established institutional or local communication protocol.
6. Initiate patient care within your professional scope of practice and arrange for prompt referral appropriate to the identified condition(s).
7. Use reliable information sources (e.g., infection control department, state or local public health agency, Centers for Disease Control and Prevention) for current referral and management guidelines.
8. Provide reliable information to others (e.g., institutional administration, other patients) as relevant to the specific practice site and emergency response protocol.
9. Communicate risks and actions taken clearly and accurately to patients and concerned others.
10. Identify and manage the expected stress/anxiety associated with emergency events, making referrals for mental health services if needed.
11. Participate in post-event feedback and assessment of response with the local public health system and take needed steps to improve future response.

All of the following must be part of the protocol of the facility where you are assigned. Your orientation in this facility should include the plan for emergencies and disasters. For the health care provider the following steps should be taken or followed according to the plan the facility already has in place:

1. **EVACUATION** - patients should be evacuated to a secure place. Staff and patients should remain there until given the "all clear". Charts should be removed by the designated staff member and taken to the prearranged area.
2. **EQUIPMENT AVAILABILITY** - You should know where the following items are located so that the least amount of time will be used to collect them.

- Keys-housekeeping staff will be aware of the location of all the keys
 - Blankets- additional blankets may be needed and gotten from housekeeping staff
 - Oxygen Tanks (portable)- the ED, Stress Room or Respiratory Therapy areas of the facility
 - Carts- the ER, Ambulatory Care Unit, Surgery, Radiology, Ultrasound, EKG / Stress Room
 - Other- bandages, sutures, sterile scrub brushes, saline, skin cleanser, waterless hand cleaner, gloves, fracture immobilization, splinting and casting material, backboard, and support equipment (chest tube, airway, suture trays, etc.)
3. **PATIENT IDENTIFICATION** - One person should be assigned to be responsible for patient id practices. They will keep a list of patients, their location within the facility and condition.
 4. **RECORDS** - In order to preserve patient records and move the records and equipment necessary for their care to another facility, a person will need to be assigned this task.
 5. **SECURITY and PUBLIC INFORMATION** – The medical facility should have security in place to guard against unauthorized entry following a disaster. In addition, phone staff should be advised not to give out any information concerning a disaster to any caller.
 6. **RECOVERY** – The facility, as part of their emergency plan, will have pre-disaster photos of equipment and buildings already in place. Similarly, after the disaster, photos can be taken by facility designees to document the effects and damage caused by the disaster. This does not come under the scope of health care provider.

All medical facilities should conduct drills and training for emergencies. This way any potential problem can be revealed and corrected before they are actually tested. Joint Commission mandates hospitals to hold at least 2 disaster drills per year to include treatment and transportation exercises. The Joint Commission evaluates the staff and the plan once a year.

FIRES

Having an accepted plan for fire emergency and hazards in the workplace is of the utmost importance. There are many fire hazards in the healthcare environment that can harm patients and staff if you do not have a plan. Many healthcare facilities use the “R.A.C.E.” system when a fire breaks out. Using the word RACE is a convenient way to remember what to do.

R= Rescue (or remove) patients and staff in immediate danger

A=Alarm (or activate the alarm)

C=Contain the fire

E=Extinguish the fire

EARTHQUAKES

Almost no place on earth is free from earthquakes. They are not infrequent and can occur up to several million each year across the globe. Some are extremely devastating and others are barely noticed. The main concern for medical institutions is the loss of power. Use the following as general guidelines and always be up to date on the individual policies of the facility where you work.

During the Quake

1. Don't panic. If you are inside, stay inside. The greatest danger is from falling debris just outside the building and near the outside walls. Instruct all people inside to move into the hallways. If there is no time, have all take cover under beds or tables. Stay away from windows and glass.
2. Never use an open flame device. No candles, no matches. Put out any cigarettes and fires. If you are outside, move away from the building and utility wires. Once outside, stay there until all shaking stops.

After the Quake

Here are steps to take after the shaking stops:

1. Check for injuries. Follow treatment procedures as instructed
2. Do not use open flame devices until the building has been inspected and declared safe
3. Once building has been declared safe, check the utilities. If you smell gas, open windows and shut off the main gas valve.
4. Do not use telephones, unless you absolutely have to.
5. If the building is damaged, do not allow anyone to enter until “All Clear”.

Fires can be caused by earthquakes. They can be even more devastating than the earthquake because they damage equipment, utilities and water sources. Be especially alert for fires, leaking gas and other dangerous effects of the quake. If there is a fire, you **MUST** follow the procedures set forth for fires unless told otherwise.

BOMB THREATS

Steps to follow during a bomb threat received by phone should include the following:

1. Don't panic
2. Keep the caller on the line as long as possible
3. Record every word spoken by the caller as best you can.
4. Listen for any strange or unusual background noises which might be helpful in providing clues to law enforcement.
5. Listen for accents, gender, speech impairments, nervousness, and whether the voice is familiar or unfamiliar.
6. Record everything you can. You may not be able to recall as well as you think you can when the moment has passed.

After the caller hangs up, IMMEDIATELY contact the switchboard and give as much information as possible. This person should contact the Police Department and then make this announcement over the intercom:

“ATTENTION PLEASE. CODE 50 IS NOW IN EFFECT”

The switchboard operator will use whatever code is appropriate for your facility. All staff should be familiar with the code system in the facility. They will differ. For example one facility may use color, another number and still others use letters or any combination of these. It is up to you and the emergency preparedness team to ensure all staff know the codes.

Questions to ask include:

- Where is the bomb located
- When will it go off?
- What does it look like?
- What kind of bomb is it?
- Did You place the bomb? If yes, why?
- What is your name?

If you receive a suspicious package, inform the authorities immediately. Do not move the package. Signs of a suspicious package include:

- No return address
- Poorly handwritten
- Excessive postage
- Misspelled words
- Strange odor
- Foreign postage
- Strange sounds

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The following services and community responders will need to be contacted:

Fire Department

Hospital Administrator

All Nursing Administrators/Managers

Safety Management Director

Environmental Services Director

Maintenance

Once a search has begun, only authorized law enforcement will remain in the building. The removal of any suspicious or dangerous item (s) will be conducted by the appropriate authorities as quickly as possible. Once the building has been secured and determined safe, the "All Clear" should be announced.

Safety Management Director
Environmental Services
Director Maintenance

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RIOTS

Riots or civil disturbances **MUST** be part of your emergency preparedness plan. In this case, you should notify your supervisor who will in turn notify the appropriate people in authority. It is important that the hospital entrance nearest the location of the occurrence is secured. Always remember to remain calm. Those in charge will take steps to handle every situation. Your job is to ensure the safety and comfort of your patients and to report any incident to the proper authorities. Make no attempt to negotiate, make promises or concessions with any one involved in the disturbance.

A facility's Emergency Preparedness Plan is only useful if it is practiced and updated regularly. It is also only effective if the staff of health care providers is made aware of this plan and is regularly given orientation and practice implementing the steps to be taken. The safety of the patient is the responsibility of the health care provider. The Emergency Preparedness Plan will enable you to fulfill that promise to your patient in most emergent situations.

ENVIRONMENTAL AND FIRE SAFETY

Introduction

No matter where you work in the healthcare field, you come across unique and possibly fatal hazards everyday. This handbook will show you how to protect yourself from some of the most common hazards.

Slips, Trips & Falls

You can reduce your risk of injury from slips, trips and falls if you are aware of your surroundings. Sources of slip, trip and fall hazards include:

- Wet floors
- Un-tacked carpets
- Cords
- Poor lighting or too much lighting

If you observe a hazard, correct it or report it to your supervisor. In addition:

- Don't rush down corridors. Take shorter, slower steps. Maintain your center of balance under you.
- Wear sensible shoes with good traction and support.

Back Safety

Some healthcare workers have as much strain on their backs as construction workers. To avoid back injury, stay physically fit and maintain good posture.

When lifting patient or heavy items:

- Bend your hips and knees – not your waist
- Lift with your leg muscles – not your back or arm muscles
- Avoid twisting
- Never lift a load higher than your waist
- Keep the load close to your body
- If you need help lifting or moving a load, ask for it.

Electrical Safety

To manage electricity safely:

- Report all shocks immediately – even tingles
- Never work around electricity when you or your surroundings are wet. Remove metal jewelry, watches and belt buckles.
- Don't use so-called "octopus" adapters. Plugging too many cords into one outlet can overload the circuit.
- Check GFCI outlets regularly. Push the test button. The reset button should pop out. Press the reset button to reactivate.
- Examine all cords and plugs routinely. Replace any that are damaged or that heat up when used.
- Keep cords away from heat and water. Don't run cords under rugs or through doorways.
- Never attach cords to the floor, wall or other objects with tacks or pins.
- Use grounded, three-hole outlets or adapt ungrounded outlets with a standard plug adapter. Never break off or bend the third prong on a grounded plug.
- Don't use damaged outlets or adapters that let you plug extra cords into an outlet.
- Don't use any electrical device that blows a fuse, trips a circuit breaker, shocks or appears damaged.
- Follow safety instructions when using electrical equipment.

Fire Safety

Prepare yourself before fire strikes in your workplace:

- Memorize all exit and emergency routes.
- Identify all fire alarms.
- Learn how to operate fire extinguishers.
- The first 2-3 minutes are most critical. It is a RACE for safety.

RACE is the acronym for :

RESCUE-or REMOVE anyone in danger to a safe place
ACTIVATE- or sound the alarm

CONTAIN-close all doors or windows
EXTINGUISH-grab the nearest fire extinguisher and put it out!

PASS is the acronym for using the extinguisher:

PULL the PIN breaking the plastic seal
AIM at the base of the fire
SQUEEZE the two handles together
SWEEP in a back and forth motion to extinguish the flames

Remember, smoke and heat are just as deadly as flames:

- Don't touch or open any door without first testing the amount of heat radiating from it.
- Stay low to the floor to avoid inhaling too much smoke.

If a person is on fire, wrap them in a blanket and pat the fire area. Do not fan. If a blanket is not available, roll the person over, from side to side until the fire is out. Once the fire is out, remove all clothing as this will stop the burning process and cover the person with a clean sheet and/or towels. Do not cover the face. Remove the person to the ER immediately. Keep them as calm as possible.

Disinfections and Sterilization

Develop a mental eye for spotting potential hazards that cannot be seen, heard, felt or smelled:

- Recognize what needs to be disinfected and sterilized and learn appropriate methods for each.
- Generally, semi-critical equipment can be disinfected. Critical equipment requires the more effective sterilization.

Handling Medical Waste

Blood and other body fluids can carry the human immunodeficiency virus (HIV), the hepatitis B virus (HBV), drug-resistant organisms (DRO's) and radioactive waste. Therefore, it is important that all medical waste related to patient care be treated as potentially hazardous.

Examples of medical waste include:

- Sharps
- Blood
- Body Fluids
- Specimens
- Soiled laundry
- Dirty dressings

Blood Borne Pathogens

Your employer has developed an Exposure Control Plan to help implement the requirements of OSHA's Blood Borne Pathogens Standard. Make sure you are familiar with both documents. Treat all medical waste and blood as contaminated and act accordingly.

- Needle sticks are one of the most common ways diseases are transmitted on the job. Do not bend, recap, shear, or break used needles and other sharps.
- Immediately after using sharps, place in an appropriate, puncture-resistant, leak proof, color-coded container
- Minimize splashing, spraying, and spattering when performing procedures involving blood or other potentially infectious materials.
- Separate and label all medical waste at the source. Use separate containers for each type of waste.
- Red or red-orange labels, bags or containers with the biohazard symbol warn you that contents are biohazardous materials.
- Don't eat, drink, smoke, apply cosmetics or handle contact lenses where there is a reasonable likelihood of occupational exposure.
- Don't keep food or drink in refrigerator, freezer, cabinets or on shelves, countertops or benches where blood or other potentially infectious materials are present.

COMPRESSED GAS SAFETY Compressed gas cylinders need to be treated with utmost care and respect. Hazards associated with compressed gases include:

- Oxygen displacement
- Fires
- Explosions

- Toxic gas exposures
- Physical hazards associated with high-pressure systems

Keep these facts in mind:

- If the contents of a compressed gas cylinder are released too quickly, the cylinder can become an uncontrollable projectile. • If the cylinder tips over, it may explode.
- Compressed gases should be handled only by experienced and properly trained workers.
- Special storage, use, and handling precautions are necessary in order to control the hazards associated with compressed gas.

GOOD HOUSEKEEPING

Your facility's Exposure Control Plan lists specific methods and schedules for cleaning surfaces that may be contaminated. Some general rules:

- Protective coverings on equipment and surfaces must be replaced if contaminated or at the end of the work shift.
- Use a broom and dustpan or tongs to pick up broken glass – not your hands.
- Handle contaminated laundry as little as possible and with minimal agitation.
- Use leak proof bags to transfer contaminated laundry.

PERSONAL PROTECTIVE EQUIPMENT

Personal protective equipment (PPE) is a vital barrier between your body and danger. PPE may include:

- Gloves
- Gown
- Apron
- Goggles
- Face Shield
- Mouthpiece
- Resuscitation bags or other ventilation devices

Disposable single-use gloves are the most common type of PPE. Heavy-duty utility gloves are used for housekeeping duties and direct contact with medical waste.

- Cover cuts and abrasions with bandages before being gloved.
- Replace PPE as soon as practical if contaminated or immediately if torn or punctured and no longer offering barrier protection.

HAZARD COMMUNICATION

In addition to medical waste, there are other hazardous substances on the job such as cleaning solvents, anesthetics and radioactive materials.

Your written HazCom Program provides a range of information and training. Become familiar with it and know where it is located. In particular, it will tell you:

- Which hazards are in your work area
- How to identify and read Material Safety Data Sheets (MSDSs)
- What you should do if a label is missing or torn
- What happens when substances are mixed
- How to dispose of hazardous substances
- What first aid to give in an emergency

RADIATION SAFETY

There are two primary ways you can encounter radiation in a healthcare environment:

- External beam sources, like x-rays or gamma rays.
- Radioactive sources used internally for patient diagnosis or treatment.

Follow these guidelines to avoid harmful effects of exposure:

- Minimize your time exposed to radiation source.
- Maximize distance between yourself and radiation source.

- Use shielding and protective clothing when appropriate.
- Never touch anything with a radioactive warning label unless you are trained and authorized to do so.
- When caring for patients being treated with radioactive materials, dispose of syringes, radioactive liquid and other waste properly.
- You may enter the room of a patient being treated with radiation to perform normal duties, but you should limit the time spent in the room.

Handwashing & Glove Removal

Hand washing keeps you from transferring hazardous materials from your hands to other areas of your body, patients, or the environment.

- When dealing with any potentially hazardous material, always thoroughly wash your hands before and after handling it.
- No barrier is 100 percent effective. After each activity, remove gloves and wash hands before putting on a new pair.
- When removing gloves, pull one glove off from the outside top and hold in gloved hand. With exposed hand, peel second glove down from top tucking first glove inside second. Don't touch outside of glove. Dispose of entire bundle promptly in the proper waste receptacle.
- Wash all surfaces of the hands with soap, friction and running water for a minimum of 15 seconds.
- If infectious material gets on your hands, the sooner you wash it off, the less your chance of becoming infected.
- If hands or any areas come in contact with blood or other potentially infectious material, wash with non-abrasive soap and running water immediately.
- If mucous membranes are exposed to contamination, flush with water for about 15 minutes, then seek medical attention.
- If there is no sink in your work area, appropriate antiseptic hand cleanser or novelettes will be provided. But you must still wash with soap and running water as soon as possible.
- Wash hands between patients so as not to transfer contaminants.

ETHICS

Healthcare ethics involves each caregiver's sense of right and wrong, and the duties owed to patients and families. It involves four main principles:

1. Autonomy, which is to honor patients' rights to make their own decisions regarding care
2. Beneficence, which is to help patients advance their own well-being
3. Non-maleficence, which means to do no harm
4. Justice, which means to be fair and treat all patients the same

Although all four principles are of equal importance, in U.S. caregiving the respect for patient autonomy often take priority over the others.

ETHICAL STANDARDS

The Joint Commission (TJC) has produced a set of standards called Ethics, Rights, and Responsibilities. These standards serve as a guide in decision-making and healthcare delivery for providers and organizations. The goal of the Joint Commission standards is to:

- Ensure that care, treatment, and services are provided in a way that respects and promotes dignity, autonomy, positive self-regard, civil rights, and involvement of patients
- Consider each patient's abilities and resources, the demands of his or her environment, and the requirements and expectations of providers and those they serve
- Ensure that the family is involved in care and treatment decisions, with the patient's approval TJC standards cover three areas:
 1. Organizational Ethics
 2. Individual Rights
 3. Individual Responsibilities

These three areas are described in the following sections.

ORGANIZATIONAL ETHICS According to The Joint Commission, organizational ethics apply to the environment in which healthcare is delivered. It involves:

- The responsibility that a facility has to the patients and community it serves
- The connection between ethical healthcare and ethical business practices
- The requirement that care is provided within the facility's scope, mission, and applicable regulations

There are three aspects of organizational ethics:

1. Procedural justice – The policies in place for decision-making should be coherent, consistent, and transparent
2. Distributive justice – The fair allocation of resources, rewards, benefits, and discipline within the facility
3. Professionalism – The practice of upholding the moral principles and commitments valued by the profession and the public.

The Joint Commission states that you as a healthcare worker should:

- Demonstrate respect for human dignity, honesty, integrity, and trustworthiness
- Demonstrate autonomy and self-regulation of your profession (such as through peer review and other processes)
- Participate in resource allocation decisions
- Safeguard confidences and privacy

INDIVIDUAL RIGHTS According to The Joint Commission, individual rights involve:

- How a facility respects the culture and rights of patients during staff interactions
- How the staff involves patients in care decisions

The standards for individual rights include these five considerations:

1. **Shared Decision-Making** – In order to deliver the highest quality care, providers are no longer expected only to provide information to patients – but to partner with patients as well.

- Clinicians bring their specialized knowledge of science, medicine, and technology
- Patients weigh that information along with their preferences, values, and experiences

2. **Informed Consent** – Shared decision-making is documented through the process of informed consent. It means that patients have the capacity to make decisions and can appreciate their available options, and that their decisions are voluntary.

3. **Advance Care Planning** – Advance care planning is a way to promote shared decision-making at times when patients don't have the ability to make such decisions. Patients can document their wishes and/or name a proxy to make decisions about their treatments at times when they are unable to do so themselves.

4. **End-of-Life Care** – This involves how decisions are made once the goals of care change from curative to palliative at the end of life. As a healthcare provider, your goals are:

- Supporting end-of-life decision-making
- Ensuring that decisions made are consistent with the values and desires of the patient
- Respecting the individual rights of patients

5. **Privacy and confidentiality** – In addition to protecting patients' autonomy, their personal information must be protected as well. Privacy and confidentiality in healthcare refers to the protection of information that relates to:

- The past, present, or future physical or mental health or condition of an individual
- The care provided to an individual
- The past, present, or future payments for healthcare

INDIVIDUAL RESPONSIBILITIES According to The Joint Commission, individual responsibilities involve the patient's role in the healthcare process. When patients are partners in care, the safety of healthcare delivery is enhanced. Some ethical decisions can be made only by the patient. Healthcare providers can inform, consult, and advise, but only the patient can ultimately decide what quality of life is acceptable to him or her.

SHARED DECISION-MAKING WITH PATIENTS

This includes:

- Decision-making capacity –ability of patients to make their own healthcare decisions
- Informed consent process –ensuring that the decision is voluntary, and documenting the decision
- Surrogate decision-making –responsibilities of a person authorized to make decisions for the patient
- Advance care planning – Statement made by a capable patient regarding decisions in the event they lose that capacity in the future
- Limits to patient choice – Questions relating to choice of care setting, choice of provider, demands for unconventional treatment, etc.

PATIENT PRIVACY AND CONFIDENTIALITY Protecting patient privacy and confidentiality involves:

- Privacy – Protecting patients by maintaining privacy free of unwanted intrusions and in controlling data about themselves
- Confidentiality – Nondisclosure of information obtained as part of the clinician-patient relationship

PROFESSIONALISM IN PATIENT CARE Professionalism in patient care involves how well an organization fosters behavior appropriate for healthcare professionals.

This includes:

- Conflicts of Interest – Situations that may compromise a caregiver’s duty to patients, including inappropriate business or personal relationships
- Truth-Telling – Open, honest communication with patients
- Challenging Clinical Relationships –Management of relationships with patients and/or their family and loved ones who present challenging or disruptive behaviors, requests, or demands
- Respect for Diverse Cultural/Religious Perspectives – Clinician interactions with patients and/or their family and loved ones of different ethnicity, religion, sexual orientation, gender, age, etc.
- Respect in Interprofessional Relationships – Recognition and respect for unique cultures, values, roles, and expertise of other healthcare professionals, and development of cooperative and trusting relationships among professionals

ETHICAL PRACTICES IN THE WORKPLACE Ethical practice in the workplace involves how well the organization supports ethical behavior in common, everyday interactions.

This includes:

- Respect and Dignity – Employee privacy, personal safety, respect for diversity, respectful behavior toward others, etc.
- Ethical Climate – Openness to ethics discussion, perceived pressure to engage in unethical conduct, etc.

EXAMPLES OF ETHICAL DILEMMAS Two significant ethical dilemmas commonly facing healthcare professionals involve documentation and financial remuneration (gift-giving to providers).

1. Documentation related to care provided to the client could involve:

- Was the medication actually given?
- Was care rendered to the patient?
- Was treatment protocol followed?
- Was a medication incident reported even if no adverse reaction was observed?
- Was care delivered in a timely manner?

2. Financial remuneration by patients to healthcare professionals.

- This could be as little as a small “tip” of \$5 to the nurse for taking “good care” of a patient by the family
- Or it could be as significant as an all-expense-paid trip to Las Vegas for a physician, by a pharmaceutical company to say thank you for writing prescriptions for their medication

Here are some ethical dilemmas to consider:

- You have had a hectic shift and did not complete the task of weighing a patient. How do you document the weight for this patient?
- You are asked to provide an update on a patient and are unsure who is asking. What is an appropriate response?
- A coworker returns from lunch looking confused, has slurred speech, and smells like alcohol. What is the ethical response?

Each of these examples demonstrates a situation in which you’re required to make a decision. In each case, it is important to remember:

- Honesty is the best policy.
- Follow your organization’s chain of command if you are unsure about what to do.
- Refer to your organization’s policies and procedures regarding the issue, if applicable.
- Always keep patient safety as your number-one priority.

As a healthcare worker, your ultimate moral and ethical obligation is to your patients. By learning new ways of incorporating ethics into patient care, and approaches for dealing with ethical issues as they arise, you are empowered to do the right thing – because it is the right thing to do.

HAZARDOUS CHEMICALS

WHAT YOU DON'T KNOW

As a healthcare worker, you know the power of chemicals. They make your job easier, more effective – and they help save lives. Yet it takes just a moment of carelessness, ignorance or poor judgment to turn one of these powerful tools into a destructive weapon. Because when it comes to chemicals, what you don't know can hurt you – and fast.

That's why the Hazard Communication Standard developed by the Occupational Safety and Health Administration (OSHA) is so important. It guarantees your "Right-to-Know" about potential chemical hazards in your workplace.

KNOWING THE RISKS

A chemical can be a physical hazard, a health hazard or both.

- A physical hazard can cause a dangerous situation like a fire or an explosion.
- A health hazard can damage your health when a chemical is inhaled, eaten, or splashed on your skin or in your eyes.
- Acute health hazards hurt you rapidly, after short-term exposure. Examples: poisoning and chemical burns.
- Chronic health hazards harm you more slowly, after long-term exposure. Examples: cancer and heart damage.

NO ONE IS IMMUNE

You probably know that chemicals are used somewhere in your facility, such as the laboratory. But here are some facts you may not know:

- Hazardous chemicals are used throughout healthcare facilities, even in nursing units. For example, powerful anti-cancer drugs can actually cause cancer and other serious health problems in nurses and pharmacists who mix them and in housekeeping staff that clean up spills and remove waste.
- Chemicals aren't just liquids in containers. Your Hazard Communication Program covers chemicals in all forms – solids, liquids, gases, vapors, fumes and mists. If it is a hazard and you can be exposed to it, it will be covered in the Hazard Communication Program. Here are some examples:
 1. Anesthetic gases can cause headaches, nausea, decreased mental alertness, impaired motor coordination, birth defects, miscarriages and cancer.
 2. Ethylene oxide, a gas used to sterilize hospital equipment, can damage skin, respiratory and nervous systems, and cause sterility, birth defects and cancer.
 3. Oxygen, used in operating and recovery rooms, may be piped throughout some hospitals, making other materials highly flammable.

Products like disinfectants and grease cutters seem harmless, but they're solvents that can damage skin and eyes. Some chemicals used in healthcare facilities can cause reproductive damage, including birth defects, infertility, impotence and miscarriage.

- Reproductive hazards can affect both men and women.
- Reproductive hazards may possibly be caused by ethylene oxide, fluorinated hydrocarbons, anti-cancer drugs, mercury, nitrous oxide, formaldehyde and various ingredients in cleaning solutions.
- If you are pregnant or plan to be, understand that your unborn baby may be particularly vulnerable.

YOUR HAZCOM PROGRAM

You can find out how to work safely with the hazardous chemicals in your workplace by reading your employer's written Hazard Communication Program. It includes:

- A list of all hazardous chemicals present in your facility, including those in unlabeled pipes
- Information about how your employer will provide warning labels, Material Safety Data Sheets (MSDS) and information and training for employees who work with hazardous chemicals on a routine or non-routine basis.
- The names and numbers of those who are responsible for seeing that the program is carried out in your facility.

LABELS PROTECT YOU

A warning label is designed to alert you that a chemical is dangerous. It will show:

- The product's chemical name
- Any hazardous ingredients
- Hazard warnings
- The chemical manufacturer's name and address

By law, every chemical shipped into your facility must have a warning label attached to it by its producer. After that, your employer is responsible for seeing that containers stay labeled. This includes:

- Replacing any damaged, incomplete or missing labels
- Seeing that the new container is labeled when a chemical is transferred to another container.

Labels are not required:

- If a number of stationary containers in an area hold chemicals with similar hazards, your employer can post warning signs instead of labeling each container.
- On pipes that contain chemicals – even if they contain hazardous chemicals or gases. Never leave an unmarked container of a hazardous chemical unattended.

Never leave an unmarked container of a hazardous chemical unattended.

UNLABELED CONTAINER?

Never assume its contents are harmless. Some facilities even require containers of water to be labeled. Follow your facility labeling procedures to the letter.

MSDS: YOUR NEXT STEP

For detailed information about the hazards of a chemical and how to control them, check out the chemical's Material Safety Data Sheet (MSDS). Even though a chemical's identity can be withheld if it is a trade secret, The manufacturer must provide full information on the chemical's hazards and how to control them.

- Chemical suppliers must provide an MSDS on every hazardous chemical they ship into your workplace.
- Your employer ensures that the MSDS for every chemical you work with is available to you in your work area during working hours.
- To see the MSDS for a chemical you work with, just ask your supervisor.

MSDS all contain similar vital information on a number of key points, including:

- The name of the chemical on the product container, its chemical name and any common names, such as “formalin” for formaldehyde
- The manufacturer name, address, phone number, plus an emergency phone number you can use to get immediate information on specific chemical hazards
- Any hazardous ingredients of a chemical
- Safe exposure limits, such as Permissible Exposure Limits (PEL) and Threshold Limit Values (TLV)
- Physical information to help you identify the chemical and its characteristics, such as appearance, odor, boiling point, vapor pressure, vapor density, solubility in water, melting point and evaporation rate.

- Fire and explosion information:
 - The chemical flash point, or temperature at which it ignites
 - What to put on the fire to extinguish it safely
 - Special firefighting techniques and equipment
 - Any unusual fire or explosion hazards
- Health hazards caused by the chemical itself
- Symptoms of overexposure, both acute and chronic
- Medical conditions that may be aggravated by exposure

- How the chemical can cause cancer
- First-aid emergency procedures—sometimes listed separately at the beginning of the form for quick reference
- Dangers from chemical reactions with the material:
 - Conditions or other materials that can cause reactions with chemicals you are using
 - Any dangerous substances that can be produced in reaction with other chemicals or in atmospheric change

HOW TO DEAL WITH SPILLS AND LEAKS:

- Clean up techniques
- Personal protective equipment to be used during clean up
- How to dispose of waste material properly

Always notify your supervisor of a chemical spill immediately. And make sure you are trained and wearing appropriate protective gear before you attempt clean up.

- Special protection information on the MSDS includes any personal protective equipment you’ll need to work safely with the chemical.
- Additional special precautions to follow when handling the chemical may include:
 - What you need to clean up a spill or extinguish a fire
 - Other health and safety information
- Get to know the MSDS for the chemicals you work with now—before the problem occurs
- Two MSDS for the same chemical? Use the MSDS with the most complete information
- Check the date of the last revision to find out how correct the MSDS information is.

TRAINING: OFF TO A SAFE START

Another important source of information on hazardous chemicals is your employer’s training program. You will be trained before working with chemicals and whenever the hazards change. You will learn:

- How to understand your facility’s written Hazard Communication Program
- How to read and use warning labels and MSDS

It will also cover:

- How to detect the release of hazardous chemicals
- The specific hazards you face from chemicals you may be exposed to on the job
- How to protect yourself on the job through the use of personal protective equipment and safe work practices

IT’S UP TO YOU

Your “Right-to-Know” does no good unless you exercise it. Be sure to read all warning labels and check out the MSDS for the chemicals you work with. Then put that knowledge to work for you on the job by wearing appropriate personal protective equipment and following safety procedures carefully.

HIPAA

Health Insurance Portability and Accountability Act

As the industry continues to move toward electronic sharing of patient records, protecting the privacy of health information becomes more challenging. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted in 1996 to address these concerns.

WHO MUST COMPLY WITH HIPAA?

According to HIPAA, all "Covered Entities" must comply with privacy and security rules. Covered Entities include:

1. Health care providers . Under HIPAA, a health care provide is defined as any person/organization that furnishes, bills or is paid for health care services and transmits and stores that information; and/or a person/organization that engages a third party to process, transmit, and store claims
2. Health plans (9nsurance companies)
3. Healthcare clearinghouses, which are entities that process certain information such as billing services, repricing companies or community health management information systems

WHAT IS PROTECTED HEALTH INFORMATION (PHI) ?

Protected Health Information (PHI) is individually identifiable health information or information that is linked to a patient. PHI relates to:

- A person's past, present, or future physical or mental health or condition
- The provision of healthcare to a person
- The past, present, or future payment for the provision of healthcare to the person

Individually identifiable health information is either:

- Health information that specifically identifies a person or
- Information that could reasonably be expected to identify a person, even if that person is not named.

These are just a sample of types of information that can identify an individual's PHI under HIPAA:

- Patient's name
- Patient's address
- Dates directly related to a person, i.e. birth date, admission date, discharge date, date of death
- Telephone number or email address
- Social Security number, medical record number or account number
- Health plan beneficiary number (insurance number)
- Vehicle license plate number or VIN
- Fingerprints or voice prints (biometric identifiers)
- Full-face photographs

HOW SHOULD PHI BE USED AND DISCLOSED?

Please bear these important facts in mind when considering the privacy of individuals:

- You must comply with HIPAA if you are gathering, storing, and transmitting patient information
- If you fail to follow HIPAA regulations, you or your organization may be subject to fines
- PHI can be disclosed without consent when it is a necessary part of treatment, payment or healthcare operations.

HIPAA allows the disclosure of PHI :

- For treatment or payment
- When authorized by the individual
- When required by law

MINIMUM NECESSARY STANDARD RULE

The Minimum Necessary Standard Rule states that only the information needed to get the job done should be provided. In addition, the following rules apply:

- Healthcare organizations must obtain permission or authorization from a patient for the purpose of marketing, advertising, and other purposes
- Healthcare organizations must establish written privacy policies and procedures regarding PHI
- Caregivers should refer to their facility's health information policies and procedures regarding the use of PHI

HIPAA PRIVACY AND SECURITY RULES

The Privacy Rule

The Privacy Rule protects all PHI which is individually identifiable health information that is gathered, stored, or transmitted on paper, orally or by any media (i.e electronic).

The HIPAA Privacy Rule requirements are:

- Applicable to most health care providers
- Set a federal standard for protecting PHI across all mediums (electronic, paper and speech)
- Limit how entities may use/disclose PHI they receive or create
 1. Give individuals the right to examine and obtain a copy of information in the medical records and the right to ask entities to amend their medical record if information is not accurate or complete
- Establish civil penalties and impose administrative rules/requirements

Under the HIPAA Privacy Rule:

- All patients must receive an organization's Notice of Privacy Practices
- Patients may give a verbal authorization to provide PHI to friends and family
- Patients are notified of their rights to complain about an organization's compliance with the Privacy Rule.
- Patients have the right to access and amend their own PHI

THE SECURITY RULE

The Security Rule establishes national standards to protect health information that is transferred in electronic form. The Rule requires appropriate safeguards to ensure the confidentiality and security of electronic PHI.

The US Office of Civil Rights together with the Department of Justice is responsible for enforcing this rule and imposing criminal penalties (fines or imprisonment) for HIPAA violations of PHI.

COMPRISING PHI

There are many ways in which PHI can be compromised by healthcare workers. These are a sample:

- Verbal conversations
- Using unprotected computer hard drives or copy machines
- Fax transmissions
- Through mobile devices, laptops, flash drives, etc
- Via cell phones
- By disposing PHI in the trash
- Unlocked file cabinets, unsecured networks
- Through unauthorized access such as viewing the PHI of some one else's patient

HIPAA VIOLATIONS

A HIPAA violation is the use /disclosure of PHI that compromises an individual's right to privacy or security and poses significant risk of financial, reputational, or other harm.

CAREGIVER RECOMMENDATIONS

ways to help you as the caregiver follow the HIPAA rules/regulations regarding patient confidentiality:

- ✓ Make sure conversations about patients are done in a confidential area.
- ✓ Do not discuss a patient's condition in front of other patients, visitors or family members in a hallway.

- ✓ Do not have conversations about patients in public places, such as elevators, hallways or the cafeteria
- ✓ Make sure that patient-related information is not visible to the public, i.e. computer screens. Log off computers when not in use
- ✓ Never share your password used for desktop and portable media devices

To prevent accidental disclosure of PHI:

- ✓ Do not send PHI by email if at all possible
- ✓ Do not post patient information or photos on social media
- ✓ Use a fax cover sheet when faxing PHI-make sure the fax number is correct.

HITECH ACT AND ELECTRONIC HEALTH RECORDS

HITECH stands for Health Information Technology for Economic and Clinical Health and was created in 2009 to stimulate the adoption of electronic health records (EHR), addressing the privacy and security of media transmitted Health information.

The EHR may include the following:

- Demographics
- Progress notes
- Problems
- Medications and vital signs
- Past medical history
- Immunizations, lab data and radiology reports

The HITECH ACT is an amendment to HIPAA that provides for more responsibility and protection for the PHI in electronic form. This act requires:

- Increased development and use of EHR in the workplace
- Increased development and monitoring of EHR security in the workplace (who will access it and “need to know”)
- Immediate reporting of any security breaches
- Increased penalties for HIPAA breaches
- Periodic audits by the US Dept of Health and Human Services
- Mandatory penalties for willful neglect

Health care workers need to know how to balance confidentiality with the need for effective communication to provide the best patient care.

INFECTION CONTROL/BLOODBORNE PATHOGENS

HAND HYGIENE

Hand-washing is considered the single most important procedure for preventing nosocomial (hospital - acquired) infections. Any healthcare worker involved in direct or indirect patient care must know how and when to perform proper hand hygiene.

The World Health Organization states that hands must always be properly washed:

1. Before patient contact
2. Before performing an aseptic procedure (a procedure that must be free from bacteria and other microorganisms)
3. After exposure to any body fluids
4. After patient contact
5. After contact with patient surroundings (touching items in the immediate patient care environment, even if you don't touch the patient)

If your hands are not visibly soiled, you may use an alcohol-based rub:

1. Apply the product to the palm of one hand.
2. Rub your hands together, covering all surfaces of hands and fingers.
3. Rub until your hands are dry.

If your hands are soiled, wash with soap and water following these procedures:

1. Wet your hands first with water.
2. Apply soap; liquid, bar, or powdered forms of plain soap are acceptable.
3. Rub your hands together vigorously for at least 15 seconds, covering all surfaces of your hands and fingers.
4. Rinse your hands with water and dry thoroughly with a disposable towel.
5. Use the towel to turn off the faucet.
6. Avoid using very hot water, since repeated exposure to hot water may increase the risk of dermatitis.

If you use hand lotion:

- You should have your own container; shared bottles can easily become contaminated.
- Use only water-based products and only those that are hospital-approved. Just because a product washes off with water does not mean it is water-based.
- Using lanolin or oil-based lotions before donning gloves will seriously weaken the gloves, increasing the risk that germs will pass through the gloves.

Fingernails:

- Numerous studies have been conducted on artificial nails, the nail hygiene of healthcare personnel, and the transmission of healthcare-associated infections to patients.
- The U.S. Centers for Disease Control and Prevention (CDC) states that nail tips should be less than one-quarter inch long.
- The CDC and the World Health Organization state that those who have direct contact with patients at high risk should not have artificial fingernails or extenders.

GLOVES

Personal Protective Equipment (PPE) is specialized clothing or equipment designed for your protection against infection. Gloves are a type of PPE.

Gloves **MUST** be worn when there is a possibility of contact with:

1. Blood and/or body fluids
2. Mucous membranes
3. Non-intact (broken) skin
4. Contact with contaminated items

Keep these important facts in mind regarding gloves:

- Wear gloves that fit properly.
- Do not wear the same pair of gloves for the care of more than one patient.
- Do not wash gloves so that you can reuse them.
- Remove and/or change gloves after you complete your task and whenever the gloves become soiled or damaged.
- Turn the gloves inside out when removing them, and dispose of them in the proper receptacle.
- Clean your hands before putting gloves on and also immediately after removing them.
- Never wear multiple layers of gloves in order to “peel off” layers between tasks.
- Always wear the right gloves for the job:
 - Wear heavy work gloves for cleaning.
 - Never wear latex gloves when caring for a patient with a latex allergy; instead, wear a synthetic glove such as vinyl.

Latex is contained in a variety of products such as gloves, catheters, adhesive bandages and tape, and more. It is also present in a variety of household items such as rubber bands, balloons, condoms, and dental dams.

Allergic reactions to latex range from skin irritation and itching to life-threatening episodes of anaphylactic shock. It is the responsibility of healthcare workers to protect themselves, coworkers and patients from unnecessary exposure to latex.

Some important points to remember about latex allergies:

- Ask patients questions about allergies, including latex allergies, in terms that they understand.
- Document findings in the patient chart.
- All latex products, including gloves, MUST be kept away from allergic patients and staff.
- Latex products release latex allergens into the air, and these allergens may cause reactions in latex-allergic persons.
- Glove powder from latex gloves may carry enough latex allergen through the air to cause reactions in allergic persons.
- If you suspect that you have a latex allergy, contact Employee Health for an appointment to rule out this allergy.

GOWNS, MASKS, EYE PROTECTION

Other types of Personal Protective Equipment (PPE) include gowns, masks, and eye protection. Wear a gown that is appropriate to your task, to protect your skin and prevent soiling or contamination of your clothing during procedures or activities when you are likely to come in contact with blood, body fluids, excretions, or secretions.

- Do not wear the same gown for the care of more than one patient.
- Remove a soiled gown as soon as possible.
- Practice hand hygiene after removal of gown.

Wear a mask and eye protection or a face shield to protect the mucous membranes of your eyes, nose, and mouth during procedures or activities when you are likely to come in contact with blood, body fluids, excretions, or secretions. To protect your respiratory tract from airborne infectious agent such as tuberculosis (TB), use a respirator (commonly called the “N95 mask”) when necessary.

SAFE INJECTION PRACTICES

According to the U.S. Centers for Disease Control and Prevention (CDC), improper use of syringes, needles, and medication vials during routine healthcare procedures have resulted in transmission of bloodborne viruses such as hepatitis and human immunodeficiency virus (HIV). Recommendations by the CDC for safe injection practices include:

- Follow proper infection control practices.

- Maintain Aseptic Technique when preparing and administering injected medications (follow hand-washing guidelines and maintain a sterile field).
- Never administer medications from the same syringe to more than one patient, even if the needle is changed.
- Never enter a vial with a used syringe or needle.
- Do not use medications packaged as single-dose or single-use for more than one patient.
- Do not use bags of intravenous solution as a common source of supply for more than one patient.
- Limit the use of multi-dose vials and dedicate them to a single patient whenever possible.
- Always use facemasks when injected material or inserting a catheter into the epidural or subdural space.

RESPIRATORY INFECTIONS/COUGH ETIQUETTE

Coughs and sneezes produce droplets that can be inhaled by people nearby, spreading viruses. Following simple “cough etiquette” procedures can help protect you as a healthcare worker as well as patients and visitors at your facility.

- Cover your mouth and nose when you cough or sneeze, with a tissue if at all possible.
- Throw used tissues away immediately.
- Use a surgical mask for patients who are coughing, if tolerated and appropriate.
- Use a surgical mask yourself if you are coughing.
- Clean your hands after contact with respiratory secretions.
- Stay at least three feet away, if possible, from people with respiratory infections.

BLOODBORNE PATHOGENS

Bloodborne pathogens are infectious microorganisms in human blood that can cause disease. Examples are hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV, the virus that causes AIDS). Healthcare workers are at risk for exposure through needle sticks or other sharps related injuries. All used sharps are considered contaminated.

It is essential to follow these guidelines:

- Never bend or break needles and other used sharps after use.
- Never recap contaminated needles.
- Always use needle-based safety devices when available.
- Never carry a used sharp in a pocket.
- Dispose of sharps in designated sharps disposal containers.
- Sharps disposal containers should be sealed and removed when three-quarters full to avoid overflow.
- Do not attempt to remove anything from a sharps disposal container.
- Properly dispose of all sharp objects, such as syringes with needles and scalpels, after use.

The U.S. Occupational Safety and Health Administration requires employers to:

- Establish an exposure control plan and update it annually
- Implement the use of Standard Precautions (treating all blood and other potentially infectious material as if known to be infectious for bloodborne pathogens)
- Identify and use engineering controls (sharps disposal containers, self-sheathing needles, and safer medical devices such as needleless systems)
- Identify and ensure the use of work practice controls (appropriate practices for handling and disposing of contaminated sharps, handling specimens, handling laundry, and cleaning contaminated surfaces and items)
- Provide Personal Protective Equipment (PPE)
- Make hepatitis B vaccinations available to all workers with occupational exposure
- Make post-exposure evaluation and follow-up available to any occupationally exposed worker who experiences an exposure incident • Use labels and signs to communicate hazards
- Provide information and training to workers, and maintain worker medical and training records

HEPATITIS

Hepatitis is a serious disease of the liver, an organ necessary for life. Hepatitis B (HBV) and hepatitis C (HCV), the two most serious kinds of hepatitis, are similar kinds of liver infections caused by different viruses.

Although there are fewer new hepatitis C infections each year compared with hepatitis B, there are more deaths in the long term due to hepatitis C.

About 50% of hepatitis B infections and 75% of hepatitis C infections cause no initial symptoms. When symptoms do occur, they include:

- Jaundice (yellowing of skin and eyes)
- Loss of appetite
- Dark urine
- Nausea and vomiting
- Fever
- Fatigue
- Clay-colored bowel movements
- Joint pain
- Abdominal pain

Hepatitis B and hepatitis C viruses are transmitted through blood and body fluids. Methods of bloodborne transmission of HBV and HCV that you should be aware of include:

- Blood splashes from minor cuts and nosebleeds
- Procedures that involve blood
- Hemodialysis
- Sharing personal items like nail clippers, razors, and toothbrushes
- Sharing needles for intravenous drug use
- Body piercing and tattoos

Precautions for Healthcare Workers

Although it is rare, healthcare workers are at risk of becoming infected with hepatitis. Even exposure to a small amount of blood from an infected person can cause hepatitis. Here are guidelines to follow:

- Assume that blood and other body fluids from all patients are potentially infectious.
- Routinely use Personal Protective Equipment (PPE) such as goggles and masks if you might come in contact with blood or body fluids
- Immediately wash your hands and other skin surfaces after contact with blood and body fluids.
- Carefully handle and dispose of sharp instruments during and after use.
- The CDC's Advisory Committee on Immunization Practices recommends that all healthcare workers at risk for exposure to blood or blood-contaminated body fluids receive the hepatitis B vaccination.

HIV/AIDS

HIV (human immunodeficiency virus) is the virus that causes AIDS (acquired immunodeficiency syndrome). HIV weakens a person's immune system by gradually destroying the body's CD4 cells, which fight disease and infection. This makes a person more likely to get other infections or infection-related cancers. AIDS is considered to be the last stage of HIV infection.

Currently, no effective cure exists for HIV or AIDS. With antiretroviral therapy (ART), people can be treated before HIV progresses and have a nearly normal life expectancy. However, ART treatment is a lifetime therapy and must be strictly followed. Many people infected with HIV may not feel sick or even know they have the virus for many years. During that time, the virus, a bloodborne pathogen, can infect other people – including healthcare workers. To prevent the transmission of HIV, implement Standard Precautions (treating all blood and other potentially infectious material as if known to be infectious for bloodborne pathogens)

TRANSMISSION-BASED PRECAUTIONS

As a healthcare worker, you should be aware of the three specific Transmission-Based Precautions that are used for patients when there is a risk of the spread of infection by direct or indirect contact:

1. Contact Precautions
2. Droplet Precautions
3. Airborne Precautions

Contact Precautions Contact Precautions are used for:

- Patients infected with multidrug-resistant organisms (MDROs)
- Situations where excessive wound drainage, fecal incontinence (may include patients with norovirus, rotavirus, or *C. difficile*), or other discharges from the body suggest an increased risk of transmission

Healthcare workers caring for patients on Contact Precautions should:

- Wear appropriate Personal Protective Equipment (PPE) such as gown and gloves when entering the patient's room
- Discard the PPE before exiting the patient's room to contain the pathogens
- Place those patients in a single room when possible

Droplet Precautions Droplet Precautions are used in cases where respiratory secretions (saliva, mucus) could spread an infection. These patients may not need special air handling and ventilation in their room, but a single room is preferred.

Droplet Precautions may be used for patients with:

- Influenza (the flu)
 - Whooping cough (pertussis)
 - Adenovirus, which can cause bronchitis, pneumonia, diarrhea, and pink eye
 - Group A streptococcus, which can cause strep throat
- Healthcare personnel caring for patients on

Droplet Precautions should:

- Wear a mask (a respirator is not necessary) for close contact with the patient
- Put the mask on as soon as they enter the patient's room
- Put a mask on the patient, if tolerated, when transporting the patient outside the room

Airborne Precautions Airborne Precautions are used for patients with pathogens that remain infectious over long distances when suspended in the air. This includes:

- Measles
- Chickenpox (varicella)
- Tuberculosis
- Smallpox

When Airborne Precautions are necessary:

- An airborne infection isolation room (AIIR), which is a room with special air handling and ventilation equipment, is preferred.
- Healthcare personnel caring for patients on Airborne Precautions should wear a mask or respirator, depending on the disease-specific recommendations, which is donned prior to room entry.
- Whenever possible, non-immune healthcare workers should not care for patients with vaccine preventable airborne diseases (measles, chickenpox, smallpox).

MULTIDRUG-RESISTANT ORGANISMS (MDRO)

Multidrug-resistant organisms (MDROs) are microorganisms, primarily bacteria, that are resistant to antimicrobial agents and therefore can be difficult to treat. Common MDROs are VRE and MRSA.

VRE (Vancomycin-Resistant Enterococci) Vancomycin-resistant enterococci (VRE) are bacterial strains of the genus *Enterococcus* that are resistant to the antibiotic vancomycin. Enterococci are organisms found normally in the intestinal tract and, in females, in the vaginal tract. People at higher risk

for VRE are those who have been ill and have been taking many antibiotics or have weakened immune systems due to illness or age.

VRE:

- Are found most often in the stool
- Can also be found in the blood, urine, and wounds, or wherever it can be carried by blood
- Can be spread to other people by contact between persons

VRE are hardy organisms. They can survive on hard surfaces for 7 to 10 days and on hands for hours. But it is easy to kill them with hand-washing and the proper use of disinfectants.

Healthcare workers treating VRE patients must follow these rules:

- Gloves **MUST** be worn before or upon entry to patient's room.
- Hands **MUST** be washed after glove removal and before leaving the room.
- Gowns **MUST** be worn by anyone having contact with VRE patients or items that the patient may have come in contact with.
- A standard surgical mask is necessary if the organism is in the respiratory tract for close contact with the patient, which is defined as being within 2 to 3 feet.

MRSA (Methicillin-Resistant Staphylococcus Aureus) MRSA is a strain of the germ *Staphylococcus aureus* that has developed resistance to most of the antibiotics commonly used to treat staph infections. MRSA is passed from person to person through contact.

- A person who is infected with MRSA may have it in their nose as well as on their hands – so whenever they touch others, they can pass the germ along.
- MRSA can be transmitted from someone in contact with a MRSA patient to another patient. Healthcare workers treating MRSA patients must follow these rules:
- Use Personal Protective Equipment (PPE), including gloves and gowns, if it can be reasonably anticipated that contact with blood or other potentially infectious materials may occur.
- Hands must be washed after touching blood, body fluids, secretions, excretions, and contaminated items. Also wash hands after glove removal and before leaving the room.
- A standard surgical mask is necessary if the organism is in the respiratory tract and close contact with the patient is required, which is defined as being within 2 to 3 feet.

TUBERCULOSIS

Tuberculosis (TB) is a disease that is caused by bacteria that are carried through the air by tiny droplets. TB mainly attacks the lungs, but any part of the body can be affected, including the kidneys, spine, and brain. With long-term medication, tuberculosis can be cured.

Symptoms of TB include:

- Chest pain
- Prolonged productive cough (3 weeks or longer)
- Coughing up of blood or sputum
- Fever, chills, night sweats
- Weight loss, lack of appetite
- Weakness or fatigue

TB transmission:

- TB is transmitted through the air when a person with TB in the lungs or throat coughs, sneezes, or speaks, infecting those nearby if they inhale the infectious airborne droplets.
- According to the U.S. Centers for Disease Control and Prevention (CDC), TB is **NOT** spread by shaking someone's hand, sharing food or drink, touching bed linens or toilet seats, sharing toothbrushes, or kissing.

There are two types of tests for TB – a skin test or TB blood test. People working in healthcare settings should receive an initial TB skin test upon hire, and then annual tests depending on the type of setting.

Special precautions for healthcare workers regarding TB patients:

- TB patients should be in private rooms with their door kept closed.
- Pulmonary TB patients should be in a negative pressure ventilated room or an AIIR (airborne infection isolation room).
- Healthcare workers should wear a special “fit-tested” mask such as an N-95 or greater to provide at least 95% efficiency, and receive training on proper fitting and how to wear it correctly.
- The N-95 or greater efficiency mask should be worn when entering the patient’s room and while in the room.
- Patients should be kept in their rooms as much as possible; if transportation is necessary, patient **MUST** wear a high-efficiency mask (if medically feasible).
- Patients should be encouraged to cough or sneeze directly into tissues and to dispose of them.
- **HANDS MUST BE WASHED** after touching the patient or potentially contaminated articles, and after taking off gloves, mask, and/or gown.

EBOLA

Ebola is a rare and deadly disease that first occurred in remote villages in central Africa but has affected people in other countries around the world. Symptoms of Ebola may appear between 2 and 21 days after exposure and include:

- Fever
- Muscle pain
- Weakness
- Vomiting
- Fatigue
- Severe headache
- Diarrhea
- Abdominal pain
- Internal or external bleeding (from skin, eyes, gums)

It is difficult to diagnose a person in the first few days of contracting Ebola, mainly because the early symptoms are often seen in many other illnesses. The screening process includes taking a recent travel history. Confirmation of Ebola virus infection is with blood tests.

How Ebola is Transmitted Ebola can infect humans and other mammals, including bats, monkeys, and apes. Human-to-human transmission occurs through direct contact with blood or body fluids of an infected person.

Healthcare providers caring for Ebola patients, as well as the family and friends in close contact with Ebola patients, are at the highest risk of contracting Ebola because they are more likely to come into contact with their blood or body fluids.

The virus also can be spread through contact with objects that have been contaminated with the virus, such as:

- Clothes
- Bedding
- Needles
- Syringes/sharps
- Medical equipment

Currently there is no FDA-approved vaccine or medicine available for Ebola. These basic interventions, when used early, can significantly improve the chances of survival:

- Providing intravenous (IV) fluids and electrolytes
- Maintaining oxygen status and blood pressure
- Treating other infections that may occur

Caring for a Suspected Ebola Patient If a patient has met the criteria for Ebola:

- Healthcare providers should implement Standard, Contact, and Droplet Precautions using appropriate Personal Protective Equipment (PPE).
- The patient should be placed in isolation in a single patient room with a private bathroom.
- The patient's door(s) should be kept closed.
- A log should be maintained of all persons entering the patient's room.
- Public health officials should be notified.

Special Precautions for Healthcare Workers Here are recommendations from the U.S. Centers for Disease Control and Prevention (CDC) for healthcare workers in close contact with patients who have suspected or known Ebola infection:

1. ALL body parts should be completely covered when putting on Personal Protective Equipment (PPE).
2. Impermeable garment should be:
 - Single-use (disposable) fluid-resistant or impermeable gown that extends to at least midcalf, OR
 - Coverall without integrated hood
3. Respiratory protection should be:
 - PAPR (powered air purifying respirator), a hooded respirator with a full-face shield, helmet, or headpiece. Any reusable helmet or headpiece must be covered with a single-use hood that extends to the shoulders and fully covers the neck and is compatible with the selected PAPR, OR
 - A single-use N95 respirator in combination with single-use surgical hood extending to the shoulders and single-use full-face shield.
4. Single-use boot covers that are waterproof and go to at least mid-calf
5. Single-use examination gloves with extended cuffs, using double-glove technique (sterile for some procedures)
6. Single-use apron that is waterproof and covers the torso to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea

Healthcare workers should receive rigorous and repeated training to ensure they are knowledgeable and proficient in putting on (donning) and taking off (doffing) PPE prior to managing an Ebola patient. The sequence for donning and doffing are critical to avoiding exposure. A clear layout and separation between clean and potentially contaminated areas is critical to prevent contamination and exposure. Non-dedicated, non-disposable equipment used for patient care should be immediately cleaned and disinfected according to manufacturer's instructions and hospital policies.

Additional Infection Control Practices for Ebola

1. Limit the use of needles and other sharps as much as possible.
2. All needle and sharps should be handled with extreme care.
3. Dispose of all needles and sharps in puncture-proof, sealed containers.
4. Keep hands away from the face.
5. Limit touching surfaces and body fluids.
6. Immediately disinfect any visibly contaminated PPE surfaces, equipment, or patient care area surfaces using an EPA-registered disinfectant wipe.
7. Perform regular cleaning and disinfection of patient care surfaces, even if visible contamination is not seen.
8. Perform frequent disinfection of gloved hands using an alcohol-based hand rub, particularly after handling body fluids.

Aerosol Generating Procedures (AGP's) It has not been established that Ebola can be contracted through airborne transmission; however, there may be some patients with severe pulmonary involvement or who during certain invasive procedures can potentially produce aerosols. Aerosol Generating Procedures (AGPs) include:

- Airway suctioning
- Aerosolized or nebulized medication administration

- Bronchoscopy
- Endotracheal intubation and extubation
- Positive pressure ventilation via face mask

In these instances, facilities may choose to adhere to the following CDC recommendations:

- Visitors should not be present.
- Limit number of individuals entering room.
- Only pertinent healthcare personnel needed for procedure are present.
- Conduct the procedure in a private room or ideally, when possible, in an airborne infection isolation room (AIIR).
- All doors should be kept closed; entry and exit should be limited or eliminated if possible during the procedure.
- Use strict PPE recommendations for these procedures.

Environmental Cleaning & Control The CDC recommends the following environmental cleaning practices for any care areas of known or suspected Ebola virus patients. This especially applies to Environmental Services staff but is also for anyone who would be performing cleaning tasks.

- Wear Ebola PPE during cleaning procedures, and follow Ebola donning and doffing procedures.
- Use an EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (norovirus, rotavirus, adenovirus, poliovirus).
- Avoid contamination of reusable porous surfaces that cannot be made single use.
- Use disposable cleaning cloths, mop cloths, and wipes, and dispose of these in leak-proof bags.
- Use a rigid waste receptacle designed to support the bag to help minimize contamination of the bag's exterior.

Keep these cleaning facts in mind in cases of diagnosed or suspected Ebola:

- Daily cleaning and disinfection of hard, non-porous surfaces (high-touch surfaces such as bed rails and over bed tables, housekeeping surfaces such as floors and counters) should be done.
- Remove all upholstered furniture and decorative curtains from patient rooms before use.
- Mattresses and pillows should have plastic covers or other protective covering to prevent fluids from leaking through.
- Patient rooms should not be carpeted.
- Basic principles for blood or body substance spill management should be followed as outlined by OSHA's Bloodborne Pathogen.
- Ebola-associated waste that has been appropriately incinerated, autoclaved, or otherwise inactivated is not infectious, does not pose a health risk, and is not considered to be regulated medical waste or a hazardous material under federal law.
- Waste items transported offsite for disposal that is contaminated or suspected of being contaminated with Ebola virus must be packaged and transported in accordance with the Department of Transportation's (DOT) Hazardous Materials Regulations. This includes:

- Medical equipment
- Sharps
- Linens
- Used healthcare products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, or byproducts of cleaning)
- Used Personal Protection Equipment (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.)

If you develop sudden fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after exposure to an Ebola patient, you should:

- Not report to work or should immediately stop working
- Notify your supervisor
- Seek prompt medical evaluation and testing
- Notify local and state health departments
- Comply with work exclusion until it is established that you are no longer infectious to others

Post-Mortem Care for Ebola Patients Unfortunately, there will be Ebola-related deaths. Healthcare workers who will provide post-mortem care for these patients must know and understand their organization's policies and procedures related to providing post-mortem care for Ebola patients

HANDLING AND DISPOSAL OF INFECTIOUS WASTES

Remember these simple steps when dealing with infectious materials or waste (such as blood and body fluids, human tissue, sharps, needles, scalpels, IV tubing):

1. Infectious waste should be placed in closable leak-proof containers – color-coded, labeled, or tagged with the biohazard symbol.
2. Waste **MUST** be separated into appropriate containers.
3. Biohazard bags should be used for contaminated materials that are saturated with blood or other potentially infectious material.
4. Sharps **MUST NOT** be recapped.
5. Sharps **MUST** be placed in approved puncture-resistant biohazard sharps container, only up to the three-quarters-full mark.
6. Fluids **MUST** be emptied into the sanitary sewer system.
7. Fluid-filled container that cannot be emptied prior to disposal **MUST** be placed in biohazard receptacle.
8. Always protect yourself by wearing Personal Protective Equipment (PPE) when handling infectious waste.

When handling specimens:

1. Laboratory specimens from all patients should be handled with equal care.
2. All non-blood specimen containers **MUST** be securely closed before transport.
3. Blood specimens and other glass containers **MUST** be transported in a manner that reduces the risk of breakage.
4. Specimens with visible soiling on their containers **MUST** be properly cleaned before transport to the lab.
5. If the lab tag becomes visibly soiled, issue a replacement tag for the specimen.
6. Workers transporting specimens should wash their hands after delivering them to the lab. A glove may be worn on the hand used to carry the specimen, leaving the ungloved hand free for opening doors, pushing elevator buttons, etc. A tray or box can make it easier to transport multiple specimens..

NATIONAL PATIENT SAFETY GOALS 2017

National Patient Safety Goals for Hospitals is meant to inform healthcare providers how to reliably identify patients for whom services and treatments are intended. Patients can be identified in several ways, for example, patient name, telephone number or assigned identification number. The recommended method is patient name and birth date.

TWO PATIENT IDENTIFIERS

Care givers must use at least 2 patient identifiers for the following:

- Administering medications
- Administering blood or blood components
- Collecting blood samples and other specimens
- Providing treatments or procedures
- Label specimen containers in the presence of the patient

The patient's room number is NEVER used as a patient identifier.

GOAL 1

ELIMINATE TRANSFUSION ERRORS RELATED TO PATIENT MISIDENTIFICATION

1. For blood or blood component transfusion, do the following:
 - Match the blood or blood component to the order
 - Match the patient to the blood or blood component
 - Use the 2-person verification process or a one-person verification process accompanied by automated identification technology such as bar coding.
2. In the 2-person identifier process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient.
3. When using the 2-person verification process, the second individual conducting the identification verification is qualified to participate in the process as determined by the hospital.

GOAL 2

IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS.

Report critical results of tests and diagnostic procedures on a timely basis. When working in a facility, you must be aware of the facility's written procedures to address the following:

- What is the definition of critical results of tests and diagnostic procedures
- Who conducts and who reports the critical results of tests and diagnostic procedures
- Who will implement the procedures for managing critical results of tests and diagnostics
- Who will schedule the efficient reporting of critical results of tests and diagnostics

GOAL 3

IMPROVE THE SAFETY OF USING MEDICATIONS

When solutions or medications are removed from their original containers and put into unlabeled ones, medications and other substances can become lethal. In order to prevent medication errors follow these guidelines:

- Label medications and solutions that are not immediately administered.
- Label any medication or solutions that is transferred from the original package and put into another
- Labels will include the following: medication name, strength, amount of medication (if not apparent from the container, diluent and volume (if not apparent from the container, expiration date (when not used within 24 hours) and expiration time when expiration occurs in less than 24 hours.
- Verify all medications both verbally and visually. Verification is done by 2 qualified persons when the

- person preparing the medication is not the person who will administer it.
- Label each medication as soon as it is prepared unless immediately administered.
- Immediately discard any medication found unlabeled.
- Remove all containers on the sterile field and discard their contents at the conclusion of the procedure.
- All medication both on and off the sterile field and the labels are reviewed by entering and exiting staff responsible for the management of medications.

MAINTAIN AND COMMUNICATE ACCURATE PATIENT MEDICATION INFORMATION

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
 - Current medications include those taken at scheduled times and those taken on an as-needed basis
 - It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the Element of Performance.
2. Define the types of medication information to be collected in non-24-hour settings and different patient circumstances.
 - Examples of non-24-hour settings include the ER department, primary care, outpatient radiology ambulatory surgery and diagnostic settings.
 - Examples of medication information that may be collected include name, dose, route, frequency, and purpose.
3. Compare medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies. Discrepancies include omission, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison.
4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he/she is discharged from the hospital or at the end of an outpatient encounter (for example name, dose, route, frequency, purpose). When the only medications prescribed are for a short duration the medication information the hospital provides may include only those medications.
5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter. Examples include instructing the patient to give a list to his/her primary care physician; to update the information when medications are discontinued, doses are changed, or new medication (including over the counter products) are added; and to carry medication information at all times in the event of emergency situations.

GOAL 6

REDUCE THE HARM ASSOCIATED WITH CLINICAL ALARM SYSTEMS

If clinical alarm systems are not managed properly, they can compromise patient safety. At times individual alarms are difficult to detect. There may also be many alert signals at the same time and staff may become desensitized to the alarms and may even ignore or disable them. The wide spectrum of limits, levels and default settings can be overwhelming to someone who is not accustomed to them as well. Each facility needs to develop a systematic, coordinated approach to clinical alarm system management. For example:

- Clinical appropriate settings for alarm signals
- When alarm signals can be disabled
- When alarm parameters can be changed
- Who in the organization has the authority to set alarm parameters
- Who in the organization has the authority to change alarm parameters
- Who in the organization has the authority to set alarm parameters to "off"
- Monitoring and responding to alarm signals
- Checking individual alarm signals for accurate settings, proper operation, and detectability

Alarm system safety needs to be a hospital priority. Some ways to manage the alarm problems are to identify the

most important alarm signals to manage based on the following:

- Input from the medical staff and clinical departments
- Risk to patients if the alarm signal is not attended to or if it malfunctions
- Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
- Potential for patient harm based on internal incident history
- Education of staff and contractors about the purpose and operation of alarm systems
- Published best practices and guidelines

GOAL 7

REDUCE THE RISK OF HEALTH CARE – ASSOCIATED INFECTIONS

1. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the Center for Disease Control (CDC) and/or the World Health Organizations (WHO) guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.
2. The elements of performance for this requirement are designed to help reduce or prevent health care–associated infections from epidemiologically important multidrug-resistant organisms (MDROs). Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission.
 - Educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.
 - Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection strategies
 - Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.
 - Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following: - Multidrug-resistant organism infection rates using evidence-based metrics - Compliance with evidence-based guidelines or best practices - Evaluation of the education program provided to staff and licensed independent practitioners
 - Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.
 - Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).
 - When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.
 - When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.
3. Implement evidence-based practices to prevent central line-associated bloodstream infections.

CENTRAL LINE CATHETERS

Central Line (CVC and PICC) Catheters can be a source of bloodstream infection. Once again education is key in managing central lines and bloodstream infections.

- Educate staff and licensed independent practitioners involved in managing central lines and the associated bloodstream infections and the importance of prevention. Educate upon hire, annually thereafter and when this procedure is added to the job responsibility of a practitioner.
- Educate patients and their families before inserting the catheter concerning bloodstream associated

infections

- Observe all policies and procedures concerning the reduction of central line-associated infections
- Perform regular risk assessments for central line infection, monitor the compliance and then evaluate the effectiveness of prevention methods.
- Use a checklist for the catheter insertion that is standardized for all health care providers to include hand hygiene protocols.
- Perform hand hygiene prior to catheter insertion or manipulation.
- For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.
- Use a supply cart that carries all necessary components for the insertion of central venous catheters
- Use the standardized protocol for sterile barrier precautions
- Use an antiseptic for skin preparation during the insertion that is endorsed by professional organizations
- Use a standardized method to disinfect catheter hubs and ports before accessing.
- Evaluate ALL catheters on a regular basis and remove any that are nonessential.

SURGICAL SITE INFECTION

Surgical Site Infection prevention requires education and procedures as seen below. Health care providers, patients and their families need to be educated as to the risks and ways to prevent infection at the surgical site. Part of the effort to reduce infection in these cases is the following:

1. Education occurs upon hire, annually thereafter and when involvement in surgical procedure is added to an individual's responsibilities.
2. Educate patients and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.
3. Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).
4. As part of the effort to reduce surgical site infections:
 - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
 - Select surgical site infection measures using best practices or evidence-based guidelines.
 - Monitor compliance with best practices or evidence-based guidelines.
 - Evaluate the effectiveness of prevention efforts
 - Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.
 - Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.
 - When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.

PRACTICES TO PREVENT INDWELLING CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

1. Educate staff and licensed independent practitioners involved in the use of indwelling urinary catheters about CAUTI and the importance of infection prevention.
 - Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual's job responsibilities.
 - Ongoing education and competence assessment occur at intervals established by the organization.
2. Educate patients who will have an indwelling catheter, and their families as needed, on CAUTI prevention and the symptoms of a urinary tract infection.
3. Develop written criteria, using established evidence-based guidelines, for placement of an indwelling urinary catheter.
4. Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following:

5. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:

- Selecting measures using evidence-based guidelines or best practices
- Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance
- Monitoring compliance with evidence-based guidelines or best practices
- Evaluating the effectiveness of prevention efforts

UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE AND WRONG SURGERY

The Universal Protocol is based on the following principles:

- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and, as needed, the family are involved in the process.
- Consistent implementation of a standardized protocol is most effective in achieving safety.

The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. Organizations should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are: available prior to the procedure, correctly labeled and matched, and are consistent with the patient's expectations and the team's understanding of the whole process.

TIME OUT PRIOR TO PROCEDURE

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

PAIN MANAGEMENT

TYPES OF PAIN

Pain is often described as either acute or chronic. These terms describe the duration of pain and how it may respond to treatment – but they do not describe how severe the pain is. Cancer pain is sometimes considered as a separate type of pain.

Acute Pain: Acute pain is caused by a specific physical condition and generally lasts less than 4 weeks. Some examples are:

- Pain following surgery or a procedure
- Pain from an illness such as a sore throat or ear infection
- Pain following an injury

Acute pain:

- Has a well-defined onset
- Is temporary • Is predictable
- Is treatable Once the condition causing the pain no longer exists, the pain will go away.

Chronic Pain: Chronic pain is defined in various ways because it may not have a specific onset or time course. Typically, pain that lasts 3 to 6 months or longer is said to be chronic.

Chronic pain:

- May not respond predictably to treatment
- May not result from a particular injury or event

Cancer Pain Cancer pain can be acute or chronic. If the cancer is not curable, the pain may worsen as the disease progresses. Cancer pain may be caused by:

- The disease itself
- Treatments (such as surgery, chemotherapy, radiation)
- Infections

Chronic pain and cancer pain can cause the most serious problems by:

- Interfering with a patient's lifestyle and activities
- Reducing a patient's quality of life
- Wearing a patient down
- Causing a patient to give up hope
- Causing a patient to consider suicide

MYTHS ABOUT PAIN

There are many myths about pain, and they can have a negative influence on effective pain management. One common myth is that pain medication (especially drugs such as morphine, Demerol, or codeine) should not be used for long-term illness until there is no other choice, because they are addictive. This may mean, for example, that an opioid medicine may not be ordered for someone with cancer pain until the patient is dying, in order to prevent addiction. In some cases, pain medication may be withheld even at the end of life, because of side effects.

Other common myths are:

- Chronic pain cannot be managed.
- Sleep is a sign that a patient has no pain.
- Pain in the absence of obvious injury or other factors is a sign of serious illness.
- People of certain ethnic or cultural backgrounds will over-report pain and other groups will under-report pain.
- Someone in pain will always have changes in vital signs.

EVALUATING PAIN

When a patient does report pain, evaluate using the following seven considerations.

- Onset: When did the pain begin?
- Duration: Is the pain continuous, or does it come and go? If the pain is not continuous, how long does it last?
Location: Where does it hurt?
- Description: What kind of pain is it? (for example, burning, stabbing, cramping, aching, biting, dull, sharp, gnawing)
- Severity: How severe is the pain? (using your facility's pain assessment tool) What kinds of things make the pain worse? Is the pain associated with any particular activity? (for example, eating)
- Relief: Does anything relieve the pain and, if so, for how long? What prescribed or over-the-counter medications (including dosage and frequency) has the patient taken to relieve the pain?
- Effects: How does the pain interfere with the

PAIN MANAGEMENT STRATEGIES

Pain management strategies must be selected to meet the individual needs of each patient. This requires:

- An assessment of the pain
- An assessment of the effectiveness of previous interventions

Pain management decisions are not made by healthcare professionals alone. Pain is a unique experience for each individual, and patient education is an important part of the process. When developing a pain management strategy, it is important to anticipate the patient's pain needs and to take a preventive approach. This is especially true when the patient is undergoing procedures that are known to be painful, such as surgery.

A preventive approach to pain management can help to minimize stress on the patient and family. This approach also reduces problems associated with poor pain management, such as:

- Longer hospital stay
- Reduced mobility
- Increased stress on immune system
- Decreased energy reserves

NON-PHARMACOLOGIC PAIN MANAGEMENT

Non-pharmacologic interventions are alternative measures that do not use drugs. The methods selected depend on the needs of the patient.

Non-pharmacologic pain management methods include:

- Relaxation and distraction techniques
- Physical interventions

Relaxation and distraction techniques work best if they are practiced before they are needed for pain relief.

They include:

- Deep breathing (with focus on breathing techniques)
- Listening to music
- Guided imagery
- Biofeedback
- Hypnosis

Physical interventions that can help in the treatment of pain include:

- Massage
- Exercise (especially for chronic pain)

- Applying heat or cold
 - No longer than 20 minutes
 - Be careful of extreme heat or cold that could damage tissue
- Acupuncture
- Position change
- TENS (transcutaneous electrical nerve stimulation), which controls pain by stimulating the nerves at the pain location and helping to block pain signals

NON-OPIOID MEDICATIONS

When medication is used to control pain, the best strategy is to use the least strong drug that still gives adequate pain relief. Usually, pain control measures begin with non-opioid (non-narcotic) drugs. Non-opioids are generally available in both over-the-counter and prescription strengths.

They include:

- Acetaminophen (Tylenol)
- Nonsteroidal anti-inflammatory drugs (NSAIDs) such as aspirin, ibuprofen (Advil), and naproxen sodium (Aleve)

Non-opioids are usually taken by mouth or by suppository. They may also be used in combination with opioids.

- The most common side effect of acetaminophen is hepatotoxicity (liver involvement), which is most common with an overdose.
- The most common side effects of NSAIDs are stomach irritation and prolonged bleeding time.

If the non-opioid medication does not relieve the pain, it may require:

- An increase in dosage
- An increase in frequency
- An increase to the next level of drug

OPIOID MEDICATIONS

Opioids (narcotics):

- Are drugs developed from plant-based opium
- Can be either natural or synthetic
- Are used for moderate to severe pain Pure Agonists One class of opioids is known as pure agonists, which refers to their specific mechanism for pain relief.

These types of opioids include:

- Morphine
- Hydromorphone (Dilaudid)
- Fentanyl
- Codeine

Side effects of opioids include:

- Euphoria
- Sedation
- Constipation
- Nausea and vomiting
- Itching
- Urinary retention
- Hypotension
- Respiratory distress

Over time, patients may develop a tolerance for opioids, meaning they require higher dosages to achieve the same pain relief. However, the usual reason for increasing dosage is because of disease progression. Patients who have received opioids for a long period of time may experience withdrawal when the drug is

stopped. This means that patients should not be taken off the drug suddenly but should gradually decrease the drug level over several days.

There are two important things to remember about opioids and other pain drugs:

- Drug-seeking behavior MAY NOT be a sign of addiction.
- Drug-seeking behavior MAY BE a sign of inadequate pain relief.

Other Opioids

Other types of opioids – such as nalbuphine (Nubain) and butorphanol (Stadol) – provide less analgesia but fewer side effects. There is also a limit to their effectiveness.

- After a point, higher doses do not increase analgesia.
- These drugs are sometimes used to reverse analgesia and side effects caused by pure agonists.

Administration of Opioids

Opioids are given by mouth. As pain level increases, they can be administered in other ways to deliver a higher level of pain relief:

- Sublingually (under the tongue)
- Buccally (placed in the cheek area if the patient is unable to swallow)
- Dermal patch (for continuous release)
- Intravenous (IV) by continuous infusion or intermittent dosage
- Patient-controlled analgesia (PCA), which allows a patient to increase the dosage of an intravenous drug when the pain increases
- Intramuscular or subcutaneous injection
- Suppository

ADJUVANT MEDICATIONS Other drugs that may help in pain control are adjuvants.

These include:

- Corticosteroids
- Antidepressants
- Local anesthetics
- Anticonvulsants

These drugs are used to:

- Enhance the effectiveness of a primary analgesic
- Limit the side effects of a primary analgesic (usually an opioid)
- Treat concurrent symptoms that increase pain
- Provide analgesia for certain types of pain that are not relieved by opioids

PAIN AND END-OF-LIFE CARE

In healthcare, much of the focus is on curative care, in which the goal is for patients to get better. When this goal cannot be met, a patient is considered to be terminally ill. The patient or family may have decided to discontinue curative treatment or there may be no curative treatment available. In this case, palliative care becomes necessary.

The objectives of palliative care are:

- To make the patient as comfortable as possible
- To support the patient and family during this end-of-life period

When caring for a terminally ill patient, you should:

1. Anticipate pain needs and provide relief before the pain becomes severe
2. Remember that larger doses of analgesia may be needed because of tolerance to the drug and/or because of the progressive disease state
3. Assess the patient frequently for pain management needs

4. Discuss the pain management plan with the patient and family
5. Assure the family that everything possible is being done to keep the patient comfortable

Opioids are often the medication of choice for end-of-life pain.

- They are safe and effective for treating moderate to severe pain.
- They have side effects that can be managed effectively.

Pain management is a critical part of patient care, and it is easier to manage pain before it becomes severe. So it is vital for healthcare workers to be able to identify signs of pain while setting aside their own beliefs and misconceptions about how pain is tolerated. All patients in your care have the right to effective pain management. Your understanding of when and how to assess and treat pain is an integral part of your role as a healthcare provider.

PATIENT RESTRAINTS AND SECLUSION

Restraining a patient raises serious concerns, such as infringement on patient autonomy, limits on freedom of movement, claims of battery, and risk of physical and/or psychological injury, and even death, resulting from restraints. Therefore, before using restraints, healthcare professionals must carefully weigh the risks and benefits, and they always should consider whether alternatives to restraint or seclusion are available.

Physical restraints:

- Are any manual methods, devices, materials, or equipment that immobilize or reduce the ability of a person to move his or her arms, legs, body or head freely
- Are any medications used as restrictions to manage a person's behavior or restrict the person's freedom of movement that are not part of a standard treatment or dosage for the person's condition
- Do not include devices such as orthopedically prescribed equipment, surgical bandages, protective helmets, or other methods that involve the physical holding of a patient:
 - o For the purpose of conducting routine physical examinations or tests
 - o To protect the patient from falling out of bed
 - o To permit the patient to participate in activities without the risk of physical harm

Seclusion:

- Is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving
- May only be used for the management of violent or self-destructive behavior

The **medical/surgical restraint designation** applies when it is needed to support medical care and healing. For example, the patient may be trying to pull out lines or tubes or has a fracture requiring restricted mobility and less-restrictive methods haven't worked.

The **behavioral management restraint designation** applies:

- When a patient is exhibiting violent, destructive, or aggressive behavior that presents an immediate, serious danger to the patient or to others, and
- When the patient has no lines or tubes that could be pulled out and does not have any other health problem requiring restricted mobility

TYPES OF RESTRAINTS

- Bed rails can provide assistance with bed mobility, repositioning, and getting out of bed. Raised bed rails, however, are considered a physical restraint when they restrict a patient from getting out of bed.
- Lap and wheelchair belts, which function similarly to seatbelts, can also be considered a restraint and are used for patients with neurologic disorders that affect balance and movement.
- Lap trays support upper body positioning for patients who are in wheelchairs. If not easily removed, a lap tray is considered a physical restraint because it prevents the patient from standing up or getting out of the wheelchair.
- Belt restraints are used to prevent a patient from getting out of a chair or bed in order to reduce risk of falling.
 - Be sure there are no wrinkles in the patient's gown under the belt, as this can increase the risk for pressure ulcers.
 - Do not position the belt over the patient's chest, as this can interfere with breathing.
- Limb restraints are wrapped around a patient's wrists or ankles and are attached to the bed or chair to prevent limb movement. Limb restraints are used to keep patients from getting out of bed

without supervision and from touching and interfering with medical equipment (such as IV needles and pumps, monitors, nasogastric tubes) that is necessary for treatment.

-Be sure not to apply these restraints too tightly so that circulation is not impaired. A good strategy is to ensure that at least two fingers can be placed between the secured restraint and the arm or leg.

-Do not apply them near an IV site, because occlusion or infiltration of the IV can occur.

- Elbow restraints prevent a patient's arms from flexing and are commonly used to keep patients from pulling at an IV site. These restraints are made of fabric with slots for flat pieces of plastic or wood, which keep the restraint device from bending and immobilize the elbow.

- Mitt restraints can be placed on patients who try to use their hands to scratch themselves or to undo limb or elbow restraints.

INITIATING RESTRAINT OR SECLUSION

Examples of patient conditions that might call for the use of restraints are:

- Poor mobility
- Impaired cognition
- High physical dependency
- High risk for falls
- Incidence of falls
- Psychoactive medication use

The desired outcome of applying physical restraints is:

- To protect patients and/or healthcare providers from harm when other interventions have proven ineffective or insufficient
- To prevent patients from performing certain activities – such as getting out of bed unattended or trying to remove an endotracheal tube – that could impact their recovery

Before initiating restraint or seclusion, consider:

- Whether other less restrictive options are possible
- All potential physical and psychological risks of their use

Give special consideration to vulnerable persons such as:

- Those who are obese or frail
- Those who have medical comorbidities
- Those with intellectual or developmental disabilities
- Those whose repeatedly challenging behaviors put them at risk for incomplete assessments

APPLYING A PHYSICAL RESTRAINT

The Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) have developed guidelines regarding the use of physical restraints. They include:

- Physical restraints must have a written order from the treating clinician.
- Restraints are to be used in accordance with facility policy on restraint use, facility/unit protocol, and manufacturer instructions.
- Special consideration should be given to preserve patient dignity.
- Special consideration should be given to protect the patient from physical harm (such as skin breakdown or respiratory impairment) during restraint use.
- Restraints must be removed as soon as it is considered safe to do so.
- Patients who are at increased risk for intentionally harming others might be placed in seclusion instead of having physical restraints applied.

Guidelines regarding the application of a restraint include:

- Nurses and other healthcare personnel who have received specialized training regarding physical restraint application can apply them.
- Trained staff can be assisted by other personnel, but monitoring and assessing patients who are being restrained cannot be delegated to assistive personnel.
- Family members can be present during physical restraint use and, in some cases when it is appropriate to the situation, can be encouraged to sit with the patient to alleviate the need for restraint.

The guidelines for physical restraints do not apply to immobilization procedures or devices that are:

- Used during or immediately following surgical or other procedures (such as the use of IV arm boards)
- Used as protective equipment (such as helmets)
- Used as adaptive devices

COMPLICATIONS OF RESTRAINTS

Potential complications associated with the use of mechanical devices for patient restraint include:

- Asphyxiation
- Strangulation
- Death due to aspiration after vomiting and being unable to clear the airway
- Death due to inability to escape from the building in the event of fire or other disaster
- Occlusion of blood circulation
- Nerve damage
- Blood loss from blood vessels injured by the patient when struggling against the restraints
- Falls
- Loss of muscle tone
- Development and/or worsening of pressure ulcers
- Decreased mobility
- Agitation, frustration
- Reduced bone mass
- Stiffness
- Loss of dignity
- Incontinence, constipation

IMPORTANT CONSIDERATIONS

Some important considerations include:

- Your facility must have a written policy for use of restraint devices that is in accordance with federal and state laws as well as guidelines issued by the Centers for Medicare and Medicaid Services and The Joint Commission.
- Restraint should not be used as a punishment or to reduce behaviors (aside from behaviors that can cause self-injury or injure others) that are disturbing to staff.
- Clinical care facilities cannot legally use restraint devices unless device use is determined to be essential in preventing disruption of necessary care and treatment.
- Failure to use restraints can lead to legal liability if preventable injuries occur

Physical restraint can only be used under the orders of a physician or other treating clinician and according to unit or healthcare facility protocol.

- Orders for physical restraint cannot be written as a standing order.
- If physical restraints are applied to a patient because of violent or aggressive behavior in an emergency situation when a written order does not exist, the treating clinician must be contacted within a reasonable amount of time to produce a written order. In general, a physician or other prescribing clinician must make a face-to-face assessment of the patient and his or her condition within 1 hour of application of the restraint.
- The assessment of the physician or other prescribing clinician should include evaluating:
 - o The patient's need for physical restraint
 - o The patient's reaction to physical restraint

- o The patient's behavioral and medical condition
- o The need to continue or discontinue physical restraint
- If the assessment is performed by a nurse or physician assistant, the nurse or physician assistant must consult with the physician or other treating clinician as soon as possible following the assessment.
- The Joint Commission states (unless state law is more restrictive) that each order for physical restraint is to be renewed within the following limits:
 - o Every 4 hours for adult patients ages 18 and older
 - o Every 2 hours for children and adolescents ages 9 to 17
 - o Every hour for children under age 9
 - o For a maximum of 24 consecutive hours

Appropriate use of restraints in the healthcare setting promotes patient and staff safety. Documentation should clearly reflect the need for restraints for medical or safety reasons.

Hospitals and healthcare professionals can incur liability from inappropriate use of restraints or seclusion and for failure to use restraints or seclusion to protect a patient. Therefore, you must carefully evaluate each situation in which use of restraints or seclusion is considered.

PATIENT RIGHTS

Patient rights are outlined in the Patient's Bill of Rights, developed by the American Hospital Association (AHA). This bill refers to the legal rights, or guarantees, for patients receiving medical care, treatment, and services in the United States. The intent of the Patient's Bill of Rights is to provide patients with optimal healthcare services while also preserving their dignity, personal rights, and legal rights. In addition, each state defines specific patient rights that are protected under state law. The AHA was one of the first advocates for developing the Patient's Bill of Rights. In 1973, the AHA developed 12 rights to inform patients about what to expect during hospitalization.

PURPOSE/OVERALL GOAL This module outlines the 12 rights that comprise the Patient's Bill of Rights developed by the American Hospital Association, and explains the responsibilities of nurses and patients in ensuring those rights are honored. The goal of this module is to make you, as a healthcare provider, aware of patient rights so you can deliver the highest quality care possible.

COURSE OBJECTIVES After completing this module, the learner should be able to: 1. Describe the rights that patients have according to the Patient's Bill of Rights 2. Explain the role of healthcare providers in protecting these patient rights 3. Define the role of nurses as patient advocates 4. Define the responsibilities that patients have related to their care. The Patient's Bill of Rights for each and every patient:

THE PATIENT'S BILL OF RIGHTS

First developed by the American Hospital Association (AHA) in 1973 and updated several times since then, the Patient's Bill of Rights ensures that all patients receive the best possible healthcare while also maintaining their legal and personal rights and preserving their dignity. The following is a summary of these rights. All patients have the right to:

1. Considerate and respectful care Patients should be in an environment that preserves their privacy, promotes a positive self-image, and be called by the name they prefer.
2. Appoint someone to make healthcare decisions for them This involves creating and executing an advance directive.
3. Current and understandable information about their health Patients have the right to be told the truth about their diagnosis and prognosis, and that it be provided in a language they understand.
4. Refuse treatment Patients can refuse any portion or all of the treatment recommended or prescribed to them by their medical provider.
5. Privacy Patients should be allowed privacy during health discussions with their provider, treatments, procedures, and examinations.
6. Resolution of conflict When patients have a grievance regarding any part of the care provided to them, they should be told about the process or policy involved in how to file a complaint.
7. Review their medical records A patient is entitled to see their records as well as receive an itemized bill for healthcare services provided.
8. Refuse to participate in research studies A patient is entitled to refuse an experimental drug or other therapy in a research study, even if it is recommended by their provider.
9. Confidentiality of their information All communication about a patient's health, including their history, diagnosis, treatment, and plan of care should be kept confidential between the patient and only those involved in the care of the patient.
10. Continuity of care A patient is entitled to the most comprehensive, high-quality care at a reasonable cost.
11. Knowledge of business relationships that influence care Patients have to right to know about relationships among a hospital, educational institutions, other healthcare providers, or payers that may positively or negatively affect the care provided to them.
12. Be transferred to another medical facility In the event of an emergency, federal regulations require hospitals to either provide treatment until a patient is stabilized, or if capability does not exist, transfer the patient to another hospital. Hospitals are also required to accept transfers if they are capable and provide care as quickly as possible, regardless of the patient's ability to pay or insurance coverage.

NURSES AS PATIENT ADVOCATE

The toll that illness can take on a patient, and the complicated world of modern healthcare, can make it difficult for patients to understand and exercise their rights. So it is important for all healthcare professionals, particularly nurses, to serve as advocates in helping to protect the rights of patients who can't speak or act for themselves. As advocates, nurses can assist vulnerable patients and their families in creating, implementing, following, and evaluating a plan of care – while ensuring that this plan is consistent with the patient's values and spiritual and cultural needs. To become an effective advocate, you must embrace two important concepts:

1. Reverence. Reverence means a willingness to respect a patient's autonomy. Healthcare professionals should not try to control the patient's thoughts, ideas, suggestions, or principles.
2. Fidelity. Fidelity means accepting and upholding the patient's decisions. This requires open communication and trust.

PATIENT RESPONSIBILITIES

High-quality, effective patient care is the responsibility not only of healthcare providers, but of patients as well.

Patients share these responsibilities related to their care:

1. To follow hospital rules and regulations, and ask about anything they don't understand
2. To cooperate with caregivers and follow the plan of care to which they have agreed, with the understanding that they can change their mind at any time
3. To notify their physician, nurse, or other caregivers if they don't understand their diagnosis, treatment, or prognosis
4. To inform caregivers if they feel overwhelmed or too sick to have visitors
5. To ask about what to expect regarding pain and pain management:
 - To discuss pain relief options with the doctor and/or nurse to develop a pain management plan
 - To ask for pain relief when pain first begins
 - To help the doctor and/or nurse in assessing their pain
 - To communicate with them when pain is not relieved o To discuss any worries related to taking pain medication
6. To respect the privacy of a roommate, if in a semi-private room
7. To accept financial obligations associated with their care
8. To let nurses, physicians, other caregivers, or the Patient Relations Department know if they are dissatisfied with any aspect of their care
9. To be considerate of the rights of other patients, staff, and policies of the facility, such as rules regarding a non-smoking campus and limits to the number of visitors

CONCLUSION As a healthcare provider, it is your responsibility to:

- Learn about patient rights so you can advocate for your patients and protect their legal rights in your healthcare facility.
- Inform your patients of their legal rights.
- Ensure your patients have received a written copy of your facility's Patient's Bill of Rights in basic and clear language.
- Learn about patient rights that are protected under your state's statute

SEXUAL HARASSMENT

Educating employees about the facts and misconceptions surrounding sexual harassment is an important step in preventing or stopping this type of harmful behavior. Some individuals may not immediately realize that their words or deeds can be considered sexual harassment. And others who are targets of sexual harassment may think that it must be tolerated.

DEFINITION

Sexual harassment in the workplace often takes the form of unwanted sexual favors or verbal or physical conduct of a sexual nature which:

- Either reveals or implies an effect on employment
- Unreasonably interferes with work performance
- Creates an intimidating, hostile, or offensive work environment

Sexual harassment is an illegal form of sex discrimination, which is prohibited by Title VII of the Civil Rights Act. To be considered sexual harassment, the physical or verbal conduct in question must be both unwelcome and of a sexual nature.

- Advances are unwelcome when they are not solicited and are considered undesirable and offensive.
- Even if a person concedes to these advances, it cannot be concluded that the advances are welcome.

LAWS AND SEXUAL HARASSMENT

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According to the American Nurses Association, sexual harassment violates Title VII under two legal theories:

- Quid pro quo--Quid pro quo means "this for that." In this context, it involves expressed or implied demands for sexual favors in exchange for: some benefit, such as a promotion or pay increase or to avoid some detriment, such as termination or demotion
- Hostile environment--Hostile work environment harassment occurs when speech or conduct is so severe and pervasive that it creates an intimidating or demeaning environment that negatively affects a person's job performance. This type of harassment can be perpetrated by anyone in the work environment (including a peer, supervisor, subordinate, vendor, customer, etc)

TYPES OF SEXUAL HARASSMENT

1. Gender Harassment- the most common type of sexual harassment. It involves generalized sexist statements and behavior that convey insulting or degrading attitudes about women.
2. Seductive Behavior -this involves unwanted, inappropriate, and offensive sexual advances.
3. Sexual Bribery-solicitation of sexual activity or other sex-linked behavior by promise of reward. The proposition may be either overt or subtle.
4. Sexual Coercion- involves coercing sexual activity or other sex-linked behavior by threatening retaliation.
5. Sexual Imposition- involves forceful touching, feeling, or grabbing, or sexual assault.

EFFECTS OF SEXUAL HARASSMENT

Psychological reactions:

- Depression, anxiety, shock, denial
- Anger, fear, frustration, irritability
- Insecurity, embarrassment, feelings of betrayal
- Confusion, feelings of being powerless

- Shame, self-consciousness, low self-esteem
- Guilt, self-blame, isolation

Physiological reactions:

- Headaches
- Lethargy
- Gastrointestinal distress
- Dermatological reactions
- Weight fluctuations
- Sleep disturbances, nightmares
- Phobias, panic reactions
- Sexual problems

Career-related effects:

- Decreased job satisfaction
- Unfavorable performance evaluations
- Loss of job or promotion
- Drop in work performance due to stress
- Absenteeism
- Withdrawal from work
- Change in career goals

WHAT TO DO IF YOU ARE A VICTIM

You SHOULD:

- Say “NO” to the harasser. Explain that you find the harasser’s words, actions, and behavior offensive and request that it be stopped.
- Follow your employer’s policy for reporting the behavior.
- Keep a record of what happened and when, including dates, times, places, witnesses, etc.

You SHOULD NOT:

- Disregard sexually harassing behavior, hoping it will go away
- Blame yourself for the harassment

Sexual harassment is a very serious matter. It is important for all employees, regardless of profession, to understand their employer’s policy on how to report behavior that may be considered harassment. Understanding what constitutes sexual harassment, and what should be done about it, will assist in minimizing or eliminating it. Consistent communication, empowerment, and appropriate interventions can help create a culture where sexual harassment is not tolerated.

WORKPLACE VIOLENCE

As a healthcare employee, you must be aware of the risk of workplace violence and know what to do if you experience it – for your personal safety as well as the safety of patients and others at your facility.

Examples of workplace violence include the following:

1. Threats – Expressions of intent to cause harm, such as:

- Verbal threats
- Threatening body language
- Written threats

2. Bullying – Verbal abuse that:

- Isolates the victim from others
- Interferes with the victim's work
- Sometimes attacks the victim's credibility

3. Physical assaults – Attacks that include:

- Slapping or hitting
- Rape
- Homicide
- Use of weapons such as firearms, bombs, knives

4. Muggings – Aggravated assaults, usually conducted by surprise and with intent to rob

RISK FACTORS

Although anyone working in a healthcare facility may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk.

Other healthcare personnel at increased risk of violence include:

- Emergency response personnel
- Hospital safety officers
- All healthcare providers

Violence may occur anywhere in a healthcare facility, but it is most frequent in the following areas:

- Psychiatric units
- Emergency departments
- Waiting rooms
- Skilled nursing facilities

EFFECTS OF WORKPLACE VIOLENCE

The effects of workplace violence can range in intensity and include the following:

- Minor and serious physical injuries
- Temporary and permanent physical disability
- Psychological trauma
- Death

Workplace violence may also lead to negative organizational outcomes such as:

- Poor employee morale
- Increased job stress
- Higher employee turnover
- Reduced trust of management and coworkers
- Hostile working environment
- Poor organizational image

FACTORS CONTRIBUTING TO WORKPLACE VIOLENCE

Certain patient conditions can increase the risk for violence in the healthcare setting, such as:

- Personality disorders
- Psychosis
- Dementia
- Developmental impairment
- History of violence
- Substance abuse

In addition, certain occupational factors can also contribute, such as:

- Understaffing on a unit (few clinical personnel and large volume of patients)
- Lack of patient privacy
- Use of restraints and/or seclusion
- High volume of activity (admissions, discharges, visitors, etc.) on the unit
- Long waits for service
- Transporting patients to/from procedures
- Overcrowded, uncomfortable waiting rooms
- Working alone, especially during high volume of activity
- Poor environmental design (poorly lit hallways, corridors, parking garage, etc.)
- Lack of training for internal staff
- Presence of personal weapons

PREVENTION STRATEGIES

To prevent violence in healthcare facilities, organizations should develop a safety and health program. Organizations should evaluate this program periodically. Although risk factors for violence are unique to each facility and its work environment, general prevention strategies can be followed

For example:

- Develop emergency signaling, alarms, and monitoring systems.
- Install security devices such as metal detectors to prevent armed persons from entering the facility, cameras, good lighting in hallways and parking garages.
- Design the triage area and other public areas to minimize the risk of assault
- Install enclosed nurses' stations. • Install deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas. • Arrange
- Provide staff restrooms and emergency exits.
- Provide all workers with training in how to recognize and manage escalating behavior and potential and actual assaults, and how to safely resolve conflicts

SAFETY TIPS FOR HEALTHCARE WORKERS

Watch for warning signals that may be associated with impending violence, such as:

- Verbally expressed anger and frustration
- Body language such as threatening gestures
- Signs of drug or alcohol use
- Presence of a weapon

If you see warning signals, use these techniques to help diffuse anger:

- Display calm and caring attitude
- Don't threaten retaliation
- Don't give orders
- Acknowledge the person's feelings (for example, "I know you are frustrated")
- Avoid any behavior that could be interpreted as aggressive, such as:
 - o Moving rapidly
 - o Getting too close
 - o Touching

o Speaking loudly

Be alert:

- Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
- Be vigilant throughout the encounter.
- Don't isolate yourself with a potentially violent person.
- Always keep an open path for exiting; don't let a potentially violent person stand between you and the door. Take these steps if you can't defuse the situation quickly:
- Remove yourself from the situation (walk away).
- Call security or 911 for help.
- Report any violent incidents to your manager

As a healthcare worker, you should be alert and cautious when interacting with patients and visitors. Actively participate in your facility's safety training programs, and become familiar with your facility's policies and procedures on violence prevention.