Manual for Joint Commission and OSHA Core Mandatories Part II
Nursing - 2016

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Age Specific: Patient Care Concerns

Every patient is different. This can be said of their age group, too, because with each comes different medical needs. While any patient can experience general ailments, such as a broken arm or nervous stomach, each age group brings its own specific conditions that you as the caregiver **MUST** be aware of. Further, in order to accurately and thoroughly assess patients across all age groups, you must find a way to effectively communicate with them. You must understand their needs and what they might be facing at their time of life.

In assessing and assisting all patients, you must be mindful of their primary language, whether they have speech or hearing impairments or if they are confused, depressed or present with signs of illness or stress. You must ascertain whether they may have learning disabilities, cultural differences that may preclude fair medical treatment, and you must understand their family structure.

However, in assessing and assisting very young patients, you must also be mindful of an additional set of factors. For example, in neonates and infants, their vital signs must be checked carefully, and you should address their growth and development, their feeding habits, and their bond with parental figures.

With older children, there is yet another set of factors to consider, such as peer pressure and how it may play into the condition with which they present. In adolescent patients, you must be very aware of their privacy. They are growing toward becoming sexual beings and are usually starting puberty by this age. They are extremely aware of their bodies and easily embarrassed. Their feelings must be considered with great care.

In assessing and assisting adult patients, there are other factors to consider. And each age group has its own set. As a caregiver, it is critical that you educate yourself about these factors so that you can do your job effectively. In order to do so, you must become an effective communicator.

**Communication Across The Ages**

Clear communication with the patient can be the key to providing age-specific care. At just about any age there may be barriers to communication that you should look for. Give the person your full attention and observe closely. You may not be able to eliminate barriers, but you can minimize them by increasing your awareness.

**From Birth to Old Age**

From birth to old age, there are certain qualities and needs that most people share with others their age as they progress together through each stage of life. As a healthcare worker, you provide care to people of all ages. By understanding the age-specific needs usually associated with each stage of life, you can provide better, more appropriate care, tailored to the needs of each individual.
For every patient across all age groups you should:

- assess primary language
- check for speech or hearing impairments
- check for confusion / depression / signs of illness or stress
- be aware of possible learning disabilities
  - be mindful of cultural differences
  - understand family structure

Assess Primary Language and Check for Impairments

You should assess the patient’s primary language and whether communication might be clearer with the help of a translator. Determine if confusion or depression might be a sign of physical or mental illness.

Confusion / Depression / Signs of Illness or Stress

Find out if the patient is under stress, or worried about healthcare decisions that might affect their schooling, job or family.

Learning Disabilities and Other

Check for any apparent learning disabilities, and make an effort to understand the patient’s family structure and support system.

Neonates: Birth - 28 Days

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

- reflexes
- good APGAR scores
- vital signs
- weight gain
- blood glucose levels

The presence of normal reflexes, such as grasping, gagging and startling, are key for the neonate. Other important concerns are for good APGAR scores, age-appropriate vital signs - temperature, pulse and respiration - steady weight gain and blood glucose levels when appropriate.

Always handle the neonate in a gentle, comforting manner to avoid over-stimulation. Teach parents proper childcare skills for feeding, diapering, cord care and bathing. Be sure that parents understand the importance of keeping the infant warm.
New parents also need to be taught to look for jaundice, fever, and to avoid certain sleeping positions associated with Sudden Infant Death Syndrome (SIDS). Make sure parents understand the importance of safety devices such as car seats.

**Infants and Toddlers: 0 - 3 Years**

Infants and toddlers are in a period of rapid growth and learning. They explore the world through direct sensory contact. Though they are dependent, they are beginning to develop a separate self. Key care issues at this age are to foster good child-parent bonds, keep immunizations and checkups on schedule, and provide a safe living environment.

During checkups, ask parents of toddlers about the child’s feeding habits, motor skills, and if any vision or hearing problems have been noticed. Remind parents that children develop at different speeds, and that colds or flu are common among young children in daycare. Hand washing should be emphasized as a way to prevent disease transmission.

Check the toddler’s teeth and review the essentials of tooth care with the parents. Encourage parents to communicate with the child, and to touch and cuddle. All of these nurturing techniques help to promote healthy bonds and good parenting. With infants, limit the number of staff workers assigned to each one to avoid “stranger anxiety,” and always speak to an infant before a touch to avoid startling her.

**Young Children: 4 - 6 Years**

When a child reaches the age of 4 to 6 years, they begin to need rules and boundaries, praise and feedback. It is important for the parents to keep immunizations and checkups on schedule and learn healthy habits for nutrition and grooming. In addition, parents may need to learn about safety equipment, such as bicycle helmets, and elbow and kneepads for skateboarding, and safety issues regarding fire and the pool.

**Reduce Fear and Anxiety**

When providing care, explain any procedures to both the parents and the child to help avoid fearful fantasies in the child. Never lie to the child about whether something will hurt; reassure them that it won’t hurt for long. Explain grooming and hygiene as an infection control technique. Encourage the child to make reasonable choices.

**Older Children: 7 - 12 Years**

Use toys and games to help teach the child and reduce fear of health issues. Use talking, singing and distraction like colorful stickers to divert attention from procedures that may be frightening. Always encourage the child to ask questions and talk about feelings to encourage the development of independence and social skills.
From ages 7 to 12, growth continues slowly until there is a spurt at puberty. Children in this age group are becoming mentally active and developing a greater sense of self. They have a great need to fit in with peers, and social activities take on increased importance. Key emotional health and safety issues at this age are to learn to feel competent and useful, to continue immunizations and checkups, and to begin to obtain honest information about alcohol, drugs and sexuality. It is also time to begin learning playground safety habits and how to resolve conflicts peacefully.

At this age, vital signs approach the norms of the adult patient. Questions may arise about the development of secondary sexual characteristics and should be dealt with honestly. Privacy is a key issue.

Do your best to guide the child toward a healthy lifestyle and safety choices, including exercise and nutrition. Help parents talk to the child about peer pressure regarding smoking, substance abuse, and sexuality. Often, an outside authority, such as a healthcare worker, can be a big help.

**Adolescents: 13 - 20 Years**

Between ages 13 and 20, an adolescent’s body transforms into an adult, sexually mature body, and complex thinking develops. Adolescents need help to balance identity development with the need for close relationships. Peer groups can come into conflict with family demands, and it can become a time when they challenge authority.

During this time in a child’s life, the following issues should be considered:

- privacy and respect
- checkups
- sexual responsibility and substance abuse
- risk taking and handling violence

Key emotional, health and safety issues during adolescence include privacy and respect and finding ways to foster teamwork. Checkups should continue, and adolescents must learn about sexual responsibility, and ways to resist the increased temptations toward substance abuse. Risk taking, particularly in driving and risky sports, needs to be addressed. Adolescents should also learn ways to peacefully handle potentially violent situations.

Begin looking for signs of common adolescent health problems, such as the nutritional disorders obesity, anorexia, and bulimia. Watch for acne and sexually related health problems like STDs and pregnancy. Reassure adolescents that stress and their individual body changes are normal.

Adolescent patients should be treated as adults to foster an atmosphere of trust and respect. Speak to them directly instead of talking through their parents. Explain procedures, and encourage questions. Be considerate of sensitive issues, such as appearance and relationships. Adolescents with a family history of genetically related diseases should learn about their family history and be screened appropriately. Adolescent girls should be taught breast self-examination; boys should be taught testicular self-examination.
Young Adults: 21 - 39 Years

Young adults 21 to 39 years of age have reached physical and sexual maturity and are acquiring new skills and seeking partnership. Key concerns are support, honesty and respect for their personal values. They need to have regular health checkups and updated immunizations. They should be encouraged to pursue exercise, good nutrition, and weight control, and to be aware of long-term health risks, such as heart disease and cancer. They should also give attention to safety hazards at home and work.

Young adults need to be monitored for STDs, and be taught testicular and breast self-examination. Discuss issues related to stress, as this stage in life usually includes major changes, such as marriage, having children, and career adjustments. Since young adults may feel invulnerable to disease and ignore early warning signs, encourage monitoring for any signs of chronic conditions. Explain the specifics of a healthy physical workout, including warm-up and stretching, and emphasize the importance of proper nutrition and diet.

Middle Adults: 40 - 64 Years

Middle adults, ages 40 to 64, continue to learn and be creative. Many may re-evaluate priorities and start to plan for retirement. Middle adults should be screened for chronic conditions that often develop at this age, such as diabetes, prostate disorders and breast cancer. Women should have counseling on menopause, taking estrogen, and measures to prevent osteoporosis.

The healthcare worker should encourage middle adults to express freely any worries about the future and encourage them to plan for a healthy and active retirement. The stress of mid-life crisis may require specific psychiatric interventions for some patients, so be alert for signs of depression or other mental illness. Also, be alert for patient stress resulting from being in the “sandwich generation,” or the generation responsible for caring for their parents as well as their children. Remind middle adult patients to make this a positive stage of life.

Older Adults: 65 - 79 Years

Older adults continue to learn and think, but some decline in physical abilities and sensory perception. New roles may require adjustment, such as being a grandparent, or returning to single life after the death of a spouse. Aspects of aging need to be accepted with extra effort made to remain active.

Stay alert to signs and complaints of the more common chronic conditions at this age, such as arthritis, hypertension, hearing impairment, and heart disease. Also watch for digestive and esophageal problems such as reflux, and bladder and bowel problems. The healthcare worker should encourage older adult patients to express feelings about their life accomplishments, as well as feelings of loss and grief. Use of medications can grow to include multiple medications and become complex. It is important to help older adult patients work out a manageable medication schedule.
Explain any procedure using appropriate terms. Provide warmth if necessary because of the possibility of decreased heat regulation. Be alert to the development of any impairment that may inhibit mobility or daily activities. Suggest practical ways of dealing with any impairment, but don’t assume impairments exist.

Advice on home safety may be important. Offer contacts for support services. Encourage social activities or volunteer work to keep older adult patients engaged. The sense of giving back and staying active can make all the difference in a person’s emotional outlook at this age.

**Adults 80 and Older**

There is no reason to assume mental decline has occurred in patients 80 and older. There may be signs of confusion, but those may just signal a treatable illness or depression. Encourage expression of feelings and thought, encourage humor, and remind them to stay positive to help prevent depression. Health should be monitored closely, and proper nutrition, exercise and rest should be encouraged.

**Chronic Illnesses and Health Problems**

Be on the alert for chronic illnesses and major health problems in patients 80 and over. Medications can become even more complicated and may require you to work out very detailed plans, possibly with color coding and reminder timers to help the patient follow a schedule. Update immunizations, particularly against influenza, which can be life threatening for older adults. The patient’s living environment should be monitored to prevent falls. Safety grips, ramps and similar aides may be crucial.

Encourage healthy eating and adequate fluid intake. Monitor changes in digestive functions, such as taste, chewing, and bowel functions, which might compromise proper nutrition. However, avoid treating an older adult like a child, as patients will likely sense and resent being patronized.

**Conclusion**

With every patient there are different needs and a different set of age-related medical and psychological factors that may affect their health. An efficient caretaker knows the differences between each age group and knows how to communicate with patients effectively in order to provide the most accurate assessments and the highest level of care. In this way, caretakers also go far in protecting themselves and their institutions from potential lawsuits that can result from perceived inadequate care and lack of understanding.
Cultural Diversity

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Cultural Diversity

Cultural competence is a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups.

Cultural competence also focuses its attention on population-specific issues including:

- Health-related beliefs and cultural values (the socioeconomic perspective)
- Disease prevalence (the epidemiological perspective)
- Treatment efficacy (the outcome perspective)

According to the Joint Commission’s publication “Advancing Effective Communication, Cultural Competence, and Patient and Family-Centered Care: A Roadmap for Hospitals”, in order for organizations and healthcare personnel to meet cultural competence it is essential to do the following:

1. Value diversity
2. Assess themselves
3. Manage dynamics of difference
4. Acquire and institutionalize cultural knowledge
5. Adapt to diversity and the cultural contexts of individuals and communities served

Effective communication and incorporating cultural concepts throughout the entire encounter, from admission to discharge, can increase patient satisfaction and adherence with treatment.

1. Value Diversity

As clinicians, we need to “check our own pulse” and become aware of personal attitudes, beliefs, biases, and behaviors that may influence (consciously or unconsciously) our care of patients as well as our interactions with professional colleagues and staff from diverse racial, ethnic, and sociocultural backgrounds.

Every clinical encounter is cross-cultural. Developing partnerships with our patients and maintaining “cultural humility” can help us to learn and better understand the historical, familial, community, occupational, and environmental contexts in which our patients live. It should be understood that there is no “one” way to treat any racial and ethnic group, given the great sociocultural diversity within these broad classifications. We need instead to have a framework of interventions that can be individualized and applied in a patient- and family-centered fashion.

Clinical and preventive care needs to be evidence-based, flexible, authentic, and ethical. We need to appropriately tailor our interventions to patients, families, and communities.
Cookbook approaches about working with patients from diverse sociocultural backgrounds are not useful and instead risk potentially dangerous stereotyping and overgeneralization. Important intergenerational differences exist, and diversity is often greater within groups than between them.

It is important to understand not only patient and community barriers to care, but also physician and healthcare system barriers to care. To eliminate racial and ethnic disparity, healthcare providers and organizations need to become more culturally and linguistically competent. We need to challenge and confront racism, sexism, classism, and other forms of prejudice and discrimination that occur in clinical encounters as well as in the society-at-large.

Through collaboration and achieving a better understanding and appreciation of our commonalities and differences, patients and physicians can become empowered to work together with others to help eliminate racial and ethnic disparities in healthcare. (Betancourt and Like, 2000)

2. Assess Themselves

Cultural competence begins with an honest desire not to allow biases to keep us from treating every individual with respect. It requires an honest assessment of our positive and negative assumptions about others. This is not easy — no one wants to admit that they suffer from cultural ignorance, or in the worst case, harbor negative stereotypes and prejudices.

Learning to evaluate our own level of cultural competency **MUST** be part of our ongoing effort to provide better healthcare.

Prior Assumptions and Prejudice

Unfounded assumptions that lead to prejudicial thoughts usually exist below the level of our awareness. They are often untested and unexamined; yet they shape how we act. One way to deal with these assumptions and prejudices is to bring them to the surface and examine them. Practicing this skill helps providers to understand the impact of our unconscious or automatic thinking on themselves and others. Practicing this skill also helps providers to create new mental models of their patients that will, in turn, contribute to the quality of healthcare for all patients.

3. Manage Dynamics of Difference

“Patient adherence to treatment (also compliance) is the degree to which patients adhere to medical advice and take medicines as directed. Adherence depends not only on patient acceptance of information about the health threat itself but also on the practitioner’s ability to persuade the patient that the treatment is worthwhile and on the patient’s perception of the practitioner’s credibility, empathy, interest, and concern.”

*Management Sciences for Health and World Health Organization 1997, 428*
Adherence to treatment can be a challenge for any patient, no matter what her/his culture. When the practitioner and patient come from different cultures and speak different languages, the challenges to effective communication and to the patient’s ability to adhere to treatment are greatly increased.

How can a provider convey “credibility, empathy, interest, and concern” to a patient from a different culture? The key to adherence is effective communication between provider and patient.

There are five activities that can contribute greatly to this communication:

1) Asking non-judgmental questions

Put yourself in your patient’s shoes. Try to imagine her viewpoint, values, daily responsibilities, and problems. Encourage the patient to be honest and open with you about his beliefs and concerns. Many cultures place a different value on time than the busy Western health provider. Acting in a hurried or impatient manner can seem like a sign of disrespect. Take time to ask questions and listen—this investment of time on your part will show the patient that you are sincere in wanting to learn about her illness. A patient who feels respected will be more likely to respond honestly and completely.

The following are examples of the kinds of questions that may help the provider gain important insights.

- Learn the patient’s perspective. What do you think caused your illness? What kind of impact has it had on your life? What remedies have you tried? What do you hope to get out of this visit?
- Explore the patient’s social and family context. Is money a concern, and should we consider less expensive treatment options first? Is your illness having an impact on your spouse or children? Do you have friends or relatives who can help you adhere to treatments—perhaps watch your children while you buy your medicine or attend follow-up visits? Will you be able to read the directions on the medicine bottle, and if not, is there a responsible person in your family who can read them for you?

2) Listening carefully

Listen to the patient without interrupting or letting your mind wander. Show your genuine interest in the patient’s replies. Be still—don’t fidget or sigh. Take notes, but don’t doodle. You can show that you have been listening by rephrasing the patient’s comments. This will give your patient an opportunity to understand what you heard him say, and to explain again if what you understood is not what he meant to say. These misunderstandings are common even when the patient and practitioner come from the same culture. When a patient and practitioner come from different cultures, the likelihood of miscommunication is greatly increased.
3) Setting realistic goals for behavior change

Changing behaviors is a challenge for all of us. Patient adherence may improve if you consider the social and family context of your patient and adjust your recommended treatment accordingly.

Dietary changes are among the most difficult. Adherence to treatment is a complex issue. Cultural factors can further complicate a patient’s ability to adhere to recommended treatment. Food and diet are closely related to culture. A patient care plan often includes a change in diet. Yet her culture may include dietary restrictions based on age, state of health, and/or gender. For example, some cultures have strict beliefs about the kinds of food a woman can eat during pregnancy or if she has recently given birth. Others follow food guidelines based on religious beliefs. By showing respect and understanding for the patient as an individual and as part of a cultural tradition, you will be better able to elicit relevant information about beliefs and traditions and the personal as well as cultural challenges to adherence. You can then help the patient find ways to gradually change dietary patterns that are harmful to his health.

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

Reducing sugar intake can be a problem in some families.

- Do they eat dessert with every dinner, or with every lunch and dinner?
- Will the family feel deprived if they change this habit?
- Will they be supportive of a family member who needs to reduce her intake of sweets?

Maybe they would consider having desserts only on Saturday and Sunday, instead of every day—or at one meal a day instead of two. Salt intake is another example. If a family is accustomed to using soy sauce with most meals, it is probably unrealistic to expect them to eliminate soy sauce from their diet. Would they be happy using a reduced-salt soy sauce?

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

4) Solving problems together

For many adults, a lecture (whether from a practitioner, boss, family member, or teacher) is not the most effective way to receive and act on a health message. If you are trying to explain a treatment and find a patient looking away, stirring restlessly, or sighing, it may be a sign that you have lost the patient’s attention. Most adults are better able to pay attention and remember instructions if they are involved in identifying their problems and seeking practical solutions.

For example, let’s say that your patient is not supposed to drink alcohol. Ask him what he would do if he were at a family event where alcoholic beverages were provided for everyone. Your patient’s
answer may reveal that she is more concerned with offending other family members or her boss than she is with following your advice. You may be able to offer him a way out of his dilemma—say, a tactful, humorous remark, or a glass of club soda that looks like an alcoholic drink. (Management Sciences for Health 1997, 45)

You might try a role play: Ask the patient to pretend that she is explaining her health problems and the necessary care to family members.” (London 1998, 45) This will reveal how well he understands his illness and treatment, and help to clear up any misconceptions.

5) Working with an Interpreter

Professional interpretation requires a minimum level of proficiency in two languages and the demonstrated ability to convey a complex message using words and grammar that are appropriate to both the provider and the patient. Professional interpreters are trained to convey messages without the distortion that can result from interjecting their own opinions, beliefs, or prejudices.

Family members, friends, and “informal” interpreters are more likely to modify what the patient has actually said in their effort to be helpful. Indeed, relying on these types of interpreters may mean that a health organization or individual provider is violating Title VI of the Civil Rights Act of 1964. Title VI and its supporting regulations guarantee individuals with limited English proficiency (LEP) any language assistance they need to guarantee “meaningful access” to health and social services that receive any form of federal funding.

Make a diligent effort to find professionally trained, qualified interpreters.

The most basic requirement is that you have access to an experienced and skilled interpreter who can truly aid communication rather than getting in the way or distorting the messages that you and the patient want to communicate. (Incidentally, the term “interpret” generally refers to spoken language and “translate” to written language. The skills required for these two disciplines are obviously different, though many interpreters can translate as well.)

Being bilingual in English and another language does not qualify an individual as an interpreter (just as speaking English competently does not qualify an individual to teach the language). A professional interpreter has the special skills needed to fully understand what both people want to say and to make their messages clear in two languages.

In addition, like any professional, a qualified interpreter knows her role, her limitations, and her responsibilities as an interpreter for others.

Qualified medical interpreters have additional skills that enable them to work effectively in health settings. They have studied the basics of anatomy and physiology. They may know the meanings of medical terms, diseases, and procedures in specialty areas and should be able to quickly make complex medical terminology understandable in the everyday language of the patients. They know the words that may be “taboo” in the language or culture of the patient and the euphemisms that may be used
Instead. They are familiar with the common health beliefs and practices of the cultures whose languages they speak. They understand and have been taught to handle the “triadic” relationship—the dynamics introduced by the introduction of a third person into a medical encounter.

They “must know how to engage both provider and patient effectively and efficiently in accessing the nuances and hidden socio-cultural assumptions embedded in each other’s language, which could lead to dangerous consequences if left unexplored.” (Massachusetts Medical Interpreters Association and Educational Development Center, Inc. 1995, 3)

Don’t depend on children or other relatives and friends, or nonmedical staff, to interpret.

Because of the high level of skill needed by professional interpreters, it follows that it is inadvisable to ask children or relatives or friends of the patient to interpret. For the same reasons, nonmedical staff members should not be asked to interpret unless it is a dire emergency and more qualified professionals are not available. If bilingual, staff with other responsibilities do the interpreting, they MUST NOT try to do two things at once, e.g., interpreting and counseling.

4. Acquire and Institutionalize Cultural Knowledge

In some cultures direct eye contact is viewed as a rude behavior, where others welcome that directness. Nonverbal communication can be divided into several categories: facial expressions, head movements, hand and arm gestures, physical space, touching, eye contact, and physical postures.

Facial expressions

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

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

Hand and Arm Gestures

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

Personal Space

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

Touching

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

**Eye Contact**

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

**Physical Postures**

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

In many of the world’s cultures, an individual’s health problems are also considered the family’s problems, and it is considered threatening to exclude family members from any medical interaction. For these patients, providers MUST address the individual’s health problem in the context of his or her family. Family members can provide valuable information regarding the patient’s diet, health behavior, daily activities, and types of alternative medications used. Their involvement in a treatment plan may be vital to a patient’s ability to adhere to the recommended treatment.

At the same time, it is not always culturally appropriate to involve family members, and the provider MUST be sensitive about when it may NOT be appropriate to involve certain family members. For example, it is NOT appropriate to ask family members to serve as medical interpreters during clinical encounters.

Pregnancy and Childbirth

In many cultures, men are not involved in the activities surrounding pregnancy or childbirth. Despite this apparent exclusion, husbands are responsible for making decisions and giving permission for treatment, medication, and hospital stay. A provider needs to be ready to involve the mother, mother-in-law, sister, and aunt (rather than the husband) in the development of the patient care plan during the pregnancy and after childbirth in families that follow this tradition. Female relatives may also be the most appropriate persons to take care of such tasks as having the husband sign the necessary consent forms or explaining suggested treatment options.

5. Adapt to diversity and the cultural contexts of individuals and communities served

Gender and Taboos

The roles of men and women, and the issues that they are able to discuss openly together, may be strictly prescribed by different cultures. If a patient does not speak English and an interpreter is not available, the provider should be careful about using a family member to interpret for the patient. For example, a son should not act as an interpreter with his mother’s obstetrician, nor should a wife act as an interpreter when speaking with her husband’s urologist or even cardiologist.

Food: An Important Factor in Culture

The food normally served in US hospitals tends to cater to what is seen as a “typical” bland American diet. This poses a significant problem for patients whose standard diet may be significantly different. The provider and attending nurses should engage the patient’s family in this issue. Can they bring food to the hospital? Do they know that certain foods will be beneficial and that others may be less beneficial? By involving the family in designing an appropriate diet for the patient, the provider will
ensure that the family will bring food that is beneficial rather than harmful and will increase the likelihood that the patient will have a healthy diet after discharge.

**Alternative Medicine: How will it interact with recommended treatment?**

Many patients may be taking other medications, some prescribed by another provider and some by a traditional healthcare provider. Often the patient’s family is a valuable source of information about all medications the patient is taking, particularly alternative medications with which the provider may be unfamiliar. With this knowledge, the provider can explore the possible consequences of taking certain alternative medicines along with the prescribed medications and avoid dangerous interactions (if any) between Western medicines and traditional herbs. These concerns can be discussed openly and respectfully with the patient and his family.

In summary, relating to the patient’s family and maintaining open lines of communication with family members may be vital to a patient’s health. The culturally competent provider will discuss with the patient the patterns of decision making in the family. Understanding the complex and often delicate interactions that may exist between family members will go a long way towards working with family members as a valuable resource, rather than an intrusion into the provider-patient relationship.

**Clinical Outcome**

Cultural competence can have a real impact on clinical outcomes. Ignoring culture can lead to negative health consequences in many ways:

- Patients may choose not to access needed services for fear of being misunderstood or disrespected;
- Providers may miss opportunities for screening because they are not familiar with the prevalence of conditions among certain minority groups (Lavizzo-Mourey and Mackenzie 1996; Lawson 1996; Moffic and Kinzie 1996);
- Providers may fail to take into account differing responses to medication (Lavizzo-Mourey and Mackenzie 1996; Lawson 1996; Moffic and Kinzie 1996);
- Providers may lack knowledge about traditional remedies, leading to harmful drug interactions (Lavizzo-Mourey and Mackenzie 1996; Lawson 1996; Moffic and Kinzie 1996);
- Providers may make diagnostic errors resulting from miscommunication (Lavizzo-Mourey and Mackenzie 1996; Lawson 1996; Moffic and Kinzie 1996);
- Patients may not adhere to medical advice because they do not understand or do not trust the provider;
- Providers may order fewer diagnostic tests for patients of different cultural backgrounds because they may not understand or believe the patient’s description of symptoms. Alternatively, providers may order more diagnostic tests to compensate for not understanding what their patients are saying.
The Impact of Cultural Competency

Many minority Americans, especially those with limited English proficiency, face barriers to accessing healthcare and getting appropriate treatment. Culturally competent healthcare could result in:

- More successful patient education, because culturally competent clinicians can target, tailor, and communicate health-related messages more effectively.
- Increases in patients’ health-care-seeking behavior, by improving trust and understanding between clinician and patient.
- More appropriate testing and screening, because clinicians will have more knowledge about the genetic background, risk exposure, and common health-related behavior in various cultural groups.
- Fewer diagnostic errors, as a result of more comprehensive and more accurate medical histories.
- Avoidance of drug complications, by discovering home or folk remedies used by patients.
- Greater adherence to medical advice, because clinicians establish a treatment plan that is most consistent with the patient’s cultural beliefs and lifestyle. Thus, patients better understand how to follow the treatment plan.
- Expanded choices and access to high-quality clinicians, because patients are no longer restricted to a small pool of clinicians who share their language and culture.

References


Ethics

1. Ethics Philosophy ................................................................. E: 1
2. Ethics Theory ........................................................................ E: 2
3. Ethics Education ....................................................................... E: 3
4. Ethics and “Good Business Practice” .................................... E: 4
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Ethics

Today’s healthcare professional is trained from either the two-year associate degree program or the four-year baccalaureate program. Much attention has been paid in recent years to the training of ethics for these students. Many leaders of the profession believe that student healthcare professionals have too little training concerning the ethics of patient care. Is it ethical for the student healthcare professional to document an assessment of a patient’s pain level after administration of pain medications when the student forgot to reassess? Of course not. Is it ethical for the student healthcare professional to accept a candy bar from a patient’s family for a good day’s work? Is acceptance of such a small token unethical? Probably not, but where is the invisible line between right and wrong (ethical and unethical) drawn? If the student works tomorrow, will that patient receive “better” care than the next patient who did not even say “thank you” to the student?

1. Ethics Philosophy

It has been said that ethics is a set of philosophical beliefs and practices concerned with values and human rights with a sense of duty to self and society. There are basically two modern-day theories of ethics. Consequentialism (which is the nature of secondary result) bases decisions on what provides the greatest good to society while minimizing any detrimental effects. The ideas of beneficence and non-malfeasance are derived from the consequentialism train of thought. The opposing theory of non-consequentialism asserts that good or bad is inherent in any act, making it independent of the consequences. Non-consequentialist theory is the root of the principles of autonomy, justice, and veracity (which means devotion to the truth).

One author states that ethical thought for the modern-day healthcare professional involves valuation of the patient’s physical, emotional, and spiritual needs, respect for individuality, and focus on a multi-disciplinary approach to care and patient advocacy. This thought process then fulfills the requirements of the consequentialistic approach to ethical nursing care.

In order for the healthcare professional to reach ethical care when adopting the non-consequentialistic approach to nursing care, the healthcare professional must provide autonomy, justice, and veracity with patient interaction. This means the healthcare professional must allow the patient the right of self-determination regarding health decisions. Healthcare professional provision of justice to the patient requires that policy and procedure for healthcare are consistent and equitable among the patient population, allowing fairness and balance in patient care. Veracity is, of course, truthfulness and trustworthiness. One author finds that healthcare professionals are still among the professionals noted to be most trustworthy, allowing for effective patient care to take place.

Although all the characteristics of both theories are valuable, the underlying premise is whether one believes in providing maximum good with minimum bad or to perform an act independent of the effects. Two prevailing theorists provide principles that govern humans in their interactions with society and the world.
2. Ethics Theory

Lawrence Kohlberg provides a theory of moral development that describes justice and its development as humans interact with their environments. This theorist believes that moral maturity is determined by the reasons given for an act being “right or wrong”. Kohlberg’s six stages were grouped into three levels: pre-conventional, conventional, and post-conventional.

**Level I (Pre-Conventional)**

1. Obedience & punishment orientation
2. Self-interest orientation
   (What’s in it for me?)

**Level 2 (Conventional)**

3. Interpersonal accord & conformity
   (The good boy / good girl attitude)
4. Authority & social-order maintaining orientation
   (Law & order morality)

**Level 3 (Post-Conventional)**

5. Social contract orientation
6. Universal ethical principles
   (Principled conscience)

Kohlberg asserts that most people only reach stage 3 or 4. Stage 3 is concern for others and their feelings with motivation to follow rules and expectations. Stage 4 is the upholding of social order and maintenance of society’s welfare. He believes that most of us do not reach the upper stages. Stage 5 is upholding basic rights even when they conflict with rules of the group. Stage 6 is where the individual assumes guidance by universal ethical principles that all humanity must follow. Kohlberg’s studies provided only male involvement. Females are not as pertinent to his theory of ethical development. Kohlberg’s theory suggests that one reason for unethical behavior is the individual’s inability to develop morality without defying one’s own reasoning. For example, nursing students who have not been challenged by an instructor cannot move to the next stage of reasoning. A nursing student who does not interact with an instructor who believes that falsifying a blood pressure entry is wrong may not identify this as a wrong, thereby never moving to the next level of moral reasoning. Also, application of Kohlberg’s ideology to the nursing profession implies that female healthcare professionals are by nature less advanced in moral development.

Another modern-day theorist is Carol Gilligan who studied Kohlberg and then challenged his theory. Development of her own theory of ethical evolution provides for the insertion of women into the moral and ethical discussion. Gilligan described the female moral dilemma as a struggle between an ethic of care and the individual’s responsibility to self and others. Gilligan’s three studies found that
women judge themselves on the basis of their capacity to care. This suggests that responsibility and relationships are important ingredients to moral development. In a profession where the vast majority of members are female, this theory lends itself appropriately to the study of ethics in nursing. Gilligan proposes that unethical behavior is related to the nursing student’s internal conflict of patient care and personal integrity, compassion, and personal autonomy. Thus, unethical behavior can stem from the need to care for another’s needs in lieu of meeting the needs of the self. One author implies that this cycle then leads to exhaustion and frustration. Gilligan then hypothesizes that an ethic of care can only develop when the individual student, or healthcare professional, understands human relationships and social interactions and that these are interdependent. One can meet the standards of ethics needed by members of the nursing profession only when an understanding is reached that there are self needs to be met as well as patient needs.

3. Ethics Education

Education of future healthcare professionals would benefit from learning environments that enhance the moral development of students. Promotion of honesty and allowing students to correct their own mistakes and solve problems permit moral thinking and development. An understanding of ethics, professionalism, and nursing practice is key to this type of learning environment. Compared to medical schools, nursing programs are lacking in the education of topics concerning ethics. While medical schools were found to explore seven ethics-related topics, only two such topics were found in nursing schools by one author. This same author found a lack of core ethics objectives, gaps in clinical ethics topics and a desire by many faculties to improve ethics education in their respective programs.

One author found a lack of integrity in the student-faculty relationship. Academic dishonesty leads to doubt and mistrust in the student on behalf of faculty members. One study found that 15 percent of students admitted to recording interventions such as medication administration without having done so. In the classroom, 27 percent of students in the study had plagiarized, while 10 percent had turned in another person’s work as their own. Using Kohlberg’s theory, a system should be provided that allows students to interact with various individuals who possess different morals and are at varying stages of moral development. Kohlberg’s ideas uphold that this would create a situation where students would then have the opportunity to reach higher levels of moral development from exposure to peers and superiors at higher levels themselves. Gilligan’s ideas also support this system with the belief that the student might accept responsibility for themselves and others, leading to an awareness of the resulting reciprocity of this interaction. Ultimately, Gilligan’s theory implies that students move away from self-centeredness to an understanding of the interconnectedness of themselves and others. While this discussion concerns nursing students, it gives an insight to practicing healthcare professionals and how these individuals differ in their mannerisms and beliefs. To achieve an environment where healthcare professionals are at a higher level of moral development, the educational system must recognize these interventions need to take place before the student becomes the healthcare professional or primary caregiver of patients with ever-increasing needs and higher levels of acuity.

There is a trickle-down effect to this ethics-poor environment. Nursing students who are devoid of moral and ethical practice will most likely become healthcare professionals who also lack these same characteristics. Educators who teach and apply ethics ideas and behaviors can expect some
improvement in this area for students and potential healthcare professionals. Case studies abound where healthcare professionals must put aside their own system of values and beliefs in order to care for particular patients.

4. Ethics and “Good Business Practice”

Even before modern day healthcare delivery, healthcare professionals have been riddled with instances where ethics have played a role in patient care. The healthcare professional must provide beneficent care (meaning doing or producing good), while avoiding malfeasance (meaning wrongdoing or misconduct). However, does beneficence apply to the individual patient or to society as a whole? Is it considered misconduct to provide information to outside sources regarding a patient that will lead to protection of the greater population? These and other questions provide the framework that involves ethical decision-making for the healthcare professional.

There are many instances throughout the Healthcare Professionals career where they will be faced with ethical decisions on whether what they are practicing is “good business”. Although many people believe working at hospitals or healthcare facilities may not appear to be a business, it certainly is. Healthcare facilities rely on their employees to treat their clients (patients) with respect and dignity, and to be honest and forthright with their day to day decision making, related to client / patient interaction.

The two largest ethical dilemmas facing the healthcare professional:

1. Documentation related to care provided to the client: was the medication actually given, was care rendered to the patient, was treatment protocol followed, was a medication incident reported even if no adverse reaction was observed, was care delivered in a timely manner, etc.

2. Financial remuneration by client / patient to the healthcare professional: it could be as little as a small “tip” of $5 to the nurse for taking “good care” of a patient by the family, or an all expensed paid trip to Las Vegas for a physician, by the drug company to say thank you for writing prescriptions of your drug.

It is important for healthcare professionals to identify how these issues could negatively affect not only how they are viewed as a professional, but also negatively affect the company they work for. This could also be a company violation that can lead to suspension and termination.

Again, ethics needs to play a major role in the development of the healthcare professionals. Healthcare professionals have been identified as one of the most important advocates for patients and healthcare decisions. Healthcare professionals are bound by laws and ethical thought to provide safe care for patients. There are ethics frameworks to help govern the nursing profession. The healthcare professional also brings to the table his / her own morals and beliefs. Understanding how these separate concepts interact within healthcare professionals is important to the future education of nursing students. Students who are given information regarding this mind set are more attuned to others’ needs, either patients or fellow healthcare professionals.
5. References


National Patient Safety Goals for Hospitals - 2016

Nursing Manual

National Patient Safety Goals for Hospitals .............. NG: 1

Goal 1 ........................................................................ NG: 1
Goal 2 ........................................................................ NG: 2
Goal 3 ........................................................................ NG: 2
Goal 6 ........................................................................ NG: 8
Goal 7 ........................................................................ NG: 9
Goal 15 ....................................................................... NG: 15
Universal Protocol ....................................................... NG: 16
Goal 1
*Improve the accuracy of patient identification.*

**NPSG.01.01.01**
*Use at least two patient identifiers when providing care, treatment, and services.*

**Rationale for NPSG.01.01.01**
Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual’s name, an assigned identification number, telephone number, or other person-specific identifier.

**Elements of Performance for NPSG.01.01.01**
1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1)

2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1)

**NPSG.01.03.01**
*Eliminate transfusion errors related to patient misidentification.*

**Elements of Performance for NPSG.01.03.01**
1. Before initiating a blood or blood component transfusion:
   - Match the blood or blood component to the order.
   - Match the patient to the blood or blood component.
   - Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding.
   (See also NPSG.01.01.01, EPs 1 and 2)
2. When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient.

3. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process, as determined by the hospital.

Goal 2

*Improve the effectiveness of communication among caregivers.*

**NPSG.02.03.01**

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

**Rationale for NPSG.02.03.01**

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

**Elements of Performance for NPSG.02.03.01**

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

2. Implement the procedures for managing the critical results of tests and diagnostic procedures.

3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

Goal 3

*Improve the safety of using medications.*

**NPSG.03.04.01**

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

Note: Medication containers include syringes, medicine cups, and basins.
Rationale for NPSG.03.04.01

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

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

Elements of Performance for NPSG.03.04.01

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.

   Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Refer to NPSG.03.04.01, EP 5, for information on timing of labeling.

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

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

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

4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.
Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

6. Immediately discard any medication or solution found unlabeled.

7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.

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

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

NPSG.03.05.01
Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient’s laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thromboembolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient’s laboratory values for coagulation will remain within, or close to, normal values.

Rationale for NPSG.03.05.01

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

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.
Elements of Performance for NPSG.03.05.01

1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
   
   Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.

2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.

3. Before starting a patient on warfarin, assess the patient’s baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.
   
   Note: The patient’s baseline coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors.

4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.

5. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.

6. A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.

7. Provide education regarding anticoagulant therapy to staff, patients, and families.
   
   Patient/family education includes the following:
   
   - The importance of follow-up monitoring
   - Compliance
   - Drug-food interactions
   - The potential for adverse drug reactions and interactions

8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.
Introduction to Reconciling Medication Information

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

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

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

In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide to patients. It is often important for clinicians to know what medications the patient is taking when planning care, treatment, or services, even in situations where medications are not used. A new requirement in this NPSG addresses the patient’s role in medication safety: it requires organizations to inform the patient about the importance of maintaining updated medication information.

NPSG.03.06.01
Maintain and communicate accurate patient medication information.

Rationale for NPSG.03.06.01

There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future.
Elements of Performance for NPSG.03.06.01

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.

   Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis.

   Note 2: It is often difficult to obtain complete information on current medications from a patient, a good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the Element of Performance.

2. Define the types of medication information to be collected in non-24-hour settings and different patient circumstances.

   Note 1: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.

   Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose.

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

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

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

   Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.

5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

   Note: Examples include instructing the patient to give a list to his or her primary care physician to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. For information on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.
Goal 6

Reduce the harm associated with clinical alarm systems.

NPSG.06.01.01

Improve the safety of clinical alarm systems

Rationale for NPSG.06.01.01

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

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

Additional information on alarm safety can be found on the AAMI website http://www.aami.org/htsi/alarms/. Also, the ECRI Institute has identified alarm hazards as one of the top technology hazards for 2013; more information on this hazard list can be found at http://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx.

Elements of Performance for NPSG.06.01.01

1. Leaders establish alarm system safety as a hospital priority.

2. Identify the most important alarm signals to manage based on the following:
   • Input from the medical staff and clinical departments
   • Risk to patients if the alarm signal is not attended to or if it malfunctions
   • Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
   • Potential for patient harm based on internal incident history
   • Published best practices and guidelines

(For more information on managing medical equipment risks, refer to Standard EC.02.04.01.)
3. Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following:
   - Clinical appropriate settings for alarm signals
   - When alarm signals can be disabled
   - When alarm parameters can be changed
   - Who in the organization has the authority to set alarm parameters
   - Who in the organization has the authority to change alarm parameters
   - Who in the organization has the authority to set alarm parameters to “off”
   - Monitoring and responding to alarm signals
   - Checking individual alarm signals for accurate settings, proper operation, and detectability (For more information, refer to Standard EC.02.04.03)

4. Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.

Goal 7
 Reduce the risk of health care–associated infections.

NPSG.07.01.01
 Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

Rationale for NPSG.07.01.01

According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization. Consequently, health care-associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.

Elements of Performance for NPSG.07.01.01

1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 5)
2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 3)
3. Improve compliance with hand hygiene guidelines based on established goals.

**NPSG.07.03.01**

*Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.*

Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

**Rationale for NPSG.07.03.01**

Patients continue to acquire health care–associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care–associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient’s environment are essential strategies for preventing the spread of health care–associated infections. Hand hygiene is addressed in NPSG.07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC.02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC.02.02.01.

**Elements of Performance for NPSG.07.03.01**

1. Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1-5)

2. Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.
   
   Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the hospital.

3. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection strategies.

4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.

   Note: Surveillance may be targeted rather than hospital-wide.
5. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
   - Multidrug-resistant organism infection rates using evidence-based metrics
   - Compliance with evidence-based guidelines or best practices
   - Evaluation of the education program provided to staff and licensed independent practitioners

   Note: Surveillance may be targeted rather than hospital-wide.

6. Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

7. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.

   Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.

9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

   Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.

   Note 2: Each hospital may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.

**NPSG.07.04.01**  
*Implement evidence-based practices to prevent central line–associated bloodstream infections.*

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

**Elements of Performance for NPSG.07.04.01**

1. Educate staff and licensed independent practitioners who are involved in managing central lines
about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual’s job responsibilities.

2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention.

3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

4. Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital-wide, not targeted.

5. Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

6. Use a catheter checklist and a standardized protocol for central venous catheter insertion.

7. Perform hand hygiene prior to catheter insertion or manipulation.

8. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.

9. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.

10. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.

11. Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations.

Note: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

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12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.

13. Evaluate all central venous catheters routinely and remove nonessential catheters.

**NPSG.07.05.01**

*Implement evidence-based practices for preventing surgical site infections.*

**Elements of Performance for NPSG.07.05.01**

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities.

2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.

3. Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

4. As part of the effort to reduce surgical site infections:
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
   - Select surgical site infection measures using best practices or evidence-based guidelines.
   - Monitor compliance with best practices or evidence-based guidelines.
   - Evaluate the effectiveness of prevention efforts.

Note: Surveillances may be targeted to certain procedures based on the hospital’s risk assessment.

5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The hospital’s measurement strategies follow evidence-based guidelines.

Note 1: Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.

Note 2: The NHSN is the Centers for disease Control and Prevention’s health care-associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data.
needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care-associated infections. For more information on NHSN procedural codes, see [http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html](http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html).

6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.

Note: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.**

8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.

Note: ** See note above.**

**NPSG.07.06.01**

*Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).*

Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is not consensus that these practices apply to children.

**Elements of Performance for NPSG.07.06.01**

1. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:
   - Limiting use and duration to situations necessary for patient care
   - Using aseptic techniques for site preparation, equipment, and supplies

2. Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:
   - Securing catheters for unobstructed urine flow and drainage
   - Maintaining the sterility of the urine collection system
   - Replacing the urine collection system when required
- Collecting urine samples

3. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
   - Selecting measures using evidence-based guidelines or best practices
   - Monitoring compliance with evidence-based guidelines or best practices
   - Evaluating the effectiveness of prevention efforts

Note: Surveillance may be targeted to areas with a high volume of patients using in-dwelling catheters. High-volume areas are identified through the hospital’s risk assessment as required in IC.01.03.01, EP 2.

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

NPSG.15.01.01
Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Rationale for NPSG.15.01.01

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

Elements of Performance for NPSG.15.01.01

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

2. Address the patient’s immediate safety needs and most appropriate setting for treatment.

3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.
Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Surgery™

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

The Universal Protocol is based on the following principles:

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

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

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

Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.
UP.01.01
Conduct a preprocedure verification process.

Rationale for UP.01.01
Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

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

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

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

- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

Elements of Performance for UP.01.01

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

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

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:

   - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
   - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
   - Any required blood products, implants, devices, and/or special equipment for the procedure
Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

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

**Introduction to UP.01.02.01**

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

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

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

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

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

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.
UP.01.02.01

Mark the procedure site.

Elements of Performance for UP.01.02.01

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

   Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.

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

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

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

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

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).
Note: Examples of other situations that involve alternative processes include:
- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

UP.01.03.01

*A time-out is performed before the procedure.*

**Rationale for UP.01.03.01**

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

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

**Elements of Performance for UP.01.03.01**

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.

2. The time-out has the following characteristics:
   - It is standardized, as defined by the hospital.
   - It is initiated by a designated member of the team.
   - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.

4. During the time-out, the team members agree, at a minimum, on the following:
   - Correct patient identity
   - The correct site
   - The procedure to be done

5. Document the completion of the time-out.

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

1. The Patient Rights Movement .................................................. PR: 1
2. Nurse as Patient Advocate ....................................................... PR: 2
3. Patient Bill of Rights .............................................................. PR: 2
4. Patient Responsibilities .......................................................... PR: 4
1. The Patient Rights Movement

The patient rights movement is as slow as a glacier, equally relentless at changing the landscape, but ultimately healthy. That it is not as organized and identifiable as other consumer movements is explained by the fact that when individuals are sick or injured, they are not themselves, and their first priority is to regain their health and their identity.

F. Scott Fitzgerald perhaps put it best in his masterpiece of American fiction, The Great Gatsby: “[There is] no difference between men, in intelligence or race, so profound as the difference between the sick and the well.” Thus, sick and injured citizens often voluntarily relinquish rights they would otherwise vigorously assert in the hope that this will aid their recovery. In the words of Dr. Oliver Wendell Holmes, “There is nothing men will not do, there is nothing they have not done, to recover their health and save their lives.” He describes some of the extremes to which sick people have gone, including being half drowned, half cooked, seared with hot irons, and crimped with knives.

There are additional reasons why there are few organized groups of patient-consumers that apply specifically to hospitalized patients. First, most people in a hospital are sick and are not physically or psychologically capable of either exercising their own rights or organizing to help protect and assert the rights of others. Second, the average length of stay in most American acute-care hospitals is less than a week, hardly long enough to build any type of an inpatient organization. Third, when outside the hospital, most Americans prefer not to think about hospitalization, just as we prefer not to think about death, and so do not plan for it.

Local patient rights organizations have been built around some neighborhood health centers, and by individuals interested in specific populations (such as children), specific occurrences (such as childbirth), or specific diseases (such as kidney failure or AIDS). There is even one national patient rights organization, the People’s Medical Society. On the whole, however, the movement for rights in healthcare is diffuse and unstructured.

Recognition of patient rights in the form of a Patient Bill of Rights is a necessary, but not sufficient, step in the protection and promotion of patient rights. Rights are not self-actualizing. We may look forward to the day when all physicians, nurses, and allied health professionals will accord patients their basic human rights as a matter of course, but this day has not yet come. Until this goal is attained, mechanisms that can help to ensure that patient rights are protected and honored will be absolute necessities.
2. Nurse as Patient Advocate

The effects of illness and the complexities of modern healthcare can keep your patient from reaching her treatment goals. Find out what you can do to ease his / her journey.

For years, nurses have recognized the duty to protect the rights of patients who can’t fend for themselves. As advocates, nurses have helped vulnerable patients and their loved ones map out and follow a treatment course consistent with the patients’ values.

To become effective advocates, we need to embrace two ideals: The first is reverence for our patient-a willingness to respect his / her autonomy and not try to control him / her. The second is fidelity-accepting and upholding his / her decisions-so open communication and trust are essential. Once we commit to these ideals, we approach the central task of advocacy-reaching out to the healthcare system to help our patient achieve his / her goals.

3. Patient Bill of Rights

1. to considerate and respectful care given by competent personnel;
2. to quality care and professional standards that are continually maintained and evaluated;
3. to have impartial access to the resources of the hospital indicated for your care without regard to race, color, creed, national origin, beliefs, values, language, functional status, disability, age, sex, sexual preference, handicap or source of payment;
4. to hear from your physician, in language you can reasonably be expected to understand, your diagnosis, the treatment prescribed for you, the prognosis of your illness, any alternative treatments and possible complications and any instruction required to follow up care; also to review your medical records and to have the information explained or interpreted as necessary, except when restricted by law;
5. to know the facility rules and regulations that apply to your conduct as a patient and to receive materials at the time of admission regarding hospital rules and regulations, patient’s rights and complaint / grievance mechanisms;
6. to know by name the attending physicians responsible for coordinating your care and the names of other professionals involved in your care;
7. to be informed about the general nature, risks and alternatives of any procedures or treatments prescribed for you so that you or your authorized representative can give informed consent prior to the event except for
8. to expect emergency procedures to be implemented without unnecessary delay;
9. to, in collaboration with your physician, make decisions involving your healthcare, and participate in the development and implementation of your plan of care including the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of this action;
10. to be provided education about pain management including pharmacological and non-pharmacological interventions for pain management; a concerned staff committed to pain prevention and management; a staff that believes your reports of pain and who will respond promptly to your reports of pain; and pain management will be regularly reassessed and modified to achieve optimal pain control;

11. to not be awakened by hospital staff unless medically necessary and to medical and nursing treatment that avoids unnecessary physical and mental discomfort and needless duplication;

12. to be provided access to spiritual care in a manner consistent with your faith and religious tradition;

13. to assistance in obtaining consultation with another physician at your request and expense;

14. to expect your personal privacy to be respected, consistent with the care prescribed for you and to expect all communications and records pertaining to your care to be kept confidential;

15. to expect that the facility will provide a mechanism whereby you are informed upon discharge of your continuing healthcare requirements following discharge and the possible means for meeting them;

16. when medically permissible, to be transferred to another facility only after you have been given complete information and explanation concerning the needs for and alternatives to such transfer;

17. to be given the benefit of participation in clinical training programs offered by the institution;

18. to be informed of any human experimentation research or donor programs the hospital may propose which would affect your care or treatment so that you or your authorized representative can give consent prior to the event;

19. to examine and receive an explanation of your hospital bill, regardless of the source of payment and to identify available financial information;

20. to participate in the consideration of ethical issues that arise in your care and to formulate advance directives;

21. to expect your rights and responsibilities to be extended to your authorized representative if you are unable to act on your own behalf or if you are underage as in the case of a neonate, child, or adolescent;

22. to have access when possible to an interpreter;

23. to speak with your physician or nurse or to contact the Patient Relations Department for assistance in the resolution of any concerns or complaints you have regarding your care; grievances may be filed with the Patient Relations Department. Information regarding governing state agencies is also available in the Patient Relations Department;

24. to have a family member / representative of your choice and your own physician notified promptly of your admission to the hospital;

25. to not be denied access to an individual or agency who is authorized to act on your behalf or assert or protect;
26. to receive care in a safe setting and be free from all forms of abuse and harassment;
27. to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff; and,
28. the faculty shall provide a patient or patient designee, upon request, access to all information contained in the patient’s medical records. A patient’s access to medical records may be restricted by the patient’s attending physician. If the physician restricts the patient’s access to information in the patient’s medical record, the physician shall record the reasons in the patient’s medical record. Access shall be restricted only for sound medical reason. A patient’s designee may have access to the information in the patient’s medical records even if the physician restricts the patient’s access to those records.

4. Patient Responsibilities

1. to know and follow hospital rules and regulations;
2. to give cooperation and to follow the care for which you have given consent and which was prescribed or recommended for you by your physician, nurses, or allied health personnel;
3. to notify your physician or the nurse manager if you do not understand your diagnosis, treatment, or prognosis;
4. to let the nurse manager and your family know if you feel you are receiving too many outside visitors;
5. to ask your doctor or nurse what to expect regarding pain and pain management; to discuss pain relief options with your doctor and nurse to develop a pain management plan; to ask for pain relief when pain first begins; to help your doctor and nurse assess your pain; to tell your doctor or nurse if your pain is not relieved; and to tell your doctor or nurse about any worries you have about taking pain medication;
6. to respect the privacy of your roommate;
7. to accept your financial obligations associated with your care;
8. to advise your charge nurse, physician, or Patient Relations of any dissatisfaction you may have in regard to your care at the hospital;
9. to be considerate of the rights of other patients and hospital personnel and to assist in the control of, smoking and the number of visitors you receive.
Patient Safety Systems and Events

1. Key Terms
2. Sentinel Events
3. Comprehensive Systematic Analysis
4. Action Plans
5. Patient Safety Systems
6. Conclusion
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Patient Safety Systems and Events

Today’s healthcare professional is highly trained in multiple facets of patient care. The increasing complexity of healthcare along with the expanding medical knowledge can be overwhelming and difficult to manage at times. Other factors can add to the stress and fatigue within the healthcare environment, such as turnover within the healthcare team, increased expectations to reduce costs, and changes in technology. A top priority of healthcare professionals and organizations is to “do no harm”, but human error, equipment failure, or a system breakdown can result in a patient safety event. Typically, however, the result is due to flaws or failures in the systems and processes.

As the importance for sustainable improvements in patient safety and the quality of patient care increases, the attention to patient safety has never been greater. Although much attention is paid to prevent patient harm, understanding the concepts and definitions related to patient safety events is a crucial step in taking a proactive approach to preventing potential harm.

1. Key Terms

Patient Safety Event is an event, incident, or condition that could have resulted or did result in harm to a patient.

Adverse Event is a patient safety event that resulted in harm to a patient. Adverse events should prompt notification of hospital leaders, investigation, and corrective actions. An adverse event may or may not result from an error.

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

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

No-Harm Event is a patient safety event that reaches the patient but does not cause harm.

Close Call (or “Near Miss” or “Good Catch”) is a patient safety event that did not reach the patient. Close calls should be tracked and used as opportunities to prevent harm.

Hazardous (or “unsafe”) Conditions is a circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event. Hazardous Conditions should be tracked and used as opportunities to prevent harm.
2. Sentinel Events

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

- Unanticipated death or major permanent loss of function (not related to the natural course of the patient’s illness or underlying condition)
- One of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition):
  - Suicide
  - Unanticipated death of a full-term infant
  - Abduction of any patient
  - Discharge of an infant to the wrong family
  - Rape, assault (leading to death or permanent loss of function), or homicide of
    - Any patient
    - Staff member, licensed independent practitioner, visitor, or vendor while on site at the healthcare organization

The following are examples of Sentinel Events that are reviewable under the Joint Commission’s Sentinel Event Policy:

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on the wrong side of the patient’s body, on the wrong site of the patient’s body, or on the wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- A patient is abducted from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in death or major permanent loss of function of a staff member, licensed independent practitioner, visitor, or vendor
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery
Patient safety events that are NOT reviewable under the Joint Commission’s Sentinel Event Policy include:

- Any close call (“near miss”)
- Full or expected return of limb or bodily function to the same level as prior to the adverse event by discharge or within two weeks of the initial loss of said function, whichever is the longer period
- Any sentinel event that has not affected a recipient of care (patient, individual, resident)
- Medication errors that do not result in death or major permanent loss of function
- Suicide other than in an around-the-clock care setting or following elopement from such a setting
- A death or loss of function following a discharge against medical advice (AMA)
- Unsuccessful suicide attempts unless resulting in a major permanent loss of function
- Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical sequelae

3. Comprehensive Systematic Analysis

Organizations accredited by the Joint Commission are required to complete a comprehensive systematic analysis to identify the contributory factors of the sentinel event. A Root Cause Analysis (RCA) is one such method for completing this analysis. Key characteristics of a RCA are:

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

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

An Action Plan is the product of the comprehensive systematic analysis that identifies the strategies the organization intends to implement to reduce the risk of a similar event occurring in the future. The action plan must address the following:

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

5. Patient Safety Systems

To help reduce variation, reduce risk, and improve quality, organizations should have an integrated patient safety system that includes the following:

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

A key factor in preventing patient harm is conducting a proactive risk assessment. This evaluates processes for potential failures, addresses the consequences of such failures, and identifies parts of the process that need improvement.

6. Conclusion

Throughout the organization, all parties of the healthcare team should participate in the prevention and preservation of patient safety through regular education and frequent reminders about potential high-risk and hazard-prone processes. Organizations that employ a blame-free culture (one in which no one is ridiculed or reprimanded for errors) are the most successful in gaining employee cooperation with reporting as well as remedying near-miss and actual adverse events. If a patient safety event occurs, a comprehensive systematic analysis should be performed with staff and leaders within the organization. Contributing factors should be identified and reviewed within the interprofessional team. Action plans will identify strategies to reduce the risk of reoccurrence and should not be directed at individual performance or behavior. Review and transparency of information regarding patient safety events is a critical component in an organization’s ongoing development of a culture of safety. Lessons learned from these analyses should be openly shared throughout the organization as a means of preventing future errors and system breakdown.
7. References


The Joint Commission, Health Care Staffing Services Certification Manual: Patient Safety Events