RAPID REGULATORY COMPLIANCE:
CLINICAL: PART I

Welcome to Rapid Regulatory Compliance: Clinical: Part I.

Reviewing and updating knowledge of regulatory requirements periodically helps all healthcare workers maintain standards and comply with laws and regulations.

While some standards and regulations stay the same, changes occur when federal and state leaders identify new problems or a need to clarify or enhance standards and regulations.

This course will rapidly review and update your knowledge of:

- Compliance and sexual harassment
- Patient rights
- Patient care and protection

For additional information on the topics discussed in this course, please refer to the courses listed on the right.

As your partner, HealthStream strives to provide its customers with excellence in regulatory learning solutions. As new guidelines are continually issued by regulatory agencies, we work to update courses, as needed, in a timely manner. Since responsibility for complying with new guidelines remains with your organization, HealthStream encourages you to routinely check all relevant regulatory agencies directly for the latest updates for clinical/organizational guidelines.

If you have concerns about any aspect of the safety or quality of patient care in your organization, be aware that you may report these concerns directly to your organization's accrediting agency.

Courses discussing topics in detail:

- *Patient Rights*
- *Informed Consent*
- *Sexual Harassment*
- *Corporate Compliance*
- *End-of-Life Care*
- *Advance Directives*
- *Developmentally Appropriate Care of the Adult Patient*
- *Cultural Competence: Background and Benefits*
- *Identifying and Assessing Victims of Abuse and Neglect*
- *Introduction to Performance Improvement*
- *Performance Improvement in the Workplace*
- *Pain Management*

AFTER COMPLETING THIS REVIEW, YOU SHOULD BE ABLE TO:

- Recognize key relevant compliance laws and regulations for healthcare
- Identify the legal definition of sexual harassment
- Identify patient rights
- Describe the importance of patient rights
- Identify key regulatory requirements for the use of restraint and seclusion
- Identify regulatory requirements with regard to victims of assault, abuse, and/or neglect
- Describe best practice recommendations for the use of opioids
- Identify patients at risk for suicide
- Describe the quality assurance and performance improvement (QAPI) regulation

Course Outline

This introductory lesson provides an overview of the course rationale, learning objectives, and outline. This lesson will also discuss corporate compliance including laws, regulations, and consequences of noncompliance. Sexual harassment also will be reviewed.

LESSON 2

will cover patient rights and relevance to care provision.

LESSON 3

will focus on standards and issues pertaining to patient care and protection.

Lesson 1: Introduction, Compliance, and Sexual Harassment
- Corporate compliance
  - Applicable laws and regulations
- Sexual harassment

Lesson 2: Patient Rights
- Respect, safety, and nondiscrimination
- Confidentiality
- Informed consent
- Participation in care
- Advance directive and advance orders
- Visitation rights
- Grievances

Lesson 3: Patient Care and Protection
- Developmentally appropriate care
- Restraint and seclusion
- Patient assault and abuse in the healthcare setting
- Victims of abuse and neglect
- Opioid use
- Suicide risk
- Quality assurance and performance improvement (QAPI)

Corporate Compliance: Applicable Laws and Regulations

Corporate compliance means following business laws and regulations.

Laws and regulations for healthcare are:

- **Medicare regulations**
- **Federal False Claims Act**
- **Stark Law**
- **Anti-Kickback Statute**
- **Sections of the Social Security Act**
- **Affordable Care Act**
- **Emergency Medical Treatment and Labor Act (EMTALA)**
- **Health Insurance Portability and Accountability Act (HIPAA)**

Let's take a closer look at each of these on the following screens.

In recent years, government agencies have started to look more closely for healthcare fraud and misconduct.

A lot of federal money has been used to investigate and prosecute suspected fraud.

This has increased the number of providers convicted of fraud.

Next

Special Notes

Organization Notes

Questions on Civil Rights

- Compliance Helpline: 1-800-450-2339 or 715-847-2166
- Email at Compliance@aspirus.org
- Submit a Question or Concern through Safety Zone

- **Anti-Kickback Statute**
- **Sections of the Social Security Act**
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Let's first look at:

- Medicare regulations
- Federal False Claims Act
- Stark Law

Corporate Compliance: Applicable Laws and Regulations

Let's look first at:

- Medicare Regulations
- Federal False Claims Act
- Stark Law

FEDERAL FALSE CLAIMS ACT

The Federal False Claims Act makes it illegal to submit a falsified bill to a government agency. This act:

- **Applies to healthcare because Medicare is a government agency**
- **Allows a citizen who has evidence of fraud to sue on behalf of the government. This "whistleblower" is protected from retaliation for reporting the fraud.**

Note: State laws also focus on false claims in addition to the Federal False Claims Act.

Corporate Compliance: Applicable Laws and Regulations

Let's look first at:

- Medicare Regulations
- Federal False Claims Act
- Stark Law

STARK LAW

The Ethics in Patient Referrals Act (EPRA) is commonly known as the Stark Law. The Stark Law makes it illegal for physicians to refer patients to facilities or providers:

- **If the physician has a financial relationship with the facility or provider**
- **If the physician's immediate family has a financial relationship with the facility or provider**

Note: This law does not apply in certain cases.

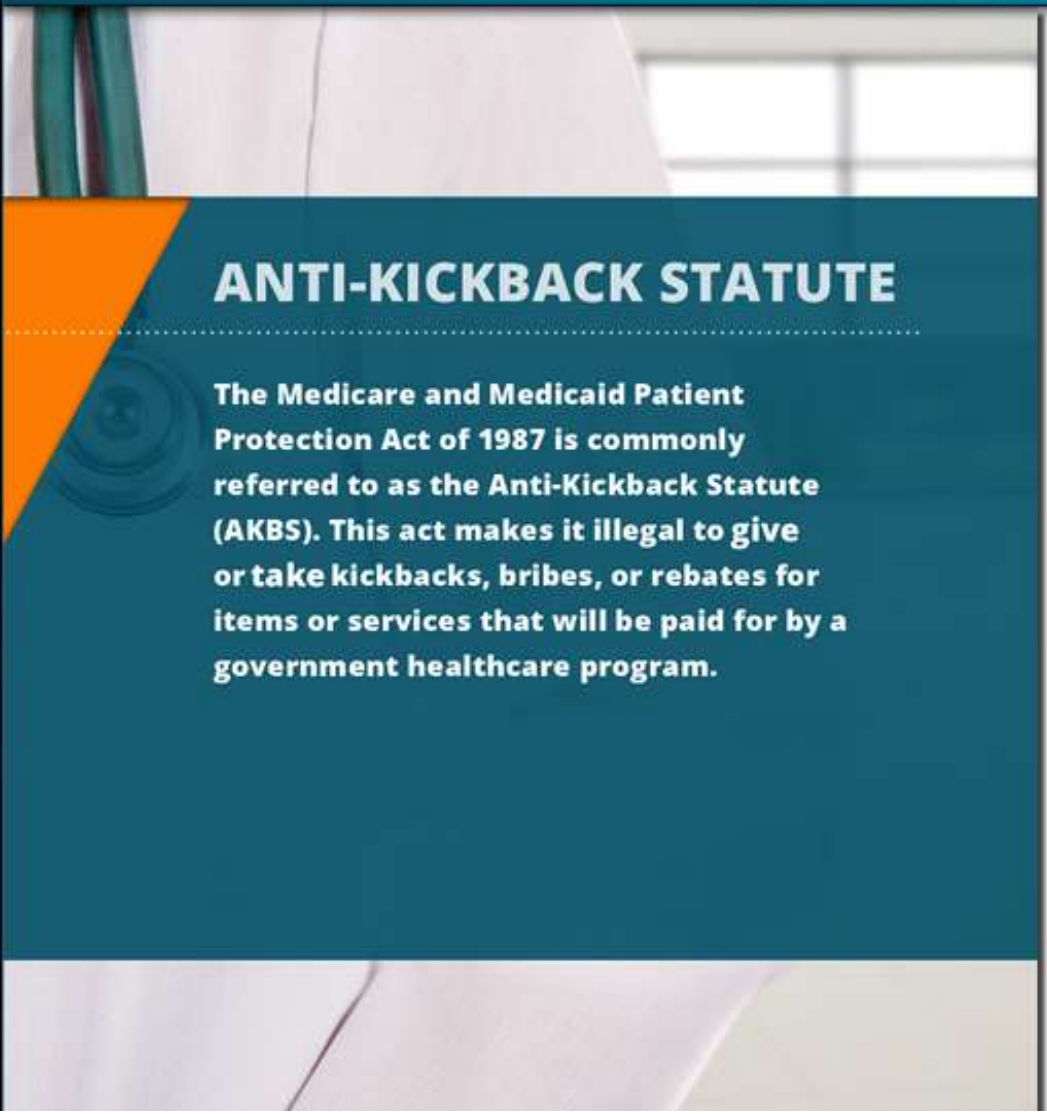
Corporate Compliance: Applicable Laws and Regulations

Let's look first at:

- Medicare Regulations
- Federal False Claims Act
- Stark Law

Let's next look at:

- **Anti-Kickback Statute**
- **Sections of the Social Security Act**
- **Affordable Care Act**



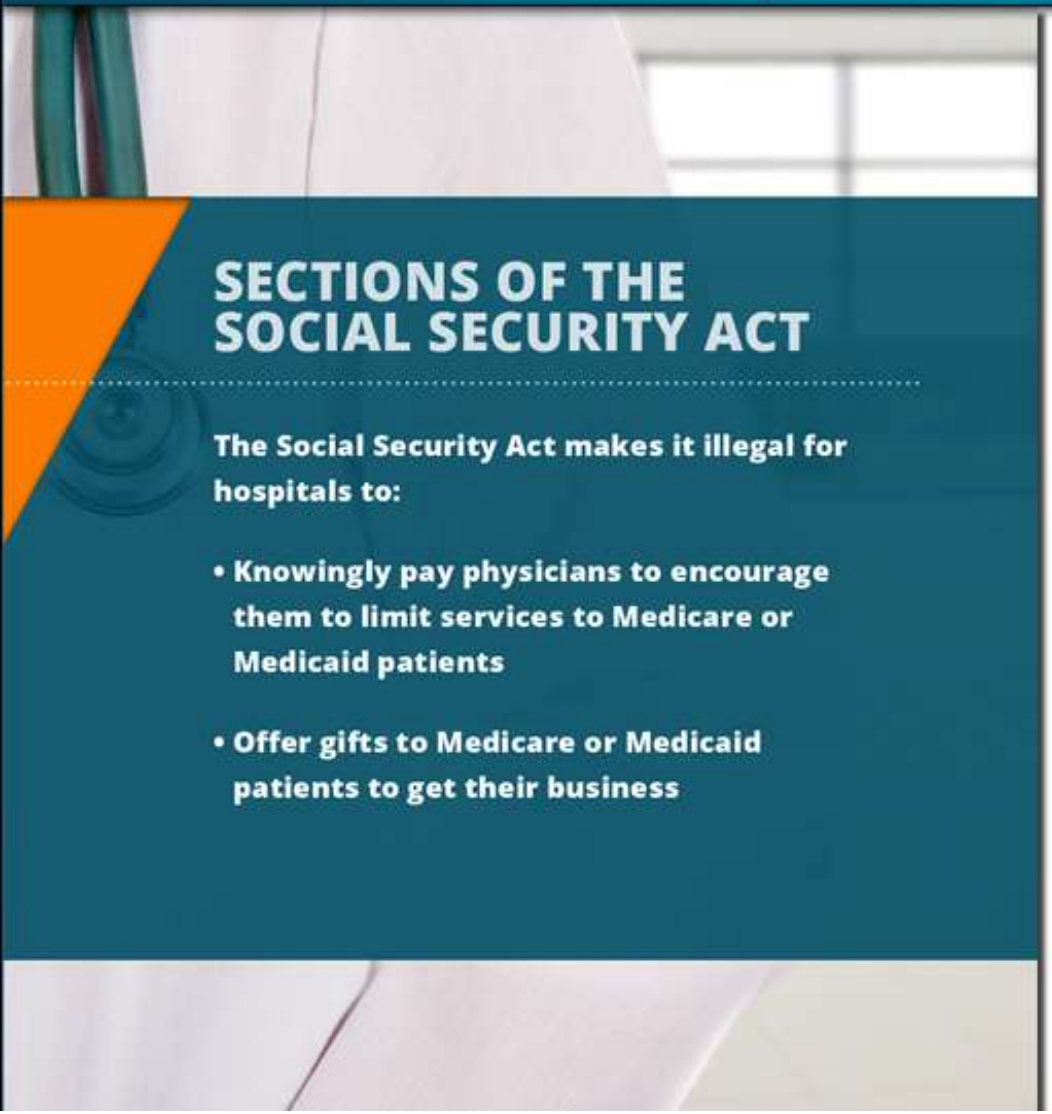
ANTI-KICKBACK STATUTE

The Medicare and Medicaid Patient Protection Act of 1987 is commonly referred to as the Anti-Kickback Statute (AKBS). This act makes it illegal to give or take kickbacks, bribes, or rebates for items or services that will be paid for by a government healthcare program.

Let's next look at:

- Anti-Kickback Statute
- Sections of the Social Security Act
- Affordable Care Act

Next



SECTIONS OF THE SOCIAL SECURITY ACT

The Social Security Act makes it illegal for hospitals to:

- **Knowingly pay physicians to encourage them to limit services to Medicare or Medicaid patients**
- **Offer gifts to Medicare or Medicaid patients to get their business**

Let's next look at:

- Anti-Kickback Statute
- Sections of the Social Security Act
- Affordable Care Act

AFFORDABLE CARE ACT

The Affordable Care Act has resulted in the recovery of over a billion dollars in healthcare fraud by:

- Increasing federal sentencing guidelines by 20–50% for crimes with over $1 million dollars in losses
- Requiring providers in areas at high risk for fraud and abuse to undergo additional screening and on-site visits
- Using data-mining techniques to detect fraud and abuse
- Using additional resources to fight fraud and abuse

Let's next look at:

- Anti-Kickback Statute
- Sections of the Social Security Act
- Affordable Care Act

Special Notes

Organization Notes

The Patient Protection and Affordable Care Act (Section 1557) requires entities to:

- Post Notice of Consumer Rights
- Provide a specific complaint/grieve procedures
- Use Taglines in top 15 languages alerting consumers of free language interpreting service
- Post Nondiscrimination Notices/ Babel Notices

- Increasing federal sentencing guidelines by 20–50% for crimes with over $1 million dollars in losses
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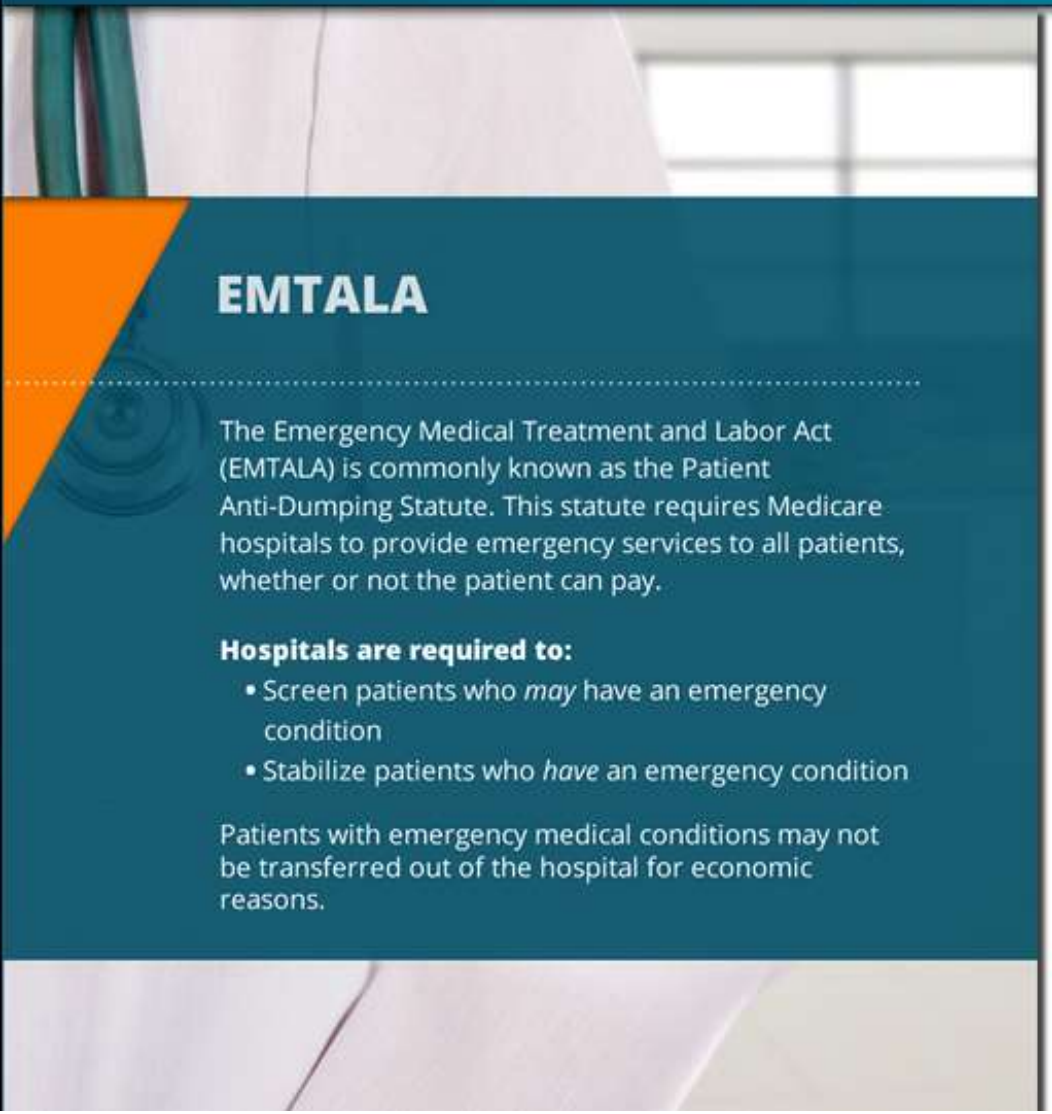
Finally let's look at:

- **EMTALA**
- **HIPAA**



EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) is commonly known as the Patient Anti-Dumping Statute. This statute requires Medicare hospitals to provide emergency services to all patients, whether or not the patient can pay.

Hospitals are required to:

- Screen patients who *may* have an emergency condition
- Stabilize patients who *have* an emergency condition

Patients with emergency medical conditions may not be transferred out of the hospital for economic reasons.

Finally, let's look at:

- **EMTALA**
- **HIPAA**

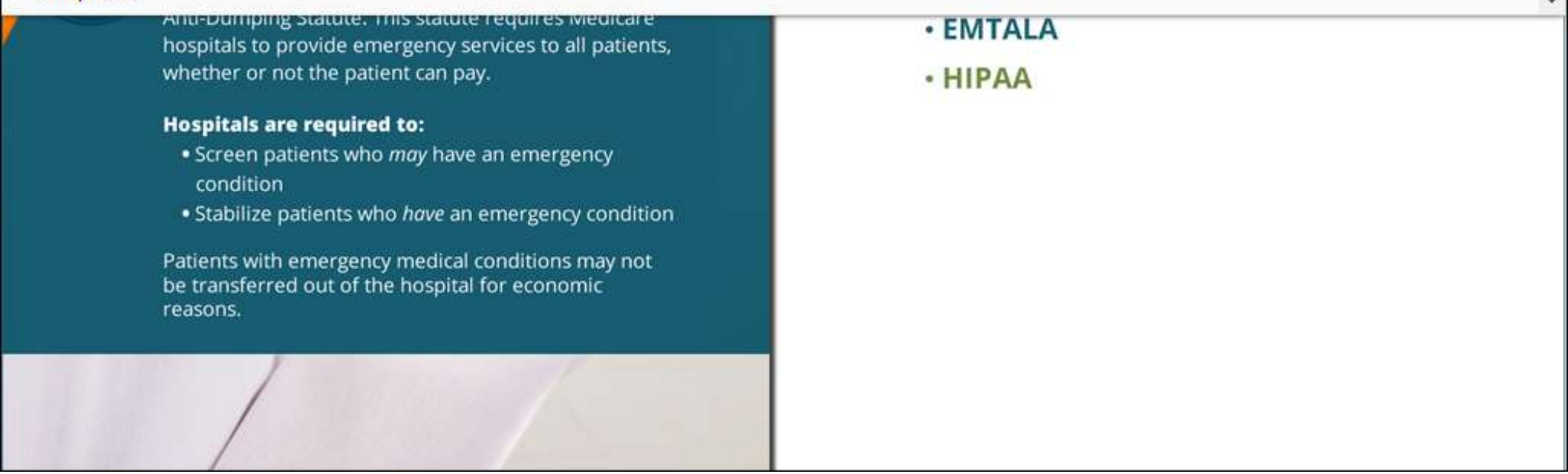
Special Notes

Organization Notes

If a patient presents on the **hospital campus** and requests emergency medical attention **or** appears to have an emergency medical condition, **or** is in active labor, it is important to follow these important steps:

1. Follow your hospital policy on transporting individuals to the emergency room and/or birthing center (for active labor patients only). Do not let them drive to the nearest entrance!

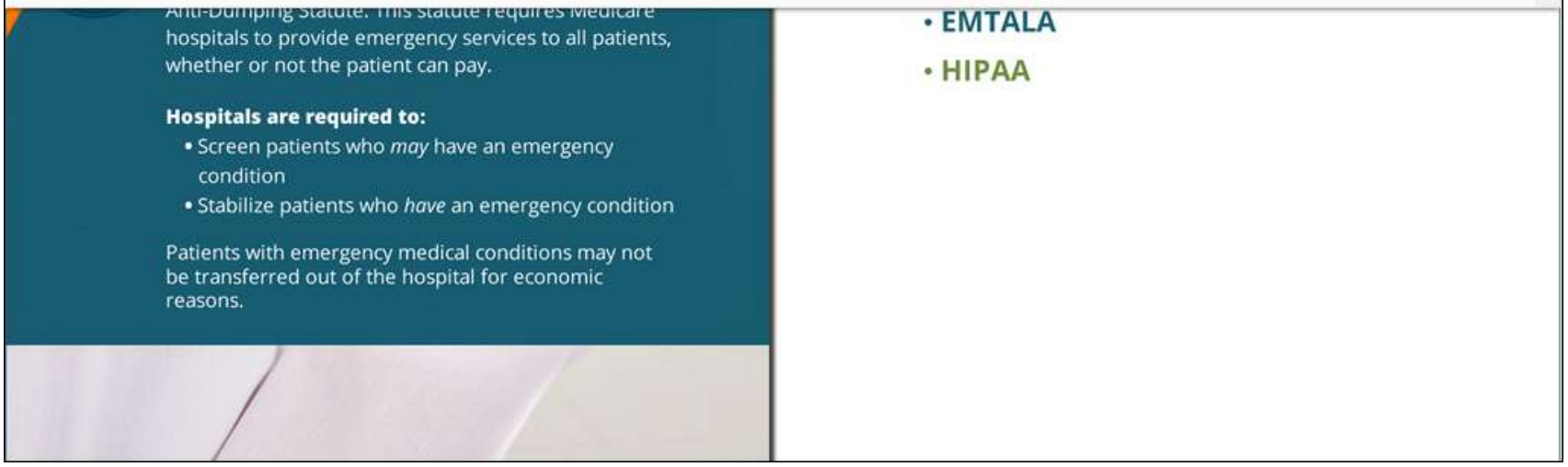
2. Do not obtain any insurance or financial information prior to the patient being seen by a qualified medical professional and a medical screening exam has been completed.

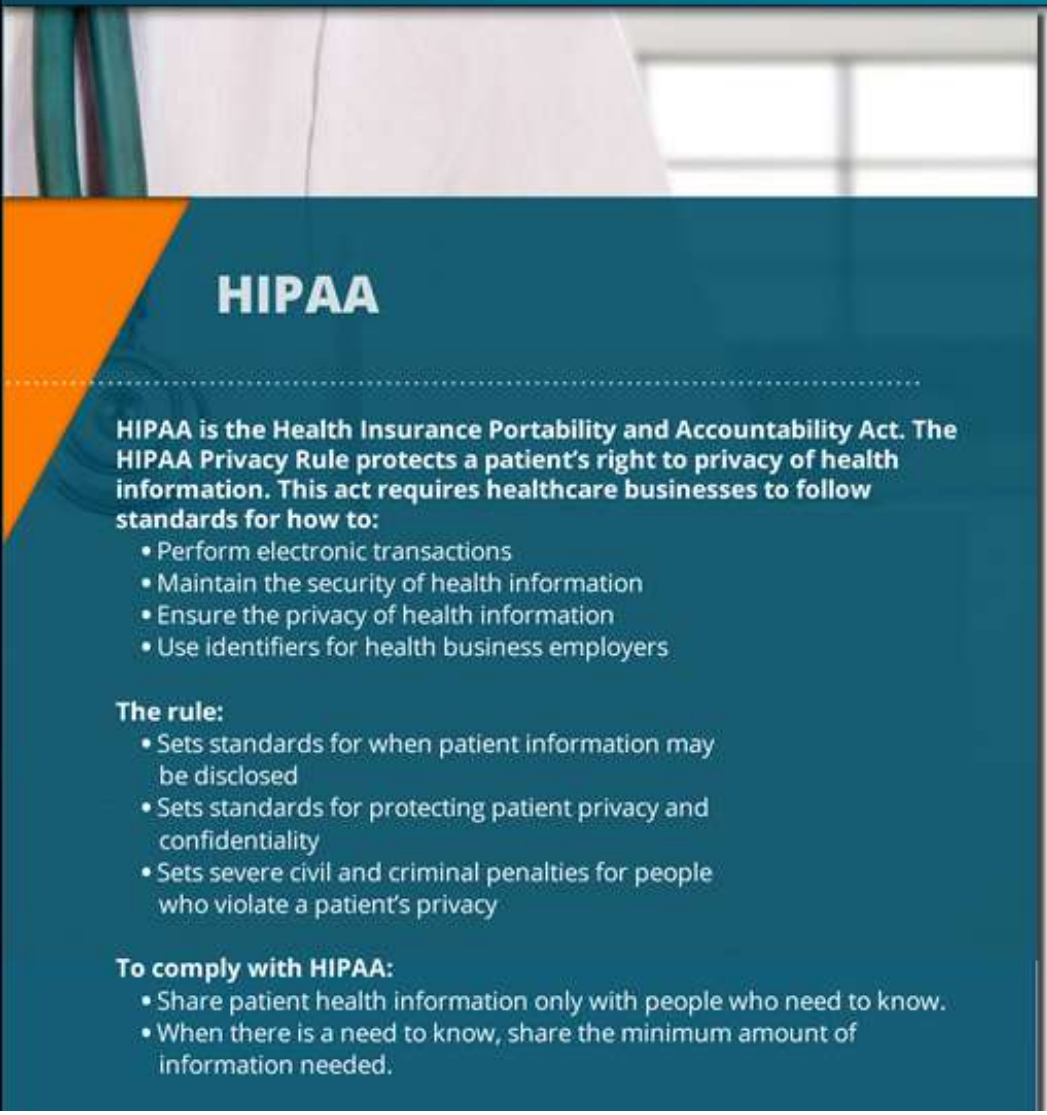


Hospital property is defined as the entire main hospital campus. This includes:

- **The parking lot**
- **The sidewalk**
- **The driveway**
- **Hospital departments**
- **Any building owned by the hospital and within 250 yards of the hospital**

If an EMTALA violation occurs, our organization may be obligated to report it to the Centers for Medicare and Medicaid ("CMS") in which a complaint survey may be conducted and/or the organization is at risk for paying fines or losing our CMS license.





HIPAA

HIPAA is the Health Insurance Portability and Accountability Act. The HIPAA Privacy Rule protects a patient's right to privacy of health information. This act requires healthcare businesses to follow standards for how to:

- Perform electronic transactions
- Maintain the security of health information
- Ensure the privacy of health information
- Use identifiers for health business employers

The rule:

- Sets standards for when patient information may be disclosed
- Sets standards for protecting patient privacy and confidentiality
- Sets severe civil and criminal penalties for people who violate a patient's privacy

To comply with HIPAA:

- Share patient health information only with people who need to know.
- When there is a need to know, share the minimum amount of information needed.

Finally, let's look at:

- **EMTALA**
- **HIPAA**

Corporate Compliance: Potential Consequences of Noncompliance

If a provider is convicted of breaking any of the laws described on the previous screens, penalties can include:

- **Criminal fines**
- **Civil damages**
- **Jail time**
- **Exclusion from Medicare or other government programs**

In addition, a conviction can lead to serious public relations harm.

Corporate Compliance: Compliance Program

To help prevent misconduct, healthcare facilities have **corporate compliance programs.**

A good compliance program reduces the risk of error or fraud.

It does so by giving guidelines for how to do your job in an ethical and legal way.

A copy of your facility's compliance program should be readily available to you. Ask your supervisor for more information.

Next

Special Notes

Organization Notes

The Civil Rights Act of 1964 mandates that it is:

- Illegal to discriminate
- Illegal to retaliate
- Provides for reasonable accommodations
- Regarding religion practices

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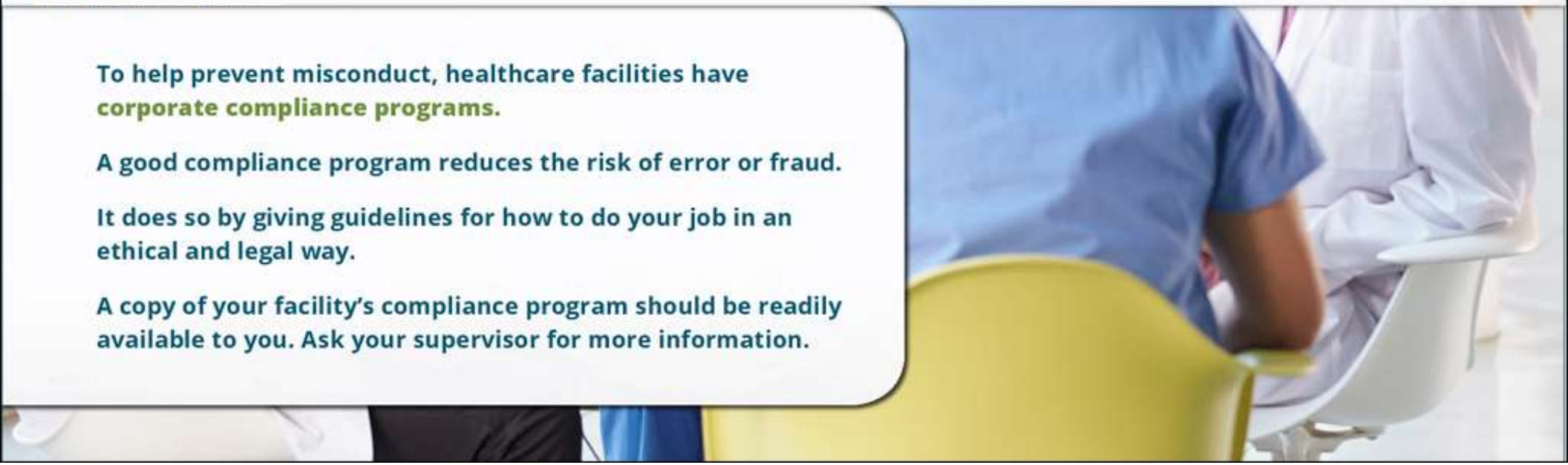

Organization Notes

American with Disabilities Act (ADA)

- Illegal to discriminate
- Guarantees equal treatment
- Reasonable modification to polices and procedures
- Service animals
- Accessible facilities
- Communication methods

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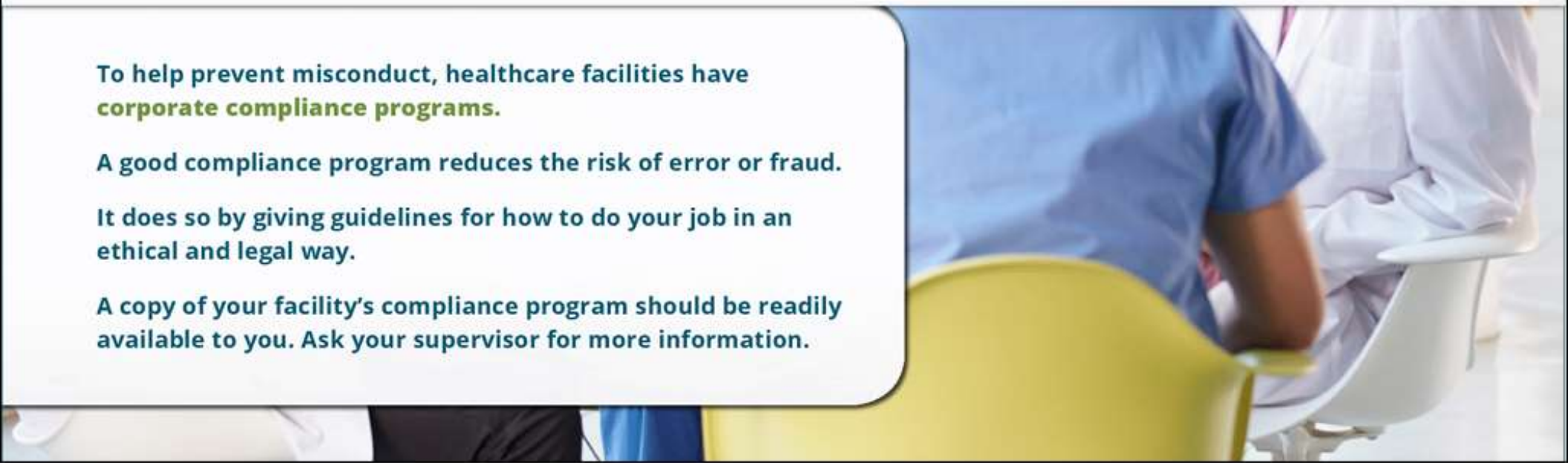


Sexual Harassment

Sexual harassment is common in the healthcare industry. In fact, over 50% of female nurses, physicians, and students report experiencing sexual harassment.

Harassment is a form of employment discrimination that violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967 (ADEA), and the Americans with Disabilities Act of 1990 (ADA).

Harassment is defined as unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information. Harassment becomes unlawful when:

1. enduring the offensive conduct becomes a condition of continued employment, or
2. the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.

Sexual Harassment

Harassment can occur in a variety of circumstances, including, but not limited to, the following:

- The harasser can be the victim's supervisor, a supervisor in another area, an agent of the employer, a co-worker, or someone who is not an employee, such as a client or customer.
- The victim does not have to be the person harassed but can be anyone affected by the offensive conduct.
- Unlawful harassment may occur without economic injury to, or discharge of, the victim.

Anti-discrimination laws prohibit harassment against individuals in retaliation for filing a discrimination charge, testifying, or participating in any way in an investigation, proceeding, or lawsuit under these laws; or for opposing employment practices that they reasonably believe discriminate against individuals, in violation of these laws.

Individual states have laws regarding sexual harassment, sometimes with broader application than federal laws.

The U.S. Equal Employment Opportunity Commission (EEOC) is responsible for implementing the laws.

Types of Sexual Harassment

The Supreme Court has outlined two different types of sexual harassment covered by Title VII of the Civil Rights Act:

- *Quid pro quo*: Job security, advancement, or benefits are tied to sexual favors. This type includes unwelcome sexual advances, requests for sexual favors, or physical or verbal conduct of a sexual nature that are tied directly or implicitly to employment.
- *Hostile work environment*: Inappropriate behavior is so pervasive and severe that it permeates the workplace and interferes with the individual's ability to carry out the duties of the job.

See the table on the next page for examples of sexual harassment.

Examples of Sexual Harassment

Verbal (spoken or written)	• Offensive teasing, joking, questioning • Suggestive remarks or sounds • Terms of endearment, such as "honey," "sweetie," or "hunk" • Requests for sexual favors • Whistling, catcalls • Inappropriate emails, letters, memos, telephone calls • Comments about appearance, clothing • Threats • Spreading rumors about a person's personal or sexual life
Non-verbal	• Sexual gestures (licking, making hand signals, eating in provocative manner) • Winking • Leering/looking inappropriately at a person's body or body parts • Blocking a person's path, following the person • Giving personal gifts
Visual	• Sexual exposure, including "flashing" or "mooning" • Offensive pictures, pornography, posters, pin-ups • Offensive screensavers • Email with offensive jokes, cartoons, and pictures
Physical	• Touching, brushing against the body, patting, stroking, hugging, kissing, fondling, raping • Massaging the neck or shoulders
Psychological	• Repeated undesired social invitations, proposals, or contact resulting in anxiety and stress

Sexual Harassment by Patients

Nurses and other healthcare workers are frequently harassed by patients. It is common for nurses to be hit, spat upon, and grabbed, especially for those working in the emergency department where people may be confused or influenced by drugs or alcohol. Patients sometimes expose themselves, make inappropriate comments, or engage in other forms of harassment that contribute to a hostile environment.

This type of behavior is not acceptable, but the patient's condition must be considered when planning an intervention. For example, if a patient has dementia, he or she may not be responsible for the behavior. However, the employee and supervisor or other team members should work together to find a way to prevent or manage the offending behavior.

What to Do if Sexual Harassment Occurs

Employees are encouraged to inform the harasser directly that the conduct is unwelcome and must stop. Employees should also report harassment to management at an early stage to prevent its escalation. Here are actions to take when sexual harassment occurs.

Say "No" and ask the person to stop.
Consensual behavior is not sexual harassment, so the employee must be very clear about saying "No."

- If asked for a date, "I already have plans" or "I have a girlfriend" or "I don't like workplace romances" is not the same as "No, I don't want to date."
- Laughing uncomfortably at a dirty joke is not the same as saying "I don't want to hear dirty jokes. They make me uncomfortable."
- Ignoring pornographic pictures is not the same as saying, "I find those pictures offensive and would like them removed."
- NOTE: If a patient sexually harasses a healthcare worker, the employee should deal with the matter directly: "Your behavior is inappropriate and not acceptable."

Document the incident.

- Write down the details of the incident including the date, time, and location. List the names of other people who were present during the incident.
- Make copies of any materials or photos related to the incident.

Report the incident.

- Tell your supervisor or another person in a supervisory position what happened.
- Follow your company's policies for reporting the incident to Human Resources, your union steward, etc.

Your Role in Preventing Sexual Harassment

Whereas some behavior is so blatantly offensive that it is clearly sexual harassment, much behavior falls into a gray area. Behavior does not constitute sexual harassment if it is welcome. This is key. Dating co-workers, flirting and joking around may not be sexual harassment if everyone involved and present finds it acceptable. That said, avoiding behaviors that may be considered sexual harassment is the best course of action.

Every employee's role in preventing sexual harassment is to:

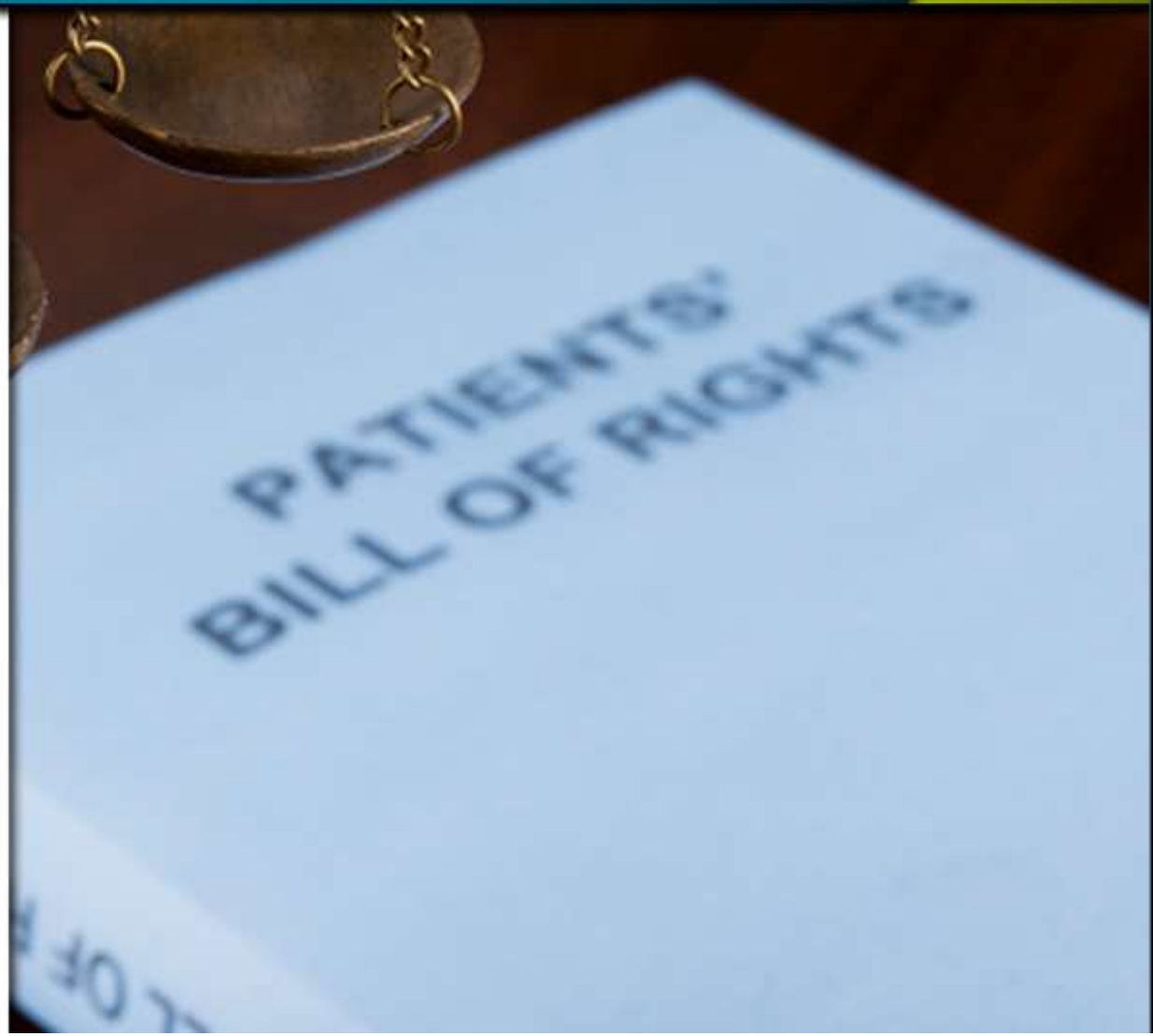
- Review their organization's sexual harassment policy
- Attend required training on sexual harassment
- Know what sexual harassment means
- Avoid behaviors that may be considered harassment by coworkers, subordinates, supervisors, or patients and/or customers

The Centers for Medicare and Medicaid Services (CMS) requires participating organizations to protect and promote the rights of patients. Accreditation agencies have similar requirements.

All providers should provide care that respects an individual's right to:

- Dignity and respect
- Personal privacy and protection of health information
- Information on health status and medical condition
- Self-determination and the ability to make choices
- Be involved in their own care
- Safety
- Civil rights

This lesson addresses these rights.



Organization Notes

Patient's Rights: Equal Access, Equal Care

Physical and/or Mental Disability

•Facility is ADA accessible inside and outside (i.e. parking lot, curb ramps, sidewalk, entrance, hallways, bathrooms, signs, doors, light switches, room seating, drinking fountains, gift shop, etc

•Accompanied by a Service Animal (not the same as a therapy or emotional support animal)

•Individuals may be asked only two questions upon entering hospital/clinic facility:
- °Is this service animal required because of disability?
- °What work or task has the dog or miniature horse been trained to perform?

- Personal privacy and protection of health information
- Information on health status and medical condition
- Self-determination and the ability to make choices
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This lesson addresses these rights.

Patients have the right to respectful care.

Respect means valuing the patient's needs, wants, ideas, and feelings and collaborating with them to help them achieve their goals.

Respect involves recognizing a person's culture, preferences, and rights.

Respectful actions include:

- Seeking to understand an individual's needs and being considerate, attentive, and compassionate
- Communicating clearly in a language and manner that the individual can understand
- Involving each patient in his or her care while guiding them to healthy choices
- Demonstrating sensitivity to each person's culture

Patients have the right to safety and security.

Do your part to ensure a safe environment of care for your patients.

Know your facility's policies for:

- **Environmental safety:**
  - o Reporting risks
  - o Responding to product notices and recalls
  - o Managing hazardous waste and use of PPE
  - o Temperature control for drugs and food
  - o Fire and electrical safety
- **Infection control:**
  - o Hand hygiene and Standard Precautions
  - o Antibiotic stewardship
- **Security:**
  - o Pay attention to safety and security systems specific to your work environment.
  - o Orient contractors and volunteers to these policies before they begin their work.

All patients have the right to fair and equal delivery of healthcare services.

This is true regardless of:

- Race, ethnicity, or national origin
- Religion or political affiliation
- Level of education
- Place of residence or business
- Age, gender, or marital status
- Personal appearance
- Mental or physical disability
- Sexual orientation
- Genetic information
- Source of payment

Special Notes

Organization Notes

Limited English Proficiency (LEP) or Hearing/Vision Impairment

•Receive Assistive Services free of charge, video, Audio, or oral interpretation
•Interpreter, 24 hours a day, 7 days a week, in a timely manner
•Telephone language line
•Translated documents or written in native language
•Portable communication device, hearing impaired
•Auxiliary aids such as an iPad, paper, pencil, whiteboard
•Braille Signage

- Level of education
- Place of residence or business
- Age, gender, or marital status
- Personal appearance
- Mental or physical disability
- Sexual orientation
- Genetic information
- Source of payment

Patients have the right to privacy and confidentiality.

Always use a private place for:

- Case discussion and consultation
- Patient examination and treatment

A patient's medical records may be shared with:

- Clinicians directly involved in the patient's case
- Regulatory agencies looking into a facility's quality of care
- Other people with a legal or regulatory right to see the records

Only authorized employees should have access to areas where medical records are stored.

Next

Confidentiality: Necessary Disclosures

Patient confidentiality is not absolute.

A provider may have a duty to breach confidentiality when there is a conflict between:

- Patient autonomy (the right of the patient to control his or her own health information) and
- Nonmaleficence (protecting the patient or others from harm)

Examples are:

- A patient threatens serious self-harm or harm to someone else.
- The patient is a suspected victim of child abuse or neglect.
- The information relates to a crime.
- The patient is not fit to drive.

Confidentiality: Necessary Disclosures

Before revealing patient information, be sure to check state and local law.

Review HIPAA guidelines for allowed disclosures of protected health information (PHI).

If you decide to go forward with a disclosure:

- Talk to the patient first. Ask for the patient's consent. Ideally, the patient will consent to the disclosure. If not, it is still okay to reveal the information, if you have determined that it is legal and ethical to do so.
- Disclose the information in a way that minimizes any harm to the patient.
- Follow state and federal guidelines for disclosing the information.

Participation in Treatment Decisions: Informed Consent

PARENTS MUST CONSENT TO CARE FOR THEIR MINOR CHILDREN.

Patients have the right to make decisions about their care. In order to do so, patients must be given accurate information in a manner they can understand. The physician or other **licensed independent practitioner (LIP)** should discuss **all** treatment options with a patient. This includes the option of no treatment.

For each treatment option, the patient needs to know:

- Risks
- Benefits
- Potential medical consequences

The patient can then give informed consent or refusal for treatment.

Note: A minor (anyone under the age of 18 in most states) with certain health conditions may consent for treatment without parental consent. These conditions include pregnancy, sexually transmitted diseases, sexual abuse, and certain mental health conditions such as alcohol or drug abuse. For more specific information on the treatment of minors in your state, visit their website.

Advance Directives: Definitions

Patients have the right to make decisions about their care. This is true even when they are no longer able to communicate those decisions directly.

An **advance directive** is a legal document that helps protect this right.

There are two types of advance directives:
- Living will
- Durable power of attorney for healthcare

Additional tools for participating in future healthcare decisions are the:
- Do-not-resuscitate (DNR) order
- Do-not-intubate (DNI) order
- **Physician's Order for Life-Sustaining Treatment (POLST)**

Advance Directives: Definitions

LIVING WILL

In a living will, a patient documents his or her wishes for future treatment in the event of terminal illness. It does not appoint a representative. A living will goes into effect if and when a patient develops a terminal condition that makes it impossible to communicate healthcare decisions directly. Patients can write living wills at any time.

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DURABLE POWER OF ATTORNEY FOR HEALTHCARE

In this document, the patient appoints a representative to make healthcare decisions. The power of attorney goes into effect if and when the patient loses the ability to communicate his or her own decisions.

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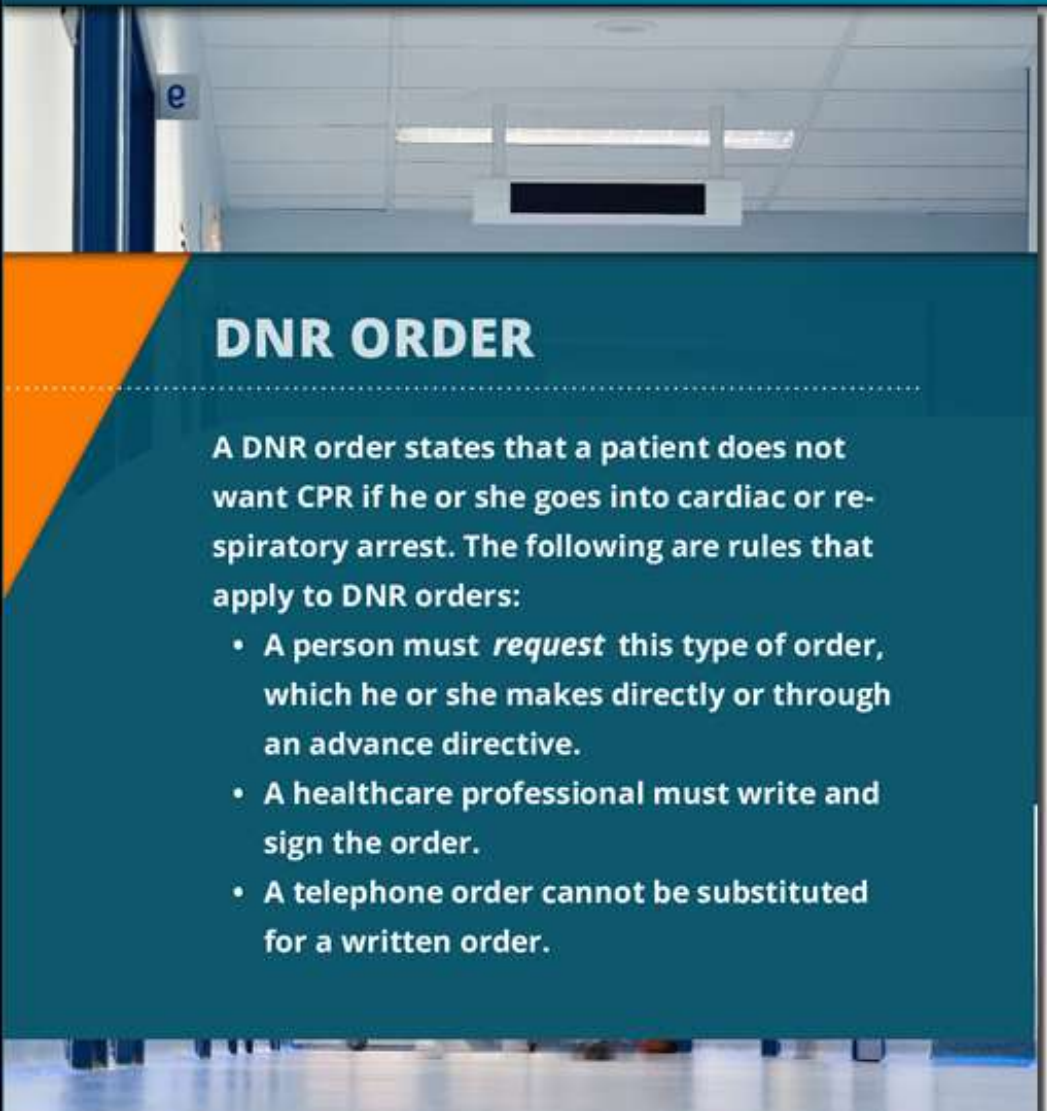

DNR ORDER

A DNR order states that a patient does not want CPR if he or she goes into cardiac or respiratory arrest. The following are rules that apply to DNR orders:

- **A person must *request* this type of order, which he or she makes directly or through an advance directive.**
- **A healthcare professional must write and sign the order.**
- **A telephone order cannot be substituted for a written order.**

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Advance Directives: Definitions

DNI ORDER

A DNI order states that a patient does not want an endotracheal tube inserted if he or she has trouble breathing or goes into respiratory arrest. The same rules apply for a DNR.

Patients have the right to make decisions about their care. This is true even when they are no longer able to communicate those decisions directly.

An **advance directive** is a legal document that helps protect this right.

There are two types of advance directive:

- **Living will**
- **Durable power of attorney for healthcare**

Additional tools for participating in future healthcare decisions are the:

- **Do-not-resuscitate (DNR) order**
- **Do-not-intubate (DNI) order**
- **Physician's Order for Life-Sustaining Treatment (POLST)**

Advance Directives: Definitions

POLST

Individuals who have an advanced illness or who are very old and frail should have a Physician Order for Life-Sustaining Treatment (POLST) form. (The name for this form can vary from state to state, so be sure to know your state's name for it.) This document protects an individual's wishes during transfers in care.

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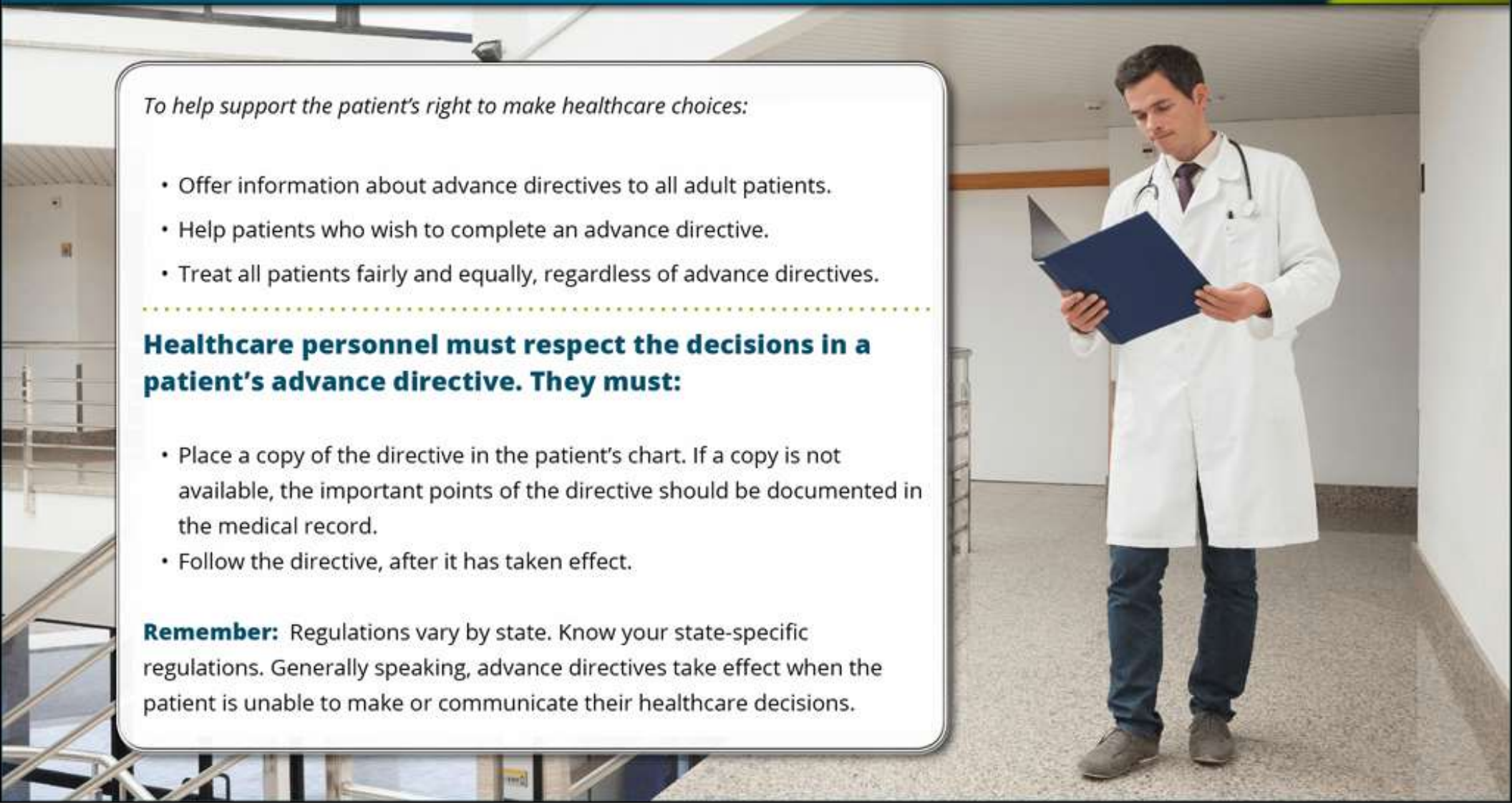
Advance Directives: Your Role



To help support the patient's right to make healthcare choices:

- Offer information about advance directives to all adult patients.
- Help patients who wish to complete an advance directive.
- Treat all patients fairly and equally, regardless of advance directives.

Healthcare personnel must respect the decisions in a patient's advance directive. They must:

- Place a copy of the directive in the patient's chart. If a copy is not available, the important points of the directive should be documented in the medical record.
- Follow the directive, after it has taken effect.

Remember: Regulations vary by state. Know your state-specific regulations. Generally speaking, advance directives take effect when the patient is unable to make or communicate their healthcare decisions.

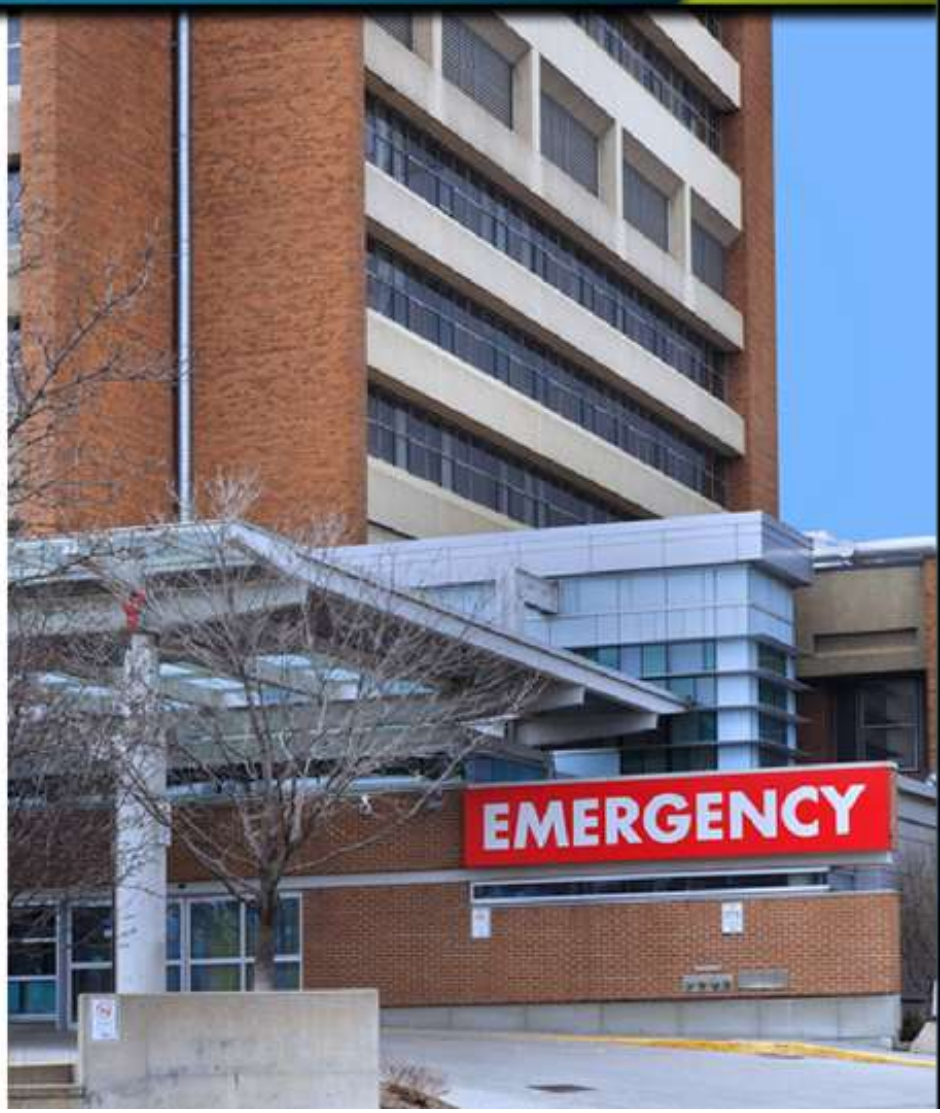
Access to Emergency Services: Prudent Layperson

Patients have the right to emergency medical treatment, even if the symptoms do not represent a life-threatening emergency.

For example, a person who is experiencing severe chest pain, perspiring, and having difficulty breathing thinks he is having a heart attack. Upon evaluation, the emergency department (ED) physician determines that he is having an anxiety attack.

In the past, managed care plans have refused to cover the cost of this type of ED service. They argued that they do not have to pay for emergency services when an event was not life threatning.

If a prudent layperson would consider the situation to be an emergency, even though the symptoms were not determined to be life threatening, the cost of care must be reimbursed. Individuals have a right to have emergency medical treatment.



Patient Visitation Rights

A patient has the right to decide on who his or her visitors are, even if they are not related to the patient.

Visitors may:

- Include spouses, domestic partners (same or opposite sex), family members, friends, or other support individuals the patient chooses
- Be restricted or limited for clinical or safety reasons, as described in the hospital's written policies
- Not be denied visiting privileges on the basis of race, color, national origin, sex, religion, age, sexual orientation, gender identity, or disability
- Have full and equal visitation privileges as consented to by the patient
- Be allowed to remain with the patient for emotional support during the hospital stay
- Include other patients, provided that these patients do not have infections that could endanger the patients they are visiting

The hospital should have written policies for visitors and for patients and should inform the patient about the patient's rights to visitors, including any limitations and the reasons for them.

Grievances

Patients have the right to complain about the quality of their health-care. Common causes for complaints include:

- Wait times
- Operating hours
- Conduct of staff
- Adequacy of staff

Many patient complaints can be addressed quickly.

When complaints cannot be resolved quickly and easily, patients have the right to file a grievance.

If a patient wishes to file a grievance:

- Explain the grievance process at your facility. This includes providing the name of the staff person the patient should contact.
- Explain that grievances may be filed with state agencies. This is true whether or not the patient has already used the facility's internal grievance process.
- Give the patient the phone number and address for filing a grievance with the state.

At each stage of life, human beings exhibit predictable:

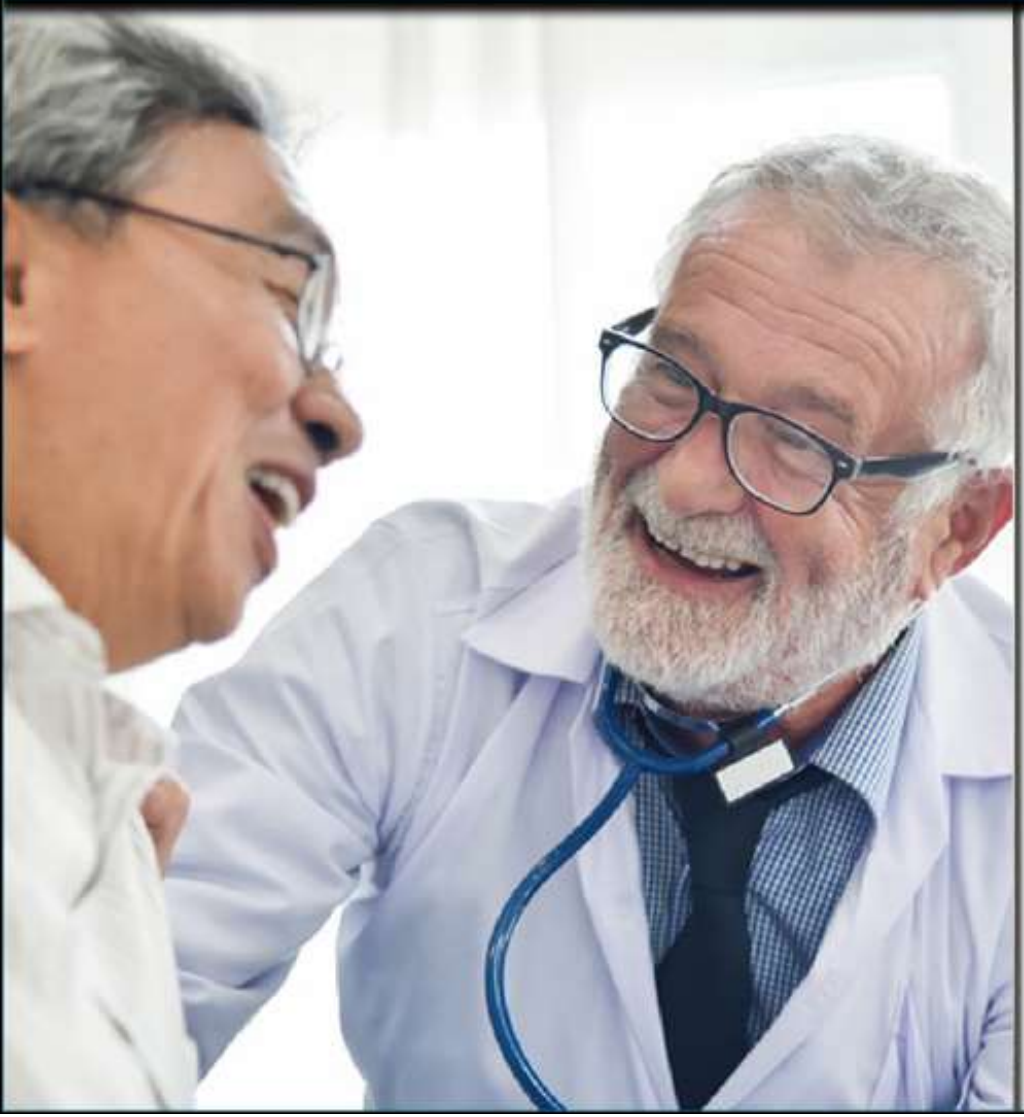
- Characteristics
- Needs
- Developmental challenges
- Milestones

Understanding these challenges and milestones helps you provide developmentally appropriate care.

A provider who is competent in providing developmentally appropriate care can:

- Utilize patient data to determine a patient's health status, such as illness or injury, chronic conditions, and ability to manage daily activities
- Interpret patient information to identify healthcare needs, such as changes in medication or nutrition
- Provide appropriate care according to a patient's age and developmental needs

Cultural Sensitivity and Competence



Cultural sensitivity promotes health and healing by meeting the needs of the individual.

Cultural competence means having the ability to understand, appreciate, and interact with persons whose values, beliefs, and practices may be different from your own.

Being culturally sensitive includes:

- Learning what is important to an individual and respecting those preferences
- Being sensitive to their communication needs
- Promoting wellbeing by respecting the needs of all individuals

Being aware of and sensitive to an individual's values, beliefs, and practices is a cornerstone of person-centered care.

Restraint and Seclusion: Definitions

It is every person's right to be free from abuse, neglect, and exploitation.

This also includes freedom from:

- Corporal (physical) punishment
- Involuntary seclusion and any physical or chemical restraint not required to treat a person's symptoms

Any device that a person *cannot remove at will or upon request* is considered a restraint.

Restraints must not be used for discipline or for staff convenience.

Restraint and Seclusion: Appropriate Use

Restraint is any method for limiting:

- Patient movement
- Patient activity
- A patient's normal ability to reach parts of their own body

When a drug that is not standard treatment for a medical condition is given in order to restrict movement, it is considered restraint. This does not include using medications for standard clinical treatment of illness.

Seclusion means placing a patient alone in a room. The patient is not allowed to leave the room.

Restraint and Seclusion: Risks and Early Interventions

Use of restraint has risks. Patients can suffocate, strangle, or experience respiratory or cardiac arrest.

Best practice is to intervene early and find alternatives to restraint.
These proactive interventions often work best to avoid restraint use:

- Meet an individual's basic needs. It is often the only step needed to prevent agitation and difficult behaviors.
- Identify and mitigate stressors and triggers of agitation and aggression.
- Create a calm environment.
- Reconcile medications to avoid behavioral side effects and drug-drug interactions.

Restraint and Seclusion: Safely Using Restraint

Restraints can help keep a person safe.

- The decision to use restraint or seclusion is based on the patient's *behavior*. Each patient must be assessed to determine if restraint or seclusion is needed. It should never be a first choice.
- Use of restraints or seclusion should never be used for coercion, discipline, punishment, retaliation, or staff convenience.

When the use of restraints is indicated for a medical symptom or condition:

- Use must be preceded by a physician's order.
- Restraints must be the least restrictive possible.
- If chemical, the medical indication must be documented.
- They must be used for the least amount of time.
- Documentation must reflect ongoing evaluation.

Healthcare professionals must be familiar with the regulations governing the use of restraints and the facility's policies and procedures.

Restraint and Seclusion: Orders for Violent Patients

Maximum duration of an order for restraint or seclusion: Violent, self-destructive patient

Four Hours:
Adults 18 & over

Two Hours:
Children 9 to 17

One Hour:
Children under 9

Restraint or seclusion for violent patients must be ordered by a physician, clinical psychologist, or LIP:

- Orders must be issued on a case-by-case basis.
- Orders are time-limited.
- **PRN** orders are NOT acceptable
- Every 24 hours, the physician, clinical psychologist, or LIP who is primarily responsible for the patient must see and re-evaluate the patient before writing a new order.

Restraint and Seclusion: Evaluation and Monitoring

Violent, self-destructive patients who have been placed in restraints or seclusion must be evaluated within an hour and re-evaluated in person by the provider primarily responsible for his or her care every 24 hours.

The evaluation must focus on:

- The patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavior condition
- The need to continue or terminate the restraint or seclusion

Patients also must be monitored during restraint or seclusion by qualified and trained staff according to organizational policy.

Some states may have more restrictive statutes or regulations.

Restraint and Seclusion: Staff Training

To ensure patient safety and dignity, all staff members involved in the use of restraint and seclusion must be trained and competent. Only trained staff members should apply and remove restraints.

Staff must be trained in order to competently:

- Identify behaviors, events, and situations that may trigger circumstances that require the use of restraint or seclusion
- Use nonphysical intervention skills
- Use an assessment of the patient's status or condition to choose the least restrictive intervention
- Safely apply and use all types of restraint and seclusion
- Recognize signs of physical distress in held, restrained, or secluded patients
- Know the behavioral criteria for terminating restraint or seclusion
- Assess a restrained patient's status and physical needs
- Use first aid techniques (with certification in the use of cardiopulmonary resuscitation)

Restraint and Seclusion: Documentation and Reporting

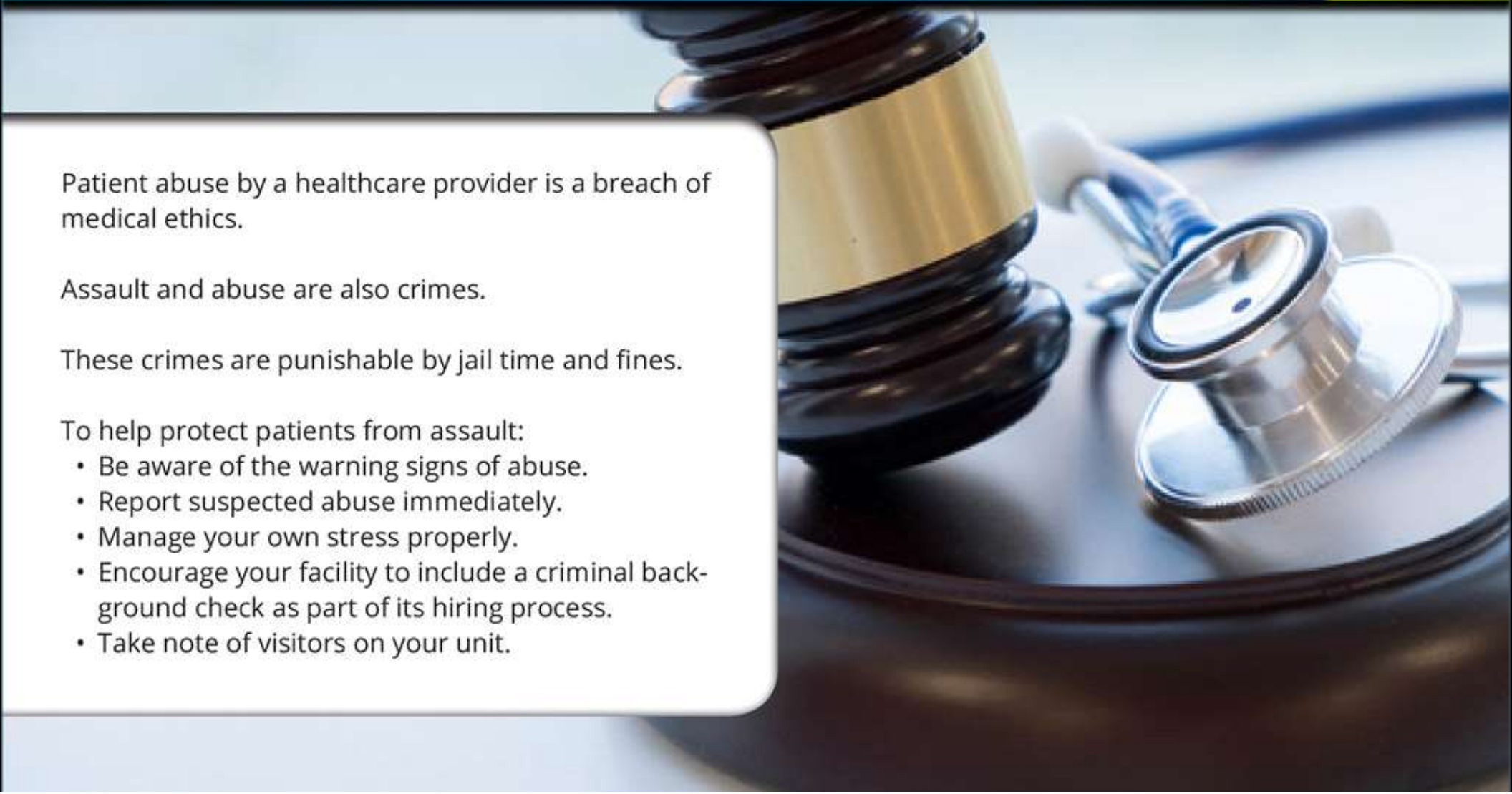
Restraint and seclusion must be documented fully in the patient's medical record.

Documentation should include:

- In-person medical and behavioral evaluations
- Description of the patient's behavior
- Alternatives or less restrictive interventions attempted
- Patient's condition and/or symptoms that warranted use of restraint or seclusion
- The LIP's order
- Patient's response to intervention
- Communications with the ordering physician
- Modifications to the plan of care

Hospitals also must report deaths associated with the use of restraint and seclusion to the Centers for Medicare and Medicaid Services (CMS).

Patient Assault and Abuse



Patient abuse by a healthcare provider is a breach of medical ethics.

Assault and abuse are also crimes.

These crimes are punishable by jail time and fines.

To help protect patients from assault:

- Be aware of the warning signs of abuse.
- Report suspected abuse immediately.
- Manage your own stress properly.
- Encourage your facility to include a criminal background check as part of its hiring process.
- Take note of visitors on your unit.

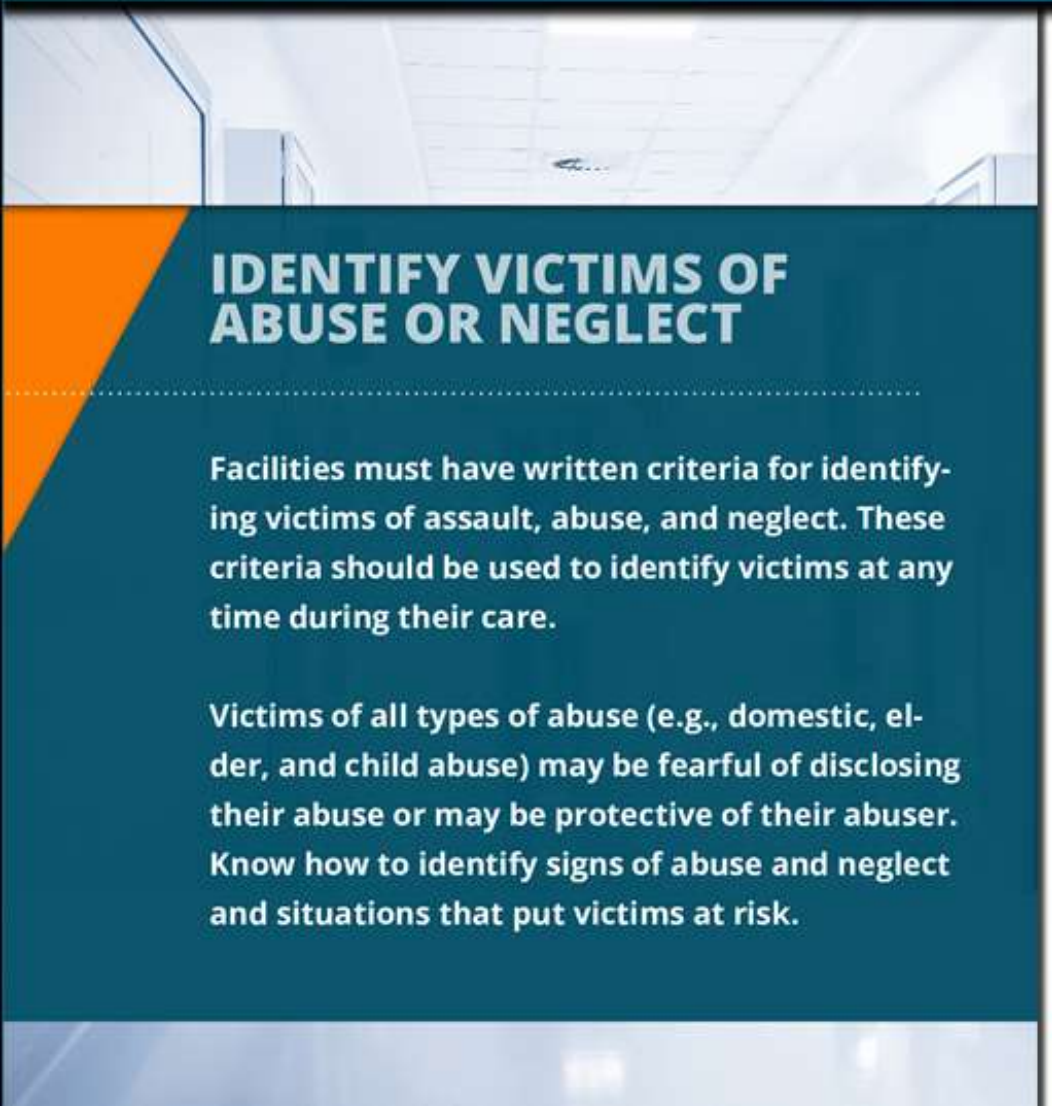
Patients also may be abused outside the healthcare setting.

As a healthcare provider, you are in a unique position to identify victims of abuse.

Review and know your organization's policies and procedures related to abuse and neglect.

With regard to victims of abuse and neglect, accrediting organizations require that accredited facilities:

- Identify victims of abuse or neglect
- Educate healthcare staff
- Assess and refer victims to available resources
- Report abuse and neglect



IDENTIFY VICTIMS OF ABUSE OR NEGLECT

Facilities must have written criteria for identifying victims of assault, abuse, and neglect. These criteria should be used to identify victims at any time during their care.

Victims of all types of abuse (e.g., domestic, elder, and child abuse) may be fearful of disclosing their abuse or may be protective of their abuser. Know how to identify signs of abuse and neglect and situations that put victims at risk.

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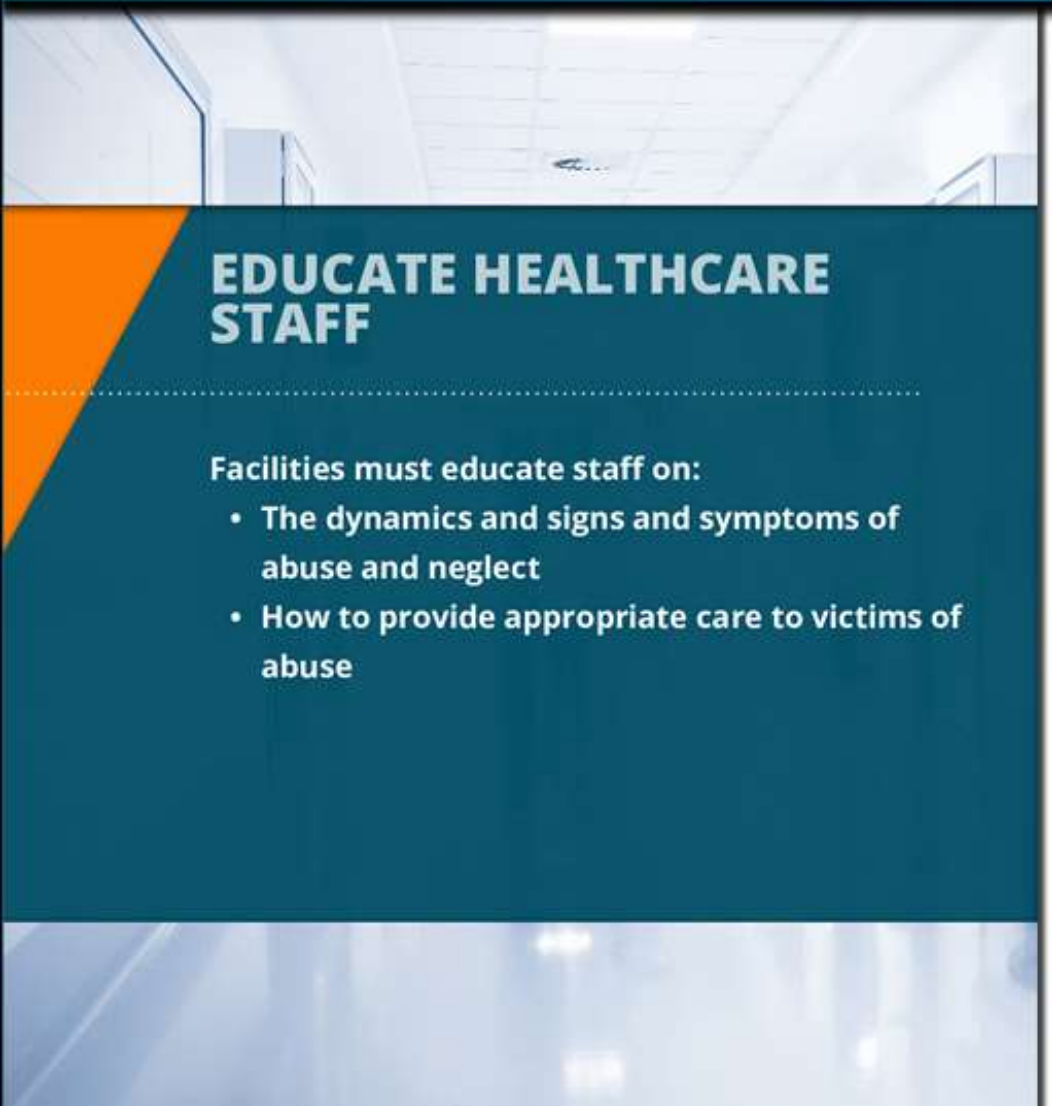

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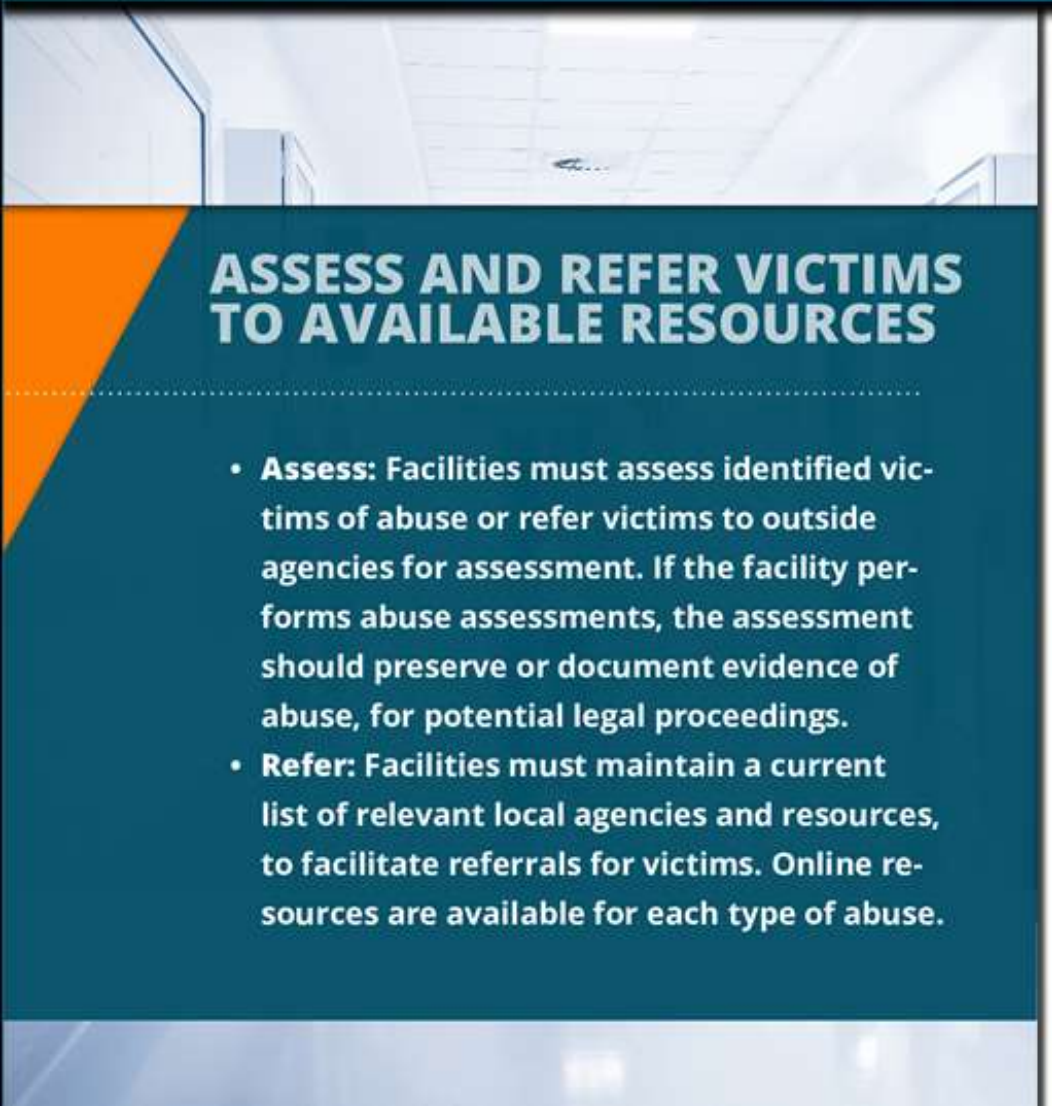

ASSESS AND REFER VICTIMS TO AVAILABLE RESOURCES

- **Assess:** Facilities must assess identified victims of abuse or refer victims to outside agencies for assessment. If the facility performs abuse assessments, the assessment should preserve or document evidence of abuse, for potential legal proceedings.
- **Refer:** Facilities must maintain a current list of relevant local agencies and resources, to facilitate referrals for victims. Online resources are available for each type of abuse.

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REPORT ABUSE AND NEGLECT

Facilities must be familiar with local and state law and report abuse and neglect accordingly.

Most states require healthcare providers to report certain cases of domestic violence.

Many states require healthcare providers to report known or suspected elder abuse and neglect.

All states require healthcare providers to report suspected child abuse and neglect.

Be certain that you understand:

- **What you are required to report**
- **How to report**
- **Protection for mandatory reporters**
- **Potential penalties for failure to report**

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- **Assess and refer victims to available resources**
- **Report abuse and neglect**

Identifying and Assessing Victims of Abuse and Neglect: Educate

EDUCATE YOURSELF ABOUT THE DYNAMICS OF ABUSE.

Domestic violence

The victim is an adult or adolescent. In the majority of cases, the victim is a woman.

The abuser is a person who is, was, or wishes to be in an intimate relationship with the victim. In most cases, the abuser is a man.

The abuse may be physical, sexual, and/or psychological. The goal of the abuse is to control the victim.

Elder abuse and neglect

Elders may be abused, neglected, or exploited. This mistreatment may be physical, sexual, psychological, or financial.

The perpetrator may be a family member or other caregiver.

Child abuse and neglect

Child abuse may be physical, emotional, or sexual.

Child neglect occurs when a child's basic needs are not met.

ASSESS VICTIMS OF ABUSE (OR REFER FOR APPROPRIATE ASSESSMENT).

Unless a patient is in crisis, complete assessment of a victim of domestic violence may be conducted over several encounters.

The assessment should document or preserve evidence of abuse. Potential evidence includes:

- A thorough written record
- Detailed written description of injuries (with or without photographs)
- Forensic evidence of sexual or physical assault

Collect, store, and transfer forensic evidence according to state and local evidence protocols.

To assess a victim of elder abuse or neglect, evaluate the patient's:

- Access to healthcare
- Cognitive status
- Emotional status
- Overall health and functional status
- Social and financial resources

Evidence of elder abuse should be documented as described for domestic violence.

When child abuse is suspected:

- Perform a thorough pediatric health assessment.
- Interview the parents/ caretakers and the child, if possible. Interviews should be separate.
- Collect evidence as described for domestic violence.

Along with identifying signs of abuse, all staff should be able to recognize the signs of a stroke and be able to initiate emergency response procedures.

- BALANCE
  - Sudden loss of coordination or balance
- EYES
  - Sudden change in vision
- FACE
  - Sudden weakness on one side of the face or facial droop
- ARM
  - Sudden arm or leg weakness or numbness, usually on one side of the body
- SPEECH
  - Sudden slurred speech, trouble speaking, trouble understanding speech
- TERRIBLE HEADACHE
  - Sudden onset of a terrible headache

Follow facility process in alerting the response team or calling emergency medical professionals, timely treatment is important.

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- Collect evidence as described for domestic violence.

Use of opioid pain medication presents serious risks, including misuse, overdose, and opioid use disorder.

The need to provide pain relief must be balanced with the responsibility not to expose individuals to the risk of addiction, mitigating opportunities for drug diversion, trafficking, and the addiction of others.

Always use evidence-based treatment guidelines to manage acute and chronic pain.

Opioid Use and Acute Pain

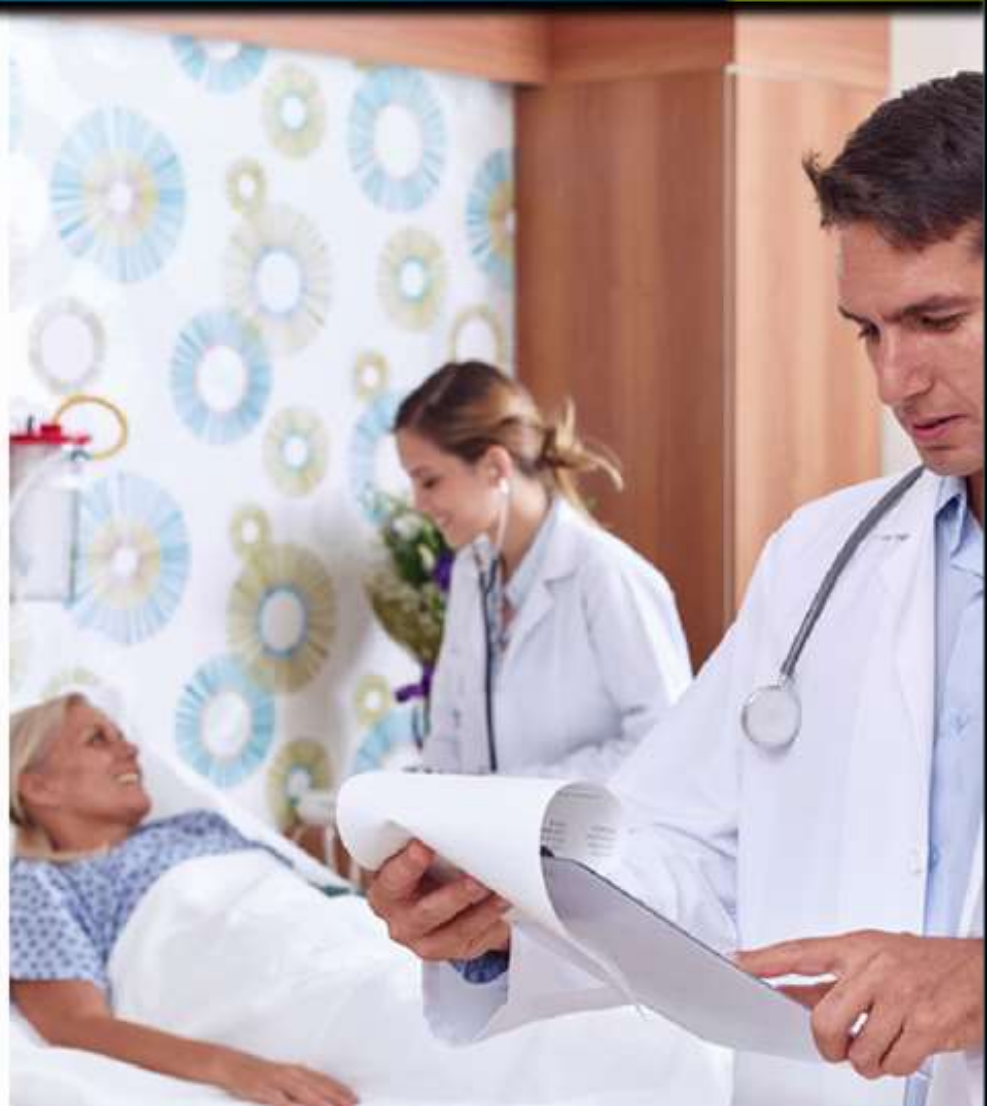
When managing acute pain, remember that opioid-naïve individuals are at greatest risk of respiratory depression and require diligent monitoring, especially during the first 24 hours. Recall that sedation usually precedes respiratory depression.

The Centers for Disease Control and Prevention (CDC) recommends that prescribers use:

- The lowest effective dose of immediate-release opioids
- No greater a quantity than needed for the expected duration of pain that is *severe enough to require opioids*

Three days or fewer is usually adequate. More than 7 days, at which point tolerance can develop, is rarely needed.

Long-term opioid use often begins with treatment of acute pain.



Opiates are not first-line therapy for *chronic* pain and should be considered only if the benefits outweigh the risks. Non-pharmacologic and non-opioid medications are preferred.

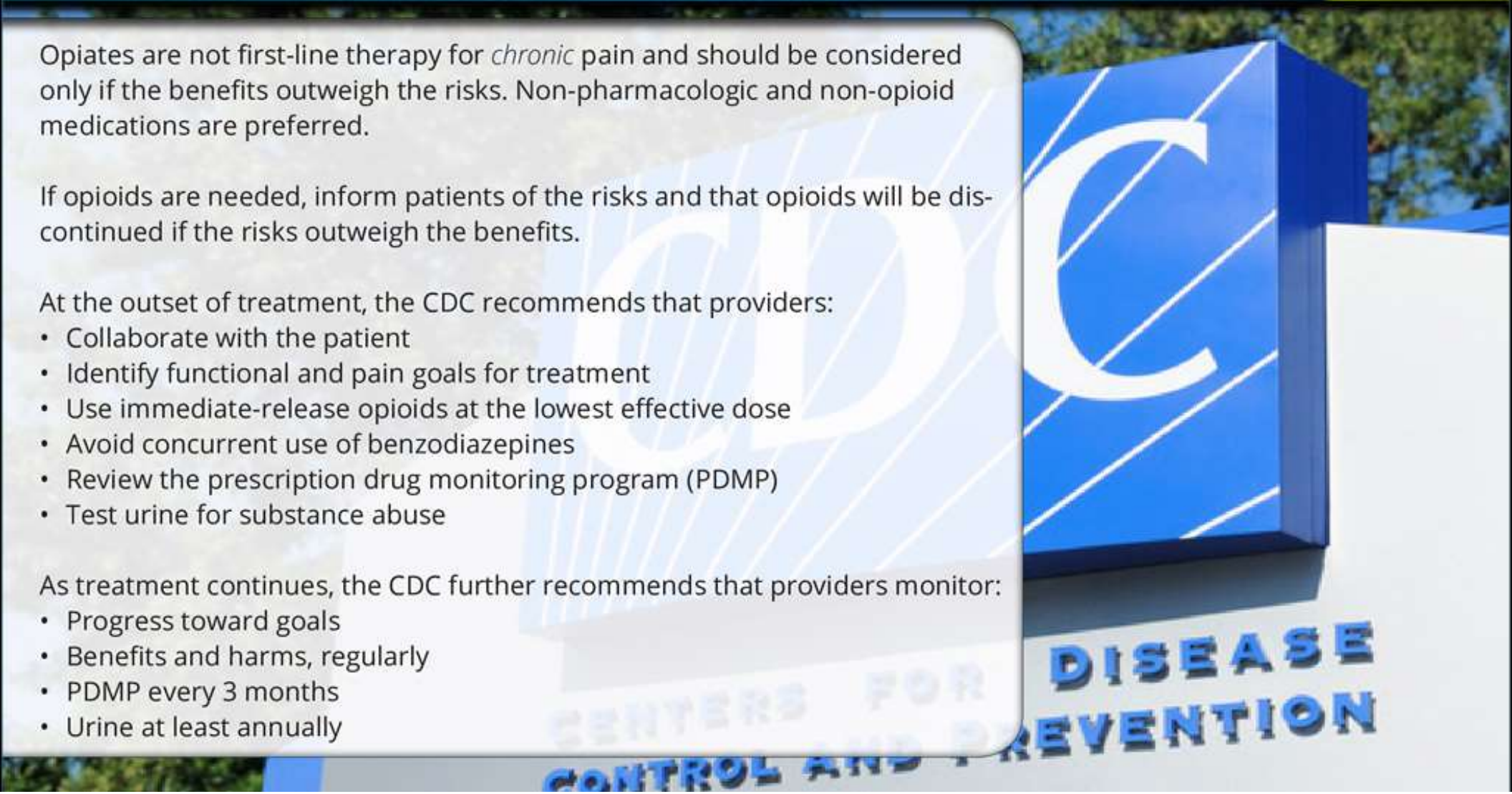
If opioids are needed, inform patients of the risks and that opioids will be discontinued if the risks outweigh the benefits.

At the outset of treatment, the CDC recommends that providers:

- Collaborate with the patient
- Identify functional and pain goals for treatment
- Use immediate-release opioids at the lowest effective dose
- Avoid concurrent use of benzodiazepines
- Review the prescription drug monitoring program (PDMP)
- Test urine for substance abuse

As treatment continues, the CDC further recommends that providers monitor:

- Progress toward goals
- Benefits and harms, regularly
- PDMP every 3 months
- Urine at least annually



Opioid Use and Chronic Pain

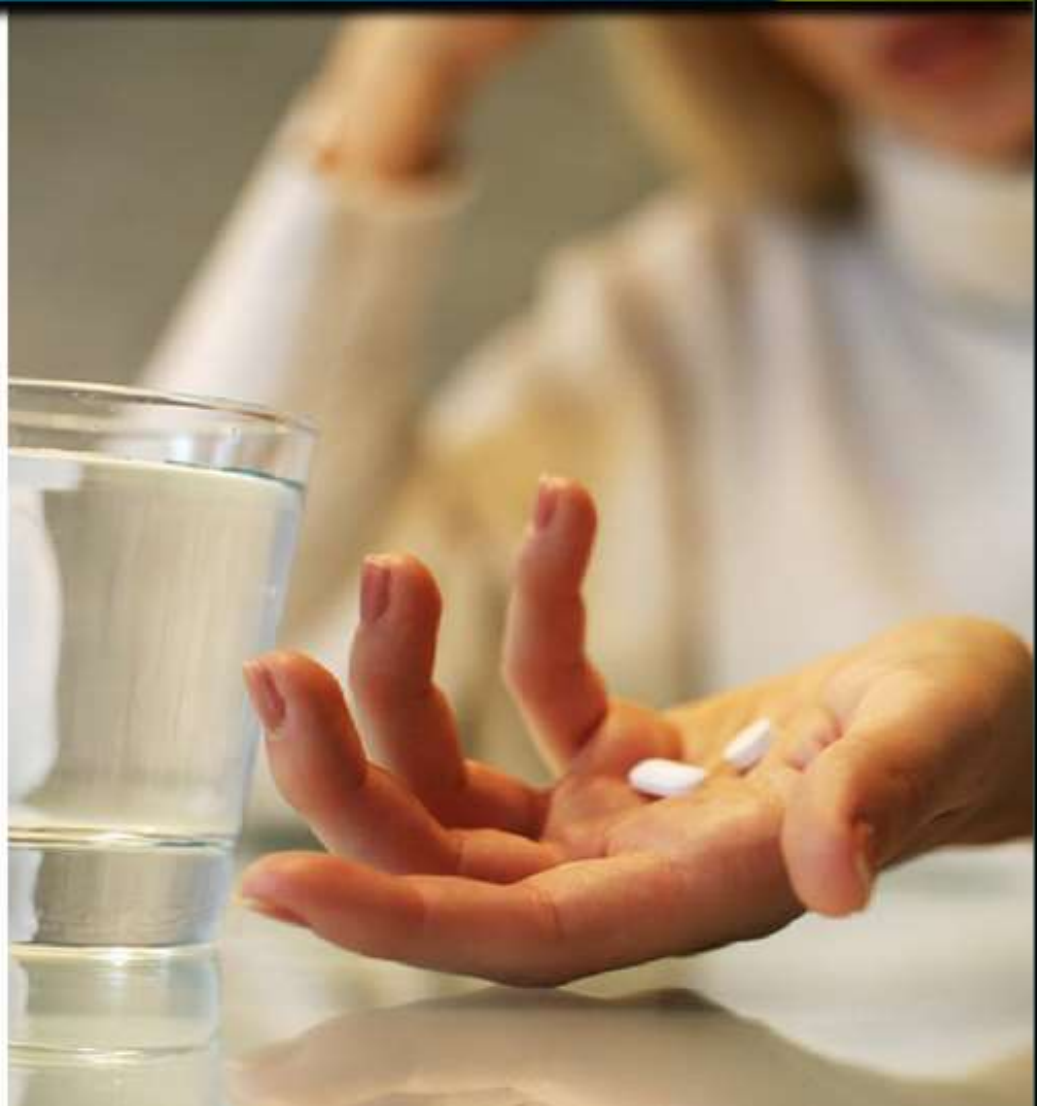
It is also critical to intervene and direct care appropriately for people who are misusing opioids.

Long-term use of opioids in high doses can cause opioid misuse, opioid use disorder (OUD), overdose, and even death. One of every four patients who are prescribed opioids struggles with addiction.

When starting or tapering opioids, use a Controlled Substance Treatment Agreement to facilitate effective communication and to clarify patient responsibilities in their plan of care.

Ensure that naloxone is available in homes where overdose is a risk and educate family members on its use and the signs and symptoms of overdose.

Some patients are critically threatened by OUD and require the help of clinicians who are well trained in medication-assisted treatment (MAT).



OUD and Medication-Assisted Treatment (MAT)

MAT is the *most effective* known intervention for long-term recovery from opioid use disorder, yet it is *not* the most widely used treatment.

MAT combines one of three Food and Drug Administration (FDA) approved medications (methadone, buprenorphine, and naltrexone) with behavioral therapy for preventing relapse and for maintenance treatment of OUD.

Increased screening and diagnosis of opioid use disorder and **improved access to and use of MAT** are critical to making a positive impact on the opioid epidemic.

MAT = Methadone or Buprenorphine or Naltrexone + Behavioral Therapy

Make an impact on the opioid epidemic. Refer to MAT.

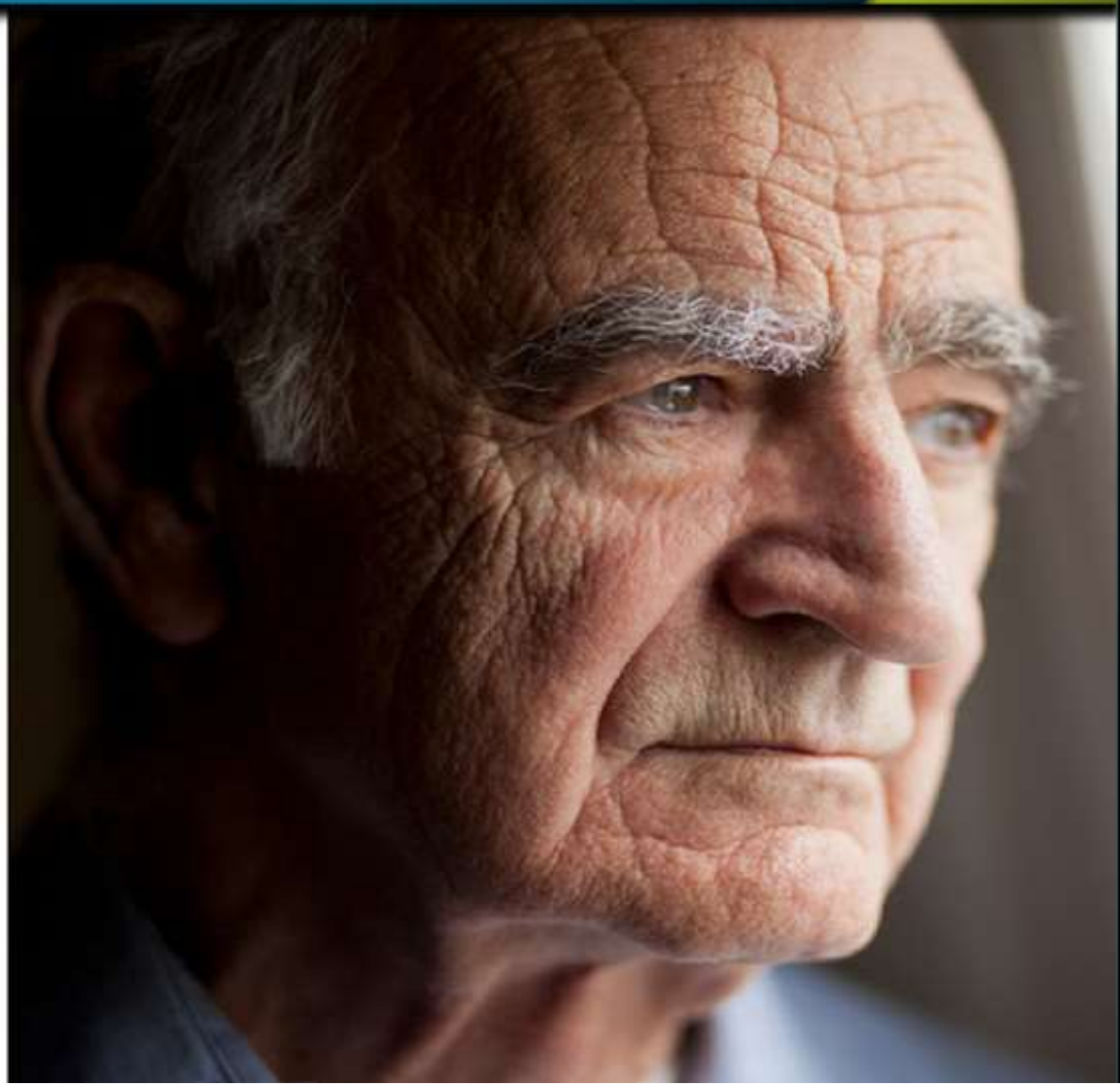
Suicide Risk and Prevention

Suicide is another risk that you should be aware of and be prepared to take steps for prevention.

Individuals who feel they are a burden to others, are in unbearable pain, have serious illness, feel loss of purpose and meaning, and feel trapped are at risk for suicide. Explore their feelings with them. Ask if they ever consider hurting themselves or ending their lives.

Make sure that you:

- Know the risk factors.
- Screen for suicide risk.
- For people in crisis, provide one-on-one observation until transfer to a safe place is arranged.
- Ensure your facility has a list of resources that you can refer someone to.
- Know the National Suicide Prevention Hotline number. Keep it in your phone.
- For those with suicidal ideation:
  - Request the individual's permission to contact family, friends, and/or an outside resource.
  - Engage the individual's family and significant others in care planning.
  - Provide them with the hotline number.
  - Help them identify coping strategies.
  - Restrict access to lethal means.
  - Arrange and ensure follow-up.



Special Notes

Organization Notes

Recognize if the past or present health history includes mental, psychosocial diagnoses. Anxiety and depressive disorders often occur in combination more than independent. Assess for feelings of sadness, hopelessness, lack of interest in activities as signs of a depressive disorder. Assess for uncontrolled nervousness, uneasy, apprehension, and worry as signs of anxiety. These signs can affect quality of life and should be addressed in plan of care.

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Quality Assurance and Performance Improvement (QAPI)

Quality improvement is a critical component of healthcare today and is woven into all of the healthcare regulations, including those for long-term care.

Facilities are required to develop, fully implement, and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that focuses on systems of care, outcomes of care, and quality of life.

All staff should receive training about the organization's QAPI goals and plan and about their responsibility to participate in improvement initiatives. It is important to note that everyone is responsible for improving the quality of care. When policies and procedures are changed, it is often a result of the work done by the QAPI teams.