### Manual for Joint Commission and OSHA Core Mandatories

#### Part III

<table>
<thead>
<tr>
<th>Topic</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse: Child, Elder, Intimate Partner</td>
<td>AB: 1</td>
</tr>
<tr>
<td>Advance Healthcare Directives</td>
<td>AD: 1</td>
</tr>
<tr>
<td>Domestic Abuse/Intimate Partner Violence</td>
<td>DV: 1</td>
</tr>
<tr>
<td>Pain Management</td>
<td>PM: 1</td>
</tr>
<tr>
<td>Patient Restraints and Seclusion</td>
<td>RES: 1</td>
</tr>
<tr>
<td>Sexual Harassment</td>
<td>SH: 1</td>
</tr>
<tr>
<td>Workplace Violence</td>
<td>WV: 1</td>
</tr>
</tbody>
</table>

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Abuse: Child, Elder, Intimate Partner

1. Introduction ................................................................. AB: 1
2. Purpose/Overall Goal ................................................... AB: 1
3. Course Objectives ....................................................... AB: 1
4. Child Abuse ............................................................... AB: 2
5. Types of Child Abuse .................................................. AB: 3
6. Signs of Child Abuse ................................................... AB: 5
7. Reporting Child Abuse ................................................ AB: 6
8. Elder Abuse ............................................................... AB: 7
9. Types of Elder Abuse .................................................. AB: 8
10. Reporting Elder Abuse ............................................... AB: 8
11. Intimate Partner Violence ............................................ AB: 11
12. Types of Intimate Partner Violence ............................... AB: 12
13. The Cycle of Intimate Partner Violence ......................... AB: 14
15. Reporting Intimate Partner Violence ............................. AB: 16
16. Conclusion .............................................................. AB: 17

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Abuse: Child, Elder, Intimate Partner

INTRODUCTION

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

The statistics regarding abuse are disturbing:

- In 2014, more than 700,000 children were abused and/or neglected in the U.S.
- In 2015, more than 2.1 million cases of elder abuse were reported in the U.S.
- On average, nearly 20 people per minute are physically abused by an intimate partner in the U.S.

Many victims end up seeking medical care at hospitals, physician offices, and clinics. Healthcare providers are likely to encounter victims of abuse from time to time, and they can play a critical role in recognizing, reporting, and helping victims of abuse.

PURPOSE/OVERALL GOAL

This module outlines what providers need to know about child abuse, elder abuse, and intimate partner violence. It explains the types of abuse that can be experienced by each, how to recognize the signs, and what providers should do if abuse is suspected.

The goal of this module is to give providers the information they need to effectively identify and report suspected cases of abuse in the patients they may be caring for.

COURSE OBJECTIVES

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

1. Define types and possible signs of child abuse
2. Define types and possible signs of elder abuse
3. Define types and possible signs of intimate partner violence
4. Describe what providers should do – and what they should not do – if abuse is suspected
CHILD ABUSE

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

- Any recent act or failure to act on the part of a parent, caretaker, or other person who has responsibility for a child which results in the child’s death, serious physical or emotional harm, sexual abuse or exploitation, or
- An act or failure to act which presents an imminent risk of serious harm to the child

A child is:

- Someone who is less than 18 years old, or
- The age defined by the Child Protection Act of the state in which the child resides (except in the case of sexual abuse)

The U.S. Centers for Disease Control and Prevention (CDC) defines two categories of child maltreatment (abuse and neglect):

1. Acts of commission (child abuse):
   - Physical abuse
   - Sexual abuse
   - Emotional abuse

   - Failure to provide, such as physical, emotional, medical, or educational neglect
   - Failure to supervise, such as inadequate supervision and exposure to violent environments
TYPES OF CHILD ABUSE

1. **Physical Abuse**
   Physical abuse is any action that causes physical harm to a child, even if the harm is not intentional, as in over-punishment. It includes:
   - Kicking
   - Punching
   - Hitting
   - Biting
   - Burning
   - Shaking

2. **Sexual Abuse**
   Sexual abuse is inappropriate sexual behavior with a child. It includes:
   - Fondling a child’s genitals
   - Making the child fondle the adult’s genitals
   - Intercourse
   - Incest
   - Rape
   - Sexual exploitation

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

3. **Emotional/Psychological Abuse**
   Emotional abuse is an act, by parents or caregivers, that could cause behavioral, cognitive (affecting the thinking process), emotional, or mental disorders. Examples of this type of abuse include:
   - Bizarre forms of punishment such as locking a child in a dark closet, basement, or attic
   - Constant criticism, threats, or rejection
   - Withholding love, support, or guidance

Emotional abuse is generally present with most other forms of abuse and is often hard to prove.

4. **Abandonment**
   Abandonment of a child is when:
   - A parent’s identity or whereabouts are unknown
   - The child has been left alone in circumstances where the child suffers serious harm
   - The parent has failed to maintain contact with the child or provide reasonable support for a specified period of time
5. **Neglect**

Neglect is the failure to provide for a child’s basic physical, medical, educational, or emotional needs.

It is important to note that allowances must be made for cultural values, poverty, and other factors that might be part of the reason for neglect. For example, people living in poverty may not be able to afford the medication the child needs.

- Physical neglect includes the failure to provide food, not allowing a runaway to come home, or inadequate supervision so that the child is endangered.
- Medical neglect includes failure to provide or withholding medical treatment or other life-sustaining treatments including water and nutrition, when the treatment would most likely result in correction of a medical condition. This does not include cases where there is no chance of recovery from illness, such as a child with terminal cancer or a newborn with a condition that is incompatible with life.
- Emotional neglect includes not responding to the emotional needs of a child, exposing a child to domestic violence, allowing a child to use drugs and/or alcohol, and the failure to provide the necessary psychological care.
- Educational neglect includes failure to educate a child or attend to special educational needs.

6. **Substance Abuse**

Many states consider substance abuse a form of child abuse and neglect. It may include the following circumstances:

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

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

**Signs of physical abuse include:**
- Injuries inconsistent with the explanation of the injury (for example, an infant who is not yet walking or crawling with a broken leg, or injuries on both sides of the body because of a fall, since injuries due to a fall are usually found on one side only)
- Injuries in several stages of healing, such as old bruises and new bruises
- Evidence of old fractures
- Injuries such as rope burns, scalding, and cigarette burns

**Signs of sexual abuse include:**
- Provocative behavior or knowledge of sexual matters inconsistent with child’s age
- Suicidal gestures
- Behavior problems
- Diagnosis of sexually transmitted disease in a child

**Signs of emotional/psychological abuse include:**
- Poor development of basic skills
- Anxiety or insecurity
- Withdrawal
- Destructive behavior
- Aggression or angry outbursts

**Signs of neglect include:**
- Malnutrition
- Failure to keep medical appointments or prescribed treatment
- Child not dressed for the weather
- Child not taking medicine as prescribed

Be mindful that factors such as poverty may appear as neglect.
REPORTING CHILD ABUSE

In all states, it is MANDATORY that healthcare professionals report suspected cases of child abuse.

Your facility may have its own policies about who files the actual report. As a healthcare worker, you should become familiar with your facility’s policies in this regard.

If a child tells you he or she was abused, or if you suspect abuse:
1. Notify the appropriate state agency as per your facility’s policy (your facility will have a hotline number to call), and they will get the details from the child.
2. DO NOT interview the child; studies show that the testimony of children is less accurate when they are asked to repeat it.
3. DO NOT allow the child to leave with the caregiver until the state agency is contacted and you have their permission to allow the child to leave with the parent/caregiver.

Each state has its own statutes defining:
- The procedure for reporting suspected cases of child abuse to Child Protective Services
- Who must file the report
- Other factors such as criminal punishment for abuse
ELDER ABUSE

Elder abuse is:

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

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

Elder abuse can occur in these settings:

1. **Domestic elder abuse.** This is abuse of an older person by someone who has a special relationship with the elder, such as an intimate partner, spouse, sibling, child, friend, or caregiver. The abuse occurs in the older person’s home or in the home of the caregiver.

2. **Institutional elder abuse.** This is abuse of an older person that occurs in a residential facility for older persons such as a nursing home, foster home, group home, or boarding house. In institutions, the persons who are the abusers have been hired to provide care and protection for elders.
TYPES OF ELDER ABUSE

1. Physical Abuse
Physical abuse is intentional physical pain or injury inflicted on an elder by a person who is responsible for his or her care. Examples include:
- Slapping
- Bruising
- Use of unreasonable physical restraint
- Deprivation of food or water
- Over-medicating or under-medicating

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

2. Sexual Abuse
Sexual abuse (a type of physical abuse) is any nonconsensual sexual contact or sexual act with any person incapable of giving consent. This includes, but is not limited to:
- Unwanted touching
- Sexually explicit photographing
- All types of sexual assault or battery, such as rape, sodomy, or coerced nudity

Signs of sexual abuse include:
- Elder’s report of being sexually abused
- Torn, stained or bloody underclothing
- Bruises or other injuries around breasts or genitals
- Unexplained vaginal or rectal bleeding
- Unexplained sexually transmitted disease (STDs) such as gonorrhea or syphilis

3. Emotional or Psychological Abuse
Emotional or psychological abuse is the infliction of mental or emotional suffering (anguish, pain, or distress) through verbal or nonverbal acts by a person who is in a position of trust. Examples include:
- Verbal assault
- Humiliation
- Intimidation or threats
- Isolation from family and/or friends

Signs of psychological abuse include:
- Elder report of psychological abuse
- Elder being very agitated and upset
- Elder being withdrawn and uncommunicative or nonresponsive
- Unusual behavior often attributed to dementia (hitting, biting)
4. **Neglect**
Neglect is the failure of a caretaker to provide adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision to avoid physical harm, mental anguish, or mental illness to the elder. Examples include:
- Failure to assist with personal hygiene or the provision of clothes
- Failure to protect an elder from health and safety hazards

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

5. **Abandonment**
Abandonment is the desertion by an individual who has assumed responsibility for providing care for an elder or by a person with physical custody of an elder. This includes:
- The desertion of an elder at a clinical facility, shopping mall, or other public location
- Elder report of being abandoned

6. **Financial or Material Exploitation**
Financial or material exploitation is the theft or improper use of an elder’s money or property, without his or her consent, for someone else’s benefit. Examples include:
- Forcing or tricking the elder into selling his or her home
- Forging a signature on pension checks, wills, or financial documents
- Misusing “power of attorney”
- Not allowing the older person to buy needed items such as clothes
- Using the elder’s ATM without permission or taking over bank accounts without permission
- Making changes to the elder’s will without approval
- Providing substandard care despite an elder’s ability to pay
- Unexplained disappearance of funds or valuable possessions
- Elder report of financial exploitation

7. **Self-Neglect**
Self-neglect (also known as self-abuse) is the behavior of an elderly person that threatens his or her own health or safety, such as not providing himself/herself with enough food or water, clothing, shelter, safety, personal hygiene, and/or medication. Self-neglect usually occurs when an elder lives alone.

This excludes any competent older people who make a conscious and voluntary decision to engage in acts that threaten their health or safety and who understand the consequences of those decisions.

Signs of self-neglect include:
- Grossly inadequate housing or homelessness
- Lack of the necessary medical aids
- Hazardous, unsafe, or unclean living conditions
- Dehydration, malnutrition, poor personal hygiene, improperly treated medical conditions
REPORTING ELDER ABUSE

Healthcare professionals in all states are required by law to report any suspected cases of elder abuse.

Your facility may direct the procedure for reporting. All calls are confidential and must be made to your state’s hotline. The investigation will be carried out by the state’s Adult Protective Services.

If abuse is suspected or an elder tells you he or she was abused:
  - Document all findings, including any statements the victim and caretaker make
  - DO NOT allow the elder to leave without permission from the state Adult Protective Services

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

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

Intimate Partner Violence is also known as:
- Domestic violence
- Domestic abuse
- Intimate partner abuse

Intimate Partner Violence happens in all types of intimate relationships:
- Between married couples
- Between unmarried couples
- Between same-sex couples
- Between couples living together or apart

In a relationship where Intimate Partner Violence exists, one person is forced to change his or her behavior because of abuse or the perceived threat of abuse.

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

1. **Physical Abuse**
   Physical abuse is the infliction of pain or physical injury by the victim’s partner. A physical abuser may:
   - Hit, push, kick, slap, hold down, or throw things at the victim
   - Harm a victim’s children, pets, or property
   - Commit battery (a threat of violence accompanied by the ability to carry out the threat)

2. **Sexual Abuse**
   Sexual abuse is violence by the victim’s partner in which sex is used to hurt, degrade, dominate, humiliate, or gain power over the victim. It is an act of aggression.

   The abuse may involve force, coercion, bribes, threats, or corruption, and may include prostitution or money. Abusers may brag or boast to the victim about sexual activities with another person, or compare the victim’s sex actions to those of other persons.

   A victim of sexual abuse may:
   - Be treated as a sex object
   - Be called sexual names
   - Be forced into sexual activities by the abuser
   - Develop an inability to trust, which leads to secrecy and nondisclosure

3. **Psychological Abuse**
   Psychological abuse includes:
   - Intimidation
   - Degradation
   - Coercion
   - False accusations
   - Humiliation
   - Ridicule
   - Threats of physical harm

4. **Financial Abuse**
   Financial abuse of an intimate partner is the misuse or exertion of control over money, access to money, or possessions. It includes stealing and lying about money.

   A financial abuser may:
   - Remove large sums of money from the victim’s bank account
   - Deny the victim the ability to pay bills or buy necessities
   - Deprive the victim of money or access to money
   - Deny the victim job freedom
5. Emotional Abuse

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

Victims of emotional abuse may be:
- Put down by their partner
- Told no one else will want them if the partner leaves
- Ignored or isolated

Emotional abuse is cruel and destructive. It is almost always present in situations where other forms of Intimate Partner Violence occur.
THE CYCLE OF INTIMATE PARTNER VIOLENCE

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

The three phases of the cycle of Intimate Partner Violence are:
1. Tension-building phase
2. Crisis phase
3. Honeymoon phase

Phase 1: Tension-Building Phase
The tension-building phase is characterized by stress.
- The abuser shows signs of increasing irritation with the victim, often finding fault with everything he or she does.
- The victim becomes fearful and tries to find ways to appease the abuser.

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

Phase 3: Honeymoon Phase
The honeymoon phase is characterized by a return to calmer behavior.
- The abuser is sorry and promises to get help and never do this again.
- The abuser may offer affection to the victim.
IDENTIFYING INTIMATE PARTNER VIOLENCE

Victims of Intimate Partner Violence often have obvious physical injuries. Others may have vague complaints and deny abuse.

When a patient denies Intimate Partner Violence, the following signs may alert healthcare workers to suspect abuse:

- A pattern of missed appointments
- Delays in seeking treatment
- Frequent medical visits for vague complaints with lack of evidence of physical causes
- Injuries in several stages of healing, such as old bruises, and evidence of old fractures
- Injuries during pregnancy (because pregnancy is a high-risk situation for abuse)
- Injuries inconsistent with the explanation of the injury

Examples of situations in which the explanation of the injuries are inconsistent with the injuries:

- Someone states that the injuries are caused by a fall, and yet the bruises and cuts, on the hands and arms, are consistent with self-defense injuries.
- Someone states that the injuries are caused by a fall, and yet the injuries are found on both sides of the body (usually, in a fall, injuries are on one side only).
REPORTING INTIMATE PARTNER VIOLENCE

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

As a healthcare worker, your responsibilities include:
- Screening patients for signs of abuse
- Documenting all findings including the victim’s statements
- Ensuring domestic violence information is available in waiting areas and restrooms
- Knowing the options and inform the person about options
- Making referrals, as indicated

Use the acronym RADAR as a guide:
- R = Routinely screen patients
- A = Ask direct questions so the person can answer “yes” or “no”
- D = Document your findings
- A = Assess the person’s safety
- R = Review options and referrals

Options for victims include:
- Pressing charges to have the abuser arrested
- Obtaining an injunction or restraining order against abuser (the purpose of the restraining order is to prevent the abuser from communication or associating with the victim)
- Going to a safe house or shelter for protection and accommodations
- Going back home
- Getting help when ready

BE CAUTIOUS about giving victims a phone number to call for help. The abuser may find it and respond abusively. Instead:
- Help victims memorize the number.
- Tell them how to find the numbers for help.
- Tell them the names of organizations or websites they can look up when it is safe.

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

Where to get help: www.thehotline.org
CONCLUSION

Healthcare providers are in a powerful position to help victims of abuse. You do not need to be an expert on interpersonal relationships and domestic violence to do this. But you should know the risk factors and signs of abuse, and how to report it.

Healthcare providers can take advantage of their unique roles to assess patients of all ages for mistreatment. Knowing what to do if abuse is suspected is critical.

Your role as a provider can make a difference.

REFERENCES:
Advance Healthcare Directives

Advance Healthcare Directives ........................................ AD

1. Introduction ....................................................................... AD: 1
2. Purpose/Overall Goal ........................................................ AD: 1
3. Course Objectives ............................................................ AD: 1
4. About Advance Healthcare Directives ............................. AD: 2
5. Benefits of Advance Healthcare Directives ...................... AD: 3
6. Value of Advance Healthcare Directives ........................... AD: 4
7. Barriers to Advance Healthcare Directives ....................... AD: 5
8. Types of Advance Healthcare Directives ........................... AD: 6
9. Important Considerations ................................................ AD: 7
10. Benefits of Planning Ahead ............................................. AD: 8
11. Conclusion ....................................................................... AD: 9
Advance Healthcare Directives

INTRODUCTION

With today's advanced medical technology and new drug therapies, it is important for individuals to plan for future decision-making as it relates to their medical care. Unexpected health issues can make it difficult or impossible for some people to make important decisions regarding their care at the time they need it.

Advance healthcare directives (AHDs) are legal documents that address these decisions. As a healthcare worker, you should be aware of what these documents mean and how they may affect the care you deliver.

Being familiar with AHDs is also an important part of lowering medical costs. Studies show that almost one-third of all Medicare spending is done in the last weeks or months of a person’s life, and many of these expenses are for patients without any type of AHD in place.

Increasing awareness and education surrounding AHDs can lead to positive impacts on the economic, moral, and ethical issues related to end-of-life care.

PURPOSE/OVERALL GOAL

This module explains what providers need to know about advance healthcare directives (AHDs), including what can be included in them and their benefits and importance.

The goal of this module is to help you as a healthcare worker explain AHD options to patients if the opportunity presents, and to know the fact about AHD provisions so you can help implement them if necessary.

COURSE OBJECTIVES

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

1. Describe the purpose of advance healthcare directives (AHDs)
2. Define what AHDs commonly cover
3. Describe the provider’s role in implementing an AHD
4. Explain the barriers to an AHD
5. Describe important considerations related to AHDs

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ABOUT ADVANCE HEALTHCARE DIRECTIVES

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

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

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

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

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

Such decisions are based on each person’s:

<ul>
  <li>Personal values</li>
  <li>Preferences</li>
  <li>Discussions with loved ones</li>
</ul>
BENEFITS OF ADVANCE HEALTHCARE DIRECTIVES

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

Studies funded by the Agency for Healthcare Research and Quality (AHRQ) have shown that people who talked with their family, physician, or others about their preferences for end-of-life care:
- Had less fear and anxiety
- Felt more in control of their own medical care
- Believed their doctor had a better understanding of their wishes

Other potential benefits of advance care planning, according to the National Institutes of Health, include:
- Decreased personal worry
- Decreased feelings of helplessness and guilt for the family
- Decreased implementation of costly, specialized medical interventions
- Decreased overall healthcare costs
VALUE OF ADVANCE HEALTHCARE DIRECTIVES

Advance healthcare directives (AHDs) are legal documents that address a person’s wishes concerning medical treatments in the event they are incapacitated or unable to speak for themselves.

An AHD is an umbrella term that encompasses all forms of written documents in which a person indicates his or her healthcare preferences while cognitively and physically able to make these decisions.

AHDs are a required component of the Patient Self-Determination Act (PSDA), legislation enacted by the U.S. Congress in 1990 that obligates healthcare institutions to do the following:
- To inquire about a person’s AHD status when he or she is admitted to a healthcare facility
- If the person has an AHD, to incorporate it into his or her medical records

Hospitals and healthcare facilities may offer patients the opportunity to complete an AHD if they do not already have one – but they are not required by the PSDA to do so.

AHDs are important because they:
- Give patients control of their medical care when they become incapacitated
- Provide guidance to healthcare professionals and families so that care decisions are consistent with the patient’s values and preferences
- Afford legal immunity for healthcare professionals and family members from civil and criminal liability when AHDs are followed in good faith

AHDs can be completed by adults age 18 and older and emancipated minors who are of sound mind and acting without undue influence.
BARRIERS TO ADVANCE HEALTHCARE DIRECTIVES

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

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

Advance healthcare directives (AHDs) commonly cover:

- What types of medical conditions the person would or would not want treated (such as a terminal illness)
- What types of medical interventions the person would or would not want (such as a feeding tube or ventilator)
- Under what conditions the person would or would not want life prolonged (such as a persistent vegetative state)
- Organ donation decisions
- Whom the person designates as decision-making healthcare agent or proxy should he or she be unable to make decisions independently
- What the individual values most (such as time spent with family, mental competence, pain relief)

Types of advance healthcare directives include:

- **A living will or a Natural Death Act Declaration**, which usually states the person’s desire to not receive life-sustaining treatment in the event of terminal illness or permanent unconsciousness
- **A medical or treatment directive**, which is a written directive that describes the patient’s wishes in certain situations
- **A durable power of attorney for health care**, which identifies one individual (and an alternate, if desired) as a decision maker for the person
  - The person does not have to be a relative
  - It does not appoint anyone to make legal or financial decisions – only those related to healthcare
- **A combination AHD**, which is a document that includes both a living will and a durable power of attorney or other healthcare-related directives
- **Do-not-resuscitate (DNR) directives**, which prohibit the use of CPR in the event of cardiac or pulmonary arrest
  - AHDs do not necessarily include a DNR
  - A DNR can be in place without an AHD
- **A values history**, which present a patient’s values about healthcare and quality of life, and is intended to help providers and family members in end-of-life planning
  - It often includes treatment preferences
  - It can also include the appointment of a healthcare agent or proxy
- **Organ and tissue donation wishes**, which also can be specified as part of an AHD
  - Common organ and tissue donations include the heart, lungs, pancreas, kidneys, corneas, liver, skin
  - There is no age limit for donating
  - In some states, this information is on a donation card that is carried or noted on a driver’s license
IMPORTANT CONSIDERATIONS

The steps involved in planning for advance healthcare directives (AHDs) are:

1. Obtaining a living will form and a durable power of attorney for healthcare form. These are available from a healthcare provider or institution, or they can be downloaded from a reputable website.
2. The forms must be completed, signed, and dated. Since these forms are legal, it is not necessary for an attorney to create them. State laws regarding the format of these documents vary.
3. In some states, the forms must be notarized; other states just required that they be signed and witnessed.
4. Copies of these forms should be given to family members and healthcare providers.
5. Copies also should be given to the hospital when admitted.

It is important to know these aspects of AHDs:
- Emergency medical technicians cannot honor the AHD and are required to stabilize a person during transfer to a hospital. Once there and evaluated by a physician, an AHD can be put into place.
- AHDs do not expire but can be changed as often as desired. Once a new AHD is written, it invalidates the previous one.
- An AHD does not go into effect while a person is mentally and physically able to make decisions; it only goes into effect when the person becomes incapable of doing so.
- Even in cases where an AHD is in place, family members and/or providers may disagree on the type and course of care for a person. In this case, you should be aware of your institution’s policies and procedures for resolving these types of conflicts.

The portability of advance healthcare directives is also important to understand.
- Every state has its own laws regarding AHDs.
- Not all states recognize AHDs from another state.
- In some cases, if the laws are similar, a state will accept the AHDs.
- Knowing state-specific statutes is important for all healthcare professionals.
BENEFITS OF PLANNING AHEAD

For individuals, the benefits of planning ahead include:
- Comfort in the knowledge that they are prepared for end-of-life care
- A stronger sense of independence
- Knowing that their personal wishes are more likely to be honored
- Knowing that their healthcare proxy is clearly identified
- Fostering trust among family members
- Knowing that their advance healthcare directives (AHDs) can be enacted in a timely manner

For family members, the benefits include:
- Clearly knowing their loved one’s wishes for care
- Less chance of conflict among family members and providers in the event the person is incapacitated
- Less chance of guilt, since they will know that decisions made are in agreement with the person’s values

Aging with Dignity has developed a helpful planning tool, called Five Wishes, for thoughtfully making these types of decisions. Five Wishes is a popular living will because it is written in everyday language and helps people express their wishes in personal and spiritual areas in addition to medical and legal.

This tool is available at https://agingwithdignity.org/five-wishes/about-five-wishes.
CONCLUSION

More than one out of four older Americans face questions about medical treatment near the end of life but are not capable of making those decisions. As a provider – and as a possible patient yourself one day – it is important for you to understand the purpose of advance healthcare directives (AHDs) and the role they play in modern medicine.

The future cannot be predicted, and in many cases an AHD is never used. But having one can give patients, their families, and their providers some peace of mind.

REFERENCES:

Domestic Abuse/Intimate Partner Violence

1. Introduction ................................................................. DV: 1
2. Purpose/Overall Goal ....................................................... DV: 1
3. Course Objectives .......................................................... DV: 1
5. Types of Domestic Abuse/Intimate Partner Violence ........ DV: 3
6. The Cycle of Violence .................................................... DV: 5
8. Abuser Profile .............................................................. DV: 7
9. Statistics ........................................................................ DV: 8
10. Presentation and Assessment .......................................... DV: 9
11. Asking About Domestic Abuse/Intimate Partner Violence ....DV: 10
12. Intervention and Treatment ............................................ DV: 11
13. Safety Plan .................................................................... DV: 13
14. Conclusion ..................................................................... DV: 15
INTRODUCTION

Domestic abuse and intimate partner violence are terms used interchangeably to describe some form of abusive behavior by one person to another within a relationship.

In the past, this type of abuse was believed to occur only in a marital relationship where the husband was the abuser and the wife was the victim. Today, it is known that domestic abuse/intimate partner violence can exist in any type of personal intimate relationship, regardless of gender, marital status, or sexual orientation.

As a healthcare worker, you are in a position to identify and help victims of domestic abuse/intimate partner violence. To do so, it is essential to understand the facts about such violence and how you can recognize its clinical presentation.

PURPOSE/OVERALL GOAL

This module provides an overview of the domestic abuse/intimate partner violence that unfortunately exists in today’s society, and how you as a healthcare worker can help potential victims who may come to you for care.

The goal of this module is to ensure you are equipped to understand, recognize, and respond appropriately to potential abuse victims in order to deliver the best care possible to meet their needs.

COURSE OBJECTIVES

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

1. Define various types of domestic abuse/intimate partner violence
2. Describe general characteristics of abusers and their victims
3. Explain how to identify potential abuse victims
4. Describe how to deliver appropriate care to victims of abuse
5. Describe how to help victims preserve their safety going forward
DEFINING DOMESTIC ABUSE/INTIMATE PARTNER VIOLENCE

Domestic abuse/intimate partner violence is a pattern of threatening or violent behavior toward an intimate partner, used to establish power and control. It can involve physical, sexual, psychological, financial, or emotional abuse.

This type of abuse can happen in all types of intimate relationships:

- Married couples
- Unmarried couples
- Same-sex couples
- Couples living apart

In a relationship where domestic abuse/intimate partner abuse exists:

- One person is forced to change his or her behavior because of abuse or the perceived threat of abuse.
- The abuser seeks to exhibit power or gain control over the victim in various ways.
- The abuse may occur sporadically or continuously, with incidents building upon previous incidents to increase the underlying threat.
TYPES OF DOMESTIC ABUSE/INTIMATE PARTNER VIOLENCE

There are five main categories of domestic abuse/intimate partner violence: physical, sexual, psychological, financial, and emotional.

Physical Abuse
Physical abuse is the infliction of pain or injury by the victim’s partner. Physical abuse involves:
- Hitting, slapping, punching
- Pushing
- Kicking
- Choking
- Holding the victim down
- Assaulting the victim with a weapon
- Throwing things at the victim
- Harming the victim’s children, pets, or property

Sexual Abuse
Sexual abuse is an act of aggression by the victim’s partner in which sex is used to hurt, degrade, dominate, humiliate, or gain power over the victim. The abuse may involve:
- Force
- Coercion
- Bribes
- Threats
- Prostitution

The victim may be treated as a sex object, called sexual names, or forced into sexual activities by the abuser, who:
- May brag or boast to the victim about sexual activities with another person
- Compare the victim’s sex actions to those of other persons

Victims of sexual abuse become unable to trust others, which leads to secrecy and non-disclosure.

Psychological Abuse
Psychological abuse includes:
- Intimidation
- Degradation
- Coercion
- False accusations
- Humiliation
- Ridicule
- Threats of physical harm

Stalking is a form of psychological abuse. Psychological abuse expressed through the Internet is called cyberstalking.
Financial Abuse

Financial abuse of an intimate partner involves:
- Misusing the control over money
- Misusing access to money or possessions
- Stealing and lying about money

A financial abuser may:
- Remove large sums of money from the victim’s bank account
- Deny the victim the ability to pay bills or buy necessities
- Deprive the victim of money or access to money
- Deny the victim job freedom

Emotional Abuse

Emotional abuse is behavior that causes feelings of unworthiness. It can interfere with the positive development of another person. Victims of emotional abuse may be:
- Put down by their partner
- Told no one else will want them if the partner leaves
- Ignored or isolated

An emotional abuser may withhold affection from the victim, or use jealousy, passion, or anger to justify actions. Emotional abuse is almost always present in situations where other forms of domestic abuse/intimate partner violence occur.
THE CYCLE OF VIOLENCE

The term “cycle of violence” describes the recurring pattern of domestic violence. It consists of three phases:

1. Tension-building phase
2. Crisis phase
3. Reconciliation or “honeymoon” phase

Phase 1: Tension-Building Phase
In the tension-building phase, the victim:
- Is forced to suppress his or her own negative emotions in order to preserve the peace
- Will attempt to be compliant and understanding in an attempt to avoid violence

However, despite these attempts by the victim, over time the abuser will become increasingly violent. In some cases, the victim will attempt to encourage violence as a way to end the intolerable anxiety.

Phase 2: Crisis Phase
The crisis phase is characterized by abuse and/or violence, which for some victims is perceived as a relief from the increasing tension and uncertainty of when the abuse will occur.

This is the time when a victim is most open to intervention.

Phase 3: Reconciliation or “Honeymoon” Phase
In this phase, the abuser:
- Feels contrite
- Expresses love
- Promises to reform

As a result, feelings of optimism and hope can inhibit the victim’s ability to ask for help or take seriously the opinions of friends and outside professionals.
REASONS WHY VICTIMS STAY

Victims of domestic abuse/intimate partner violence are often asked why they remain in the abusive relationship. Some basic reasons include the following:

1. **Hope.** In the “honeymoon phase” the abuser appears to have regained sanity and compassion. The abused partner wants to hold on to this peaceful, caring partner and to believe that the abuse will not happen again.

2. **Love.** Domestic violence often occurs in relationships where previously there was love and where a partner is deeply invested in the other’s affection. They will do anything to keep this allegiance alive.

3. **Dependence.** Victims may be psychologically, emotionally, and/or financially dependent on their partner. Despite the abuse, victims may try to protect their partners from police intervention and frequently do not report instances of rape and violence. If questioned a few days after the traumatic event, they will often deny having been assaulted or may minimize the assault.

4. **Powerlessness.** Those who are abused for a long period of time can become worn down and passive in response to abuse. The need to endure replaces the need to fight or escape. Anger toward the abuser turns inward and mixes with self-blame, anxiety, and denial.

5. **Fear.** This may be the most significant factor. Victims believe that seeking help, prosecution, or separation will only escalate the violence and perhaps lead to kidnap, murder, or other violence. Statistics show that approximately half of those prosecuted for abuse threaten revenge – and 30% actually take revenge.
ABUSER PROFILE

There are certain behaviors likely to be found in an abuser. They include:

- Calls the partner names
- Blames the victim for injuries
- Is obsessed with the victim
- Is enraged or hostile
- Is an underachiever (low job status considering education)
- Has a low threshold of anger
- Appears distraught and/or wild-eyed
- Expresses jealousy
- Has a previous record of violence
- May have killed pets
- May have made threats
- May have attempted suicide or is threatening suicide
- Has access to or uses alcohol, drugs, guns
- Uses alcohol and cocaine in combination
- Has a history of family violence
- May have been abused as a child
- Has a psychiatric history

Actions that abusers have taken include:

- Throwing objects
- Hitting the wall
- Biting or kicking
- Attempted strangulation
- Threatening with a weapon
- Assault with a weapon
- Hitting with a closed fist

The following are psychologically abusive techniques common to abusers:

- Keeping weapons in the house
- Continuously criticizing the victim’s clothing, housekeeping, friends, etc.
- Manipulating to restrict the victim and maintain the victim’s dependence
- Threats, including physical violence and public humiliation
- Indications of power (“You can’t get away from me. I’ll follow you, I know where you are.”)
- Forcing sleep deprivation in the victim
- Attempted isolation of the victim (cutting off means of medical attention, monopolizing the attention of the victim, curtailing the victim’s relationship with children, pets, relatives)
The following are recent U.S. statistics for domestic abuse/intimate partner violence:

- Intimate partner violence affects more than 12 million people annually.
- Nearly 5.3 million incidents of domestic violence occur annually among women ages 18 and older, with 3.2 million occurring among men.
- Approximately 1.5 million women are raped or physically assaulted by an intimate partner annually.
- According to the U.S. Centers for Disease Control and Prevention (CDC), lesbians, gay men, and bisexual people experience intimate partner violence at the same or higher rates as non-LGB people.
- A home in which family fighting such as hitting occurs is 4.4 times more likely to be the scene of a homicide than one in which there is no violence.
- Almost 2 million injuries occur each year as a result of domestic violence; approximately one-third of these victims will seek care in an emergency department.

Victims at greater risk are:

- Pregnant women
- Disabled males and females
- Women from families with an income below $10,000
- Women whose job or educational level is higher than their partner’s
PRESENTATION AND ASSESSMENT

As a healthcare worker, you should be aware of some of the potential signs of abuse in patients who may seek care at your facility.

Some tips to keep in mind:
- Take the history of a patient with suspicious injuries in private.
- If a translator is required, do not use a member of the patient’s family; use a professional translator only.
- An abuser may hover over a patient and refuse to let her or him answer questions.
- Inform patients that there are limits to confidentiality and that there are mandatory reporting requirements that healthcare professionals must follow.
- Multiple prior visits to the Emergency Department may suggest a history of abuse.

If you are talking with a suspected abuser:
- Be careful not to use judgmental language. For example, say “What did you do after you pushed her up against the wall?” rather than “What did you do after you beat her?”
- Do not validate statements such as “She made me so mad; that’s why I hit her” by looking or sounding sympathetic.

Some potential signs of abuse may include the following:
- Pain with no visible evidence of injury
- Symptoms of stress, such as panic attacks, palpitations, dizziness, abdominal pain, and chronic headaches
- Depression or suicide attempt
- A victim’s frequent use of sedatives, sleeping pills, or pain medication
- Signs of abuse hidden under the scalp, makeup, jewelry, and clothing
- Injuries at multiple sites (especially bilaterally in the extremities), fingernail scratches, cigarette burns, rope burns, abrasions, minor lacerations, welts, or a burst blood vessel in the eye
- Bite marks
- Contusions, abrasions, or lacerations with circular or linear patterns (from straps or belts)
- Vaginal or labial hematomas or lacerations, recto-vaginal foreign bodies, vaginal or urinary tract infections, or a history of sexual transmitted diseases
- Unexplained spontaneous abortion, miscarriage, or premature labor
ASKING ABOUT DOMESTIC ABUSE/INTIMATE PARTNER VIOLENCE

Raising awareness among healthcare providers has been shown to improve identification of individuals experiencing domestic abuse/intimate partner violence. You must become familiar with your facility’s policies and procedures for interviewing suspected victims, as well as the mandatory reporting requirements in your state.

Various screening tools are available to help providers know what to ask about domestic abuse/intimate partner violence. Among them is the SAFE protocol, an acronym for Stress, Afraid/abused, Friends/family, and Emergency plan.

1. Stress. Ask patients:
   - What stress do you experience in your relationships?
   - Do you feel safe in your relationship?
   - Should I be concerned for your safety?

2. Afraid/abused. Ask patients:
   - What happens when you and your partner disagree?
   - Do any situations exist in your relationships in which you have felt afraid?
   - Has your partner ever threatened to abuse you or your children?
   - Have you been physically hurt by your partner?
   - Has your partner forced you to have unwanted sexual relations?

3. Friends/family. Ask patients:
   - If you have been hurt, are your friends or family aware of it?
   - Do you think you could tell them if it did happen?
   - Would they be able to give you support?

4. Emergency plan. Ask patients:
   - Do you have a safe place to go and the resources you (and your children) need in an emergency?
   - If you are in danger now, would you like help in locating a shelter?
   - Do you have a plan for escape?
   - Would you like to talk with a social worker, counselor, or physician to develop an emergency plan?
INTERVENTION AND TREATMENT

Paramedics
EMS personnel are in the unique position of being the only health professionals who have actual eyewitness exposure to the domestic abuse home environment.
- Especially in responding to situations unrelated to abuse, they may find evidence that would otherwise be unsuspected and unreported.
- They may be the only health professionals able to recognize, report, or suggest intervention.

Emergency Department
Talking to hospital staff is often the only opportunity victims have to seek professional help.
- It is reported that at least 40% of domestic violence victims do not contact the police.
- Of female homicide victims, 44% visited an emergency room two years before their murder.
- A high index of suspicion and routine screening for domestic violence is crucial.

Caring for a victim of domestic abuse/intimate partner violence may include:
- Diagnosing physical injury
- Acknowledging, reassuring, evaluating, and treating emotional injury
- Determining risks to victim and children
- Assessing safety options

Healthcare Professionals
Healthcare professionals should be aware that patients receiving appropriate intervention have less chance of developing long-term conditions such as PTSD, anxiety disorders, depression, substance abuse and paranoia.
- Use plain and simple language to explain procedures and respect the patient’s modesty.
- Touch patients only with their permission.
- Let the victim know she or he is respected, cared for, and listened to.

To the extent permitted by law, patients should be allowed to make their own choices once they are informed of the following key messages:
- Nobody deserves abuse. There is no excuse for it, and it is not the fault of the victim.
- You are not alone. Facing domestic violence is a team effort.
- You have a right to receive help. There is help in the form of support, shelter and legal advice.
- Domestic violence occurs often in our society, continues over time, and increases in frequency and severity.
- Domestic violence is believed to have negative long-term effects on children who are hurt or forced to witness it.
- Domestic violence is a crime, and resources are available to help.
Medical Chart
A legible medical record may mean the difference between punishing an offender and letting him or her go free. It should contain:

- The details of all findings, interventions and actions
- A description of the abusive event, present complaints, patient’s behavior, and related physical or mental health problems
- Detailed descriptions of the patient’s injuries, including type, location, size, color, and apparent age

Other steps to take:

- Preserve any physical evidence such as damaged clothing, jewelry, and weapons.
- If the abusive event is reported to the police, the medical record should reflect that it was reported, including the date and time the report was taken and the name and badge number of the officers who responded.
- Do not presume a police report replaces the need for a clear, documented medical record.

Hospital
Hospitals have specific, unique responsibilities in the aftermath of domestic violence.

- Every attempt must be made to provide a safe temporary haven for a victim and children.
- A compassionate attitude on the part of staff, reinforced by informational posters about domestic violence, can let the patient know the situation is taken seriously.
- The patient’s medical record must document:
  - Consent or patient compliance forms
  - Evidentiary material
  - Required notifications and information releases
  - Referrals to private or public agencies

Legal Intervention and Abuse Reporting
Respond quickly if the patient wants immediate help in the form of law enforcement or legal referral.
- Let the patient know that domestic violence is a crime and that help is available.
- In jurisdictions mandated to report abuse, explain the legal obligation.
- Explain the local response and follow-up, and address the risk of reprisal and possible need for shelter or emergency protection.

Healthcare providers have an ongoing role in mitigating the potential harm that may result from obeying the law.

- Ensure the patient is safe while waiting for the police, and stay with the patient throughout the police interview if he or she requests it.
- Determine the risk to victim and children after the report is filed.
- Ask the patient, “If you return home now, will you be in danger?” and “Have you had any thoughts of harming or killing yourself or anyone else?”
- Obtain a consultation with a psychiatrist if the patient is suicidal or homicidal.
- Take very seriously any threats by the abuser to kill the victim, children, or himself or herself as well as any need to restrain the abuser.
SAFETY PLAN

Tell victims of domestic abuse/intimate partner violence that they can:

- Obtain a free personalized safety plan by calling the Family Violence Prevention Fund at 1-800-313-1310 (but to be aware that written materials such as this may pose a danger if found by the abuser)
- Obtain information online at www.thehotline.org
- Call the National Domestic Violence Hotline at 1-800-799-7233 for help

Counsel the patient on the following safety guidelines:

- Try to avoid arguments in small rooms or rooms with access to weapons.
- Be aware that alcohol and drugs decrease your ability to think and act quickly to protect yourself and your children.
- If possible, ask a friend or neighbor to call police if they hear suspicious noises from your house or over the phone.
- Teach children and friends a code word so they know when to call for help.
- Teach children how to use the telephone to contact police or fire departments (911 is preferable to dialing 0).
- Hide for emergency access:
  - Driver’s license
  - Social security cards
  - Birth certificates, green cards, passports
  - School and health records
  - Welfare identification
  - Insurance records
  - Automobile titles, leases, rental agreements
  - Mortgage papers
  - Marriage license
  - Address book
  - Copies of legal and court documents
  - Money, checkbook, bankbook, and credit card (in your own name if possible)
  - Small supply of medications, clothing, toys, and other comfort items
  - Items of special sentimental value
  - Small sellable objects
  - Extra set of keys to car, house, office, and safe-deposit box

If the victim no longer lives with the abuser, encourage him or her to:

- Change locks on doors and windows as soon as possible
- Live in a home with steel or metal doors
- Install safety devices such as extra locks, window bars, motion-detecting lights, and electronic security systems
- Install smoke detectors, fire extinguishers, and rope ladders for upper windows (leave inside until needed)
Determine from victims:
- What type of help would be valuable?
- What changes they would like to make in their situation?
- What steps might help to implement those changes?
- Is the abuser threatening to kill the victim, and how seriously does the victim take these threats?
- Is there stalking or escalating violence?

Consider:
- Hospital admission if there is no safe place for the patient to go
- Hospitalization in consultation with a psychiatrist if the patient is suicidal or homicidal
- Referral to a primary care provider if the patient wants to go home
- Arranging access to a shelter or other option, such as a motel
- Determining if there is a friend or family member who can provide safe housing for the victim and/or children
CONCLUSION

Domestic abuse/intimate partner violence is a major public health problem in the United States. Victims experience physical injury, mental health consequences such as extreme anxiety and self-esteem issues, suicide attempts, and health problems such as gastrointestinal disorders, substance abuse, and sexually transmitted diseases. These can lead to hospitalization, disability, or death.

As a healthcare worker, you can take steps to help these victims if you understand what to look for, the right questions to ask, and the appropriate actions to take.

REFERENCES:

Pain Management

1. Introduction ................................................................. PM: 1
2. Purpose/Overall Goal ....................................................... PM: 1
3. Course Objectives .......................................................... PM: 1
4. Defining Pain ............................................................... PM: 2
5. Factors Influencing Pain ................................................ PM: 3
6. Types of Pain ............................................................... PM: 4
7. Myths About Pain .......................................................... PM: 5
8. Assessing Pain ............................................................. PM: 6
10. Pain Management Strategies .......................................... PM: 8
11. Non-Pharmacologic Pain Management ............................ PM: 9
12. Non-Opioid Medications ................................................ PM: 10
13. Opioid Medications ...................................................... PM: 11
15. Pain and End-of-Life Care .............................................. PM: 14
16. Conclusion ................................................................. PM: 15
Pain Management

INTRODUCTION

The American Pain Society and The Joint Commission considers pain to be the fifth vital sign – as important to assess and measure as pulse, respiration, temperature, and blood pressure. As with the traditional vital signs, steps must be taken to correct the situation when an assessment shows something is amiss.

Every patient has the right to effective pain management. Treatment of pain is also important to recovery. Uncontrolled pain can lengthen a patient’s hospital stay, decrease a patient’s activity level, and cause unnecessary stress on the body.

PURPOSE/OVERALL GOAL

This module explains types of pain, how it is evaluated, and how it is treated. Myths about pain, pharmacologic and non-pharmacologic management options, and end-of-life care are included.

The goal of this module is to help you as a healthcare worker understand effective ways in which pain can managed in order to deliver the highest quality care possible to patients.

COURSE OBJECTIVES

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

1. Describe the types of pain that may be experienced
2. Define the impact of pain on individuals
3. Demonstrate how pain is assessed and evaluated
4. Define pharmacologic and non-pharmacologic ways of managing pain
5. Describe the role of pain management in end-of-life care
DEFINING PAIN

Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. It can be caused by trauma and a wide variety of disorders, diagnostic tests, or treatments.

Pain is the most common reason why people in the United States seek medical care.
- One in three Americans suffers from some form of chronic pain.
- More than 100 million Americans report chronic pain.
- Approximately 50 million Americans are partially or totally disabled by chronic pain.
- The annual economic cost of chronic pain in adults, including healthcare expenses and lost productivity, is estimated at $560 to $630 billion.

The Joint Commission (TJC) sets these standards to assess and manage pain:
1. All patients are screened for pain when admitted.
2. Patients are reassessed regularly for pain.
3. Patients are taught about pain control.

According to TJC, strategies for managing pain should take into account:
- The patient’s current presentation
- The healthcare provider’s clinical judgment
- The risks and benefits associated with pain-relief strategies, including potential risk of dependency, addiction, and abuse

It is important to remember that:
- Pain is very subjective.
- Pain is whatever the patient says it is.
- Pain may be experienced differently by each individual.
FACTORS INFLUENCING PAIN

A number of factors can influence the way in which pain is experienced:
- A person’s previous experience with pain
- The meaning of pain for each person
- A person’s beliefs about pain
- A person’s usual coping mechanisms
- A person’s psychological state

Family and social expectations can also play a role. The experience of pain may be influenced by the way a person was brought up to view and deal with pain, and by the expectations of the patient’s culture or society. In addition, some people are physically more or less sensitive than others to actual or anticipated injury.

It is also important to recognize that pain can increase because of social and emotional factors as well as changes in disease state.

In addition to discomfort, lack of pain relief can affect a patient’s:
- Immune system function
- Activities of daily living, such as sleep, nutrition, and mobility
- Ability to work
- Length of hospital stay

Remember: It is easier to manage pain BEFORE it becomes severe.
**TYPES OF PAIN**

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

**Acute Pain**
Acute pain is caused by a specific physical condition and generally lasts less than 4 weeks. Some examples are:
- Pain following surgery or a procedure
- Pain from an illness such as a sore throat or ear infection
- Pain following an injury

Acute pain:
- Has a well-defined onset
- Is temporary
- Is predictable
- Is treatable

Once the condition causing the pain no longer exists, the pain will go away.

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

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

**Cancer Pain**
Cancer pain can be acute or chronic. If the cancer is not curable, the pain may worsen as the disease progresses. Cancer pain may be caused by:
- The disease itself
- Treatments (such as surgery, chemotherapy, radiation)
- Infections

Chronic pain and cancer pain can cause the most serious problems by:
- Interfering with a patient’s lifestyle and activities
- Reducing a patient’s quality of life
- Wearing a patient down
- Causing a patient to give up hope
- Causing a patient to consider suicide
MYTHS ABOUT PAIN

There are many myths about pain, and they can have a negative influence on effective pain management.

One common myth is that pain medication (especially drugs such as morphine, Demerol, or codeine) should not be used for long-term illness until there is no other choice, because they are addictive.

This may mean, for example, that an opioid medicine may not be ordered for someone with cancer pain until the patient is dying, in order to prevent addiction. In some cases, pain medication may be withheld even at the end of life, because of side effects.

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

As with other vital signs, pain needs to be assessed when a patient is first admitted and at certain times during treatment. Follow-up pain assessments should take place:

- At regular intervals
- After any intervention to decrease pain (to find out if the intervention helped)

There are a number of physical signs that can show that someone may be in pain, including:

- Grimacing, crying, moaning
- Tension
- Withdrawal
- Restlessness
- Guarded movements
- Rubbing the area of pain

Also keep in mind:

- Increased pulse, respirations, and blood pressure may also be signs of pain. These may not be accurate signs, however, so they should only be used when a patient is not able to report pain verbally.
- Record any physical signs you see, as well as the patient’s report of any pain. This will help you and other staff to be alert for the signs later.
- Remember that every patient experiences pain differently. Any signs you observe apply only to that patient.

Even though there may be some physical signs, the best indication of pain is what the patient says. To assess pain, your healthcare facility will have a pain assessment tool. The tool will have some kind of a rating scale. You need to become familiar with the assessment tool your facility uses.

For example, the tool might ask patients to rate their pain on a scale from 1 to 10, with 1 being no pain and 10 being the worst pain imaginable. Some facilities use a graphic scale with faces that range from a smiley face to one with a large grimace and tears for severe pain.

In addition to assessing patients for pain, you should discuss your facility’s policy regarding pain control. Explain to the patient and family the facility’s commitment to pain management, and tell them whom to notify if:

- The patient experiences pain
- The pain is not relieved after an intervention
EVALUATING PAIN

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

1. **Onset:**
   - When did the pain begin?

2. **Duration:**
   - Is the pain continuous, or does it come and go?
   - If the pain is not continuous, how long does it last?

3. **Location:**
   - Where does it hurt?

4. **Description:**
   - What kind of pain is it? (for example, burning, stabbing, cramping, aching, biting, dull, sharp, gnawing)

5. **Severity:**
   - How severe is the pain? (using your facility’s pain assessment tool)
   - What kinds of things make the pain worse?
   - Is the pain associated with any particular activity? (for example, eating)

6. **Relief:**
   - Does anything relieve the pain and, if so, for how long?
   - What prescribed or over-the-counter medications (including dosage and frequency) has the patient taken to relieve the pain?

7. **Effects:**
   - How does the pain interfere with the patient’s normal activities of daily living?
PAIN MANAGEMENT STRATEGIES

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

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

Pain management decisions are not made by healthcare professionals alone. Pain is a unique experience for each individual, and patient education is an important part of the process.

When developing a pain management strategy, it is important to anticipate the patient’s pain needs and to take a preventive approach. This is especially true when the patient is undergoing procedures that are known to be painful, such as surgery.

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

- Longer hospital stay
- Reduced mobility
- Increased stress on immune system
- Decreased energy reserves
NON-PHARMACOLOGIC PAIN MANAGEMENT

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

Non-pharmacologic pain management methods include:
- Relaxation and distraction techniques
- Physical interventions

Relaxation and distraction techniques work best if they are practiced before they are needed for pain relief. They include:
- Deep breathing (with focus on breathing techniques)
- Listening to music
- Guided imagery
- Biofeedback
- Hypnosis

Physical interventions that can help in the treatment of pain include:
- Massage
- Exercise (especially for chronic pain)
- Applying heat or cold
  - No longer than 20 minutes
  - Be careful of extreme heat or cold that could damage tissue
- Acupuncture
- Position change
- TENS (transcutaneous electrical nerve stimulation), which controls pain by stimulating the nerves at the pain location and helping to block pain signals
NON-OPIOID MEDICATIONS

When medication is used to control pain, the best strategy is to use the least strong drug that still gives adequate pain relief. Usually, pain control measures begin with non-opioid (non-narcotic) drugs.

Non-opioids are generally available in both over-the-counter and prescription strengths. They include:
- Acetaminophen (Tylenol)
- Nonsteroidal anti-inflammatory drugs (NSAIDS) such as aspirin, ibuprofen (Advil), and naproxen sodium (Aleve)

Non-opioids are usually taken by mouth or by suppository. They may also be used in combination with opioids.
- The most common side effect of acetaminophen is hepatotoxicity (liver involvement), which is most common with an overdose.
- The most common side effects of NSAIDS are stomach irritation and prolonged bleeding time.

If the non-opioid medication does not relieve the pain, it may require:
- An increase in dosage
- An increase in frequency
- An increase to the next level of drug
**OPIOID MEDICATIONS**

Opioids (narcotics):
- Are drugs developed from plant-based opium
- Can be either natural or synthetic
- Are used for moderate to severe pain

**Pure Agonists**
One class of opioids is known as pure agonists, which refers to their specific mechanism for pain relief. These types of opioids include:
- Morphine
- Hydromorphone (Dilaudid)
- Fentanyl
- Codeine

Side effects of opioids include:
- Euphoria
- Sedation
- Constipation
- Nausea and vomiting
- Itching
- Urinary retention
- Hypotension
- Respiratory distress

Over time, patients may develop a tolerance for opioids, meaning they require higher dosages to achieve the same pain relief. However, the usual reason for increasing dosage is because of disease progression.

Patients who have received opioids for a long period of time may experience withdrawal when the drug is stopped. This means that patients should not be taken off the drug suddenly but should gradually decrease the drug level over several days.

There are two important things to remember about opioids and other pain drugs:
- Drug-seeking behavior MAY NOT be a sign of addiction.
- Drug-seeking behavior MAY BE a sign of inadequate pain relief.

**Other Opioids**
Other types of opioids – such as nalbuphine (Nubain) and butorphanol (Stadol) – provide less analgesia but fewer side effects. There is also a limit to their effectiveness.
- After a point, higher doses do not increase analgesia.
- These drugs are sometimes used to reverse analgesia and side effects caused by pure agonists.
Administration of Opioids

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

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

Other drugs that may help in pain control are adjuvants. These include:

- Corticosteroids
- Antidepressants
- Local anesthetics
- Anticonvulsants

These drugs are used to:

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

In healthcare, much of the focus is on curative care, in which the goal is for patients to get better. When this goal cannot be met, a patient is considered to be terminally ill.

The patient or family may have decided to discontinue curative treatment or there may be no curative treatment available. In this case, palliative care becomes necessary.

The objectives of palliative care are:
- To make the patient as comfortable as possible
- To support the patient and family during this end-of-life period

When caring for a terminally ill patient, you should:
1. Anticipate pain needs and provide relief before the pain becomes severe
2. Remember that larger doses of analgesia may be needed because of tolerance to the drug and/or because of the progressive disease state
3. Assess the patient frequently for pain management needs
4. Discuss the pain management plan with the patient and family
5. Assure the family that everything possible is being done to keep the patient comfortable

Opioids are often the medication of choice for end-of-life pain.
- They are safe and effective for treating moderate to severe pain.
- They have side effects that can be managed effectively.
CONCLUSION

Pain management is a critical part of patient care, and it is easier to manage pain before it becomes severe. So it is vital for healthcare workers to be able to identify signs of pain while setting aside their own beliefs and misconceptions about how pain is tolerated.

All patients in your care have the right to effective pain management. Your understanding of when and how to assess and treat pain is an integral part of your role as a healthcare provider.

REFERENCES:

- Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education.
Patient Restraints and Seclusion

1. Introduction ................................................................. RES: 1
2. Purpose/Overall Goal ...................................................... RES: 1
3. Course Objectives .......................................................... RES: 1
4. Defining Restraint and Seclusion ....................................... RES: 2
5. Categories of Restraint Use .............................................. RES: 3
6. Types of Restraints .......................................................... RES: 4
7. Initiating Restraint or Seclusion ......................................... RES: 5
8. Applying a Physical Restraint ............................................ RES: 6
9. Complications of Restraints .............................................. RES: 7
10. Important Considerations ................................................ RES: 8
11. Conclusion ................................................................. RES: 9
Patient Restraints and Seclusion

INTRODUCTION

Restraints are any means used to restrict a patient’s movement, activity, or access to his or her body. Patients generally have a right to be free from restraints unless restraint is necessary to treat their medical symptoms or to prevent them from harming themselves or others.

In recent years, a move toward reducing and, if possible, eliminating the use of restraints within healthcare facilities has occurred. Restraining a patient raises serious concerns, such as infringement on patient autonomy, limits on freedom of movement, claims of battery, and risk of physical and/or psychological injury, and even death, resulting from restraints.

Therefore, before using restraints, healthcare professionals must carefully weigh the risks and benefits, and they always should consider whether alternatives to restraint or seclusion are available.

PURPOSE/OVERALL GOAL

This module focuses on physical restraint and seclusion. It outlines the types of restraints used in the healthcare setting, how and when they may be applied, standards for their use, and important considerations for providers to understand.

The goal of this module is to ensure that restraint and seclusion are used appropriately, correctly, and according to established standards for the patients in your care.

COURSE OBJECTIVES

After completing this module, the learner should be able to:
  1. Define restraint and seclusion
  2. Describe types of restraints used in healthcare
  3. Explain conditions for which restraint and seclusion may be used
  4. Explain standards regarding the use of physical restraints
  5. Describe the benefits and complications associated with restraint use
DEFINING RESTRAINT AND SECLUSION

The U.S. Centers for Medicare & Medicaid Services provides the following definitions for restraints and seclusion.

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

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

There are two general categories of restraint use:

1. Medical/surgical
2. Behavioral management

Each category is defined based on the clinical justification for using the restraint and has its own set of requirements related to physician orders, monitoring, and documentation.

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

The **behavioral management restraint designation** applies:

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

It is important for you as a provider to become familiar with the various types of restraints used in the healthcare setting.

- Bed rails can provide assistance with bed mobility, repositioning, and getting out of bed. Raised bed rails, however, are considered a physical restraint when they restrict a patient from getting out of bed.
- Lap and wheelchair belts, which function similarly to seatbelts, can also be considered a restraint and are used for patients with neurologic disorders that affect balance and movement.
- Lap trays support upper body positioning for patients who are in wheelchairs. If not easily removed, a lap tray is considered a physical restraint because it prevents the patient from standing up or getting out of the wheelchair.
- Belt restraints are used to prevent a patient from getting out of a chair or bed in order to reduce risk of falling.
  - Be sure there are no wrinkles in the patient’s gown under the belt, as this can increase the risk for pressure ulcers.
  - Do not position the belt over the patient’s chest, as this can interfere with breathing.
- Limb restraints are wrapped around a patient’s wrists or ankles and are attached to the bed or chair to prevent limb movement. Limb restraints are used to keep patients from getting out of bed without supervision and from touching and interfering with medical equipment (such as IV needles and pumps, monitors, nasogastric tubes) that is necessary for treatment.
  - Be sure not to apply these restraints too tightly so that circulation is not impaired. A good strategy is to ensure that at least two fingers can be placed between the secured restraint and the arm or leg.
  - Do not apply them near an IV site, because occlusion or infiltration of the IV can occur.
- Elbow restraints prevent a patient’s arms from flexing and are commonly used to keep patients from pulling at an IV site. These restraints are made of fabric with slots for flat pieces of plastic or wood, which keep the restraint device from bending and immobilize the elbow.
- Mitt restraints can be placed on patients who try to use their hands to scratch themselves or to undo limb or elbow restraints.
INITIATING RESTRAINT OR SECLUSION

Restraint or seclusion should be initiated:
- Only when less restrictive measures are ineffective
- Only by staff members who have been trained in their use

Examples of patient conditions that might call for the use of restraints are:
- Poor mobility
- Impaired cognition
- High physical dependency
- High risk for falls
- Incidence of falls
- Psychoactive medication use

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

Before initiating restraint or seclusion, consider:
- Whether other less restrictive options are possible
- All potential physical and psychological risks of their use

Give special consideration to vulnerable persons such as:
- Those who are obese or frail
- Those who have medical comorbidities
- Those with intellectual or developmental disabilities
- Those whose repeatedly challenging behaviors put them at risk for incomplete assessments
APPLYING A PHYSICAL RESTRAINT

A physical restraint:
- Is a device applied to a patient in order to immobilize or prevent the patient from freely moving his or her arms, legs, head, and/or body
- Is intended to prevent patient interference with medical procedures, reduce risk for falls and injury, and/or prevent a potentially violent or aggressive patient from causing harm to self or others

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

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

The guidelines for physical restraints do not apply to immobilization procedures or devices that are:
- Used during or immediately following surgical or other procedures (such as the use of IV arm boards)
- Used as protective equipment (such as helmets)
- Used as adaptive devices
COMPLICATIONS OF RESTRAINTS

Physical restraints can cause injury and even death if applied inappropriately or if the patient is not correctly monitored after restraints are applied. The majority of deaths that have occurred were associated with the use of a vest restraint, frequently called a “Posey vest,” which is now banned in many healthcare facilities.

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

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

The use of physical restraints carries legal and ethical implications. A careful evaluation is required when deciding whether to initiate restraint or seclusion.

- There is growing emphasis on the need for providers to seek alternatives to the use of physical restraints.
- At the same time, studies have shown that the risks associated with failure to take immediate action can outweigh the risks of harm associated with the use of restraint or seclusion.

Some important considerations include:

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

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

- Orders for physical restraint cannot be written as a standing order.
- If physical restraints are applied to a patient because of violent or aggressive behavior in an emergency situation when a written order does not exist, the treating clinician must be contacted within a reasonable amount of time to produce a written order. In general, a physician or other prescribing clinician must make a face-to-face assessment of the patient and his or her condition within 1 hour of application of the restraint.
- The assessment of the physician or other prescribing clinician should include evaluating:
  - The patient’s need for physical restraint
  - The patient’s reaction to physical restraint
  - The patient’s behavioral and medical condition
  - The need to continue or discontinue physical restraint
- If the assessment is performed by a nurse or physician assistant, the nurse or physician assistant must consult with the physician or other treating clinician as soon as possible following the assessment.
- The Joint Commission states (unless state law is more restrictive) that each order for physical restraint is to be renewed within the following limits:
  - Every 4 hours for adult patients ages 18 and older
  - Every 2 hours for children and adolescents ages 9 to 17
  - Every hour for children under age 9
  - For a maximum of 24 consecutive hours
CONCLUSION

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

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

REFERENCES:

Sexual Harassment

INTRODUCTION

Sexual harassment occurs in many different settings within society, including in the workplace. Healthcare organizations are unfortunately not immune to this type of conduct.

Some individuals may not immediately realize that their words or deeds can be considered sexual harassment. And others who are targets of sexual harassment may think that it must be tolerated.

Educating employees about the facts and misconceptions surrounding sexual harassment is an important step in preventing or stopping this type of harmful behavior.

PURPOSE/OVERALL GOAL

This module presents facts about sexual harassment in the workplace. It includes an overview of the laws pertaining to this type of harassment, what constitutes sexual harassment, the impact that it can have, and what you should do if you experience it.

The goal of this module is to equip you as a healthcare worker with the information you need to understand sexual harassment and deal with it appropriately if it occurs.

COURSE OBJECTIVES

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

1. Define sexual harassment
2. Explain laws regarding sexual harassment
3. Describe various types of sexual harassment
4. Explain how sexual harassment can impact a victim
5. Describe the steps that a victim of sexual harassment should take
DEFINITION OF SEXUAL HARASSMENT

Sexual harassment is uninvited and unwelcome verbal or physical conduct directed at an employee or coworker because of his or her sex.

In general, sexual harassment in the workplace includes situations where:
- There is a demand for sexual favors in exchange for a job benefit
- An unwanted condition on any person's employment is imposed because of that person's sex

Sexual harassment in the workplace often takes the form of unwanted sexual favors or verbal or physical conduct of a sexual nature which:
- Either reveals or implies an effect on employment
- Unreasonably interferes with work performance
- Creates an intimidating, hostile, or offensive work environment

According to the U.S. Equal Employment Opportunity Commission, in 2015:
- Approximately 83% of sexual harassment cases were filed by females
- Approximately 17% of sexual harassment cases were filed by males
LAWS REGARDING SEXUAL HARASSMENT

Sexual harassment is an illegal form of sex discrimination, which is prohibited by Title VII of the Civil Rights Act.

To be considered sexual harassment, the physical or verbal conduct in question must be both unwelcome and of a sexual nature.

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

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

- Quid pro quo
- Hostile environment

**Quid pro quo harassment** is perpetrated by someone who is in a position of power or authority over another person. Quid pro quo means “this for that.” In this context, it involves expressed or implied demands for sexual favors in exchange for:

- Some benefit, such as a promotion or pay increase
- To avoid some detriment, such as termination or demotion

**Hostile work environment harassment** arises when speech or conduct is so severe and pervasive that it creates an intimidating or demeaning environment that negatively affects a person’s job performance. This type of harassment can be perpetrated by anyone in the work environment, including a peer, supervisor, subordinate, vendor, customer, or contractor.

Examples of conduct that might create a hostile work environment include:

- Inappropriate touching
- Sexual jokes or comments
- Repeated requests for dates
- A work environment where offensive pictures are displayed

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IMPORTANT FACTS ABOUT SEXUAL HARASSMENT

Sexual harassment can occur in a variety of circumstances, such as:

- The victim and the harasser do not have to be of the opposite sex. They could both be female or both be male.
- A direct supervisor, a supervisor from another unit or department, a coworker, or a vendor could all be harassers.
- Anyone affected by the offensive conduct could be the victim – it does not have to be the person being harassed.

In order to prevent sexual harassment, all employees should:

- Be educated on harassment prevention
- Be given a variety of example cases of sexual harassment
- Understand the organization’s zero-tolerance policy

Training should also include:

- The process for filing a complaint
- Explaining how a grievance is handled

Maintaining confidentiality is a crucial step in ensuring that victims do not fear retaliation if they speak up.
TYPES OF SEXUAL HARASSMENT

1. Gender Harassment
   This is the most common type of sexual harassment. It involves generalized sexist statements and behavior that convey insulting or degrading attitudes about women. Examples include:
   - Insulting remarks
   - Offensive written comments or graffiti
   - Obscene jokes

2. Seductive Behavior
   This involves unwanted, inappropriate, and offensive sexual advances. Examples include:
   - Repeated unwanted sexual invitations
   - Insistent requests for dinner, drinks, or dates
   - Persistent letters, phone calls, text messages, posts on social media, and other invitations

3. Sexual Bribery
   This is solicitation of sexual activity or other sex-linked behavior by promise of reward. The proposition may be either overt or subtle.

4. Sexual Coercion
   This involves coercing sexual activity or other sex-linked behavior by threatening retaliation. Examples include:
   - Negative performance evaluations
   - Withholding of promotions
   - Threat of employment termination

5. Sexual Imposition
   This involves forceful touching, feeling, or grabbing, or sexual assault.
EFFECTS OF SEXUAL HARASSMENT

Being sexually harassed can impact a person’s:

- Psychological health
- Physical well-being
- Career development

According to the American Psychological Association, women who have been harassed often change their jobs, career goals, job assignments, educational programs, or academic majors.

Psychological and physical reactions to being harassed are similar to reactions to other forms of stress.

Psychological reactions:

- Depression, anxiety, shock, denial
- Anger, fear, frustration, irritability
- Insecurity, embarrassment, feelings of betrayal
- Confusion, feelings of being powerless
- Shame, self-consciousness, low self-esteem
- Guilt, self-blame, isolation

Physiological reactions:

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

Career-related effects:

- Decreased job satisfaction
- Unfavorable performance evaluations
- Loss of job or promotion
- Drop in work performance due to stress
- Absenteeism
- Withdrawal from work
- Change in career goals
WHAT TO DO IF YOU ARE A VICTIM

If you are a victim of sexual harassment, the American Psychological Association recommends the following actions.

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

You SHOULD NOT:
- Disregard sexually harassing behavior, hoping it will go away
- Blame yourself for the harassment

Sexual harassment is a very serious matter. It is important for all employees, regardless of profession, to understand their employer’s policy on how to report behavior that may be considered harassment.
CONCLUSION

Sexual harassment is a persistent and destructive problem in the U.S. workplace. In a facility that involves patient care, the toll that sexual harassment takes on a victim can impact the quality of care that is delivered.

Understanding what constitutes sexual harassment, and what should be done about it, will assist in minimizing or eliminating it. Consistent communication, empowerment, and appropriate interventions can help create a culture where sexual harassment is not tolerated.

REFERENCES:

Workplace Violence

INTRODUCTION

Workplace violence involves any act or threat of physical harm, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It can range from threats and verbal abuse to physical assaults and even homicide.

Workplace violence is a recognized hazard in the healthcare industry. It can affect and involve employees, patients, vendors, and visitors.

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

PURPOSE/OVERALL GOAL

This module provides an overview of workplace violence in the healthcare setting. It includes information on prevalence, risk factors, prevention strategies, and safety advice for healthcare employees.

The goal of this module is to ensure that you understand the facts about workplace violence and what to do if you encounter it in the course of your work in the healthcare field.

COURSE OBJECTIVES

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

1. Define the types of workplace violence that exist
2. Describe risk factors for violent behavior in a healthcare setting
3. Describe strategies to help prevent workplace violence
4. Define safety measures for healthcare workers to take
DEFINING WORKPLACE VIOLENCE

Workplace violence ranges from offensive or threatening language to homicide. The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site.

An estimated 2 million Americans experience some form of workplace violence each year:
- 60% of these incidents occur in healthcare facilities
- About 50% of emergency department workers are physically assaulted
- Between 97% and 100% of emergency department workers experience some form of verbal abuse

Examples of workplace violence include the following:

1. **Threats** – Expressions of intent to cause harm, such as:
   - Verbal threats
   - Threatening body language
   - Written threats

2. **Bullying** – Verbal abuse that:
   - Isolates the victim from others
   - Interferes with the victim’s work
   - Sometimes attacks the victim’s credibility

3. **Physical assaults** – Attacks that include:
   - Slapping or hitting
   - Rape
   - Homicide
   - Use of weapons such as firearms, bombs, knives

4. **Muggings** – Aggravated assaults, usually conducted by surprise and with intent to rob
RISK FACTORS FOR WORKPLACE VIOLENCE

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

Other healthcare personnel at increased risk of violence include:
- Emergency response personnel
- Hospital safety officers
- All healthcare providers

Violence may occur anywhere in a healthcare facility, but it is most frequent in the following areas:
- Psychiatric units
- Emergency departments
- Waiting rooms
- Skilled nursing facilities
EFFECTS OF WORKPLACE VIOLENCE

The effects of workplace violence can range in intensity and include the following:
- Minor and serious physical injuries
- Temporary and permanent physical disability
- Psychological trauma
- Death

Workplace violence may also lead to negative organizational outcomes such as:
- Poor employee morale
- Increased job stress
- Higher employee turnover
- Reduced trust of management and coworkers
- Hostile working environment
- Poor organizational image
FACTORS CONTRIBUTING TO WORKPLACE VIOLENCE

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

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

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

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

To prevent violence in healthcare facilities, organizations should develop a safety and health program that includes:
- Management commitment
- Employee participation
- Hazard identification
- Safety and health training
- Hazard prevention, control, and reporting

Organizations should evaluate this program periodically. Although risk factors for violence are unique to each facility and its work environment, general prevention strategies can be followed.

Environmental designs can also help with prevention:
- Develop emergency signaling, alarms, and monitoring systems.
- Install security devices such as metal detectors to prevent armed persons from entering the facility.
- Install other security devices such as cameras and good lighting in hallways, parking garages, corridors.
- Provide security escorts to parking lots at night.
- Design waiting areas to accommodate visitors and patients who may have a delay in service.
- Design the triage area and other public areas to minimize the risk of assault.
- Provide staff restrooms and emergency exits.
- Install enclosed nurses’ stations.
- Install deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas.
- Arrange furniture and other objects to minimize their use as weapons.

Behavior modification strategies to help prevent workplace violence include:
- Provide all workers with training in how to recognize and manage escalating behavior and potential and actual assaults, and how to safely resolve conflicts.

Administrative strategies could include:
- Design staffing patterns to prevent personnel from working alone and to minimize patient waiting time.
- Restrict the movement of the public in facilities by card-controlled or keypad access.
- Develop a system for alerting security personnel when violence is threatened.
- Implement a zero-tolerance policy that prohibits any form of violence between staff members.
DEALING WITH THE CONSEQUENCES

Even with the best preventive measures in place, violence still may occur in the healthcare workplace.

Facilities should be prepared to deal with the consequences of this violence by:

- Providing an environment that promotes open communication
- Developing written procedures for reporting and responding to violence
- Offering and encouraging counseling whenever a worker is threatened or assaulted
SAFETY TIPS FOR HEALTHCARE WORKERS

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

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

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

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

Be alert:

- Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
- Be vigilant throughout the encounter.
- Don’t isolate yourself with a potentially violent person.
- Always keep an open path for exiting; don’t let a potentially violent person stand between you and the door.

Take these steps if you can’t defuse the situation quickly:

- Remove yourself from the situation (walk away).
- Call security or 911 for help.
- Report any violent incidents to your manager.
CONCLUSION

There is no universal strategy that can prevent workplace violence. It is the responsibility of all healthcare facilities to develop a comprehensive violence prevention program.

Because risk factors vary among facilities – and even within them – the best approach is to identify risk factors in specific work scenarios and develop strategies to reduce them. A zero-tolerance policy that prohibits any form of workplace violence should be enforced.

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

REFERENCES: