



Student Orientation Module 2011



Please Read the Module and Answer the Questions. Please submit in completed all requirements and answered questions two weeks prior to the start date of the Clinical Rotation to Connie Gonzalez Room 6603 – Organization Development/Education Department. For any questions please call (305)854-4400 ext 2748, Fax: (305) 285-2665, or Mail in to:

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2011 Annual Mandatory Review

Bloodborne Pathogens and the Use of Personal Protective Equipment

Title 29 of the Code of Federal Regulations 1910.1030 – The United States Occupational Safety and Health Administration (or OSHA) Bloodborne Pathogens Standard

Bloodborne pathogens (BBP) are viruses or infectious agents carried by human blood or other potentially infectious materials (OPIM) such as semen, vaginal secretions, any unfixed human tissue or organs, and other body fluids. These pathogens can enter our bodies and cause disease and immune deficiencies, which can sometimes lead to death. Some of the diseases caused by BBPs are Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV).

These pathogens may enter the body and infect a person through a variety of means, such as handling medical waste, medical procedures, or an accidental injury with a contaminated sharp object. Potential objects include

- Used needles
- Broken glass
- Any sharp object that can break through the skin

Direct transmission of BBPs may occur when infectious material comes in contact with

- Open cuts
- Punctures
- Nicks
- Skin abrasions or rashes
- Mucous membranes such as the eyes or oral membranes in the mouth.

Indirect transmission of BBPs may occur by touching a contaminated surface and transferring the infectious material to your eyes, mouth or an open sore. Good hand washing with soap and water or the use of antimicrobial hand rubs is the most effective way to prevent infection by dangerous pathogens.

Some potential exposure risks common in the healthcare setting include

- Contact with patient's open wounds or other infected body secretions
- Cleaning or working with contaminated equipment or instruments
- Cleaning contaminated surfaces

There are several ways to reduce or prevent exposure.

- Wash your hands before eating, drinking, or handling contact lenses.
- Do NOT eat, drink, or apply cosmetics in any area where there is a reasonable likelihood of exposure.
- If you have cuts or sores, cover them with an occlusive bandage.
- Treat all blood and body fluids of all people as though they are potentially infectious.
- NEVER recap, bend, break, or shear used needles.
- Use safety devices specially engineered to minimize exposure risk. Safety sharps have built-in safety features and needless systems that help with the safe collection of body fluids after initial venous or arterial access is established.
- Immediately dispose of sharps in an approved sharps container – NEVER in the trash!
- NEVER attempt to push or force a used sharps into a sharps container.
- Personal Protective Equipment (or PPE) should be used when there is a potential for contact with blood or body fluids.
- Use gloves to protect hands for jobs that require touching of blood or body fluids.

- Use protective gowns to protect clothing from splashes or smears of blood or body fluids. Use masks and face shields to protect the mouth, nose, and eyes from sprays or splashes of blood or body fluids.
- Replace any PPE that is torn or punctured immediately
- When removing contaminated PPE
 - Avoid touching the outside of gloves and other contaminated PPE with bare skin
 - Dispose of used PPE in the proper container before leaving the contaminated area.
 - Wash your hands or use alcohol-based hand cleanser immediately after removing PPE

OSHA's Bloodborne Pathogens Standard also includes a requirement for facilities to identify employees who may have occupational exposure to blood or OPIM [29 CFR 1910.1030(b)], and establish a written Exposure Control Plan to minimize the risk of employee exposure. All healthcare personnel covered by the Exposure Control Plan must be offered the Hepatitis B vaccine free of charge within 10 days of initial appointment. The vaccine is effective, safe, and highly recommended for all employees who may come into contact with blood or body fluids.

Talk to your supervisor for specific information regarding

- Your facility's Exposure Control Plan.
- Location of PPE
- Procedure for Spill Clean Up involving potentially infectious material

If you are exposed to potentially infectious blood or body fluids, the following procedures should be taken.

- If contact occurred with intact skin, wash with soap and water. Use non-abrasive antibacterial soap if possible.
- For needle sticks or contact with cuts or non-intact skin, wash with antimicrobial soap and water, then pour 3% hydrogen peroxide over the exposed area.
- For contact with the mouth, spit and rinse the mouth with 3% hydrogen peroxide
- For contact with the eyes, remove contact lenses and rinse eyes with water or saline
- Report the exposure immediately to your supervisor and your employee health personnel. OSHA requires all employers to make immediately available a free confidential medical evaluation and follow-up to an employee reporting an exposure. The United States Centers for Disease Control and Prevention (or CDC) recommendations for the management of occupational exposures to HBV, HCV, and HIV may be found at the CDC website at: <http://www.cdc.gov/niosh/topics/bbp/#treatment>.

All percutaneous injuries from contaminated sharps must be recorded on the

- OSHA 300 Log and the employer's
- Sharps Injury Log that includes
 - o Type and brand of device involved in the incident
 - o Department or work area where the exposure occurred
 - o Explanation of how the incident occurred.

Hazardous Materials in the Workplace and Material Safety Data Sheets (MSDS)

OSHA 29 CFR 1910.1200(a) Hazard Communication Standard

Material Safety Data Sheets (MSDS) are prepared and distributed by each manufacturer of a hazardous chemical and contain the following information

- Name
- Physical characteristics
- Fire and explosion information

- Reactivity, health hazards
- Any specific special protection precautions, and
- Use, handling, and storage procedures

Individual work areas have access to MSDS information through Mercy on line should maintain a MSDS for every chemical

would maintain a MSDS for every chemical used or stored in the area. Each employee should have ready access to the MSDS information. In other words, MSDS information should NOT be kept in a locked filing cabinet. It is important for you, as an employee, to know where the MSDS sheets are located on Mercy on line and how to use the information. There is also a website where this information may be accessed: www.hazard.com/msds.

Labels on incoming containers of hazardous chemicals may NOT be removed or defaced. Label information must contain

- The identity of the hazardous chemical, and
- Relevant health and physical hazards

Labels for any chemicals NOT prepared in-house must contain the

- Name and address of the manufacturer
- Emergency phone number
- Instructions for proper storage and handling
- Basic protective clothing and equipment, and
- Procedures that are needed to work safely with the chemical

Personal Protective Equipment (PPE) must be available for your protection when dealing with potential hazardous chemicals. Proper PPE includes

- Respirator or mask to prevent being exposed to dangerous vapors, gases or aerosols
- Protective apron/gown for working with disease-causing substances or harmful chemicals
- Goggles with side shields for handling chemicals or other substances that may splash into your eyes, although full-face shields may also be required
- Protective gloves for
 - o working with infectious materials or body fluids
 - o removing glassware from autoclaves, and
 - o handling chemical solvents

As an employee you have the right to

- Be informed of potential exposure to hazardous chemicals – should know what you are handling and what PPE should be used to prevent exposure
- Have access to the workplace chemical list and MSDSs. If you request to see an MSDS for a product you use at work, and your employer CANNOT show it to you, after one working day, you may refuse to work with that product until you are shown the correct MSDS. If you request your own personal copy of a MSDS, your employer has 15 working days to provide it.
- Be trained on the hazards of chemicals to which you may be exposed
- Be informed about the necessary protective measures and be provided with appropriate personal protective equipment and clothing, and
- Register a complaint WITHOUT fear of reprisals
 - o Type and brand of device involved in the incident
 - o Department or work area where the exposure occurred
 - o Explanation of how the incident occurred.

Fire Safety

Fire can be devastating in any setting but especially in a healthcare facility. It can destroy lives, property, and impact the economic viability of a facility. There are systems within a healthcare environment to warn of fire dangers and occurrences. But what can you do if you are the first on the scene of a healthcare fire? Remember the acronym RACE.

- R – rescue patients and yourself from the area where the fire is located
- A – alarm –pull the fire station alarm and call your hospital’s fire code.
- C – close all doors to confine the fire
- E – extinguish the fire or evacuate patients and yourself

There are fire extinguishers stationed throughout your facility. You should be trained in operating one. When using fire extinguishers, remember the acronym PASS.

- P – pull the pin
- A – aim at the base of the fire
- S – squeeze the trigger
- S – sweep from side to side

There are several different types of extinguishers to be used for specific classes of materials. Most extinguishers are classified as follows

- A – for fires involving ordinary combustibles like wood or paper
- B – for flammable liquids, gases, gasoline and grease
- C – for electrical wiring and equipment
- ABC – for combination fires
- D – for combustible metals like magnesium

Attempting to extinguish even a small fire carries some risk. Fires can increase in size and intensity in seconds, blocking the exit path of the fire fighter and creating a hazardous atmosphere. In addition, portable fire extinguishers contain a limited amount of extinguishing agent and can be discharged in a matter of seconds. Therefore, individuals should attempt to fight **ONLY** very small or incipient stage fires.

Prior to fighting any fire with a portable fire extinguisher you must perform a risk assessment that evaluates the fire size, the fire fighters evacuation path, and the atmosphere in the vicinity of the fire. The following are questions that should be answered before attempting to extinguish a fire with a portable fire extinguisher.

- Is the fire too big? You should **NOT** attempt to extinguish fires that involve flammable solvents, have spread more than 60 square feet, are partially hidden behind a wall or ceiling, or cannot be reached from a standing position.
- Is the air safe to breathe? If the fire **CANNOT** be extinguished without the use of respiratory equipment, you should **NOT** attempt to extinguish it.
- Is the environment too hot or smokey? You should **NOT** attempt to extinguish fires when the heat is easily felt on exposed skin making it difficult to approach within 10 to 15 feet of the fire (or the effective range of the extinguisher). You should **NOT** attempt to extinguish fires when you must crawl on the floor due to heat or smoke or when smoke is quickly filling the room causing decreased visibility.
- Is there a safe evacuation route? You should **NOT** attempt to extinguish a fire when your evacuation route could be blocked by fire, heat, or smoke.

To help ensure the safety of all staff, patients and visitors, facility employees should know the following information.

- The location and use of fire exits, alarms and extinguishers in their work areas

- The facility procedures for announcing a fire (or other emergency)
- Locations where employees should assemble to receive instructions from emergency managers
- Their specific responsibilities during an emergency or evacuation

Electrical Safety and LOCK-OUT/TAG-OUT

LOTO-29 CFR 1910.147

Electrical Safety- 29 CFR 1910 Subpart S

Electricity is a vital source of energy in the workplace. It allows us to operate machinery, computer equipment, medical equipment, and to have the light needed to do our jobs. We use it every day yet we often take its power for granted. It can injure and kill if NOT respected. According to the United States Department of Labor, 10% of all workplace fatalities are due to electrocutions. Care must be taken by ALL staff to make sure that electrical safety procedures are followed to ensure a safe environment for staff and patients.

Here are some key elements for staying safe around electricity.

- Replace and report any defective electrical cords, plugs, or equipment
- Investigate and report any unusual odors coming from electrical equipments or appliances
- Do NOT use any electrical equipment when hands, floors or equipment are wet
- Unplug any electrical appliances NOT in use
- Do NOT overload electrical circuits- in most cases, only one piece of electronic equipment should be plugged into an outlet
- Extension cords should be approved by the maintenance department prior to use
- Un-fused, multiple outlet extension cords should NOT be used
- Do NOT use an adapter that converts 3-prong plugs to 2-prong plugs
- Report any equipment that is damaged
- Report any shock from equipment, including small tingles that may indicate the potential for major shocks, and take equipment out of service immediately

In addition to the basic electrical safety measures, the Occupational Safety and Health Administration (or OSHA) has created Lock-out/Tag-out (LOTO) standards which identify procedures necessary to shut down and prevent the accidental or intentional restarting of faulty equipment. Equipment needing maintenance may have “locks” placed on them to prevent anyone from re-energizing the equipment. This process is referred to as “Lock-out.” When locks are NOT available, labels may be applied to the equipment indicating that it must NOT be used. This is called “tag-out.”

The Department of Labor estimates that following Lock-out/Tag-out (LOTO) procedures can prevent an estimated 120 fatalities and 50,000 injuries annually.

The OSHA LOTO standard allows each employer to develop their own LOTO policy that is suited to the specific needs and equipment used in the facility. Employers are also responsible for providing the appropriate LOTO training for employees who use electrical or mechanical equipment. While the specific procedures for each facility will vary, there are common guidelines that can be applied to all facilities.

- ALL faulty equipment should be immediately unplugged and moved to a location designated by your facility for inoperative equipment.
- Do NOT attempt to use any equipment that has been locked-out or tagged-out
- Do NOT attempt to remove any LOTO devices or otherwise tamper with LOTO measures
- LOTO devices should be removed ONLY by a qualified technician once the equipment has been repaired and tested to make sure it is safe for use.

Additional information on electrical safety and LOTO procedures can be found at www.OSHA.gov

Utility Systems Management

EC.02.05.01 EP1 - The hospital designs and installs utility systems that meet patient care and operational needs.

§482.41 CoP: Physical Environment The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.(A-0700)

What is a Utility System?

Examples of Utility Systems are

- electrical distribution
- emergency power
- horizontal and vertical transport (elevators and pneumatic tube systems)
- heating, ventilating, and air conditioning
- plumbing
- boiler and steam
- medical gases
- medical/surgical vacuum, and
- facility communication systems (nurse call, overhead paging, computer, and telephone)

What should the goal of a good Utilities Management Plan be?

The goal of this plan should be to provide an environment of care (EC) that is

- safe, controlled, and comfortable
- reduce the potential for health care acquired illness
- minimize the risks associated with utility failures, and
- to ensure the operational reliability of utility systems

These goals should be consistent with the healthcare organization's mission in providing quality healthcare and to ensure the safety of patients and staff.

What are the objectives of a good Utilities Management Plan?

A plan should be designed to protect people, equipment, property, and the environment by ensuring the safe and reliable operation of the utility systems that impact life support, infection control, environmental support, equipment support, and communications. Some primary objectives of a plan could be

- ensuring compliance with applicable regulatory requirements, standards and guidelines, and manufacturers' recommendations
- carrying out an effective preventive maintenance program
- providing operator and user training
- maintaining reference documents for each system
- establishing effective contingency plans in the event of a utility system failure
- monitoring equipment performance and identifying improvement opportunities
- maintaining required permits and licenses

Who is involved in the Utilities Management Plan?

All members of the staff should be familiar with their facility's Utilities Management Plan and their role in the event of a system failure or malfunction. All staff must be trained and competent in safe operation and use of

utility systems and in emergency response and reporting procedures in their individual areas of responsibility. Your responsibilities may vary according to your job title and role within the facility.

Some key things every employee should know about the Utility System Management

- How system failure and malfunctions should be reported for repair. Who do you call when you know or suspect something is wrong? For example, what do I do if I smell an unusual smell like something burning?
- How to access alternative sources of essential utilities. If you work in or with a critical area or system such as the ones listed earlier, how do you employ backup systems in case of a failure?
- How your facility will communicate procedures and responsibilities to staff that relate to Utilities Management. Who do you go to for information regarding the Utilities Management Plan?
- Procedures to be followed for turning off malfunctioning systems. If you know a utility has failed in your area of responsibility, how do you shut the system down in a safe manner?
- Which areas are designated as critical in regards to requiring emergency power? Some typical critical areas are
 - o blood storage units
 - o emergency care areas
 - o life support systems
 - o elevators and other forms of egress necessary for emergency evacuation
 - o operating rooms

Back Safety

Your back is the main supporting structure of your entire body. Understanding and applying the basics of back care can mean the difference between a healthy back and a serious back injury.

A number of physical conditions such as curvature of the spine (scoliosis), arthritis, and herniated discs can cause back pain. The majority of backaches are due to poor posture and weak supporting muscles. By utilizing proper posture when you sit, stand, lift, move, and recline, you can decrease the incident of back injury. With exercises that strengthen and increase flexibility, you can prevent most common backaches. The result is freedom from back pain and a stronger, healthier back.

Lifting correctly is very important. Safe lifting is easy to learn, simple to do, and may be one of the most important skills you will ever learn. Using these techniques will help keep your back in balance and could protect you from accidental strain and overload.

How can you lift safely?

First, visualize the lift. Then, ask yourself these 3 main questions.

- Can I reasonably lift this load myself without risk of injury to myself or anyone else?
- Is it compact enough to hold close to my body?
- Do I need to remove anything from the path where the load will be carried?

If the answer is “no” or “I’m not sure,” STOP! Get help and clear your path. NEVER attempt to lift a patient on your own. Get the lifting equipment.

Once you have help or have determined that the load is small and compact enough to lift, balance your stance by placing your feet shoulder-width apart. Tuck your pelvis slightly forward and tighten your abdominal muscles. Bend your knees and use the large muscles in your legs to support your back to carry the weight. You should NOT use the muscles in your back to provide support for the load.

Make sure the load is held as close to your body as possible, tuck in your chin to keep your head and neck in a straight line. Grip the object with the palms of your hands and your fingers.

Be very careful to avoid twisting at your hips or knees while lifting or carrying. Keep your frame in line at all times. Turn by moving with your feet and walking in the direction you want to move.

When 2 or more people are involved in lifting, clear and direct communication is essential to a smooth, injury-free process for all involved. The team lead should make sure the team is ready for the lift by checking posture, grip, position, and verbal confirmation that everyone is ready. He/she should communicate the lifting plan making sure everyone understands the transfer goal, route, final destination, and any special instructions. For example:

Transfer goal: "The plan is to move the box from this counter to room 105 across the hall." Route: "We'll take the route around the nurse's station to south."

Final destination: "When we get there, we'll place it on the counter to the right of the sink" Special instructions: "The box is heavier on this side than the other."

Before attempting to lift and carry an object, a lift test should be initiated. The item should be lifted a few inches to make sure the load can safely be lifted and carried to the final destination.

Preventing Slips, Trips, and Falls

OSHA 29 CFR 1910 Subpart D

Falls prevention is a serious issue for all hospital staff. According to the Occupational Safety and Health Administration (or OSHA), slips, trips and falls are responsible for 15% of all accidental deaths, and are second only to motor vehicles as a cause of fatalities. Falls also cost businesses billions of dollars each year due to lost time and productivity, workers compensation claims, and lawsuits. The risks for slips and falls are even greater in the healthcare facility because patients often have conditions that compromise their strength, eyesight, and/or balance.

There are 2 basic types of falls.

1. Same-Level Falls: These are high frequency/low severity falls (Same-Level Falls are generally slips or trips)
2. Elevated Falls: These are lower frequency/higher severity falls (over 60% of Elevated Falls are from less than 10 feet)

There are simple steps each person can take to help make your facility a fall free zone.

- Keep all work areas, hallways, and stairs properly lit.
- Keep aisles and stairs free of clutter.
- Do NOT block or obstruct exits or walkways.
- Keep equipment and tools off the floor and stored in cabinets or closets.
- Look for potential trip hazards such as loose carpet and tiles or broken pavement and report them immediately.
 - As little as a 3/8" rise in a walkway can cause a person to trip and fall.
 - Avoid laying power cords across doorways or other walkways. (If power cords must be placed in walkways, tape them down or use a cord cover to minimize the trip hazard.)
 - When working above floor level always use proper ladders or step stools – NEVER use a chair or climb on furniture.
 - Make sure that all the feet of the ladder are on stable, level ground.

- NEVER use a ladder in front of a door unless the door is locked and/or guarded.
- Avoid actions that can result in a loss of balance and potential falls on a ladder.
 - o Do NOT stand higher than the third rung on any ladder.
 - o Observe the 3-point rule on ladders. ALWAYS have at least one hand and two feet in contact with the ladder at ALL times.
 - o Do NOT “stretch,” stand on your toes, or reach beyond normal arms length while on a ladder (use a taller ladder instead)
- Do NOT jump from ladders, loading docks or other elevated locations no matter how close to the ground you are.
 - Be aware of potential falls hazards from ice, snow, or standing water.
 - o Report ice and snow accumulation immediately.
 - o Clean up spills right away and post a “wet floor” sign.
- Wear appropriate shoes for your job duties.
- Shoes with nonskid soles provide much more stability on waxed floors than high heels or leather soles.

Emergency Management

The emergency management plan for your organization should describe how it will establish and maintain a program to ensure effective response to disasters or emergencies affecting the environment of care.

There are 4 phases of emergency management activities.

1. Mitigation: activities to lessen the severity and impact a potential disaster or emergency may have on its operation
2. Preparedness: activities an organization undertakes to build capacity and identify resources that may be utilized should a disaster or emergency occur.
3. Response: activity and organization to ensure the safety and security of patients, visitors, and staff.
4. Recovery: planned activities to reestablish the functions and structure of the organization following a disaster or emergency.

Your facility’s emergency management plan should include

- Procedures to conduct a hazard vulnerability analysis
- A description of how, when, and by whom the plan should be activated
- The organization’s involvement with community-wide emergency response agencies
- How and when to notify internal and external authorities of emergencies
- How and when to notify personnel when emergency response measures are initiated
- The process to identify personnel responsibilities when response is initiated.
- Procedures to allow assignment of available personnel in emergencies to cover necessary staff positions
- Patient activities such as scheduling modification and discontinuation of service, control of patient information, and patient transportation during an emergency
 - Staff activities such as the provision of support to families affected by the emergency
 - Logistics of critical supplies
 - Procedures for security, crowd control, traffic, and interaction with the news media
 - The process for evacuation of the facility, both horizontally and vertically, when the environment cannot support adequate patient care and treatment
 - Provisions for an alternative care site when the environment cannot support adequate patient care, such as
 - o management of patient necessities
 - o patient tracking
 - o inter-facility communication

- o transportation of patients, staff, equipment, and supplies, and the
- o process for reestablishing operations following a disaster

Awareness and orientation to the emergency management plan is an important aspect of preparedness. Because most disasters occur with little warning, it is important for staff to know their specific roles and responsibilities during an emergency or disaster. If you are unsure of your role, talk to your supervisor or contact your facility's safety officer. The 4 most important things you should know about your role during a disaster are

1. where to report
2. what your role will be
3. how and where supplies and equipment will be distributed
4. how communication will be handled

EMERGENCY CODES

Emergency codes are used by hospitals and other healthcare facilities as a way to notify staff of emergency situations without causing undue concern for patients or visitors. Any viewer of prime time television is familiar with the most common emergency code (Code Blue) which in many facilities indicates a medical emergency.

Emergency codes often follow a color coding format although other formats such as a number system are sometimes used. Many facilities use coding systems that are similar, nevertheless, the specific color code may have different meanings at each facility.

Failing to know the meaning of the codes and your responsibilities during these emergencies could lead to a dangerous situation for you or co-workers and patients. In 1999, following a tragic incident in a California hospital, the Healthcare Association of California developed a universal set of emergency codes. The goal of the universal code system was to standardize codes across all facilities so that staff working at multiple facilities or moving from one facility to another would be able to recognize the emergency codes without having to learn multiple code systems. Many states and healthcare systems have adopted the universal emergency code system. However, no matter which system your facility uses for emergency codes, it is the responsibility of each employee to "Know the Codes." This means you should be able to answer the following questions.

- What is the meaning of each code?
- What procedure should be followed to initiate an emergency code?
- What is my responsibility for responding to each code?
- Who is responsible for coordinating code response in my work area?
- What code will be used to give the "all clear" signal once the emergency has been resolved?

MERCY HOSPITAL EMERGENCY PROCEDURES:

To report an emergency in the Hospital: dial "77", state the emergency and location; give the operator all pertinent information.

The operator announces the code via an overhead page and/or personal pagers to appropriate personnel. For emergencies outside the Hospital dial 911. Mercy Professional Building I and II (MPB 1 and MPB 2) and Bayside Pavilion will dial 911 and 77.

EMERGENCY MANAGEMENT CODES FOR MERCY HOSPITAL:

| CODE | DEFINITION | ACTIONS Employee Action |
|------|------------|----------------------------|
|------|------------|----------------------------|

| | | |
|---------------|--|--|
| Code Blue | Signals an actual or potential Cardio-Pulmonary Arrest in an adult | Call 77 to report the code and location Code team will report to scene. |
| Code K | Signals an actual or potential Pediatric Cardio-Pulmonary Arrest | Call 77 to report the code and location Code team will report to scene. |
| Code Rescue | Signals serious patient clinical deterioration | Dial 77 on the phone and advice operator – Code Rescue and patient location |
| Code Orange | Signals hazardous materials has been spilled or leaked | Call 77; follow departmental hazardous procedures. <i>Hazmat Team or EMS report to scene.</i> Avoid inhaling vapors, close off the affected area and evacuate people if necessary |
| Code Pink | Infant / Child Abduction/missing | Call 77 report a description(age, sex and hair color)and give the location where the infant/child was last seen. Remain in department; report suspicious activities to Security. <i>Security and Plant Operations respond.</i> |
| Code D | Signals the Hospital is activating it's internal or external Disaster plan requiring hospital wide involvement and resources | Contact manager; follow departmental disaster plan. <i>All assigned personnel will respond or report to their command center</i> |
| Code Black | Signals the hospital has received a Bomb threat | Remain calm; alert someone to call 77 and stay on phone with caller; ask where and when the bomb will explode; note background noises, voice characteristics such as gender, pitch, and accent; DO NOT TOUCH or MOVE SUSPITIOUS ITEMS. <i>Security and Plant Operations respond.</i> |
| Rainbow Alert | Psychiatric Emergency | Call 77; Rainbow Alert Team responds. |
| Code Red | Signals a Fire has been discovered | Report fire by using pull station or call 77; Begin the R.A.C.E procedures; extinguish fire using appropriate P.A.S.S method <i>Security and Plant Operations respond.</i> |
| Code Silver | Hostage Situation | Call Security, Ext. 2768 and state Code Silver Security will report to the scene |

Information Technology (IT) Security

The Health Insurance Portability and Accountability Act of 1996 (or HIPAA) is a federal law designed to establish standards and requirements for electronic transmission and storage of personal health information.

HIPAA creates national standards to protect individuals' medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records.
- It establishes appropriate safeguards that healthcare providers and others must achieve to protect the privacy of health information.
- It holds violators accountable with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data for example, to protect public health.

Password Management

Your password is the first level of security for your computer and the entire system. How often should you change your password? It is a good policy to change your password every 90 days. Changing it frequently will help keep it secure. When developing your password

- Make your password 8 to 15 characters long
- Use a combination of letters, letters (both upper and lower case), numbers, and symbols
- Make sure that your password is different from previously used passwords
- Try using mnemonics when creating passwords (like acronyms, such as NgoYp!Ne2F. which translates into Never Give Out Your Passwords! Not Even To Friends).

Some things to avoid when creating a secure password include

- NEVER use your name (first, last, middle, or even a nickname) in any form as your password or part of your password
- Do NOT use other information that can be found out easily - names of family members, names of pets, favorite sport team, telephone numbers or street names
- Do NOT use a word that you can find in the dictionary
- Do NOT use dates like your birthday or anniversary
- NEVER share your password, even with co-workers or family
- NEVER include your password on an e-mail
- NEVER write down your password

Spam/Spyware/Viruses

Every day most of us receive dozens of unsolicited commercial e-mails known popularly as "spam." How can you reduce spam?

- Use the Junk E-mail Filter on Outlook –
 1. right click on an e-mail that you would like to stop, and
 2. click on Junk E-mail, then
 3. add Sender to Block Senders List
- Commercial spam filters are also an excellent way to get rid of unwanted e-mails – many can be purchased along with your anti-virus software
- Do NOT use your work e-mail address when registering on the Internet

Spyware (sometimes called a spybot or tracking software) is Internet technology that gathers information about a person or organization without their knowledge. This information is often then sent to advertisers or other interested parties. Spyware usually gets on your computer through a software virus or as the result of installing a new program. Spyware can be initiated by

- Visiting a website
- Viewing an HTML e-mail message
- Deceptive pop-up windows

There is a variety of things that you can do to reduce Spyware. Many anti-virus software programs have spyware filters, but you can help by being very careful when clicking on pop-ups.

A computer virus is a hidden program that secretly copies itself from computer to computer and destroys programs, data, or hardware. It's an executable file designed to replicate itself while avoiding detection. An executable file is a computer file that can run as a program - it often ends with .exe. Anti-virus programs must be updated continuously to look for new and modified viruses. You can prevent getting a computer virus by screening your e-mails. Opening an infected e-mail message will infect your computer and the computers of the people to whom you send e-mails – all without your knowledge. Be aware that viruses can also come into your computer through instant messaging programs. Once you have selected the file, it sends the virus to everyone in your contact list.

Social Engineering

Social engineering is a computer security term for tricking individuals into revealing their password or other personal and financial information. A classic social engineering trick is for a hacker to send e-mail claiming to be a system administrator. The hacker will claim to need your password for some important system administrative work, and ask you to e-mail it to him/her. This is called “phishing.” Hackers forge e-mails, making it look like it came from somebody you know as a legitimate business or system administrator. Often the hacker will send this message to every user on a system, hoping that one or two users will fall for the trick. Phishing e-mails will look creditable, but remember that you should NEVER be asked for your password or account information. If you do receive a phishing e-mail, make sure to mark it as spam and delete it.

Physical Security

Through your computer, you have access to a great deal of information – often confidential or high security information. Because of this, you must make time to take the following necessary steps to keep your computer and data secure.

- Do NOT let anyone look over your shoulder when you are entering your password
- Log off your computer when you are going to be away from it
- Be aware of your surroundings and the people that work in your area. Watch for unfamiliar people.
- Ask for ID (identification) from anyone who tells you that they are there to fix or add programs to your computer. IT personnel will have their ID badges with them
- NEVER leave a laptop computer unattended in a public place to prevent it from being
 1. stolen and/or
 2. used as a portal to its network
- Keep track of portable and data-storage devices (laptops/phones/CDs/DVDs/USBs/etc.).
- Remember to NEVER put confidential information on portable or data storage devices

Computer Updates and Patches Physical Security

Updating your computer with the latest operating system and security files is another way that you can keep your data safe. Updates and patches help secure the computer, makes the computer work more efficiently, and helps safeguard your computer from viruses, spam, and spyware.

An update is a programming file that deals with keeping the information current on your computer. A patch is a programming file that fixes a bug or a problem that hinders your operating system.

Reporting Security Incidences

When you observe something that is suspicious or have a computer problem, always report the incident to your supervisor and the IT department. Examples of vulnerable security situations or problems include

- Confidential information that has been knowingly or unknowingly compromised
- Your computer seems much slower than usual or just isn't “acting” right
- You can't access your data

- You aren't able to get into the computer
- Your password doesn't work
- You observe someone at your computer who is NOT from IT or your department

When reporting an incident, make sure you have this information:

- The incident type
- A description of the incident
- Date and time of the incident

Workplace Violence and Inappropriate Behavior

The General Duty clause of the Occupational Safety and Health Administration requires employers to provide a safe and healthful workplace for all workers covered by OSHA. Employers who do NOT take reasonable steps to prevent or abate a recognized violence hazards in the workplace may be cited.

Workplace violence is violence or the threat of violence against workers. It can occur inside or outside the workplace and can range from threats and verbal abuse to physical assaults and homicide. Workplace violence is one of the leading causes of job-related deaths. Approximately 2 million American workers are victims of workplace violence each year. Healthcare workers are at increased risk due to the nature of service they provide, and the late night/early morning hours they sometimes work.

Workplace violence includes:

- Hitting, shoving, kicking
- Verbal or non-verbal threats
- Intentional damage to Mercy property such as slamming doors, hitting walls or breaking equipment.

NOTHING can guarantee that an employee will NOT become a victim of workplace violence. These steps, however, can help reduce the odds.

- Learn how to recognize, avoid, or diffuse potentially violent situations.
- Notify supervisors to any concerns about safety or security, and report all incidents in writing.
- Be aware of your location at all times - avoid traveling alone into unfamiliar locations or situations whenever possible.
- Do NOT allow yourself to become isolated or trapped with a potentially violent person.
- Know your work area floor plan and be aware of exit locations in case a violent situation arises
- Carry only minimal amounts of money and required identification into the workplace.
- If a situation seems strange, out of the ordinary, unsafe, or if someone threatens or reveals a weapon, alert Security immediately, stay away, and prevent others from entering the area.
- Do NOT intentionally put yourself in a potentially harmful situation.
- Remove yourself from a potentially violent situation quickly and call security

Add info from Weapons or Hostage – Code Silver slide

Inappropriate Behavior (LD.03.01.01)EP 4

Inappropriate behavior or disruptive behavior from hospital staff has been identified by The Joint Commission as a major threat to patient safety. The Joint Commission defines inappropriate behavior as: “Conduct by an individual working in the organization that intimidates others to the extent that quality and safety could be compromised. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude language, may be threatening, or may involve physical contact.” This inappropriate conduct can prevent healthcare workers from communicating effectively with the rest of the healthcare team and as a result, information critical for the patients’ treatment. Patients who have witnessed this behavior may also lose respect or trust in their care providers and this may impact the decision they make related to their own care.

The Joint Commission issued a Sentinel Alert on July 9th, 2008 titled, “Behaviors that Undermine a Culture of Safety”. In this Sentinel Alert, the Joint Commission requires hospitals to address disruptive behavior by defining a code of conduct that lists acceptable as well as inappropriate or disruptive behaviors. ALL staff including physician and non-physicians should be educated on the facilities code of conduct.

Inappropriate behaviors may include:

- Demeaning, disrespectful, profane, insulting, or abusive language
- Name calling
- Intimidation
- Inappropriate arguments with patients, family members, staff or other care providers
- Sexual comments, inappropriate touching, or other forms of sexual harassment
- Open displays of anger such as throwing objects or yelling
- Public criticism
- Retaliation against any person who reports inappropriate conduct
- Insensitive comments about a patient’s medical condition, appearance, situation, etc.
- Jokes or demeaning comments about race, ethnicity, religion, sexual orientation, age, physical appearance, socioeconomic status, or educational status
- Use or threat to use unwarranted physical force with patients, family members, staff, or others
- Refusing to work collaboratively or cooperatively with others
- Creating rigid or inflexible barriers to requests for assistance or cooperation.

Organizations must create and implement policies for managing inappropriate behaviors. Leaders should model appropriate behavior and must hold ALL staff and care providers accountable for their behavior decisions.

Sexual Harassment

29 C.F.R Part 1604.11

Sexual harassment is a form of workplace discrimination that violates Title VII of the Civil Rights Act of 1964. It occurs whenever unwelcome conduct on the basis of gender affects a person’s job. It is defined by the Equal Employment Opportunity Commission as: Unwelcome sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature that is used as a basis of employment decisions, has the purpose of interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.

There are 2 types of sexual harassment.

1. Hostile work environment: This type of harassment can result from the gender-based unwelcome conduct of supervisors, coworkers, customers, vendors, or anyone else with whom the victimized employee interacts on the job. It may include
 - unfulfilled threats to impose an employment stipulation based on a sexual act
 - discussing sexual activities
 - telling off-color jokes
 - unnecessary touching
 - excessive commenting on physical attributes
 - displaying sexually explicit pictures
 - using demeaning or inappropriate terms such as “babe”
 - using indecent gestures
 - sabotaging the victim’s work
 - engaging in hostile, physical conduct, and
 - using crude or offensive language

It is important to remember that victims or harassers can be male or female, and the harasser does NOT have to be of the opposite sex.

2. **Quid pro quo:** This type of harassment is conducted by a supervisor or someone with authority and is limited to harassment based on sex. The term literally means “this for that” and signifies a supervisor demanding a sexual favor and then basing an employment demand, positive or negative, on the employee’s reaction to the demand.

To create a sexually hostile environment, unwelcome conduct based on gender must meet two requirements:

- It must be subjectively abusive to the person affected.
- It must be objectively severe or pervasive enough to create a work environment that a reasonable person would find abusive.

It is best to avoid all sexually-charged conduct and conversations in the workplace. Here are some questions to ask in order to determine if behavior is, or could be, sexual harassment.

- Is the conduct sexual in nature?
- Is the conduct offensive to persons who witness it?
- Is the behavior being initiated by only 1 of the parties who have power over the other party?
- Does the employee have to tolerate that type of conduct in order to keep his or her job?
- Does the conduct make the employee’s job unpleasant?

If the answer is yes, this behavior should be stopped.

If you experience or witness sexual harassment, you should tell the person harassing you that the sexual conduct is unwelcome. This usually stops most of the problems. If it doesn’t stop, report it to your supervisor or a human resources representative immediately. If an investigation is needed, it is important that you cooperate completely in the process. If an employer finds that sexual harassment did occur, disciplinary measures may be taken up to and including the termination of the harasser.

Supervisors, managers, and administrators, who receive a complaint of unlawful harassment, personally observe it, or otherwise become aware of it, are responsible to immediately notify the Vice President of HR and Administrative Services, Manager of HR, or Employee Relations Specialist to determine the appropriate course of action.

The Healthcare Team

In 1999 the Institute of Medicine published *To Err Is Human: Building a Safer Health System*. This report suggests that medical errors are responsible for 98,000 deaths annually, which is more than from automobile accidents, breast cancer, or AIDS. The Agency for Healthcare Research and Quality supports the approach of healthcare teams as a strategy to enhance patient safety and reduce medical errors.

Good healthcare teamwork depends on each individual’s willingness to cooperate, coordinate, and communicate while remaining focused on a shared goal of achieving optimal outcomes for all patients.

Research has identified three types of competencies that are critical for effective teamwork:

1. **Teamwork-related knowledge**
Selected members should know the range of skills required, when particular behaviors are appropriate, and how the skills and behaviors are manifested in a team setting, if they are to function as a team.
2. **Teamwork-related skills**

This is the learned capacity to interact with other team members at a minimal level of proficiency.

3. Teamwork-related attitudes

This is the internal state that influences a team member's decision to act in a particular way. Positive attitudes toward teamwork and a mutual trust among team members are critical to successful team processes.

The following are ways to contribute positively to the healthcare team:

Dependability

- Consistency is the key
- Follow through by doing what you say you'll do
- Get your share of the work done in a timely manner
- Commit to quality work

Listening

- Good listeners absorb, understand and consider different ideas and points of view without arguing or debating
- They can take constructive criticism without becoming defensive

Sharing openly and willingly

- Take steps to keep the whole team informed
- Get in the habit of passing day-to-day information on to other members of the team. Don't assume they know everything that is going on. Honest, open, respectful communication is the most essential element to good teamwork!

Active participation –

- Come to meetings prepared
- Be willing to speak up in discussions
- Do your fair share of the work and pitch in to help others when they are overloaded
- Don't wait to be asked to participate, willingly volunteer

Constructive Communication

- Express your ideas clearly, directly and honestly with respect for others
- Don't shy away from sharing your opinions, but make sure they are positive, confident and respectful
- Be willing to admit mistakes and accept feedback

Problem-Solving –

- Deal with problems in a solution-oriented manner
- Don't dwell on problems
- Don't pass blame
- Don't ignore problems
- Collaborate with other team members to form action plans

Flexibility –

- Be open to change
- Don't complain about or avoid suggestions for new strategies
- Compromise when necessary
- Be forgiving of other team members

Respect and support other team members –

- Be sensitive to differences of opinions
- Have a sense of humor

- Keep professionalism and courtesy as the cornerstone of communication
- Be accepting of a variety of personalities and temperaments
- Celebrate accomplishments of the team
- Recognize other team members for their contributions

Patient Safety: Identifying and Reporting Medical Errors

Medical errors are human errors or mistakes that occur in healthcare. In the U.S., medical errors are estimated to result in over 100,000 unnecessary deaths over 1 million injuries each year.

In 2000, The Institute of Medicine released "To Err Is Human", which asserts that the problem in medical errors is not bad people in healthcare - it is that good people are working in bad systems that need to be made safer.

When mistakes happen to a patient, the question is always, why did it happen? The following are some of the categories of causes of medical errors.

1. Poor communication or inadequate information flow
 - Between the patient and the provider
 - Between one level of care to another
 - From one facility to another
 - Between workers of different shifts
 - Between different departments or disciplines such as nurse to physician or respiratory therapist to nurse
 - Between different providers such as emergency room physician to primary care physician and primary care physicians to specialists
2. Human factors –
 - When policies, guidelines, procedures and protocols are not followed properly, errors often arise. For example: failure to abide by hand-off policy is known to lead to poor understanding of the patients condition; treatments; and medication which in turn may lead to an untoward outcome..
 - Poor labeling of specimens or inadequate documentation
 - Impaired healthcare workers due to alcohol, drugs, or lack of adequate rest
 - Poor handwriting leading to misinterpretation of orders
3. Patient-related issues –
 - Improper patient identification, incomplete patient assessment, failure to obtain consent, and inadequate patient education may lead to costly errors.
 - Patients have a responsibility to take an active role in their care. When they don't errors may occur. Some of these are:
 - o Lack of compliance with a treatment plan or medications
 - o Fear of legal issues by failing to admit to taking illicit drugs
 - o Fear of social issues by failing to admit to certain lifestyle or social habits
 - o Failure to read and follow medication labels and instructions fully
4. Organizational transfer of knowledge/staff competency¹ – This can include deficiencies in orientation or training, and lack of, or inconsistent, education and training for those providing care related to the area where a new employee or temporary workers are assigned.
5. Staffing patterns/work flow – When physicians, nurses, and other healthcare workers are asked to care for too many patients or when processes are cumbersome and require repeated steps – errors often occur.

6. Technical failures –Equipment and devices such as infusion pumps or monitors can fail and lead to significant harm to patients. In other instances, inadequate instruction for equipment use and poorly designed equipment may lead to injuries.

7. Inadequate policies and procedures – Failures in a process of care are often traced to poorly communicated, non-existent, or clinically inadequate policies and procedures.

Any employee, physician, or other individual who provides care, treatment, or services and who has concerns about the safety or quality of care provided in the organization may report these concerns to the Joint Commission without disciplinary, retaliatory, or punitive action by the organization. For reporting information see: <http://www.jointcommission.org>

According to the Agency for Healthcare Research and Quality (AHRQ), hospitals are finding success in reducing medical errors by:

- Changes in Organizational Culture – Organizations have found that to encourage reporting of medical errors, it is important to adopt a culture that eliminates blame and shame.
- Involvement of Key Leaders – When key leaders make regular visits to clinical units to discuss and survey patient safety, risks and hazards, they are corrected in a timely manner.
- Education of Providers – When personnel are trained in and understand the use of root-cause analysis, the quality of information obtained from the medical error reporting system is enhanced. Root cause analysis is an error analysis technique for determining the contributing causes of adverse events. This process provides a precise corrective action to be implemented throughout organizational processes and procedures.
- Establishment of Patient Safety Committees – Special patient safety committees consisting of multiple healthcare disciplines such as physicians, nurses, pharmacists, and other healthcare providers examine medical error reports and assist with creating action plans to eliminate additional risk.
- Development and Adoption of Safe Protocols and Procedures – The use of evidence-based practice standards provides consistent practices to improve patient outcomes.
- Technology – The use of technology such as computerized physician order entry as a tool to catch potential medical errors and provide suggestions for evidence-based practice standards implementation has been shown to improve patient outcomes.

Recognizing the Impaired Healthcare Worker

According to the U.S. Department of Health and Human Services, people who abuse drugs or alcohol are 3.5 times more likely to be involved in an accident at work, and more than 500 million workdays are lost to workers that abuse one substance or another. Obviously, the stakes are even higher for healthcare workers providing care to patients in an environment that truly can be life or death.

Impaired healthcare worker can include nurses, physicians, and others whose ability to function in their usual role has been reduced or otherwise compromised by internal or external forces. These forces can include prescription, over-the-counter, or illegal drug use, and the consumption of alcohol.

Making a mistake or error in judgment doesn't necessarily mean a co-worker is impaired – but when a persistent pattern emerges, attention and possible intervention may be needed.

Patterns of the following signs may indicate a co-worker is impaired and could present a safety risk to patients include:

- Bloodshot eyes
- Constricted or dilated pupils
- Shivering when it is NOT cold
- Tremors or shaking
- The smell of alcohol on their breath
- The smell of burning leaves on their clothing
- The lack of coordination in walking
- Inappropriate sleepiness or drowsiness
- Deterioration in attire and personal hygiene
- Wearing long sleeves when inappropriate
- Taking longer than usual to perform an ordinary task

Some behaviors or personality changes that may indicate impairment include:

- Excessive absenteeism and an excessive number of sick days
- Frequent disappearances from work areas: such as long restroom breaks, excessive trips to medication stock room, or unexplained long disappearances
- Slurred speech or sentences that don't make sense
- Wild mood swings – (such as happy to sad, helpful to unhelpful) that are noticeable to co-workers
- Unreliable for meetings, appointments, and shifts
- Frequent confusion, memory loss, or trouble remembering instructions or details
- Worsening handwriting or charting
- Seem unusually withdrawn or isolated

Some specific behaviors or habits known to occur in instances where healthcare workers have been impaired include

- Spending an excessive amount of time near drug supplies during shifts
- Work performance varies wildly (such as on task one day, many mistakes the next)
- Writing or requesting prescriptions for large doses or narcotics
- Heavy rate of recorded drug waste during shifts
- Sloppy or inappropriate record-keeping especially in relation to drug shortages
- Insisting on administering narcotics or other drugs to patients themselves

What should you do if you suspect a co-worker may be impaired?

Trust is one of the fundamental expectations patients have in those providing healthcare to them. When you recognize the signs discussed in this program, it is time to demonstrate concern. Report the signs and patterns you notice to your supervisor! By doing so, you may not only be preventing a potentially life-threatening accident, you could be saving someone's job, career, and family as well.

It is natural to want to give your co-workers the benefit of the doubt or to keep them from disciplinary action. In some instances it may be difficult to speak up about your concerns due to fear of retribution, angering your co-worker, or causing him/her to lose their job. However, you have a legal, professional, and ethical responsibility to protect your patients and co-workers from the potential dangers of an impaired healthcare worker. For example, the law already requires theft of any controlled substance from a healthcare facility to be reported to federal authorities.

Likely your facility has policies and procedures requiring you to report concerns with a supervisor if you think a co-worker is impaired by drugs or alcohol. While each facility's response may differ, those in leadership roles have a duty to take reports and concerns seriously, confidentially, and to intervene appropriately on behalf of patient safety.

It is important to note that drug abuse and drug dealing are serious problems that should be handled by qualified professionals. You should NEVER intervene on your own. Contact your supervisor, security, or notify local law enforcement.

Handoff Communication

The Joint Commission has identified a break-down in communication as the root cause of at least 65% of all adverse events.

Handoff communication or handoff of care communication is a real-time, interactive process for passing patient information from one caregiver or team to another for the purpose of maintaining continuity and safety of the patient's care. Every hospital is required to implement a standardized approach to handoff communication. This includes an institutional definition of when handoffs must occur and what elements must be communicated. The handoff must occur verbally and include an opportunity to ask and respond to questions.

During a patient's stay in the hospital, there are multiple occasions when he/she will be handed-off to another caregiver or team. Some of those include nursing shift changes, temporary relief of coverage, nursing and physician hand-offs from an emergency department to an acute care department, transfers within the inpatient setting such as the radiology department, physical therapy, and surgery, transfers to different hospitals, and long-term care facilities. Each time one of these transfers occurs, an opportunity for error exists due to the lack of adequate information flow.

Here are 3 strategies to ensure handoffs are effective:

1. Use clear language and avoid confusing terms. Don't use jargon that could be misinterpreted.
2. Use effective communication techniques such as:
 - Limiting interruptions during the handoff
 - Focus on the most information to be exchanged and avoid irrelevant details
 - Allow adequate time for a thorough information exchange
 - Use read-back or check-back techniques to make sure there is a common understanding
 - Encourage questions between caregivers
3. Standardize shift-to-shift and unit-to-unit reporting. Items to be included in handoff communication varies by setting and discipline but may include:
 - Patient's medical status
 - Resuscitation status
 - Relevant lab values
 - Allergies
 - Isolation
 - Fall Risk
 - Latest vital signs
 - Current problems
 - A to-do list for the accepting caregiver

A common, standardized communication tool used at Mercy is SBAR which stands for situation, background, assessment, recommendation.

Service-Oriented Care

Outstanding, memorable, and customer-oriented service have long been seen as a competitive business strategy in non-healthcare organizations. Increasing competition in the healthcare industry has created more choices for patients when deciding where to receive services, and by whom. As a result, healthcare organizations use customer satisfaction surveys as a way of measuring quality. Sir William Osler, MD, known as the Father of Modern Medicine, is quoted as saying, “patients don’t care how much you know until they know how much you care”.

Patient expectations are their preconceived notions about what should happen during a hospital visit. It is a mental picture of the actions and attitudes of the workers as well as the outcomes that the patient anticipates should occur. The patient experience is what he or she sees, hears, and senses from the time of arrival until the experience ends. Patients compare their expectations with how they perceive the experience. If perception exceeds expectations, satisfaction occurs. If expectations are greater than perception, the outcome is dissatisfaction. Both satisfaction and dissatisfaction are individually unique and personal states. Patients who are satisfied perceive the medical care they receive as higher quality, are loyal to those providing the care, and are more likely to refer others.

Expectations vary from one patient to another and from one visit to another. However, research shows that there are 3 basic expectations that patients say are essential to a quality experience:

- Confidence in the healthcare team – they want to know staff have the knowledge and skills necessary to provide quality care
- Trust in the healthcare team – they expect staff to be truthful and to do what they say they will do
- Caring concern demonstrated by the healthcare team – they want to be treated with compassion

HCAHPS (may need input from Karin Williamson to make this section more specific to Mercy)

The Hospital Consumer Assessment of Healthcare Providers and Systems, (HCAHPS), is a national, publicly-reported survey of patients’ perspectives of hospital care. It was created by a partnership between Centers for Medicare & Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ) for 3 purposes:

1. To provide meaningful comparisons of hospitals on topics that are important to consumers.
2. To provide incentives for hospitals to improve quality of care.
3. To increase transparency of hospital quality and enhance public accountability.

An HCAHPS survey may be conducted following a patient’s visit to the hospital. The survey may be mailed to the patient’s home, or it may be conducted by phone. Patients are asked a number of questions about their hospital experience. These questions are used to measure 10 topics:

1. Communication with nurses
2. Communication with doctors
3. Responsiveness of hospital staff
4. Pain management
5. Communication about medicines
6. Discharge information
7. Cleanliness of hospital environment
8. Quietness of hospital environment
9. Overall rating of the hospital
10. Willingness to recommend the hospital

As of July 2007, hospitals required to collect and report HCAHPS data may be penalized by the Centers for Medicare and Medicaid Services (CMS) if they fail to do so. Critical Access Hospitals may voluntarily participate in HCAHPS; however, they are NOT subject to penalties if they do NOT participate. For more information, visit www.hcahpsonline.org.

In March, 2008, CMS began to make HCAHPS results available to the public. New data is published quarterly and are posted on the Hospital Compare website, found at www.hospitalcompare.hhs.gov. Consumers of healthcare services may view survey results for a specific hospital and compare them to others.

Creating a Service-Oriented Environment

Good communication is the heart and soul of quality service in health care. It is essential in meeting the basic expectations of confidence, trust, and caring concern. Three of the 10 topics measured by the HCAHPS survey relate to communication.

Communication is more than just words. It includes a handshake, a smile, eye contact, a touch on the shoulder, and the silent moments between the words where emotional and personal connections are made. Active listening is a key element of good communication. Patients want to know you hear and understand what they are telling you with their words and body language. Paraphrase and repeat back patient's statements and overall message to demonstrate that you hear and understand. Ask probing, open-ended questions, and don't interrupt while they're speaking.

Here are a few tips to remember when caring and communicating with patients:

- Introduce yourself
 - o Always make a point to acknowledge patients and their visitors by introducing yourself to them. Make sure you include your job title or role.
 - o Let them know what you're there to do. If you have particular training or expertise relevant to a procedure you're performing, be sure to share it with your patients. This reduces anxiety, puts patients at ease knowing, and gives them confidence which is one of the 3 basic expectations of all patients.
- Explain all procedures thoroughly
 - o Make sure you give detailed information to patients about what they are experiencing or are about to experience.
 - o You should always use layman's terms in your communication
 - o Always be truthful when discussing whether or not a procedure may cause pain or discomfort. Trust is one of the 3 basic expectations of all patients.
 - o Check for understanding by asking the patient to repeat back what they heard.
- Be sensitive to patient's fears, worries, and concerns
 - o Be empathetic by putting yourself in the patient's place and trying to imagine what fears, worries, and concerns they may have.
 - o More than anything, patients want to know you care. Caring Concern is one of the 3 common expectations of all patients.
- Find out what great service means for each individual patient
 - o People have individual likes/dislikes, tastes, and preferences. By taking a few minutes to ask your patients about their personal preferences, you will know how to deliver the service they want.
 - Be timely in your responses
 - o Great care should be taken to meet your patient's needs in a timely manner.

- o Communicate reasonable and clear expectations about wait times associated with call lights, procedures, provider visits, etc.
 - Phrases such as “not long” or “quite a while” can be very misleading. Be as specific as possible being careful not to underestimate wait times as this may lead to disappointment if the time extends beyond what they have been told. Remember patients need to be able to trust what you say will happen.
- Pay attention to the little things
 - o Many times, it’s the unexpected things someone does that make the biggest difference in the service experience. Look for ways you can deliver outstanding service that may go beyond the patient’s expectations. This adds to the accumulation of good experiences and shows caring concern.
 -
- Support your team
 - o Patients want to know their care is well coordinated and communicated to all members of the healthcare team. Tell them when and how you have communicated about their care with another member of the team.
 - o Make sure you support your co-workers to your patients by telling them how they do a great job.
 - o Never blame or criticize a co-worker to a patient. This creates a sense of mistrust and anxiety.

Service Recovery

When a patient is disappointed by unmet expectations or when a mistake has occurred, no matter who is at fault, or how minor the problem may seem, it needs attention quickly, efficiently, and personally. Service recovery includes 3 actions:

- Acknowledge
 - Apologize
 - Amend
- Acknowledge – There are 2 elements of acknowledgement:
1. Acknowledge the error or mistake: For example: “I told you someone would be here to get you for your procedure in 15 minutes and it has now been 45”.
 2. Acknowledge the impact to the patient: Whatever physical or emotional result of the mistake should be acknowledged. For example: “I can see that you are upset and frustrated.”
- Even if it is NOT your fault personally, you should take responsibility as an agent of the organization where the error occurred.

Apologize – Saying “I’m sorry” is a critical step in service recovery. However, even more critical is that the apology is delivered with sincerity. An insincere apology will do more harm than no apology at all. Often, errors and unmet expectations occur due to circumstances that are not your fault. It is very important NOT to make excuses or to blame others for the error. An apology does NOT necessarily mean that you personally accept blame for the problem. However, you should apologize as an agent of the organization where the error occurred. An apology conveys concern which is one of the 3 common expectations of all patients. You should apologize for the impact of the error. For example, “Mr. Jones, I’m sorry that you’re upset and that someone hasn’t been here to get you for the procedure.” Again, do NOT pass blame as this may come across as an excuse voiding the apology, and could erode confidence in the healthcare team. For example: you should NOT say, “the radiology department staff told me they would be here in 15 minutes – it’s not my fault.”

Amend –Amending a situation means taking action! Depending on the degree of the error, an appropriate action to amend the situation will vary. If the error is seemingly minor, it could include making a phone call or offering to do what you can to make the patient more comfortable. For example, “I will call right now to find out what has caused the delay and to get a new estimate on when they will be here to get you for the procedure. In the mean time, what can I do to make you more comfortable while you wait?”

In other cases where minor errors or mistakes occur, staff should be empowered to amend. Free parking passes, cafeteria meal tickets, flowers from the hospital gift shop, or a teddy bear when children have been impacted are

some tangible items that may be used to amend an error. They should always be presented as a token to show your regret for the situation but not as compensation to erase the error.

When serious errors occur or when patients show signs of becoming hostile, you should contact security, your supervisor, members of guest services personnel, and sometimes risk management.

Care and Communication for Diverse Populations

People's ideas and opinions may differ drastically from yours, yet their perspectives should be seen as assets. Everyone makes a unique contribution to the team, to the world, and to society. Understanding cultural diversity gives us the opportunity to participate in and see the world differently.

An inclusive environment is one in which all individuals feel respected by and connected to one another. Individuals accept differences and don't rely on stereotypes. Stereotype is a perceived or over-simplified generalization about an entire group of people without regard for their individual differences. Inclusive organizations break down stereotypes by providing an environment in which people can form open and honest relationships.

Cultural diversity is a very broad topic. Diversity is often thought of as different ethnic groups but actually encompasses

- ethnicity
- race
- gender
- age
- social economic status
- religion
- nationality or region, and
- place of employment or school

The combination of the many different cultural groups we belong to creates a unique cultural identity for each of us.

Individuals who are sensitive to cultural diversity

- Gain the skills and awareness that encourages harmony and productivity
- Minimize stereotypical thinking that interferes with successful cross-cultural relations
- Accurately interpret the behaviors and needs of different cultures that they come in contact with
- Understand that motivation can vary from culture to culture

Individuals that have culturally sensitive attitudes are

- Aware of cultural differences
- Appreciate individuality
- Avoid prejudging
- Examine the subtle and NOT so subtle biases and stereotypes that impact interactions
- Refuse to participate in conversations that may reinforce prejudice or bias
- Treat others with respect for their different perspective

When communicating with someone from a different culture:

- Do NOT condescend or patronize
- Check for understanding

- Think about how others might perceive comments and actions
- Think about what you are going to say
- Think about the words you use
- If English is not their first language, speak slowly and clearly at a moderate tone and level

Most importantly, treat all people with respect and dignity.

Age Specific Care and Communication

When delivering quality care to patients of various ages, all healthcare employees need to understand and consider the different abilities and needs inherent in various life stages.

Neonates: Birth to 28 days –

- Neonates are in a stage of total dependency.
 - o They focus on faces and sometimes smile in response.
 - o Vision beyond a few feet is blurred.
- One should handle neonates in a gentle, comforting, secure manner. Over-stimulation by loud noises should be avoided.
- Neonates need to be kept slightly warmer than adults as their systems may not be able to regulate heat.
- Parents should be taught proper
 - o feeding and nutrition,
 - o cord care,
 - o symptoms such as fever that may indicate the need for medical attention,
 - o the importance of car seats and other safety devices, and
 - o proper sleeping positions to reduce the risk of Sudden Infant Death Syndrome (SIDS)

Infants and Toddlers: 0 to 3 years –

- Infants and toddlers are in a period of very rapid growth and development.
 - o They learn by hearing, smelling, touching, tasting, and seeing.
 - o Communication at this age is crying, babbling, and using a few simple words.
- It is important to pay attention to appropriate body weight at this stage since this may indicate the need for nutritional counseling or medical attention.
 - o At this stage, infants and toddlers may experience irritable behavior, low-grade fever, and drooling associated with teething.
- Parent and child bonding are very important during this developmental period. Hugging, cuddling, touching and talking should be encouraged.
- Stranger anxiety is common during this stage. It is important to limit the number of staff assigned to each infant or toddler.

Young Children: 4 to 6 years –

- Physical growth begins to slow at this stage, but motor skill development will accelerate.
 - o They begin to dress and toilet independently.
 - o They begin to become sensitive to the feelings of others.
- Young children will begin to become more independent of their parents at this stage and not fear strangers to the extent they did as toddlers.
 - o Healthcare workers should involve children in their care.
 - o Procedures and diagnosis should be explained to children in basic ways, and it is important never to lie to a child about whether or not a procedure may cause pain.

- o However, it is a good idea to reassure a child that care will be taken to minimize pain both in intensity and duration.
- Children at this age need to be able to make as many choices as reasonably possible about their care.
- Routines are a source of security for children at this age. One should try to incorporate home routines as much as possible.
- Toys, games, singing, talking, playing, and creating are useful tools for communicating and providing a comfortable atmosphere for children.

Older Children: 7 to 12 years –

- At this stage, children’s minds become very active.
- o They are eager to learn, and they love to share stories and knowledge.
- o Reading and writing skills develop quickly at this stage.
- o Curiosity about alcohol, drugs, and sex may begin to occur during this time.
- Independence from parents becomes increasingly apparent during this stage as peers and school activities begin to take on more importance. This is a good time to teach peaceful conflict resolutions skills.
- Procedures should be explained in straight forward terms using correct terminology.
- Privacy during this stage is very important.
- Habits learned during this stage tend to last a lifetime. This is a good time to begin forming healthy habits such as exercise and good nutrition.
- Parents should be taught and encouraged to initiate conversations about
 - o smoking,
 - o peer pressure,
 - o sexuality,
 - o substance abuse,
 - o eating disorders,
 - o and other topics common among children at this age.
- o Children will begin to establish firm beliefs and ideas about these issues during this time.

Adolescents: 13 to 20 years –

- This is the stage when a child’s body matures and transforms into an adult body. Physical appearance becomes increasingly important.
- Complex moral thinking develops as adolescents begin to form their own ideas, morals, and values. This may lead to questioning and/or challenging authority. Healthy, respectful communication skills should be taught and encouraged as a way of exploring differing opinions and ideas.
- Common health concerns during this stage include
 - o obesity,
 - o anorexia,
 - o bulimia,
 - o acne,
 - o substance abuse,
 - o unplanned pregnancy,
 - o STDs (sexually transmitted diseases),
 - o stress-related issues, and
 - o emotional disorders.
- Healthcare workers should communicate directly with adolescents and NOT through their parents.
- One should always be considerate of how healthcare issues, treatments, or procedures may affect an adolescent’s appearance and social relationships.
- Encourage questions and communication regarding fear. It is important to respect an adolescent’s cultural beliefs.

- Adolescents need to feel in control of their choices. They may have difficulty accepting demands or instructions. Acceptance is most successful when health advice is offered in the form of suggestions or opportunities.

Young Adults: 21 to 39 years –

- People in this age have reached physical and sexual maturity, and healthy body maintenance becomes the focus. Exercise, proper nutrition, and weight control should be encouraged. However, most adults in this stage understand the concept of healthy behavior.
- The need for regular check-ups, and preventive exams should be emphasized to minimize the risk of issues like heart disease and cancer. Risk-factors and symptoms associated with common diseases should be clearly communicated since individuals in this stage may feel invulnerable and tend to ignore or deny health problems.
- Careers, families, communities, hobbies, and social relationships play an important role in most decision-making. Healthcare workers should be sensitive to the impact of hospitalization and illness on jobs and families, and the emotional and/or stress-related issues common during this stage.
- Communication that reflects honesty and respect for personal values and choices is very important.

Middle Adults: 40 to 64 years –

- Life experiences tend to be the basis of learning and problem solving during this stage. Many times, life priorities are reevaluated and prioritized. Plans for retirement begin to take on greater emphasis.
- Chronic health conditions such as diabetes, prostate disorders, and breast cancer often develop during this time. Women may experience menopause. Regular check-ups should be encouraged.
- Visual and auditory acuteness begin to diminish and reflexes begin to slow. The impact of these changes should be discussed in relation to driving and other activities of daily living.
- Healthcare workers should be especially aware and sensitive to signs of depression and other mental illnesses during this time. “Mid-life crisis” or feelings of doubt and insignificance often occur during these years. A hopeful attitude and optimism are important for emotional well-being. People’s abilities and contributions to society should be emphasized.
- This age is often referred to as the “sandwich generation” because people tend to have great concerns regarding both their children and their parents at the same time.
- Exploring personal interests, volunteerism, travel, and leisure should be encouraged as these activities often create a sense of value and enjoyment.

Older Adults: 65 to 79 years –

- Older adults are active learners/thinkers and may pass along valuable skills and wisdom to younger generations.
- Decline in physical and sensory ability may need frequent evaluation in relation to activities of daily living. It is important to promote physical, mental, and social activities which can be useful in preventing depression.
- Frequent episodes of grief occur at this time as people lose friends, spouses, siblings, and others family members. Grief counseling should be encouraged.
- The body’s immune system often weakens during this stage, and immunizations are key in preventing debilitating illnesses such as influenza.
- Conditions commonly seen in this stage include arthritis, high blood pressure, hearing impairment, heart disease, osteoporosis, esophageal reflux, bowel and bladder conditions.
- The use of multiple medications during this stage can become complicated. Medication management should be explained and monitored.
- The body’s ability to regulate heat may diminish. Healthcare workers should be alert to the need for extra warmth.
- Healthcare workers should involve older adults in all decision-making related to their care. Fear of losing independence or control in regard to their bodies is common. They may appreciate being reassured that

all aspects of their condition, procedures, medications, and care will be clearly and openly communicated to them.

Adults 80 and older –

- While healthcare workers should be alert for signs of mental decline and confusion, often people in this stage are very capable of making their own healthcare decision. Avoid treating these individuals like children.
- Regular check-ups and screenings should be encouraged.
 - o rest,
 - o proper nutrition,
 - o mild to moderate exercise, and
 - o avoidance of stress are important in maintaining health
- The environment should be free of hazards that could lead to falls which can be devastating at this age.
- Social interactions, a sense of humor, and an active mind are keys to emotional well-being during this time.
- Medication management may require detailed plans including the use of
 - o color-coding,
 - o time reminders, and
 - o close monitoring.
- End-of-life decisions and information regarding living wills and advanced directives should be supported.

Patient Rights and Responsibilities

The Patient’s Bill of Rights was adopted by the U.S. Advisory Commission on Consumer Protection and Quality in the Health Care Industry in 1998. The basic components of the bill are as follows.

- **Information Disclosure:** As a patient, you have the right to accurate and easy-to-understand information from your healthcare facility, healthcare professionals, and health plans. If you speak another language or have any disabilities that make it difficult to understand, help should be provided to you so that you may make informed healthcare decisions.
- **Choice of Providers and Plans:** As a patient, you have the right to choose healthcare providers as needed.
- **Access to Emergency Services:** As a patient, if you have a condition (such as severe pain, an injury, or sudden illness) and you feel your health is in serious danger, you have the right to be screened and stabilized using emergency service whenever and wherever you need them **WITHOUT** the need for authorization and **WITHOUT** financial penalty.
- **Participation in Treatment Decisions:** As a patient, you have a right to make treatment decisions based on available options and to take part in decisions about your care. If you **CANNOT** make your own decisions, you may select a parent, surrogate, guardian, family member, or other person to make them for you.
- **Respect and Non-discrimination –** As a patient, you have a right to considerate, respectful care from all healthcare personnel that does **NOT** discriminate against you.

- Confidentiality of Health Information – As a patient, you have the right to privacy when talking about your healthcare information with healthcare providers. You have the right to read your medical record. You have a right to ask that your record be changed if it is NOT accurate.
- Complaints and Appeals: As a patient, you have the right to a fair, fast, and objective review of any complaints you have against your health plan, doctors, hospital, or other healthcare personnel. This includes complaints about waiting times, operating hours, the actions of healthcare personnel, and the adequacy of healthcare facilities.

Other patient rights include:

- The right to respect for cultural and personal values, beliefs, and preferences
- The right to pain management
- The right to reasonable accommodation to a patient’s religious and/or other spiritual services and/or practices

Patient Information Privacy and HIPAA (Health Insurance Portability and Accountability Act)

We live in an information age. More information is available than ever before, increasing daily with the rapid advancement of technology. BUT...patients have a right to control who has access to their personal and private health information. Patients must be assured their personal information will remain private and be limited only to those who need the information for treatment, payment, and healthcare operations. Only people with an authorized “need to know” should have access to the protected information. What does this mean to you? When faced with access to someone’s protected health information, ask yourself this question: “Is it necessary for me to know this to do my job?” If the answer is “no,” don’t look at it or involve yourself in a conversation about it. If the answer is “yes,” access only the information necessary and protect it from others without a need to know.

With the enactment of the Health Insurance Portability and Accountability Act of 1996 (or HIPAA), a patient’s right to have his or her health information kept private and secure became more than just an ethical obligation between healthcare professionals – it is now the law. (HIPAA) is a federal law designed to establish standards and requirements for electronic transmission and storage of an individual’s personal health information.

The U.S. Department of Health and Human Services-Office for Civil Rights will enforce HIPAA. Civil penalties may include: fines up to \$100 for each violation of the law, per person, up to (but not to exceed) \$1.5 Million for each identical requirement or prohibition. There could also be criminal penalties for wrongful disclosure. These penalties increase as the severity of the offense increases.

What are the patient’s privacy rights? • Right to request restrictions of information use and disclosure

- Right to request confidential communication
- Right to request access, to inspect, and/or copy any of their protected health information
- Right to amend their protected health information
- Right to an accounting of disclosures of their protected health information
- Right to file a complaint of a privacy violation

How can you help protect patient privacy? Patients receiving medical care expect privacy whether in the hospital, outpatient lab, gift shop, cafeteria or anywhere in your facility. Your facility has committed itself to protecting the patient’s PHI (or Protected Health Information). Examples of protecting this information include

- Patient care or discussion of care should be kept private by closing doors, drawing privacy curtains, or using unit conference rooms. Never discuss patient information in a public area such as the cafeteria, elevator, or lobby.
- Medical records should not be left where others can see them or gain access to them
- All test results should be kept private
- Patient records and information should be out of public access or viewing
- Paper records or any documents with protected health information should be shredded when no longer needed (unless part of the medical record, if so, should be placed in the medical record)
- Electronic records should be kept secure and your facility should monitor those who gain access to specific records

Infection Control

Standard Precautions

Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. It includes a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status in any setting in which healthcare is delivered. These include: hand hygiene, use of gloves, gown, mask, eye protection, or face shield (depending on the anticipated exposure), and safe injection practices. Equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents.

In 2007, the Centers for Disease Control and Prevention (or CDC) added new components to standard precautions. These are: respiratory hygiene and cough etiquette, safe injection practices, and use of masks for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures.

Respiratory hygiene and cough etiquette are strategies targeted at patients, family members, and friends with undiagnosed transmissible respiratory infections, but applies to any person with signs of illness including cough, congestion, runny nose, or increased production of respiratory secretions when entering a healthcare facility.

Elements of respiratory hygiene and cough etiquette include:

- Covering the mouth and nose with a tissue when coughing and prompt disposal of used tissues.
- When tissues are NOT available, cough and sneeze into your sleeve, NOT into your hands where pathogens may be easily transferred.
- Hand hygiene should be implemented immediately after contact with respiratory secretions.
- The use of surgical masks may be used during extended periods of time such as in the emergency room waiting area.
- Separating individuals by at least 3 feet with respiratory infections in common waiting areas.
- Educating staff, patients, and visitors.
- Posting signs with instructions to patients, family members and friends.

Standard precautions include the following recommendations:

- Hand hygiene
 - o Avoid unnecessary touching of surfaces to prevent contamination of clean hands and transmission of pathogens from contaminated hands to surfaces.

- o When hands are visibly dirty, wash hands with soap and water. Alcohol-based hand rubs may NOT be effective when hands are excessively soiled with blood, body fluids, or other material.
- o When NOT visibly dirty, use an alcohol-based hand rub on hands.
 - Before having direct contact with patients
 - After contact with patients
 - After moving from a contaminated body site to a clean body site
 - After contact with inanimate objects such as equipment
 - After removing gloves
- o Do NOT wear artificial fingernails or extenders as they are known to harbor harmful pathogens and lead to infection transmission.

- Personal protective equipment (PPE)
 - o Use the appropriate form of PPE when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur.
 - o Prevent contamination of clothing and skin while removing PPE.
 - o Remove and discard PPE before leaving the patient's room.

- Gloves
 - o Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, or potentially contaminated intact skin could occur
 - o Wear gloves that fit and are appropriate to the task
 - Wear disposable gloves when providing direct patient care
 - Wear disposable or reusable utility gloves for cleaning the environment
 - o Remove gloves after contact with a patient and/or the surrounding environment using proper technique to prevent hand contamination. Do NOT wear the same pair of gloves for care of more than one patient.

- Gowns
 - o Wear a gown to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood or body fluids is anticipated.
 - o Do NOT reuse gowns, even for repeated contacts with the same patient.
 - o Remove and discard before leaving the patient's room.

- Mouth, nose, eye protection
 - o Select masks, goggles, face shields, and combinations of each to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes/sprays of blood or other body fluids (e.g., coughing, sneezing)
 - o During aerosol-generating procedures such as suctioning in patients who are NOT suspected of being infected with an agent for which respiratory protection is recommended (e.g., Mycobacterium tuberculosis), wear a face shield and mask that fully covers the face and eyes.

- Patient placement – Patients who pose a risk of transmission to others should be placed in a single-patient room when available.

- Patient-care equipment and instruments and devices
 - o Remove any visible soiling on equipment, instruments or devices using a recommended cleaning agent before disinfection or sterilization is performed.
 - o Wear PPE according to the level of anticipated contamination when handling patient-care equipment or instruments and devices that are visibly soiled or may have been contaminated with blood or other body fluids.

- Care of the environment

- o Clean and disinfect surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to patients such as bed rails or over-the-bed tables, and frequently touched surfaces in the patient care environment such as door knobs or surfaces near the toilet, on a more frequent schedule compared to that for other surfaces.
- o Use United States Environmental Protection Agency (EPA) registered disinfectants that have microbiocidal activity against pathogens most likely to contaminate the patient-care area.
- o Multi-use electronic equipment that is moved in and out of patient rooms should be cleaned and disinfected frequently (e.g., daily).
- o Textiles and laundry – Sheets, towels and patient gowns should be handled with minimal agitation to avoid contamination of air, surfaces and persons.
 - Safe injection practices – These recommendations apply to the use of needles and cannulas that replace needles, and where applicable, intravenous delivery systems.
 - o Use aseptic technique to avoid contamination of sterile injection equipment.
 - o Do NOT administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulas, and syringes are single-use items.
 - o Use fluid infusion and administration sets on one patient only and dispose appropriately after use.
 - o Use single dose vials whenever possible.
 - o Do NOT use medications from single dose vials on multiple patients or combine leftover contents for later use.
 - o If multi-dose vials must be used, the needle, cannula, and syringe must be sterile.
 - o Do NOT keep multi-dose vials in the immediate patient treatment area. Discard if sterility is compromised or questionable.
 - o Do NOT use bags or bottles of intravenous solution as a common source of supply for multiple patients.
 - Special lumbar puncture procedures – Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space.
 - Workers must adhere to federal and state requirements (e.g., United States Occupational Safety and Health Administration [OSHA]) for protection of healthcare personnel from exposure to bloodborne pathogens.

Transmission-Based Precautions

There are three categories of transmission-based precautions:

1. Contact precautions
2. Droplet precautions
3. Airborne precautions

These precautions are used when standard precautions may NOT be completely sufficient to stop transmission. The term “isolation” is often used with these terms to describe the type of precautions healthcare workers and/or patient visitors should use when entering a patient’s room.

1. Contact (touch) is the most important and frequent mode of healthcare-associated infection
 - Direct contact is the physical transfer of microorganisms between a susceptible host and an infected person
 - Indirect-contact involves contact of a susceptible host with a contaminated object, such as contaminated instruments, needles, dressings or contaminated hands that are NOT washed or gloves that are NOT changed between patients
 - People should wear gloves and gowns when in contact with the patient or surfaces in the patient room
 - Patients being transported should wear gloves and a disposable gown
2. Droplets (mist or sneeze) are the very fine drops of liquid generated from the source person primarily during coughing, sneezing, and talking, or during certain procedures. When the droplets are propelled through the air a short distance (3 to 6 feet), and deposited on the host’s mucous membranes (conjunctiva, nasal mucosa, or mouth), transmission occurs.

- People should wear masks with face shields when within 3 to 6 feet of the patient
- Patients being transported should wear a mask without a face shield

3. Airborne is either residue from evaporated droplets containing microorganisms or dust particles containing the infectious agent. Microorganisms, such as *M. tuberculosis*, Varicella zoster virus (the virus that causes chicken pox and shingles), and the rubeola virus are carried in this manner and can be dispersed widely by air currents. Therefore, special air handling and ventilation is required.

- People should wear an N95 respirator mask when entering the patient's room
- Patients being transported should wear a regular surgical mask

Personnel in areas where patients will be transferred should be notified of the patient's transmission-based precautions before transfer occurs.

Preventing and Controlling Seasonal and H1N1 Influenza

According to the CDC, seasonal influenza and H1N1 influenza, (sometimes called Swine Flu) are highly contagious viral diseases that spread from person to person. Signs and symptoms may include fever, chills, cough, sore throat, runny or stuffy nose, body aches, headache, dizziness, fatigue, nausea, vomiting, and diarrhea. Cough, sore throat and a runny nose are sometimes associated. A person is generally infectious from 1 day before symptoms occur to 7 days after symptoms begin. In generally healthy individuals, the influenza virus may cause minor illness. However, many affected patients will experience severe disease and sometimes even death.

Modes of Influenza Transmission

Both seasonal and H1N1 influenza viruses are transmitted from person to person through:

- Droplet exposure of mucosal surfaces such as the eyes, nose, and mouth and by respiratory secretions from coughing and/or sneezing
- Contact, usually of hands, with an infectious patient or surface that is contaminated with secretions followed by self-inoculation of the virus onto mucosal surfaces (touching the eyes, nose, or mouth)
- Small particle aerosols in the vicinity of the infectious individual

Transmission of influenza through the air over long distances, such as from one patient room to another, is thought NOT to occur. All respiratory secretions and body fluids, including diarrheal stools, of patients with H1N1 influenza are considered to be potentially infectious.

Facilities should use a hierarchy of controls to prevent exposure of healthcare personnel and patients and prevent influenza transmission within healthcare settings:

1. Elimination of potential exposures: Eliminating the potential source of exposure ranks highest in the hierarchy of controls. Examples of interventions in this category include:

- Minimizing outpatient or emergency room visits for patients with mild influenza-like illness who do NOT have risk factors for complications
- Postponing elective visits by patients with suspected or confirmed influenza until they are no longer infectious
- Denying facility entry to visitors who are sick
- Keeping personnel at home while they are ill to reduce the risk of spreading influenza

2. Engineering controls: Engineering controls rank second in the hierarchy of controls. They are particularly effective because they reduce or eliminate exposures at the source. Examples of engineering controls include:

- Using partitions in triage areas and other public spaces to reduce exposures by shielding personnel and other patients
 - Using exhaust ventilation such as hoods, tents, or booths for aerosol generating procedures and/or laboratory manipulations
 - Using ventilation controls in ambulances
 - Installing hands-free soap and water dispensers, and receptacles for garbage and linens to minimize environmental contact
 - Conducting aerosol-generating procedures in an airborne infection isolation room to prevent the spread of aerosols to other parts of the facility
 - Using closed suctioning systems for airway suction in intubated patients.

3. Administrative controls: Administrative controls are required work practices and policies that prevent exposures. Examples of administrative controls include:

- Promoting and providing vaccination to all healthcare personnel
- Performing hand hygiene frequently, including before and after all patient contact, contact with respiratory secretions, and before putting on and upon removal of PPE (personal protective equipment). Soap and water or alcohol-based hand sanitizers should be used.
- Enforcing exclusion of ill healthcare personnel
- Implementing respiratory hygiene and cough etiquette strategies
- Making tissues, hand sanitizer, and masks available in waiting areas
- Rapidly identifying and isolating patients with suspected or known cases of influenza
- Assigning dedicated staff to minimize the number of healthcare personnel exposed to those with suspected or confirmed influenza.
- Placing face masks on patients when entering emergency rooms or when being moved from one area to another
 - Limiting movement of patients from one area to another to only when medically necessary
 - Communicating information about patients with suspected, probable or confirmed influenza to appropriate personnel before transferring them to other departments in the facility
 - Minimizing wait times while in waiting or multi-patient holding areas
 - Limiting the number of persons involved with aerosol-generating procedures such as bronchoscopy, sputum induction, endotracheal intubation and extubation, open suctioning of airways, CPR, and autopsies.
 - Establishing protocols for cleaning high-touch surfaces such as elevator buttons and work stations. The H1N1 virus may live 2 to 8 hours outside the body on hard surfaces such as countertops and door knobs.

4. Personal protective equipment (PPE): PPE is effective only if used throughout potential exposure periods, is used and maintained properly, and must function properly. PPE will not be effective if adherence is incomplete or when exposures to infectious patients or ill co-workers are unrecognized.

Seasonal and H1N1 Influenza Vaccinations

The CDC has long recommended annual, seasonal influenza vaccination for all healthcare employees, emergency medical services personnel, and healthcare volunteers. Priority should be given to these groups when administering the 2009 H1N1 influenza vaccine. To improve adherence, the CDC recommends that vaccination be offered free of charge and during working hours.

Vaccination for seasonal influenza is known to reduce the likelihood of contracting the disease by 70% to 90% in healthy individuals under age 65. However, the key cause of influenza outbreaks in healthcare is a result of

64% of employees being unvaccinated. This is very troubling for the many patients and personnel who are at higher risk of contracting influenza and for experiencing influenza-related complications.

Isolation Recommendations

Regular seasonal influenza isolation guidelines differ from those recommended by the CDC for 2009 H1N1 influenza. Seasonal influenza guidelines include Standard Precautions and Droplet Precautions including the use of a face mask (NOT an N95 respirator) and eye shield when working within 6 feet of a patient with suspected or confirmed seasonal influenza.

As of October 3, 2009, 99% of circulating influenza viruses in the United States were H1N1 influenza. Therefore, the CDC recommends the following isolation precautions for all healthcare personnel working within 6 feet of patients with suspected influenza and patients with confirmed H1N1 influenza.

These recommendation apply uniquely to the special circumstances of the 2009 H1N1 pandemic during the fall and winter of 2009-2010 and the CDC will continue to revisit its guidance as new information becomes available, within this season if necessary.

**Information used to create this educational module was obtained from the CDC website on October 18, 2009.

Standard Precautions - For all patient care, use non-sterile gloves for any contact with potentially infectious material, followed by hand hygiene immediately after glove removal; use gowns along with eye protection for any activity that might generate splashes of respiratory secretions or other infectious material.

Respiratory Protection – The CDC recommends the use of respiratory protection that is at least as protective as a fit-tested disposable N95 respirator for healthcare personnel who are in close contact with patients with suspected or confirmed H1N1 influenza. This includes those providing direct medical care and those providing support activities such as delivering meal trays and cleaning a patient's room.

Prioritized respirator use: If a shortage of respirators exists despite efforts to obtain and maintain a sufficient supply for anticipated needs, a facility should consider shifting to a prioritized respirator use mode. In this mode, respirator use is prioritized to ensure availability for healthcare personnel at most risk from 2009 H1N1 influenza exposure. To assure that respirators are likely to be available for the most important uses, facilities should maintain a reserve sufficient to meet the estimated needs for performing aerosol-generating procedures and for managing patients with diseases other than influenza (such as Mycobacterium Tuberculosis) that require respiratory protection until supplies are expected to be replenished.

Isolation precautions for patients with influenza symptoms should be continued for 7 days after illness onset, or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. In some cases, facilities may choose to extend isolation precautions for longer periods such as in the case of children younger than 2 years of age or severely immunocompromised patients who may shed the virus for longer periods of time. Communication regarding the patient's diagnosis with post hospital care providers (e.g. home healthcare agencies, long-term care facilities) as well as transporting agencies is essential.

Healthcare personnel should self-assess for symptoms of febrile respiratory illness. In most cases, decisions about work restrictions and assignments for personnel should be guided by clinical signs and symptoms rather than by laboratory testing for influenza.

Anyone with the following emergency warning signs needs urgent medical attention and should seek medical care promptly:

- Difficulty breathing or shortness of breath
- Pain or pressure in the chest or abdomen
- Sudden dizziness
- Confusion
- Severe or persistent vomiting
- Flu-like symptoms improve but then return with fever and worsened cough

Healthcare personnel who develop a fever and respiratory symptoms should:

- Not report to work, or if at work, promptly notify their supervisor and infection control or occupational health personnel
- Stay home for at least 24 hours after they no longer have a fever without the use of fever-reducing medicines. Those caring for immunocompromised patients should be excluded from work or reassigned for 7 days from symptom onset or until resolution of symptoms, whichever is longer.
- Practice frequent hand hygiene, respiratory hygiene, and cough etiquette after returning to work

Healthcare personnel who develop acute respiratory symptoms without fever should:

- Be allowed to continue or return to work unless assigned in areas where severely immunocompromised patients are provided care. In this case they should be reassigned or excluded from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer.
- Practice frequent hand hygiene, respiratory hygiene, and cough etiquette while at work or when returning to work.

Facilities should consider offering alternative work environments as an accommodation for employees at higher risk for complications of 2009 H1N1 influenza during periods of increased influenza activity or if influenza severity increases. They should not require a doctor's note for workers with influenza to validate their illness or return to work.

Personnel at higher risk for complications from influenza infection include:

- Pregnant women
- Persons 65 years of age or older
- Persons with chronic diseases such as asthma, heart disease, diabetes, diseases that suppress the immune system

Vaccination and early treatment with antiviral medications are very important for healthcare personnel at higher risk for influenza complications because they can prevent hospitalizations and deaths. Healthcare personnel at higher risk for complications should check with their healthcare provider if they become ill so that they can receive early treatment.

Preventing and Controlling Tuberculosis

Tuberculosis (TB) continues to be a public health problem in the United States.

Major contributing factors include

- HIV/AIDS (human immunodeficiency virus and acquired immunodeficiency syndrome) and other immune-compromising diseases
- Travel to and from areas with a high prevalence of TB such as Asia, Africa, the Caribbean, and Latin America
- High risk areas of transmission such as nursing homes, prisons, and homeless shelters
- Certain populations such as the very young, the very old, and economically suppressed
- Close contact with individuals known to have infectious TB
- Alcoholics and IV drug users
- Groups known to have a high incidence of tuberculosis include blacks, Asians, Pacific Islanders, American Indians, Alaska Natives, and Hispanics.

TB is an airborne, infectious, communicable disease that can occur acutely or chronically. The disease is spread when a person with untreated, active TB coughs, sneezes, laughs, talks, or sings. Infection may occur when susceptible persons inhale airborne bacteria exhaled by an infected person. Transmission can be decreased by

- Early detection and appropriate isolation of patients with suspected or confirmed TB
- Effective drug therapy
- Patient teaching and adherence to respiratory hygiene and cough etiquette
- Avoiding aerosol-generating procedures such as bronchoscopy unless medically necessary in patients with suspected or confirmed cases of TB
 - Adequate ventilation, high efficiency particulate air (or HEPA) filtration, and open air
 - Ultra violet lights

For healthcare personnel, screening for TB is required upon employment, annually, and as necessary. Some symptoms of TB include

- Loss of weight, loss of appetite
- Feeling good in the morning but excessively tired in the evening
- The need to cough and clear the throat in the morning
- Possible elevated temperature in the evening
- Hemoptysis or coughing up blood

As the disease progresses, the symptoms worsen and often include

- Indigestion, abdominal pain, or vomiting
- Persistent cough lasting longer than three weeks
- Night sweats that are so extreme that bedding is soaked
- Rapid weight loss and loss of strength

Completed drug therapy is essential. Treatment may last for 6-9 months and may include several drugs. TB has evolved to become resistant to drugs. People hospitalized with suspected TB should be placed in airborne isolation precautions that include a negative pressure ventilated private room with the door kept closed. All people entering the room should wear a personal respirator (N95 respirator mask) and wash their hands upon entering leaving the room.

Transporting of patients with suspected or confirmed TB should be avoided unless medically necessary. However, when necessary, they should wear a surgical mask while out of the negative pressure environment, and observe respiratory hygiene and cough etiquette.

Ethical Aspects of Care

Ethics are defined as:

1. Standards of conduct and moral judgment
2. System of moral principles
3. Group's principles or code
4. Values relating to human conduct with respect to rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions.

Some view law and ethics as one and the same. However, actions that are lawful are NOT necessarily ethical, and actions that are ethical are NOT necessarily lawful. Law is the minimum performance that is expected in society.

A moral ethic is a moral framework for decision-making, and it allows the refinement of guidelines, judgments, and actions. Each person is a moral agent whose actions or inactions have moral consequences for which that person is responsible. No one's conduct can be excused by claiming that "orders were being followed." Sometimes it seems easier to go along for the sake of getting along rather than risking disapproval by speaking out. Failing to speak out when we know we should is a violation of our duty as a moral agent.

There are four principles that should be reflected in all healthcare professionals' personal ethic.

1. Respect for persons – There are four elements to consider in respect for persons:
 - a. Autonomy – Autonomy requires that one act in a way to allow others to govern themselves. Patients should NOT be coerced or forced. When unable to make decisions for themselves, they should be allowed to name someone to make decisions for them. Autonomy is the underlying principle in consent for treatment.
 - b. Truth telling – Even if knowing the truth causes harm, people have the right to know the truth.
 - c. Confidentiality – Healthcare workers have a duty to keep secret what they learn about patients in the course of their work. Information shared between members of the healthcare team that is in the best interest of the patient is NOT considered secret. Meeting legal requirements may result in morally justified exceptions to confidentiality.
 - d. Fidelity – This means that healthcare workers have a duty to perform their job and to keep their word.
2. Beneficence – Beneficence is rooted in the Hippocratic tradition and is defined as acting with charity and kindness.
3. Nonmaleficence – Nonmaleficence comes from the Latin phrase *primum non nocere* which means first, do no harm. This means that before any action or inaction is taken on behalf of the patient, one must first determine that it will not cause harm.
4. Justice – There are many definitions for justice. Aristotle defined justice as equals being treated equally, and unequals unequally. Most people think of justice as fairness. In any case, justice should be applied to making sound decisions based on clear criteria.

The patient care, treatment and services provided in our facility directly reflects the moral ethic of each employee on the healthcare team. Your facility's dedication to ethical care and responsible business practices significantly impact the patient's experience of and response to care, treatment, and services. Patients deserve practices that safeguard their personal dignity, and respect their cultural, psychosocial, and spiritual values. The individual patient's values influence their perceptions and needs. When healthcare workers respect these values and understand the importance they hold, they will be able to more successfully provide appropriate care, services, and treatments.

Organizational ethics include:

- Consistently following ethical behavior in its care, treatment, services, and business practices
- Addressing conflicts of interest
- Assuring integrity in decisions based on identified healthcare needs of the patients
- Making ongoing care provisions when any type of denial is initiated

Individual rights involving the facility include:

- Respecting the rights of all patients
- Patients receiving information regarding their rights and the right to and need for effective communication
- Patients being involved in the decisions regarding their care, treatment, and services, including respect for their wishes relating to end-of-life decisions
- Obtaining informed consent; informing the patient about the outcomes, including unanticipated outcomes
- Obtaining consent regarding patient information and/or records for purposes other than identification, diagnosis, or treatment of the patient
- Patients receiving adequate information about the personnel responsible for the delivery of their care, treatment, and services
- Patients' right to refuse care, treatment, and services in accordance with law and regulation
- Patients' right to pain management
- Organizational protection regarding research subjects and their rights in reference to research/investigation/clinical trials involving human subjects

- Organizational respect regarding the needs of patients for:
 - o confidentiality
 - o privacy
 - o security
 - o access to protective and advocacy services
 - o freedom from:
 - mental abuse
 - physical abuse
 - sexual abuse
 - verbal abuse
 - neglect
 - exploitation

Accommodating patients' religious and spiritual practices:

As healthcare workers, we have an ethical responsibility to support patient spirituality if and when the patient deems it relevant, and we must avoid being judgmental when patient beliefs and values conflict with our own. Patients' religious and spiritual beliefs should be screened for and when requested, pastoral or chaplain care should be implemented. This is critical to good care, and the lack of appropriate spiritual referrals can constitute a form of patient neglect. I think "neglect" is a bit strong use of the word since neglect has a "legal" definition. I would leave it at "this is critical to good care."

Some questions that that may be used as a screening tool include:

- Do you consider yourself spiritual or religious?
- How important are your spiritual or religious beliefs to you?
- Do your beliefs influence how you care for yourself?
- Do you belong to a spiritual community?
- How might healthcare providers best address your needs in this area?

Patients and their family members often draw on their religious or spiritual beliefs to cope with illness. Some of those beliefs may include rituals, meditation, music, prayer, sacred narratives, or other inspirational readings. Several clinical studies show that support for these practices plays an important role in health and healing.

Some of those benefits include:

- Stress reduction
- Recovery from illness
- Reduction of depression
- Substance abuse prevention and recovery
- Prevention of heart disease and high blood pressure
- Mitigation of pain
- Adjustment to disability
- Recovery from cardiac surgery in the elderly

As healthcare workers, it is our duty to respect and accommodate patients' religious and spiritual beliefs and practices. It takes a dedicated commitment on everyone's part (facility, staff and patients) to provide knowledgeable, respectful, and appropriate care, treatments, and services.

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End-of-Life Care

Due to the nature of the healthcare setting, healthcare workers will encounter a number of patients with terminal illnesses at various stages of the end-of-life process. During this time, patients and their families experience special needs that each healthcare worker should understand and respect.

The goal of end-of-life care is to comfort. Comfort is defined as a verb to soothe, console, or reassure; to bring cheer to. Comfort is defined as a noun as relief in affliction; consolation; solace. Cultural beliefs and other individual human differences should be respected when providing comfort. Each patient has unique ideas, desires, and concerns with respect to the dying process. Having end-of-life wishes followed, whatever they are, and being treated with respect while dying are common wishes among all patients.

There are 4 comfort needs near the end-of-life:

- I. Physical Comfort – Pain and discomfort can come from a variety of problems often associated with the dying process. For each problem, there are specific things that healthcare workers can do to help.
 - A. Pain
 1. Experts believe that care for the dying should focus on relieving physical pain without worrying about possible long-term drug dependencies or abuse
 2. Pain is easier to prevent than it is to relieve. Care should be taken to stay ahead of pain by administering medication in a timely manner.
 3. Patients and their families should be encouraged to talk to their doctors about the need for more or different pain control measures if relief is NOT being achieved
 4. Pain can affect the mood of patients. It may cause them to seem angry or short-tempered. Great care should be taken to be understanding during periods of extreme irritability. Patients may NOT be able to share feelings or thoughts in a rational manner during periods of pain. Healthcare workers should exercise extreme patience and compassion. Families may need help understanding this type of irritability when their loved ones are uncharacteristically short-tempered and angry.
 - B. Breathing problems
 1. Dyspnea or shortness of breath is common during end-of-life. This may make communication difficult and frustrating for patients and their family members. Try raising the head of the bed, opening the window, and/or using a fan to circulate air in the room. Doctors may prescribe extra oxygen.
 2. People very near death may have noisy breathing called a death rattle. This is caused by fluids collecting in the throat or by the throat muscles relaxing. Even though this is sometimes very upsetting to the family, it is important to let them know that it usually isn't upsetting to the person dying. Turning the patient on their side may help.
 - C. Skin irritation
 1. Skin irritations can be very uncomfortable. Excessive dryness can make skin more fragile. Gentle application of alcohol-free lotion can relieve dry skin and create a very soothing sensation.
 2. Dryness on the face, lips and eyes can be a common cause of discomfort near death. A damp cloth placed over the eyes may relieve dryness. If the inside of the mouth seems dry, use a damp cloth or specially-treated swabs to wipe the area. If the patient is on oxygen, workers and family members should strictly avoid the use of petroleum products on lips.
 3. Sitting or lying in one position puts constant pressure on sensitive skin which can lead to painful pressure ulcers. It is important to turn or reposition the patient every couple of hours to prevent this condition.

Foam pads are useful on bony areas such as heels, ankles, and elbows. Extra care should be taken to make sure skin is kept clean.

D. Digestive problems

1. Nausea, vomiting, constipation, and loss of appetite are common end-of-life complaints. Medication is often successful in relieving these symptoms. Patients or their family members should be encouraged to talk to their doctor if these symptoms occur.

2. Patients often lose their appetite during the dying process. Favorite foods should be offered in frequent, small amounts, but patients should NOT be forced to eat.

3. Sometimes, a conscious decision to give up food can be a part of a person's acceptance that death is near. This decision should be respected.

E. Temperature sensitivity – Patients who are dying may NOT be able to tell you they are too hot or too cold. It is important to watch for clues such as pushing blankets away or shivering. Offering extra blankets or a fan when needed is helpful.

F. Fatigue – Lack of energy and tiredness are common during the end-of-life process. Care should be taken to keep activities simple. Allow rest between care, treatments, and procedures. Encourage family members and visitors to respect a patient's need for a quiet, restful environment. Cultural differences often play a role in interaction between family members, friends, and patients during this time. Healthcare workers should be respectful of these different needs and beliefs.

II. Mental and Emotional Comfort – People often experience depression and anxiety at various stages of the end-of-life process. Talking and sharing these feelings may be helpful. Sometimes counseling or medication may be needed.

Families and healthcare workers should also be sensitive to special fears or concerns during this time. Patients sometimes worry about those they may leave behind. Many people are afraid of being left alone when they die. Grieving family members may feel the need to pull away because they are worried their grief will discourage the one dying. Extra care should be taken to encourage family members to stay near. They should understand their presence is usually comforting. Touching by holding hands or gentle massage is soothing to many dying patients.

Setting a comforting mood may ease mental and emotional stress during the dying process. It is important to understand what the patient used to reduce stress at earlier times in his/her life. Music and soft lighting may help with relaxation and lessen pain. For some people, keeping distracting noises like televisions and radios to a minimum is important.

III. Spiritual Comfort – A person's spiritual needs may be as compelling as their physical needs. Spiritual needs often involve finding meaning in one's life and ending disagreements with others. Many people find solace in their faith. Visits from a pastor, rabbi, priest, minister, chaplain, or other spiritual leader may provide peaceful resolution to unsettling issues. Religious symbols are an important aspect of many cultures during the dying process. Great care should be taken to respect these spiritual needs during this time. This may also serve to comfort the family at this difficult time.

Family and friends should be encouraged to talk to, NOT about the person who is dying. Many medical professionals feel that even unconscious patients may hear and understand when people talk to them. People should identify themselves as they enter the patient's room.

There may come a time when a dying person who has been confused suddenly seems to have clear-thinking. Take advantage of these moments, but understand that it might only be temporary, NOT necessarily a sign the patient is getting better.

IV. Practical Comfort – When a person nears the end of their life, friends and family members often tend to many practical everyday tasks such as banking, picking up mail, household chores, pet care, and much more. These extra tasks may be especially overwhelming for loved ones during this time when grief is already taking a toll. As a healthcare worker, it is important to offer support to caregivers by asking how they are and offering to be a good listener when they need a shoulder to lean on. You may NOT be in a position to help with some of the more personal things. However, simply being attentive to patients and their families, and being dependable to take care of the small and seemingly trivial tasks that are your responsibility (without the family having to ask) will be greatly appreciated. Small things like offering to get a cup of coffee for a tired family member who has been with a patient during a long night will be well received.

Identifying and Reporting Victims of Abuse and Neglect

As a healthcare professional, one should act as a patient advocate. As uncomfortable as it may be to discuss or question the sensitive areas of abuse, violence, and neglect, it is essential to accurately assess, document, and report such offenses or suspicions to the proper authorities. In Florida, anyone who reports a suspected case of abuse in good faith is immune from criminal and civil liability; however, failure to report suspected abuse may result in civil liability. Reporting of abuse will be done by the first staff member who identifies possible abuse.

Some examples of reportable issues include but are NOT limited to:

- Severe malnutrition in children
- Suspected or documented child abuse or neglect
- Intimate partner abuse or violence including (only if the victim chooses to report, unless the victim is a vulnerable adult):
 - o physical abuse
 - o emotional abuse
 - o sexual abuse
 - o financial abuse
 - o verbal abuse
- Certain accidents or mechanisms of injury such as the following are reportable only under Wounds of Violence statutes but not necessarily as abuse:
 - o stabbings
 - o gunshot wounds
 - o suspicious terrorist-type behaviors
- Vulnerable adult abuse, exploitation, neglect which also includes:
 - o threats
 - o physical violence
 - o abuse that includes:
 - sexual
 - emotional
 - physical
 - financial
 - intentional social isolation

Some possible signs of vulnerable adult abuse that may indicate the need for further investigation include:

- Physical abuse
 - o Unexplained bruises, welts, scars, broken bones, sprains, or dislocations
 - o Signs of being restrained such as rope marks on wrists
 - o A caregiver's refusal to allow you see the elder alone
- Emotional abuse
 - o Threatening, belittling, or controlling caregivers
 - o Signs such as rocking, sucking, or mumbling to oneself
- Sexual abuse
 - o Bruises around the breasts or genitals
 - o Unexplained venereal disease or genital infections
 - o Unexplained vaginal or anal bleeding
 - o Torn, stained, or bloody underclothing
- Neglect
 - o Unusual weight loss, malnutrition, dehydration
 - o Pressure ulcers
 - o Unsanitary conditions (such as dirt, bugs, dirty clothing)
 - o Unsuitable clothing for the weather
 - o Unsafe living conditions such as no heat or running water
 - o Desertion of the elder in a public place

The National Center on Elder Abuse website provides reporting information for each state.
http://www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/Help_Hotline.aspx

Information and referral is also available from the national Eldercare Locator, a public service of the U.S. Administration on Aging. Call toll-free 1-800-677-1116. This number is available Monday through Friday 9 AM-8 PM (except U.S. federal holidays). If you feel the person could be in immediate danger, contact local law enforcement as soon as possible. The Florida hotline is 1-800-96-ABUSE

Some general signs of possible child abuse that may indicate the need for further investigation:

- Physical abuse
 - o Unexplained bruises, welts, scars, broken bones, sprains, or dislocations
 - o Unexplained burns, especially on the palms, feet, abdomen, or buttocks
 - o Signs of being tied up such as rope marks
- Emotional abuse
 - o Eating disorders
 - o Extreme developmental delays of speech or motor skills
 - o Weight or height substantially below normal
 - o Flat or bald spots on the head of infants
 - o Rocking or head banging
- Sexual abuse
 - o Torn, stained, or bloody underclothing
 - o Unexplained sore throats, yeast or urinary infections
 - o Sexually transmitted diseases
 - o Bruising or bleeding in the genital area or anal area
 - o Pregnancy
 - o Difficulty walking or sitting when not compatible with a diagnosed medical condition
- Neglect
 - o Poor hygiene, untreated diaper rash, bed sores, body odor
 - o Unsuitable clothing for the weather
 - o Untreated injuries or illnesses
 - o Lack of immunizations

- o Indications of prolonged exposure to the elements such as excessive sunburns, insect bites, colds, frost bite
- o Begging for food or leftovers

If you suspect a child is in immediate danger, contact local law enforcement or child protective services as soon as possible. You may also call 1-800-4-A-CHILD (1-800-422-4453) the Childhelp National Child Abuse Hotline – available 24 hours per day. The Childhelp website provides additional information and resources and may be accessed at <http://www.childhelp.org/>. The Florida hotline is 1-800-96-ABUSE

Domestic Violence

Domestic violence includes incidents of violence between married couples, family members, roommates, dating couples, and those in gay, lesbian, bisexual and transgendered (LGBT) relationships. In an abusive relationship there are a number of tactics the abuser may use in order to maintain power and control over a partner.

Physical violence often results in obvious injuries such as black eyes or bruises on the arms and wrists. If these signs exist, it is important to ask the cause of the injuries. Suspected victims should be questioned away from suspected abusers. Even if plausible excuses are given, it is a good idea to ask if anyone had a part in causing the injuries. Ensure the person that their safety is your concern and priority. Truth about the source of an abusive injury will likely not be told if the person believes it will lead to more abuse.

Emotional and verbal abuse is often considered to leave some of the deepest scars. It may include:

- Insults or put-downs
- Public humiliation
- Name-calling
- Mind games
- Manipulations

Isolation is a common tactic used by a jealous abuser who may insist on the victim not seeing his/her friends or family members. Frequent job absenteeism and decreased productivity associated with domestic violence may increase feelings of isolation.

Intimidation, accusations, and threats made by an abuser in a domestic violence situation often include physical violence, suicide, or taking children away as a tactic to control a victim. The effects of these incidents must not be minimized. Often, an abuser will accuse the victim of, for example, looking at other men, wanting to be with other men, flirting, or having affairs. This is used as an attempt to have an excuse for a beating or to make the abuser feel justified in his/her actions.

As a healthcare worker, unless you have the patient's consent or the patient is incapacitated you cannot report domestic violence – it becomes the capacitated patient's decision whether or not they wish to report an act of domestic violence. We have the ethical responsibility to listen and be available to our patient and provide them with the information on how to report and places to go for support. Early identification and treatment can help mitigate long-term effects of abuse or neglect. Once consent is given, report call local law enforcement agency or the national domestic violence hotline at: 1-800-799-SAFE. Or, contact the National Coalition Against Domestic Violence at: <http://www.ncadv.org/>. Domestic Violence in Florida can only be reported with the consent of the victim.

Sensitivity to Organ Donation

An extreme shortage of available organs and tissue severely limit needed transplantation to thousands of people suffering from end-stage organ disease. There are complex issues and factors associated with the organ donation process. Healthcare professionals are responsible to recognize and evaluate potential organ donors, establish and maintain a relationship with Organ Procurement Organizations (OPO) representatives, and support donation decisions in a non-judgmental manner. The OPO representative will contact the family regarding organ donation.

Organ Donation Legislation

The Federal Omnibus Budget Reconciliation Act (OBRA) of 1986 required all hospitals receiving Medicare and Medicaid funding to have policies in place to identify potential organ donors and to inform families of the donation process. In 1998, the Healthcare Financing Administration (HCFA) enacted a rule requiring a trained, designated requestor to talk to families about organ donation. This training must meet specific criteria and be provided by an Organ Procurement Organization.

In the United States, regulation of organ donation is left to each state within the limits of the National Organ Transplant Act of 1968. Each state's Uniform Anatomical Gift Act seeks to standardize organ donation rules and processes across states. Many states have worked to allow for organ donation consent by notation on a driver's license. However, relatives can still dissent even if evidence exists that the potential organ donor consented.

Donor organs are matched to waiting recipients by a national computer registry called the National Organ Procurement and Transplantation Network (OPTN). This registry is operated by an organization known as the United Network for Organ Sharing (UNOS).

Organ Procurement Organizations

An Organ Procurement Organization or OPO links potential donors with recipients, coordinates donations, and perform the many tasks associated with the retrieval, preservation, and transplantation of organs. There are approximately 70 OPOs in the US. Hospitals are required by law to notify an OPO quickly when someone is about to die or has died. The OPO is responsible for reviewing the patient's record with the nurse and determining medical suitability for donation. If it is determined that organ and/or tissue donation is appropriate, they will have a representative contact the deceased patient's family to offer them the option of organ and/or tissue donation.

Deceased Donors

Organ donation requires healthcare professionals to recognize the incurable nature of the patient's injury or illness and to communicate this effectively to the patient's family. The legally sanctioned definition of death is complete and irreversible cessation of all brain activity (brain death). The recovery of organs from donors after cardiopulmonary death (DCD) accounts for approximately 4% of all donations. Most DCD programs in the U.S. are limited to situations where the donor's family has made a decision to have life support withdrawn soon enough for retrieval of viable organs. Eighty-four percent of cadaveric organ donations are the result of head trauma, stroke, or cerebral vascular accident.

The "dead-donor rule" refers to two widely accepted ethical norms that govern practices of organ procurement for transplantation: (1) vital organs should only be taken from dead patients, and (2) living patients should not be killed for or by organ procurement. It is generally assumed that a violation of these ethical norms would constitute euthanasia state laws, and therefore have legal consequences.

Organ donation facts

- Several types of organs and tissues may be donated for transplantation. They include: kidneys, liver, heart, lung, pancreas, corneas, bone marrow, skin, bone, heart valves, veins, tendons, and intestines. However, not every donor may be eligible to donate all organs and tissue.
- The average number of organs recovered from a single donor across all age groups is 3.5.
- One variable that affects potential organ donation is the necessary preservation time for various organs. Skin, bone and heart valves may be preserved for 5 years or more, while hearts and lungs may only be preserved for up to 5 hours.
- Acceptable organ donors can range in age from newborn to 65 years or more. A person's physical condition determines if he/she can donate, not age.
- Every day in the U.S., 16 to 17 people die while waiting for organ transplantation.
- In September 2009, there were over 111,700 people in need of an organ or tissue transplantation.
- In 2008 there were a total of 14,207 deceased and living donors.
- Kidneys are the most needed organ, with over 86,200 patients in need of a kidney; 16,500 in need of a liver; 5,000 waiting for corneas; 2,800 for a heart; 1,900 for a lung; and 1,700 in need of a pancreas.
- Almost all major religions accept organ donation or accept the right of the individual to make their own decisions. Most religions consider it an act of charity to donate organs and are in favor of it. Jehovah's Witnesses require organs to be drained of blood due to their interpretation of disallowance of blood transfusion from the Bible. Muslims require written consent from the donor. Orthodox Jews consider it obligatory if it will save a life as long as the donor is considered dead as defined by Jewish law. Those who follow the customs of Gypsies and the Shinto faith may disfavor organ transplantation and donation.

Providing families with organ donation options

Nurses and other caregivers most intimately involved with patients and their families have an enormous impact on how organ donation options are delivered and how they are accepted by those with decision-making authority. Their role is to educate and facilitate, but not to persuade or manipulate. They should assist families in arriving at the best decision for them at that particular time. The most important thing to remember when providing family members with organ donation options is that no matter what the decision – it should be honored and respected.

Once a patient has been identified as meeting the criteria for organ donation by the OPO, providing organ donation options to the family is a critical step in the process. Healthcare professionals have a duty to provide options, education, and support for decisions – no matter what their own personal organ donation beliefs are. Studies show that there are 4 critical factors that can affect a family's decision to give consent. They are:

1. Trust in the medical system and the persons initiating the request
2. The understanding and acceptance of brain death
3. The timing and setting of the request
4. Sensitivity of those providing donation option education

Steps to follow when providing organ donation options

1. Separate the act of informing the family of death from the discussion of organ donation
2. Provide the family a comfortable, private place to grieve and enough time to adequately absorb the news.
3. Allow the family as much time as possible with the body of their loved one.
4. Establish a non-judgmental, respectful, and sensitive atmosphere that respects both donation and non-donation decisions. Some studies show that when the requestor is of the same race/culture as the family, the delivery is perceived to be more sensitive resulting in a higher rate of consent.
5. Provide as much education, counseling, and support as needed. Answer questions in layman's terms and be ready to repeat as many times as necessary. During the grieving process, families may be slower to absorb and understand the often complex organ donation process.

6. Give families as much time to make their decision without pressure. You may need to allow them to have time alone, letting them know when you'll be back to answer questions.
7. No matter what decision is made, let them know that their wishes are respected and honored.

Assessment and Management of Pain

Pain can have a serious impact on your patients' quality of life. It can influence mood, sleep, activities of daily living, and it has serious psychological implications. Chronic pain erodes the ability to cope resulting in feelings of hopelessness, loneliness, anxiety, depression, frustration, and anger. Suicidal ideation and completed suicide are related to chronic pain with 33% of all chronic pain sufferers reporting thoughts of suicide.

A recent study found that pain was the most prevalent symptom reported by all medical-surgical patients with 74% of them reporting pain and half of those rating it as severe or very severe. The Veterans Health Administration requires that pain be viewed as the 5th vital sign as it may indicate changes in patient condition.

Pain is subjective. The clinical definition of pain by the International Association for the Study of Pain states that pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. A widely used definition of pain used in nursing since 1968 states that pain is whatever the experiencing person says, existing whenever he/she says it does.

Statistics from the National Pain Awareness survey include:

- 43% of adults (83 million) report that pain frequently affects their participation in life's activities
- 55% of senior citizens report suffering from pain on a daily basis
- 64% of pain sufferers will see a doctor only when they CANNOT stand the pain any longer
- 42% of people believe their pain is misunderstood by their physician

Ethical principles of beneficence – the duty to benefit another, and nonmaleficence – the duty to do no harm, require healthcare professionals to ensure good pain management and comfort to all patients. The principles of justice and dignity require healthcare professionals to provide humane, compassionate care to all patients by promptly recognizing, treating, monitoring, assessing and reassessing pain.

According to the American Society of Nursing Pain Management, the following are recommended pain assessment techniques:

1. Self-report – Self-reporting is the most reliable way to assess a patient for pain. However, for a variety of reasons, some patients are unable to verbalize their pain. In that case further investigation, assessment, and observation are needed.
2. Search for causes of pain – Surgery, positioning, heel sticks, wound care, blood draws, etc., are known to trigger pain. Procedures known to cause pain should be treated before initiation of the pain.
3. Observe behavior – When self-reporting isn't possible, one should observe behavior as a valid approach to pain assessment. Some behaviors that may indicate pain in adults include facial grimacing, moaning, rubbing of body parts, agitation, restlessness, irritability, confusion, and combativeness. Infants and children may react to pain by change in facial expression; high-pitched, harsh cries; sleeping and withdrawn behavior; posturing; irritability; agitation; and restlessness.
4. Surrogate reporting – Many times parents, caregivers, or other family members with knowledge of usual and past behaviors may assist in identifying the presence of pain. However, these observations should be used with other evidence whenever possible.
5. Attempt an analgesic trial – If assessment indicates that pain is likely, an analgesic trial should be implemented based on the estimated intensity of pain, patient's pathology, and analgesic history. If behaviors

improve, assume pain was the cause and continue the analgesic adding appropriate nonpharmacologic interventions. If behavior continues, more aggressive analgesic interventions should be considered. Other potential causes of behaviors should be explored.

Other pain management responsibilities include:

- Ongoing assessment and reassessment of every patient for pain
- Education of patients and families about their roles in managing pain, as well as the potential limitations and side effects of pain treatments
- Consideration of personal, cultural, spiritual, and ethical beliefs in the treatment of pain
- Communication to patients and families that pain management is an important part of their care

It is very important for you to know that your hospital is committed to pain management. It takes a team effort. This team includes:

- Physicians
- Nurses
- Physical therapists
- Occupational therapists
- Respiratory therapists
- Mental health professionals
- Social workers
- Pharmacists
- Others in the healthcare environment
- Patient and family

The focal points of the team approach are:

- Understanding the importance of the pain management standards
- Utilizing a multidisciplinary methodology
- Identifying opportunities for improvement through ongoing communication and analysis of protocols
- Educating providers and staff on the comprehensive nature and involvement required
- Assessing provider/staff knowledge and validating competency
- Continually striving for improvement throughout your organization

Competent pain management is a challenge in our healthcare environment today. Yet, it is vitally important to our patients. It is up to you to know your facility's pain management standards and the involvement necessary by you to help it succeed.

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Patient Safety / Preventing and Reporting Medical Errors

In today's complex healthcare environment, opportunity for error is high. Errors range from lack of communication between the patient and the healthcare professional, to miscoding a medication in a dispensing

system, to a sodium error in a therapeutic diet. Every level of personnel and systems contains an opportunity for error.

A research document released by the Institute of Medicine (IOM), *To Err is Human: Building a Safer Healthcare System*, revealed the epidemic of medical errors. It reported that over 100,000 people die in the U.S. from medical errors every year costing the economy up to 29 billion dollars.

Types of Medical Errors

The IOM defines an error as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.

Active and Latent Errors

There are two basic types of medical errors:

- Active - Active errors are realized almost immediately and occur at the level of the individual.
- Latent - Latent errors may not be realized for months or even years, and often lead to residual active errors. These types of errors are usually a result of a faulty system design, installation, or maintenance of equipment; or an ineffective organizational infrastructure.

Near Misses and Code 15/Sentinel Events

A near miss is a narrowly avoided medical error that could have resulted in harm but did not. Near misses allow opportunities to develop safety strategies to prevent an error in the future.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury includes loss of limb or body function. The term “sentinel” is used because it signifies the need for immediate investigation and action.

Not all sentinel events are medical errors and not all medical errors are sentinel events. The Joint Commission requires accredited organizations to identify and respond to sentinel events. A thorough investigation, implementation of improvements to reduce risk, and monitoring the effectiveness of the improvements are all required as part of the sentinel event action plan.

Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Errors

Surgery is an area of healthcare in which medical errors and near misses can be prevented. Any invasive procedure that exposes patients to more than minimal risk, including procedures performed in setting other than the operating room (OR), such as a special procedure unit, endoscopy unit, and an interventional radiology suite. The Joint Commission has found wrong-site surgeries to be the third highest-ranking sentinel event with communication failure being the most frequent root cause.

Universal Protocol is a strategy developed by The Joint Commission to prevent surgery errors. This protocol is designed to be used in all areas where invasive procedures are performed. It is based on prevention theories that drive safety practice in high risk industries such as aviation and the development of nuclear weapons.

The three key elements of the Universal Protocol are:

- preoperative verification
- marking the operative site
- taking a time out

This protocol has been shown to drastically reduce surgery errors that are attributable to interruptions, distractions, and too many forms or procedures being performed.

All healthcare personnel should be knowledgeable about the Universal Protocol and consistently adhere to the three key elements. When they feel patient safety is being compromised, they have an obligation as the patient’s advocate to speak up.

Medication Errors

Medication errors are the most common type of medical error. They are usually complex and are rarely the result of one person's actions. Medication systems rely on the involvement of several people, and every time a document or medication changes hands, the risk of an error is present.

The three most frequently reported types of medication errors:

- Omission errors (failure to administer an ordered medication dose)
- Improper dose/quantity errors (any medication dose, strength or quantity that differs from that prescribed)
- Unauthorized drug errors (the medication dispensed and/or administered was not authorized by the prescriber); this category includes dispensing or administering the wrong drug.

Other findings included:

- The primary contributing factors to medication errors were distractions and workload increases.
- Insulin, heparin and warfarin were the medications most often associated with errors.
- In 32% of the records where documented action was taken due to a medication error, the personnel involved with initiating or perpetuating the error were reportedly not informed of their involvement in the medication error event.
- 56% of medication errors occur due to ordering
- 34% occur due to administration
- The 5 medications most often associated with death or serious injury are: insulin, opiates and narcotics, injectable potassium chloride, intravenous anticoagulants, and sodium chloride solutions above 0.9%.

Areas that are particularly prone to error are:

- Verbal orders
- Handwritten orders
- High-alert drugs
- Infusion pump errors
- Look alike, sound alike drugs

Healthcare personnel authorized to administer medications have a duty to protect their patients from medication errors. The five main "rights" of medication administration should be observed with every medication dose administered. They are:

- Right patient
- Right drug
- Right dose
- Right route
- Right time

Factors impacting medical errors

Errors occur as a result of a complex interaction of factors. Healthcare personnel with the best of intentions cannot prevent all errors. They must be well-informed about when and where errors are likely to occur.

At the root of medical errors are a variety of factors such as:

- Breakdown in communication
- Staffing issues
- Distraction factors
- Lack of the availability of needed information
- Organizational culture issues
- Lack of teamwork among healthcare personnel
- Lack of effective leadership
- Inadequate documentation

- Failure to follow policies and protocols
- Lack of appropriate and effective policies
- Excessive healthcare personnel fatigue
- Chemically impaired healthcare personnel
- Lack of competency and credentialing

Ineffective communication is the leading cause of medical errors. Some of the risk factors include language barriers associated with culture and ethnicity; socioeconomic variables such as education, literacy, and income; gender differences among providers and patients; personality differences; hierarchy and power issues; trust issues; environmental issues such as noise, interruptions, time constraints, heavy workload, multiple conversations, and absent face-to-face conversations.

Reducing Medical Errors

Research has shown that some specific factors are known to reduce medical errors:

- Healthcare personnel should take active steps to minimize or eliminate distractions when checking transcribed or computerized orders or when preparing medications before administration.
- Actively focus on the task at hand and avoid being rushed, no matter what the situation.
- Be a supportive and active member of the healthcare team by offering to help co-workers when they are involved in time-sensitive situations that could lead to distractions or short-cuts.
- Always use at least two patient identifiers when: labeling, delivering, maintaining specimen integrity; preparing and administering blood products and medications; and when performing procedures.
- Healthcare organizations should set policies limiting telephone and verbal orders only when absolutely necessary. A read-back of orders should always be used to confirm orders to the prescriber. The practitioner should always return verbal acknowledgement of the accuracy of the order.
- Practitioners with prescribing authority should double-sign and double-check high-alert medications – especially those with narrow ranges of values for therapeutic effect.
- Good, effective hand washing has been proven to reduce the incidence of healthcare associated infections. The use of alcohol-based hand rubs, eliminating artificial nails, keeping nails less than one quarter of an inch in length, and changing gloves between patients are also effective strategies to reduce the risk of infection and should be observed in accordance with CDC hand hygiene guidelines.
- All patients should be assessed for risk of falls due to altered mental status, recent environmental change, need to urinate, strength and balance. An effective fall strategy should be implemented for all patients known to be at risk.
- Healthcare fatigue is known to increase the risk of medical errors. Healthcare personnel have a duty to report to work rested and prepared.
- Report suspicions chemical impairment among personnel
- Do not report to work when ill – especially when running a temperature. Not only does this provide risk of infection transmission to patients and co-workers, it is known to cause fatigue and impairment of decision-making ability.
- Healthcare personnel who “float” from one department to another may not have all the knowledge necessary for all situations.
- Personnel should be able to recognize and respond to changes in a patient’s condition . They must be able to directly request additional assistance from specially trained individuals when the patient’s condition appears to be worsening.
- Personnel should have adequate training and experience with medical equipment.
- The use of effective hand-off communication procedures should be followed in all instances when patient care is transferred from one person to another.
- All personnel have a responsibility to speak up when conditions are inadequate to provide safe patient care.
- Healthcare leaders have a duty to promote a culture of patient safety. They should take immediate and effective action to stop inappropriate personnel behaviors that are known to increase the risk of medical errors.

They should also support an environment where the focus on reports of medical errors is on finding a solution to reduce future risk and not on blame.

Reporting Medical Errors

Medical errors and near-misses must be reported before the end of your shift. The person who was involved in the incident should be the one reporting doing the Incident Report. The medical error and near misses are reported thru Mercy On-Line. Anyone who decides not to report such instances eliminates the possibility of investigation and new actions that may prevent similar errors in the future. **However, the healthcare culture must be one in which personal accountability increases reporting and decreases errors.** Fear of harsh punishment and humiliation reduce error reports, and rather than blame being the focus of investigation and action, leaders and review boards should be oriented in the accountability of a just culture and remain vigilant in providing strategies to reduce error risk. Negligent, reckless conduct and deliberate policy violations require individual accountability to be emphasized and discipline is justified in these situations. Responses to all errors should be framed by the nature of the event.

Preventing Healthcare-Associated Infections Due to Multidrug-Resistant Organisms (MDROs)

According to the Centers for Disease Control and Prevention (CDC), the prevention and control of MDROs is a national priority – one that requires all healthcare facilities to assume responsibility. Multidrug-resistant organisms are defined as bacteria (excluding *M. tuberculosis*) that are resistant to one or more classes of antimicrobial agents and usually are resistant to all but 1 or 2 commercially available antimicrobial agents. In most instances, MDRO infections have clinical manifestations that are similar to infections caused by susceptible pathogens. However, options for treating patients with these infections are often extremely limited. Resistance to each new agent for the treatment of MRSA (methicillin-resistant *Staphylococcus aureus*) and VRE (vancomycin-resistant enterococci) infections has emerged in clinical isolates. This situation often results in antibiotic usage patterns that suppress normal flora and create a favorable environment for the development of colonization or infection when exposed to potential MDR pathogens.

When compared to patients without the presence of MDROs, those with MDROs experience increased lengths of stays, higher hospital charges, and an increased incidence of mortality.

The prevalence of MDROs in U.S. hospitals has steadily increased over the past several decades. In the early 1990s, MRSA accounted for 20% to 25% of *Staphylococcus aureus* in hospitalized patients. In 2003, 59.5% of *S. aureus* in ICU (intensive care units) were MRSA. VRE in hospitalized patients increased from <1% in 1990 to 28.5% in 2003.

Once MDROs are introduced into a healthcare setting, transmission and persistence of the resistant strain is determined by the availability of:

- vulnerable patients
- selective pressure exerted by antimicrobial use
- increased potential for transmission from larger numbers of colonized or infected patients
- impact of implementation and adherence to prevention efforts

Patients who are especially vulnerable to colonization or infection include those with:

- severe disease or underlying medical conditions
- recent surgeries, and/or

- indwelling medical devices

The CDC campaign to prevent antimicrobial resistance in healthcare settings presents strategies for prevention and control of MDROs. Some of those strategies include the following:

Infection-Prevention Strategies

Step 1: Vaccinate

- Give the influenza and/or pneumococcal vaccine to at-risk adults, infants, and children before discharge.
- Review immunization records for infants/children and catch-up with routine vaccinations.
- Healthcare personnel should get the influenza vaccine annually

Step 2: Remove catheters as soon as possible

- Use only when essential
- Use correct catheter
- Use proper insertion and catheter-care protocols

Diagnose and treat infections effectively

Step 3: Target the pathogen

- Culture the patient
- Target therapy to known pathogens and antimicrobial susceptibility test results
- Target empiric therapy to likely pathogens

Step 4: Access the experts – Consult infectious disease experts for patients with serious infections

Use antimicrobials wisely

Step 5: Practice antimicrobial control

Step 6: Use local data

- Know your antibiogram and patient population
- Know your formulary

Step 7: Treat infection, NOT contamination

- Use proper asepsis for blood and other cultures
- Culture the blood, NOT the skin or catheter hub
- Treat pneumonia, NOT tracheal aspirate
- Treat bacteremia, NOT the catheter tip
- Treat urinary tract infections, NOT the indwelling catheter

Step 8: Know when to say NO to vancomycin

- Treat only infection, NOT contaminants or colonization
- Consider other antimicrobials when treating MRSA

Step 9: Stop antimicrobial treatment

- When infection is cured
- When cultures are negative and infection is unlikely
- When infection is NOT diagnosed

Prevent transmission

Step 10: Isolate the pathogen

- Use standard infection control precautions
- Contain infectious body fluids (follow airborne, droplet, and contact precautions)

- Adhere to recommended environmental cleaning practices

Step 11: Break the chain

- Stay home when you're sick
- Promote respiratory hygiene and cough etiquette
- Keep hands clean – wash with soap and water when visibly soiled and use alcohol based hand cleansers
- Especially with children, restrict visitors with respiratory or gastrointestinal tract infections

Prevention of Central Line-Associated Bloodstream Infections

Bloodstream infections (BSI) occur due to all types of intravascular catheters. However, central venous catheters (CVCs) are associated with the most serious catheter-related infections. Approximately 250,000 CVC-associated BSIs occur in the U.S. each year. The cost of caring for patients in the U.S. with CVC-associated BSIs ranges from \$296 million to \$2.3 billion annually. Each CVC-associated BSI costs approximately \$25,000 per episode. Attributable mortality is estimated at 12% to 25% for each infection.

The following are some of the CDC recommendations for placement and care of CVCs, including peripherally inserted central catheters (PICC), hemodialysis, and pulmonary artery catheters in adult and pediatric patients.

General Principles

- Use a CVC with the minimum number of ports or lumens essential for the patient's management.
- Use totally implantable access devices for patients who require long-term, intermittent vascular access.

For patients requiring frequent access, a PICC or tunneled CVC is preferred.

- Use a cuffed CVC for dialysis if access is anticipated to be prolonged.
- Use a fistula or graft instead of a CVC for permanent access for dialysis.
- Do NOT use dialysis catheters for drawing blood except under emergency circumstances.

Selection of catheter insertion site

- Weigh the risk and benefits of placing a device at a recommended site to reduce infectious complications against the risk for mechanical complications.
- Use a subclavian site (rather than a jugular or a femoral site) in adult patients to minimize risk for non-tunneled CVC placement.
- Place dialysis and pheresis catheters in a jugular or femoral vein rather than a subclavian vein to avoid venous stenosis if catheter access is needed.

Maximal sterile barrier precautions during catheter insertion

- Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet for insertion of CVCs.
- Use a sterile sleeve to protect pulmonary artery catheters during insertion.

Replacement of catheter

- Do NOT routinely replace CVCs, PICCs, dialysis catheters, or pulmonary artery catheters to prevent catheter-related infections.
- Do NOT remove CVCs or PICCs on the basis of fever alone.

Catheter and catheter-site care

- Designate one port exclusively for hyperalimentation if a multilumen catheter is used to administer parenteral nutrition.

- Do NOT routinely use antibiotic lock solutions to prevent CRBSIs (catheter-related bloodstream infections). Only use in special circumstances.
- Catheter-site dressing regimens
 - o Replace the catheter dressing when it becomes damp, loosened, soiled, or when inspection of the site is necessary.
 - o Replace dressings u(transparent CHG dressings) every 96 hours, except in those pediatric patients in which the risk for dislodging the catheter outweighs the benefit of changing the dressing.
 - o
- Ensure catheter-site care is compatible with catheter material.

Preventing Surgical Site Infections

There are approximately 27 million surgical procedures performed in the U.S. each year. Surgical site infections (SSIs) are the most common cause of healthcare acquired infections (HAIs), accounting for 38% of all such infections. When surgical patients with HAIs die, 77% of the deaths are related to the infection. SSIs increase a patient's hospital stay by approximately 10 days and cost an additional \$2,000 to \$4,000 in extra charges.

There are certain patient and operation characteristics that may influence the risk of surgical site infection development. Some of those characteristics include:

Patient

- Age
- Nutritional status
- Presence of diabetes
- Smoking
- Obesity
- Infections at a remote body site
- Colonization with microorganisms
- Altered immune response
- Length of preoperative stay

Operation

- Duration of surgical scrub
- Skin antisepsis
- Preoperative shaving
- Preoperative skin prep
- Duration of operation
- Antimicrobial prophylaxis
- Operating room ventilation
- Inadequate sterilization of instruments
- Foreign material in surgical site
- Surgical drains
- Surgical technique
- Poor hemostasis
- Failure to obliterate dead space
- Tissue trauma

An SSI prevention measure can be defined as an action or set of actions intentionally taken to reduce the risk of an SSI. The following measures are some of the CDC recommendations to prevent surgical site infections.

Preparation of the patient

- When possible, identify and treat all infections remote to the surgical site before elective operations.
- Do NOT remove hair preoperatively unless it will interfere with the operation.
- If hair is removed, remove immediately before the operation with clippers.
- Control blood glucose levels in all diabetic patients. Avoid hyperglycemia perioperatively.
- Encourage tobacco cessation. At a minimum, abstain for at least 30 days before elective operation.
- Do NOT withhold necessary blood products as a means to prevent SSI.
- Require patients to bathe or shower with an antiseptic skin agent the night before.
- Thoroughly wash around the incision site to remove gross contamination before antiseptic skin prep.
- Apply skin prep in concentric circles moving toward the periphery in a large enough area to extend the incision or create new incisions or drain sites.
- Keep preoperative hospital stay as short as possible.

Hand and forearm antisepsis for surgical team

- Keep nails short and do NOT wear artificial nails
- Perform preoperative scrub at least 2 to 5 minutes with an appropriate antiseptic. Scrub hands, forearms, and elbows.
- After surgical scrub, keep hands up and away from the body so water runs from the tips of the fingers toward the elbows. Dry hands with sterile towel, and don sterile gown and gloves.
- Clean underneath each fingernail prior to first surgical scrub each day.
- Do NOT wear hand or arm jewelry.

Management of infected or colonized surgical personnel

- Encourage personnel who have signs of transmissible infectious illness to report conditions promptly.
- Surgical personnel who have draining skin lesions should be restricted from duty until adequate therapy and infection are resolved.

Antimicrobial prophylaxis

- Administer IV (intravenous) prophylactic antibiotic so that a bactericidal concentration is established in serum and tissue when incision is made.
- Maintain therapeutic levels throughout operation and until a few hours (at most) after incision is closed in operating room.

Cleaning and disinfection of environmental surfaces

Use an Environmental Protection Agency (EPA)-approved hospital disinfectant to clean the areas before the next operation when visible soiling, or contamination with blood, or other body fluids occurs.

Sterilization of surgical instruments

- Sterilize all surgical instruments according to published guidelines.
- Perform flash sterilization only for patient care items that will be used immediately.
- Do NOT flash sterilize for reasons of convenience or to save time.

Surgical attire and drapes

- Wear surgical mask that fully covers the mouth and nose when an operation is about to begin, is underway, or if sterile instruments are exposed. Wear throughout operation.
- Wear a cap or hood to cover hair on the head and face.
- Use surgical gowns and drapes that are effective barriers when wet.

- Change scrub suits that are visibly soiled or contaminated by blood or other potentially infectious material.

Asepsis and surgical technique

- Adhere to the principles of asepsis.
- Assemble sterile equipment and solutions immediately prior to use.
- Handle tissue gently.
- Leave incision site open to heal if the site is heavily contaminated.
- If drainage is necessary, used closed suction drain at a distant site from operative incision, and remove as soon as possible.

Postoperative incision care

- Protect with sterile dressing 24 to 48 hours postoperatively an incision that has been closed primarily.
- Wash hands before and after dressing changes and any contact with surgical site.
- Use sterile technique for all incision dressing changes.
- Educate family on incision site care and symptoms of SSI.

Management of Patients in Restraint or Seclusion

Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. All patients have the right to be free from restraints that are not medically necessary or used for purposes other than patient benefit or safety. However, in specific instances and for specific patients who are acting, or threatening to act, in a harmful, violent way toward themselves or others, the use of restraints may be initiated in compliance with strict standards.

Basic types of restraint that may be used include:

- Physical restraint or force – holding a patient in order to prevent freedom of movement
- Mechanical restraint (Immobilizers) - a device, such as a vest restraint, wrist, or ankle restraints to restrain a patient (this excludes devices prescribed for medical purposes)
 - Chemical restraint – medicating a patient against his/her will for the intended purpose of restraint rather than for treatment
 - Seclusion
 - o placing the patient alone in a room, such as a locked security room, so that he/she CANNOT see or speak with patients or staff, and
 - o the patient CANNOT leave or believes he/she CANNOT leave
 - o acceptable only if seclusion resources are available in a behavioral health unit or the emergency department
 - Any other means which unreasonably limits freedom of movement such as tucking a patient's sheets in so tightly that he/she cannot move more freely.

Some devices or equipment that may be restrictive in nature but that are generally NOT considered restraints include:

- IV (intravenous therapy) arm boards or wrist support for arterial lines.
- Positioning devices such as a foam wedge
- Side rails on a stretcher, when patients are recovering from anesthesia or are sedated, or are used to prevent patients from falling out of bed. However, when side rails are used inappropriately to restrict patient's freedom to exit the bed, they will be considered a restraint device.

Restraint should NEVER be used for:

- Treatment
- Punishment
- Behavior modification
- Staff convenience
- PRN, which is an acronym that stands for the Latin phrase pro re nata, commonly used in medicine to mean as needed, or as the situation arises, or that administration of medical treatment is left to the caregiver or the patient's prerogative

A mechanism that does not restrict a patient's movement or mobility, but may be effective in maintaining patient safety and well being should be attempted prior to the initiation of a restraint.

Examples of preventive and alternative strategies could include:

- Provision of companionship and/or supervision of the patient
- Placing the patient by the nurse's station
- Providing soothing distractions such as TV, music, walking, conversation, quiet environment, massage, or reading to the patient
- Changes or elimination of troublesome treatments/medications when indicated and ordered by a physician

When restraint is needed, it must be the least restrictive and most appropriate alternative available. For example a wrap-around belt may be considered less restrictive than a vest restraint because it allows for less restriction of the upper torso, arms, and hands. But, a patient placed in a wheelchair could slump over with the use of a belt, impairing respiratory function. In this case, the use of a vest would be a more appropriate option. If a confused patient has shown evidence of attempts to pull out his/her endotracheal tube, a vest restraint would not be effective in preventing this danger to the patient. In this case, the use of soft wrist restraints would be a more appropriate choice. The use of and reasons for restraint should always be explained to the patient and/or family. If the patient or family refuses the application of restraints and safety continues to be at risk, the physician should be notified immediately for further interventions.

Restraints used for medical necessity to improve the patient's well-being or prevent interruption of treatment require at least the following:

- Assessment, determination, and documentation that other, less restrictive measures have been found to be ineffective to protect the patient and others
- Orders written by a licensed independent practitioner and CANNOT be written as PRN
 - o The order must include the following:
 - Date and time the order was written
 - The reason for the restraint
 - Type of restraint to be used
 - Extremity or body parts to be restrained
 - Duration of application
 - Notification to the patient's attending physician as soon as possible, if ordered by another LIP/RN
 - Telephone or verbal restraint orders must be countersigned by the physician within 24 hours of receipt of the order.
- New orders following a face-to-face evaluation by the physician must be conducted every 24-hour time-period while the patient is in restraints
 - Clinical justification of continued use of restraint must be documented and the orders for restraint renewed each calendar day
 - Implementation of safe and appropriate restraining techniques
 - Termination at the earliest possible time

- Continual assessment, monitoring, and reevaluation of the restrained patient's condition must be conducted at a minimum of every hour and should include:
 - o Vital signs, hydration, circulation, level of distress and agitation, skin integrity, and general care needs such as eating, toileting, and range of motion.
 - o Maintaining the patient's right, dignity, and safety
 - o Consideration of alternatives or less restrictive methods
 - o Review of criteria for restraint release which includes changes in patient's behavior or clinical condition
 - o Checking to ensure restrains are appropriately applied

Restraints used for behavioral health reasons to prevent patients from harming self or others require at least the following:

- Assessment, determination, and documentation that other, less restrictive measures have been found to be ineffective to protect the patient and others
- Orders written by a licensed independent practitioner and CANNOT be written as PRN
- o The order must include the following:
 - Date and time the order was written
 - The reason for the restraint
 - Type of restraint to be used
 - Extremity or body parts to be restrained
 - Duration of application
 - Notification to the patient's attending physician as soon as possible, if ordered by another LIP/RN
 - Telephone or verbal restraint orders must be countersigned by the physician within 24 hours of receipt of the order.
- Initial face to face evaluation and restraint order must be obtained within 1 hours of restraint application
- Clinical justification of continued use of restraint must be documented and the orders for restraint renewed every 4 hours as well as face to face evaluation by a physician every 4 hours
 - Implementation of safe and appropriate restraining techniques
 - Termination at the earliest possible time
 - Continual assessment, monitoring, and reevaluation of the restrained patient's condition must be conducted at a minimum of every 15 minutes should include:
 - o Vital signs, hydration, circulation, level of distress and agitation, skin integrity, and general care needs such as eating, toileting, and range of motion.
 - o Maintaining the patient's right, dignity, and safety
 - o Consideration of alternatives or less restrictive methods
 - o Review of criteria for restraint release which includes: cessation of threats, recognition of verbal or physical escalation, in behavioral control, contracting for safety
 - o Checking to ensure restrains are appropriately applied

Documentation for a patient in a restrictive device should include, but is not limited to:

- Clinical justification for the use of restraints (the actual behavior)
- Date and time of placement of restraint
- Type of restraint and the extremity or body part restrained
- Alternatives attempted prior to application of restraint
- Patient's clinical condition, circulation, skin integrity, attention to hydration, and elimination at least every hour
 - Discussion with patient and/or family regarding need for restraint
 - Assessment and reassessment data
 - Criteria used for continuation and discontinuation of device
 - Time of removal

Staff applying restraint should demonstrate competency with the physical application and use of restraint, as well as the requirements and facility policies and procedures for the use. They should be applied and removed in accordance with the following:

- Restraints should only be applied by qualified, trained staff
- The type of restraint used should match the type of restraint ordered
- Restraints should be applied with safe and appropriate technique
- Restraints should be removed
 - o Only by authorized, trained staff
 - o As soon as the patient no longer displays behaviors that would put them at risk to harm themselves or others
 - o As soon as the patient no longer exhibits behavior that disrupts medical interventions
- Devices are to be applied and removed in accordance with manufacturer's instructions and for their intended purposes
 - Restraints should be secured to the bedsprings or frame if being used while the patient is in bed. They should never be tied to the mattress or side rails. Knots should be tied so that they may be released quickly in the event of an emergency.

Management of Patients Receiving Moderate Sedation

Moderate sedation, sometimes called conscious sedation, is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep sedation is a controlled state of depressed consciousness or state of unconsciousness from which the patient is NOT easily aroused.

There is a partial or complete loss of:

- Ability to purposefully respond to physical or verbal stimuli
- Protective reflexes
- Ability to independently maintain a patent airway

Because sedation-to-anesthesia is a continuum, it is not always possible to predict how an individual patient receiving medication with the intent to achieve moderate sedation will respond. Therefore, only qualified individuals who are trained in professional standards and techniques should administer agents to predictably achieve desired levels of sedation. They must diligently monitor patients in order to maintain them at the desired level of sedation.

Procedures involving moderate sedation typically consist of:

- Endoscopic examinations
- Vascular and cardiac catheterizations
- Bronchoscopy
- Bone marrow aspirations
- Certain radiologic studies

Moderate sedation procedures can be done in numerous locations in the facility. It is because of the variables of patient acuity, procedure complexity, various locations, and the potential for emergency situations that competency in moderate sedation is essential. Emergency procedures must be in place to ensure that experts in airway management, intubation, and advanced life support are readily available.

Certain patients may NOT be suited for moderate sedation.

Intense assessments should be done for patients with a history of:

- Seizures
- Severe cardiovascular disease
- Medical instability
- Obesity
- Pregnancy
- Substance abuse or
- Inability to communicate

A thorough assessment should be completed prior to sedation.

The purpose of the assessment is to collect information needed:

- Pre-procedural assessment by the physician performing the procedure
- Laboratory evaluation
- Detailed history and physical including prior use of sedating agents and the patient's response to those agents
- Current medications
- Allergies and history of previous adverse reactions
- Vital signs
- Level of consciousness
- NPO status (NPO is an acronym for Nil per os or Nulla per orem which are Latin phrases for a medical instruction meaning to withhold oral food and fluids from a patient)
- Pregnancy status
- Any history of substance abuse
- Consent and informed consent for the procedure
- Consent and informed consent for sedation
- Any physical risk that would complicate emergency procedures such as:
 - o significant obesity
 - o receding chin or shortened neck
 - o rheumatoid arthritis, and/or
 - o limited range of motion in neck and jaw

Patients should be classified by the American Society of Anesthesiology (ASA) classification system. Any patient receiving an ASA-III or greater requires consultation and/or sedation administered by an anesthesiologist or CRNA.

ASA Scoring

- ASA I Healthy patient without medical problems
 - ASA II Mild systemic disease or conditions that need to be treated (diabetes, smoking, asthma, thyroid disease)
 - ASA III Severe systemic diseases that limit activity but are not incapacitating (complicated or uncontrolled diabetes, uncontrolled hypertension, coronary artery disease, COPD, CVA)
 - ASA IV Severe systemic disease that is incapacitating and is a constant threat to life (severe CAD, CHF, ESRD, steroid dependent COPD)
 - ASA V A moribund patient not expected to survive 24 hours with or without intervention
- “E” Added if any of the above categories is an emergency

During the procedure the following must be at least minimally assessed and documented:

- Vital signs every 5-15 minutes or more often as needed

- Dose, route, medication, time of administration, and effects of the conscious sedation agent(s)
- Any other medications including dose, route, time, and effects
- Oxygen therapy including liters per minute and means of delivery
- Level of consciousness throughout the procedure and throughout recovery
- Any untoward reactions together with all necessary interventions and resolutions
- Type and amount of all IV (intravenous) fluids, blood, and blood products used

Continuous monitoring must be done by a designated qualified individual, such as an RN (registered nurse) or physician, and that specific individual must be present at all times. Provision for potential emergencies must be immediately available.

Emergency equipment must be present at the time of administration of moderate sedation, including:

- Oxygen/oxygen source with regulator/flowmeter
- Suction, suction catheters (soft and hard)
- Bag and mask (Ambu) in appropriate sizes
- Oral/nasopharyngeal airways in appropriate sizes and lubricant
- Intubation equipment such as ET (endotracheal) tubes, laryngoscopes, and stylets
- Pulse oximeter which should be used throughout the procedure and recovery
- Cardiac monitor which should be used throughout the procedure and recovery
- EKG (electrocardiogram) equipment
- Non-invasive blood pressure monitor
- Defibrillator
- IV equipment including personal protective equipment
- Crash cart or emergency medication box

The patient is considered recovered only when the patient has returned to the pre-procedural, pre-sedation state in respect to their airway, breathing, circulation, and level of consciousness. Only at this point can the patient be transferred to a less intensely monitored level of care. If the patient has received an antagonist, constant monitoring must continue for at least 2 hours by a qualified RN.

It is the responsibility of the professional healthcare provider to deliver the most competent and safe care to their patients. As part of your facility's professional team, you are required to know your facility's policies and procedures.

Bariatric Sensitivity Module

Please go to the following link on you tube to view the video:

Weight Bias in Healthcare

http://www.youtube.com/watch?v=IZLzHFgE0AQ&feature=player_embedded

After viewing the video please answer the questions in the post-test

Objectives

Participants will be able to:

- Define weight bias
- Describe how weight bias shows up in medical practices
- Identify the victims and sources of weight bias
- Describe the consequences of weight bias on the patient

National Statistics

In the United States the prevalence of weight discrimination in adults is more common among women than racial discrimination and more common for all adults than discrimination based on ethnicity, religion, sexual orientation, or physical disability.

* Survey by Yale Rudd Center

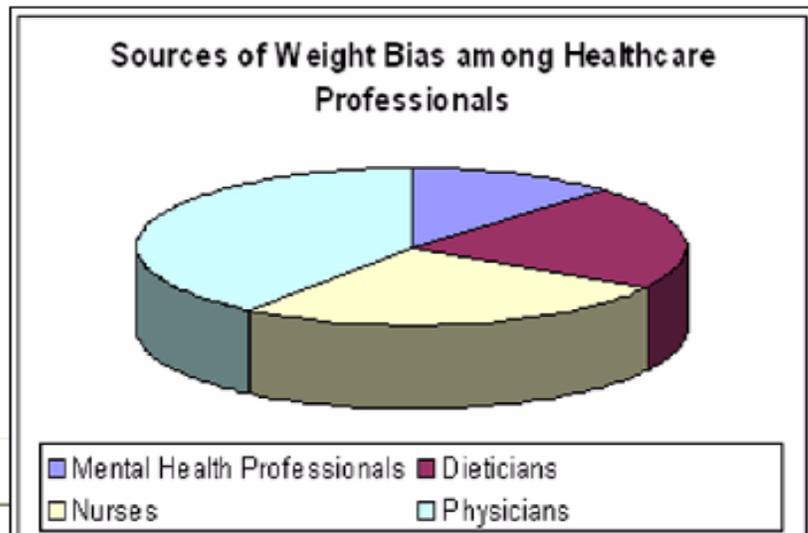
Healthcare professionals may sometimes falsely have the attitude that a weight condition is the patient's fault and that there is merely something wrong with their attitude.

National Statistics

- 6 out of 10 patients in the United States are already overweight or obese
- the rate has doubled among adults in the past 20 years
- the rate has tripled in teens in the past 20 years

Sources of Weight Bias among Healthcare Professionals

- 21% from Mental Health Professionals
- 37% from Dieticians
- 46% from Nurses
- 69% Physicians



Questions to ask yourself which help identify personal attitudes

- Do I make assumptions based on weight regarding character, intelligence, success, lifestyle, etc.?
- Am I comfortable working with patients of all sizes?
- Do I give appropriate feedback to encourage healthful behavior change?
- Am I sensitive to the needs and concerns of obese individuals?
- Do I treat the individual or only the condition?

Complexity of Obesity

Causes of obesity are a combination of:

- Genetic Factors
- Environmental Factors
- Psychological Factors

Keys to Bias-Free Treatment:

- Consider that patients may have previously experienced bias from others
- Explore all causes of the patient's presenting problems, not just weight
- Recognize that many patients have tried to lose weight repeatedly
- Acknowledge the difficulty of making lifestyle changes
- Recognize that small weight losses can result in significant health gains
- Emphasize behavior changes with patients rather than focusing only on weight:
 - Increase consumption of fruits and vegetables
 - Reduce intake of soda
 - Walk more frequently during the day