CHECKpoint IV: Clinical Care
(PROGRAM: 40723)

Presenter: Narrated

COURSE OBJECTIVES

∗ Explain pain assessment and management techniques, restraint and seclusion procedures, handoff communication methods, and fall and suicide prevention measures.

∗ Recognize the problem infections from multi-drug resistant organisms present and identify prevention methods for healthcare-associated infections caused by multi-drug resistant organisms.

∗ Identify ways to prevent catheter-associated urinary tract infections, central line-associated bloodstream infections, and surgical site infections, and understand the placement and care of central venous catheters and how to safely handle sterile supplies and devices.

∗ Understand the ethics of healthcare, including religion and spirituality, end-of-life care, organ donation, and whistleblower protections.

∗ Discuss cultural and age-related competencies.

Module 1: Assessment/Management of Pain

Pain Assessment

Patients have a right to appropriate pain assessment and management. Continuous, unrelieved pain is a known contributor to adverse outcomes, such as post-surgical infections, poor wound healing, deep vein thrombosis, pulmonary embolism, pneumonia, depression, and even suicide. These complications not only affect the patient's health, but can also lead to extended lengths of stay, unnecessary readmissions, dissatisfaction with care, and may put clinicians and institutions at risk for legal action.

Assessment of pain is key to effective pain management. Assessment methods and parameters should be guided by facility setting and policy -- methods used to evaluate pain should be based on a patient's age, condition, understanding and written criteria -- as well as patient ability to understand and respond. Pain should be assessed regularly and reassessed after each intervention to evaluate effect.

Pain History

When collecting and documenting a pain history, it is important to include the following:

* Previous and ongoing instances and types of pain
* Previous methods used for pain control that have been helpful and unhelpful
* Typical coping responses to pain, including any psychiatric disorders, depression, anxiety, or substance abuse
* Patient and family preferences, expectations, and beliefs about pain and pain treatment
* Barriers to communication about pain

Elements of Pain Assessment

Intensity
* A number of scales have been validated for assessment of pain intensity. Individual patient characteristics along with institutional policies should drive the selection of the appropriate scale. A scale should be used consistently, but should not be used as the sole measure of pain intensity.
* Visual scales allow patients to point to or otherwise indicate an intensity rating based on a visual series of numbers or pictures.
* Verbal scales use common words, such as mild, moderate, or severe.
* Verbal numeric scales allow patients to verbally rate pain based on a series of numbers, such as 0 to 10.
* For patients with limited cognitive ability, nonverbal patients, neonates, infants, and children, other scales may be available by facility and setting.

Location
* When possible, ask the patient to point to or be specific about the location of pain. For example, the patient says he has pain in his abdomen but points to the right lower quadrant -- or complains of backache but points to the left flank.

Description
* Ask the patient to describe the pain. This may help in identifying the cause. Musculoskeletal pain is often described as dull, aching, cramping, stabbing, or throbbing. Nerve-related pain is often described as stinging, shooting, tingling, or like an electric shock.

Impact
* The impact of pain on the ability to perform bodily functions, sleep, maintain a healthy mood, and perform activities of daily living are important considerations.

Alleviating and Aggravating Factors
* Factors such as position, room temperature, and certain movements that either improve or worsen pain are helpful for identifying cause and appropriate interventions.

Physiological and Behavioral Responses
* Physiologic responses, such as rapid heart rate, increased respiratory rate, and hypertension, may help in identifying the presence and intensity of pain.
* Grimacing, moaning, and crying, are sometimes exhibited with pain, however, patients may experience pain WITHOUT these responses.

Assessment Barriers and Special Populations

Self-reporting is the most accurate means of assessing pain, however, patients may not always be able to report. Caregivers and family members may help. Efforts should be made to overcome barriers in collecting an accurate assessment, such as the use of interpreters when language barriers exist, visual tools for the hearing impaired, and verbal tools for the visually impaired.

The elderly:
* A variety of medical conditions associated with aging often make it difficult to distinguish acute from chronic pain. Clinicians must use patience and good communication when posing questions and allowing time to respond. Use assessment tools that are sensitive to cognitive, language, and sensory impairments. Family members or caregivers may provide information about the patient's pain history and response to treatments.

Infants and young children:
* Special rating scales are available for infants and young children that use a combination of behavioral and physiological factors, such as crying, facial expression, changes in vital signs, withdrawn behavior, posturing, irritability, restlessness, and an altered sleeping pattern. Family members may assist.

Cognitively impaired:
* Both self-reporting and observations are necessary when assessing pain in this population. Assessment tools and rating scales should be carefully selected according to the unique abilities of each individual and should be used consistently over the course of a typical event. Input from family members or caregivers may provide additional insight for establishing baselines and selecting interventions.

Pain Management Responsibilities

An effective pain management plan includes pharmacological and non-pharmacological interventions, which are selected based on individual patient characteristics, preferences, safety concerns, and setting.

* Non-pharmacological interventions include but are not limited to: relaxation techniques; positioning, compression, splinting; application of heat or cold; massage; and neurostimulation.
* The synergistic use of different pharmacological analgesics results in the need for lower doses to control pain and fewer side effects. A balanced analgesia plan includes: Non-opioids, such as acetaminophen, and nonsteroidal anti-inflammatory drugs (NSAIDs); opioids; adjuvant analgesics that include local anesthetics, antidepressants, and anticonvulsants.

<u>Pharmacological Options</u>

Pharmacological analgesic selection should be based on:

* Patient goals and preferences
* Pain history and assessment
* Procedures, surgeries, and activities
* Potential toxicity based on factors such as age and patient conditions
* Cost
* Setting

The body of evidence on pain management supports the following principles for the use of pharmacological analgesics:

* A fixed-dose schedule (around the clock) should be used when continuous pain is expected

* For breakthrough or activity-related pain, use of a rapid-onset analgesic
* Acetaminophen or NSAIDs are recommended for mild to moderate pain
* Adjuvants, such as anticonvulsants or antidepressants, are often used for specific types of pain
* Opioid administration should begin with a low dose titrated to comfort and safety
* Assessment of the effect of previous doses including intensity, relief, and side effects should guide modifications
* If one analgesic is not providing adequate relief, another in the same class may show better results, as patients respond differently to various drugs

General Safety Precautions

The following are general safety precautions:
* When administering pain medications that have a sedative effect, use fall precautions
* For patient-controlled analgesia (PCA) infusions, use systems to double-check drug and dose
* For catheter administrations, for example epidural or intrathecal, use initial dose testing and monitor response
* Protect skin when applying cold or heat

Safe Use of Opioids

The same binding action of opioids with cell receptors in the nervous system that blocks pain signals can also cause sedation, decreased respiration, reduced blood pressure, nausea, euphoria, and decreased bowel motility. These effects can be dangerous or life-threatening. The following are important safety precautions:

* Screen for respiratory risk factors, such as sleep apnea and snoring; morbid obesity; older age; upper abdominal and thoracic surgeries; history of analgesic abuse or increased opioid dose requirements; longer length of general anesthesia; receiving other sedating drugs; pulmonary or cardiac disease, or major organ failure; smoking history
* Assess patients for a fentanyl patch, implanted drug delivery system, or infusion pump before administering a new opioid
* Take extra precautions with those new to opioids. Assess patient response to an initial dose before increasing or prescribing long-term use
* Avoid rapid dose escalation above routine levels in opioid-tolerant patients

∗ Take extra precautions during care transitions between units, facilities, and when discharging patients to their home as drug levels may reach peak concentrations during this time
∗ Sedation level and respiratory status are more reliable measures for preventing respiratory depression than pulse oximetry or apnea monitoring. Decreased oxygen saturation is a later sign of impending respiratory depression
∗ Take extra precaution with patients also taking antidepressants or anticonvulsant drugs, as these combinations may cause significant sedative effects.

<u>Patient and Family Education</u>

The following points provide a guide for educating patients about pain management:
∗ Reasonable expectations for pain control
∗ The importance of controlling pain before it reaches an intolerable level
∗ Responsibilities for reporting pain and changes in pain
∗ Both pharmacological and nonpharmacological options for managing pain
∗ Minor side effects and ways to manage them
∗ Dangerous side effects and what to do should they occur

Module 2: Restraint and Seclusion, Handoff Communication, and Fall and Suicide Prevention

Restraint and Seclusion

Physical restraint is any human and/or mechanical force that restricts a patient's freedom of movement. It may involve:

∗ Tucking in a sheet so tightly the patient's movement is restricted
∗ The use of wrist, ankle, or waist restraint devices
∗ Keeping side rails raised to prevent a patient from getting out of bed
∗ Holding a patient's body or part of the body against his or her will in a manner that restricts movement

Chemical restraint is any medication which is not part of the standard treatment of care for the patient's medical or psychiatric condition, that is used for the purpose of restricting or managing behavior.

Seclusion is holding, or threatening to hold a person in a room or space involuntarily and preventing him or her from leaving.

Restraint or seclusion of any kind should only be used for the management of behavior that jeopardizes the immediate physical safety of the patient, staff, or others. Patients have the right to be free from restraint and seclusion used for any other purpose. They should NEVER be used for:

* Punishment
* Behavior modification
* Staff convenience

Only a patient's CURRENT behavior may be used to determine the need for restraints. A history of violence or previous self-harm are not enough to justify their use. When indicated, the least restrictive form of restraint necessary to protect the patient and others from harm must be used and should be removed at the earliest possible time.

Restraint does not include:

* Orthopedically prescribed devices
* Surgical dressings or bandages
* Protective helmets

Address any issue that is underlying a patient's disruptive behavior, as an underlying treatment or medication the patient is receiving may be leading to the behavior that requires restraint use.

Preventative and alternative strategies should be tried before using any form of restraint or seclusion that restricts a patient's movement, such as:

* Providing companionship or extra supervision
* Placing a patient near a nurse's station
* Soothing distractors like TV, music, walking, conversation, or books
* Changing or eliminating bothersome treatments, procedures, or medications when ordered by a provider

If alternatives have been proven insufficient or ineffective, restraint may be appropriate. When used, a provider order must be obtained – standing orders should not be used.

Staff applying restraints and seclusion MUST be trained and demonstrate expertise with:

* The physical application, use, and removal of restraint
* Implementation of seclusion
* Monitoring, assessment, and care of a patient in restraint or seclusion

Restraints should be removed ONLY by authorized, trained staff. They should never be tied to the mattress or side rails; knots must be tied so they may be released quickly in the event of an emergency. Restraints must be removed as soon as the patient no longer displays violent or self-destructive behaviors regardless of the length of time stated in the order.

The use of restraint and seclusion must be documented. Information should include but is not limited to:

* Clinical justification
* Type of restraint used
* Clinical condition
* Assessment information, such as vital signs, behavior, injuries, nutrition, hydration, respiratory and circulatory status, skin integrity, range of motion, hygiene, elimination, and physical comfort
* Criteria used to continue or stop restraint use
* Date and time of application and removal

Laws and standards in most states require a patient in restraints to be evaluated face-to-face at least every hour. Some may have shorter parameters. The Centers for Medicare and Medicaid Services and other accrediting agencies, like The Joint Commission, regulate restraints and seclusion. All providers and staff must be familiar with applicable laws, standards, and organizational policies.

Handoff Communication

An estimated 80% of serious medical errors involve miscommunication during patient handoffs. Handoff, handover, or handoff-of-care communication is an interactive process for passing up-to-date patient information from one clinician or team of clinicians to another for the purpose of ensuring the continuity and safety of the patient's care. Patient care handoffs happen during care transitions, such as: shift or break changes, discharges, transfers, and consultations.

According to the American Medical Association, "handoffs should provide timely, accurate information about the patient's care plan, treatment, current condition, and any recent or anticipated changes. Handoffs should: 1) be standardized and clearly defined; and 2) involve face-to-face exchange between the caregivers involved."

The verbal handoff may include previous care, treatment, allergies, any current problems, and recommendations for the accepting caretaker. Specific items to be included in handoff communication vary by setting and discipline.

Some effective techniques for handoffs are:

* Use common language and avoid medical jargon, confusing words, or unacceptable abbreviations
* Limiting interruptions and protecting confidentiality
* Focusing on the important details and avoiding unnecessary information
* Allowing enough time for complete exchange
* Using read-back or check-back techniques to make sure everyone understands clearly
* Encouraging questions

Many accrediting agencies require organizations to standardize handoff communication. There are many established strategies, so follow your facility's process and policy.

One common interactive tool is SBAR, which stands for four categories of communication:

* Situation -- a concise overview of the pertinent issues, patient complaints, and diagnoses are stated
* Background -- the sender communicates the patient's relevant history and physical assessment pertinent to the problem, treatment, clinical course, and important changes.
* Assessment -- a best assessment of what is happening with the patient and facts which support those judgments are summarized.
* Recommendation -- an explanation of what needs to be done for the patient is shared.

Another common handoff technique is "I PASS the BATON."

* Introduction -- the sender and receiver introduce themselves and their role or job.
* Patient -- the patient's name, identifiers, age, sex, and location are stated.
* Assessment -- what is happening with the patient and facts which support those judgments are summarized.
* Situation -- a concise statement is made about the patient's current status, relevant changes, code status, and response to treatments.
* Safety concerns -- critical lab values, allergies, and safety alerts, such as fall status are reviewed.

* Background -- the sender goes over comorbidities, medications, and pertinent history.
* Actions -- actions that have been taken or are required are covered along with a brief rationale.
* Timing -- the level of urgency, explicit timing, and prioritization of actions are summarized.
* Ownership -- those responsible for care or actions are listed, such as nurse, doctor, team, patient, and family.
* Next -- the plan for what should happen next is covered.

When communicating a patient's condition, the assessment of suicide risk should be included. Patients at risk often have acute depression, anxiety, agitation, or medical problems like chronic pain, illness, or terminal cancer.

Your institution should have a system of screening protocols and procedures in place to address suicide risk. After screening, the patient condition should be communicated rapidly to mental health professionals and all affected personnel.

Fall Prevention

Hundreds of thousands of patients fall in healthcare facilities every year. According to The Joint Commission, falls with serious injury are consistently among the top 10 reported sentinel events. Healthcare institutions must assess the potential of patient falls based on patient population and setting, and a formal policy should be put in place for those at risk.

All healthcare workers must be alert to the potential for falls and provide a safe environment in order to prevent them.

Universal fall precautions apply to all patients regardless of fall risk and include the following:

* Familiarize the patient with the environment.
* Maintain a call light within reach and have the patient demonstrate use.
* Keep personal possessions within reach.
* Keep the hospital bed brakes locked and place in low position when the patient is resting. Raise to a comfortable height when transferring out of bed.
* Keep wheelchair locks in "locked" position when stationary.
* Keep non-slip, comfortable, well-fitting footwear on the patient.
* Use nightlights or supplemental lighting.
* Keep floor surfaces clean and dry. Clean up all spills promptly.

* Keep patient care areas uncluttered.
* Follow safe patient handling practices.

Some factors that can contribute to patient falls are:

* A history of falls. Patients with a history of fall in the past three months should be considered at higher risk for future falls
* Impaired mobility and use of assistive devices, such as canes, crutches, wheelchairs, and walkers
* Medications that cause drowsiness, confusion, impaired balance, or orthostatic blood pressure changes
* Patients with delirium, dementia, psychosis, agitation, or confusion
* A history of incontinence or frequent toileting needs
* Being tethered to equipment, such as an IV pole that could cause a patient to trip
* Visual impairments that may cause a patient not to see an environmental hazard
* Orthostatic hypotension, which may cause lightheadedness or fainting when standing
* Slippery or wet floors
* Obstructed pathways

Communication between patients, family members, visitors, and healthcare staff is an important factor for fall prevention.

Suicide Prevention

Suicide is the 10th leading cause of death in the U.S., and the number and rate of suicides is rising. It is estimated that 1 in 5 suicide fatalities are seen in an emergency department in the month prior to their death.

The CDC and SAMHSA list these risk factors for suicide:

* A family history of suicide or child abuse
* Previous suicide attempt or attempts
* Having lost someone close to suicide, and local epidemics of suicide
* A history of mental disorders, particularly clinical depression and mood disorders or alcohol or substance abuse
* Loss of a relationship
* Social loss
* Work or financial loss

∗ Physical illness and chronic or painful medical conditions
∗ Feelings of hopelessness or isolation
∗ Impulsive or aggressive tendencies
∗ Barriers to accessing mental health treatment, certain cultural beliefs, and unwillingness to seek help due to social stigma
∗ Easy access to lethal methods

Some groups at higher risk than the general population are LGBT people, American Indians and Alaskan Natives, people in the justice or child welfare systems, those who engage in non-suicidal self-injury, members of the Armed Forces and veterans, men in midlife, and older men.

Screening recommendations vary. The organization, Zero Suicide, recommends screening EVERY patient for suicide risk at their initial encounter with every healthcare provider. The Suicide Prevention Resource Center recommends emergency departments conduct universal or selective screening for suicide risk. The Joint Commission requires that hospitals "Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care."

All recommendations agree that screening policies should be consistent and patients should be screened using a validated screening tool.

Anytime a patient screens positive, an evidence-based process should be used to conduct a suicide assessment.

Review screening questionnaires before the patient leaves the appointment or is discharged.

∗ Refer for a secondary assessment if the patient is determined to be at risk. If a patient screens positive for suicide ideation but denies suicide risk or declines treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If a patient declines consent, HIPAA allows these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others. From this step forward, behavioral health clinicians should be included in the care team by consultation or referral.
∗ Use assessment results to determine what level of safety measure is needed. Keep patients who are in acute suicidal crisis in a safe healthcare environment, under one-to-one observation. Do not leave them by themselves. Provide immediate care through an emergency department, inpatient psychiatric unit, or

crisis resource. The most common way of committing suicide in hospitalized patients is by ligature. Prevention efforts should be primarily focused on mitigating risks associated with hanging, and additional suicide prevention efforts may be best directed toward reducing the risk of suicide immediately following discharge. Inpatient behavioral healthcare settings, psychiatric hospitals, and locked psychiatric inpatient units in general hospitals should conduct environmental risk assessments to be ligature-resistant. Other settings should identify environmental risks, identify patients at high risk of suicide, and protect those patients from the environmental risks.

∗ Check patients and visitors for items that could be used for suicide attempt or to harm others. Keep them away from anchor points for hanging, and material that can be used for self-injury, such as cords, bandages, sheets, restraint belts, plastic bags, elastic tubing, and oxygen tubing.

For patients at lower risk, make referrals to outpatient behavioral health and other providers for follow-up care within one week of initial assessment, rather than leaving it up to the patient to make the appointment.

For patients with suicidal ideation:

∗ Give the patient and family members the number to the Suicide & Crisis Lifeline, 988, as well as local crisis and peer support organizations. For all service members, their families, and veterans -- including members of the National Guard and reserve -- The Military Crisis Line, online chat, and text-messaging service is confidential and free 24 hours a day, 7 days a week, 365 days a year.

∗ Plan safety measures by identifying possible coping strategies with the patient, and provide resources for reducing risks. Suicide contracts are not recommended by experts. Review the plan at every interaction until the patient is no longer at risk.

∗ Restrict access to lethal means, such as firearms, prescription medications, and other items and discuss ways of removing or locking firearms and other weapons away during crisis. Restricting access is important! Many suicides occur with little planning during a short-term crisis, and both intent and means are required to attempt suicide.

The ZeroSuicide toolkit has many resources including screening instruments, and more information on preventing suicide. http://zerosuicide.sprc.org/toolkit

Another resource is The Joint Commission Suicide Prevention Portal.
https://www.jointcommission.org/topics/suicide_prevention_portal.aspx

Module 3: MDROs and Preventing Healthcare-associated Infections

Magnitude of the Problem of MDROs (Multidrug-Resistant Organisms)

The CDC defines multidrug-resistant organisms as microorganisms -- predominantly bacteria -- that are resistant to one or more classes of antimicrobial agents. The transmission and lifespan of resistant strains is determined by the prevalence of vulnerable patients, use of antibiotics beyond their evidence-based necessity, large numbers of colonized or infected patients, and implementation and adherence to control efforts. Patients with underlying medical conditions, severe disease, recent surgery, or indwelling medical devices are especially vulnerable to infection by MDROs.

The CDC report, Antibiotic Resistance Threats in the United States, 2019, lists 18 germs into one of three categories of urgent, serious, and concerning on their newly developed Watch List, a new resource listing threats with potential to spread or become a challenge in the United States due to antibiotic resistance. Three additional organisms are on the CDC's Watch List

Gram-negative bacterial infections, such as *Enterobacteriaceae*, *Pseudomonas aeruginosa*, and *Acinetobacter*, are especially concerning, as these are almost or entirely untreatable, because they are resistant to most or all currently available antimicrobial agents.

MDROs posing more serious threats, such as CRE, are referred to as "nightmare bacteria" because of the limited treatment options and difficulty in controlling spread.

Here are the 5 Urgent Threats:

* Carbapenem-resistant *Acinetobacter*
* *Candida auris*
* *Clostridioides difficile*
* Carbapenem-resistant *Enterobacterales*
* Drug-resistant *Neisseria gonorrhoeae*

These are the 11 MDROs considered Serious Threats:

* Drug-resistant *Campylobacter*
* Drug-resistant *Candida*
* ESBL-producing *Enterobacterales*
* Vancomycin-resistant *Enterococci* (VRE)

* Multidrug-resistant *Pseudomonas aeruginosa*
* Drug-resistant nontyphoidal *Salmonella*
* Drug-resistant *Salmonella* serotype Typhi
* Drug-resistant *Shigella*
* Methicillin-resistant *Staphylococcus aureus* (MRSA)
* Drug-resistant *Streptococcus pneumoniae*
* Drug-resistant Tuberculosis

These are the 3 organisms on the Watch List:

* Azole-resistant *Aspergillus fumigatus*
* Drug-resistant *Mycoplasma genitalium*
* Drug-resistant *Bordetella pertussis*

Clostridioides difficile, also known as **C. diff**, is typically diagnosed in people who have taken prolonged, frequent antibiotics. This germ causes the colon to become inflamed, resulting in life-threatening diarrhea. There were over 12,000 deaths from *C. diff* in 2017. It is very contagious, spreading from person-to-person on contaminated equipment, hands, bed linens, bed rails, and bathroom fixtures. Antibiotics can be used to treat *C. diff*.

Methicillin-resistant *Staphylococcus aureus* (**MRSA)** is a staph infection resistant to almost all antibiotic treatment. It is usually spread by person-to-person, but also on objects.

Vancomycin-resistant enterococci (VRE) affects people who have been on the antibiotic vancomycin for a long time, and those with weak immune systems or who have had a major surgical procedure, and people with medical devices, such as catheters. This germ lives in the intestinal tract and the female genital tract. It is spread by contact with contaminated surfaces or equipment, or through person-to-person spread, often because of contaminated hands, but it is not airborne.

Carbapenem-resistant *Enterobacterales* (CRE) mostly infect patients in healthcare settings, typically not a healthy person. The bacteria are often found in a person's gut, but strains can move to other parts of the body. The most common type of CRE is **ced*Klebsiella pneumoniae* carbapenemase**, or **KPC**. These infections can spread quickly, and have high death rates. You can get these germs from skin contact with an infected person, or contaminated medical equipment. CRE is a multidrug-resistant, gram-negative organism. Some bacteria in this family are resistant to nearly all antibiotics.

Pseudomonas aeruginosa causes many types of healthcare-associated infections, including pneumonia, bloodstream infections, urinary tract infections, and surgical site infections. It can spread through contaminated hands, equipment, or surfaces.

Healthcare settings amplify resistance threats. Vulnerable populations cared for in healthcare settings, such as the young, elderly, and sick, face greater risks for antibiotic resistance threats. Since patients travel throughout facilities for tests, treatments, and sometimes even meals, the deadly, resistant healthcare-associated germs spread throughout facilities and even into communities. Without appropriate infection and prevention control practices in place, germs spread across all settings. Hand hygiene is only one example of strategies employed to decrease germ spread within healthcare settings.

Prevention and Control of MDROs

Healthcare organizations face challenges in preventing the spread of MDROs. Some strategies employed by institutions continue to be innovative and effective in preventing MDRO infections, stopping the spread to other individuals, and saving lives. Challenges in healthcare include:

* Stopping the spread of infection from inpatient settings to non-hospital settings, such as rehabilitation, long-term care, and assisted living facilities.
* Controlling the spread of germs in healthcare environments on inanimate surfaces, such as counters, beds, intravenous pumps, etc.
* Inconsistency in the adoption of the CDC bundle of recommendations, or partial implementation of CDC recommendations, continues to challenge healthcare organizations.
* As seen with the Novel Coronavirus, challenges may present from outside of the United States and emerge with little or no warning. Facilities may be unprepared to face the emerging threats.

The Joint Commission recommends ALL staff should be trained on transmission routes of MDROs. Since MDROs frequently spread by contact and from touching infected items, such as bed rails, tray tables, medical equipment, and objects that staff are transporting by hand, hygiene is key to stopping their spread. Some preventative measures include:

* Environment of care measures, including decontamination of medical equipment; preventing device and procedure-related infections, such as from urinary catheters, central lines or surgery, by cleaning with evidence-based perineal and skin disinfectants, such as chlorhexidine, when tubes and lines are placed and during routine care represents a strategy that works in healthcare.

∗ Hand hygiene -- ensuring the proper and correct handwashing is done, especially before and after contact with patients with MDROs

∗ Contact precautions -- this includes, when possible, giving patients with MDROs their own rooms, own equipment, and own staff; wearing personal protective gear when with patients with MDROs; alerting a receiving facility about the transfer of these patients; being aware when a patient with an MDRO transfers to your facility; making sure labs immediately alert clinical and infection prevention staff when MDROs are identified; discontinuing devices like urinary catheters as soon as possible

∗ Use of antimicrobials. Antimicrobials are products to kill or slow the spread of these organisms. The CDC says *C. difficile* can survive on floors and around toilets in its spore form for up to six months. Extensive cleaning of these rooms can help prevent transmission of the organism. The recommended approach to environmental infection control with respect to *C. difficile* is meticulous cleaning, followed by disinfection, using hypochlorite-based germicides as appropriate. There are no EPA-registered surface disinfectants with label claims for inactivation of *C. difficile* spores available, so this recommendation is based on the best available evidence from the scientific literature.

The CDC uses four core actions to fight back against antibiotic resistance, a contributing factor to MDROs:

∗ Preventing infections and preventing the spread of resistance: Clean shared items and surfaces, and thoroughly disinfect rooms of infected patients. Environmental services are essential in preventing infection. Always use standard contact precautions. Alert the receiving facility when a patient with an MDRO transfers. When possible, dedicate rooms, staff, and equipment to patients with an MDRO. Remove temporary medical devices, such as catheters and ventilators from patients as soon as possible. Clean hands with soap and water or hand rubs before and after any patient contact, and after removing gloves. Around organisms not killed by alcohol hand rubs, such as *C. difficile*, wear gloves and then wash your hands with soap and water after removing them. Take advantage of available immunizations.

∗ Tracking: Report cases of antibiotic resistant infections. The CDC tracks the information and looks for risk factors. The National Strategy goal for reporting and tracking emphasizes the need to inform healthcare staff on how to use antibiogram data to optimize therapy and outcomes. Reporting requirements will increase, but so will the ready availability of critical data for practitioners. This information may identify specific ways to prevent the spreading of germs.

* Improving antibiotic prescribing and stewardship: Almost half of antibiotic use in people is unnecessary and inappropriate. Making a commitment to use antibiotics appropriately and safely to treat disease, to choose the right medicine, and to administer the antibiotics in the right way every time is called antibiotic stewardship. Interventions to improve antibiotic prescribing fall into three categories:

    Broad interventions – "time out" after 48 hours to reassess the continued need and choice of antibiotic, based on clinical data and diagnostic evidence, prior authorization policies that require expert reviews of antibiotic choice and use before administering, and quality control auditing and feedback.

    Pharmacy-driven interventions – consultation for therapy and dose adjustments, alerts for overlapping therapies, automatic stop orders for time-sensitive antibiotic prescriptions, and monitoring for antibiotic-related drug interactions.

    Infection and syndrome-specific interventions – protocols for diagnosis and treatment based on culture results, optimized dose and duration based on current guidelines, and to prevent unnecessary antibiotic prescriptions.

* Developing new drugs and diagnostic tests: Antibiotic resistance happens as part of a natural process in which bacteria change. The bacteria can be slowed but not stopped. So, new drugs and new tests will be needed to keep up with the development of these evolving germs.

Module 4: Preventing Patient Infections

CAUTIs

According to the Centers for Disease Control and Prevention, catheter-associated urinary tract infections (CAUTIs) are the most common and most dangerous preventable healthcare-associated infection (HAI). CAUTIs occur when pathogens enter the urinary tract through a urinary catheter, during insertion or while the catheter remains in the urinary tract.

CAUTIs can cause infections of the bladder, blood, epididymis, and prostrate. They can lead to septic arthritis, inflammation of the testicles in males, and meningitis. CAUTIs can cause severe discomfort, prolonged hospital stays, increased costs, and even death.

The CDC guidelines for prevention of CAUTIs and appropriate urinary catheter use include these core strategies:

*   Insert catheters only for appropriate indications
*   Leave catheters in place only as long as needed
*   Ensure that only properly trained persons insert and maintain catheters using aseptic technique and sterile equipment
*   Clean the skin around the area where the catheter will be inserted
*   Following aseptic insertion, maintain a closed drainage system
*   Maintain unobstructed urine flow
*   Practice hand hygiene and standard (or appropriate isolation) precautions.

Consider alternatives to indwelling urinary catheterization, such as condom catheters, penis pouches, incontinence products, and bladder scanners for assessing urine volume.

Use proper techniques during catheter maintenance:

*   Always use proper hand hygiene before and after touching a catheter
*   Avoid disconnecting the catheter and drain tube to prevent germs from getting into the catheter tube
*   Secure the catheter to the leg to prevent pulling on the catheter
*   Keep the bag lower than the bladder to prevent urine from going back into the bladder
*   Empty the bag often, and keep the drainage spout from touching anything.

Most CAUTIs can be treated with antibiotics, catheter removal, or changing of the catheter. Healthcare providers should determine the best treatment for each patient.

Magnitude of Problem of CLABSIs

A central venous catheter (CVC), or central line, is a catheter placed in a large vein in the neck, chest, or groin, to give medications or fluids, or to collect blood for tests. They can remain in place for weeks or months. Examples of CVCs are:

*   Nontunneled CVCs (subclavian, jugular)
*   Tunneled CVCs (Broviac, Hickman, Groshong)
*   Dialysis catheter (Quinton)
*   Peripherally inserted central catheters (PICCs)
*   Implanted ports (Permacath)

A central line-associated bloodstream infection (CLABSI) is a serious infection that occurs when bacteria or other germs enter the bloodstream by way of the central line.

Some risk factors for CLABSIs include:

∗ A prolonged stay in the hospital before a catheter is inserted
∗ Multiple CVCs and/or multiple lumens
∗ Emergency insertion
∗ Extended use of catheter on a patient
∗ Catheters inserted at the femoral site
∗ Poor care of CVCs
∗ Receiving total parenteral nutrition

Placement and Care of CVCs

The CDC recommends the following strategies for placement and care of CVCs.

For selection of central catheters and sites:

∗ Weigh the risks and benefits of placing a CVC at a recommended site to reduce infection risk against the risk for mechanical complications.
∗ Avoid the femoral vein in adult patients.
∗ Use a subclavian site rather than a jugular or femoral in adults for non-tunneled CVCs.
∗ Avoid the subclavian site for hemodialysis in patients with advanced kidney disease.
∗ Use a fistula or graft for dialysis in those with chronic renal failure for permanent access.
∗ If available, use ultrasound guidance to place CVCs.
∗ Use a minimum number of ports or lumens essential for management of the patient.
∗ Promptly remove any catheter that is no longer essential.
∗ When adherence to aseptic technique cannot be ensured (like emergency insertions) replace as soon as possible.

Recommendations for hygiene and aseptic technique for CVC placement are:

∗ Perform hand hygiene before and after palpating catheter insertion sites, as well as before and after inserting, replacing, accessing, repairing, or dressing a CVC.

* Do not palpate the site after application of antiseptic, unless aseptic technique is maintained.
* Maintain aseptic technique for insertion and care.
* Use new sterile gloves before handling a new CVC for guidewire exchanges.
* Use maximal sterile barrier precautions, including cap, mask, sterile gown, sterile gloves, and a sterile full-body drape during insertion.

Skin preparation recommendations are:

* Use a greater than 0.5% chlorhexidine prep with alcohol before insertion and during dressing changes. If a contraindication to chlorhexidine exists, iodine and iodophor or 70% alcohol can be used as alternatives.
* Antiseptics should be allowed to dry according to manufacturer's recommendations.

Recommendations for catheter site dressing regimens are:

* Use sterile gauze or a sterile, transparent, semipermeable dressing to cover the site.
* For patients who are sweating or if the site is oozing, use a gauze dressing until resolved.
* Replace catheter site dressing if it becomes damp, loosened, or visibly soiled.
* Do not use antibiotic ointment or creams on the site, except for dialysis catheters.
* Do not submerge the catheter or catheter site in water. Showering should be permitted with precautions, to reduce introducing organisms into the catheter.
* Replace gauze dressings used on short-term CVC sites every two days.
* Replace transparent dressings on short-term CVC at least every seven days, except in pediatric patients where the risk of dislodgement outweighs dressing change benefits.
* Replace transparent dressings on tunneled or implanted CVC sites no more than once per week, until the insertion site has healed (unless the dressing is soiled or loose).
* Ensure catheter care is compatible with catheter material.

* Regularly monitor catheter site visually when changing the dressing, or by palpation through an intact dressing, depending on the patient's clinical situation. For tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local bloodstream infection, remove the dressing for thorough examination.
* Encourage patients to report any change in the site or any new discomfort.

Replacement guidelines for CVCs, including PICCs and hemodialysis catheters are:

* Do not routinely replace CVCs, PICCs, hemodialysis catheters, or pulmonary artery catheters, to prevent catheter-related infections.
* Do not remove CVCs or PICCs on the basis of fever alone. Use clinical judgment for removal if infection is evidenced elsewhere, or if a non-infectious cause of fever is suspected.
* Do not routinely use guidewire exchanges for a non-tunneled catheter suspected of infection.
* Use a guidewire exchange to replace a malfunctioning non-tunneled catheter if no evidence of infection is present.
* Use new sterile gloves before handling a new CVC for guidewire exchanges.

For replacement of administration sets, the following are recommended:

* In patients not receiving blood, blood products, or fat emulsions, replace continuously used administration sets, including secondary sets and add-on devices, no more than at every 96th hour, but at least every seven days.
* Replace tubing used to administer blood, blood products, or fat emulsions within 24 hours of initiating the infusion.
* Replace tubing used to administer propofol infusions every 6 or 12 hours, when the vial is changed, per manufacturer's recommendations.

For needleless intravascular catheter systems, recommendations are:

* Change the needleless components at least as frequently as the administration set. There is no benefit to changing more frequently than every 72 hours.
* Change needleless connectors no more than every 72 hours or according to manufacturer's recommendations.
* Ensure all components are compatible to minimize leaks and breaks in the system.
* Minimize contamination risk by scrubbing the access port with an appropriate antiseptic and accessing the port only with sterile devices.

* Use a needleless system to access IV tubing.
* When needleless systems are used, a split septum valve may be preferred over some mechanical valves due to increased risk of infection with the mechanical valves.

Other recommendations are:

* Use a 2% chlorhexidine wash for daily skin cleansing.
* Use a sutureless securement device to reduce risk of infection.
* Do not administer systemic antimicrobial prophylaxis routinely before insertion or during use of an intravascular catheter.
* Do not routinely use anticoagulant therapy to reduce catheter-related infection risk in general patient populations.

SSIs

A surgical site infection, or SSI, is an infection that occurs after surgery in a part of the body where the surgery took place.

Several factors influence the risk of developing SSIs. Patient risk factors include:
* Age
* Nutritional status
* Diabetes
* Smoking
* Obesity
* Other infections
* Colonization
* Immunosuppression
* Length of preoperative stay

Operative risk factors are:
* Duration of surgical scrub
* Skin antisepsis
* Preoperative hair removal
* Preoperative skin preparation
* Duration of operation
* Antimicrobial prophylaxis
* Operation room ventilation

* Inadequate instrument sterilization
* Retention of foreign material
* Surgical drains
* Surgical technique, such as poor hemostasis, failure to obliterate dead space, and tissue trauma

Core Prevention Strategies based on high levels of scientific evidence include the following:

Parenteral Antimicrobial Prophylaxis:

* Administer preoperative antimicrobial agents only when indicated based on published clinical practice guidelines and timed such that a bactericidal concentration of the agents is established in the serum and tissues when the incision is made.
* Administer the appropriate parenteral prophylactic antimicrobial agents before skin incision in all cesarean section procedures.
* Follow your institution's policies and procedures regarding adjusting antimicrobial prophylaxis dose based on the patient's weight in obese and morbidly obese patients.
* Select the appropriate antibiotic based on surgical procedure, the most common pathogens causing SSIs for the procedure, and published recommendations.
* In clean and clean-contaminated procedures, do not administer additional prophylactic antimicrobial agent doses after the surgical incision is closed in the operating room, even in the presence of a drain.

Non-parenteral Antimicrobial Prophylaxis:

* Do not apply antimicrobial agents (i.e., ointments, solutions, or powders) to the surgical incision for the prevention of SSI.
* Application of autologous platelet rich plasma is not necessary for the prevention of SSI.
* Consider the use of triclosan-coated sutures for the prevention of SSI.
* When possible, identify and treat remote infections, and postpone the operation until resolved.
* Do not remove hair at the operative site unless it will interfere with the operation. If hair removal is necessary, use clippers or a depilatory agent -- not a razor.

Antiseptic Prophylaxis:

* Advise patients to shower or bathe (full body) with soap (antimicrobial or non-antimicrobial) or an antiseptic agent, on at least the night before the operative day.
* Perform intraoperative skin preparation with an alcohol-based antiseptic agent unless contraindicated.
* Application of a microbial sealant immediately after intraoperative skin preparation is not necessary for the prevention of SSI.
* The use of plastic adhesive drapes with or without antimicrobial properties is not necessary for the prevention of SSI.
* Consider intraoperative irrigation of deep or subcutaneous tissues with aqueous iodophor solution for the prevention of SSI. Intraperitoneal lavage with aqueous iodophor solution in contaminated or dirty abdominal procedures is not necessary.
* Maintain perioperative normothermia.
* For patients with normal pulmonary function undergoing general anesthesia with endotracheal intubation, administer increased FIO2 during surgery and after extubation in the immediate postoperative period. To optimize tissue oxygen delivery, maintain perioperative normothermia and adequate volume replacement.
* Keep OR doors closed during surgery, except as needed for passage of equipment, personnel, and the patient.
* Protect the primary wound closure with a sterile dressing for 24 to 48 hours post op.
* For colorectal surgeries, mechanically prepare the colon (enemas, cathartic agents), and consider administering non-absorbable oral antimicrobial agents in divided doses on the day before the operation.
* Implement perioperative glycemic control, and use blood glucose target levels less than 200 mg/dL in patients with and without diabetes.

Certain patient and operation characteristics influence the risk of SSIs. Health problems, such as allergies, diabetes, and obesity could affect a patient's surgery and treatment. Patients who smoke also get more SSIs. Patients who shave near their surgery site risk developing an infection.

Other SSI prevention measures include only the following:

* Patients should control blood glucose levels and stop smoking for at least 30 days prior to surgeries.

* Do not withhold transfusion of necessary blood products as a means to prevent SSIs.
* The patient's preoperative hospital stay should be kept as short as possible.
* Surgical teams should perform a preoperative surgical scrub based upon manufacturer's written instructions that are specific to the scrub solution to be used and according to healthcare facility policy and procedures. The surgical scrub should include fingertips, hands, forearms, and should end two inches above the elbows. Clean under each fingernail using a disposable nail cleaner under running water. After the surgical scrub, keep hands up and away from the body so water runs down from the tips of the fingers toward the elbows. Dry hands with a sterile towel and don proper personal protective equipment immediately.
* Wear a mask that covers the mouth and nose when an operation is about to begin, is underway, or if sterile instruments are exposed. Use a cap or hood to cover hair on the head and face. Use surgical gowns and drapes to protect against liquids. Change scrub suits that are visibly soiled or contaminated by blood or other potentially infectious material.
* Personnel should report signs of a contagious infectious illness promptly to avoid spreading infection.
* Surgical personnel who have draining skin lesions should be restricted from duty, until they've received adequate treatment and the infection is gone.
* When cleaning and disinfecting environmental surfaces, use an EPA-approved hospital disinfectant. Clean the areas before the next operation and when visibly dirty or contaminated with blood or other body fluids.
* Sterilize 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.
* Wash hands before and after dressing changes or any contact with the surgical site during postoperative care. Use sterile methods for all dressing changes. Use sterile dressings for primary closed wounds for 24 to 48 hours after surgery.
* Diagnose and treat infections quickly and effectively.
* Make sure the patient and family understand incision-site care and symptoms of SSI, which may include fever, redness around the surgical site, and drainage of cloudy fluid from the surgical wound.

Accrediting agencies require facilities to implement evidence-based practices for preventing surgical site infections. Know and follow your facility's SSI guidelines.

Safely Handling Sterile Supplies and Devices

All patients have the right to receive care in a safe setting, which includes the right to be protected from harm from expired or compromised supplies and devices. It is essential for employers to ensure proper employee knowledge and training in handling sterile supplies and devices in order to achieve best patient outcomes.

Storing Sterile Supplies and Devices

It is the responsibility of the organization to find the best location for storing sterile supplies and devices. There are several factors to consider when choosing the best location for storage. Employees should have ready access to all supplies and devices necessary to fulfill their job functions. Supplies should also be optimally stocked at all times. All supplies should be checked regularly to ensure they have not passed their expiration date, and all expired items should be discarded immediately. The storage area should always be maintained in a manner to ensure that all sterile supplies and devices are stored safely. All items must remain free from contamination or the risk of contamination, and in good condition where packaging will not be damaged.

Hierarchical System for Maintaining Packaged Sterile Supplies and Devices

Humidity and temperature are both important factors to consider regarding safely handling packaged sterile items. Taking the following hierarchical approach to the storage of temperature- and humidity-sensitive products can help to ensure safety. At the first level, the organization must be compliant with building code requirements. This means that, at minimum, deemed organizations must fulfill Centers for Medicare and Medicaid Services criteria for new facilities and existing facilities that have been renovated. If a local authority has published more restrictive building codes, the organization must meet the most restrictive requirement.

Standards set forth by ASHRAE, The American Society of Heating Refrigerating and Air-Conditioning Engineers, requires that if a room has been designated as a Central Medical and Surgical Supply Area, there are criteria that must be met. There must be a positive air pressure relationship to adjacent areas. There must be a minimum outdoor air exchange of two per hour. There must be a minimum total air exchange of four per hour. There must be a maximum relative humidity of 60 percent. And there must be a temperature range of 72 to 78 degrees Fahrenheit or 22 to 26 degrees Celsius.

At the second level of hierarchy, the organization meets Conditions of Participation or Conditions for Coverage according to CMS. Per CMS, sterile packages must be stored so that sterility is not compromised, and all items must be inspected before use. At the third level of hierarchy, the organization must follow the manufacturer's instructions for storage and use as indicated on the label, including humidity and temperature requirements.

The fourth level of hierarchy involves evidence-based guidelines and national standards. Almost all evidence-based guidelines agree that sterile supply areas must be well-ventilated and maintained to protect items from damage to packaging, contamination, moisture, dust, and temperature and humidity extremes. Such guidelines apply to Medical Surgical Supply Areas as well as storage rooms with mixed clean and sterile supplies.

Reading Device Labels

Knowing how to read and understand item labels is essential for safely handing sterile packaged items and devices. Employers must ensure that all employees are adequately trained to correctly read and interpret device labels.

Device manufacturers use several criteria when developing their labels. The label should reflect the intended use of the product; for example, a single-patient vs. multiple-patient item. It should advise the user to thoroughly clean the device, as well as the correct microbiocidal process for the device based on intended use. And it should have technically feasible, comprehensive, and understandable instructions.

In 2016, the FDA published a final rule, revising its medical device labeling regulation. The revised FDA regulation now allows for the optional inclusion of "stand-alone" symbols in labeling WITHOUT explanatory text which can help the end user to easily understand key information about an item at a glance. Key stand-alone symbols that all employees should recognize include the umbrella, indicating that a device must be protected from moisture; the hourglass, indicating the expiration date; and the two with the prohibition sign over it, indicating that the device is intended for one single use.

Employee Training

The most important way to ensure safe handling of sterile packaged supplies and devices is employee training. Employees should be trained to follow the hierarchical approach to infection prevention for sterile items, and to pay appropriate attention to expiration dates and torn or damaged packaging. They must be adequately trained to read and interpret device labels, including stand-alone symbols, which can be done utilizing graphic methods, such as posters. Employees should also be educated about how and where to report concerns regarding sterile devices and supplies, and where to find information specific to instructions for use if they have questions.

Module 5: Ethical Aspects of Care

Ethics

Ethics involves recognizing right from wrong. Healthcare organizations must always have and follow policies of ethical behavior in care, treatment, and services. They must prevent conflicts of interest and make decisions based on patients' needs.

Each healthcare worker is responsible for the result of his or her actions or inactions. Failing to speak out when we see unethical behavior is a violation of ethical duty. "Following orders" is never an excuse for unethical acts.

Four basic principles in medical ethics should be followed. First, healthcare workers in institutions should protect all patients' right to maintain control over their own care. This is called autonomy. Patients must be made aware of their rights and have those rights protected.

Patients must receive truthful information about their diagnosis, prognosis, or therapy, and be allowed to make decisions about their care.

Second, patients must be treated with kindness. Healthcare workers should put a patient's best interest first. This is beneficence, or the act of doing good.

The third principle is non-maleficence. It means, to do no harm to patients.

The last principle is justice. Healthcare workers should make sound decisions based on clear, evidence-based criteria.

Organizations must consistently call for and follow policies of ethical behavior during care, treatment, services, and in business. They must prevent conflicts of interest and make decisions based on identified needs of patients. They must make provisions for ongoing care if services are denied to a patient, and they must respect patients' rights.

Religion and Spirituality

You have an ethical responsibility to respect the patient's religious or spiritual beliefs and practices. Failing to provide appropriate spiritual referrals can constitute a form of patient neglect, and can have an impact on the patient's care and recovery. A common example would involve religious dietary practices -- failing to screen for these could have a negative impact on a patient's experience and health. Always screen for a patient's religious and spiritual beliefs.

Some screening questions include "How important are your spiritual or religious beliefs to you?", "Do your beliefs influence how you care for yourself?" and "Do you want to talk to

someone about religious matters?" If they say yes, contact the chaplain or a spiritual leader of their choice.

Should you pray with a patient? Most guidelines say don't pray with a patient, unless you have his or her request and a clergy member isn't available. A safer option, if a patient wishes to pray, is to ask them to lead the prayer.

Some patients and their family members may have beliefs that include rituals, music, prayer, or sacred narratives unfamiliar to you. It's your job to accommodate these religious and spiritual beliefs and practices. Implicit in that statement is that the requested practice does not cause harm and is not excluded by law and regulation.

End of Life: Compassionate Care, Organ Donation

The goal of care at the end of life is to prevent or ease suffering as much as possible while respecting the dying person's wishes. Respect the patient and family's cultural beliefs and needs 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 patients.

There are four areas of comfort needed: physical comfort, mental and emotional comfort, spiritual comfort, and practical comfort.

A dying person can be uncomfortable because of pain, breathing problems, skin irritation, digestive problems, temperature sensitivity, or fatigue.

Patients may not be able to share feelings or thoughts in a rational manner during periods of pain and may not be able to tell you they are in pain. Watch for signs like changes in facial expression and unrest. Stay ahead of pain; prevent it instead of waiting to relieve it. Administer medication on time.

Reassure patients and their families that the focus of pain treatment is to relieve suffering. They don't need to be concerned about drug dependency or addiction at this time. Encourage patients and their families to speak up if pain is not being controlled. It may be possible to increase or change medications.

Shortness of breath is common at the end of life. Try raising the bed, opening a window, using a vaporizer, or having a fan circulate air in the room. A doctor may also prescribe oxygen.

Reassure families the noisy breathing of people near death, caused by fluids collecting in the throat or by the throat muscles relaxing, is not usually upsetting to the patient.

Skin problems can be very uncomfortable. Skin irritations, and dryness of the lips, mouth, and eyes is very common at the end of life. Excessive dryness can make the skin more fragile. Alcohol-free lotion can soften and protect the skin and prevent future discomfort. Oral swabs can help relieve mouth and lip dryness. Use a damp cloth to soothe dry eyes. Watch for irritation or rash on the skin. It's important to turn or reposition a patient every couple of hours to prevent pressure injuries. Use foam pads on bony areas, such as heels, ankles, and elbows. Take extra care to make sure skin is kept clean.

Digestive problems are common with end-of-life patients. Medication can help a patient experiencing nausea, constipation, vomiting, or loss of appetite, so encourage patients and their families to tell their doctor about these symptoms.

Offer patients who want to eat but have lost their appetite, food in frequent, small amounts. Never force a patient to eat. When possible, support a patient's request to have favorite foods or meals brought from home. Arrange to have comfort food available at the patient's request and when the patient has an appetite and wants to eat. Sometimes a patient at the end of life makes a conscious decision to stop eating. You may need to help the family understand and respect this decision.

Dying patients may not be able to say they are too warm or too cold. It's important to watch for this temperature sensitivity. Signs include shivering or pushing blankets away. You can remove blankets, offer extra blankets, try a fan, a cool cloth on a patient's head, or adjust the room temperature.

People nearing the end of life often feel tired and have little or no energy. Keep activities simple. Allow rest between care, treatments, and procedures.

Cultural differences often play a role in the interaction between family members, friends, and patients during this time. Respect the patient and family's cultural beliefs and needs when providing comfort.

End-of-life care also includes helping a dying patient manage mental and emotional needs. Be sensitive to their fears and concerns. Depression and anxiety are common. Counseling and medication may help. Encourage family to stay close if the patient wishes it. Explain that pain and fear can impact their loved one's mood and behavior. Most people are not familiar with what to expect at the end-of-life process, but you can help the family understand and ease their fears.

People nearing the end of life often need spiritual comfort, and find comfort in their faith. Respect all spiritual needs during this time. If requested, a visit from a spiritual leader can comfort patients and their families.

Encourage visitors to talk to, not about, the patient and to identify themselves when they enter the room.

Adjust the physical environment, as much as possible, to a patient's wishes. When possible, use some of the ways the patient reduced stress before, such as music and soft lighting.

Family and friends are often dealing with grief and much more. They may have extra chores and duties like taking care of the patient's home or business. You or your facility may be able to help. It may be possible to provide a private room where the family can rest during a bedside vigil. Asking about their health and being understanding and supportive can make a big difference to loved ones and family at this difficult time.

Families or patients may need to make a decision about organ donation. Organ donation should be considered part of the overall care process. Healthcare facilities are responsible for recognizing and evaluating potential donors, and are held accountable by federal regulation for setting the process in motion through timely referrals of potential donors. This includes using clinical indicators to identify potential donors, a system which tracks the timeliness of referrals, a corrective action plan when referrals are made too late, and working with organ procurement organizations to ensure that staff is educated on the process.

A facility will notify its local organ procurement organization, or O.P.O., of every potentially eligible donor. The following steps should take place when a patient is deemed eligible.

* At the appropriate time, an O.P.O. requestor will work with the hospital staff to plan a discussion about donation with the family.
* Together, the hospital and the O.P.O. will determine the best way, time, and place to discuss the donation opportunity with the family.
* A determination will be made of who should be present during the conversation.
* Hospitals should ensure the O.P.O. requestor is present and part of the team when the donation conversation occurs -- they have been specially trained to talk to a possible donor or family about donation.

Accrediting bodies issue guidelines to ensure that standards for the handling of donor organ tissues meet minimal requirements. Be knowledgeable about your facility's policies and your accrediting organization's standards.

It is your responsibility to provide potential donors or their families with support, compassion, and respect for any decision they make, regardless of your own personal donation beliefs.

Whistleblower Protections

A whistleblower is a person who learns of unethical, illegal, or unsafe work practices in their organization and reports them to the proper authorities. Whistleblowers have rights. They are protected by several federal and state laws from retaliation. Even if a whistleblower's claims turn out to be false, the person is protected against retaliation as long as the report of wrongdoing was made in good faith. Illegal retaliation actions may include: blacklisting, demoting, denying overtime or promotion, disciplining, denying benefits, failing to hire or rehire, firing or laying off, intimidation, making threats, reassignment to a less desirable job, reducing pay or hours, and suspension.

The Occupational Safety and Health Act protects workers who complain about unsafe or unhealthy working conditions. If your employer retaliates against you as a whistleblower, contact the Occupational Safety and Health Administration (OSHA).

In addition to OSHA, the following agencies provide anti-retaliation protections in various capacities:

The U.S. Equal Employment Opportunity Commission (EEOC) enforces laws that prohibit discrimination against employees because of race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability, or genetic information, and retaliation against employees for opposing such discrimination. To file a complaint, visit eeoc.gov or call 1-800-669-4000.

The Wage and Hour Division of the U.S. Department of Labor enforces Federal laws on the minimum wage, overtime pay, wage recordkeeping, child labor requirements of the Fair Labor Standards Act, the Family and Medical Leave Act, migrant and seasonal worker protections, worker protections in certain temporary guest worker programs, and the prevailing wages for government-funded service and construction contracts. To file a complaint, visit www.dol.gov/whd or call 1-866-4-USWAGE (1-866-487-9243).

The National Labor Relations Board (NLRB) protects the rights of most private-sector employees to join together, with or without a union, to improve their wages and working conditions. To file a charge, visit www.nlrb.gov or call 1 866-667-NLRB (6572).

Whistleblowers may be eligible for a reward if they report violations of the Stark Law. For more information, see CMS's Stark Law website.

You can report wrongdoing to a supervisor, facility management, and state or federal agencies. You can keep your identity confidential with most agencies.

You must file your complaint within legal time limits – the limit is 30 days for the Occupational Safety and Health Act.

Cultural and Age-Related Competencies

<u>Cultural</u>

Our country is growing more diverse every generation. Understanding and being comfortable with those whose racial, ethnic, socioeconomic, and cultural backgrounds are different from yours can add satisfaction and pleasure to your job, as well as help you do that job better. Be aware of, and sensitive to, cultural diversity, life situations, and other factors that shape a person's identity.

Culture refers to unified patterns of behavior including language, thoughts, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Culture can affect the following:

* How a patient describes symptoms and defines illness
* Perceived causes of illness
* Understanding of disease process, treatment expectations, and decision making
* Patient attitudes and interactions with healthcare workers
* Selection of treatment
* Decision to seek treatment

Culturally-sensitive care respects diversity and recognizes that cultural factors, such as language, communication styles, beliefs, attitudes, and behaviors can affect health care. Cultural sensitivity involves racial and ethnic groups, but also populations, such as the elderly, people with disabilities, and persons identifying as lesbian, gay, bisexual, transgender, queer or questioning, and/or intersex or LGBTQI.

The Office of Minority Health at the U.S. Department of Health and Human Services addresses the needs of helping health equity, improving quality, and ending healthcare differences. This is done in part through the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. These standards cover the need for education and training about respectful quality care and services, diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Accrediting agencies require staff be trained on sensitivity to cultural diversity based on their job duties. Those who provide interpreting or translation services must have defined qualifications and skills.

There are two common approaches to educate on cultural differences -- programs that are either group specific or those that apply generic or universal models. There are some concerns about cultural sensitivity programs that use a group-specific approach to teach about the attitudes, values, and beliefs of a specific cultural group. They fear this approach can lead to stereotyping and oversimplifying the diversity within a specific group. The universal approach on cultural sensitivity training uses reflective awareness, empathy, and active listening techniques. This method examines mental structures contributing to cultural insensitivity or blindness, such as implicit biases or stereotypes.

Techniques that can improve your acceptance of cultural differences include:

* Awareness of your own cultural values
* Awareness of cultural differences
* Valuing diversity
* Managing the dynamics of difference
* Developing cultural knowledge
* The ability to adapt to the cultural context of a case

Here are some ways to improve cultural sensitivity:

* Identify and address communication needs. This should be done throughout the patient process from admissions, treatment, and transfer, through discharge.
* Identify the patient's preferred language for discussing healthcare.
* Use an interpreter, if needed. The Joint Commission found that relying on untrained interpreters is more likely to result in misinterpretation, lower quality of care, or could even lead to an adverse event. Untrained individuals, such as family members, friends, other patients, or untrained bilingual staff should not be used to provide language access services during medical interviews. It may be okay to use untrained interpreters for social conversations, or to convey simple messages with patients, provided the messages or the use of the untrained person does not violate confidential patient rights.
* Determine whether the patient needs help completing medical forms.
* Identify if the patient uses any assistive devices.
* Ask the patient if there are any additional needs that may affect his or her care.
* Identify patient cultural, religious, or spiritual beliefs or practices that influence care.
* Identify patient dietary needs or restrictions that may affect care. Some patients may not eat certain foods based on religious or spiritual beliefs or customs.
* Accommodate patient cultural, religious, or spiritual beliefs and practices.

<u>Age-Related</u>

A patient's healthcare should be adapted to their needs, and some of these needs are impacted by age. Recognizing qualities that age groups often share can sometimes help you improve relationships with patients and their families, and meet their specific needs. It will help the patient feel more comfortable and more engaged and active in their own care.

Ages are usually grouped into neonate, infant, toddler, preschool, school age, adolescent, young adult, adult to middle age, and later adult to geriatric.

Neonates are infants from birth to 28 days. They are still developing their very basic body functions, such as digestion, temperature regulation, and sleeping. Communication is through touch, voice volume, and voice. Be familiar with issues, such as jaundice, nutrition, cord care, fever, and especially sleeping positions that are associated with SIDS.

The next age group is infants and toddlers between the ages of 28 days and three years old. There are big differences developmentally, physically, and emotionally in this age group. Focus on keeping immunizations and check-ups on schedule. Providing proper nutrition, oral care, and routine screenings are standard issues.

Children from four to six years old have some similarities, but a lot of differences as well. For most children, growth slows a bit at this stage, but learning and motor skills increase. The U.S. Preventive Services Task Force recommends vision screenings for all children between ages three and five. Screenings may help find conditions, such as lazy eye, which can be treated effectively if caught early. This group should also keep up with immunizations and check-ups.

Children ages 7 to 12 will be close to hitting another growth spurt with adolescence. Some children enter into an adolescent growth spurt a little earlier at age 10 or 11. Issues of concern in this age group include nutrition, physical activity, and peer pressure.

During adolescence, growth will speed up. This is also a time of sexual maturing with issues of sexuality and substance abuse. This age group also needs assistance with management and assessment of nutrition, physical activity, and peer pressure. Children in this age group also face emotional changes as personal identity development starts.

The next age group is young adults, ages 21 to 39. Encourage this age group to think about healthy living choices, such as nutrition, exercise, annual check-ups, and stress management. Educate them on the long-term consequences of bad lifestyle decisions at this age.

The middle adult group is between the ages of 40 and 64. Discuss and encourage screening for health issues that commonly begin to occur at this stage of life. Be supportive and open about issues that may arise apart from physical health that may affect mental or emotional

health and can also affect physical health down the road. Among conditions that begin to appear at this age are cardiovascular conditions, osteoarthritis, non-specific chest pain, and back problems. These can often result in hospitalization.

As people age, they tend to use more hospital services and prescription medicines. People 65 and older often experience a decline in physical and mental abilities, though not all do. Nutritional, emotional, health, and safety needs begin to change at this stage. It's important to allow older adults time to discuss their medical concerns, and to treat them with respect. Try to avoid rapid fire questions and confusing medical jargon. Some of the most frequent principal diagnoses for inpatient hospital stays include congestive heart failure, pneumonia, osteoarthritis, and abnormal cardiac rhythms. Clinical preventative services can prevent disease or detect disease early when treatment is more effective. These services include screenings for chronic conditions, immunizations for diseases such as influenza and pneumonia, and counseling about personal health behaviors.

Awareness of age-related needs helps when caring for patients. While age groups have their own general characteristics, remember, each patient is an individual. Don't stereotype because of age, but do be aware of issues that might be unique to, and heavily impact people at different ages.