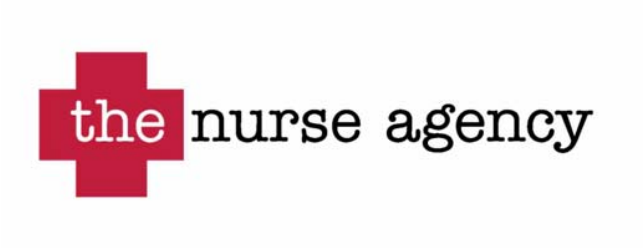

The Nurse Agency Orientation

This packet includes important material about:

- Emergency Preparedness for the Healthcare Provider (OSHA requirements)
- Age Appropriate Care Throughout the Life Span
- The Health Insurance Portability and Accountability Act of 1996
- Pain Management Policy
- Drug Free Workplace Policy
- Sexual Harassment Policy
- Cultural Diversity and Sensitivity Policy
- JCAHO National Patient Safety Goals
- The Rights of Patients and Ethical Aspects of Care
- Patient Restraint Policy

OSHA: Emergency Preparedness for the Healthcare Worker

Every healthcare facility expects its staff to be prepared in the event of an emergency. The following information is designed to prepare The Nurse Agency employees according to OSHA guidelines for emergency situations, especially fire, hazardous chemicals and infection control.

Fire Safety

The prepared nurse should always check his/her assigned area before his/her shift begins. Make a mental note of the following: locations and type of **fire extinguishers**; locations and accessibility of **fire exits** and **fire doors**; and, locations and operating procedures of fire **alarms**.

If you hear a fire alarm, **report to your assigned area**. If patients are concerned, **calmly reassure** them that a plan is in operation. **Close doors and windows**. **Account for all patients**. Instruct visitors per the fire safety plan. **Authorized personnel** should **shut off equipment** per the safety plan. All personnel should **prepare for evacuation**.

If you see fire or smoke in a patient are, get help then:

R - - - **Rescue** anyone in immediate danger.
A - - - Activate the fire **alarm**.
C - - - **Contain** the fire by closing doors and windows.
E - - -**Extinguish** the fire if you are able.

Fire Extinguishers

There are three (3) **classes of fire**:

A - - - Ordinary combustibles: wood, cloth, paper, plastic
B - - - Flammable liquids
C - - - Live electrical

Extinguishers marked "A" extinguish with ordinary water, by cooling and smothering the fire. Type "A" extinguishers should NOT be used on flammable liquids or live electrical fires.

"BC" extinguishers can be either dry chemical or carbon dioxide extinguishers. These are for flammable liquid or electrical fires only. They should NOT be used for ordinary combustibles.

An "ABC" Multipurpose type of extinguisher is the most common found in the healthcare setting. It extinguishes using dry chemicals by smothering the fire and forming a fire retardant coating.

To operate a fire extinguisher, you should always read the directions first. Next, think "PASS."

P - - - Pull the locking pin.
A - - - Aim nozzle at the base of the fire.
S - - - Squeeze the handle.
S - - - Sweep from side to side.

Hazardous Chemicals

It is common sense to know the hazards of the chemicals with which you may come into contact. Though you may not see, smell or feel the presence of hazardous chemicals, you should be aware of basic hazards.

Flammable Chemicals

These chemicals give off flammable vapors even at room temperature. When vapors are heavier than air, they concentrate in low places. Then, even a spark or small flame can touch off a disastrous fire.

To control these flammable vapors:
1. Keep in a tightly closed, approved container.
2. Use only in ventilated areas, or outdoors.
3. Keep only small amounts on hand.
4. Clean up or report spills or leaks immediately.
5. Use approved waste disposal containers.
6. Wear required protection.
7. Keep in separate storage areas.
8. Control ignition sources; keep away from heat, sparks or flame.

Reactive Chemicals

Reactive chemicals are unstable! A violent chemical change can be set off by certain conditions, including heat, motion, water, decomposition, or mixing.

Toxic Chemicals

Toxic chemicals can poison internal organs, the nervous system or brain.

Corrosive Chemicals

Corrosive chemicals can destroy, irritate, or sensitize living cells. Exposure may occur immediately or over time. Entry may be through the eyes, nose, mouth, or contact with or through the skin.

Protect yourself by:
1. Equipment and controls
2. Safe work procedures
3. Personal protection equipment

Employers and employees share the responsibility of maintaining a safe work environment.

A - - - - B - - - - C - - - - D

A. Written Program
The written program shows how the "Haz Com" Standard works, and employee's right to know. It also includes an inventory of chemicals.

B. Material Safety Data Sheets
Material safety data sheets include:
1. Chemical identification: product name, manufacturer, chemical formula, severity
2. Hazardous ingredients: hazards, exposure limits
3. Physical Data: how it looks and acts
4. Fire – Explosion: temperature/concentration for ignition, fire fighting facts
5. Health Hazards: effects, symptoms, first aid
6. Reactive Data: causes for being unstable
7. Spill – Leak: how to clean up; disposal
8. Special Protection: personal protection equipment
9. Precautions: any other details

C. Labels

The labels on hazardous chemicals give you the "quick facts".

1. Manufacturer
2. Name of chemical
3. A 'signal word", such as "DANGER" to tell you how serious
4. Type of hazard
5. Precautions to take for safe handling
6. May also include basics for first aid, spills, fire, storage, disposal,

ALWAYS REPLACE A MISSING OR DAMAGED LABEL!

D. Training

To begin, employees should be informed of their right to know and have access to the written "Haz Com" program.

Employees should be informed:

1. Of chemical: health and physical hazards
2. How to detect chemical presence: appearance, odor, monitor, alarm
3. How to use labels and material safety data sheets
4. How to protect: by using controls and safety equipment; by using safe work procedures; by wearing personal protection equipment for each type of exposure
5. Emergency procedures: first aid if exposed; clean up if spills; waste disposal system

Infection Control

Infection control breaks the chain of transmission between the germ reservoir and the susceptible host. These procedures, known as "Universal Precautions," isolate body substances and other sources of infection.

Sources of infection

Sources of infection may be direct, indirect, droplets, contaminated food or water, air ventilation, or insects or parasites.

Depending on the type of germ, entry may be through the eyes, nose, mouth, non-intact skin, or other means.

Infection control procedures require some judgment. Types of germs and exposure can differ. Conditions may change your exposure.

Universal Precautions should be practiced with all patients!

Universal precautions include:

1. Handwashing: before and after each patient contact, after exposure, after glove removal, before and after each shift, before eating, after toilet, after blowing nose. Use proper washing techniques.
2. Needles: Dispose of needles and sharps into puncture resistant containers immediately after use. Prevent needle sticks; do not bend, remove or recap.
3. Germ Barriers: Wear gloves when likely to touch body substances, mucous membranes, or other potential contaminant.

Wear protective eyewear and mask if a procedure releases droplets into the air. Wear a gown or apron as needed if splashing or soiling of clothing is a risk.

4. Waste Disposal: Properly handle, bag and label infectious material before transport. Precautions vary, so follow local, state and federal policies.
5. Decontamination: Decontamination includes disinfecting and sterilizing. Clean up infectious spills immediately, wearing gloves; or report spills per policy.
6. Isolation: Be aware of isolation procedures for individual healthcare settings.

7. Ventilation: Negative air pressure exhausts airborne germs safely outside.
8. Immunization: Be aware of immunization requirements for healthcare settings. The Nurse Agency requires documentation for immunity to Rubella, Rubeola, Varicella, and Hepatitis B.
9. Education: Employees should be informed regarding infection control procedures for routine and high-risk conditions.

Tuberculosis

Tuberculosis, or "TB," is an infectious disease spread person to person through the air and into the lungs. Symptoms may include weakness, fatigue, fever, weight loss, night sweats, cough, bloody sputum and chest pain. It is a serious disease that can be fatal. Exposure to TB can occur when people are sharing the same breathing space as in crowded areas, families, group or homeless shelters, or healthcare settings. In the healthcare setting TB exposures may occur in "isolation" areas, during procedures that cause coughing, during transport of a known or suspected TB case, or in cases that are undiagnosed such as in the emergency department.
If a patient is diagnosed with TB, he/she should be placed on isolation to limit exposure, and given the prescribed treatment. If you are exposed to TB, you must have a PPD, or "TB Test" to determine if you have acquired the TB infection. If you have acquired the infection, a chest x-ray will determine if you have the disease. Medication can be provided to treat the TB infection, and a normal work schedule can be maintained if you are asymptomatic.

REMEMBER: TB IS PREVENTED BY INFECTION CONTROL AND TREATED WITH MEDICATION!

Bloodborne Infections

Hepatitis-B Virus (HBV) and Human Immunodeficiency Virus (HIV) are two blood borne infections for which healthcare workers are at risk. It is important to know a few facts about these diseases to adequately protect yourself.

Hepatitis-B Virus

Hepatitis-B is a major occupational risk for healthcare workers. Your infection potential depends on exposure to contaminated blood and body fluids. Hepatitis-B is **not** transmitted by casual contact such as touching, shaking hands, or eating food prepared by infected individuals. It is **not** transmitted from drinking fountains, telephones or other surfaces. Hepatitis-B may have no symptoms, or may have flu-like symptoms: nausea, vomiting, fatigue, fever, muscle aches, diarrhea, jaundice. Hepatitis-B may develop cirrhosis or liver cancer.

It is easy for healthcare workers to protect themselves from Hepatitis-B with an immunization. The Hepatitis-B immunization is a three-part IM injection that is not required for healthcare workers, but is strongly recommended.

Human Immunodeficiency Virus

HIV weakens the body's defense against infections which can result in the life-threatening illness AIDS. HIV is **NOT** transmitted through casual contact. The healthcare worker is at risk because HIV is transmitted by direct contact with infected blood or body fluids.
Symptoms of AIDS may include swollen lymph glands, night sweats, fever, weight loss, diarrhea, fatigue, or white spots in the mouth. An individual with a weakened immune system is prone to infections such as Pneumocystis corinii pneumonia and Kaposi sarcoma skin cancer. Currently, there is no immunization that can prevent AIDS. The only option for controlling HIV is prevention.

The best prevention for both HIV and Hepatitis-B is "Universal Precautions."

The following is a review of "Universal Precautions."

Personal Protection Equipment

Personal protection equipment prevents exposure through the eyes, nose, mouth and non-intact skin.

1. Gloves: Used when you are likely to touch body fluids.
   Change after each patient contact.
   Use disposable exam/surgical gloves.
   Gloves are required for phlebotomy.
   Housekeeping gloves may be reused if intact and properly cleaned.

2. Protective Eyewear and Mask: Used if likely to have blood or body fluid droplets in the air.

3. Gown: Used if body fluids are likely to splash or soil clothes.

4. Resuscitation equipment: Used to avoid mouth-to-mouth contact.

THE PERSONAL PROTECTION EQUIPMENT USED WILL REQUIRE SOME JUDGMENT FOR EXPOSURE RISK FOR EACH CLINICAL SITUATION.

Infectious Waste and Linen

Before transport, bag and label for disposal or decontamination per the hospital's policy and procedure. This should include the infection warning: "Biohazard."

Instrument Care

Proper instrument care prevents infection through cuts, punctures and non-intact skin.

1. DO NOT recap, bend, break or remove needles.
2. USE CAUTION when using, cleaning or disposing of sharps or instruments.
3. Place all disposable needle-syringe units and sharps into APPROVED PUNCTURE-RESISTANT CONTAINERS immediately after use.
4. If a bloodborne cut or puncture incident occurs, REPORT FOR TREATMENT immediately and comply with follow-up procedures.

Handwashing

Handwashing must be: 1. Immediate and thorough
2. Before and after each patient contact
3. After exposure to contamination

Wash other skin surfaces if exposed to infected body fluids.

Disinfecting

Clean up and disinfect spills immediately, per hospital policy.

Age Appropriate Care Through the Life Span

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires that any healthcare providers who have patient contact be competent in age appropriate characteristics and needs. JCAHO requires that all individuals with patient contact receive education and training related to the characteristics and needs of the age groups with which they come into contact. Although the following information may include age groups with for which you do not provide care, it is important to understand an overview of the needs across the life span.

AGE GROUPS: A DEFINITION

Although it is not always clear when one age group ends and another begins, the following is a generalized definition of the age groups.

Infant	Birth to one year
Toddler	One to three years
Preschool	Three to five years
School Age	Five to twelve years
Adolescent	Twelve to eighteen years
Young Adult	Eighteen to forty-four years
Middle Age Adult	Forty five to sixty five years
Old Adult	Over sixty five

Although all characteristics of an age group do not apply to all individuals, they are meant to be guidelines that should be considered when providing care to patients of differing ages.

DEVELOPMENTAL NEEDS

The developmental psychologist Erik Erikson probably most notably writes about developmental needs across the life span. He has identified eight stages with corresponding tasks that must be met and resolved in order for individuals to progress through the life span in a fulfilling manner.

Health care providers must consider the developmental challenges facing their patients and adjust their care accordingly.

ERIKSON'S STAGES

Age Group	Task	Lack of Resolution
Infant	Development of trust	Mistrust; failure to thrive
Toddler	Autonomy Self-control & will power	Shame and doubt Low frustration tolerance
Preschool	Initiative; confidence Has purpose and direction	Guilt Fear of punishment
School age	Industry; self-confidence Competency	Inferiority Fears about meeting expectations

Adolescent	Identity formation Devotion and fidelity Sense of self	Role confusion Poor self-concept
Young adult	Intimacy Affiliation and love	Isolation Avoidance of relationships
Middle age	Generativity; production Concern about others	Stagnation; self absorption Lack of concern about others
Old adult	Ego integrity; wisdom Views life with satisfaction	Despair Life is meaningless

COGNITIVE DEVELOPMENT THROUGH THE LIFE SPAN

Developmental psychologist Jean Piaget is considered to be the primary source on how humans develop cognitively from birth through age twelve. He developed his theories after hundreds of hours of direct observation of children of all ages. Piaget defined three major stages of cognitive development: pre-operations, concrete operations and formal operations. He theorizes that cognitive development is nearly complete by age fifteen when the child is capable of abstract thought.

AGE	STAGE	FEATURES
Up to 2 years	Sensorimotor thought	6 substages Physical manipulation of objects
2 to 7 years	Preoperational symbolic functioning	Language development
7 to 11 years	Concrete operations	Logical reasoning Can solve concrete problems
11 to 15 years	Formal operations	Fully developed Complex, logical abstract thought. Manipulation of abstract concepts

SAFETY THROUGH THE LIFE SPAN

Safety is a basic human need that is of paramount importance to healthcare providers for all age groups of patients. During all phases of childhood and the later years safety needs are the greatest. Some childhood characteristics that make safety a primary concern are lack of impulse control, lack of good judgment, intense curiosity, and the need to develop autonomy. Older adults may suffer from cognitive impairment, sensory loss and the degenerative changes of aging. These make safety a primary concern for healthcare providers caring for an aging population.

PHARMACOLOGY THROUGH THE LIFE SPAN

Pharmacology dosage and route considerations vary according to the characteristics of virtually all age groups. For pre-adolescent children dosage is determined according to the weight of the child in kilograms. By the time a child reaches adolescence most adult dosages are usually acceptable. As with all medications, the nurse should knowledgeable about any medication

he/she is administering and should question or clarify and medication orders that are unclear or seem inappropriate.

For children, the oral route of administration is preferred. Liquid forms should be used when appropriate. Pharmacological implications for very young children involve close monitoring of the effects of medication. In these age groups absorption and metabolic rates may be unpredictable.

The aging adult population has special pharmacological considerations based on distinguishing characteristics of this group. Diminished blood flow, decreased peristalsis, and slowing of the basal metabolic rate lead to changes in physical functioning. As with young children, older adults may require close monitoring based on the unpredictability of absorption. A general rule with the elderly is to "start low and go slow."

If a swallowing disorder is a concern, medications may need to be crushed or given in liquid form. Always consult a pharmacist to see if either is a possibility since some medications may be time-release, enteric-coated, sublingual, effervescent, or foul tasting.

NUTRITION AND HYDRATION THROUGH THE LIFE SPAN

Nutritional needs and considerations vary somewhat across the life span. Caloric requirements are greatest during infancy, adolescence, pregnancy and lactation.
Infants require iron supplements and fat from whole milk. They should be introduced to solids beginning with cereal at four to six months of age. New foods should be introduced slowly so that intolerances can be determined.

Toddlers like finger foods and should be introduced to utensils and cups instead of bottle-feeding and caregiver feeding. Preschoolers will begin to develop food preferences and the manual dexterity to use utensils. School age children prefer fast food and dining with friends. Adolescents, despite their increased nutritional needs, demonstrate irregular eating patterns and a preference for fast food and snacks. It is also during adolescence that eating disorders such as anorexia, bulimia and trendy diets may emerge.

In the absence of pregnancy and lactation, the nutritional needs of the young and middle adult remain fairly constant. For the aging adult, fewer calories are required as appetite and digestive processes decrease. Other factors affecting nutritional status to be considered are dentition, financial resources, physical limitations and the ability to get to and from the store. "Meals on Wheels" may be a resource for the homebound elderly.

AGE RELATED IMPLICATIONS FOR THE HEALTH CARE PROVIDER

There are many other aspects of health care delivery that must be considered based on age characteristics. These include patient and family education, discharge planning, motivational techniques, ability to participate in care, communication techniques, and the impact of illness or hospitalization on the patient. The families of infants and the cognitively impaired must be the focus of teaching. Toddlers and school age children, however, must be given explanations according to their developmental stages. Very often dolls and puppets may be effective props for teaching these age groups.

Discharge planning may also be affected by the age of the patient. Age appropriate community resources must be considered. Reporting mechanisms and agencies for age related abuse also vary.

A patient's level of involvement in care is also affected by age. While a minor may have an opinion regarding healthcare, decision-making is usually placed on the parent or legal guardian.

At the other end of the life span, the older adult may be physically or cognitively impaired and unable to participate in certain decisions or aspects of his/her care.

The meaning of illness and hospitalization varies widely across the life span. For an infant, it means separation from the primary caregiver. For a school age child it means missing school. For an adolescent it means separation form the peer group. For the young adult illness may mean loss of a job. For the older adult, illness may bring up issues of physical decline or mortality.

HIPAA Fact Sheet

PROTECTING THE PRIVACY OF PATIENTS' HEALTH INFORMATION

Overview: *The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.*

Congress called on HHS to issue patient privacy protections as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA included provisions designed to encourage electronic transactions and also required new safeguards to protect the security and confidentiality of health information. The final regulation covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions (e.g., enrollment, billing and eligibility verification) electronically. Most health insurers, pharmacies, doctors and other health care providers were required to comply with these federal standards beginning April 14, 2003. As provided by Congress, certain small health plans have an additional year to comply. HHS has conducted extensive outreach and provided guidance and technical assistant to these providers and businesses to make it as easy as possible for them to implement the new privacy protections. These efforts include answers to hundreds of common questions about the rule, as well as explanations and descriptions about key elements of the rule. These materials are available at http://www.hhs.gov/ocr/hipaa.

PATIENT PROTECTIONS

The new privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these new standards include:

- **Access To Medical Records.** Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. Health plans, doctors, hospitals, clinics, nursing homes and other covered entities generally should provide access these records within 30 days and may charge patients for the cost of copying and sending the records.

- **Notice of Privacy Practices.** Covered health plans, doctors and other health care providers must provide a notice to their patients how they may use personal medical information and their rights under the new privacy regulation. Doctors, hospitals and other direct-care providers generally will provide the notice on the patient's first visit following the April 14, 2003, compliance date and upon request. Patients generally will be

asked to sign, initial or otherwise acknowledge that they received this notice. Health plans generally must mail the notice to their enrollees by April 14 and again if the notice changes significantly. Patients also may ask covered entities to restrict the use or disclosure of their information beyond the practices included in the notice, but the covered entities would not have to agree to the changes.

- **Limits on Use of Personal Medical Information.** The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. In other situations, though, personal health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose. In addition, patients would have to sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.

- **Prohibition on Marketing.** The final privacy rule sets new restrictions and limits on the use of patient information for marketing purposes. Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.

- **Stronger State Laws.** The new federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; the privacy rule will set a national "floor" of privacy standards that protect all Americans, and any state law providing additional protections would continue to apply. When a state law requires a certain disclosure -- such as reporting an infectious disease outbreak to the public health authorities -- the federal privacy regulations would not preempt the state law.

- **Confidential communications.** Under the privacy rule, patients can request that their doctors, health plans and other covered entities take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask a doctor to call his or her office rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.

- **Complaints.** Consumers may file a formal complaint regarding the privacy practices of a covered health plan or provider. Such complaints can be made directly to the covered provider or health plan or to HHS' Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation. Information about filing complaints should be included in each covered entity's notice of privacy practices. Consumers can find out more information about filing a complaint at http://www.hhs.gov/ocr/hipaa or by calling (866) 627-7748.

HEALTH PLANS AND PROVIDERS

The privacy rule requires health plans, pharmacies, doctors and other covered entities to establish policies and procedures to protect the confidentiality of protected health information about their patients. These requirements are flexible and scalable to allow different covered entities to implement them as appropriate for their businesses or practices. Covered entities must provide all the protections for patients cited above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered entities must take some additional steps to protect patient privacy:

- **Written Privacy Procedures.** The rule requires covered entities to have written privacy procedures, including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.

- **Employee Training and Privacy Officer.** Covered entities must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed. If covered entities learn an employee failed to follow these procedures, they must take appropriate disciplinary action.

- **Public Responsibilities.** In limited circumstances, the final rule permits -- but does not require --covered entities to continue certain existing disclosures of health information for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an Institutional Review Board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. The privacy rule generally establishes new safeguards and limits on these disclosures. Where no other law requires disclosures in these situations, covered entities may continue to use their professional judgment to decide whether to make such disclosures based on their own policies and ethical principles.

- **Equivalent Requirements For Government.** The provisions of the final rule generally apply equally to private sector and public sector covered entities. For example, private hospitals and government-run hospitals covered by the rule have to comply with the full range of requirements.

OUTREACH AND ENFORCEMENT

HHS' Office for Civil Rights (OCR) oversees and enforces the new federal privacy regulations. Led by OCR, HHS has issued extensive guidance and technical assistance materials to make it as easy as possible for covered entities to comply with the new requirements. Key elements of OCR's outreach and enforcement efforts include:

- **Guidance and technical assistance materials.** HHS has issued extensive guidance and technical materials to explain the privacy rule, including an extensive, searchable collection of frequently asked questions that address major aspects of the rule. HHS will continue to expand and update these materials to further assist covered entities in complying. These materials are available at http://www.hhs.gov/ocr/hipaa/assist.html.

- **Conferences and seminars.** HHS has participated in hundreds of conferences, trade association meetings and conference calls to explain and clarify the provisions of the privacy regulation. These included a series of regional conferences sponsored by HHS, as well as many held by professional associations and trade groups. HHS will continue these outreach efforts to encourage compliance with the privacy requirements.

- **Information line.** To help covered entities find out information about the privacy regulation and other administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, OCR and HHS' Centers for Medicare & Medicaid Services have established a toll-free information line. The number is (866) 627-7748.

- **Complaint investigations.** Enforcement will be primarily complaint-driven. OCR will investigate complaints and work to make sure that consumers receive the privacy rights and protections required under the new regulations. When appropriate, OCR can impose civil monetary penalties for violations of the privacy rule provisions. Potential criminal violations of the law would be referred to the U.S. Department of Justice for further investigation and appropriate action.

- **Civil and Criminal Penalties.** Congress provided civil and criminal penalties for covered entities that misuse personal health information. For civil violations of the standards, OCR may impose monetary penalties up to $100 per violation, up to $25,000 per year, for each requirement or prohibition violated. Criminal penalties apply for certain actions such as knowingly obtaining protected health information in violation of the law. Criminal penalties can range up to $50,000 and one year in prison for certain offenses; up to $100,000 and up to five years in prison if the offenses are committed under "false pretenses"; and up to $250,000 and up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain or malicious harm.

PAIN MANAGEMENT STANDARDS

All patients should be assessed for pain factors and history, initially upon presentation to the facility, then subsequently thereafter according to assessment finding. All patients should receive treatment for pain relief as warranted and should be monitored for effectiveness.

ASSESSMENT/REASSESSMENT:

The RN should assess the patient for pain factors and history upon presentation during the initial assessment and document findings.

When pain is identified, either acute or chronic, a more comprehensive assessment should be performed and pain management implemented in the patient's multidisciplinary plan of care.

Pain intensity should be measured with an appropriate measurement tool.

1. A pain scale of 0 – 10 (0 = no pain, 10 = worst pain) should be utilized for adult patient. * If they cannot understand or are unwilling to use the scale the following tools may be utilized.
2. Wong Baker FACES pain scale (smile-frown).
3. Behaviors and/or symptoms should be evaluated regarding presence of pain on patients who are cognitively impaired or unable to communicate.

Description(s) of pain, noting patient's personal words, should be documented including:

1. Location of pain area(s)
2. Quality and/or patterns of radiation.
3. Onset, duration and/or precipitating factors
4. Pain management history and effectiveness:
    - Consider personal values, beliefs and culture.
    - Evaluate myths about opioid analgesics regarding addiction, physical dependence and/or tolerance to this type of medication.
    - Evaluate the type of communication the patient utilizes to report pain (verbal or behavioral).
    - Utilize family input if appropriate. **The patients personal interview should always be considered first if able to communicate and not cognitively impaired.**
5. Effects of pain on daily life – level of impact
6. Patients pain goal. (What level is acceptable?)

7. Patient's knowledge level of disease process(s) related to pain, medications and/or alternative treatment prescribed.

Either a RN or a LPN may perform the reassessment utilizing the Pain Management Flow sheet for documentation.

Reassessments should be performed according to type of pain and level of effectiveness regarding medication and or treatment utilized.

The following standards should be flexible according to individual patient responses to medication and/or treatment.

1. Cardiac pain should be reassessed every five – (5) minutes whenever the treatment prescribed warrants the use of nitrates and/or intravenous medication, ordered on five – (5) minutes intervals, to manage pain.

2. Acute/chronic pain should be reassessed thirty – (30) minutes to one (1) hour after medication(s) and/or alternative treatment(s) administered.

The physician should be notified when ***any*** type of prescribed pain management regimen is not effective in relieving patient's pain.

INTERVENTIONS:

Analgesics and treatments should be administered as prescribed.

Nurses should routinely (every 4 hours while the patient is awake) evaluate the patient for pain management.

PRN medications/treatments should be offered when the patients personal pain goal is exceeded or their pain is greater than four (4) on the pain scale.

Analgesics ordered should be administered by the least painful route, if possible.
Reassess the effectiveness according to the type of pain and the treatment rendered.

Non-pharmacological interventions should be offered and taught:

1. Heat/cold packs as prescribed
2. Repositioning, turning and/or ambulating as tolerated.
3. Relaxation exercises i.e.: deep breathing, rhythmic breathing and/or "peaceful past" memory meditation.
4. Distraction

The physician should be notified for any type of pain management, which is not effective.

AGE RELATED CONSIDERATIONS:

Geriatric:

1. Drug metabolism is slower in the elderly due to decreased hepatic and renal function.
2. At greater risk for drug-drug and drug-disease interactions due to multiple diseases and medications.
3. Barriers to pain assessment include cognitive, visual, hearing and motor impairments.
4. At risk for over and/or under treatment of analgesics:
    - NSAIDS increase the risk of renal toxicity

- Opioids have a higher peak and last longer leading to prolonged sedation and respiratory depression.

Pediatric:

1. More frequent assessment/reassessment and intervention are required due to a higher metabolic rate.
2. Emotional distress accentuates pain.
3. Children in pain may regress.
4. Observation of behavior and self-report are the primary methods for assessment.

PATIENT EDUCATION:

Patient and/or family teaching should begin after initial pain assessment with identified knowledge deficit areas.

The Patient Education Record should reflect the type of teaching performed and patient/family response.

The Care Plan should reflect knowledge deficit areas and be evaluated once a day for progress toward stated goals.

The Physician should be notified for multiple, different interventions that are not effective and/or if patient/family is non-compliant.

STAFF EDUCATION:

Direct care employees should receive education/training regarding pain assessment and management initially during new employee hospital orientation then thereafter annually through hospital orientation.

After receiving education/training the employee should be able to:

1. Perform appropriate pain assessment and reassessments
2. Render appropriate pain management regimens through multidisciplinary efforts.
3. Teach patient/family appropriate pain management on individualized basis.

Drug-Free Workplace Policy

The use of drugs undermines the quality and safety of job performance, endangers co-workers and patients, and brings discredit to The Nurse Agency and the nursing community. The Nurse Agency will not tolerate the use of drugs by its employees in any job-related context and is committed to the eradication of drugs from the workplace.

To this end, it is the policy of The Nurse Agency that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance on the job is strictly prohibited. Anyone in violation of this policy is subject to severe disciplinary action, including discharge.

Policy Regarding Sexual Harassment in Employment

Statement of Company Policy

The Nurse Agency is committed to providing a workplace that is free from all forms of discrimination, including sexual harassment. Any employee's behavior that fits the definition of sexual harassment is a form of misconduct which may result in disciplinary action up to and including dismissal. Sexual harassment could also subject this company and, in some cases, an individual to substantial civil penalties.

The company's policy on sexual harassment is part of its overall affirmative action efforts pursuant to state and federal laws prohibiting discrimination based on age, race, color, religion, national origin, citizenship status, unfavorable discharge from the military, marital status, disability, and gender. Specifically, sexual harassment is prohibited by the Civil Rights Act of 1964, as amended in 1991, and the Illinois Human Rights Act.

Each employee of this company bears the responsibility to refrain from sexual harassment in the workplace. No employee -male or female- should be subjected to unsolicited or unwelcome sexual overtures or conduct in the workplace. Furthermore, it is the responsibility of all supervisors to make sure that the work environment is free from sexual harassment. All forms of discrimination and conduct which can be considered harassing, coercive or disruptive, or which create a hostile or offensive environment must be eliminated. Instances of sexual harassment must be investigated in a prompt and effective manner.

All employees of this company, particularly those in a supervisory or management capacity, are expected to become familiar with the contents of this Policy and to abide by the requirements it establishes.

Definition of Sexual Harassment

According to the Illinois Human Rights Act, sexual harassment is defined as: Any unwelcome sexual advances or requests for sexual favors or any conduct of a sexual nature when;

(1) submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment.

(2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or

(3) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

The courts have determined that sexual harassment is a form of discrimination under Title VII of the Civil Rights Act of 1964, as amended in 1991.

One example of sexual harassment is where a qualified individual is denied employment opportunities and benefits that are, instead, awarded to an individual who submits (voluntarily or under coercion) to sexual advances or sexual favors. Another example is where an individual must submit to unwelcome sexual conduct in order to receive an employment opportunity.

Other conduct commonly considered to be sexual harassment includes:

- Verbal: sexual innuendos, suggestive comments, insults, humor and jokes about sex, anatomy or gender-specific traits, sexual propositions, threats, repeated requests for dates, or statements about other employees, even outside their presence, of a sexual nature.
- Non-verbal: Suggestive or insulting sounds (whistling), leering, obscene gestures, sexually suggestive bodily gestures, "catcalls", "smacking", or "kissing" noises
- Visual: posters, signs, pin-ups or slogans of a sexual nature.
- Physical: Touching, unwelcome hugging or kissing, pinching, brushing the body, coerced sexual intercourse, or actual assault.

Sexual harassment most frequently involves a man harassing a woman. However, it can also involve a woman harassing a man or harassment between members of the same gender.

The most severe and overt forms of sexual harassment are easier to determine. On the other end of the spectrum, some sexual harassment is more subtle and depends to some extent on individual perception and interpretation. The trend in the courts is to assess sexual harassment by a standard of what would offend a "reasonable woman" or "reasonable man", depending on the gender of the alleged victim.

An example of the most subtle form of sexual harassment is the use of endearments. The use of terms such as "honey", "darling", and "sweetheart" is objectionable to many women who believe that these terms undermine their authority and their ability to deal with men on an equal and professional level.

Another example is the use of a compliment that could potentially be interpreted as sexual in nature. Below are three statements that might be made about the appearance of a woman in the workplace:

"That's an attractive dress you have on."
"That's an attractive dress. It really looks good on you."
"That's an attractive dress. You really fill it out well."

The first statement appears to be simply a compliment. The last is the most likely to be perceived as sexual harassment depending on the perceptions and values of the person to whom it is directed. To avoid the possibility of offending an employee, it is best to follow a course of conduct above reproach, or to err on the side of caution.

Responsibility of Individual Employees

Each individual employee has the responsibility to refrain from sexual harassment in the workplace.

An individual employee who sexually harasses a fellow worker is, of course, liable for his or her individual conduct.

The harassing employee will be subject to disciplinary action up to and including discharge in accord with the company's disciplinary policy and the terms of any applicable collective bargaining agreement.

The company has designated Ann Weist, Director of Staffing to coordinate the company's sexual harassment policy compliance. Ann can be reached at (773) 779-8200. She is available to consult with employees regarding their obligations under this policy.

Responsibility of Supervisory Employees

Each supervisor is responsible for maintaining the workplace free from sexual harassment. This is accomplished by promoting a professional environment and by dealing with sexual harassment as with all other forms of employee misconduct.

The courts have found that organizations as well as supervisors can be held liable for damages related to sexual harassment by a manager, supervisor, employee, or third party (an individual who is not an employee but does business with an organization, such as a customer, contractor, sales representative, or repair person).

Liability is either based on an organization's responsibility to maintain a certain level of order and discipline, or on the supervisor acting as an agent of the organization. As such, supervisors must act quickly and responsibly not only to minimize their own liability but also that of the company.

Specifically, a supervisor must address an observed incident of sexual harassment or a complaint, with seriousness, take prompt action to investigate it, report it, and end it, implement appropriate disciplinary action, and observe strict confidentiality. This also applies to cases where an employee tells the supervisor about behavior that constitutes sexual harassment but does not want to make a formal complaint.

In addition, supervisors must ensure that no retaliation will result against an employee making a sexual harassment complaint.

Supervisors in need of information regarding their obligations under this policy or procedures to follow upon receipt of a complaint of sexual harassment should contact Ann Weist, Director of Staffing at (773) 779-8200.

Procedures for filing a complaint of Sexual Harrassment

Internal

An employee who either observes or believes herself/himself to be the object of sexual harassment should deal with the incident(s) as directly and firmly as possible by clearly communicating her/his position to the supervisor, Ann Weist, and to the offending employee. It is not necessary for the sexual harassment to be directed at the person making the complaint.

Each incident of sexual harassment should be documented or recorded. A note should be made of the date, time, place, what was said or done, and by whom. The documentation may be augmented by written records such as letters, notes, memos, and telephone messages.

No one making a complaint of sexual harassment will be retaliated against even if a complaint made in good faith is not substantiated. Any witness to an incident of sexual harassment is also protected from retaliation.

The process for making a complaint about sexual harassment falls into several stages.

1. Direct Communication. If there is sexually harassing behavior in the workplace, the harassed employee should directly and clearly express her\his objection that the conduct is unwelcome and request that the offending behavior stop. The initial message may be verbal. If subsequent messages are needed, they should be put in writing in a note or a memo.

2. Contact Supervisory Personnel. At the same time direct communication is undertaken, or in the event the employee feels threatened or intimidated by the situation, the problem must be promptly reported to the immediate supervisor or the EEO Officer. If the harasser is the immediate supervisor, the problem should be reported to the next level of supervision of the EEO Officer.

3. Formal Written Complaint. An employee may also report incidents of sexual harassment directly to the EEO Officer. The EEO Officer will counsel the reporting employee and be available to assist with filing a formal complaint. The Company will fully investigate the complaint, and will advise the complainant and the alleged harasser of the results of the investigation.

External

The Company hopes that any incident of sexual harassment can be resolved through the internal process outlined above. All employees, however, have the right to file formal charges with the Illinois Department of Human Rights (IDHR) and/or the United States Equal Employment Opportunity Commission (EEOC). A charge with IDHR must be filed within 180 days of the incident of sexual harassment. A charge with EEOC must be filed within 300 days of the incident.

Guidelines for Nurses Interacting with Clients with Differing Culture or Ethnicity

As an RN working in the clinical setting you will be caring for many people who have a different culture or ethnicity than you. It is important that all patients be treated with respect and compassion. The following guidelines should help you accomplish this. Make sure when working through The Nurse Agency that you:

Convey respect for the individual and respect for his/her values, beliefs, and cultural and ethnic practices.

Learn about the major ethnic or cultural groups with whom you are likely to have contact.

Be aware of your own communication, e.g. facial expressions and body language, and how it may be interpreted.

Be aware of your own biases, prejudices, and stereotypes

When a patient describes a belief that differs from your own, e.g. the cause of her swollen feet, try to relate the patient's belief to your own, thus conveying interest and respect for the patient's belief.

Recognize the cultural symbols and practices that can often bring a patient comfort.

Support the patient's practices and incorporate them into nursing practice whenever it is possible and they are not contraindicated for health reasons.

Do not impose a cultural practice on a patient without knowing whether it is acceptable.

Be aware the color of a patient's skin does not always determine his/her culture.

Take time to learn how a client views health, illness, grieving, and the health care system.

Be aware of your own attitudes and beliefs about health and objectively examine the logic of those attitudes and beliefs and their origins.

Be open to learning about different beliefs and values and learn not to be threatened when they differ from your own.

JCAHO National Patient Safety Goals

Introduction

The purpose of the Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety. The Goals highlight problematic areas in health care and describe evidence and expert-based solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care, the Goals focus on system-wide solutions, wherever possible.

2006 Hospitals' National Patient Safety Goals

Note: New Goals and Requirements are indicated in **bold**.

Goal: Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

Goal: Improve the effectiveness of communication among caregivers.

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- **Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.**

Goal: Improve the safety of using medications.

- Standardize and limit the number of drug concentrations available in the organization.
- Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.
- **Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.**

Goal: Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

Goal: Reduce the risk of health care-associated infections.

- Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goal: Accurately and completely reconcile medications across the continuum of care.

- Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
- A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

Goal: Reduce the risk of patient harm resulting from falls.

- **Implement a fall reduction program and evaluate the effectiveness of the program.**

Patients Rights and Ethical Aspects of Care, Treatment and Services

All persons are entitled to certain, specific rights while they are patients within a facility, including rights outlined by government mandate such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The right to be treated with dignity and respect at all times and under all circumstances.
- The right to impartial access to care, treatment and other medical services that are available or medically indicated. This right is entitled regardless of race, creed, sex, national origin, communicable disease status, religion, marital status, veteran status, or any other protected class under relevant Federal or State law, or the ability to pay for treatments or services.
- The right to the truth in all aspects of care or treatments provided.
- The right to have personal, spiritual or cultural beliefs, preferences and/or choices respected at all times.
- The right to be actively involved in all treatment decisions including:
    - The right to access information, including access to medical records.
    - The right to be informed of alternative treatments and/or therapies.
    - The right to refuse treatment.
    - The right to receive an estimate of the cost of care or treatment options.
    - The right to receive clearly stated treatment goals and objectives in terms the patient can understand.
    - The right to appropriate medical consultations regarding treatment.
    - The right to question all aspects of treatment, care and the decisions made relative to that care and treatment.
- The right to have personal preferences and choices regarding treatment options or the refusal of treatment respected.
- The right to know the identity (including the name and professional status) of the attending physician and all health care providers who are involved with the patient's care, as well as the right to know the reason for the presence of any individual.
- The right to privacy and confidentiality (within legal limits) of all personal and/or medical information and preferences regarding patient care and treatment including, but not limited to the following:
    - The right to refuse to speak with or see anyone who is not directly involved in patient care activities (including visitors, family members or other individuals).

    - The right to be interviewed and examined in surroundings that assure reasonable visual and auditory privacy and confidentiality.
    - The right to expect that any discussion or consultation involving the patient's care will be conducted discreetly and that individuals who are not directly involved in the patient's care will not be present without the patient's permission.
- The right to be free from all restraints or seclusion (whether physical, chemical or other types) unless a restraint is being utilized for the express purpose of protecting personal safety of the patient or the patient's care providers.
- The right to receive as much or as little information about any proposed treatment or procedure in order to provide adequate knowledge to give an informed consent or refusal for those treatments or procedures. Except in cases of emergency, this information shall include the following:
    - A description of the procedure or treatment.
    - The medically significant risks involved in the treatment.
    - Alternate plans of treatment and the risks involved in each of those alternatives.
    - Knowledge of the name of the person(s) who will perform the treatment or procedure.
- The right to continuity of care from the time of admission until the time of discharge including the ability to know, in advance, of the time and location of any appointments for treatment.
- The right to Spiritual Care upon request.
- The right to receive care in a safe, secure environment free from verbal or physical abuse or harassment, as well as the right to access protective services (including the right to notify government agencies of neglect or abuse).
- The right to effective management of pain (including the right to be informed that appropriate pain management is a goal of every patient care plan).
- The right to file a formal concern (grievance) regarding the care and treatments received and the right to prompt resolution of that concern. Formal concerns may be filed either in writing or by phone.
- The right to know the financial implications of all treatment choices and the right to have all bills and available payment options explained in understandable terms.
- The right to make an Advance Directive in order to state treatment preferences in the event a patient is unable to speak for him or herself. Advance Directives include a Rights of the Terminally Ill Declaration (Living Will) and a Durable Power of Attorney for Healthcare.
- The right to leave the hospital at any time (unless restricted by law), even against the advice of a physician or other health care provider.
- The right to take part in experimental treatments or research or to decline participation in experimental treatments or research without negative effects to other aspects of hospitalization or treatments.
- The right to be informed of the need for continuing health care requirements following discharge from the hospital.
- The right to know which hospital policies and/or procedures apply to a patient's conduct while they are a patient.
- The right to participate in ethical questions that may arise in the course of care and treatment, including:
    - Ethical questions of the course of care or treatment being proposed.
    - Issues of conflict resolution.
    - Issues related to treatment decisions and options, including end-of-life treatment decisions such as forgoing or withdrawing life-sustaining treatment.
- The right to all of the seven rights outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which include all of the following:
    - The right to receive notice of a health care provider's privacy policy and procedures.
    - The right to view all of their personal, protected health information (PHI).

- The right to access a record of all disclosures related to their medical care.
- The right to complain, both to the health care provider and the Department of Health and Human Services regarding any aspect of their care.
- The right to receive confidential communications.
- The right to request amendments and corrections to their personal information that is thought to be incorrect.
- The right to request restrictions on the use and disclosure of their PHI.

PATIENT RESTRAINT STANDARDS

Physical restraints may be required during a patient's stay in the hospital when less restrictive measures are inadequate in preventing a patient from hurting themselves or others. The following pages compare the *HCFA (Health Care Financing Administration) Rules* with the *JCAHO Standards* regarding Patient Restraints. Please familiarize yourself with *both* of these standards as our clients will have policies based on one or both of them.

Please see next page.

Standards for Seclusion/Restraint for Behavioral Management: May 2000

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
	Application: Rules related to restraint/seclusion concern their use in two situations: respectively, standard (e), use of restraint in medical and post-surgical care; and standard (f), **emergency** use of restraints/seclusion in behavior management. For both situations, it is important to note that these requirements **are not specific to any treatment setting**, but to the situation the restraint is being used to address. **Emergency:** a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious dangers to the safety of the patient, other patients, staff, or others. **NOTE:** The behavior management standard does not apply to situations where the patient is restrained to address the risk of a fall or to control wandering.	**Application:** The behavioral health care standards for restraint/seclusion apply to any use of restraint and seclusion for behavioral health care reasons. Standards TX.7.1 through TX.7.1.16 apply to ***all behavioral health care settings*** in which restraint or seclusion is used. Selected standards TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8 and Standards TX.7.1.10 and TX.7.1.11 apply to ***non-behavioral health care settings*** in which restraint or seclusion is used for behavioral health reasons: • acute care hospital that does not have a psychiatric unit; • acute care hospital to receive medical or surgical services; • emergency department for assessment, stabilization, treatment or awaiting transfer to a psychiatric hospital/unit; • awaiting transfer from a non-psychiatric bed to a psychiatric bed/unit after receiving medical/surgical care	
Definition of Restraint: placement of a patient in a posey vest and/or soft wrist/ankle restraints. **Definition of Seclusion:** placement of a patient in a locked security room.	**Restraint:** any manual method or physical or mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment, attached or adjacent to the patient's body that he or **she cannot easily remove**. (Any object may be a restraint by functional definition: e.g., tucking sheets, side rails, geri chair, etc.). **Drug Used as a Restraint:** a medication used to restrict the patient's freedom of movement in medical-post surgical situations or for the emergency control of behavior, and is not a standard treatment for the patient's medical or psychiatric condition. **Seclusion:** involuntarily confining an individual alone to a room or an area where he/she is physically prevented from leaving. **Time Out:** restriction of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self-control.	**Restraint:** the direct application of physical force to an individual, without the individual's permission, to restrict his/her freedom of movement. **Seclusion:** the involuntary confinement of a person in a locked room. **Time-out:** a procedure used to assist the individual to regain emotional control by removing the individual from his/her immediate environment and restricting the individual to a quiet area or unlocked quiet room.	

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
When is restraint/seclusion used: • When the patient poses an immediate danger to self an/or others; • When the patient threatens serious disruption to the therapeutic environment; • When less restrictive measures/approaches are/have been unsuccessful.	Seclusion or restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective. Emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or others.	Restraint and seclusion are used only in an **emergency**, when there is an imminent risk of an individual physically harming himself or herself or others, including staff. Non-physical interventions are the **preferred** intervention, unless safety issues demand an immediate physical response. **Definition of Emergency:** when there is **imminent risk** of an individual physically harming himself or herself, staff or others; when non-physical interventions are not viable; and safety issues require an immediate physical response.	
	Initial Assessment: Comprehensive assessment is critical in coming to an effective intervention decision of what would be the greater benefit to a patient. Evaluation of whether devices could be used as restraints must include: • how they benefit the patient; • whether a less restrictive device/intervention could offer the same benefit at less risk. If the effect of using an object fits the definition of restraint for that patient at that time, then for that patient at that time, the device is a restraint.	**Initial Assessment:** The initial assessment of each individual at the time of admission or intake assists in obtaining information about the individual that could help minimize the use of restraint/seclusion. This initial assessment identifies: • techniques, methods, or tools that would help the individual control his/her behavior; • pre-existing medical conditions/physical disabilities and limitations that would place the patient at greater physical risk; and • any history of sexual/physical abuse that would place the patient at greater psychological risk.	

Orders:
• An attending physician must give the order to restrain/secure the patient.
• The RN may assume this responsibility in an emergency; but a physician's order must be obtained within one hour of placing the patient in restraints or seclusion.
• The MD order must include clinical justification for the use of restraint/seclusion, including specific behavior(s) which requires the need for such intervention.
• Written orders must be time-limited and may not exceed 4 hours for adults and 2 hours for adolescents.
• The MD may continue the original order, in 4-hour increments (2 hour for adolescents) for a maximum of 24 hours without a face-to-face contact.
• The use of PRN orders for restraint/seclusion is
	Orders for the use of Restraint/Seclusion:
	• Must be written by a physician or other licensed independent practitioner (LIP) permitted by the State and hospital to order a restraint/seclusion
	• May never be written as a standing order or on an as needed basis (i.e., PRN)
	• Must be time limited to 4 hours for adults; 2 hours for children and adolescents ages 10 to 17; or 1 hour for patients under 9 years of age
	• May only be renewed in accordance with these time limits for up to a total of 24 hours
	• Must be in accordance with a **written modification** to the patient's plan of care
	• Must be implemented in the least restrictive manner possible (i.e., less intrusive measures were tried/documented)
	• Must be in accordance with safe and appropriate
		Orders for the use of Restraint/Seclusion:
		• All restraint/seclusion is used and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his/her LIP designee
		• Written or verbal orders for initial and continuing use of restraint/seclusion are time limited to:
		  • **4 hours** for individuals **18 and older**
		  • **2 hours** for children and adolescents **9 to 17**
		  • **1 hour** for children **under age 9**
		• Orders for restraint/seclusion are not written as a standing order or on an as needed basis (i.e., PRN)
		• The organization may authorize qualified registered nurses or other qualified, trained staff members who are not LIPs to *initiate* the use of restraint/seclusion
		• The qualified RN or other qualified staff notifies the LIP and an order is obtained **no longer than one hour** after the	

strictly prohibited. • When restraints/seclusion are discontinued early and the same behavior is still evident, the original order can be reapplied if alternatives remain ineffective. The time limit for the original order is cumulative. Release of the patient from restraints/seclusion for a period longer than 60 minutes requires obtaining a new MD order to include additional clinical justification.	restraining techniques • Must be ended at the earliest possible time • If restraints/seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints and the requirements restart. • After the original order expires, a physician or LIP (if allowed under State law) must see and assess the patient before issuing a new order	initiation of restraint/seclusion • The LIP reviews with the staff the physical and psychological status of the patient, determines whether restraint/seclusion should be continued, gives staff guidance in identifying ways to help the individual regain control in order to discontinue restraint/seclusion, and gives an order • If restraint/seclusion needs to continue beyond the expiration of the time-limited order, **a new order (written or verbal) for restraint/seclusion is obtained** from the LIP, or his/her LIP designee limited to the time frames outlined above	

<u>Ongoing Assessment of the Need for Continuation:</u>
• The attending MD or his/her designee (i.e., RN) must reassess the patient's status every 4 hours to determine the need for continuation. Designation of this responsibility by the MD to the RN must be included in the written order.
	<u>Ongoing Assessment of the Need for Continuation:</u>
	• An MD or other LIP must see and evaluate the need for restraint/seclusion **within 1 hour** after the initiation of this intervention (***a telephone call is not adequate***)
	• The MD is not required to perform another face-to-face assessment of the patient after 4 hours (or 2 hours or 1 hour for younger patients). When the original order is about to expire, a nurse can telephone the MD or LIP, report the results of his/her most recent assessment, and request that the original order be renewed for another period of time (not to exceed the time limits established in the regulation).
		<u>Ongoing Assessment of the Need for Continuation:</u>
		• Individuals who are in restraint/seclusion are regularly reevaluated every
		  • **4 hours** for individuals **18 and older**
		  • **2 hours** for children and adolescents **9 to 17**
		  • **1 hour** for children **under age 9**
		• The LIP who is primarily responsible for the individual's ongoing care, or his/her LIP designee, conducts an in-person evaluation of the individual **within 4 hours** of the initiation of restraint/seclusion for individuals **ages 18 or over**; **within 2 hours** of initiation for children and adolescents **age 17 and under**
		• This in-person reevaluation may be delegated to:
		  • his/her LIP designee
		  • a **qualified RN** or other **qualified, trained staff** who is authorized by the organization to perform this function (see training requirements in intent)
		• **Minimum** time frames for an in-person reevaluation by the LIP are at least every
		  • **8 hours** for individuals **18 years and older**, and
		  • **4 hours** for individuals **ages 17 and younger**
		• If the individual is **no longer in restraint/seclusion** when an original *verbal* order expires, the LIP conducts an in-person evaluation of the individual **within 24 hours** of the initiation of restraint/seclusion	

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
Notification Requirements: • All uses of restraint/seclusion are to be recorded on the Critical Incident Log for each new restraint/seclusion event • All uses of restraint/seclusion are reported daily to the Medical Director or a designee (Nurse Coordinator) for review. • If restraint/seclusion continues beyond 48 hours or if the patient requires restraint/seclusion more than 4 times in one week, the RN will request a case conference with the MD and other team members to discuss alternatives.	**Notification Requirements:** • The RN who initiates restraint/seclusion must consult with the patient's treating MD, as soon as possible, if the restraint/seclusion is not ordered by the patient's treating MD	**Notification Requirements:** • The individual's family is notified promptly of the initiation of restraint or seclusion, in cases where the individual has consented to have the family kept informed regarding his/her care and the family has agreed to be notified. • Clinical leadership is informed of instances in which individuals experience extended, or multiple episodes of, restraint/seclusion (e.g., remains in restraint/seclusion for **more than 12 hours**; experiences **2 or** more separate episodes of restraint/seclusion of any duration **within 12 hours**). The leadership is notified **every 24 hours** if either of the above conditions continue.	
Monitoring/Care Requirements: • Each restrained/secured patient will be placed on the appropriate PICR (10/15 minute flow sheet) • Nursing staff will check the patient every 15 minutes (or less) depending upon patient need. (Children 14 years of age or younger must be checked every 10 minutes or less). • Each reassessment for monitoring purposes is used to determine the patient's well being and must be documented. • If the patient's condition warrants, restraints are removed every 2 hours and the patient exercised (while awake). If the patient is assessed to be at risk for violence, the restraints will not be removed unless repositioning, circulation and mobility is impaired. (Under these circumstances, the restraint is removed from one extremity at a time with range of motion provided to the free extremity.) • The personal needs of the patient (e.g., nourishment, fluids, hygiene, and use of the toilet) must be attended to every 2 hours while awake during each 8-hour shift. Other comfort measures are provided as appropriate and desired by the patient. • If a patient is restrained in a security room, the door to the room may not be locked. Any patient in 4-point restraints will be monitored 1:1 by staff.	**Monitoring/Care Requirements:** The frequency of monitoring will vary according to the type and design of the device/intervention as well as the emotional, psychological and physical condition, needs, and symptoms of the patient. • A restraint and seclusion may not be used simultaneously unless the patient is -- ➢ Continually monitored face-to-face by an assigned staff member; or ➢ Continually monitored by staff using both video and audio equipment. (This monitoring must be done in close proximity to the patient.) • The condition of the patient who is in a restraint or in seclusion must be continually be assessed, monitored, and reevaluated. • The frequency of monitoring will vary according to the type and design of the device or intervention as well as the emotional, psychological and physical condition, needs, and symptoms of the patient. • Hospital policy should describe: ➢ which staff are responsible for assessing and monitoring the patient; ➢ time frames for monitoring vital signs, respiratory and cardiac status, skin integrity, intake/output, weight, hygiene, injury, etc.; ➢ opportunities for offering fluids and nourishment,	**Monitoring/Care Requirements:** • A **trained and competent staff member** assesses the individual **at the initiation** of restraint/seclusion and **every 15 minutes** thereafter, to include: ➢ signs of injury; ➢ nutrition/hydration; ➢ circulation and range of motion in extremities; ➢ vital signs; ➢ hygiene and elimination; ➢ physical and psychological status and comfort; and ➢ readiness for discontinuation of restraint/seclusion. • Monitoring is accomplished through continuous in-person observation by an assigned staff member • After the first hour, an individual in seclusion only, may be continuously monitored using simultaneous video and audio equipment, if this is consistent with the individual's condition or wishes. • If the individual is in a physical hold, a second staff person is assigned to observe the individual. • The individual is made aware of the rationale for restraint/seclusion and the behavior criteria for its discontinuation (e.g., ability to contract for safety; orientation to the environment; and/or cessation of verbal threats).	

	toileting/elimination, range of motion, exercise of limbs and systematic release of restrained limbs; ➢ assessment of mental status; ➢ assessment and justification for continued use of restraint/seclusion; ➢ who has the authority to discontinue restraints or seclusion, and, under what circumstances.		
Documentation: The medical record for a restrained/secured patient must include: • precipitating factors and patient's behavior prior to intervention; • less restrictive alternatives used and the patient's response; • explanation given to patient addressing the reason for restraint seclusion and conditions for discontinuation; • RN assessment at the time of initiation and notification of attending MD; • initiation of PICR with visual checks every 15 minutes; • reassessment by the RN at regular intervals (at least once per shift); • attention to patient needs by nursing staff; • time of discontinuation of restraint seclusion and patient's response; • MD signature with date/time for each order received.	**Documentation:** Documentation in the patient's record should include: • the patient's behavior and the intervention used; • the rationale for the use of the physical restraint or seclusion; • the patient's response to the use of physical restraint/seclusion. Documentation in the patient's record should indicate a clear progression in how techniques are implemented with less intrusive restrictive interventions attempted (or considered) prior to the introduction of more restrictive measures.	**Documentation:** Medical records document that the use of restraint/seclusion is consistent with organization policy. The clinical record verifies: • that the individual/family was **informed of the organization's policy** on the use of restraint/seclusion; • any **pre-existing medical conditions** or any physical disabilities that would place the individual at greater risk during restraint/seclusion; and • any **history of sexual or physical abuse** that would place the individual at greater psychological risk during restraint/seclusion. **Each** episode of use is recorded to include: • the **circumstances** that led to their use; • consideration or failure of **non-physical interventions**; • the **rationale** for the type of physical intervention selected; • **notification** of the individual's family, when appropriate; • **written orders** for use; • **behavior criteria** for discontinuation of restraint/seclusion; • **informing the individual** of behavior criteria for discontinuation of restraint/seclusion; • **each verbal order** received from a LIP; • **each in-person evaluation** and reevaluation of the patient; • **15 minute assessments** of the patient's status; • **assistance provided** to the patient to help him/her meet the behavior criteria for discontinuation of restraint/seclusion; • evidence of **continuous monitoring**; • **debriefing** of the individual with staff; and • any injuries that are sustained and treatment received for these **injuries…**or any **deaths** resulting from injury. Documentation is accomplished in a manner that allows for the collection and analysis of data for performance improvement activities.	

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Staff Training: Staff with direct patient care responsibilities are trained in: • identification of potential risk behaviors; • the appropriate use of alternative strategies; • correct application and removal of restraints; • clinical strategies to meet emergent patient needs.	**Staff Training:** All staff who have direct patient contact must have ongoing education and training in: • the proper and safe use of restraint/seclusion application and techniques; • alternative methods for handling behavior symptoms, and situations that traditionally have been treated through the use of restraints/seclusion	**Staff Training:** **All direct care staff** are trained/competent to minimize the use of restraint and seclusion, and **demonstrate an understanding**: • of the underlying causes of threatening behaviors; • that some aggressive behavior may be related to a medical condition; • of how their own behaviors can affect the behaviors of patients; • of the use of de-escalation, medication, self-protection and other techniques, such as time-out; and • in recognizing signs of physical distress in individuals who are restrained/secluded. All staff **authorized to physically apply restraint or seclusion** receive **ongoing training** and **demonstrate competence** in the safe use of restraints, including: • physical holding techniques; • take-down procedures; and • the application and removal of mechanical restraints. Staff who are **authorized to perform 15 minute assessments** of individuals in restraint/seclusion **receive ongoing training** and **demonstrate competence** in: • taking vital signs and interpreting their relevance; • recognizing nutritional/hydration needs; • checking circulation and range of motion in extremities; • addressing hygiene and elimination needs; • addressing physical and psychological status and comfort; • assisting individuals in meeting behavior criteria for the discontinuation of restraint/seclusion; • recognizing when to contact a medically trained LIP or EMS to evaluate/treat the patient's physical condition. Staff who are **authorized to initiate restraint/seclusion**, in the absence of a LIP, and/or perform evaluations/reevaluations of individuals who are in restraint/seclusion are **educated** and **demonstrate competence** in: • recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and • the use of behavior criteria for the discontinuation of restraint/seclusion and how to assist individuals in meeting this criteria.	