

Core Mandatory Part II (Nursing)

Core Mandatory Part II (Nursing)

Section 1: Age-Specific Patient Care

Introduction

Purpose/Overall Goal

Course Objectives

Communication Across the Ages

Complex Communication Needs

Neonates: Birth-28 Days

Infants and Toddlers: 0-3 Years

Young Children: 4-6 Years

Older Children: 7-12 Years

Adolescents: 13-20 Years

Young Adults: 21-39 Years

Middle Adults: 40-64 Years

Older Adults: 65-79 Years

Adults Age 80 And Older

Summary

References

Section 2: Cultural Competence

Introduction

Purpose/Overall Goal

Course Objectives

Cultural Diversity

Valuing Diversity

Assessing One's Own Cultural Competency

Managing Cultural Differences

Managing Cultural Differences: Asking Non-Judgemental Questions

Managing Cultural Differences: Listening Carefully

Managing Cultural Differences: Setting Realistic Goals for Behavior Change

Managing Cultural Differences: Solving Problems Together

Managing Cultural Differences: Working with An Interpreter

Incorporating Cultural Knowledge into Care

Adapting to Diversity

Barriers to Culturally Competent Care

Clinical Outcomes

Summary

References

Section 3: Ethics

Introduction

Purpose/Overall Goal

Core Mandatory Part II (Nursing)

Course Objectives
Ethical Standards
Organizational Ethics
Individual Rights
Individual Responsibilities
Benefits of An Ethics Program
Integrated Ethics Model
Shared Decision-Making with Patients
Patient Privacy and Confidentiality
Professionalism in Patient Care
Ethical Practices in the Workplace
Summary
References

Section 4: 2021 National Patient Safety Goals for Hospitals Nursing Education Module

Introduction
Course Objectives
Goal 1: Improve the accuracy of patient identification.
Goal 2: Improve the effectiveness of communication among caregivers.
Goal 3: Improve the safety of using medications.
Goal 6: Reduce the harm associated with clinical alarm systems.
Goal 7: Reduce the risk of healthcare-associated infections.
Goal 15: The hospital identifies safety risks inherent in its patient population.
Universal Protocol
Resources

Section 5: Patient Rights

Introduction
Purpose/Overall Goal
Course Objectives
The Patient's Bill Of Rights
Nurses as Patient Advocate
Patient Responsibilities
Summary
References

Section 6: Patient Safety Systems and Events

Introduction
Purpose/Overall Goal
Course Objectives
Key Terms
Sentinel Events
Comprehensive Systematic Analysis
Action Plans
Patient Safety Systems

Core Mandatory Part II (Nursing)

Summary

References

Section 7: Conclusion

Course Summary

Course Contributor

Congratulations!

Section 1: Age-Specific Patient Care

Introduction

Every patient is different – and so is every age group. As a caregiver, you must be aware of certain considerations related to each age group and ways to effectively communicate with patients of various ages.

It is important to understand patient needs and what they might be facing at certain times of their lives. This can help you identify issues such as speech or hearing impairments, stress, learning disabilities, depression, and much more.

Educating yourself about these factors can help you deliver the best care possible to your patients.

Purpose/Overall Goal

This module outlines age-specific care and best practices for nine different age groups, from birth to age 80 and beyond.

The goal of this module is to provide healthcare workers with information on how to physical, emotional, social, spiritual, and other needs for different age groups, and how to adjust your patient care with age-specific needs in mind.

Course Objectives

After completing this module, the learner should be able to:

- Demonstrate appropriate communication skills for various age groups
- Describe appropriate healthcare practices for various age groups
- Explain physical and emotional considerations for patients of different ages
- Describe common health conditions to assess in patients at various life stages

Communication Across the Ages

As a healthcare worker, clear communication with patients is key to providing good age-specific care. Each age group has unique physical, psychosocial, and cognitive needs, as well as unique fears and stressors.

By understanding the age-specific needs usually associated with each stage of life, you can provide better, more appropriate care, tailored to the needs of each individual.

For every patient across all age groups you should:

Assess primary language

- Check for speech or hearing impairments

Core Mandatory Part II (Nursing)

- Check for confusion, depression, and signs of illness or stress
- Be aware of possible learning disabilities
- Be mindful of cultural differences
- Understand family structure

Regardless of a patient's age, caregivers must respond to the need of each patient and family for:

- Safety
- Privacy
- Confidentiality
- Comfort
- Pain management
- Healthcare choices

Complex Communication Needs

Keep in mind that individuals with complex communication needs (CCN) who cannot communicate by natural speech alone have the same social, emotional, and physical needs as other individuals.

Communication supports, also known as augmentative and alternative communication (AAC), can help these individuals express themselves.

Examples of AACs include:

- Gestures and body language
- Sign language
- Paper and pencil written communications
- Picture boards or books
- Devices that produce voice output (speech generating devices) or written output
- Electronic communication aids that use picture symbols, letters, and/or words and phrases to create messages

Neonates: Birth-28 Days

The first 28 days of life are a time when neonates are in a state of total dependency and their basic body functions are being established. The following is a checklist of functions to test:

- Reflexes such as grasping, gagging, and startling
- Vital signs (temperature, pulse, respiration)
- Steady weight gain
- Blood glucose levels when appropriate

Keep these practices in mind:

- Always handle the neonate in a gentle, comforting manner to avoid overstimulation.
- Swaddling increases feeling of security and comfort.
- Teach parents proper childcare skills for feeding, diapering, cord care, and bathing.
- Teach parents to always put the baby down on his or her back for sleeping, to help avoid sudden infant death syndrome (SIDS).
- Make sure parents understand the importance of safety devices such as car seats.

Core Mandatory Part II (Nursing)

Infants and Toddlers: 0-3 Years

Infants and toddlers grow and learn rapidly. Although they are dependent, this is when they begin to develop a separate self.

With infants:

- Limit the number of staff workers assigned to each one to avoid “stranger anxiety.”
- Always speak to an infant before a touch to avoid startling him or her.

When delivering care to toddlers:

- Keep in mind that toddlers are impulsive and their moods change quickly.
- Expect an exaggerated response to pain, frustration, and changes in the environment.
- Give one direction at a time, since toddlers have a short attention span.
- Speak at eye level with the child and maintain eye contact.
- Discuss procedures with toddlers immediately before they happen, not too far in advance, since their sense of time is the immediate present.
- Use play to prepare for and explain procedures.
- Provide support and comfort during procedures.
- Use the least intrusive procedures possible, such as axillary temperature and oral medications.

When speaking with parents:

- Emphasize proper hand-washing as a way to prevent disease transmission.
- Encourage parents to communicate with the child, and to touch and cuddle.

In infants and young children, small veins may make inserting an intravenous (IV) line a challenge. Keep these facts in mind:

- Be aware that the child may want to play with the IV tubing.
- Secure the site with a transparent dressing so you can see it easily.
- Inspect and palpate the site every hour.
- Avoid wrapping tape too tightly.

Young Children: 4-6 Years

For children ages 4 to 6 years, some common fears are the dark, being left alone, and bodily injury. It is important to advise parents to:

- Keep immunizations and checkups on schedule
- Teach the child healthy habits for nutrition and grooming
- Learn about safety equipment such as bicycle helmets, elbow pads, and kneepads
- Enforce safety issues regarding fire and pools

When providing care:

- Explain the procedure to the child as well as the parents.
- Never lie to the child about whether something will hurt; instead, tell the child that it won't hurt for long.
- Preschoolers are beginning to explore their own bodies, so procedures involving the genitalia can be especially anxiety-producing.
- Explain when parents will return; preschoolers can understand this concept and can find it comforting.
- Keep in mind that children of this age engage in magical thinking and may become

Core Mandatory Part II (Nursing)

fearful based upon imagined threats.

- Emphasize that the child will wake up after anesthesia.

Be extra careful when giving medications to infants and young children.

- Because of their small size and immature body systems, children are at a higher risk for adverse effects.
- Medication errors are three times more common among pediatric patients as compared to adult patients.
- Medication errors have 10 times the potential for harm in children.

Older Children: 7-12 Years

For children ages 7 to 12, use these approaches:

- Talk, sing, or use distractions such as colorful stickers to divert attention from frightening procedures.
- Encourage the child to ask questions and talk about feelings.
- Respect the child's need for privacy.
- Allow the child to make some care decisions (such as "In which arm do you want the injection?").
- Give permission to display fear or pain.
- Prepare the child for procedures ahead of time.
- Ensure that the child understands the healthcare information you provide.

Keep these factors in mind for children at this age:

- They may have a great fear of the unknown, pain, death, loss of control, or disappointing others.
- They may resent forced dependence and lack of privacy.
- They may view illness or pain with guilt or as punishment.
- Living up to expectations is very important.

Adolescents: 13-20 Years

Between ages 13 and 20, an adolescent's body grows into sexually maturity, and complex thinking develops.

Keep the following in mind when caring for adolescents:

- Adolescent patients should be treated as adults to foster an atmosphere of trust and respect.
- Speak directly to adolescents instead of talking through their parents.
- Invite adolescents to participate in decision making and whether a parent should be present.
- Respect privacy and opinions.
- Encourage questions and verbalization of feelings.
- Be honest.
- Explain treatments and procedures thoroughly.
- Be considerate of how procedures, treatments, etc., may affect appearances and relationships.
- Discuss plans for future and how illness may affect it.

Core Mandatory Part II (Nursing)

When working with adolescents:

- Check for signs of common adolescent health problems such as the nutritional disorders, obesity, anorexia, bulimia, and sexually related health problems such as STDs.
- Adolescents with a family history of genetically related diseases should learn about their family history and be screened appropriately.
- Adolescent girls should be taught breast self-examination; adolescent boys should be taught testicular self-examination.
- Maintain an updated knowledge base about acne causes and treatments, since acne is a major concern for this age group.
- Assess illicit substance use and sexual activity in private.
- Seek follow-up referral or resources if you notice signs of depression or suicidal thoughts; suicide is the third most frequent cause of death in this age group.
- Provide support, information, and encouragement related to threats to body image.
- Expect that adolescents may experience mood swings due to hormonal changes, relationships with parents and peers, and identity adjustments.
- Adolescents may experience increased perception of pain.

Young Adults: 21-39 Years

Key concerns when caring for young adults age 21 to 39 are support, honesty, and respect for personal values. Stress can be a factor, since this stage of life usually includes major changes such as marriage, having children, and career adjustments.

Age-specific care for young adults includes:

- Involve patients with their plan of care and in making decisions.
- Support their health care decisions, even if you disagree with them.
- Explore the impact of their hospitalization or illness on work, family, and other commitments.
- Never use terms of endearment (such as honey, sweetie, darling).
- Acknowledge and respect their commitments to family and career.
- Acknowledge and address their worries about the future.

Middle Adults: 40-64 Years

Adults ages 40 to 64 are often reevaluating priorities and making plans for retirement. Respect the fact that most middle-aged adults are at the peak of their influence and authority, and they may be distressed by forced dependency in the patient role.

Be alert for:

- Serious chronic conditions that often develop at this age, such as diabetes, breast cancer, and prostate disorders
- Stress from a midlife crisis that may result in depression or other mental issues
- Stress from being in the “sandwich generation” – the generation responsible for caring for their parents as well as their children

Age-specific care for this age group includes:

- If appropriate, encourage talking about concerns, plans, finances.

Core Mandatory Part II (Nursing)

- Keep a hopeful attitude and help patients concentrate on strengths, not limitations.
- Respect their decisions and give them as much control over their care as possible.
- Never use terms of endearment (honey, sweetie, darling).
- Allow verbalization of fears and concerns.
- Provide privacy.

Check for the following conditions:

- Skin breakdown due to dryness and decreased subcutaneous tissue
- Hypertension and hyperlipidemia, which may not be the cause of hospitalization but may be detected during hospitalization
- Sleep apnea
- Skeletal injury due to diminished bone density and osteoporosis, especially in women
- Obesity due to slower metabolism
- Nutritional deficiencies
- Farsightedness, which is common in middle-aged patients; if the patient does not have reading glasses or magnifiers, ensure that any important reading material (such as forms requiring signature, menus, etc.) is printed in a larger type size, or read the materials aloud for the patient

Older Adults: 65-79 Years

Adults ages 65 to 79 may experience some decline in physical abilities and sensory perception. Use of medications can include multiple medications and can be complex. It is important to help older adult patients work out a manageable medication schedule.

Stay alert to signs of common chronic conditions at this age, such as:

- Arthritis
- Hypertension
- Hearing impairment
- Heart disease
- Digestive and esophageal problems such as reflux
- Bladder and bowel problems

Age-specific care for older adults includes:

- Explain procedures using appropriate and understandable terms.
- Provide warmth if necessary because of the possibility of decreased heat regulation.
- Provide adequate lighting.
- Be alert to impairments that may inhibit mobility or daily activities.
- Provide advice on home safety.
- Preserve dignity and autonomy as much as possible.
- Involve the family with the plan of care, if appropriate.
- Encourage reminiscing.
- Validate concerns.
- Care may require reorientation to environment, time, and day.
- Never use terms of endearment (honey, sweetie, darling).

Keep in mind that many older adults experience losses and grieve these losses, such as the

Core Mandatory Part II (Nursing)

loss of:

- Physical capabilities
- Memory
- A spouse
- Friends
- Independence

Adults Age 80 And Older

Do not assume that mental decline has occurred in all patients 80 and older. Signs of confusion may instead be signaling a treatable illness or depression.

Be on the alert for:

- Chronic illnesses and major health problems
- Complicated medication schedules that are not always followed
- Changes in digestive functions, such as taste, chewing, and bowel functions, which might compromise proper nutrition

Age-specific care for elderly and older frail adults includes:

- Do not treat older adults like children, as patients will likely sense this and resent being patronized.
- Preserve dignity and autonomy as much as possible.
- Encourage reminiscing and talking about feelings, fears, loss, grief, and end-of-life decisions.
- Promote home safety and medication safety.
- Change patients' positions frequently to avoid skin breakdown.
- Ensure patients are warm.
- Provide adequate lighting.
- Ensure safety in the hospital setting to avoid falls and injuries.
- Care may require reorientation to environment, time, and day.
- Never use terms of endearment (honey, sweetie, darling).

Keep the following in mind:

- IV starts and blood draws are often difficult due to fragile veins.
- IV therapy presents the risk of fluid overload, since fluid balance is more delicate with elderly persons.
- The elderly are particularly vulnerable to dehydration, which may present as confusion.
- Fragile skin is easily torn during tape removal, and moving in bed can also injure fragile skin.
- Fractures may result from very minor trauma due to osteoporosis.
- Sensory impairments (vision, hearing, balance problems, loss of feeling in feet) increase with age.
- Immunizations should be updated, particularly against influenza, which can be life threatening for older adults.

The Gerontological Society of America suggests these tips to improve interactions with older adults:

- Face older adults when you speak with them, with your lips at the same level as theirs.

Core Mandatory Part II (Nursing)

- Minimize background noise.
- Monitor and control your nonverbal behavior.
- Speak in simple terms when conveying critical information.
- Use visual aids such as pictures and diagrams to help clarify and reinforce comprehension of key points.
- Verify listener comprehension during a conversation.

Summary

Effective communication between you and your patients can play a major role in good healthcare outcomes. A better understanding of age-related factors influencing health and well-being can lead to better communication skills.

Knowing the differences between each age group, and knowing the best ways to communicate with each, can help you provide the most accurate assessments and the highest level of care.

References

Age-Specific Competencies and Skills. Sun Coast Hospital Pharmacy. Available at: <https://www.quia.com/files/quia/users/juliehl2/Age-Specific-Competency>. Accessed February 23, 2021.

Age-Specific Considerations in Patient Care. AMN Healthcare, Inc. Available at: <https://lms.rn.com/getpdf.php/2019.pdf>. Accessed February 23, 2021.

Augmentative and Alternative Communication (AAC). American Speech- Language-Hearing Association. Available at: <http://www.asha.org/public/speech/disorders/AAC/>. Accessed February 23, 2021.

Beukelman DR, Ray P. Communication supports in pediatric rehabilitation. *Journal of Pediatric Rehabilitation Medicine*, Vol. 3, No. 4, 2010, p. 279-288.

DeVoe JE, Wallace LS, Fryer, GE. Patient Age Influences Perceptions About Health Care Communication. *Fam Med* 2009;41(2):126-33.

Effective Communication in Children's Hospitals. Central Coast Children's Foundation Augmentative Communication Inc. Rehabilitation Engineering Research Center on Communication Enhancement. Available at: <http://www.patientprovidercommunication.org/pdf/25.pdf>. Accessed February 23, 2021.

H.E.A.D.S.S.-A Psychosocial Interview For Adolescents. <http://www.bcchildrens.ca/Youth-Health-Clinic-site/Documents/headss20assessment20guide1.pdf>. Accessed February 23, 2021.

Population-Specific Considerations. Upstate Medical University. Available at: http://www.upstate.edu/hr/document/pop_spec_clin_ss.pdf. Accessed February 23, 2021.

Society for Adolescent Health and Medicine. Available at: <http://www.adolescenthealth.org/Home.aspx>. Accessed February 23, 2021.

Speech and Language Developmental Milestones. National Institute on Deafness and Other

Core Mandatory Part II (Nursing)

Communication Disorders. Available at: <https://www.nidcd.nih.gov/health/speech-and-language>
Accessed February 23, 2021

Tips for Improving Communication with Older Patients. NIH National Institute on Aging.
<https://www.nia.nih.gov/health/tips-improving-communication-older-patients>. Accessed February 23, 2021.

Vision, Hearing, Balance, and Sensory Impairment in Americans Aged 70 Years and Over: United States, 1999-2006. U.S. Centers for Disease Control and Prevention. Available at: <https://pubmed.ncbi.nlm.nih.gov/20377973/>. Accessed October 27, 2016.

What are Age-Specific Competencies? University of Florida Health, Jacksonville. Available at: <http://ufhealthjax.org/volunteer/new/documents/age-specific-competencies.pdf>. Accessed February 23, 2021.

Section 2: Cultural Competence

Introduction

Cultural competence is the ability of healthcare providers to understand and respond effectively to the cultural and language needs of all patients. Studies show that incorporating the concepts of cultural competence into healthcare can increase patient satisfaction and lead to better outcomes.

Patients representing many cultural groups – with diverse concepts of illness and healthcare now reside in the United States. To deliver the best care possible, healthcare workers must acquire new knowledge and competencies to meet their needs.

What's more, there is clear evidence of disparity in healthcare access and health status across racial and ethnic groups within the U.S. population. This serious situation calls for educating healthcare workers about the knowledge and skills necessary to provide quality care to a diverse population.

Purpose/Overall Goal

This module outlines ways in which you as a healthcare worker can improve your awareness and understanding of various cultural factors that may influence healthcare delivery.

The goal of this module is to ensure that you have the knowledge you need to deliver the highest quality of care to diverse patient populations while respecting their traditions, beliefs, and values.

Course Objectives

After completing this module, the learner should be able to:

- Define cultural competence
- Demonstrate increased self-awareness and receptiveness to diverse patient populations
- Describe how to manage cultural differences when delivering care
- Demonstrate how to incorporate cultural understanding into care delivery
- Explain how to overcome barriers posed by cultural diversity

Core Mandatory Part II (Nursing)

Cultural Diversity

As the United States becomes more ethnically and racially diverse, healthcare workers must understand and respect patients' varied perspectives regarding health and wellness. The concept of "cultural competence" in healthcare has emerged to address factors that may contribute to racial or ethnic disparities in care delivery.

Cultural competence in healthcare describes the ability of workers to provide quality care to patients with diverse values, beliefs, and behaviors. In some cases, it may involve tailoring care delivery to meet the social, cultural, and language needs of patients.

Culture is defined as a pattern of learned beliefs and behaviors that are shared among groups. It includes:

- Thoughts and beliefs
- Styles of communicating and interacting
- Views on roles and relationships
- Values, practices, and customs

Culture is shaped by various influences, including:

- Race, ethnicity, nationality
- Language
- Gender
- Socioeconomic status
- Physical and mental ability
- Sexual orientation
- Occupation

Failing to understand and manage these sociocultural differences may have significant health consequences – for minority groups in particular.

According to The Joint Commission, five essential components of cultural competence for healthcare workers are:

- Valuing diversity
- Assessing one's own cultural competence
- Managing cultural differences
- Incorporating cultural knowledge into care
- Adapting to diversity

These five components are explained in the following sections.

Valuing Diversity

As a healthcare worker, you must become aware of your personal attitudes and biases that may consciously or unconsciously influence your care of patients as well as your interactions with colleagues.

A "one size fits all" approach to the care of patients from diverse backgrounds is not useful – and it risks potentially dangerous stereotyping and overgeneralization.

To help you value diversity, keep the following in mind:

- There is no single way to treat any racial and ethnic group, due to the great diversity

Core Mandatory Part II (Nursing)

within each.

- Interventions should be evidence-based, ethical, and flexible enough to be tailored appropriately to each patient.
- Becoming more culturally aware can help eliminate racial and ethnic disparity in care delivery.
- Challenge and confront racism, sexism, classism, and other forms of prejudice and discrimination that may occur in clinical encounters as well as in the society at large.

Assessing One's Own Cultural Competency

As a healthcare worker, assessing your own cultural competence:

- Involves an honest desire not to allow biases to keep you from treating every individual with respect
- Requires an honest reflection on what your positive and negative assumptions are about others

This is not easy; no one wants to admit that they suffer from cultural ignorance or harbor negative stereotypes and prejudices. But learning to evaluate your own level of cultural competency must be part of your ongoing effort to provide better healthcare.

Assessing your unfounded assumptions and any prejudicial thoughts:

- Helps you understand the impact of your unconscious or automatic thinking about others
- Helps you create new mental models of your patients that will, in turn, contribute to the quality of the care you deliver

Managing Cultural Differences

The key to a patient's ability to adhere to treatment is effective communication. But when healthcare providers and patients come from different cultures and perhaps speak different languages, it can be difficult to communicate effectively.

Adherence depends on:

- A patient's acceptance of information about the health threat itself
- The provider's ability to educate the patient on the benefits of a particular treatment
- The patient's perception of the provider's credibility, empathy, and concern

Five activities can contribute greatly to effective communication:

- Asking nonjudgmental questions
- Listening carefully
- Setting realistic goals for behavior change
- Solving problems together
- Working with an interpreter

These activities are described in the following sections.

Managing Cultural Differences: Asking Non-Judgemental Questions

To accomplish this:

- Be empathetic regarding your patient's viewpoints, values, daily responsibilities, and problems.
- Encourage patients to be honest and open with you about their beliefs and concerns.

Core Mandatory Part II (Nursing)

- Keep in mind that cultures place different values on time. For some, acting hurried or impatient can seem like a sign of disrespect.
- Take time to ask questions and listen. A patient who feels respected will be more likely to respond honestly and completely.

Here are examples of the kinds of questions that may help you gain important insights:

- What do you think caused your illness?
- What kind of impact has it had on your life?
- What remedies have you tried?
- What do you hope to get out of this visit?
- Is money a concern, and should we consider less expensive treatment options first?
- Is your illness having an impact on your family?
- Do you have friends or relatives who can help you adhere to treatments, such as watching your children when you buy medicine or attend follow-up visits?
- Will you be able to read the directions on the medicine bottle, and if not, is there a responsible person in your family who can read it for you?

Managing Cultural Differences: Listening Carefully

Keep in mind these tips to help you listen carefully to patients of all cultures:

- Listen to the patient without interrupting or letting your mind wander.
- Show your genuine interest in the patient's replies.
- Be still; don't fidget or sigh.
- Take notes but don't doodle.
- Show that you have been listening by rephrasing your patients' comments. This will give patients an opportunity to understand what you heard them say, and to explain again if what you understood is not what they meant.

Misunderstandings are common even when the patient and provider come from the same culture. When a patient and practitioner come from different cultures, the likelihood of miscommunication is greatly increased.

Managing Cultural Differences: Setting Realistic Goals for Behavior Change

Changing behaviors is a challenge for most people, and it could be even more so when cultural differences come into play. Patient compliance may improve if you consider the social and family context when discussing lifestyle changes.

Dietary changes are among the most difficult, because food and diet are closely related to culture. A patient care plan often includes a change in diet, yet a patient's culture may include dietary stipulations or restrictions.

- Some cultures have strict beliefs about what women can eat during pregnancy or if she has recently given birth.
- Some cultures follow food guidelines based on religious beliefs.

To help patients find ways to gradually change dietary patterns that may be harmful, you should first:

- Show respect and understanding for the patient and for the cultural tradition
- Ask about beliefs and traditions so you can learn more about them

Some Examples:

Core Mandatory Part II (Nursing)

Reducing fat in the diet can be a major challenge for some.

- Is it realistic for patients to significantly reduce fat in their diet if the family's culturally appropriate diet is rich in fats?
- Ask your patient if obesity is a problem for several family members and, if so, would it be appropriate to make fat reduction a family goal rather than a personal one?
- Perhaps this could begin by reducing the level of oil or fat in three dinners per week instead of every meal.

Reducing sugar intake also can be a problem in some families.

- Do they eat dessert with every dinner, or with every lunch and dinner?
- Will the family feel deprived if they change this habit?
- Will they be supportive of a family member who needs to reduce her intake of sweets?
- Maybe they would consider having desserts only on weekends instead of every day – or at one meal a day instead of two.

Salt intake is another example.

- If a family is accustomed to using soy sauce with most meals, it is probably unrealistic to expect them to eliminate soy sauce from their diet.
- Would they be willing to use a reduced-salt soy sauce?

Working with patients to set these types of smaller goals may lead to greater success with behavior change in the long term.

Managing Cultural Differences: Solving Problems Together

For many adults, a lecture – whether from a provider, boss, family member, or teacher – is not the most effective way to receive and act on a health message.

If you are trying to explain a treatment and find a patient looking away, stirring restlessly, or sighing, it may be a sign that you have lost the patient's attention. Most adults are better able to pay attention and remember instructions if they are involved in identifying their problems and seeking practical solutions.

For example:

You have a patient who is not supposed to drink alcohol.

- Ask him what he would do if he were at a family or work event where alcoholic beverages were provided for everyone.
- Your patient's answer may reveal that he is more concerned with offending other family members or his boss than he is with following your advice.
- You may be able to offer him a way out of his dilemma, such as a tactful humorous remark, or a glass of club soda that looks like an alcoholic drink.

You also might try role play:

- Ask the patient to pretend that he is explaining his health problems and the necessary care to family members.
- This can reveal how well he understands his illness and treatment, and can help to clear up any misconceptions.

Core Mandatory Part II (Nursing)

Managing Cultural Differences: Working with An Interpreter

Professional interpreters:

- Must be proficient in at least two languages
- Must be able to convey complex messages using words and grammar that are appropriate to both providers and patients
- Must be able to convey messages without interjecting their own opinions, beliefs, and prejudices
- Must know their role, limitations, and responsibilities as an interpreter for others

Keep in mind that in their effort to be helpful, family members, friends, and other “informal” interpreters are more likely to modify what a patient has actually said.

- Relying on these types of interpreters may mean that a health organization or individual provider is violating Title VI of the Civil Rights Act of 1964.
- Title VI and its supporting regulations guarantee individuals with limited English proficiency (LEP) any language assistance they need to guarantee “meaningful access” to health and social services that receive any form of federal funding.

Therefore, you must make a diligent effort to find professionally trained, qualified interpreters. Qualified medical interpreters have additional skills that enable them to work effectively in health settings:

- They have studied the basics of anatomy and physiology.
- They may know the meanings of medical terms, diseases, and procedures and should be able to make complex medical terminology understandable in the everyday language of patients.
- They know words that may be “taboo” in the language or culture of the patient and the euphemisms that may be used instead.
- They are familiar with the common health beliefs and practices of the cultures whose languages they speak.
- They understand and have been taught to handle the “triadic” relationship, which is the dynamics introduced by having a third person added to a medical encounter.

Keep the following in mind regarding interpreters:

- Simply being bilingual in English and another language does not qualify an individual as an interpreter.
- Don’t depend on children or other relatives and friends, or nonmedical staff, to interpret.
- Nonmedical staff members should not be asked to interpret unless it is a dire emergency and more qualified professionals are not available.
- Follow your organization’s policies and procedures for finding an interpreter appropriate for the situation; many institutions use an interpreter service for all language translation needs.

Incorporating Cultural Knowledge into Care

Incorporating cultural knowledge into care involves understanding how certain movements and customs can mean different things to different people. The U.S. Department of Health and Human Services has developed the following list of nonverbal communications to keep in mind.

Facial Expressions

Core Mandatory Part II (Nursing)

- Although smiling is an expression of happiness in most cultures, it can also signify other emotions. Some Chinese, for example, may smile when they are discussing something sad or uncomfortable.
- Winking has very different connotations in different cultures. In some Latin American cultures, winking is a romantic or sexual invitation. In Nigeria, Yorubas may wink at their children if they want them to leave the room. Many Chinese consider winking to be rude.
- In Hong Kong, it is important not to blink one's eyes conspicuously, as this may be seen as a sign of disrespect and boredom.
- Some Filipinos will point to an object by shifting their eyes toward it or pursing their lips and point with their mouth, rather than using their hands.
- Some Venezuelans may use their lips to point at something, because pointing with a finger is impolite.
- Expressions of pain or discomfort such as crying are also specific to various cultures. Some cultures may value being stoic, while others may encourage more emotion.

Head Movements

- In Lebanon, the signal for "yes" may be a nod of the head. To signal "no," a Lebanese may point his or her head sharply upward and raise the eyebrows. Saudis may signal "yes" by swiveling their head from side to side. They may signal "no" by tipping their head backward and clicking their tongue.

Hand and Arm Gestures

- The "OK" sign is interpreted in Japan as the symbol for money, because the circular shape of the index finger and thumb together suggest the shape of a coin. In Argentina, Belgium, France, Portugal, Italy, Greece, and Zimbabwe, the sign means "zero" or "nothing." In some Eastern European countries, the gesture indicates a bodily orifice and is highly offensive.
- In some parts of the U.S., to hold up crossed fingers is to wish good luck, but to hold crossed fingers behind your back negates whatever pledge or statement you're thinking. In Russia, this is a way of rudely rejecting or denying something. In Argentina and Spain, this sign is made to ward away bad luck. In China, it signifies the number ten.
- The "thumbs-up" gesture has a vulgar connotation in Iran.
- In Colombia, tapping the underside of the elbow with the fingers of the other hand suggests that someone is stingy.
- Many Chinese people point with their entire hand; using the forefinger to point is viewed as rude. Similarly, in India one may use a full hand to point, but never just a single finger.
- In Latin America, a shrug with the palms facing skyward may be interpreted as a vulgar gesture.

Personal Space

- Compared to most people in the U.S., Latin Americans are accustomed to standing and sitting close to people who are not well known to them. Even within the majority population in the U.S., there are important variations in the size of the personal space comfort zone.
- People from the Middle East may stand quite close when talking with each other.
- In some Muslim cultures, a woman may be alarmed if a man, even a male physician,

Core Mandatory Part II (Nursing)

stands or sits too close to her.

Touching

- In some cultures, light touching of the arm or a light kiss to the cheek is very common, even among people who have just met. People from Latin America and Eastern Europe may be very comfortable with this kind of touching, whereas people from many Asian cultures may prefer less physical contact with acquaintances.
- Touching another person's head is considered offensive by some people from Asia and the Middle East. It is therefore inappropriate to pat a child on the head.
- Some Chinese may be uncomfortable with physical contact early in a relationship. Although many Chinese will use a handshake to greet a Westerner, any other contact may be considered inappropriate. This is especially important to remember when dealing with older people or those in positions of authority.
- Men in Egypt tend to be more touch-oriented; a handshake may be accompanied by a gentle touching of the recipient's elbow with the fingers of the left hand.
- A strong, warm handshake is the traditional greeting between men in Latin America. However, because most Latin Americans show affection easily, male friends, like female friends, may embrace. Women may lightly brush their cheeks together.
- Throughout most of the Middle East, it is the custom to reserve the left hand for bodily hygiene. For this reason, one should never offer the left hand to shake hands or accept a gift. This is also true of some African cultures.
- A Western woman should not initiate a handshake with a man in India. Many Indian women will shake hands with a foreign woman, but not a foreign man.
- To many Indians, it is considered rather offensive to (even accidentally) step on someone's foot. Apologies should be made immediately.

Eye Contact

- Making direct eye contact is a sign of disrespect in some cultures. In other cultures, refusing to make direct eye contact is a sign of disrespect. Many Asians may be reluctant to make eye contact with an authority figure. For example, when greeting a Chinese, it is best to avoid prolonged eye contact as a sign of respect and deference.
- Many Middle Easterners have what North Americans and Europeans consider "languid eyes." It may appear that the person's eyes are half closed, but this does not express disinterest or disrespect.
- In Ghana, young children are taught not to look adults in the eye because to do so would be considered an act of defiance.
- In Latin America, good eye contact is important in both social and business situations.

Physical Postures

- In many cultures throughout the world, it is impolite to show the bottom of the shoe, which is often dirty. Therefore, one should not sit with the foot resting on the opposite knee.
- In Argentina, standing with the hands on the hips suggests anger, or a challenge.
- In many cultures, slouching or poor posture is considered to be disrespectful. For example, good posture is important in Taiwan, with Taiwanese men usually sitting with both feet firmly fixed to the floor.

Core Mandatory Part II (Nursing)

Family Interaction

In many of the world's cultures, an individual's health problems are also considered the family's problems, and it is considered threatening to exclude family members from any medical interaction.

For these patients, providers must address the individual's health problem in the context of his or her family. Family members can provide valuable information regarding the patient's diet, health behavior, daily activities, and types of alternative medications used. Their involvement in a treatment plan may be vital to a patient's ability to adhere to the recommended treatment.

At the same time, it is not always culturally appropriate to involve family members, and the provider must be sensitive about when this may NOT be appropriate.

Pregnancy and Childbirth

In many cultures, men are not involved in the activities surrounding pregnancy or childbirth. Despite this apparent exclusion, husbands are responsible for making decisions and giving permission for treatment, medication, and hospital stay.

A provider needs to be ready to involve the mother, mother-in-law, sister, and/or aunt (rather than the husband) in the development of a patient care plan during pregnancy and after childbirth in families that follow this tradition.

Female relatives may also be the most appropriate persons to take care of such tasks as having the husband sign the necessary consent forms or explaining suggested treatment options.

Adapting to Diversity

As a healthcare provider, you may find that adapting patient care to cultural diversity is often necessary. Doing this effectively involves certain cultural considerations:

- Gender and taboos
- Food
- Alternative medicine

Gender and Taboos

The roles of men and women, and the issues that they are able to discuss openly together, vary greatly from one culture to another. For example, in some cultures:

- A son should not converse with his mother's obstetrician about her care
- A wife should not converse with her husband's urologist, or even his cardiologist

Food: An Important Factor in Culture

The food normally served in U.S. hospitals tends to cater to what is seen as a "typical" bland American diet. This poses a significant problem for patients whose standard diet may be significantly different.

Providers should engage the patient's family in this issue.

- Can the family bring food to the hospital?
- Does the family know that certain foods will be beneficial and that others may be less beneficial?

By involving the family in designing an appropriate diet for the patient, the provider will ensure that the family will bring food that is beneficial and will help ensure that the patient will have a healthy diet after discharge.

Core Mandatory Part II (Nursing)

Alternative Medicine

Many patients may be taking other medications, some prescribed by another provider and some by a traditional healthcare provider. Often the patient's family is a valuable source of information about all medications the patient is taking, particularly alternative medications with which the provider may be unfamiliar.

By discussing concerns openly and respectfully with the patient and family:

- The provider can explore the possible consequences of taking certain alternative medicines along with the prescribed medications
- Avoid potentially dangerous interactions between Western medicines and traditional herbs

Barriers to Culturally Competent Care

Certain barriers can make it difficult to deliver culturally competent care. These barriers include:

- A lack of diversity in a healthcare organization's leadership and workforce
- Systems of care that are poorly designed to meet the needs of a diverse patient population
- Poor communication between providers and patients of different racial, ethnic, or cultural backgrounds

Some ways in which these barriers may be overcome include:

- Establishing and strengthening programs to develop minority healthcare leadership, to produce a core of professionals who may assume influential positions
- Hiring and promoting minorities in the healthcare workforce
- Involving community representatives in a healthcare organization's planning and quality improvement meetings

Clinical Outcomes

Cultural competence can have a significant impact on clinical outcomes. But ignoring culture can lead to negative health consequences in a number of ways:

- Patients may choose not to seek needed services for fear of being misunderstood or disrespected.
- Patients may not take medical advice because they do not understand or do not trust the provider.
- Providers may miss opportunities for screening because they are not familiar with conditions that may be prevalent among certain racial or ethnic groups.
- Providers may fail to take into account differing responses to medication.
- Providers may lack knowledge about traditional remedies used by certain cultures, leading to harmful drug interactions.
- Providers may make diagnostic errors resulting from miscommunication.
- Providers may not order appropriate diagnostic tests because they may not understand the patient's description of symptoms.

On the other hand, healthcare experts make a clear connection between cultural competence, quality improvement, and the elimination of racial or ethnic disparities.

Core Mandatory Part II (Nursing)

Summary

It is the responsibility of all healthcare workers to deliver culturally competent healthcare. You must ensure that patients of various cultures, especially those with limited English proficiency, do not face barriers when accessing healthcare and getting appropriate treatment.

When you deliver culturally competent healthcare, you could see:

- More successful patient education
- More patients seeking the healthcare they need
- More appropriate testing and screening
- Fewer diagnostic errors
- Fewer complications from prescription drugs interacting with traditional remedies used by patients
- Greater adherence to medical advice
- Expanded healthcare choices and access, if patients feel they are no longer restricted to a small pool of clinicians who share their language and culture

References

Advancing Effective Communication, Cultural Competence, and Patient- and Family- Centered Care. The Joint Commission. Available at:

<https://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>

f. Accessed February 23, 2021.

Cultural Competence in Health Care: Emerging Frameworks And Practical Approaches. The Commonwealth Fund. Available at: <https://www.commonwealthfund.org/publications/fund-reports/2002/oct/cultural-competence-health-care-emerging-frameworks-and>. Accessed February 23, 2021.

Cultural Respect. National Institutes of Health. Available at: <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect>. Accessed February 23, 2021.

Improving Cultural Competence to Reduce Health Disparities for Priority Populations. Agency for Healthcare Research and Quality. Available at:

<https://www.ncbi.nlm.nih.gov/books/NBK361126/> Accessed February 23, 2021.

Multi-Cultural Resources for Health Information. United States Department of Health and Human Services. Available at: <https://nnlm.gov/mar/guides/consumer-health/multicultural> Accessed February 23, 2021.

Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals. The California Endowment. Available at:

https://www.mghihp.edu/sites/default/files/about-us/diversity/principles_standards_cultural_competence.pdf. Accessed February 23, 2021.

What Is Cultural and Linguistic Competence? Agency for Healthcare Research and Quality. Available at: <http://www.ahrq.gov/professionals/systems/primary-care/cultural-competence-mco/cultcompdef.html>. Accessed February 23, 2021.

Core Mandatory Part II (Nursing)

Section 3: Ethics

Introduction

Healthcare ethics is a set of moral principles and values that guide providers in making choices about medical care. Healthcare ethics is also called medical ethics or bioethics.

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

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

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

Purpose/Overall Goal

This module outlines The Joint Commission's standards regarding ethics in healthcare delivery, the benefits of having an ethics program, and a new model called Integrated Ethics.

The goal of this module is to assist you as a healthcare worker in delivering ethical care to patients by providing guidelines related to decision-making, patient privacy, informed consent, end-of-life care, conflicts of interest, and more.

Course Objectives

After completing this module, the learner should be able to:

- Explain The Joint Commission's ethical standards
- Describe the ethical responsibilities of healthcare workers
- Define the individual rights of patients
- Describe the portions of the Integrated Ethics model pertaining to healthcare workers
- Describe common ethical dilemmas and how to respond appropriately

Ethical Standards

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

The goal of the Joint Commission standards is to:

- Ensure that care, treatment, and services are provided in a way that respects and promotes dignity, autonomy, positive self-regard, civil rights, and involvement of patients
- Consider each patient's abilities and resources, the demands of his or her environment, and the requirements and expectations of providers and those they serve
- Ensure that the family is involved in care and treatment decisions, with the patient's approval

TJC standards cover three areas:

- Organizational Ethics
- Individual Rights

Core Mandatory Part II (Nursing)

- Individual Responsibilities

These three areas are described in the following sections.

Organizational Ethics

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

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

There are three aspects of organizational ethics:

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

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

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

Individual Rights

According to The Joint Commission, individual rights involve:

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

The standards for individual rights include these five considerations:

- **Shared Decision-Making** – In order to deliver the highest quality care, providers are no longer expected only to provide information to patients – but to partner with patients as well.
 - Clinicians bring their specialized knowledge of science, medicine, and technology
 - Patients weigh that information along with their preferences, values, and experiences
- **Informed Consent** – Shared decision-making is documented through the process of informed consent. It means that patients have the capacity to make decisions and can appreciate their available options, and that their decisions are voluntary.
- **Advance Care Planning** – Advance care planning is a way to promote shared decision-making at times when patients don't have the ability to make such decisions. Patients can document their wishes and/or name a proxy to make decisions about their treatments at times when they are unable to do so themselves.
- **End-of-Life Care** – This involves how decisions are made once the goals of care change from curative to palliative at the end of life. As a healthcare provider, your goals

Core Mandatory Part II (Nursing)

are:

- Supporting end-of-life decision-making
 - Ensuring that decisions made are consistent with the values and desires of the patient
 - Respecting the individual rights of patients
1. **Privacy and confidentiality** – In addition to protecting patients' autonomy, their personal information must be protected as well. Privacy and confidentiality in healthcare refers to the protection of information that relates to:
- The past, present, or future physical or mental health or condition of an individual
 - The care provided to an individual
 - The past, present, or future payments for healthcare

Individual Responsibilities

According to The Joint Commission, individual responsibilities involve the patient's role in the healthcare process. When patients are partners in care, the safety of healthcare delivery is enhanced.

Some ethical decisions can be made only by the patient. Healthcare providers can inform, consult, and advise, but only the patient can ultimately decide what quality of life is acceptable to him or her.

Benefits of An Ethics Program

For healthcare facilities, having an ethics program in place has these benefits:

- Enhanced patient satisfaction
- Increased employee morale and loyalty
- Improved public relations
- Fewer wasteful or unwanted treatments
- Less diverted staff time
- Enhanced professionalism
- Fewer lawsuits
- Meets The Joint Commission's ethics standards

Traditional ethics programs at facilities have long involved the creation of ethics committees. These committees generally focus on clinical ethics issues, particularly those relating to end-of-life care.

Today there is growing interest in a new model called Integrated Ethics, developed by the National Center for Ethics in Health Care within the U.S. Department of Veterans Affairs (VA).

Integrated Ethics was designed to deal with the full range of ethical concerns in healthcare today.

Integrated Ethics Model

In the Integrated Ethics model, ethical concerns in healthcare are categorized into major domains. These domains were designed to cover the broad range of ethical issues faced by all types of healthcare organizations, including acute-care hospitals, rehabilitation hospitals, outpatient facilities, nursing homes, home care organizations, and healthcare systems.

Core Mandatory Part II (Nursing)

The domains that most pertain to you as a healthcare worker are:

- **Shared decision-making with patients** – How well the organization promotes collaborative decision-making between clinicians and patients
- **Patient privacy and confidentiality** – How well the organization protects patient privacy and confidentiality
- **Professionalism in patient care** – How well the organization fosters behavior appropriate for healthcare professionals
- **Ethical practices in the everyday workplace** – How well the organization supports ethical behavior in common, everyday interactions in the workplace

More about these four domains are in the sections that follow.

Shared Decision-Making with Patients

Shared decision-making involves how well the organization promotes collaborative decision-making between clinicians and patients. This includes:

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

Patient Privacy and Confidentiality

Protecting patient privacy and confidentiality involves:

- **Privacy** – Protecting individuals' interests in maintaining personal space free of unwanted intrusions and in controlling data about themselves
- **Confidentiality** – Nondisclosure of information obtained as part of the clinician - patient relationship

Professionalism in Patient Care

Professionalism in patient care involves how well an organization fosters behavior appropriate for healthcare professionals. This includes:

- **Conflicts of Interest** – Situations that may compromise a caregiver's fiduciary duty to patients, including inappropriate business or personal relationships
- **Truth-Telling** – Open and honest communication with patients, including disclosing bad news, adverse events, etc.
- **Challenging Clinical Relationships** – Staff management of relationships with patients and/or their family and loved ones who present challenging or disruptive behaviors, requests, or demands
- **Respect for Diverse Cultural/Religious Perspectives** – Clinician interactions with

Core Mandatory Part II (Nursing)

patients and/or their family and loved ones of different ethnicity, religion, sexual orientation, gender, age, etc.

- **Respect in Interprofessional Relationships** – Recognition and respect for unique cultures, values, roles, and expertise of other healthcare professionals, and development of cooperative and trusting relationships among professionals

Ethical Practices in the Workplace

Ethical practice in the workplace involves how well the organization supports ethical behavior in common, everyday interactions. This includes:

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

Examples of Ethical Dilemmas

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

- Documentation related to care provided to the client could involve:
 - Was the medication actually given?
 - Was care rendered to the patient?
 - Was treatment protocol followed?
 - Was a medication incident reported even if no adverse reaction was observed?
 - Was care delivered in a timely manner?
- Financial remuneration by patients to healthcare professionals.
 - This could be as little as a small “tip” of \$5 to the nurse for taking “good care” of a patient by the family
 - Or it could be as significant as an all-expense-paid trip to Las Vegas for a physician, by a pharmaceutical company to say thank you for writing prescriptions for their medication

Here are some ethical dilemmas to consider:

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

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

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

Core Mandatory Part II (Nursing)

Summary

There are many reasons why understanding and supporting ethics in patient care is so vital:

- To meet patient needs and expectations
- To address community health needs
- To enhance the quality of care
- To promote professionalism
- To enhance an organization's compliance with regulatory standards

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

References

Domains in Ethics. Integrated Ethics. Available at:

https://www.ethics.va.gov/integratedethics/IE_Resources.asp. Accessed February 23, 2021.

Ethical Principles at the Foundation of JCAHO's Ethics, Rights, and Responsibilities Standards. National Ethics Teleconference. Available at:

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjhPeg6oDvAhVEzIUkHYv4BxkQFjAAegQIARAD&url=http%3A%2F%2Fwww.ethics.va.gov%2Fdocs%2Fnet%2FNET_Topic_20040427_JCAHO_Standards_Ethics_Rights_Responsibilities.doc&usg=AOvVaw3WXevittrwFCGkK8TuZApT. Accessed February 23, 2021.

HCA's Clinical Ethics Manual. Hospital Corporation of America. Available

at: <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwi7z6-D64DvAhVGExoKHc4iC9EQFjAAegQIAxAD&url=https%3A%2F%2Fhcahealthcare.com%2Futil%2Fforms%2Fethics%2FClinical-Ethics-Manual.doc&usg=AOvVaw1AHcjW0wtTQYq7ldEmNTcr>. Accessed February 23, 2021.

Health Care Ethics: Overview of the Basics. Vermont Ethics Network. Available at:

<http://www.vtethicsnetwork.org/ethics.html>. Accessed February 23, 2021.

Integrated Ethics: An Innovative Program to Improve Ethics Quality in Health Care. The Innovation Journal: The Public Sector Innovation Journal. Available at:

<http://www.ethics.va.gov/IEoverview.pdf> Accessed February 23, 2021.

What Is Ethics Quality? Integrated Ethics. Available at:

https://www.ethics.va.gov/docs/integratedethics/what_is_ethics_qual.pdf Accessed February 23, 2021.

Section 4: 2021 National Patient Safety Goals for Hospitals Nursing Education Module

Introduction

This course will cover the 2021 National Patient Safety Goals for nursing staff in the hospital setting.

Core Mandatory Part II (Nursing)

© Joint Commission Resources: National Patient Safety Goals. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, (2021). Reprinted with permission.

Course Objectives

After taking this course, you should be able to:

- Explain the Joint Commission's 2020 National Patient Safety Goals.

Goal 1: Improve the accuracy of patient identification.

NPSG.01.01.01

Use at least two patient identifiers when providing care, treatment, and services.

Rationale for NPSG.01.01.01

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.

Newborns are at higher risk of misidentification due to their inability to speak and lack of distinguishable features. In addition to well-known misidentification errors such as wrong patient/wrong procedure, misidentification has also resulted in feeding a mother's expressed breastmilk to the wrong newborn, which poses a risk of passing bodily fluids and potential pathogens to the newborn. A reliable identification system among all providers is necessary to prevent errors.

Elements of Performance for NPSG.01.01.01

1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1)
2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1)
3. Use distinct methods of identification for newborn patients.

Note: Examples of methods to prevent misidentification may include the following:

- Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example, "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples).
- Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification).
- Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).

Goal 2: Improve the effectiveness of communication among caregivers.

NPSG.02.03.01

Report critical results of tests and diagnostic procedures on a timely basis.

Core Mandatory Part II (Nursing)

Rationale for NPSG.02.03.01

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

Elements of Performance for NPSG.02.03.01

- Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
 - The definition of critical results of tests and diagnostic procedures.
 - By whom and to whom critical results of tests and diagnostic procedures are reported.
 - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures.
- Implement the procedures for managing the critical results of tests and diagnostic procedures.
- Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

Goal 3: Improve the safety of using medications.

NPSG.03.04.01

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

Rationale for NPSG.03.04.01

Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects the basic principles of safe medication management, yet it is routine in many organizations.

The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09.

Elements of Performance for NPSG.03.04.01

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.
Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Refer to NPSG.03.04.01, EP 5, for information on timing of labeling.
2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to

Core Mandatory Part II (Nursing)

another container.

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
 - Medication or solution name
 - Strength
 - Amount of medication or solution containing medication (if not apparent from the container)
 - Diluent and volume (if not apparent from the container)
 - Expiration date when not used within 24 hours
 - Expiration time when expiration occurs in less than 24 hours

Note: The date and time are not necessary for short procedures, as defined by the hospital.

4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.

Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

6. Immediately discard any medication or solution found unlabeled.
7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.

Note: This does not apply to multiuse vials that are handled according to infection control practices.

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.

NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy. Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).

Rationale for NPSG.03.05.01

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy and the precautions they need to take. The use of

Core Mandatory Part II (Nursing)

standardized practices for anticoagulation therapy, which include patient involvement, can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, warfarin, and direct oral anticoagulants (DOACs).

Elements of Performance for NPSG.03.05.01

1. The hospital uses approved protocols and evidence-based practice guidelines for the initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug-drug and drug-food interactions; and other risk factors as applicable.
2. The hospital uses approved protocols and evidence-based practice guidelines for the reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.
3. The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants.
Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.
4. The hospital has a written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy.
Note: For all patients receiving warfarin therapy, use a current international normalized ratio (INR) to monitor and adjust the dosage. For patients on a direct oral anticoagulant (DOAC), follow evidence-based practice guidelines regarding the need for laboratory testing.
5. The hospital addresses anticoagulation safety practices through the following:
 - Establishing a process to identify, respond to, and report adverse drug events, including adverse drug event outcomes
 - Evaluating anticoagulation safety practices, taking actions to improve safety practices, and measuring the effectiveness of those actions in a time frame determined by the hospital.
6. The hospital provides education to patients and families specific to the anticoagulant medication prescribed, including the following:
 - Adherence to medication dose and schedule
 - Importance of follow-up appointments and laboratory testing (if applicable)
 - Potential drug-drug and drug-food interactions
 - The potential for adverse drug reactions
7. The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.
8. When heparin is administered intravenously and continuously, the hospital uses programmable pumps in order to provide consistent and accurate dosing.

Introduction to Reconciling Medication Information

The large number of people receiving healthcare who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and

Core Mandatory Part II (Nursing)

resolves any discrepancies.

The Joint Commission recognizes that organizations face challenges with medication reconciliation. The best medication reconciliation requires a complete understanding of what the patient was prescribed and what medications the patient is actually taking. It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As healthcare evolves with the adoption of more sophisticated systems (such as centralized databases for prescribing and collecting medication information), the effectiveness of these processes will grow.

This National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are designed to help organizations reduce negative patient outcomes associated with medication discrepancies. Some aspects of the care process that involve the management of medications are addressed in the standards rather than in this goal. These include coordinating information during transitions in care both within and outside of the organization (PC.02.02.01), patient education on safe medication use (PC.02.03.01), and communications with other providers (PC.04.02.01).

In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide to patients. It is often important for clinicians to know what medications the patient is taking when planning care, treatment, and services, even in situations where medications are not used.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

Rationale for NPSG.03.06.01

There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future.

Elements of Performance for NPSG.03.06.01

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis.
Note 2: It is often difficult to obtain complete information on current medications from a patient, a good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the Element of Performance.
2. Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings and different patient circumstances.

Core Mandatory Part II (Nursing)

Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.

3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.

Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. (See also HR.01.06.01, EP 1)

4. Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

Goal 6: Reduce the harm associated with clinical alarm systems.

NPSG.06.01.01

Improve the safety of clinical alarm systems

Rationale for NPSG.06.01.01

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety.

Note: Additional information on alarm safety can be found on the AAMI website <https://www.aamifoundation.org/coalitions/clinical-alarm-systems/complementary-research/>.

Core Mandatory Part II (Nursing)

Elements of Performance for NPSG.06.01.01

1. Leaders establish alarm system safety as a hospital priority.
2. Identify the most important alarm signals to manage based on the following:
 - Input from the medical staff and clinical departments
 - Risk to patients if the alarm signal is not attended to or if it malfunctions
 - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
 - Potential for patient harm based on internal incident history
 - Published best practices and guidelines(For more information on managing medical equipment risks, refer to Standard EC.02.04.01.)
3. Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following:
 - Clinically appropriate settings for alarm signals
 - When alarm signals can be disabled
 - When alarm parameters can be changed
 - Who in the organization has the authority to set alarm parameters
 - Who in the organization has the authority to change alarm parameters
 - Who in the organization has the authority to set alarm parameters to “off”
 - Monitoring and responding to alarm signals
 - Checking individual alarm signals for accurate settings, proper operation, and detectability (For more information, refer to Standard EC.02.04.03)
4. Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.

Goal 7: Reduce the risk of healthcare-associated infections.

NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

Rationale for NPSG.07.01.01

According to the CDC, each year, millions of people acquire an infection while receiving care, treatment, and services in a healthcare organization. Consequently, healthcare-associated infections (HAIs) are a patient safety issue affecting all types of healthcare organizations. One of the most important ways to address HAIs is by improving the hand hygiene of healthcare staff.

Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.

Elements of Performance for NPSG.07.01.01

1. Implement a program that follows categories IA, IB, and IC of either the current Centers

Core Mandatory Part II (Nursing)

for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 1)

2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 1)
3. Improve compliance with hand hygiene guidelines based on established goals.

Goal 15: The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01

Reduce the risk for suicide.

Note: EPs 2–7 apply to patients in psychiatric hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3–7 apply to all patients who express suicidal ideation during the course of care.

Rationale for NPSG.15.01.01

Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a healthcare organization is an important step in protecting these at-risk individuals.

Elements of Performance for NPSG.15.01.01

1. For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).

For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.

Note: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).

2. Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.

Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.

3. Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal

Core Mandatory Part II (Nursing)

ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.

4. Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.
5. Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:
 - Training and competence assessment of staff who care for patients at risk for suicide
 - Guidelines for reassessment
 - Monitoring patients who are at high risk for suicide
6. Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.
7. Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance.

Universal Protocol

Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Surgery™

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:

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

The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. A hospital should consider its culture when designing processes to meet the Universal Protocol. In some hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements.

Hospitals should identify the timing and location of the preprocedure verification and site

Core Mandatory Part II (Nursing)

marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time out). Preprocedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital.

Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

UP.01.01.01

Conduct a preprocedure verification process.

Rationale for UP.01.01.01

Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:

- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site.

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:

- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room
- Missing information or discrepancies are addressed before starting the procedure.

Elements of Performance for UP.01.01.01

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.

Note: The patient is involved in the verification process when possible.

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
 - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
 - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
 - Any required blood products, implants, devices, and/or special equipment for the procedure

Note: The expectation of this element of performance is that the standardized list is

Core Mandatory Part II (Nursing)

available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

3. Match the items that are to be available in the procedure area to the patient.

Introduction to UP.01.02.01

Wrong site surgery should never happen. Yet it is an ongoing problem in healthcare that compromises patient safety. Marking the procedure site is one way to protect patients; patient safety is enhanced when a consistent marking process is used throughout the hospital. Site marking is done to prevent errors when there is more than one possible location for a procedure. Examples include different limbs, fingers and toes, lesions, level of the spine, and organs. In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

Responsibility for marking the procedure site is a hotly debated topic. One position is that since the licensed independent practitioner is accountable for the procedure, he or she should mark the site. Another position is that other individuals should be able to mark the site in the interests of work flow and efficiency.

There is no evidence that patient safety is affected by the job function of the individual who marks the site. The incidence of wrong-site surgery is low enough that it is unlikely that valid data on this subject will ever be available. Furthermore, there is no clear consensus in the field on who should mark the site. Rather than remaining silent on the subject of site marking, The Joint Commission sought a solution that supports the purpose of the site mark. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. In most cases, that will be the person performing the procedure.

Recognizing the complexities of the work processes supporting invasive procedures, The Joint Commission believes that delegation of site marking to another individual is acceptable in limited situations as long as the individual is familiar with the patient and involved in the procedure. These include:

- Individuals who are permitted through a postgraduate education program to participate in the procedure
- A licensed individual who performs duties requiring collaborative or supervisory agreements with a licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs).

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.

UP.01.02.01

Mark the procedure site.

Elements of Performance for UP.01.02.01

4. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.

Note: For spinal procedures, in addition to preoperative skin marking of the general

Core Mandatory Part II (Nursing)

spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

5. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.
6. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
 - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed
 - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse (APRN) or physician assistant (PA); who is familiar with the patient; and who will be present when the procedure is performed.

Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.

7. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.

Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

8. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).

Note: Examples of other situations that involve alternative processes include:

- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

UP.01.03.01

A time-out is performed before the procedure.

Rationale for UP.01.03.01

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a timeout, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

Core Mandatory Part II (Nursing)

A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

Elements of Performance for UP.01.03.01

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.
2. The time-out has the following characteristics:
 - It is standardized, as defined by the hospital.
 - It is initiated by a designated member of the team.
 - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.
3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
4. During the time-out, the team members agree, at a minimum, on the following:
 - Correct patient identity
 - The correct site
 - The procedure to be done
5. Document the completion of the time-out.

Note: The hospital determines the amount and type of documentation.

Resources

Joint Commission National Patient Safety Goals 2021: Hospital Accreditation Program
https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2021/hap_npsg_jan2021.pdf

Section 5: Patient Rights

Introduction

Patient rights are outlined in the Patient's Bill of Rights, developed by the American Hospital Association (AHA). This bill refers to the legal rights, or guarantees, for patients receiving medical care, treatment, and services in the United States.

The intent of the Patient's Bill of Rights is to provide patients with optimal healthcare services while also preserving their dignity, personal rights, and legal rights. In addition, each state defines specific patient rights that are protected under state law.

The AHA was one of the first advocates for developing the Patient's Bill of Rights. In 1973, the AHA developed 12 rights to inform patients about what to expect during hospitalization.

Purpose/Overall Goal

This module outlines the 12 rights that comprise the Patient's Bill of Rights developed by the

Core Mandatory Part II (Nursing)

American Hospital Association, and explains the responsibilities of nurses and patients in ensuring those rights are honored.

The goal of this module is to make you, as a healthcare provider, aware of patient rights so you can deliver the highest quality care possible.

Course Objectives

After completing this module, the learner should be able to:

- Describe the rights that patients have according to the Patient's Bill of Rights
- Explain the role of healthcare providers in protecting these patient rights
- Define the role of nurses as patient advocates
- Define the responsibilities that patients have related to their care

The Patient's Bill Of Rights

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

All patients have the right to:

- **Considerate and respectful care.** Patients should be in an environment that preserves their privacy, promotes a positive self-image, and be called by the name they prefer.
- **Appoint someone to make healthcare decisions for them.** This involves creating and executing an advance directive.
- **Current and understandable information about their health.** Patients have the right to be told the truth about their diagnosis and prognosis, and that it be provided in a language they understand.
- **Refuse treatment.** Patients can refuse any portion or all of the treatment recommended or prescribed to them by their medical provider.
- **Privacy.** Patients should be allowed privacy during health discussions with their provider, treatments, procedures, and examinations.
- **Resolution of conflict.** When patients have a grievance regarding any part of the care provided to them, they should be told about the process or policy involved in how to file a complaint.
- **Review their medical records.** A patient is entitled to see their records as well as receive an itemized bill for healthcare services provided.
- **Refuse to participate in research studies.** A patient is entitled to refuse an experimental drug or other therapy in a research study, even if it is recommended by their provider.
- **Confidentiality of their information.** All communication about a patient's health, including their history, diagnosis, treatment, and plan of care should be kept confidential between the patient and only those involved in the care of the patient.
- **Continuity of care.** A patient is entitled to the most comprehensive, high-quality care at a reasonable cost.

Core Mandatory Part II (Nursing)

- **Knowledge of business relationships that influence care.** Patients have to right to know about relationships among a hospital, educational institutions, other healthcare providers, or payers that may positively or negatively affect the care provided to them.
- **Be transferred to another medical facility.** In the event of an emergency, federal regulations require hospitals to either provide treatment until a patient is stabilized, or if capability does not exist, transfer the patient to another hospital. Hospitals are also required to accept transfers if they are capable and provide care as quickly as possible, regardless of the patient's ability to pay or insurance coverage.

Nurses as Patient Advocate

The toll that illness can take on a patient, and the complicated world of modern healthcare, can make it difficult for patients to understand and exercise their rights. So, it is important for all healthcare professionals, particularly nurses, to serve as advocates in helping to protect the rights of patients who can't speak or act for themselves.

As advocates, nurses can assist vulnerable patients and their families in creating, implementing, following, and evaluating a plan of care – while ensuring that this plan is consistent with the patient's values and spiritual and cultural needs.

To become an effective advocate, you must embrace two important concepts:

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

Patient Responsibilities

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

Patients share these responsibilities related to their care:

- To follow hospital rules and regulations, and ask about anything they don't understand
- To cooperate with caregivers and follow the plan of care to which they have agreed, with the understanding that they can change their mind at any time
- To notify their physician, nurse, or other caregivers if they don't understand their diagnosis, treatment, or prognosis
- To inform caregivers if they feel overwhelmed or too sick to have visitors
- To ask about what to expect regarding pain and pain management:
 - To discuss pain relief options with the doctor and/or nurse to develop a pain management plan
 - To ask for pain relief when pain first begins
 - To help the doctor and/or nurse in assessing their pain
 - To communicate with them when pain is not relieved
 - To discuss any worries related to taking pain medication
- To respect the privacy of a roommate, if in a semi-private room

Core Mandatory Part II (Nursing)

- To accept financial obligations associated with their care
- To let nurses, physicians, other caregivers, or the Patient Relations Department know if they are dissatisfied with any aspect of their care
- To be considerate of the rights of other patients, staff, and policies of the facility, such as rules regarding a non-smoking campus and limits to the number of visitors

Summary

As a healthcare provider, it is your responsibility to:

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

References

A Patient's Bill of Rights. American Hospital Association. Available at: <https://www.americanpatient.org/aha-patients-bill-of-rights/>. Accessed February 23, 2021.

The Patient Care Partnership: Understanding Expectations, Rights and Responsibilities. <https://www.aha.org/other-resources/patient-care-partnership>. Accessed February 23, 2021.

Section 6: Patient Safety Systems and Events

Introduction

Today's healthcare professionals are highly trained in many aspects of patient care. But the increasing complexity of healthcare, coupled with expanding medical knowledge, can be overwhelming and difficult to manage at times.

Adding to stress and fatigue within the healthcare environment are other factors such as:

- Turnover within the healthcare team
- Increased expectations to reduce costs
- Changes in technology

A top priority for healthcare professionals and organizations is to "do no harm." Human error, equipment failure, or a system breakdown can result in an adverse patient safety event. Typically, however, the result is due to flaws or failures in the systems and processes.

Today, the attention to patient safety has never been greater. Understanding the concepts and definitions related to patient safety events is a crucial step in taking a proactive approach to preventing potential harm.

Purpose/Overall Goal

This module outlines the key terms regarding patient safety events, The Joint Commission's policies for when safety events occur, and the steps that organizations must take to ensure that a similar event does not occur in the future.

Core Mandatory Part II (Nursing)

The goal of this module is to help you, as a healthcare worker, understand the types of patient safety events that occur in the healthcare setting and the processes in place to address and help prevent them.

Course Objectives

After completing this module, the learner should be able to:

- Define key terms related to patient safety
- Describe the types of patient safety events that are reviewable by The Joint Commission
- Describe ways in which organizations analyze and address patient safety events
- Explain the benefits of patient safety systems

Key Terms

Patient Safety Event – This is a broad category that includes any event, incident, or condition that could have resulted or did result in harm to a patient.

Adverse Event – This is patient safety event that resulted in harm to a patient.

- If an adverse event occurs, hospital leaders should be promptly notified, and an investigation and corrective actions should take place.
- An adverse event may or may not result from an error.

Sentinel Event – This is a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that affects a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm
- Intervention required to sustain life

No-Harm Event – This is a patient safety event that affects a patient but does not cause harm.

Close Call – Also called a “near miss” or “good catch,” this is a patient safety event that did not affect a patient. Close calls should be tracked and used as opportunities to prevent harm.

Hazardous (or Unsafe) Condition – This is a circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event. Hazardous Conditions should be tracked and used as opportunities to prevent harm.

Sentinel Events

The Joint Commission partners with healthcare organizations that have experienced certain patient safety events to improve systems and prevent any further harm. But while hospitals should address all patient safety events, not all of them must be reviewed by the Commission.

The Joint Commission has defined the following criteria for sentinel events that are subject to review:

1. Unanticipated death or major permanent loss of function (not related to the natural course of the patient's illness or underlying condition)
2. One of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition):

Core Mandatory Part II (Nursing)

- Suicide
- Unanticipated death of a full-term infant
- Abduction of any patient
- Discharge of an infant to the wrong family
- Rape, assault (leading to death or permanent loss of function), or homicide of any patient, staff member, licensed independent practitioner, visitor, or vendor while on site at the healthcare organization

Reviewable Sentinel Events

The following are examples of sentinel events that are reviewable under The Joint Commission's Sentinel Event Policy:

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement (unauthorized departure) of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on:
 - The wrong side of a patient's body
 - The wrong site on a patient's body
 - The wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- Abduction of a patient from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in death or major permanent loss of function of a staff member, licensed independent practitioner, visitor, or vendor
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery

Non-Reviewable Patient Safety Events

Patient safety events that are NOT reviewable under The Joint Commission's Sentinel Event Policy include:

- Any close call ("near miss")
- Full or expected return of limb or bodily function to the same level as prior to the adverse event by discharge or within two weeks of the initial loss of said function, whichever is the longer period
- Any sentinel event that has not affected a recipient of care (patient, individual, resident)
- Medication errors that do not result in death or major permanent loss of function
- Suicide other than in an around-the-clock care setting or following elopement (unauthorized departure) from such a setting

Core Mandatory Part II (Nursing)

- A death or loss of function following a discharge against medical advice (AMA)
- Unsuccessful suicide attempts unless resulting in a major permanent loss of function
- Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical consequences

Comprehensive Systematic Analysis

Organizations accredited by The Joint Commission are required to complete a comprehensive systematic analysis to identify the causes of a sentinel event.

A Root Cause Analysis (RCA) is one such method for completing this analysis. Key characteristics of RCA are:

- Analysis is thorough and credible
- Focus is on the system and processes, not on individual performance
- Progresses from special causes in clinical processes to common causes in organizational processes
- Analysis repeatedly digs deeper by asking “Why?” – then, when answered, asks “Why?” again, and so on
- Identification of risk points and their potential contributions to this type of event
- Identification of changes that could be made in systems and processes that would reduce the risk of such events occurring in the future
- Includes participation by the leadership of the hospital and by individuals most closely involved in the processes and systems under review

RCA is just one example of an approach for conducting a comprehensive systematic analysis. Other tools and methodologies may be used by the organization to achieve that same result.

Action Plans

An Action Plan is the product of the Comprehensive Systematic Analysis that identifies the strategies the organization intends to implement to reduce the risk of a similar patient safety event occurring in the future.

The action plan must address the following:

- Action to be taken
- Responsibility for implementation
- Timelines
- Strategies for measuring the effectiveness of the actions
- Strategies for sustaining the change

One such action plan is the Failure Modes and Effects Analysis (FMEA), which is used to identify how processes or systems may fail. Using FMEA allows hospitals to:

- Identify the process or system at high risk for failure
- Determine why it might fail
- Examine the effects of failure
- Create new ideas on how to make the process safer

The goal in FMEA is to fix the potential failure before an adverse event can actually occur.

The FMEA technique was initially developed for use by the U.S. military. It was then expanded

Core Mandatory Part II (Nursing)

to the aerospace industry, nuclear power, aviation, and other fields. FMEA was introduced in healthcare in 2002 in response to The Joint Commission's requirement that hospitals perform a proactive risk assessment on all high-risk processes at least once each year.

Patient Safety Systems

To help reduce risk and improve quality, organizations should have an integrated Patient Safety System that includes the following:

- Safety culture, which is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate
- Safely integrated technologies

A key factor in preventing patient harm is conducting a proactive risk assessment, which:

- Evaluates processes for potential failures
- Addresses the consequences of such failures
- Identifies parts of the process that need improvement

Summary

Patient safety is the responsibility of all members of the healthcare team. Regular education and frequent reminders about potential high- risk and hazard-prone processes can go a long way toward preserving patient safety.

Organizations that employ a blame-free culture – one in which no one is ridiculed or reprimanded for errors – are the most successful in gaining employee cooperation with reporting as well as remedying near-miss and actual adverse events.

Review and transparency of information regarding patient safety events is critical in an organization's ongoing development of a culture of safety. Lessons learned from these analyses should be openly shared throughout the organization as a means of preventing future errors and system breakdown.

References

Patient Safety Systems (PS). The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH). Available at:

https://www.jointcommission.org/assets/1/18/PSC_for_Web.pdf. Accessed February 23, 2021

Sentinel Events (SE). The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH). Available at:

http://www.jointcommission.org/assets/1/6/CAMH_2012_Update2_24_SE.pdf. Accessed February 23, 2021.

Wilson D, Kornusky J, Pravikoff D. Adverse Healthcare Events: Prevention – Failure Modes and Effects Analysis (FMEA). Cinahl Information Systems, Glendale, CA. March 18, 2016.

Core Mandatory Part II (Nursing)

Course Contributor

The content for this course was revised by Elizabeth Kellerman RN MSN.

Elizabeth Kellerman, MSN, RN worked as a critical care nurse in an Intensive Care Unit of a community hospital and that experience provided significant training in caring for older adults. Her experience and knowledge led her to nursing education where she taught at a community college as she received her Master's in Nurse Education at Western Carolina University. As a nursing instructor, she spent time in many types of care settings including medical-surgical inpatient and community living centers. Her passion for education and training has most recently led her to a position as Subject Matter Expert and Content Writer for Relias. She is currently developing her medical writing skills through the University of California San Diego's medical writing program.

Acknowledgment: Rebecca Smallwood, RN, MBA was the previous author of this educational activity but did not participate in the revision of the current version of this course.

Congratulations!

You have finished viewing the course content.