Manual for Joint Commission and OSHA Core Mandatories
Part III - 2016

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Abuse

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What is Child Abuse?

The federal Child Abuse and Prevention Treatment Act (CAPTA) defines child abuse and neglect as: at a minimum, any recent act or failure to act on the part of a parent, caretaker, or other person who has responsibility for the child which results in 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.

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

More than 1% of all children suffer from child abuse or neglect, equivalent to 5 children in a school with 500 students.

Children living in homes where spouse abuse occurs are at higher risk for child abuse.

The CDC further defines of child maltreatment (abuse and neglect) into two categories:

2. Acts of Omission (Child Neglect): failure to provide, such as physical, emotional, medical, or educational neglect; and failure to supervise, such as inadequate supervision and exposure to violent environments.

Types of Child Abuse

- Physical abuse
- Sexual Abuse
- Emotional or Psychological abuse
- Abandonment
- Neglect
- Substance Abuse

Physical Abuse

Physical abuse is a non-accidental action such as kicking, punching, hitting, biting, burning, shaking or other action that causes physical harm to a child, even if the harm is not intentional, as in over-punishment.
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, and 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 day-care provider) or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Emotional / Psychological Abuse

Emotional abuse is an act, by parents or caregivers, which 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. It may also include constant criticism, threats, or rejection, as well as withholding love, support, or guidance. Emotional abuse is generally present with most other forms of abuse and is often hard to prove.

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, or the parent has failed to maintain contact with the child or provide reasonable support for a specified period of time.

Neglect

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

  NOTE: 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.
Substance Abuse

Substance abuse is defined by many states as circumstances that are considered a form of child abuse or neglect that may include the following:

- 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

Signs of Child Abuse

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

Signs of physical abuse include:

- Injuries inconsistent with the explanation of the injury (examples include 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 – 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 neglect include:

- Malnutrition
- Failure to keep medical appointments or prescribed treatment
- Child not dressed for the weather
- Child not taking medicine as prescribed

*Factors such as poverty may appear as neglect.

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

Reporting Child Abuse

In all states, the health professional is a MANDATED REPORTER for suspected cases of child abuse. Individual facilities may have their own policies about who files the actual report.

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 criminal punishment for abuse

If abuse is suspected or if a child tells you he or she was abused:

• Notify the appropriate state agency (your facility will have a hotline number to call) and they will get the details from the child.
• DO NOT interview the child. Studies show that the testimony of children is less accurate when they are asked to repeat it.
• 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.

The health professional is a MANDATED REPORTER of child abuse in all states.

Resources:


Elder Abuse

What is Elder Abuse?

Elder abuse is the physical, emotional, or financial mistreatment, neglect or exploitation of a person 60 years of age 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.

Situations in which elder abuse can occur:

**Domestic elder abuse**

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

**Institutional elder abuse**

Institutional elder abuse 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**

- Physical abuse
- Sexual Abuse
- Emotional or Psychological abuse
- Financial or material exploitation
- Neglect
- Abandonment
- Self-neglect

**Physical abuse**

Physical abuse is intentional physical pain or injury inflicted on an elder by the person who is responsible for his or her care. Examples include slapping, bruising, use of unreasonable physical restraint, deprivation of food or water, and over – 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
Sexual abuse

Sexual abuse is any non-consensual sexual contact or sexual act with any person incapable of giving consent. This includes, but is not limited to, unwanted touching, sexually explicit photographing, and all types of sexual assault or battery, such as rape, sodomy, or coerced nudity.

Signs of sexual abuse (a type of physical 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

Emotional or Psychological abuse

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 with an elder. Examples include verbal assault, humiliation, intimidation, threats, and isolation from the 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 non responsive
- Unusual behavior often attributed to dementia (hitting / biting)

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, and failure to protect an elder from health and safety hazards.

Signs and symptoms of 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
Abandonment

Abandonment is defined as the desertion by an individual who has assumed responsibility for providing care for an elder or by a personal with physical custody of an elder.

Signs and symptoms of abandonment include:
  • The desertion of an elder clinical facility, shopping mall or other public location
  • Elder report of being abandoned

Financial or material exploitation

Financial or material exploitation is the theft or improper use of the 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 cheques or wills, misusing “power of attorney,” and not allowing the older person to buy needed clothes.

_forcing an elder’s signature on a will is financial exploitation._

Signs of financial or material exploitation include:
  • Using the elder’s ATM without permission
  • Taking over a bank account without permission
  • Forgery of an elder’s signature on financial documents
  • Making changes to the 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

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. It occurs when the older person refuses or fails to provide himself/herself with enough food or water, clothing, shelter, safety, personal hygiene and/or medication. Self-neglect usually occurs when an elder lives alone.

The definition excludes any competent older person who makes a conscious and voluntary decision as a matter of personal choice to engage in acts that threaten their health or safety and understands the consequences of those decisions.

Signs and symptoms of self-neglect include:
  • Grossly inadequate housing or homelessness
  • Lack of the necessary medical aids
  • Hazardous or unsafe living conditions and/or unsanitary/unclean living conditions
  • Dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene
Reporting Elder Abuse

As a health professional, in any state, you are a MANDATED REPORTER of suspected cases of elder abuse. Your facility may direct the procedure for reporting. All calls are confidential and must be made to the state hotline. The investigation will be carried out by the state Adult Protective Services.

_in all states, healthcare professionals are mandated to report elder abuse._

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 call, or refer them to, this agency.

Resources:


Spouse Abuse

What is Spouse Abuse?

Spouse abuse, also known as domestic violence or 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, and social abuse of a person. Spouse abuse happens in all types of intimate relationships: between married couples, between unmarried couples, between homosexual couples, and between couples living together or apart. People of different race, income, and education are potential abusers or victims of spouse abuse. In a relationship where spouse abuse prevails, one person is forced to change their behavior because of abuse or the perceived threat of abuse.

1 in 4 women will experience violence in their lifetime.

Children, who witness family violence in their home, often grow up to be spouse abusers or victims.

Power and Control

Spouse abuse or domestic violence is the result of one person’s need for power and control over another and the belief that he or she has the right to gain the power and control in whatever way possible. Husband abuse does exist but represents only 5% of spouse abuse cases; so most examples and illustrations in this module will refer to wife abuse. The abuser seeks to exert power or gain control over the victim in a variety of ways. Ways to exert power and gain control are through:

Types of Spousal Abuse

• Physical abuse
• Sexual abuse
• Social abuse
• Financial abuse
• Emotional abuse

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, and may also harm a victim’s children, pets, or property, or commit battery (a threat of violence accompanied by the ability to carry out the threat).

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. Victims of sexual abuse have a
pronounced inability to trust, which leads to secrecy and non-disclosure. The abuse may involve force, coercion, bribes, threats, or corruption, and may include prostitution or money. A victim of sexual abuse 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, or compare the victim’s sex actions to those of other persons.

Financial abuse

Financial abuse of a spouse 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, or 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. Emotional abuse is almost always present in situations where other forms of spouse abuse occur. It is cruel and destructive. Victims of emotional abuse may be put down by their partner, told no one else will want them if the partner leaves, and ignored or isolated. An emotional abuser may withhold affection from the victim, or use jealousy, passion, or anger to justify actions.

The Cycle of Spouse Abuse

The cycle of abuse is common in many cases of spouse abuse. It results in the battered person living in a state of fear with the belief that there is no escape.

The three phases of the cycle 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 she does, and 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 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 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, promises to get help and never do this again, and may offer affection to the victim.

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**The Healthcare Worker and Spouse Abuse**

Victims of spouse abuse often have obvious physical injuries. Others may have vague complaints and deny abuse. When a patient denies spouse abuse, 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 explanation of 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).

When abuse is suspected:

- Provide privacy and the opportunity for the patient to talk. Privacy also means privacy from partner, family members, or acquaintances.
- Assure the patient of confidentiality.
- Be non-judgmental and caring.
- Ask if the partner has ever harmed or threatened to harm the patient or his or her children.
- Let patient know that there are options. Reinforce the idea that victims do not cause nor deserve the abuse.
- **DO NOT** ask a patient why he or she does not leave the abuser.
- **DO NOT** change your course of action because a patient does not admit to abuse.
Healthcare workers’ responsibilities include:

- Screening all patients for signs of abuse
- Documenting all findings including the victim’s statements
- Ensuring domestic violence information is available in waiting areas and rest rooms
- Knowing the options and inform the patient of options
- Making referrals, as indicated

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 women’s shelter for protection and accommodations
- Going back home
- Getting help when ready

BE CAUTIOUS about giving the victim a phone number to call for help. The abuser may find it and respond abusively. Instead, help the victim memorize the number, tell her how to find the numbers for help, or tell her the names of organizations she can look up in the phone book when it is safe.

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

Resource:

Domestic Violence, Lynn Barkley Burnett, Ed, MS, LLB, eMedicine Journal, co-authored by Jonathan Adler, MD.  
http://emedicine.medscape.com/article/805546-overview#a0104
Advance Care Planning, Directives and Living Wills

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Advance Care Planning

Introduction

As the nations’ population continues to age and medical technology continues to prolong the natural life course, most families are destined to face future medical decision-making in the days ahead. Families plan and prepare for many major life events: attending college, getting married, having a baby, and retiring at the end of a career. However, few plan for events such as how they would want their health care delivered if they become very ill.

These are very important decisions that should be addressed and documented so that family members, health care providers, etc. will know the patient’s wishes for their care.

What is Advance Care Planning?

According to the National Institute on Aging, “Advance care planning involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know about your preferences, often by putting them into an advance directive.”

The decisions are based on an individual’s personal values, preferences, and discussions with their loved ones.

Who Needs Advance Care Planning?

Because an accident or serious illness can happen suddenly, and at any time, every adult can benefit from Advance Care Planning. Planning is particularly important for those who are terminally ill. Research shows that people suffering from chronic illness also benefit from advance care planning. Even healthy people should consider their wishes for end-of-life care and discuss their decisions with family members or professionals, before a health care crisis occurs.

What Are the Benefits of Advance Care Planning?

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, and 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 health care costs
What Is an Advance Directive?

Advance directives are legal documents that address a person’s wishes concerning medical treatments in the event they are incapacitated or unable to speak for themselves. The two types of advance directives are the living will and the durable power of attorney.

Living Will

A living will is a written, legal document that specifies what kind of treatment a person wants in certain situations, typically emergency treatment. This may include specific care options, such as CPR if cardiac or respiratory arrest occurs, artificial feeding options, prolonged use of a respirator if unable to breathe adequately alone, and blood transfusions.

Durable Power of Attorney for Health Care

The durable power of attorney for health care allows a person to name someone, called a health care proxy, who can make medical decisions for them if they are unconscious or lose their ability to communicate. This document does not appoint anyone to make legal or financial decisions for them.

In some cases a person may not feel comfortable putting specific health decisions in writing and instead name a health care proxy to make those decisions. A health care proxy can be named in addition to or instead of a living will.

Other advance care planning documents

A person may want to specify other wishes that are not covered in the living will, such as blood transfusions or dialysis. Other issues that may arise during end of life care are DNR orders and organ and tissue donation.

A **DNR (do not resuscitate) order** is one in which a person does not want to be resuscitated in the event of cardiac arrest. The Living Will may specify that a person does not want CPR, but having a DNR order on the medical chart allows for more specific communication to the healthcare team, which decreases confusion during emergency situations. A **DNI (do not intubate) order** is similar but specifies that a patient does not want to be intubated or put on a breathing machine during emergency situations.

**Organ and tissue donation** is another decision that can be specified as a part of an advance directive that allows for a person to express their wishes. Common organ and tissue donations include the heart, lungs, pancreas, kidneys, corneas, liver, and skin. There is no age limit for donating. Several methods are used to relay this information, in some states a donation card can be carried, or it can be noted on a driver's license, or as part of their advance care planning documents.
What Are the Steps Involved in Advance Care Planning?

1. Obtain a living will form and a durable power of attorney for health care form from a health care provider. It is recommended that both forms are used.
2. Complete, sign, and date the forms. The forms are legal, and it is not necessary to hire a lawyer to create them. State laws on the format of these documents vary. Some states require that forms are notarized; others specify that signed and witnessed forms are sufficient.
3. Provide copies to family members and health care providers. Provide a copy to hospital when admitted.

The federal 1990 Patient Self-Determination Act requires hospitals, nursing homes, and other medical institutions that receive Medicare and Medicaid funding to provide written information about advance care directives to all patients at the time of admission.

Communication to Family and Loved Ones

Communication between individuals and their loved ones is important. Family members may have a difficult time discussing advance care planning, even when it becomes essential. When families do not know the wishes of their loved ones during end-of-life care should a crisis arise, families must make the decisions when they are emotionally overwrought. It is not uncommon that during such stressful periods, family emotions, conflicts, grief, and guilt further complicate the decision-making process. Some people live with the lingering doubt about whether they have made the right decision or not.

An opportunity for discussing advance care plans could be during significant life events, such as the birth of a child or death of a family member. Other opportunities when this discussion would be pertinent is while drawing up a will or estate planning, or when major illness requires that a family member move into a retirement community or nursing home.

Assistance with Advance Care Planning

Nurses and other healthcare professionals can help explore the values that will guide the decision-making process and work through family issues. They can also assist with obtaining and completing forms, and ensuring that copies of the documents are available to doctors and other appropriate professionals. Other professionals, such as elder law attorneys or geriatric case managers, can also help with advance care planning.

How to Consider Future Decisions: The Five Wishes

Aging with Dignity has developed a very helpful planning tool, called The Five Wishes, for thoughtfully making decisions on future desires that encourages people to reflect on what is most important to them (https://agingwithdignity.org/five-wishes/about-five-wishes). People should consider their goals in treatment and values in living. Quality of life is a subjectively defined experience and people value aspects of their life differently than others.
Planning ahead can have many benefits:

Benefits for the Individual

Indeed, there is much to be gained from the communication of advance care plans. For the person who has made advance care plans, benefits include:

1. Comfort in being prepared for end of life care
2. Sense of independence is enhanced
3. Personal wishes are more likely to be honored
4. Surrogate is clearly identified
5. Trust is fostered among family members, and
6. Advance care plans can be enacted in a timely manner

Benefits for Family Members

1. Clarity regarding person’s wishes
2. Increased comfort and decreased conflict among family members and between family, and provider upon person’s incapacitation
3. Preparation for eventual reflection that advance care plans were in agreement with person’s values

Portability of Advance Care Planning Documents

The portability of care plans and advance directive documents is also important to understand. Portability refers to care plans and advance directives being different from state to state. Every state has its own laws regarding advance directives. Not all states recognize advance directives from another state. In some cases, if the laws are similar a state will accept the advance directives.

It is important for healthcare professionals to know the applicable laws in their state for advance directives.

Other important aspects to consider:

Emergency medical technicians cannot honor the advance directives. In this event, emergency personnel are required to use necessary stabilization methods during transfer to a hospital. Once there and evaluated by a physician, advance directives can be implemented.

Advance directives do not expire. If a change in desires occurs a new one can be written, which invalidates the previous one.
References


Domestic Violence

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What is Domestic Violence?

When a spouse or intimate partner is victimized by another in a pattern of physical violence, psychological abuse, and/or non-consensual sexual behavior, that person is caught in an abusive cycle called Domestic Violence.

Domestic violence includes violence against men and women and can include violence in gay and lesbian relationships. The core of the problem consists of a pattern of coercive behavior practiced by a competent adult or adolescent to establish control over another competent adult or adolescent. Behaviors of violence, abuse or non-consensual sex may occur sporadically or continually over time, singly and in combination. Incidents build upon previous incidents, increasing the underlying threat and expectation of violence for all concerned.

There are three basic forms of abuse, including physical, psychological and sexual. Forms of physical violence include pushing, shoving, slapping, punching, kicking, binding, holding, choking and assault with weapons.

Psychological abuse includes intimidation, degradation, coercion, false accusations, humiliation, ridicule and threats of physical harm. Sexual abuse may involve unprotected, non-consensual or painful sexual acts.

Recurring

The term ‘cycle of violence’ describes the recurring pattern of domestic violence, which is further broken down into three components:

- Build-up of tension
- Acute violence
- Reconciliation or the “honeymoon phase”

During the acute battering stage and even the tension-building phase, the victim is most amenable to intervention. Often the resolution of acute anxiety into an actual beating is perceived as a relief from what has gone before.

In order to intervene appropriately in domestic violence, it is essential to understand the prevalence of the cycle of violence and to recognize its clinical presentation.
The tension building phase forces the battering victim to suppress his or her own negative emotions in order to preserve the peace. The victim will attempt to remain compliant and understanding in an attempt to avoid violence. However, despite any and all attempts to respond to or anticipate the needs or desires of the abuser, over time the abuser will become more and more violent more and more quickly. Sometimes the victim will attempt to encourage violence as a means of ending unendurable anxiety. During the acute battering stage and even the tension-building phase, the victim is most amenable to intervention. Often the resolution of acute anxiety into an actual beating is perceived as a relief from what has gone before.

If battering occurs, it is likely to be followed by a period in which the batterer’s contrition, expressions of love and promises to reform inhibit the victim’s ability to ask for or receive help. A feeling of optimism and hope, many positive emotions, makes it difficult for the victim to consider the recent past and take seriously the opinions of friends and outside professionals.

Victims of domestic violence are often asked why they remain in dangerous and agonizing family situations.

Some basic reasons are listed below:

1. Hope – After trauma, the need for love and understanding is felt as a driving and all-encompassing need. In the “honeymoon phase” the batterer appears to have regained sanity, compassion and appreciation in a way that normally is not revealed in the relationship. The abused partner wants to hold on to this peaceful, caring, virtually unrecognizable partner and to believe that promises made are some how binding.

2. Love – Domestic violence often occurs in relationships were love has gone before and where either or both partner is deeply invested in the other’s (perceived) affection. They will do anything to keep this allegiance alive.

3. Dependence – This barrier to healing is most frequently observed in women. Despite physical abuse of all kinds, they will move to protect their partners from police intervention and frequently do not report instances of rape and violence. If questioned after a few days of the traumatic event, they will often deny they have been assaulted or the level of abuse may be minimized.

4. Powerlessness – Those exposed to unpredictable and inescapable abuse over a long period of time become worn down and passive in response to violence. This may be increased by financial dependence. The need to endure replaces the need to fight or escape. Anger toward the abuser turns on the self and mixes with self-blame, anxiety and denial.

5. Fear – Probably the largest factor in maintaining the status quo of a violent relationship is fear. Victims know that the act of seeking help, prosecution, or separation will only escalate the violence and perhaps lead to kidnap, murder or increased violence. During prosecution, approximately half of those prosecuted threaten revenge and 30% actually take revenge.
Abuser Profile

The following is a checklist of behaviors likely to be present in an abuser:

- Calls the partner names
- May be unwilling to release victim
- Blames victim for injuries
- Is obsessed with victim
- Is enraged or hostile
- Is an underachiever (low job status considering education)
- Has a low threshold of anger
- Appears distraught, wild-eyed
- Expresses jealousy, accuses partner of promiscuity
- 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 alcohol / drugs / guns
- 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
- Has a current relationship involving abuse
- The following is a check-list of incidents he or she may have done or been reported as having done
  - Throwing objects
  - Hitting the wall
  - Biting or kicking
  - Attempted strangulation
  - Threatening with a weapon
  - Assault with a weapon
  - Hitting with closed fist
The following is a checklist of psychologically abusive techniques common to abusers:

- Keeping weapons present and available in the house
- Obsessive critique (victim’s clothing, housekeeping, friends)
- Coercion and manipulation to restrict the victim and maintain dependence
- Threats of all kinds, including physical violence and public degradation
- 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, curtailing signs of affection with children, pets, relatives, monopolizing the attention of the victim
- Indulgent, excessive behavior (gift giving in “honeymoon phase”)

**Victim Profile**

**Frequency**

An estimated 2 million women worldwide are raped each year, with true incidence perhaps double. In the U.S. in 2000, the National Violence Against Women Survey reported nearly 25% women and 7.9% men reported a former or current spouse, live-in partner or date victimized them at least once in their life. 7.7% of women reported rape and 0.3% men. The study reported 22.1% women and 7.4% men suffered physical assault.

Victimization occurs repeatedly, the same survey reported an average of 6.9 assaults by the same partner for women and 4.4 for men. Other figures suggest that a partner has stalked 5% of women and 0.6% of men in the U.S. There is disparity in result findings regarding the gender of domestic violence victims. Conventional wisdom is that women are more likely to be injured; there are also studies suggesting that male and female victims are equal.

Many victims are pregnant. Disabled males and females are at greater risk, and women from families with an income below $10,000. Women whose job or educational level is higher than their partners are also at increased risk.

**Mortality**

It is known that a home in which family fighting is the norm is 4.4 times more likely to be the scene of a homicide than one in which there is no violence.

The female is 30% more likely to be killed than the man in mixed-sex homicides, and most murders are committed with firearms. However, in approximately a third of homicides a victim-offender relationship cannot be identified, it is difficult to interpret that data.
Almost half of an estimated 4,400 interfamily murder victims are spouses. Of the 1,500 annual deaths caused from murder-suicide, 50 to 75% occur in spousal or consortial relationships. The male partner, often with a history of domestic violence, is associated with over 90% of these acts.

**Race**

The National Violence Against Women survey found that African American and Alaskan Native women and men present the highest minority figures for domestic abuse, while Asian and Pacific Islander represent the lowest. Salber and Taliaferro reported in 1998 that African Americans are 8.4 times more likely to commit spousal homicide than whites. Spousal homicide is 7.7 times higher in interracial couples than in intraracial ones.

**Gender**

Women are more likely to be attacked, injured or raped by their male partners than by anyone else. Females are six times more likely than males to suffer from violence committed by an intimate. Lone offenders identified as intimates account for 29% of all violence against females.

A high level of sexual violence is reported by battered lesbians. This may also be true of their gay counterparts but there is little documentation to support this in the literature. Approximately 11% of lesbians report being raped, assaulted or stalked by their cohabitant in comparison to 30.4% of women living with a male partner. Approximately 15% of males living with males report rape, assault or stalking in contrast to 7.7% men complaining of this from a female partner.

**Age**

Young women aged 19-29 are most likely to be victims of violence, with 20 to 30% of university women reporting date violence. Homicide among spouses peaks in the 15-24 age category (with rates declining thereafter for African Americans). The greater the age difference between spouses, the higher the risk of spousal homicide.

**Physical**

A victim of domestic violence presents with a wide variety of presenting complaints. Data from one study documents that 23% of women presented 6-10 times and another 20% sought medical attention on 11 visits before the diagnosis of abuse was finally made. It is essential for emergency physicians and nurses to be highly suspicious in order to recognize the pattern and participants in a domestic violence situation. The most common reason giving for misdiagnosis in the failure to ask the victim simple but sufficient questions. Limiting questions to specific complaints fails to reveal a pattern of domestic violence.
It is important to take the victim’s history in private. The batterer will often be in attendance, hovering over the patient and refusing to let her or him answer questions. The physician or nurse must alert the patient to limits to confidentiality and reporting requirements and make sure that the translator, if present, is neither a member of the patient or the batterer’s family.

In questioning the patient, realize that he or she may not recognize or admit to their symptoms as domestic violence. This is why it is crucial to ask specific questions that will bring out the underlying history, such as “Has your husband ever kicked you?” is preferable to “Have you ever been battered?”

Ask simple questions rather than compound or abstract ones. When questioning the family, be diplomatic and keep questions general: “Do you have any idea why your mother is so upset?” Remember that you may be questioning the perpetrator.

When talking with an abuser, be careful not to use judgmental language. Use “What did you do after you pushed her up against the wall” rather than “What did you do after you beat her.”

Take care not to validate such statements as “She made me so mad. That’s why I hit her.” by looking or sounding sympathetic.

Victim’s complaints that are related to stress and illness will predominate two to one over injury. Common complaints may include acute pain with no sign of injury, chronic pain with no visible evidence and symptoms lacking evidence of physiologic abnormality. Multiple prior visits to the Emergency Room suggest a history of battering. The patient may take accountability for injuries, and there may a delay between the trauma and the hospital visit. He or she may miss appointment and fail to take medication due to lack of money, access to transportation, or control exercised by the batterer. Threats of violence, abandonment, custody of children and institutionalization may make the victim reluctant to seek help.

Symptoms of stress including panic attacks and post-traumatic stress disorder, fatigue and chronic headache may be apparent. As depression and suicide are also common symptoms, anyone complaining of suicide attempts should be questioned. Ask about physical violence is the patient speaks of “a fight with my husband.” Be alert to the patient’s partner’s history of alcohol, drug abuse and the victim’s frequent use of tranquilizers or pain medication.

Other common symptoms may include palpitations, abdominal pain, dizziness and dyspnea, while current or past self-mutilation may be present. Female patients may present with vaginal or urinary tract infections, pelvic pain and dyspareunia, or a history of sexual transmitted diseases. The pregnant patient may present as homeless, depressed and having had little or no prenatal care. Self-induced abortion, miscarriage and intermittent bleeding may be historical. Traumas such as single-car crashes and “accidents” cast suspicion on domestic violence. The patient may appear depressed, withdrawn, and have little eye contact. Expect that signs of abuse may be hidden under the scalp, makeup, jewelry, and turtleneck collars.
Look for injuries at multiple sites, especially bilaterally in the extremities, fingernail scratches, cigarette burns, rope burns, abrasions, minor lacerations, welts, or sub-conjunctival hemorrhage. Comma-shaped or semicircular impression marks are formed from fingernails cutting into the skin. Scratch marks may be as long and as wide as the fingernail and are particularly severe from the fingernails of women assailants. Claw marks appear most dramatically and may be found randomly or in parallel formation around the neck.

Contusions, abrasions and lacerations are common forms of blunt force trauma. Pattern injuries may include circular or linear contusions, parallel contusions from linear objects, slap marks in which the digits are outlined, 1-1.5 cm diameter fingertip pressure contusions from grabbing. These may be present in the medial aspect of the upper arm. Belts, cords, shoe soles and heels may all leave contusions. Bite marks may be obvious or nonspecific. Injuries from the same object or force are inconsistent from patient to patient. In general, red, blue, purple, or black colors occur any time from one hour to resolution of the trauma. Red coloration, then, cannot be used as an indication of the age of a bruise. Yellow coloration indicates a bruise older than 18 hours.

**Strangulation**

It requires one-third the pressure to occlude the carotid arteries than it does to close the trachea. Either method accounts for strangulation, accounting for 10% of violent death in the U.S. each year. Of the three methods of strangulation, ligature and manual strangulation are both associated with domestic violence (hanging is not).

Garroting (or ligature strangulation) can be done with a telephone cord or item of clothing. Throttling (manual strangulation) characteristically is done with the hands but can be accomplished by the forearm or standing or kneeling on the patient’s throat. Dysphagia, odynophagia, hyperventilation, dyspnea or apnea may be observed, and some patients will die up to 36 hours following strangulation because of respiratory decompensation. Petechiae are commonly observed above the area of construction, including face and periorbital region. The single most common contusion is the assailant’s thumb, but there may be clusters at the sides of the neck. Ligature marks may not always be obvious. Loss of memory, nausea, uncontrollable shaking, defecation and loss of consciousness are all reported.

**Violence During Pregnancy**

The patient may present with injuries to the breast or abdomen, genitalia, unexplained pain, poor nutrition or unexplained spontaneous abortion, miscarriage or premature labor. Domestic violence often increases during pregnancy.
Sexual Assault

33-46% of women who are physically battered report marital rape. Assess for domestic violence if there is any evidence of genital injury, including vaginal or labial hematomas, lacerations, rectovaginal foreign bodies, noting dried blood and/or semen. Be especially suspicious of domestic violence when there are recurring sexually transmitted diseases.

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. There is, however, a reluctance to get involved or collect data, an attitude among paramedics that must be addressed if support is to come from their involvement.

Emergency Department

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. Talking to hospital staff may often be the only opportunity victims have to seek professional help, hence a high index of suspicion and routine screening for domestic violence is crucial to their protection.

Caring for the victim of domestic abuse is challenging yet straightforward. Beyond lifesaving intervention, there are needs to diagnose physical injury; acknowledge, reassure, evaluate and treat emotional injury; document the record, determine risks to victim and children; and assess safety options. Beyond that, one must counsel risk of escalation of violence, provide legal information, report the abuse, develop a follow-up plan, and offer referrals to shelter, legal services, counseling and facilitate such referrals.

Hospital

Hospitals have specific, unique responsibilities for the protection of materials and information that might form part of the legal process in the aftermath of domestic violence. The patient’s medical record must document consents or patient compliance forms, evidentiary material, required notifications and information releases and referrals to private or public agencies. Every attempt must be made to provide a safe temporary haven for the victim and children. The patient should be interviewed alone. A compassionate attitude on the part of staff, reinforced by informational posters about domestic violence let the patient know the situation is a public health issue taken seriously.
Management of Violence Aftermath

Patients receiving appropriate intervention have less chance of developing long-term conditions such as PTSI, 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. Carefully explaining the symptoms of trauma they may be feeling can help to reestablish a modicum of control. They should know they may feel dissociated from their body and/or reality, be subject to vivid flashbacks, repetitive recall of horrific moments in time, hyperarousal of the autonomic nervous system and a hypervigilance that may make them fearful or mistrustful of hospital staff.

Counteractive Messaging

Health professionals should 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, and there is help in the form of support, shelter and legal advice. You have a right to receive help.
• Domestic violence occurs often in our society, continues over time and increases in frequency and severity
• Domestic violence may well 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

Importance of the Medical Chart

A legible medical record may mean the difference between punishing the offender and letting him or her go free. It should contain the details of all findings, interventions and actions, including a description of the abusive event, present complaints, patient’s behavior, related physical or mental health problems, and the name, address, telephone number and relationship to the patient (and any children). It should also include detailed descriptions of the patient’s injuries, i.e., type, location, size, color and apparent age.

Preserve any physical evidence such as damaged clothing, jewelry, and weapons. Make sure to preserve the chain of evidence. If the abusive event is reported to the police, the medical record should reflect that it was, any police report, 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 obviates the need for a clear, documented medical record.

Photography and Diagrams

Use anatomical diagrams and take Polaroid photographs prior to any medical treatment. Photographs should include at least one full body shot including the patient’s face, a mid-range photo to show torso injury, and close-ups of all wounds and contusions. Take two views of each injury from different
angles and include an object such as a ruler to indicate the size of the injuries. The photographer should sign the photographs, which should then be attached to the medical record. The patient’s name, medical record number, date and time of the photograph, location, and names and titles of any witnesses should also be attached to the back of the photograph. Also clarify the injury site and the victim’s stated cause of injury.

**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 battering is a crime and 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 protective order available in every State and the District of Columbia.

The health professional has an ongoing role to mitigate the potential harm that may result from obeying the law. Ensure the patient is safe while waiting for the police and stay with her or him throughout the police interview if requested by the patient. Determine the risk to victim and children after this report is filed. As 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 perpetrator to kill the victim, children, or himself or herself as well as any need to restrain the perpetrator.

**Follow-up Plan**

Determine from the patient what type of help would be valuable or what changes they would like to make in their situation. Find out what steps might help to implement those changes. When planning disposition, determine if the patient needs immediate care, admission, or follow-up. Is the abuser threatening to kill the victim and how seriously does the patient take these threats? Is there stalking or escalating violence? Consider hospital admission if there is no safe place for the patient to go.

Consider hospitalization in consultation with a psychiatrist if the patient is suicidal or homicidal. If the patient wants to go home, a referral to a primary care provider should be given. If the patient needs immediate access to a shelter or other option such as a motel or hospital, this must be arranged. Determine the safety of children. Determine if there is a friend or family member who can provide safe housing and not collude with the perpetrator in the mistaken idea they are helping the situation. Assist the patient in calling a domestic violence hotline during the emergency room visit.

Upon leaving the hospital, and on return visits, the patient should receive emergency telephone numbers including local crisis intervention centers, the sheriff’s office, and the National Domestic Violence Hotline (1-800-799-7233). Patients being stalked via the Internet should be referred to the local police or sheriff’s department, district or state attorney, or the FBI.
Safety Plan

For a free personalized safety plan, write to the Family Violence Prevention Fund, 383 Rhode Island Street, Suite 304, San Francisco, CA 94103-5133 or call (415) 252-8900 or 1-800-313-1310, fax (415) 252-8991. Be aware that written material such as this may pose a danger to the patient once they return home.

Alert the patient of 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 and 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 agencies (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, lease or 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 patient no longer lives with the batterer, encourage her or him 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, and install smoke detectors, fire extinguishers and rope ladders for upper windows (leave inside until needed).

On the job, the patient should identify and notify a coworker, supervisor or employee counselor and, if possible, screen calls by voice mail. The patient should vary the routine of time and route in arriving and leaving for work, school and public places.

Interviewing the Patient

SAFE protocol (SJ Sebastian):

1. What stress do you experience in your relationships? Do you feel safe in your relationship (marriage)? Should I be concerned for your safety?
2. Afraid / abused: 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 or abuse do 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: 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 above to give you support?

4. Emergency plan: 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?

Partner Violence Screen (PVS) suggests the following questions:

- Have you been hit, kicked, punched, or otherwise hurt by someone with the past year? If so, by whom were you injured?
- Do you feel safe in your current relationship?
- Is a partner from a previous relationship making you feel unsafe now?
- Are you here today due to injuries from a partner?
- Are you here today because of illness or stress related to threats, violent behavior, or fears due to a partner?
- Has your partner ever prevented you from leaving the house or seeing friends or family?
- Has your partner ever destroyed things that you care about?

**Interviewing the Returning Patient**

A patient who routinely visits the Emergency Room should be asked about violence since the last visit, abuse of children since that time, personal mental health and coping strategies. Attempt to find out how many calls were placed to hotlines and what family or friends were involved in discussion. If possible, assess the patient’s ability to function at home and at work. Determine family members or friends who were contacted for help and what was their response.

Even if the patient does not request legal help, give her or him the telephone number of a referral agency or contact person. If the patient wants to pursue criminal proceedings, provide clear written instructions. If charges have been filed, dropped, heard in court, what was the outcome? Attempt to find out if the police have been involved and whether they were able to provide protection.

A history of previous attacks should be taken and include the frequency and severity of previous attack and the current level of severity of attack. Threats are important, as is the presence of weapons in the house. Question the patient about forms of manipulation and coercion, including use of isolation, monopolizing the patient, suppression of affection for children, and threats of public humiliation.
The patient’s immediate safety is critical. Attempt to determine if the partner’s level of violence, whether the children are involved, how often the patient is beaten, attacked, threatened, or hospitalized. Do attacks occur outside the home or while the patient is pregnant? Has the partner threatened to kill with a weapon or used a weapon on the patient?

Is fear of death present during an attack? Does the partner have access to a gun or have threatened to use it? Has there been a choking incident? Does the partner use drugs, get drunk every day or almost every day? Does he or she use amphetamine, angel dust, cocaine or crack? Is the partner jealous, controlling, or threatening suicide? Determine if the patient is contemplating either suicide or homicide and if there is a plan and/or a weapon.
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Pain Management

1. Facts and Myths about Pain .............................................................. PM: 1
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Pain Management

Facts and Myths about Pain

What is Pain?

Pain is the most common reason that people in the United States seek medical care.

*Pain is a sensory and emotional experience, which can depend on the person’s current psychological state, so someone with no visible injuries may be in severe pain while someone else with serious physical injuries may experience no pain at all.*

Every year, pain-related complaints result in:

- Approximately 140 million physician visits
- More than $100 billion in healthcare costs and lost work time.

More than 2.6 million people routinely take prescription medication for pain. But what is pain?

*Pain can be defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage.”*

It is important to remember that pain is very subjective. Pain is what ever the patient says it is. It is experienced differently by different people.

A number of factors can influence the way that different people experience pain:

1. Previous experience with pain
2. Meaning of pain for the individual
3. Beliefs about pain
4. Usual coping mechanisms
5. Psychological state

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

**Acute and Chronic Pain**

Pain is often described as either acute or chronic. These terms describe the duration of the pain and the way it may respond to treatment. They do not describe how severe the pain is.

*Somatic pain involves injury to skin, joints, bones, or muscle.*
Acute Pain

Acute pain is caused by a specific physical condition. It includes such things as:

- Pain following surgery
- Pain of a sore throat
- Pain of an injury

Acute pain has a well-defined onset, is temporary, is predictable, and is treatable. Once the condition causing the pain no longer exists, the pain will go away.

Chronic Pain

Chronic pain is different because it may not have a specific onset or time course. Chronic pain:

- Lasts more than a month
- May not respond predictably to treatment
- May not result from a particular injury or event

Cancer Pain

Cancer pain is sometimes considered as a separate type of pain. Cancer pain can be acute or chronic. If the cancer is not curable, the pain may get worse and worse as the disease progresses. Cancer pain may be caused by:

- The disease itself
- Treatments (such as surgery, chemotherapy, and radiation)
- Infections

Effects of Pain

Every patient has the right to adequate pain control. In addition to discomfort, lack of pain relief can affect:

- Immune system function
- Activities of daily living, such as sleep, nutrition, and mobility
- Ability to work
- Length of hospital stay.

Chronic pain and cancer pain can cause the most serious problems by:

- Interfering with the patient’s lifestyle and activities
- Reducing the patient’s quality of life
- Wearing the patient down
- Causing the patient to give up hope
- Causing the patient to consider suicide.
Myths about Pain

There are many MYTHS about pain. These can have a negative influence on effective pain management.

One common MYTH is that pain medication (especially opioids like 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:

1. Chronic pain cannot be managed
2. Sleep is a sign that a patient has no pain
3. Pain in the absence of obvious injury or other factors is a sign of serious illness
4. People of certain ethnic or cultural backgrounds will over-report pain and other groups will under-report pain
5. Someone in pain will always have changes in vital signs

*The idea that opioid medication should only be a treatment of last resort is a MYTH.*

Assessment of Pain

When to Assess Pain

Pain is now considered the fifth vital sign. As with the traditional vital signs, steps MUST be taken to correct the situation when assessment shows something wrong.

Every patient has the right to effective pain management. Treatment of pain is also important to the patient’s recovery.

Uncontrolled pain can:

- Lengthen the patient’s hospital stay
- Decrease the patient’s activity level
- Cause the patient’s body unnecessary stress

Like the other vital signs, pain needs to be assessed at certain times during treatment. This should begin when the patient is first admitted.

After admission, follow-up pain assessments should take place:

- At regular intervals
- After any intervention to decrease pain (to find out if the intervention helped)
The Joint Commission has standards for the assessment and management of pain.

Under Joint Commission standards:

1. All patients are screened for pain when admitted
2. Patients are re-assessed regularly for pain
3. Patients are taught about pain control

**Physical Signs**

There are a number of physical signs that can show that someone may be in pain.

Physical signs include:

- Grimacing
- Crying
- Moaning
- Tension
- Withdrawal
- Restlessness
- Guarded movements
- Rubbing area of pain

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 the 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.

**How to Assess Pain**

Even though there may be some physical signs, the best indication of pain is what the patient says.

To assess pain, your facility has a pain assessment tool. The tool will have some kind of a rating scale. For example, it 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 big grimace of severe pain. You need to become familiar with the assessment tool your facility uses.

When a patient does report pain, you need to know the following information:

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?

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.

Management of Pain

Pain Management Concepts

Pain management decisions are not made by healthcare professionals alone. Patients and families are also involved in the process.

Opportunities should be provided for patients and families to discuss:

• The pain experience
• Expectations and beliefs about pain
• Effectiveness of pain management interventions

*Patients and families have input into pain management decisions.*

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.

It is also important to recognize that pain can increase because of:

• Social and emotional factors
• Changes in disease state

Remember: It is easier to manage pain BEFORE it becomes severe.
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

Pain is a unique experience for each individual, and pain management strategies should be designed to meet the needs of each individual patient. Patient education is also an important part of the process.

Effective pain management includes:

1. Involving patients and families in all pain management decisions
2. Explaining how the treatment plan works and what kinds of things the patient should report
3. Rejecting MYTHS about opioid use and fears of addiction
4. Informing the patient and family of the facility’s commitment to pain relief and how to get help if needed
5. Teaching the patient about continuing pain management as a part of the discharge process

**Types of Interventions**

Pain control measures **MUST** be selected to meet the individual needs of each patient. This requires an assessment of the pain and an assessment of the effectiveness of previous interventions.

Pain control measures fall into two categories:

1. Pharmacological interventions
2. Non-pharmacological interventions

Pharmacological interventions are pain control methods that use medications. These include:

1. Opioids, such as morphine and codeine
2. Non-opioids, such as acetaminophen
3. Adjuvants, a variety of drug types that are usually used to supplement opioids or non-opioids

Non-pharmacological interventions are alternative measures that do not use drugs.

The methods that are selected will depend on the needs of the patient. Non-pharmacological pain management methods include:

1. Relaxation and distraction techniques
2. 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)
• Application of heat or cold (not longer than 20 minutes; be careful of extremes of heat or cold that could damage tissue)
• Acupuncture
• Position change
• TENS unit (trans-electrical nerve stimulation therapy). A TENS unit controls pain by stimulation the nerves at the pain location and helping to block pain signals.

Non-opioid Medications

When using drugs to control pain, the best strategy is to use the least strong drug which still gives adequate pain relief.

If the intervention does not relieve the pain, it may require:

• An increase in dosage
• An increase in frequency
• An increase to the next level of drug

_Treatment begins with the least strong drug which still gives adequate pain relief._

Usually, pain control measures begin with non-opioid (non-narcotic) drugs. Non-opioids, such as acetaminophen (Tylenol) are generally available in both over-the-counter and prescription strengths. Non-opioids are usually taken orally or by suppository. The most common side effect of acetaminophen is hepatotoxicity (liver involvement). This is most common with an overdose.

Non-opioids also include NSAIDS (NON-STEROIDAL ANTI-INFLAMATORY DRUGS), such as Advil and Motrin. These may also be used in combination with opioids.

The most common side effects of NSAIDS are:

• Gastric irritation
• Prolonged bleeding time
Opioids and Adjuvants

The name, opioids, refers to drugs that are based on opium. They can be either natural or synthetic. Opioids are used for moderate to severe pain.

Pure agonists

One class of opioids, known as “pure agonists”, which refers to their specific mechanism for pain relief, includes:

- Morphine
- Hydromorphone (Dilaudid)
- Fentanyl
- Codeine

Increased dosage of pure agonists provides increased analgesia (pain relief) and increased side effects.

Side effects include:

- Euphoria
- Sedation
- Constipation
- Nausea
- 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:

1. Drug-seeking behavior is NOT a sign of addiction.
2. Drug-seeking behavior IS a sign of inadequate pain relief.
Other opioids

Other types of opioids, nalbuphine (Nubain) and butorphanol (Stadol) provide less analgesia, but also 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 orally. As pain level increase, they are administered in other ways which deliver a higher level of pain relief:

- Sublingually (under the tongue)
- Bucally (placed in the cheek area if patient is unable to swallow)
- Dermal patch (for continuous release)
- Intravenous (IV) by continuous infusion or intermittent dosage
- Patient-controlled analgesia (PCA) using intravenous delivery
- Intramuscular or subcutaneous injection
- Suppository

Patient-controlled analgesia (PCA) allows a patient to increase the dosage of an intravenous drug when the pain increases.

Adjuvants

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

- Corticosteroids
- Antidepressants
- Local anesthetics
- Anticonvulsants

These drugs are used to:

1. Enhance the effectiveness of a primary analgesic
2. Limit the side effects of a primary analgesic (usually an opioid)
3. Treat concurrent symptoms that increase pain
4. Provide analgesia for certain types of pain that are not relieved by opioids
Pain and End-of-Life-Care

Palliative versus Curative Care

In healthcare, much of the focus is on curative care. This is as it should be. The goal is for patients to get better.

The objectives of curative care are:

- To obtain a cure
- To return patients, as much as possible, to normal functioning

Sometimes, these objectives cannot be met and the patient is considered terminally ill. The patient or family may have decided to discontinue curative treatment or there may be no curative treatment available.

The objectives of palliative care are:

- To make the patient as comfortable as possible
- To support the family during this end-of-life period

Importance of Pain Control

When caring for the terminal 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 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

*If you are concerned about side effects with opioids, remember that the objective of palliative care is to control pain and keep the patient comfortable. Higher than usual doses may be required to control the pain effectively.*

You may have to be creative in finding the best solutions for individual patients, but the family and patient provide a valuable source of help. LISTEN to your patient and his / her family.

As the disease progresses, the patient may no longer wish to eat or drink. Families find it hard to see their loved ones stop eating or drinking, and denial of what is happening is common and understandable. The family needs support during this time and help to understand the process.

*During palliative care, larger doses of analgesia may be needed because of tolerance to the drug and because of the progressive disease state.*
Patient Restraints

1. Introduction
2. Standards
3. Policy Implementation
4. Complications
5. Summary

RES: 1
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RES: 4
Patient Restraints

Introduction

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

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

In recent years, a move toward reduction of restraint use within hospitals has occurred. This trend coincides with a significant decrease in use of restraints within nursing home facilities following the passage of the Omnibus Budget Reconciliation Act of 1987. This act made it clear that restraints are to be applied as a last resort, rather than first option, to control a nursing facility resident’s behavior. This law provides that residents “have the right to be free from... any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms.”

Restraints may be used only to ensure physical safety of the resident or other residents and only pursuant to a written physician order specifying the duration and circumstances for which restraints may be used. States also have been active in passing legislation and implementing regulations aimed at reducing restraint use.

These efforts generally have been well received within the healthcare community. However, situations arise within hospitals and EDs in which restraints are not only appropriate and necessary, but also in which failure to use a restraint could result in injury to the patient or others. Restraints may be used in response to dangerous behavior, to protect patients, in connection with planned care, as part of an approved protocol, and, in some cases, as part of standard practice. Examples of these situations include the following:

- Protect patients from physically harming themselves (eg, self-extubation)
- Protect staff and/or patients’ families from patient violence
- Allow assessment of disoriented and uncooperative patients or those under the influence of alcohol or drugs
- Facilitate medically necessary procedures (eg, gastric lavage) in uncooperative patients
- Prevent elopement while patients are being evaluated for potential suicidal or homicidal behavior
- Protect disoriented patients from falls
Standards

Whenever restraints are employed, their use **MUST** be consistent with federal and state laws, hospital licensing regulations, applicable accreditation requirements (including those imposed by the Joint Commission), and, most importantly, sound clinical judgment. At a minimum, hospital policies should set forth the following standards (based in part on Joint Commission):

- Restraint use is based on the assessed needs of patients and only may be used to treat patients’ medical symptoms or to prevent patients from harming themselves or others. Never use restraints for discipline or staff convenience.

- Use the least restrictive method of restraint. Use restraints only in accordance with the written order of a licensed independent practitioner (LIP) or as part of an established hospital clinical protocol. LIPs most often are physicians. However, depending on state laws governing the scope of practice, LIPs could include physicians’ assistants or nurse practitioners. Furthermore, situations may occur in which appropriately trained supervisory / professional licensed personnel, such as a clinical nurse manager, may initiate restraints in an emergency situation before obtaining the written order.

- Written orders for restraints should include the time limitation, start and end times, type of restraint, and the frequency of monitoring and reevaluation if it differs from hospital policy. Time limitations should not exceed 24 hours. If the patient is restrained because of primary behavioral health needs, the order should not exceed 4 hours for adults, 2 hours for children aged 9-17 years, and 1 hour for children younger than 9 years.

- Clinical protocols may include standing as needed (PRN) restraint orders as part of medical, dental, diagnostic, or surgical care procedures. Such protocols must set forth patient criteria related to initiation, discontinuation, or reapplication of restraints.

- PRN orders are never appropriate for patients with primary behavioral health needs (only individual written orders are appropriate). However, if a behavioral health patient is being treated for an acute condition and meets the criteria set forth in a clinical protocol, the patient may be restrained pursuant to the PRN restraint order set forth in that protocol. States have enacted laws governing restraint use when treating mental / behavioral health problems.

- Frequency, nature, and extent of monitoring and reassessment of patients in restraints must be defined. Monitoring must be performed by direct observation of and interaction with the patient; it must include an evaluation of the continuing need for restraints and a determination regarding the patient’s well-being.

- Documentation in the medical record should include clinical justification of the necessity for restraints, a written order that complies with hospital policy, and measures taken to protect the patient’s rights, dignity, and well-being (eg, monitoring, reassessment, attention to patient needs).
• Establish criteria for removal of restraints before the written order expires; base the criteria upon the staff’s clinical evaluation that restraints are no longer necessary (eg, patient is no longer disoriented and is able to cooperate).

• Criteria for renewal of restraint orders also should be delineated.

Hospitals should institute procedures for implementing policies aimed at reducing and limiting use of restraints, educating staff on alternatives to restraints, and educating staff on proper use of restraints in compliance with hospital policy. Restraint use should be limited to individuals specifically trained to correctly use and monitor patients in restraints.

Failure to correctly use or monitor patients in restraints can lead to serious injury or even death. To assist hospitals in evaluating their own performance, consider establishing a central data collection system to review appropriateness of restraint usage and assist hospitals in identifying inappropriate use. Policies and procedures should be reviewed annually and updated as needed.

**Policy Implementation**

When restraints are necessary, practitioners must determine the most appropriate and least restrictive device that allows the patient to retain as much dignity as possible. The Joint Commission's determination of a restraint is anything that is intended to physically restrain a patient. A bed enclosure or side rails could potentially restrict a patient from leaving the bed and thus would be a restraint. However, if the patient can remove the device, it wouldn't be considered a restraint.

For example, the following physical restraints are appropriate for the following situations:

- Posey vests to prevent disoriented patients from climbing off the bed and/or stretcher
- Soft wrist restraints to protect confused patients from extubating themselves
- Security or sitters to monitor patients being evaluated for suicidal ideation
- Limb restraints (eg, upper, lower, 4-point, opposites, soft, leather) to restrain violent patients

A team of several members working together (eg, security, medical personnel) may be the best way to restrain a violent patient. Appearance of a team may convince a patient to permit application of restraints without resistance. Ideally, each team member is responsible for immobilizing one extremity. This team approach minimizes risk of injury to the patient and staff.

Although physical restraints generally are the first method employed when restraints are necessary, pharmacological restraints may be used as an alternative or adjunct to physical restraints.
Complications

Physical vs. Chemical

Patients may have injuries that result from being restrained. Most injuries are minor and include abrasions and bruises. However, more serious injuries can occur if restraints are inappropriately applied or the patient is not adequately monitored. For example, a restrained patient could overturn a bed and/or stretcher.

Complications from pharmacological sedation are more numerous than from physical restraints. Uncooperative patients often provide inadequate histories, which presents increased possibility for allergic reactions. Over sedation could lead to loss of gag reflex, compromising the patient’s ability to protect the airway. A patient who vomits while in 4-point restraints risks choking and aspiration. Pulse oximetry testing may be helpful in monitoring such patients.

Patients who are being restrained after an overdose pose particular problems because the ingested substances often are unknown. Sedation could lead to drug interactions with adverse effects. For example, **DO NOT** administer medication with anticholinergic adverse effects to patients who ingested an anticholinergic poison.

Staff considerations

Use caution whenever caring for patients in restraints. Staff injuries can occur from violent behavior, such as biting, scratching, spitting, and kicking. At times, gloves and/or masks can enhance staff protection. Be on the lookout for patients with concealed weapons or dangerous objects (eg, needles).

Summary

Appropriate use of restraints in the healthcare setting promotes patient and staff safety. Use should be pursuant to hospital policy for limited periods. Documentation should reflect the need for restraints for medical or safety reasons.

Hospitals and healthcare professionals can incur liability from inappropriate use of restraints and for failure to use restraints to protect a patient; each situation in which use of restraints is considered must be evaluated carefully.
Sexual Harassment

1. What is sexual harassment? ......................................................... SH: 1
2. What is sexually-harassing behavior?........................................ SH: 2
3. What to do if you are a victim of sexual harassment?............. SH: 3
Sexual Harassment

What is sexual harassment?

Sexual harassment is uninvited and unwelcome verbal or physical conduct directed at an employee because of his or her sex. It is a form of sex discrimination and it is illegal.

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

Unwelcome verbal or physical conduct that interfere with work performance is an example of sexual harassment.

Types of Harassment

The four types of harassment are:

- Gender – related behavior
- Seductive behavior
- Acts of bribery
- Coercion

About 90% of all sexual harassment cases filed with the EEOC are by women and about 10% by men.

Gender – related behavior

Gender – based behavior includes remarks that communicate insulting or degrading attitudes about either sex. It may include obscene jokes, other comments, graffiti, or pornography.

Seductive behavior

Seductive behavior includes unwanted and inappropriate sexual advances, which may be invitations, persistent letters, phone calls, or emails.

Acts of bribery

Bribery involves asking for sexual favors with promise of reward.

Acts of coercion

Coercion involves the demand of sexual favors by using threats such as negative performance evaluations, lack of promotion, or termination.
Gender-related and seductive behaviors are the most common harassment acts, while bribery and coercion are less.

Sending an uninvited and unwelcome, sexually-related email or letter to a coworker constitutes gender-related or seductive sexual harassment. If offers of rewards or demands for favors are included, the harassment would be classified as an act of bribery or coercion.

What is Sexually-Harassing Behavior?

Sexual harassment is illegal and each organization has penalties for such actions. Making another person feel uncomfortable through any of the following behaviors is sexual harassment:

- Certain gender-related behavior
- Seductive or unwanted sexual advances
- Bribery or promises in exchange for sexual favors
- Coercion or the demand of sexual favors by using threats

Making another person feel uncomfortable with inappropriate physical contact is sexual harassment.

Gender-related behavior includes:

- Degrading comments
- Displayed pornography or pornography sent over the Internet
- Obscene jokes
- Sexist comments
- Sexually-explicit remarks about another person
- Stereotypical or demeaning language or remarks

Seductive behavior or unwanted sexual advances include:

- Inappropriate physical contact
- Phone calls
- Emails
- Invitations
- Persistent letters

Acts of bribery or promises in exchange for sexual favors include:

- Offers of promotions
- Offers of money
- Offers of rewards
Coercion or the demand of sexual favors by using threats includes threats of:

- Negative performance evaluations
- Lack of promotion
- Termination

There is zero tolerance for sexual harassment in your workplace.

What to do if you are a victim of sexual harassment

DO NOT disregard sexually-harassing behavior, hoping it will go away.

All employees should also understand what sexual harassment is, so they do not sexually harass someone else, while believing their actions to be harmless.

- Harassment can involve persons of the same or opposite sex
- It is best to avoid sexual remarks, jokes, or material with sexual content, even if it seems harmless to you
- People not directly involved may be offended
- Women are most often the victims, but men can also be victims
Workplace Violence

1. What is workplace violence? ................................................................. WV: 1
2. Who is at risk? .................................................................................. WV: 1
3. Where may violence occur? ............................................................... WV: 1
4. What are the effects of violence? ....................................................... WV: 1
5. What are the risk factors for violence? .............................................. WV: 2
6. Prevention Strategies for Employer ................................................ WV: 2
7. Dealing With the Consequences of Violence .................................. WV: 3
8. Safety Tips for Hospital Workers .................................................... WV: 3
9. Summary ......................................................................................... WV: 4
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Workplace Violence

What is Workplace Violence?

Workplace violence ranges from offensive or threatening language to homicide. NIOSH defines workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.

Examples of violence include the following:

- **Threats**: Expressions of intent to cause harm, including verbal threats, threatening body language, and written threats.
- **Physical assaults**: Attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives.
- **Muggings**: Aggravated assaults, usually conducted by surprise and with intent to rob.

Who is at risk?

Although anyone working in a hospital may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk. Other hospital personnel at increased risk of violence include emergency response personnel, hospital safety officers, and all healthcare providers.

Where may violence occur?

Violence may occur anywhere in the hospital, but it is most frequent in the following areas:

- Psychiatric wards
- Emergency rooms
- Waiting rooms
- Geriatric units

What are the effects of violence?

The effects of violence can range in intensity and include the following:

- Minor physical injuries
- Serious physical injuries
- Temporary and permanent physical disability
- Psychological trauma
- Death

Violence may also have negative organizational outcomes such as low worker morale, increased job stress, increased worker turnover, reduced trust of management and coworkers, and a hostile working environment.
What are the risk factors for violence?

The risk factors for violence vary from hospital to hospital depending on location, size, and type of care. Common risk factors for hospital violence include the following:

- Working directly with volatile people, especially, if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses
- Working when understaffed—especially during meal times and visiting hours
- Transporting patients
- Long waits for service
- Overcrowded, uncomfortable waiting rooms
- Working alone
- Poor environmental design
- Inadequate security
- Lack of staff training and policies for preventing and managing crises with potentially volatile patients
- Drug and alcohol abuse
- Access to firearms
- Unrestricted movement of the public
- Poorly lit corridors, rooms, parking lots, and other areas

Prevention Strategies for Employer

To prevent violence in hospitals, employers should develop a safety and health program that includes management commitment, employee participation, hazard identification, safety and health training, and hazard prevention, control, and reporting. Employers should evaluate this program periodically. Although risk factors for violence are specific for each hospital and its work scenarios, employers can follow general prevention strategies.

Environmental Designs

- Develop emergency signaling, alarms, and monitoring systems.
- Install security devices such as metal detectors to prevent armed persons from entering the hospital.
- Install other security devices such as cameras and good lighting in hallways.
- Provide security escorts to the parking lots at night.
- Design waiting areas to accommodate and assist 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 Modifications**

• Provide all workers with training in recognizing and managing assaults, resolving conflicts, and maintaining hazard awareness.

**Administrative Controls**

• Design staffing patterns to prevent personnel from working alone and to minimize patient waiting time.
  • Restrict the movement of the public in hospitals by card-controlled access.
  • Develop a system for alerting security personnel when violence is threatened.

**Dealing With the Consequences of Violence**

Violence may occur in the workplace in spite of preventive measures. Employers should be prepared to deal with the consequences of this violence by providing an environment that promotes open communication and by developing written procedures for reporting and responding to violence. Employers should offer and encourage counseling whenever a worker is threatened or assaulted.

**Safety Tips for Hospital Workers**

Watch for signals that may be associated with impending violence:

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

Maintain behavior that helps diffuse anger:

• Present a calm, caring attitude.
• Don’t match the threats.
• Don’t give orders.
• Acknowledge the person’s feelings (for example, “I know you are frustrated”).
• Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or 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 the 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.
- Call security for help.
- Report any violent incidents to your management.

**Summary**

All hospitals should develop a comprehensive violence prevention program. No universal strategy exists to prevent violence. The risk factors vary from hospital to hospital and from unit to unit. Hospitals should form multidisciplinary committees that include direct-care staff as well as union representatives (if available) to identify risk factors in specific work scenarios and to develop strategies for reducing them.

All hospital workers should be alert and cautious when interacting with patients and visitors. They should actively participate in safety training programs and be familiar with their employers’ policies, procedures, and materials on violence prevention.
Bibliography


