

**PHCS
2010
REQUIRED
EDUCATION
SELF STUDY
PACKET**



Princeton HealthCare System

www.princetonhcs.org

Redefining Care.

2010 Required Education Post Test Index

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Princeton HealthCare System

Mission Statement of Princeton HealthCare System (PHCS)

The Mission of Princeton HealthCare System is to be the focal point of a comprehensive community health system that responds to the healthcare needs of our service area residents. Princeton HealthCare System will provide inpatient and outpatient care, community health education, medical education, and should promote medical and scientific research when appropriate. It is integral to the Mission of Princeton HealthCare System to continually improve quality of service to our patients and community and to provide appropriate healthcare to all.

Vision Statement of Princeton HealthCare System

Princeton HealthCare System is a premier, integrated healthcare system that strives to anticipate and respond to the lifelong needs of the residents of Central New Jersey and beyond by providing excellent clinical care. Princeton HealthCare System is recognized for its commitment to enhancing the health of its community; providing superior services to its patients, delivering outstanding value, embracing clinical innovations; providing exceptional medical and health education; and supporting a knowledgeable, skilled and caring medical and employee staff.

VALUES of PHCS physicians and our entire staff, our Health Professionals

RESPONSIVENESS: Excellent medical care is based on continuous healing relationships. Health professionals should provide care and be responsive at all times (24 hours per day, every day). The delivery of care can occur through face-to-face visits and telephone contacts and other means as appropriate.

PATIENT-CENTERED CARE: While the quality of care is uniform, care may be customized according to patient needs and values. Health professionals have the capability and responsibility to respond to individual patient choices, preferences and needs.

INFORMED CHOICES: The patient has a significant role in determining the course of his or her care. Health professionals should be able to accommodate differences in patient preferences and encourage shared decision making.

COMMUNICATION: Physicians and staff work diligently to fulfill the organization's commitment to sharing knowledge and information with patients. Health professionals should support patients' access to their own medical, clinical and other relevant information. Health professionals should communicate effectively, ensuring that patients have adequate information to make informed decisions.

EVIDENCED-BASED CARE: Decisions regarding care are evidenced-based. Health professionals should provide care based on the best available scientific standardized knowledge.

SAFETY: At Princeton HealthCare System, safety is a top priority at all times. Health professionals should strive to enhance safety by continuously paying close attention to procedural and operational systems and by following policies and procedures that help prevent and mitigate errors.

SERVICE: Patients' needs should be anticipated whenever possible. Health professionals should do their best to anticipate patient needs through listening to patients and their representatives and monitoring patient conditions.

EFFICIENCY: Health professionals should make efforts to eliminate wasting of resources, patient time, or other valuable commodities.

TEAMWORK: Cooperation among clinicians is a priority. Health professionals should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

RESPECT and COMPASSION: Health professionals should deliver care with respect and compassion.

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Princeton HealthCare System

Infection Control: Breaking the Chain of Infection

In order for infection to spread, the chain must be intact and include: an infectious microorganism, a means of transmission, and a susceptible host.

Ways to break the chain include: kill the microorganisms, prevent transmission through the use of infection control measures, and decrease the susceptibility of the host.

The components of good infection control techniques are: use of Standard Universal Precautions, hand hygiene, and other precautions as indicated.

Standard Universal Precautions

Standard Universal Precautions should be taken on all patients.

- Use barriers to prevent contact with blood or other body fluid: gloves, gowns/aprons, mask, eye protection.
- Handle all patient care equipment and linen as though it may be contaminated with potentially infectious material.
- Take every effort to prevent accidental sharp injuries and body fluid exposures.

Hand Hygiene

Hand hygiene, with soap and water or an alcohol-based gel, should be performed before and after patient contact, after removing gloves, and anytime your hands may be contaminated.

- Handwashing with soap and water should be used when hands are visibly soiled and after caring for patients with *C. difficile*.
 - ✓ Use soap and water.
 - ✓ Vigorously rub all surfaces for 15 seconds.
 - ✓ Rinse under running water. Turn off faucet using paper towels.
- Hand hygiene with alcohol-based gel may be done whenever hands are not visibly contaminated and there has been no potential contact with *C. difficile*.
 - ✓ Apply 5 ml (1 tsp) of gel in the palm of your hand.
 - ✓ Rub hands together, covering all surfaces until they are dry (15 to 25 seconds).

Other Precautions: Some conditions require more than Universal Precautions to prevent the spread of infection. In these cases, an appropriate Precautions Sign (Contact, Soap and Water Contact, Airborne, and/or Droplet) is used to indicate additional precautions are needed.

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***Clostridium difficile* for Healthcare Providers**

What is *Clostridium difficile* (*C. difficile*)?

C. difficile is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea. *C. difficile* associated disease may result in: pseudomembranous colitis, toxic megacolon, perforations of the colon, sepsis, death. Symptoms include watery diarrhea, fever, loss of appetite, nausea, and/or abdominal pain/tenderness.

***C. difficile* colonization versus *C. difficile*-associated disease.**

- Colonization: the patient exhibits no clinical symptoms and the patient tests positive for *C. difficile* organism and/or its toxin. Colonization is more common than *C. difficile*-associate disease.
- *C. difficile*-associated disease: the patient exhibits clinical symptoms and the patient tests positive for *C. difficile* organism and/or its toxin.
- Note: *C. difficile* toxin is very unstable. The toxin degrades at room temperature and may be undetectable within 2 hours after collection of the stool specimen. False negative results occur when specimens are not promptly tested or kept refrigerated until testing can be done.

New strain of *C. difficile*

The emergence of a new strain of *C. difficile*-associated disease has been reported by the Centers for Disease Control and Prevention. The new strain appears to be more virulent and produces greater quantities of toxins.

Educate patients to prevent spread.

Patient education is a critical component of *C. difficile* case management. Healthcare professionals should educate patients, caretakers, and when possible household members on methods to avoid *C. difficile* transmission to close contacts. Education should also be provided about the precautions that are being taken when the patient is hospitalized.

***C. difficile* is typically spread by:**

- *C. difficile* is shed in feces. Any surface, device, or material that becomes contaminated with feces may serve as a reservoir for the *C. difficile* spores.
- *C. difficile* spores are transferred to patients mainly via the hands of healthcare personnel and/or care givers who have touched a contaminated surface or item.

Precautions used for *C. difficile*

Soap and Water Contact Precautions should be used when caring for patients with *C. difficile*. This includes wearing gloves when in the room and washing hands with soap and water after removing gloves and before exiting the room. Wearing a gown when contact with the patient or the patient's environment is anticipated. Utilizing dedicated equipment (stethoscope, BP cuff, and thermometer) for the patient. When using patient care equipment that cannot be left in the room, the equipment should be cleaned and disinfected with an approved germicidal cleaner after use.

Reference: Centers for Disease Control and Prevention Overview of Clostridium difficile infection. http://www.cdc.gov/ncidod/dhqp/id_Cdiff.html

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MRSA (Methicillin-Resistant *S. aureus*) Information for Healthcare Professionals

What is MRSA?

MRSA is an antimicrobial-resistant type of *S. aureus* that is resistant to currently available beta-lactam antibiotics including penicillins, "anti-staphylococcal" penicillins (e.g., methicillin, amoxicillin), and cephalosporins.

When a patient has a skin infection, it may very likely be MRSA.

Recent data suggest that MRSA in the community is increasing. The spectrum of disease caused by MRSA appears to be similar to that of *S. aureus* in the community. Skin and soft tissue infections (SSTIs) and abscesses are the most frequently reported clinical manifestations.

Educate patients to prevent spread.

Patient education is a critical component of MRSA case management. Healthcare professionals should educate patients and/or families on methods to avoid MRSA transmission to close contacts. Education should also be provided about the precautions that are being taken when the patient is hospitalized.

MRSA is typically spread by:

- Having direct contact with another person's infection.
- Sharing personal items, such as towels or razors, that have touched infected skin.
- Touching surfaces or items that may be contaminated with MRSA.
- Passed from person to person by the hands of caregivers.

Precautions used for MRSA.

Contact Precautions should be used when caring for patients with MRSA. This includes wearing gloves when in the room. Wearing a gown when contact with the patient or the patient's environment is anticipated. Utilizing dedicated equipment (stethoscope, BP cuff, and thermometer) for the patient. When using patient care equipment that cannot be left in the room, the equipment should be cleaned and disinfected with an approved germicidal cleaner after use.

Reference: Centers for Disease Control and Prevention National MRSA Education Initiative.

http://www.cdc.gov/mrsa/mrsa_initiative/skin_infection/mrsa_hcp.html

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Princeton HealthCare System

ESBL (Extended-Spectrum Beta Lactamase) Information for Healthcare Professionals

What is ESBL?

ESBLs are chemicals made by certain kinds of bacteria. They break down several types of antibiotics, thus making it difficult to treat infected patients with those antibiotics. ESBL is mainly spread among patients in hospital and long-term care facilities. They usually result in infections of the urinary tract and/or intestine.

What are the risk factors for ESBL?

- Current or recent stay in a hospital or long-term facility or recent stay in ICU or NICU.
- Recent operation or wound treatment.
- Having had a urinary catheter, feeding tube or other tube placed in the body.
- Older age.
- Premature baby.
- Weakened immune system (such as after an organ transplant).
- Having long-term or frequent antibiotic treatment.

Educate patients to prevent spread.

Patient education is a critical component of ESBL case management. Healthcare professionals should educate patients and/or families on methods to avoid ESBL transmission to close contacts. Education should also be provided about the precautions that are being taken when the patient is hospitalized.

ESBL is typically spread by:

- Touching surfaces or items that may be contaminated with ESBL.
- Passed from person to person by the hands of caregivers.

Precautions used for ESBL.

Contact Precautions should be used when caring for patients with ESBL. This includes wearing gloves when in the room. Wearing a gown when contact with the patient or the patient's environment is anticipated. Utilizing dedicated equipment (stethoscope, BP cuff, and thermometer) for the patient. When using patient care equipment that cannot be left in the room, the equipment should be cleaned and disinfected with an approved germicidal cleaner after use.

Reference: <https://www.kramesondemand.com>

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Princeton HealthCare System

CRE (carbapenem-resistant/carbapenemase Enterobacteriaceae) Information for Healthcare Professionals

What is CRE?

Carbapenem-resistant *Enterobacteriaceae* (CRE) or carbapenemase-producing *Enterobacteriaceae* is emerging as an important challenge in health-care settings. Currently, carbapenem-resistant *Klebsiella pneumoniae* (CRKP) is the species of CRE most commonly encountered in the United States. CRKP is resistant to almost all available antimicrobial agents, and infections with CRKP have been associated with high rates of morbidity and mortality, particularly among persons with prolonged hospitalization and those who are critically ill and exposed to invasive devices (e.g., ventilators or central venous catheters).

How common is CRE?

Currently the prevalence of CRE is low in the majority of the U.S. hospitals.

Educate patients to prevent spread.

Patient education is a critical component of CRE case management. Healthcare professionals should educate patients and/or families on methods to avoid CRE transmission to close contacts. Education should also be provided about the precautions that are being taken when the patient is hospitalized.

CRE is typically spread by:

- Touching surfaces or items that may be contaminated with CRE.
- Passed from person to person by the hands of caregivers.

Precautions used for CRE.

Contact Precautions should be used when caring for patients with CRE. This includes wearing gloves when in the room. Wearing a gown when contact with the patient or the patient's environment is anticipated. Utilizing dedicated equipment (stethoscope, BP cuff, and thermometer) for the patient. When using patient care equipment that cannot be left in the room, the equipment should be cleaned and disinfected with an approved germicidal cleaner after use.

Reference: Guidance for Control of Infections with Carbapenem-Resistant or Carbapenemase-Producing *Enterobacteriaceae* in Acute Care Facilities. March 20, 2009 / 58(10);256-260.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5810a4.htm>

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VRE (Vancomycin-Resistant Enterococci) Information for Healthcare Professionals

What is VRE?

Enterococci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment. These bacteria can sometimes cause infections. Vancomycin is often used to treat enterococci infections. In the case of VRE, the enterococci is resistant to vancomycin.

How common is VRE?

Information collected by the Centers for Disease Control and Prevention during 2006 and 2007 showed that enterococci caused about 1 of every 8 infections in hospitals and only about 30% of these were VRE. VRE can be more common in certain groups of people such as those with weakened immune systems.

Educate patients to prevent spread.

Patient education is a critical component of VRE case management. Healthcare professionals should educate patients and/or families on methods to avoid VRE transmission to close contacts. Education should also be provided about the precautions that are being taken when the patient is hospitalized.

VRE is typically spread by:

- Touching surfaces or items that may be contaminated with VRE.
- Passed from person to person by the hands of caregivers.

Precautions used for VRE.

Contact Precautions should be used when caring for patients with VRE. This includes wearing gloves when in the room. Wearing a gown when contact with the patient or the patient's environment is anticipated. Utilizing dedicated equipment (stethoscope, BP cuff, and thermometer) for the patient. When using patient care equipment that cannot be left in the room, the equipment should be cleaned and disinfected with an approved germicidal cleaner after use.

Reference: Centers for Disease Control and Prevention Vancomycin-resistant enterococci (VRE) frequently asked questions. http://www.cdc.gov/ncidod/dhqp/ar_VRE_publicFAQ.html#

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Prevent Surgical Site Infections

Appropriate Use of Prophylactic Antibiotics

- Prophylactic antibiotic should be given within 1 hour prior to surgical incision. Due to the longer infusion time for vancomycin, it is acceptable to start this antibiotic within 2 hours prior to incision.
- Prophylactic antibiotic selection should be consistent with national guidelines.
- Prophylactic antibiotics should be discontinued within 24 hours after surgery end time.

Appropriate Hair Removal

- When hair must be removed to safely perform the procedure, it should never occur with a razor. The use of clippers is the best method for hair removal.

Controlled Postoperative Serum Glucose in Cardiac Surgery

- Glucose control for this indicator is defined as serum glucose levels below 200 mg/dl collected at or closet to 6:00 AM on each of the first two days postoperative.

Immediate Postoperative Normothermia in Colorectal Surgery

- Anesthesia, anxiety, wet skin preparations, and skin exposure in cold operating rooms can cause patients to become clinically hypothermic during surgery. Medical literature indicates that patients undergoing colorectal surgery have a decreased risk of surgical site infection if they are not allowed to become hypothermic during the perioperative period.

Educate patients to assist in preventing surgical site infections.

Patient education is an important component of preventing surgical site infections. Healthcare professionals should educate patients and/or families on the steps that are taken to prevent surgical site infection.

Reference: Institute for Healthcare Improvement. <http://www.ihp.org>

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Princeton HealthCare System

Prevention of Central Line-Associated Bloodstream Infections

Central venous catheters (CVCs) are being increasingly used in the inpatient and outpatient settings to provide long-term venous access. CVCs disrupt the integrity of the skin, making infection with bacteria and/or fungi possible. Infection may spread to the bloodstream (bacteremia) which can lead to hemodynamic changes and organ dysfunction (severe sepsis). In some cases this may lead to death.

Studies of catheter-related bloodstream infections that control for the underlying severity of illness suggest that attributable mortality for these infections is between 4 and 20 percent. Thus, it is estimated that between 500 and 4,000 US patients die annually due to bloodstream infections.

In addition, nosocomial bloodstream infections prolong hospitalization by a mean of 7 days. Estimates of attributable cost per bloodstream infection are estimated to be between \$3,700 to \$29,000.

Care bundles, in general, are groupings of best practices with respect to a disease process that individually improve care, but when applied together result in substantially greater improvement. The science supporting the bundle components is sufficiently established to be considered standard of care.

The Central Line Bundle is a group of evidence-based interventions for patients with intravascular central catheters that, when implemented together, result in better outcomes than when implemented individually.

The key components of the Central Line Bundle are:

- Hand Hygiene
- Maximal Barrier Precautions Upon Insertion
- Chlorhexidine Skin Antisepsis
- Optimal Catheter Site Selection, with Subclavian Vein as the Preferred Site for Non-Tunneled Catheters
- Daily Review of Line Necessity with Prompt Removal of Unnecessary Lines

Educate patients to assist in preventing central line-associated bloodstream infections.

Patient education is an important component of preventing central line-associated bloodstream infections. Healthcare professionals should educate patients and/or families on the steps that are taken to prevent central line-associated bloodstream infections.

Reference: Institute for Healthcare Improvement. <http://www.ihp.org>

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Princeton HealthCare System

Prevention of Catheter Associated Urinary Tract Infection (CAUTI)

How common are CAUTIs?

CAUTIs are the most frequent type of infection in acute care settings, accounting for approximately 36% of healthcare-associated infections.

What increases the risk for acquiring a CAUTI?

The risk of acquiring a CAUTI depends on the method of catheterization, duration of catheter use, quality of the catheter care, and host susceptibility. Studies have shown a strong, direct correlation between catheter use greater than six days and occurrence of CAUTI.

What steps can be taken to reduce the risk and prevent CAUTI?

- Use indwelling catheters only when medically necessary and remove when they are no longer necessary. Document indication for urinary catheter on each day of use. Consider alternatives to indwelling urethral catheters.
- Use aseptic insertion technique with appropriate hand hygiene and gloves and allow only trained healthcare providers to insert the catheter.
- Properly secure catheters after insertion to prevent movement and urethral traction.
- Maintain a sterile closed drainage system and maintain good hygiene at the catheter-urethral interface.
- Maintain unobstructed urine flow and maintain the drainage bag below the level of the bladder at all times.
- Do not change indwelling catheters or urinary drainage bags at arbitrary fixed intervals.

Reference: Guide to Elimination of Catheter-Associated Urinary Tract Infections (CAUTIs). An APIC Guide 2008.

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Prevention of Ventilator-Associated Pneumonia (VAP)

What is the impact of VAP?

VAP is the leading cause of death among hospital-acquired infections. Studies have shown that hospital mortality of ventilated patients who develop VAP is 46%, compared to 32% for ventilated patients who do not develop VAP. In addition, VAP prolongs time spent on the ventilator, increases length of stay in Critical Care, and increases the overall hospital length of stay.

What steps can be taken to reduce the risk and prevent VAP?

Utilizing a series of interventions, implemented together (a best practice bundle), has been found to achieve significantly better outcomes than when implemented individually.

What are the components of the VAP bundle?

- Elevation of the head of the bed 30 to 45 degrees.
- Daily "sedation vacations" and assessment of readiness to extubate
- Peptic ulcer disease prophylaxis
- Deep vein thrombosis prophylaxis

Reference: <http://www.ihl.org/IHI/Topics/CriticalCare/IntensiveCare/Changes/ImplementtheVentilatorBundle.htm>

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EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) is triggered when any individual comes to University Medical Center at Princeton's Emergency Department or Obstetric Unit and requests an examination or treatment. The hospital must then provide for an appropriate medical screening examination by qualified medical personnel regardless of the individual's ability to pay, including ancillary services routinely available, to determine whether an emergency medical condition exists.

With regard to treatment, the hospital provides all the medical treatment within its capabilities to minimize the risk to the individual or, in the case of a woman in labor, the woman's unborn child.

Under EMTALA we must do the following:

- Ensure that all individuals are informed about their right to a medical screening examination and stabilization for an emergency medical condition.
- Track the care provided to each individual who comes to the hospital seeking care for an emergency medical condition.
- Ensure that all individuals who request an examination or treatment to determine if an emergency medical condition exists shall be screened by qualified medical personnel and stabilized as required under EMTALA and the NJ Hospital Licensing Standards regardless of ability to pay.
- Ensure that an individual requesting or requiring a transfer for further medical care and follow-up is transferred appropriately regardless of ability to pay.

EMTALA does not apply to inpatients, including a patient admitted through the emergency department.

An individual being treated as an outpatient who develops an emergency during the encounter is not covered under EMTALA.

Policy Reference PCS E-1.2

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Princeton HealthCare System

HIPAA Security Breach Notifications

Beginning in September 2009, HIPAA covered entities such as PHCS must comply with new regulations concerning the breach (disclosure) of patient protected health information (PHI). However, sanctions (fines and penalties) will not begin for 180 days to give organizations time to prepare for these new regulations.

In summary, if a patient's protected health information is inappropriately disclosed, we must notify the patient within 60 days and keep a log of the information that was disclosed so that we can report it to the Department of Health and Human Services at the end of each year.

If more than **500** records are inappropriately disclosed, we must also communicate this to all the patients affected, immediately notify the Department of Health and Human Services and issue a press release to the media!! If 10 or more patients cannot be found (i.e. last known address was changed), then we must also place information about the breach of the information on the PHCS website. If we do not comply, we may be subject to extensive fines and penalties!!

Examples of Potential Security Breaches

- emailing PHI to the wrong person
- mailing PHI to the wrong person
- faxing PHI to the wrong person
- reviewing and/or disclosing medical records of patients outside of job responsibilities
- hacking of patient information by an outside party
- backup tapes of patient information are lost or stolen
- laptop or PDA with patient information is lost or stolen

What you must do as an employee of PHCS

- notify your supervisor or another member of management when you become aware of a potential breach of information by yourself or a colleague or,
- notify the Corporate Compliance and Privacy Officer when you become aware of a potential breach of information by yourself or a colleague by calling Lisa Hartman at 609-430-7789 or by email at lhartman@princetonhcs.org or,
- or call the HIPAA Security Officer, Ed Henry at 609-750-8728 or by email at ehenry@princetonhcs.org or,
- call the confidential Compliance Hotline at **1-800-779-4035**

What happens next?

1. we will evaluate if the breach creates a significant risk of financial, reputational or other harm to the patient
2. we will review who the information was disclosed to and determine if it is a breach or not
3. if a breach occurred, we will notify the patient in writing and include
 1. a brief description of the breach, the breach date & discovery date
 2. the type of PHI breached
 3. the steps the patient should take to protect themselves from harm
 4. what we're doing to investigate, mitigate harm & prevent recurrence
 5. who to contact for information

Policy Reference: HIPAA Security 3.3

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Princeton HealthCare System

HIPAA PRIVACY

HIPAA, The Health Insurance Portability and Accountability Act, passed in 1996. The Privacy Rule went into effect in April 2003 and was designed to:

- Protect patients' rights by giving them access to their health information and control over how it will be used.
- Protect the confidentiality, security, and privacy of all medical records and other private health information that is used or shared in any form, whether on paper, electronically, or orally by certain healthcare entities and their business associates.

To protect patient privacy

- Do not give out patient information unless you are sure it is going to the appropriate person for a legitimate reason; and release only the minimum necessary information.
- Detailed policies and procedures related to HIPAA Privacy can be found on the M-Drive under the Compliance-HIPAA folder.
- If you have a concern regarding HIPAA, please contact the **Compliance and Privacy Officer, Lisa Hartman, dial 609-430-7789 or our Hotline 1-800-779-4035**. The Compliance and Privacy Officer is located on the first floor of the University Medical Center at Princeton.

Policy References HIPAA Privacy 1.0, 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 2.0, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, and 3.0

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Princeton HealthCare System

CORPORATE COMPLIANCE OVERVIEW

- Our Corporate Compliance program is based on the principle of compliance with all laws and regulations affecting our services and on abiding by standards of integrity, honor, and concern for others. These standards are the foundation upon which our day-to-day operations exist.
- Our standards of conduct are formalized in our *Code of Ethical Conduct*, which is distributed to all employees as a reminder of our tradition of high ethical standards.
- You are strongly encouraged to report any suspected violations to your supervisors, managers, or human resources staff or you can call our Compliance Officer or the hotline.
- The Corporate Compliance Hotline was created to allow anonymous and confidential reporting of suspected violations of Princeton HealthCare System's standards of conduct and policies as well as state and federal laws and regulations. It is available twenty-four hours a day, seven days a week.
- Princeton HealthCare System has a policy forbidding retribution or retaliation for reporting of compliance issues in good faith.
- Detailed policies and procedures related to Corporate Compliance can be found on the M-Drive under the Compliance-HIPAA folder.
- **Compliance Officer, Lisa Hartman, dial 609-430-7789 or our Hotline 1-800-779-4035.** The Compliance Office is located on the first floor of the University Medical Center at Princeton.

Policy References: AS: C-1.0, C-1.1, C-1.2, C-1.4, C-1.5, C-1.6, C-1.7, C-1.8, C-1.9, C-2.1, C-2.2, C-2.3, C-2.8, C-2.9, C-3.0, C-3.1, C-3.2, C-3.3, C-3.4, C-3.5, C-3.6, C-3.7, C-3.8, C-3.9

Conflicts of Interest

I will act in good faith in all aspects of my work. I will avoid conflicts of interest or the appearance of conflicts between my private interests and my work duties. A conflict of interest may exist whenever my decisions or actions benefit me, or my family, friends or business associates.

I can avoid conflicts of interest by:

- Declining to offer, accept or provide gifts or favors, such as meals, transportation or entertainment that may create or appear to create a conflict of interest or a corrupting influence. (Meals incident to a business or professional purpose are acceptable when they do not violate any applicable law).
- Refusing any gift or gratuity that exceeds courtesy value and never accepting cash or cash equivalents in connection with my work at PHCS. (Non-cash items of courtesy value that are clearly tokens of business hospitality and do not create a conflict of interest may be acceptable).
- Maintaining unbiased relationships with actual and potential vendors and contractors.
- Exercising good faith and fair dealing in all transactions that involve my PHCS responsibilities.
- Using my position at PHCS only for the good of the organization, my patients and my fellow employees – not for my personal gain.
- Declining outside employment that conflicts with my position at PHCS.
- Obtaining approval from my supervisor and area Vice President before hiring or having a business relationship that could benefit me, my family, or friends.
- Reporting actual or perceived conflicts to my supervisor, other manager, the Corporate Compliance Officer or the PHCS Compliance Hotline.

To be sure, I can ask myself...

- Do I base my decisions on what is best for PHCS and the people we serve rather than on what is best for me?
- Has a vendor offered to take me and/or my colleagues out for a meal that may appear as a conflict of interest or a corrupting influence?
- Have I accepted a gift that a vendor's company representative paid for?
- If a patient offered me a gift that I couldn't share with my department, did I politely decline it? Did I accept a cash tip during the holidays?
- Before entering into any transaction for PHCS, do I stop to think how the transaction and its outcome will look to others? Does it appear to benefit me, my family or my friends?

2010 Required Education



Princeton HealthCare System

False Claims Act Policy

The Deficit Reduction Act (DRA) of 2005 mandated that effective January 1, 2007 any entity receiving or making annual payments under the State Medicaid plan of at least \$5 million must:

- “establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) and any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs
- Include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse”.

PHCS supports the efforts of federal and state authorities in identifying incidents of fraud and abuse and has the necessary procedures in place to prevent, detect, report and correct incidents of fraud and abuse in accordance with contractual, regulatory and statutory requirements.

False Claims Act Policy sets forth the guidelines to be followed by all employees, contractors and agents regarding the FCA and in detecting and preventing fraud, waste and abuse.

Below please find some examples of Health Care Fraud that may lead to the submission of fraudulent claims to the government:

- Falsifying billing and/or medical coding records
- Billing for services not medically necessary
- Duplicate billing for items or services
- Submitting bills for services never performed or items never furnished
- Failing to report overpayments

Under the FCA, it is a violation to knowingly submit a false claim to the government. All employees, contractors or agents with knowledge of potential fraud and abuse situations must report such situations through any of the following methods:

- Notifying their direct supervisor;
- Notifying any supervisor or member of management;
- Notifying Human Resources management;
- Contacting the PHCS Compliance Officer/Corporate Compliance Office directly at 609-430-7789 or
- Calling the confidential PHCS Compliance Hotline at 1-800-779-4035.

Retaliation or retribution for reporting issues “in good faith” is prohibited.

2010 Required Education



Princeton HealthCare System

IDENTITY THEFT and RED FLAGS RULE

Red Flags Rule – provides for the **Prevention of Identify Theft** through *Identification, Detection, Prevention and Mitigation*.

How is Princeton HealthCare complying with this?

- PHCS has developed an **Identify Theft and Fraud Incident Response Policy (Policy C-2.3)** to comply with Federal regulations to identify and detect **Red Flags** in order to prevent or lessen the impact of identity theft. **Policy C-2.3** can be found on the M-drive, select the **Compliance-HIPAA** folder, then subfolder **Policies Corporate Compliance Current**.

Why is Princeton HealthCare System Expected to Comply?

- Princeton HealthCare System is a creditor (we bill patients after services are provided to them). All companies providing any form of credit must comply with the Federal Trade Commission's **Red Flags Rule** regulation.

What are Red Flags?

- Basically, a Red Flag is something that calls your attention to “a pattern, practice, or specific activity that indicates the possible existence of identity theft”. They generally are things such as...
 - ...Suspicious documents or personal identifying information (i.e. mismatched birth dates, addresses, phone numbers or social security numbers)
 - ...Suspicious or unusual use of account
 - ...Alerts from others (i.e. patient, identity theft victim, police)

How Can I Ensure Compliance with Red Flags Rule?

- Always be on the alert for suspicious looking documents, including documents that look altered (i.e. insurance ID cards, drivers license)
- Always obtain identification documentation and ensure it is authentic (photo IDs are best)
- Ensure the documentation provided matches the patient you are caring for.
- Always maintain and respect a patient's privacy and confidentiality.

What Should I Do if I See Something Suspicious?

All Staff

- Notify Security at ext. 6464 and/or the Privacy Officer at 430-7789 immediately.
- Do not accuse someone of Identify Theft based on suspicion. Allow the Privacy Officer to conduct the investigation.

PFS, PAS and Registration Intake Staff

- Complete the Identify Theft/Patient Misidentification Alert Form (found in policy) and forward as instructed at the bottom of the form. Call Security, if a patient's visit has an Identify Theft Flag on it.

Policy Reference: C-2.3

2010 Required Education



Princeton HealthCare System

HIPAA SECURITY

HIPAA, The Health Insurance Portability and Accountability Act, passed in 1996. The Security Rule went into effect in April 2005 and was designed to:

- Ensure the confidentiality and security of patient information.
- Prevent fraud and abuse of patient information in medical records and billing information.
- Cover electronic Protective Health Information (ePHI) and deal with physical, technical, and administrative measures to ensure availability, integrity, and confidentiality of patient data.

To protect the confidentiality and security of ePHI

- Always **log off** an application or system to protect confidentiality and security of patient information.
- Do **not** disclose your computer username or password for systems such as Ulitview or Windows.
- Detailed policies and procedures related to HIPAA Security can be found on the M-Drive under the Compliance-HIPAA folder.
- If you have a concern regarding HIPAA, please contact:
 - **Compliance and Privacy Officer, Lisa Hartman**, dial **609-430-7789**, email at lhartman@princetonhcs.org or dial **Hotline 1-800-779-4035**. The Compliance and Privacy Officer is located on the first floor of the University Medical Center at Princeton or,
 - **HIPAA Security Officer, Ed Henry**, dial **609-750-8728** or email at ehenry@princetonhcs.org

Policy References HIPAA Security 1.2, 1.3, 1.8, 1.9, 2.0, 2.2, 2.3, 2.4, 2.5, 2.7, 2.8, 2.9, 3.2

2010 Required Education



Princeton HealthCare System

Limited English Proficient Patients

Upon request or determination that a patient requires an interpreter to effectively communicate, understand, and participate in their health care decisions, interpretive services will be provided to all units of Princeton HealthCare System. The Language Line Services Identification Board can be used by staff to identify the language spoken by the patient.

Princeton HealthCare System provides access to Language Interpretation Services upon request of the patient or family member. Interpretative services may include:

- Use of Language Line Services
- Certified Bilingual staff and Volunteers from the hospital volunteer program.

Many patient information and consent forms are available in both English and Spanish. Any patient speaking a language other than English or Spanish, or when the patient information or consent form is only available in English, the patient will be provided with an oral translation of documents through one of the above mentioned services.

1. Based upon the request of the patient and/or assessment of the patient, interpretive services will be requested on the patient or families behalf. The language spoken by the patient will be documented during the registration process for that hospital visit.
2. The health care team, in collaboration with the patient, will determine whether to use Language Line Services or bilingual volunteers or staff members to provide translation services.
3. If the patient requests the use of family, or friends to provide translation services the medical record must document this request including: who translated, their relationship to the patient, that the patient requested this person provide translation and that the patient was offered and refused other translation services provided through Princeton HealthCare System. The Interpreter must be over the age of 18.
4. Interpreter services should be provided during all situations when effective communication is necessary to insure that the patient is informed regarding care and treatment. Those situations may include, but are not limited to:
 - Obtaining a history and physical
 - Explanation of diagnosis or an illness or injury
 - Obtaining informed consent or permission to treat
 - Explanation of medical procedures to be done
 - Explanation about medications
 - When giving discharge instructions

Language Line Services

Interpretive Services may be accessed from any phone at Princeton HealthCare System including Dual Handset telephones by direct dialing Language Line Services at: **800-523-1786**.

The dual handset phones, which provide direct communication efficiently in a secure fashion and in a hygienic manor, are the preferred choice. These handsets are located on all inpatient nursing units at UMCP, the Outpatient Clinic, the Emergency Department, and Patient Access Services. In addition, a Dual Handset phone is available at the Switchboard for use by all other departments. The Dual Handset phone is preprogrammed with Princeton HealthCare System accounts and a personal code identifying the location of the phone. Language Line Operators can be reached by one touch access. Further directions are located on the handsets.

When contacting Language Line Services:

1. Request that the patient point to the appropriate language on the Language Line Services identification board.
2. Provide the Language Line Services Operator with the following information:
 - Client ID number: 210023
 - Organization: Princeton HealthCare System
 - Language Needed
 - Personal Code: Department or nursing unit from which you are calling
3. Language Line Services will connect the interpreter into your line. The interpreters will identify themselves by name or ID number.
4. Identify yourself as from Princeton HealthCare System. Ask for the information you need. The Interpreter will obtain the information from the patient and relay it back to you, and vice versa. This will continue until you have all the information needed. To terminate call, say "End of Call".

Bilingual Staff

Patients needing interpretive services should first be offered the assistance of the Language Line Service, especially in circumstances involving the explanation of medical procedures or medical terminology. As an alternative, staff who are certified as interpreters may be utilized.

The following policy is available on the M Drive via this pathway:

- M Drive/Patient Care Services folder/Patient Care Policies folder/General Policies and Procedures folder/ "Current" folder/ PCS I – 1.4 Interpreter Services for Limited English Proficient Patients

2010 Required Education



Princeton HealthCare System

DEAF OR HARD OF HEARING PATIENTS

Hard of Hearing Patients

Elderly patients are the most frequent patients with hearing loss. The hard of hearing (HOH) patient is stressed by illness, pain, worry, and separation from their families and it is important to be aware of their special needs.

Strategies for speaking with a HOH person include the following:

- Face the person and position your self at the person's level (sit if the patient is sitting)
- Get the person's attention prior to speaking; Do not startle or approach the person from behind
- The closer you are, the easier to understand the person
- Make sure the person is wearing his/her hearing aid and that it is turned on and working
- Stand or sit on the side of the better ear
- Background noise (TV's, rattling carts and others talking, etc.) can interfere with the patient's understanding
- Many HOH people use lip reading. Surgical masks, gum and food chewing can interfere with lip reading; Use short sentences and simple words

Deaf Patients

Communication Assessment Form

Patients who are deaf often communicate using Sign Language, while others communicate through lip reading. When caring for a deaf patient it is important to assess their individual needs. A **Communication Assessment Form** must be completed. The communication assessment is part of our policy "Services for the Hearing Impaired." The form identifies the patient's preferred methods of communication, identifies a plan for the patient during their hospitalization, and obtains the patients consent to that plan. The form should be completed during the initial interaction with the patient; ideally prior to admission. For patients that have an emergent or unexpected admission, the assessment form can be completed by emergency room or admitting nurse, admission representative, patient representative or social worker.

The original assessment form should be placed in the patient's chart. If the patient requires a sign language interpreter please contact either the **Office of Patient Relations at extension 4477** or the **nursing supervisor for assistance in scheduling a sign language interpreter**. The Policy does specify some situations where a sign language interpreter should be present to insure effective communication.

Other Services available for Deaf or Hard of Hearing Patients

- Telephone Device for the Deaf (TDDs), are available in the Emergency Department and other areas through the hospital's telephone operator.
- Amplified telephones are in most inpatient rooms with spare sets available through the telephone operators.
- Closed caption televisions are installed in some inpatient rooms. Engineering will install a closed caption set if not already in the patient's room; or the patient can be transferred to a bed having a closed caption TV.

PRINCETON HEALTHCARE SYSTEM
Princeton, New Jersey

COMMUNICATION ASSESSMENT FORM

DEAF AND HARD OF HEARING PATIENTS

Princeton HealthCare System (PHCS) is committed to meeting the needs of all of our patients. In order to assure that the services, which are provided to you, are not compromised by ineffective communication, the hospital has TTY's (Telephone/Typewriter for the Deaf) and amplified telephones available. PHCS also has resources for obtaining sign language interpreters when necessary at no cost to you.

To help us meet your needs, please complete this form.
Check each applicable item:

- I require the use of a TTY (Telephone/Typewriter for the Deaf)
- I require the use of an amplified telephone.
- I request a qualified interpreter for communication with my physician and PHCS staff. I consent to having such interpreter gain knowledge of my confidential medical information through the interpretive services.
- I prefer to lip read and speak for myself for all communications.
- I prefer written notes for brief communications.
- I require the use of closed captioning for the television.
- OTHER (Please specify) _____

Plan:

Patient Affirmation

I acknowledge that I have expressed my communication needs.

Patient (or parent, guardian, representative)

Date

Witness

Date

The following policy is available on the M Drive via this pathway:

- M Drive/Patient Care Services folder/Patient Care Policies folder/General Policies and Procedure folder/"Current" folder/PCS H-1.0 Services for Hearing Impaired Patients

2010 Required Education



Princeton HealthCare System

CULTURAL COMPETENCIES

- Involve understanding and respecting the patient's cultural values, beliefs and practices
- Consider:
 - views about health and health care
 - family and community relationships
 - language and communication styles
 - ties to another country or part of the US
 - food preferences
 - religion
 - views about death
 - other factors that may affect care needs
- It can help to have some basic knowledge about the major cultural and religious groups.
- It's important to know your own culture.
- This can help you remember that a patient may hold different views.
- For example:
 - You may have certain views about illness. You may see illness as having a physical cause (such as germs), an emotional cause (such as stress), or another cause. You may believe a particular remedy is needed for a certain illness (for example a home remedy for a cold.
 - You may value certain communication styles. For example, you may have views about whether it's polite or rude to make eye contact or touch someone during conversations

Know the culture of health care in the US.

The health care system has its own beliefs, values, and practices that may not be shared by all patients.

- For example:
 - Appointments run by clock time and promptness is valued. Appointments may be shorter than some patients expect.
 - Checkups, immunizations, and screenings are valued as preventive health measures.
 - Illness is generally seen as having a physical cause. Treatment emphasizes technology and physical procedures.
 - Patients are expected to take medications exactly as prescribed.
 - Facilities often set specific rules about visitors and visiting hours.

- By being open-minded and respectful toward their beliefs, values, and practices, you can help patients feel more comfortable.
- Factors that may differ from patient to patient include ethnic, religious, and occupational factors.
- Some people belong to more than one ethnic group, as well as cultural groups.
- Other people have fewer group identities.
- Importance of religion can vary from person to person.
- For example some people keep many daily traditions, such as eating certain foods.
- Others keep traditions only on special occasions, or not at all.

- For many different reasons, religious, ethnic, health, personal preference, etc., a person may eat or avoid certain foods at certain times, or not eat some foods at all.
- Different cultures have different ideas about how to express and respond to pain.
- Some cultures value bearing pain silently, while others expect expressiveness.
- Different cultures have different views about when to seek professional medical help, treat oneself, or be treated by a family member or traditional healer.

Language

- The degree to which a patient or staff member is fluent in English, or any other language you speak, will have a bearing on your interactions.
- A prime factor affecting this communication is your attitude toward people who speak limited English.
- How open are you to working with people who speak with accents?
- How do you feel when people speak with family members or co-workers in their native language while you are working with them?
- If you are irritated in these situations, consider what it feels like for them.
- Do you know a second language?
- How easy is it for you to use, and how confident are you about your effectiveness when using it?
- Those whose English is limited often say that they speak their native language when possible because both their explanations and their understandings can be more accurate, and because it is more comfortable.
- Language can be likened to a song that has both lyrics and melody.
- The “lyrics” (vocabulary, grammar, and syntax) are easier to learn, especially for adults, than the “melody” (the pitch, inflections, and tone of the adopted language).
- You can help overcome this barrier by paying attention to the sound of the accents you deal with most frequently, and by learning the most common substitutions people make.
- Examples are the interchanging of sh and ch by native Spanish speakers and the use of P and F and S for sh sounds by Filipinos.
- Even when someone has an extensive vocabulary in an acquired language, word order and the use of articles (the,a,an), pronouns, and prepositions may be confusing and difficult.
- In some Slavic languages, for example, there are no articles; hence it may be difficult for a native speaker of a language from the group to use the, and an properly.
- They may say, for example, “I don’t want shot.”
- Another frequent confusion occurs when native speakers of Tagalog, which does not have separate masculine and feminine pronouns, use he for she and vice versa.

Cultural Influences

- Are complex and multifaceted
- It is impossible to know all the rules about each specific group.
- Cultural generalizations categorize areas of similarity in preferences, norms, and values, which should not be applied with certainty to each individual.

•When treating a patient who is from a different background, it is more effective to investigate and check out your assumptions than to operate on incorrect predictions.

Following is a list of tips for caregivers in treating patients from other cultures:

- Avoid making judgments about the patient's beliefs and practices
 - Consider analogous beliefs or practices in which you have engaged (for example, although you may not have gone to a shaman or faith healer, you may have prayed for the health or safety of a loved one)
 - Ask questions that help you to learn about the patient's view of his/her condition
 - Find out what other treatments the patient is using
-
- Ask the patient to bring all medications that he/she is using
 - Explain procedures carefully before an examination, especially when they may be embarrassing or uncomfortable for the patient
 - Assure the patient that all attempts will be made to preserve modesty
 - Avoid touching the patient's head unless it is necessary and then explain the reasons before touching
 - Ask the patient who he/she wants to be involved in discussions about diagnoses, treatment, prognoses
 - Ask patients how much they want to be informed and who should receive information if they do not want full disclosure of themselves.

Other Aspects of Communication

- Although language differences are often cited as the main source of obstacles to multicultural settings, there is much more to communication than language.
- Variations in cultural "software" are often at the heart of the misunderstanding, frustration, and miscommunication that occurs when people from different backgrounds come together.

A number of aspects of interacting and sharing information, besides language, are significantly influenced by culture, including:

- Directness
- Gestures and facial expressions
- Distance
- Touch
- Topics appropriate for the discussion
- Degree of formality
- Forms of address
- Balance of relationship and task
- Pace and pitch
- Relationship factors of priority and status

Directness

- “Spit it out” and “Say what’s on your mind” are popular American expressions of the value of getting to the point.
- In languages that depend on subtle contextual cues and that leave it to the listener to infer meaning, as would be the preference in Arabic or Japanese, information is implied rather than stated.
- Facial expressions, body language, and tone of voice play a much greater role in cultures where people prefer indirect communication and talking around the issue.
- For example, rather than pointing out that part of a form has missing or incorrect information, indirect communicators might praise the sections that were correctly completed, implying that the incomplete section is a problem.
- In another variation among Hispanics, directness in expressing negative feelings or information is discouraged.
- This taboo may result in a patient’s not following treatment procedures and withholding critical discussion.
- Differences regarding directness can be particularly frustrating, especially when specific information and answers are needed for example, “Do you understand?” and the response is a nod or a yes.
- Individuals from Mexico and much of Asia find it nearly impossible to say no directly because it signals disrespect, can cause loss of face, and makes them feel inadequate.
- A response such as “Maybe” or “That would be difficult” is probably a polite no.
- Avoiding yes/no questions by phrasing the inquiry as a multiple choice question is one way around this impasse.
- For example, you might ask, “Which of these medications have you taken?” rather than “Did you take this one?”

Gestures and Facial Expressions

- Another culturally influenced aspect of communication is the demonstration of emotion, such as joy, affection, anger, or upset.
- Most Koreans, for instance, are taught that laughter and frequent smiling make a person appear unintelligent, so they prefer to wear a serious expression.
- While Americans widen their eyes to show anger, Chinese people narrow theirs.
- Vietnamese, conversely, consider anger a personal thing, not to be demonstrated publicly.
- Smiling and laughter may be signs of embarrassment and confusion on the part of some Asians.
- Talking with one’s hands is more common in southern Europe than in northern Europe.
- A direct stare by an African American or Arab is not meant as a challenge to your authority, while dropped eyes may be a sign of respect from Latino or Asian patients and coworkers.
- Use gestures with care, as they can have negative meanings in other cultures.
- Thumbs-up and the OK sign are obscene gestures in parts of South America and the Mediterranean.
- Pointing with the index finger and beckoning with the hand as a “come here” sign are seen as rude in some cultures much as snapping one’s fingers at someone would be viewed in the United States.

Distance

- American culture generally expects people to stand about an arm's length apart when talking in a business situation.
- Any closer is reserved for more intimate contact or seen as aggression.
- In the Middle East, however, it is normal for people to stand close enough to feel each other's breath on their faces.
- Hispanics typically favor closer proximity than to non-Hispanic whites.
- Thus, moving away and keeping greater distance might be perceived by Hispanics as aloofness and coldness.
- In much of Asia, where cities are crowded and space is at a premium, jostling and bumping in public places aren't seen as intrusive or inconsiderate, and do not require an "excuse me."
- Think about your patients and colleagues, and their use of space.
- Do you sometimes feel crowded or encroached upon?
- Are there individuals whom you have labeled pushy because they invade your space?
- Have you sensed that you overstepped an invisible boundary with someone?
- If so, you may have been dealing with differences in cultural preferences about distance.
- When interacting with patients or coworkers who prefer less physical distance, sitting closer and leaning toward them can help.
- Conversely, when greater distance is preferred, sitting across a desk, counter, or table may help.

Touch

- To touch or not to touch is only part of the question.
- Cultures also have different rules about who can be touched and where.
- A handshake is generally accepted as a standard greeting in business, yet the kind of handshake differs.
- In North America, it is a hearty grasp; in Mexico it is often a softer hold, and in Asia a soft handshake with the second hand brought up under the first is a sign of friendship and warmth.
- Religious rules may also apply.
- For devout Muslims and Orthodox Jews, touching between men and women in public is not permitted, so a handshake would not be appropriate.
- Touching the head, even tousling a child's hair as an affectionate gesture, would be considered offensive by many Asians.
- Individuals will usually let you know their preferences through their behavior.
- Following the other person's lead is generally a good guideline.
- If you need to touch someone for purposes of an examination, explain the purpose and procedure before you begin.

Topics Appropriate for Discussion

- Another difference between cultures is apparent in the subjects that are considered appropriate for discussion.

- Many Asian groups regard feelings as too private to be shared.
- Latinos generally appreciate inquiries about family members, while most Arabs and Asians regard feelings as too personal to discuss in business situations.
- In social conversations, Filipinos, Arabs, and Vietnamese might find it completely acceptable to ask the price you have paid for something or how much you earn, while most Americans would consider that behavior rude.
- Even a seemingly innocuous comment on the weather is off limits in the Muslim world, where natural phenomena are viewed as Allah's will, not to be judged by humans.
- This points to another aspect that relates to privacy.
- To many newcomers, Americans seem naively open.
- Discussing personal matters outside the family is seen as embarrassing by many cultures, and opening up to someone outside of one's own cultural group is rare.
- Thoughts, feelings, and problems are kept to oneself in most groups outside the dominant American culture.
- This difference may have implications when medical problems are stress related or exacerbated by personal or family problems.
- Keeping all family matters private is a strong code of conduct.
- For the health care professional who needs personal information, particularly in sensitive areas involving intimate behavior and bodily functions, to complete forms and do work-ups, it is less intrusive to spend time building trust and getting to know the individual.
- Furthermore, if you know that privacy is a value and that getting documentation may be uncomfortable, you can conduct the discussion in a soft unobtrusive tone.
- All of these techniques may help the patient get beyond the very difficult obstacle of talking to a stranger about personal matters.
- An aspect related to self disclosure is loss of face, important in some manner in all cultures.
- In Asia, the Middle East, and to some extent Latin America, one's dignity must be preserved at all costs.
- In fact, death is preferred to loss of face in traditional Japanese culture, hence the suicide ritual, hara-kiri, as a final way to restore honor.
- Any embarrassment can lead to loss of face, even in the dominant American culture.
- To be criticized in front of others, publicly snubbed, or fired would be humiliating in most any culture.
- However, behaviors that we see as harmless can be demeaning to others.
- Inadvertent slights or unconscious faux pas can cause serious repercussions in intercultural relationships.

Cultural Beliefs about Health, Disease, and Healers

- Following is a short summary of health-related norms and preferences of a number of ethnic groups.
- Although you need culture-specific information about the groups you care for and work with, remember to take into account the whole person, to see him/her as a unique individual.
- Do not assume that a particular patient fits the general cultural descriptions of his or her culture.

Afghan Refugees

- Practice indirect communication; avoid saying “no” directly
- Communicate by stories
- Extend ritual courtesy between people of differing status
- Will shop around for doctors
- Expect injections or pills at medical visits
- May not admit to traditional beliefs and practices

African Americans

- Classify illness according to “natural” and “unnatural”
- Combine practical, magical and religious beliefs
- Illness may be viewed as “an attack” on the body and may involve beliefs relating to blood flow (i.e. blood/flow is too thick, too thin, too much, too little)
- May seek traditional healers instead of, or in addition to, biomedical help

Chinese

- May be reluctant to seek physician care
- Expect to receive medication at visit and may lack confidence in physician who does not dispense medication
- Individual concerns are subordinate to what is best for the whole community or family
- Religion is central to beliefs

East Indians

- Reluctant to disagree with or contradict those with high status
- May say “yes” even when they do not understand
- Multidrug therapy is common and they like colored medication; injections are popular
- The “hand quality” of the physician is important and they may prefer to have their medication handed to them by the physician
- Family is involved in patient care
- Women and children typically will not visit a physician unaccompanied by a chaperone who will be present during the exam
- Reluctant to have blood drawn or donate blood
- Medical pluralism exists; resistant to Western medicine

Ethiopians

- Traditional medical beliefs consist of “indigenous magic or religious practices and beliefs”
- May use both traditional cures and Western biomedicine
- Family, friends, and religion are important
- Many times physicians are expected to communicate through family members rather than directly with the patient
- Concern is with medical diagnosis rather than prognosis
- Trust is a major factor in physician-patient relationships
- May evaluate a physician in terms of his/her warmth and manners
- Most want to be reassured by the physician that they will make it through their medical crisis

Filipinos

- Very receptive to modern medicine; yet still retain indigenous disease beliefs
- Place a high value on proper social conduct; avoiding unpleasantries, confrontations, and discourtesies
- Practice proper respect for authorities
- Often delay seeking medical attention
- Prefer Filipino practitioners or folk practitioners and value personalism
- May be receiving multiple treatments and taking multiple medications, such as herbs and medicinal drugs at once
- Role of family is ultimately important; thus it may help to have a family member or close friend present during the encounter
- Often are reserved and overly compliant; value harmony
- Group is more important than the individual

Gypsies

- Illness is a social experience; with family and friends to support the sick person
- They do not like to be alone
- May be expected to consult with older relatives in treatment decisions
- Traveling, good luck, cleanliness, and being overweight are all linked with good health
- Avoid non-gypsies and hospitals but will seek out the “best” medical care
- Will try multiple cures for an illness, including non-gypsy practitioners, gypsy remedies and faith healers
- Illness can be caused by spirits or the devil

Hispanics

- May have to seek eldest member of family for treatment consent
- Expect authoritarianism, formal friendliness and respect
- Neglecting to shake hands is an insult
- May be very respectful, nodding and saying “yes” even if they don’t agree, and will avoid directly contradicting physician

Jamaicans

- Symptoms are believed to be identical to disease, therefore if there are no symptoms, no disease exists
- Similarly, treatments are valued in terms of how quickly the symptoms disappear
- There are specific beliefs about what causes illness (hippocratic humoral concepts and germ theory) and a treatment must “fit” the illness for it to be used by the patient or considered effective
- Self-medication is common

Japanese

- Readily report large amounts of information concerning their problems during encounters
- Patient and family are often responsible for healing
- Poor prognosis should be communicated to family, not patient
- Often seek medication for a wide array of daily problems and may expect it to be dispensed in large quantities

- Social groups take precedence over individual needs
- Value harmony

Koreans

- Clients often visit clinics in groups of family or friends
- Expect a relationship of trust (mutual harmony or unity (between patient and practitioner
- May be dissatisfied with diagnoses that are not the result of laboratory tests
- Impressed by diagnostic machinery

Malaysians

- Categorize illness according to “usual” and “unusual”
- Will seek different healers for different illnesses
- Relationship with healer must be harmonious otherwise treatment will not be effective
- Will seek other healers/practitioners if treatments do not work or if relationship is not harmonious

Mien

- Family and religion are central to health beliefs
- Expect medication and injections are extremely popular, thus multidrug therapy is common
- Traditional healing is common, and many therapies are related to diet
- Believe that you must understand illness causation before you can effectively treat it

Navajos

- Silence is highly valued; signals respect and attentiveness
- Traditional Navajos prefer to be addressed by kinship titles (mother, father) rather than names
- Value handshaking
- May be offended by being rushed, interrupted, or practitioners not listening
- Have a tendency not to ask questions or confront others
- Expect to take time in their communication and establish rapport, avoid directness
- Should avoid speaking of death

Russian

- Have trouble understanding the concept of “preventive medicine” because in Russia “you don’t think about your health until after you are ill”
- Possess grand expectations for “American” medicine, to the extent that miracles can occur
- Many do not comprehend biological causes of illness because they perceive “macrosocial” causes of illness, such as “war, immigration, political difficulties, and a poor medical system”
- Appreciate physician’s personal attention and efforts to explain and answer questions

Southeast Asians

- To some, the head is sacred and should not be touched

- Similarly, because the feet are the lowliest part of the body, they should not be pointed at the patient because this is seen as an insult
- Direct gaze between people of different status is avoided
- Many adhere to politeness rules and will agree whether or not they understand, and avoid the use of “no”
- May delay seeking medical help and expect authoritarianism among physicians

Vietnamese

- Religion is central to health; believe in both “good” and “evil” spirits; obligation to family takes priority over self
- Place great importance on harmony and maintaining self control; may appear calm on the outside when actually very upset; practice ritual politeness, courtesy, and respect; especially to higher status individuals
- Touching another’s head and pointing feet toward another should be avoided; women may not shake hands but shaking hands is acceptable among men; direct eye gaze is avoided because it signals disrespect; prefer indirect communication; accept multiple causes of illness and may combine traditional and Western medicine; may be resistant to surgery and fear loss of blood
- May delay seeking medical attention; value stoicism

Suggestions for Healthcare Professionals Regarding Cross-Cultural Communication

- Pay attention to body language, facial expressions and other behavioral cues; much information may be found in what is not said
- Avoid yes/no questions; ask open ended questions or ones that give multiple choices; remember that a nod or yes may mean: “Yes, I heard” rather than “Yes, I understand” or “Yes, I agree”
- Consider that smiles and laughter may indicate discomfort or embarrassment; investigate to identify what is causing the difficulty or confusion
- Make formal introductions using titles (Mr., Mrs., Ms., Dr.) and surnames; let the individual take the lead in getting more familiar
- Greet patients with “Good Morning” or “Good Afternoon” and when possible, in their language
- If there is a language barrier, assume confusion; watch for tangible signs of understanding, such as taking out a driver’s license or social security card to get a required number
- Take your cue from the other person regarding formality, distance, and touch
- Question your assumptions about the other person’s behavior; expressions and gestures may not mean what you think; consider what a particular behavior may mean from the other person’s point of view
- Explain the reasons for all information you request or directions you give; also acknowledge any cultural differences that may present challenges or difficulties
- Use a soft, gentle tone and maintain an even temperament
- Spend time cultivating relationships by getting to know patients and coworkers and by establishing comfort before jumping into the task at hand
- Be open to including patients’ family members in discussions and meetings with patients
- Consider the best way to show respect, perhaps by addressing the “head” of the family or group first

- Use pictures and diagrams where appropriate; for example, give maps for directions or show a picture of a social security card or driver's license
- Pay attention to subtle cues that may tell you an individual's dignity has been wounded
- Recognize that differences in time consciousness may be cultural and not a sign of laziness or resistance

References

Culture and Nursing Care: A Pocket Guide. Juliene G. Lipson, Suzanne L. Dibble, Pamela A. Minarik, editors. UCSF Nursing Press, 2003.

Narayan, Mary Curry, "Cultural Assessment and Care Planning," *Home Healthcare Nurse*, Vol. 21, No. 9, pages 611-618.

2010 Required Education



Princeton HealthCare System

Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The Goals focus on problems in health care safety and how to solve them.

Identify patients correctly

Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the medicine and treatment meant for them. Make sure that the correct patient gets the correct blood type when they get a blood transfusion.

Improve staff communication

Quickly get important test results to the right staff person.

Use medicines safely

Label all medicines that are not already labeled. For example, medicines in syringes, cups and basins. Take extra care with patients who take medicines to thin their blood.

Prevent infection

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Use proven guidelines to prevent infections that are difficult to treat. Use proven guidelines to prevent infection of the blood from central lines. Use safe practices to treat the part of the body where surgery was done.

Check patient medicines

Find out what medicines each patient is taking. Make sure that it is OK for the patient to take any new medicines with their current medicines. Give a list of the patient's medicines to their next caregiver or to their regular doctor before the patient goes home. Give a list of the patient's medicines to the patient and their family before they go home. Explain the list. Some patients may get medicine in small amounts or for a short time. Make sure that it is OK for those patients to take those medicines with their current medicines.

Identify patient safety risks

Find out which patients are most likely to try to kill themselves.

2010 Required Education



Princeton HealthCare System

Behavioral HealthCare National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The Goals focus on problems in health care safety and how to solve them.

Identify clients correctly

Use at least two ways to identify clients. For example, use the client's name and date of birth. This is done to make sure that each client gets the medicine and treatment meant for them.

Prevent infection

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization.

Check client medicines

Find out what medicines each client is taking. Make sure that it is OK for the client to take any new medicines with their current medicines. Give a list of the client's medicines to their next caregiver. Give the list to the client's regular doctor before the client goes home. Give a list of the client's medicines to the client and their family before they go home. Explain the list. Some clients may get medicine in small amounts or for a short time. Make sure that it is OK for those clients to take those medicines with their current medicines.

Identify client safety risks

Find out which clients are most likely to try to kill themselves.

2010 Required Education



Princeton HealthCare System

Home Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The Goals focus on problems in health care safety and how to solve them.

- Identify patients correctly** Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the medicine and treatment meant for them.
- Prevent infection** Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization.
- Check patient medicines** Find out what medicines each patient is taking. Make sure that it is OK for the patient to take any new medicines with their current medicines. Give a list of the patient's medicines to their next caregiver. Give the list to the patient's regular doctor before the patient goes home. Give a list of the patient's medicines to the patient and their family before they go home. Explain the list. Some patients may get medicine in small amounts or for a short time. Make sure that it is OK for those patients to take those medicines with their current medicines.
- Prevent patients from** Find out which patients are most likely to fall. For example, is the patient taking any medicines that might make them weak, dizzy or sleepy? Take action to prevent falls for these patients.
- Identify patient safety risks** Find out if there are any risks for patients who are getting oxygen. For example, fires in the patient's home.

2010 Required Education



Princeton HealthCare System

Long Term Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The Goals focus on problems in health care safety and how to solve them.

- | | |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Identify residents correctly | Use at least two ways to identify residents. For example, use the resident's name and date of birth. This is done to make sure that each resident gets the medicine and treatment meant for them. |
| Use medicines safely | Take extra care with residents who take medicines to thin their blood. |
| Prevent infection | Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Use proven guidelines to prevent infection of the blood from central lines. |
| Check resident medicines | Find out what medicines each resident is taking. Make sure that it is OK for the resident to take any new medicines with their current medicines. Give a list of the resident's medicines to their next caregiver. Give the list to the resident's regular doctor before the resident goes home. Give a list of the resident's medicines to the resident and their family before they go home. Explain the list. Some residents may get medicine in small amounts or for a short time. Make sure that it is OK for those residents to take those medicines with their current medicines. |
| Prevent residents from falling | Find out which residents are most likely to fall. For example, is the resident taking any medicines that might make them weak, dizzy Or sleepy? Take action to prevent falls for these residents. |
| Prevent bed sores | Find out which residents are most likely to have bed sores. Take action to prevent bed sores in these patients. From time to time, re-check residents for bed sores. |

2010 Required Education



Princeton HealthCare System

Fall Prevention Program

A fall is defined as a sudden uncontrolled, unintentional downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions.

The UMCP Falls Prevention Program includes assessment, proactive interventions and education for patients, families and staff in an effort to prevent falls and reduce injuries.

The UMCP Falls Prevention Program is the result of multidisciplinary efforts to ensure patient safety.

Leadership sets the culture.

Nursing manages the individualized patient care of the Fall Prevention Program.

Other disciplines including Pharmacy, Engineering, Environmental Services and Rehab provide additional expertise in ensuring patient safety.

The effectiveness of Fall Prevention Program is monitored by the Performance Improvement Department.

Post patient fall management includes providing appropriated medical care and follow-up patient monitoring and notification of the following individuals: the immediate supervisor, the attending physician or designee and the patient's family member. Post fall documentation includes completing an incident report; documenting a post fall assessment in QCPR and having the manager complete a post fall assessment survey.

REMEMBER. . . .

Basic Falls Safety for All Patients

- Teach patient/family about falls risk and prevention. Provide a copy of the falls prevention brochure.
- Provide clear instructions regarding mobility restrictions, proper ambulation and transfer techniques.
- Orient patient to their environment (how to use call lights, side rails, safety bars, etc).
- Reduce environmental hazards (bed low, brakes on, 2 rails up, night light, clear walkways, non-skid slippers).
- Check food and drink needs.
- Place all patient necessities within reach.

Prevention Measures for All High Risk Patients

- Apply Star Magnet to door.
- Place a falls alert ID on patient band.
- Place patient closer to nurse's station.
- Document a fall prevention nursing care plan in QCPR
- Communicate risk of falls to all members of the healthcare team

Adapted from Patient Care Policy #: PCS-F – 1.2

2010 Required Education



Princeton HealthCare System

Caring Service

As you know, we face many tough challenges in healthcare today. Our patients and families have high expectations. In addition, **competition is fierce**. Not only do our patients and families have choice in where they go for healthcare services, but we also compete for talented staff.

Our key strategies are to be the **provider of choice** and the **employer of choice** in our service area. And the key to attaining these goals is to move our patient and employee satisfaction from good to great, where customers actually say “**Wow!**” after they have had an experience with us. How do we do this? By providing “Caring Service” throughout our system and by being “ambassadors,” whereby we spread the word about our clinical quality and safety, our expanding services, and our technology.

Interestingly enough, customers judge us on service factors, not clinical factors. Patients might not know a good x-ray from a bad one, but they do know when they are being treated well or not. In addition, research has shown that patients heal better and feel better when they are cared for and made to feel “special.” They are more likely to follow advice, take their medicine, and feel optimistic about their health.

Our patients have told us that what is important to them is communication, emotional support, sensitivity to inconvenience-- service-related factors, not clinical factors seem to be most important to patients.

It is important to remember that our patient's perceptions of their care shape our reputation. People are more likely to share a negative experience than a positive experience.

There are **key Service Points** that are particularly memorable to patients. These are times where our interactions with patient's will affect their opinion of the care and service they have received. They are:

- **Greetings**
- **Handoffs**
- **Goodbyes**

Hand-offs

Just think about how many times each day in the healthcare setting we “hand off,” or transition our patients and other customers from person to person and from service to service! We need to make these happen with tremendous care because if we don't, our patients may fall through the cracks. During every hand- off, we have the chance to assure continuity of service. We can help every customer feel safe and secure, clear about what will be happening next, and confident that they are in good hands.

The Basic WOW Hand-Off

Wowing Behaviors	Words that Wow
Make eye contact, smile, and use the person's preferred name. Make guiding gesture with hand (no need to touch the person).	"We're ready for you, Mr. Hamilton. Let me show you the way to the treatment area."
Introduce coworker by first and last name and position. Say patient's name first.	"Mr. Hamilton, I'd like you to meet Harry Parker. Harry is one of the technologists on our team."
Introduce customer by full name to coworker. Also tell preferred name.	"Harry, I'd like you to meet George Hamilton. He prefers to be called Mr. Hamilton."
Before you leave, turn to patient and smile. Build trust.	"Mr. Hamilton, you'll be in good hands with Harry!"
If patient thanks you..	"My pleasure."
Provide a warm, personal and genuine goodbye. Use the person's name. Offer a good intention.	"It was a pleasure meeting you, Mr. Hamilton, and I wish you well!"

Greetings

Keep in mind that it only takes 6 seconds to create a first impression! So, the behaviors and words we use when we greet people can make an impact on the overall customer experience. There are several key elements to a "WOW" greeting, both verbal and nonverbal.

Nonverbal Behavior

It is important that you **smile, establish and hold eye contact**. In addition, **put warmth in your voice**, and when possible, **move to the customer's level**, for example, pull up a chair to sit down next to the patient's bed. Moving to the customer's level makes the customer feel much more connected to you. They actually feel that you're taking more time with them. Doctors in the Emergency Department who sit on a stool next to their patient's receive higher ratings on satisfaction even if they take no more time with them.

Verbal Behavior/Key Words

Say Hello and welcome your customer. **State your name and position**. You may also want to add that **you are part of the team that will be caring** for the customer. **Ask and use his or her preferred name**. Then say **what you are going to do and what they can expect**.

For example: "Welcome to the Telemetry Unit, Mr. Wilson. I'm Nancy Smith, your nurse. I'm part of the team here at Princeton that will be caring for you. Do you prefer that I call you Mr. Wilson or do you prefer something different? (Call them by their preferred name immediately so you remember it, and then use it often.) First, I'm going to ask you a few questions about your health history, and then we'll be going over your doctor's orders

Verbal Behavior/Key Words

Say Hello and welcome your customer. **State your name and position**. You may also want to add that **you are part of the team that will be caring** for the customer. **Ask and use his or her preferred name**. Then say **what you are going to do and what they can expect**.

Goodbyes

Just as the greeting creates a first impression, the way in which we say “Goodbye” to the customer creates a last and *lasting* impression.

Here are some examples of “Goodbyes” to avoid:

- No goodbye at all
- “Well, I’ve gotta go pick up my kids; bye.”
- “I have other patients to take care of.”
- “I’m really busy. I can’t talk right now. Have a seat.”
- “Good luck!”

Let’s take some “tragic” or “so-so” goodbyes and turn them into “WOWS” to illustrate how to make a wonderful lasting impression.... Review the following situations for the WOW alternatives:

Situation	Tragic (or so-so) Goodbye	The WOW Alternative
Outpatient	“Stop at the front desk and give them your paperwork. Bye.”	“Thanks so much to coming to us for your care. We really appreciate your trust. I wish you well.”
Inpatient	“I’ve got to go pick up my daughter; see ya.”	“I’ll be heading home shortly. I just want to check if there is anything more I can do for you before I go? (Then), I hope you have a restful night and feel better in the morning. Pleasant dreams!”
Patient’s family member	“Don’t worry about her. She’ll be alright.”	“Thanks so much for visiting. Don’t worry tonight, because I’ll take good care of her. Good night.”
Coworker	“I’m outa here!”	“It was great working with you today. Thanks for your help.”
Telephone	“Goodbye.”	“It was a pleasure helping you. Please don’t hesitate to call me if you think of any other questions. Goodbye.”

Communication Skills

Caring Communication is the key to personalizing our service to customers. There are **Communication Skills** that we can use to improve how we communicate with our patients they are, “Quick Connecting,” “Presence,” and “Heart-to-Heart, Head-to-Head Communication.”

Quick Connecting

"Quick Connecting" is about connecting with the patient, coworker, or other customer as a "person" first, before we do any business or provide clinical care. Making a personal connection up front builds the customer's trust and confidence in us. When we are able to see the "person" behind the "patient" or "diagnosis," or the "person" behind the fellow "employee", we can more easily relate to that individual in a personal way from that moment on.

Presence

When you are fully "present" to another human being, your full attention is on them. You block out all distractions, including your external distractions (beepers, phone, etc.) and internal distractions (your mental "to-do" list, your personal worries, etc.). You are "tuned in." You are not thinking of what you are going to do next while the customer is talking.

This is not an easy skill! In the healthcare setting, a lot is going on around us. It takes will power to stay present. We have to tell ourselves to let go of what is on our minds and focus on THIS PERSON here and now.

Heart-to-Heart, Head-to-Head Communication

Whether you're handling a complaint or concern, responding to a question, or giving an explanation, there is a skill involved in addressing not just the TASK but also the PERSON. Addressing BOTH the task and the person DISTINGUISH the really good service providers from those seen as adequate.

These days, most of us have become very task-oriented. It's easy to lose touch with the PERSON behind the PATIENT. When pressed, words of empathy and connection to the patient can be overlooked.

With "Heart-to-Heart, Head-to-Head Communication", we can strengthen our interactions and reach a higher level of communication with customers. It helps us deal with both the task at hand and also the person.

"Heart-to-Heart, Head-to-Head Communication" maintains that there should be two sides to every service interaction in order to make it complete and satisfying for the customer. One side is the "Heart-to-Heart" side, which is personal or about emotions. The other side is the "Head-to-Head" side, which is about information, tasks, and plans. In many service interactions, especially since we have a lot to do, employees address only the "Head-to-Head" side, and there is no heartfelt or personal part.

So, what then is the perception of the customer when we only provide "Heart-to-Heart" communication? The customer wonders, "And what is the information?" On the other side, if we only provide the "Head-to-Head," the customer might feel satisfied with the information, but not important to you as a person.

In essence, **one side without the other is not a "WOW!"** At the very least, we have two sides to every service interaction in order to make it complete and satisfying for the customer. One side is the "Heart-to-Heart" side, which is personal or about emotions. The other side is the "Head-to-Head" side, which is about information, tasks, and plans. In many service interactions, especially since we have a lot to do, employees address only the "Head-to-Head" side, and there is no heartfelt or personal part.



"4 A's" Our Service Recovery Approach

A - ANTICIPATE

Anticipate the needs and wants of your patient/ customer

A - ACKNOWLEDGE

Acknowledge all patient and family concerns in a timely manner

A – APOLOGIZE

Apologize for the patient / families negative experience

A – AMEND

Amend the situation by taking whatever action is necessary to "make it right"

Always end your interaction with the patient / family by thanking them:

"Thank you for bringing this to our attention"

"Is there anything else that I can do for you?"

Service Recovery at PHCS is:

Responding to a situation or a problem quickly and seeking a resolution

2010 Required Education



Princeton HealthCare System

SERVICES FOR THE VISUALLY IMPAIRED PATIENT

The following information may be helpful when working with a visually impaired patient.

Patients who are visually impaired or blind often require accommodations to meet their needs. Ask a patient what his or her special needs are and what accommodations he or she requires.

As an employee of Princeton HealthCare System, please be aware of the following:

- Patients **may be** accompanied by a service animal or guide dog.
- Alternative state ID cards can be used for identification at registration in lieu of a driver's license.
- Talking books provided by the library for the blind are available at the Library of the Health Sciences for patient use during their stay.
- An escort will be provided to any patient who requests assistance in finding his or her way.
- Upon request, staff should read fully, and provide assistance in completing all registration forms and consents for treatment.
- Dietary employees will read the menu to patients and complete the patient's menu selection for the next day's meals.
- When a patient arrives in a room for treatment or admission, staff should provide an orientation to the room setup including location of call bells.
- Staff should offer patients who are blind or who have low vision assistance with their meal. They will be provided with an orientation of tray setup when the meal is served.
- A sign should be hung over the patient's bed notifying staff of the patient's visual impairment.
- When staff enters a the patient's room they should announce themselves and their purpose.
- Patients will be provided with a verbal account of procedures before a procedure is actually performed

The following policy is available on the M Drive via this pathway:

- M Drive/Patient Care Services folder/Patient Care Policies folder/General Policies and Procedure folder/"Current" folder/PCS V – 2.5 Services for the Visually Impaired Patient.

2010 Required Education



Princeton HealthCare System

Limited English Proficient Patients

Upon request or determination that a patient requires an interpreter to effectively communicate, understand, and participate in their health care decisions, interpretive services will be provided to all units of Princeton HealthCare System. The Language Line Services Identification Board can be used by staff to identify the language spoken by the patient.

Princeton HealthCare System provides access to Language Interpretation Services upon request of the patient or family member. Interpretative services may include:

- Use of Language Line Services
- Certified Bilingual staff and Volunteers from the hospital volunteer program.

Many patient information and consent forms are available in both English and Spanish. Any patient speaking a language other than English or Spanish, or when the patient information or consent form is only available in English, the patient will be provided with an oral translation of documents through one of the above mentioned services.

1. Based upon the request of the patient and/or assessment of the patient, interpretive services will be requested on the patient or families behalf. The language spoken by the patient will be documented during the registration process for that hospital visit.
2. The health care team, in collaboration with the patient, will determine whether to use Language Line Services or bilingual volunteers or staff members to provide translation services.
3. If the patient requests the use of family, or friends to provide translation services the medical record must document this request including: who translated, their relationship to the patient, that the patient requested this person provide translation and that the patient was offered and refused other translation services provided through Princeton HealthCare System. The Interpreter must be over the age of 18.
4. Interpreter services should be provided during all situations when effective communication is necessary to insure that the patient is informed regarding care and treatment. Those situations may include, but are not limited to:
 - Obtaining a history and physical
 - Explanation of diagnosis or an illness or injury
 - Obtaining informed consent or permission to treat
 - Explanation of medical procedures to be done
 - Explanation about medications
 - When giving discharge instructions

Language Line Services

Interpretive Services may be accessed from any phone at Princeton HealthCare System including Dual Handset telephones by direct dialing Language Line Services at: **800-523-1786**.

The dual handset phones, which provide direct communication efficiently in a secure fashion and in a hygienic manor, are the preferred choice. These handsets are located on all inpatient nursing units at UMCP, the Outpatient Clinic, the Emergency Department, and Patient Access Services. In addition, a Dual Handset phone is available at the Switchboard for use by all other departments. The Dual Handset phone is preprogrammed with Princeton HealthCare System accounts and a personal code identifying the location of the phone. Language Line Operators can be reached by one touch access. Further directions are located on the handsets.

When contacting Language Line Services:

1. Request that the patient point to the appropriate language on the Language Line Services identification board.
2. Provide the Language Line Services Operator with the following information:
 - Client ID number: 210023
 - Organization: Princeton HealthCare System
 - Language Needed
 - Personal Code: Department or nursing unit from which you are calling
3. Language Line Services will connect the interpreter into your line. The interpreters will identify themselves by name or ID number.
4. Identify yourself as from Princeton HealthCare System. Ask for the information you need. The Interpreter will obtain the information from the patient and relay it back to you, and vice versa. This will continue until you have all the information needed. To terminate call, say "End of Call".

Bilingual Staff

Patients needing interpretive services should first be offered the assistance of the Language Line Service, especially in circumstances involving the explanation of medical procedures or medical terminology. As an alternative, staff who are certified as interpreters may be utilized.

The following policy is available on the M Drive via this pathway:

- M Drive/Patient Care Services folder/Patient Care Policies folder/General Policies and Procedures folder/ "Current" folder/ PCS I – 1.4 Interpreter Services for Limited English Proficient Patients

2010 Required Education



Princeton HealthCare System

Subject: CONSCIENTIOUS EMPLOYEE PROTECTION ACT Policy No.: 1.14

Section: Employment

Page: 1 of 1

Date Reviewed: 03/08

1.14 – CONSCIENTIOUS EMPLOYEE PROTECTION ACT

POLICY:

To provide enforcement of the rights and privileges of the Conscientious Employee Protection Act to all employees.

PROCEDURES:

The Conscientious Employee Protection Act (CEPA) provides that:

The Princeton HealthCare System shall not take any retaliatory action against an employee because the employee does any of the following:

- a. Discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of a law, or a rule or regulation promulgated pursuant to law;
- b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation or law, or a rule or regulation promulgated pursuant to law by the employer;
or
- c. Objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes:
 1. Is in violation of a law, or a rule or regulation promulgated pursuant to law;
 2. Is fraudulent or criminal, or
 3. Is incompatible with a clear mandate of public policy concerning the public policy concerning the public health, safety or welfare.

Employees are encouraged to make such complaints in writing or can make a verbal complaint to the employer's designated representative of the alleged unlawful activity, policy or practice which the employee reasonably believes is a violation of law, rule or regulation.

PRINCETON HEALTHCARE SYSTEM

**CONSCIENTIOUS EMPLOYEE PROTECTION ACT
EMPLOYEE ACKNOWLEDGEMENT FORM**

I have been advised of Princeton HealthCare System's Conscientious Employee Protection policy 1.14 located on the M-DRIVE and I understand that it is my responsibility to read it and raise any questions regarding it with the designated contact person.

Employee's Signature

Date

Employee's Name (Printed)

PRINCETON HEALTHCARE SYSTEM

**DECLARACION DE PROTECCION
DEL EMPLEADO CONCIENZUDO**

FORMULARIO DE ACUSE DEL EMPLEADO

He recibido asesoramiento sobre la póliza de protección del empleado concienzudo de mi empleador que se encuentra localizado en M-DRIVE 1.14 y entiendo que soy responsable de leerla y hacer cualquier pregunta que tenga al respecto a la persona de contacto designada.

Firma Del Empleado

Fecha

Nombre Del Empleado (En Letras De Molde)

2010 Required Education



Princeton HealthCare System

Subject: SEXUAL (and Other) HARASSMENT
Section: Safety and Security

Policy No: 6.01
Page: 1 of 4
Reviewed: 06/08

6.01 – SEXUAL (and Other) HARASSMENT

I. POLICY PURPOSE

Princeton Healthcare System (PHCS) is opposed to all forms of unlawful discrimination, including harassment based upon sex, race, ethnicity, religion, age, disability, handicap or other unlawful harassment of one employee by another employee. PHCS emphasizes particularly that sexual harassment will not be tolerated, and, like other forms of harassment, will result in disciplinary action, up to and including unpaid suspension and discharge.

II. POLICY STATEMENT

For purposes of this policy, the term “sexual harassment” includes any unwelcome sexual attention, sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature or other offensive behavior directed against any person based upon his or her sex or sexual orientation when:

- A. Submission to or rejection of such conduct if used as the basis for employment decisions which affect the terms or conditions of employment of any individual;
- B. Such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance; or
- C. Such conduct creates an intimidating, hostile or offensive work environment.

This conduct includes, but is not limited to:

- A. Unwelcome sexual flirtations, touching, advances, jokes or propositions;
- B. Demands for sexual favors in exchange (express or implied) for favorable treatment or continued employment;
- C. Verbal abuse of a sexual nature;
- D. Graphic or suggestive comments about an individual’s dress or body or about sexual prowess or deficiencies;
- E. Sexual degrading words to describe an individual;
- F. Sexually suggestive, insulting or indecent comments or gestures; and
- G. The display in the workplace of sexually suggestive objects or pictures, including nude photographs or pictures.

Subject: SEXUAL (AND OTHER) HARASSMENT

Policy No: 6.01

Section: Safety and Security

Page: 2 of 4

Reviewed: 06/08

This policy applies to all employees. Sexual harassment is prohibited by both department managers/supervisors and co-workers. The conduct prohibited by this policy is unacceptable in any work setting, including our offices and at work-related social or athletic functions. PHCS also does not condone and prohibits harassment of our employees by individuals who are not employed by PHCS (such as vendors or contractors). In addition, while PHCS may not be able to control the actions of third parties as it would employees, PHCS will take all reasonable steps to address any employee complaint of harassment by a non-employee.

III. PROCEDURE

- A. If any employee believes that they are the victim of sexual (or other) harassment, they should report the incident immediately to his or her department manager/supervisor or Human Resources.
- B. If a manager receives a report of sexual harassment, the manager, is required to report the complaint to Human Resources.
- C. PHCS also encourages any employee who witnesses what the employee believes to be harassment to report it to their department manager/supervisor or Human Resources.
- D. Given the circumstances of the alleged harassment, it may be appropriate for the employee to report the alleged incident directly to Human Resources, rather than a department manager/supervisor. One such instance is where the alleged harasser is the person's department manager/supervisor. An individual is never required to report harassment to their department manager/supervisor.
- E. All reports of harassment will be investigated by the Human Resources department, in conjunction with the supervisor, in a confidential manner that is consistent with effective investigation. Should the allegations be credible, appropriate remedial actions will be taken against the harasser, up to and including unpaid suspension and discharge.

IV. PERFORMED BY

- A. All managers are directly responsible for maintaining and communicating this policy to their employees and ensures that each employee signs the acknowledgement form within their respective area(s) of responsibility. It is also each manager's responsibility to take those actions necessary to prevent the occurrence of sexual harassment in his or her area of responsibility.
- B. It is the responsibility of all employees to be aware of PHCS's position on conduct that may be construed to be sexual harassment and to refrain from such conduct.
- C. Each employee will be given a copy of this policy during General Orientation.

Subject: SEXUAL (AND OTHER) HARASSMENT

Policy No: 6.01

Section: Safety and Security

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Reviewed: 06/08

- D. Human Resources will be responsible for the investigation and resolution of all harassment charges.
- E. It is the responsibility of management to communicate PHCS's policy on sexual harassment to others associated with the organization, including physicians, volunteers and independent contractors.

V. NO RETALIATION

- A. PHCS also prohibits retaliation of any kind against any individual reporting a good faith complaint of harassment or for participating in a harassment investigation.
- B. Any person who retaliates against such an individual will be subject to disciplinary action, up to and including unpaid suspension and termination.
- C. Similar discipline will be enforced against individuals who have been found to have knowingly made false complaints of harassment.
- D. If you have any questions regarding PHCS's Harassment Policy, feel free to discuss those questions with your manager or Human Resources.

Acknowledgement

I, _____, hereby acknowledge that I have received Princeton Healthcare System's Harassment Policy. I have read the Policy and agree that if I have any questions about it, I will discuss with my supervisor or Human Resources. I acknowledge and agree that I will abide by the Policy and immediately report any conduct in violation of the Policy that I become aware of to my department manager/supervisor and/or Human Resources.

Print Name

Date

Signature

EACH EMPLOYEE MUST RETURN THIS ACKNOWLEDGEMENT TO THEIR DEPARTMENT MANAGER FOR FORWARDING TO THE HUMAN RESOURCES DEPARTMENT WHERE IT WILL BE RETAINED IN EACH EMPLOYEE'S PERSONNEL FILE.

2010 Required Education



Princeton HealthCare System

1.01 – SELECTION OF EMPLOYEES

POLICY

PHCS will employ individuals on a full-time, part-time and per diem basis whom in its judgment, are the best qualified. Selection will be based on:

1. Ability of prospective employees to satisfy the requirements of job descriptions and performance reviews developed for positions at PHCS.
2. Results of personal interviews.
3. Reference checks.
4. Obtaining satisfactory results of a pre-employment physical examination.
5. Obtain results of a Criminal Background Check.
6. Obtain results of Education
7. Licensure, Registration and/or Certification if a requirement of the position. Prior to start date, license, registration and/or certification of perspective employees using the Primary Source Verification system, VeCred, and/or other appropriate Primary Verification Sources will be completed.

PHCS is an Equal Opportunity Employer and will consider for employment, hire, transfer, promotion, demotion, discharge, training, and lay-off all persons without regard to their race, color, religion, national origin or ancestry, age, non-job related handicaps or disability, sex, marital status, liability for service in the Armed Forces of the United States, citizenship, or any other characteristic protected by applicable Federal or State laws.

Special Note – In all aspects of the hiring procedure, it is improper to consider or mention any of the non-job related criteria, as outlined in the above policy for selection of employees.

2010 Required Education



Princeton HealthCare System

PROCEDURE

1. Department Manager
 - completes Employee Requisition form requesting new employee
2. Human Resources Representative
 - reviews all applications and resumes
 - discusses applicants' qualifications with Department Manager and reaches agreement on whom to interview
 - interviews applicants
 - arranges for interviews with Department Manager and other personnel, as necessary
3. Department Manager
 - provides information to Human Resources Representative
 - discusses results of interviews
 - completes Hiring Manager portion Candidate Information Sheet and forwards to Human Resources
4. Human Resources Representative
 - checks references
 - makes offer of employment
 - makes arrangements for new employee to start work with a start date contingent upon:
 1. successful completion of Pre-employment physical for all employees including Physicians and Moonlighters
 2. completion of I-9 form
 3. Criminal Background Check*
 4. Education, Licensure, Registration and/or Certification Check, i.e. VeCred or other Primary Verification Sources (where applicable)
 - arranges pre-employment physical

- schedules New Employee Orientation
- gives letter to applicant confirming offer of employment on the day of the pre-employment physical.
- starts employee file including:
 - employment application
 - copy of license/registration/certification if applicable.
 - Completed references
 - Candidate information sheet
 - Clearance of Pre- Employment Physical
- notifies by letter all interviews applicants not accepted for positions

*If the applicant discloses a criminal history in the interview, and the applicant is hired, this information will be kept in the employee files along with the results of the criminal background check

2010 Required Education



Princeton HealthCare System

SUBJECT: FAMILY & MEDICAL LEAVE OF ABSENCE
SECTION: Benefits

Policy Number: 3.31
Page: 1 of 4
Reviewed: 07/09

3.31 – FAMILY & MEDICAL LEAVE OF ABSENCE **POLICY**

Under the Federal Family and Medical Leave Act (FMLA) and the New Jersey Family Leave Act (NJFLA), employees who meet certain conditions of eligibility are entitled to take a Leave of Absence for medical and/or family reasons. This policy outlines the eligibility requirements, employee entitlements and PHCS obligations. PHCS shall comply with applicable Federal and New Jersey law in delivering this entitlement to its employees.

DEFINITIONS

1. Employee: An individual who is employed on a full-time or part-time basis.
2. Spouse: A husband or wife as defined or recognized by New Jersey state law for purposes of marriage. Common law marriages, as well as other marriages prohibited by New Jersey state law, are not recognized as valid under this policy.
3. Same-Sex Domestic Partner: One partner in a civil union couple as permitted by New Jersey state law. Family leave is allowed under the NJFLA for a same-sex domestic partner.
4. Parent: Biological and individuals acting as parents
5. Son or daughter:
 - Biological child, adopted child, foster child, step-child, legal wards and other persons for whom the employee acts as parent
 - Under the age of 18 OR
 - Over the age of 18 but incapable of caring for him/herself because of physical or mental disability.
6. Covered Service Member: A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.
7. Serious health condition:
 - ♦ Illness, injury, impairment or physical or mental condition which involves
Inpatient care (overnight hospital stay)
Treatment after inpatient care
 - ♦ Continuing treatment by a health care provider because of incapacity of more than 3 calendar days
 - ♦ Care by or under the direction or referral of a health care provider resulting in a regimen of continuing treatment
8. Health care provider: Includes MD, DO, podiatrist, dentist, clinical psychologist, optometrist, dentist, clinical psychologist and other health care providers.

2010 Required Education



Princeton HealthCare System

9. Unable to perform: Means the employee is unable to work at all or unable to perform any one of the essential functions of his/her position.
10. Intermittent leave: Leave of Absence taken a day(s) or portions of a day at a time.

ELIGIBILITY

- By New Jersey state law, employees who have worked at least 1,000 hours in the preceding twelve (12) months and have been employed by PHCS for at least one (1) year are eligible to take twelve (12) weeks of family leave in a 24 month period. Beginning, July 1, 2009, New Jersey law will provide up to six (6) weeks of paid Family Leave Insurance benefits
- By Federal law, employees who have worked at least 1,250 hours in the preceding twelve (12) months and have been employed for at least one (1) year are eligible to take twelve (12) weeks of family or medical leave in a 12 month period.

MILITARY FAMILY LEAVE ENTITLEMENTS

Military Caregiver Leave

- An employee is eligible for Military Caregiver Leave in order to care for a spouse, son, daughter, parent or next of kin of a covered service member with a serious illness or injury up to a total of 26 workweeks of unpaid leave during a “single 12-month period” to care of the service member.
- A serious injury or illness is one that was incurred by a service member in the line of duty on active duty that may render the service member medically unfit to perform the duties of his or her office, grade, rank, or rating.
- The “single 12-month period” for leave to care for a covered service member begins on the first day the employee takes leave for this reason and ends 12 months later.
- An eligible employee is limited to a combined total of 26 workweeks of leave for any FMLA-qualifying reason during the “single 12-month period.” (Only 12 of the 26 weeks may be for a FMLA-qualifying reason other than to care for a covered service member.)
- Spouses employed by the same employer are limited to a combined total of 26 weeks in a “single 12-month period” if the leave is to care for a covered service member with a serious injury or illness, and for the birth and care of a newborn child, for placement of a child for adoption or foster care, or to care for a parent who has a serious health condition.

2010 Required Education



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Qualifying Exigency Leave

- An employee may take up to 12 weeks of leave for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation.

- Qualifying Exigency Leave is available to a family member of a military member in the National Guard or Reserves; it does not extend to family members of military members in the Regular Armed Forces.
- Qualifying exigencies include:
 - Issues arising from a covered military member's short notice deployment (i.e., deployment on seven or less days of notice) for a period of seven from the date of notification;
 - Military events and related activities, such as official ceremonies, programs, or events sponsored by the military or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;
 - Certain childcare and related activities arising from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on a non-routine, urgent, immediate need basis, enrolling or transferring a child in a new school or day care facility, and attending certain meetings at a school or a day care facility if they are necessary due to circumstances arising from the active duty or call to active duty of the covered military member;
 - Making or updating financial and legal arrangements to address a covered military member's absence;
 - Attending counseling provided by someone other than a health care provider for oneself, the covered military member, or the child of the covered military member, the need for which arises from the active duty or call to active duty status of the covered military member;
 - Taking up to five days of leave to spend time with a covered military member who is on short-term temporary, rest and recuperation leave during deployment;
 - Attending to certain post-deployment activities, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status, and addressing issues arising from the death of a covered military member.
 - Any other event that the employee and employer agree is a qualifying exigency.

2010 Required Education



Princeton HealthCare System

PROCEDURES

1. An employee who meets the eligibility requirements may request a Leave of Absence for family or medical reasons. If an employee is eligible for family leave, the employee's entitlement under the FMLA and NJFLA will run concurrently.
2. An employee may request a Leave of Absence for the following reasons:
 - a) **Medical reasons:** The employee's own serious health condition. This includes maternity leave. (Please also review Policy 3.03 – Sick Leave & Temporary Disability.)
 - b) **Family reasons:**
 - i) The birth of a son or daughter within twelve (12) months of the birth
 - ii) Placement of a son or daughter with the employee for adoption and in order to take care of the newly placed son or daughter within twelve (12) months of the placement
 - iii) To care of a spouse, same-sex domestic partner, son, daughter or parent with a serious health condition.
 - iv) To care for a covered service member who is recovering from a serious illness or injury sustained in the line-of-duty on active duty.
3. An employee may take a Leave of Absence on an intermittent basis for his/her own serious health condition or the serious health condition of a covered relative if such Leave is medically necessary, reasonable notice is given and the leave is scheduled in such a way not to disrupt the work of the department. Employees may take intermittent leave for birth or placement of a child only with the consent of PHCS.
4. An eligible employee must request a Leave of Absence by completing two forms: **Request for a Leave of Absence form** and a **Medical Certification form**, available in Human Resources or in the employee's department. All of the information on these forms must be completed and submitted to the employee's supervisor or department manager at least 30 days before the requested start date of the Leave. (The Medical Certification form can be submitted directly to Human Resources.) In the event that a Leave is unforeseen, the employee must give as much prior notice as possible and submit the required forms no later than fifteen (15) days after the first day of the Leave. If the employee does not submit the required forms as required, the Leave of Absence may be denied.
5. Human Resources will submit a Personal Action Form (PAF) status change form to change an employee's status. When the Leave has ended, another PAF must be submitted to end the Leave.
6. During the Leave of Absence, the employee must provide a report of their status every thirty (30) days to their supervisor/department manager and Human Resources. These reports can be provided verbally via telephone or by providing documentation from their physician. Failure to provide this certification may result in the termination of the Leave.

2010 Required Education



Princeton HealthCare System

The Joint Commission

Mission: To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.

The Joint Commission is the nation's predominant standards setting accrediting body in Healthcare. Accreditation by The Joint Commission is recognized nationwide as a symbol of quality that reflects an organizations commitment to meeting certain performance standards.

Any employee or physician who has concerns about safety or quality of care provided by Princeton HealthCare system (PHCS) should report these concerns to their Supervisor, Manager, Director, VP, HR and/or the Patient Safety Hotline at 1-877-768-7389 (1-877-PNT-SFTY). The hotline is confidential unless you would like to give your name. If the concerns cannot be resolved by PHCS, employees or physicians may contact the Joint Commission directly by calling 1-800-994-6610 or email Joint Commission at complaint@jointcommission.org

National Patient Safety Goals

The purpose of the Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety. The Goals highlight problematic areas in health care and describe evidence and expert-based solutions to these problems.

The National Patient Safety Goals (NPSG's) are derived primarily from informal recommendations made in the Joint Commission's safety newsletter, Sentinel Event Alert, recommendations from the Sentinel Event Advisory Group, sentinel events reported to the Joint Commission, and review of current patient safety literature.

The development and annual updating of the NPSG's is overseen by an expert panel of widely recognized patient safety experts, as well as nurses, physicians, pharmacists, risk managers, and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings. Each year, the Patient Safety Advisory Group (PSAG, formerly the Sentinel Event Advisory Group) works with Joint Commission staff to undertake a systematic review of the literature and available databases to identify potential new NPSG's.

2010 Required Education



Princeton HealthCare System

Electrical Safety

General Safety Precautions

1. Check all equipment and cords before using. Remove from use and report any equipment with frayed or cracked cord or a loose plug.
2. All cord-connected electrically powered appliances that are not double insulated and are used in the patient care vicinity shall be provided with a three-wire power cord and a three-pin grounding-type plug.
3. DO NOT USE any extension cord without specific approval from Engineering. Extension cords may be used only on a temporary basis in an emergency and need to be checked for size and application.
4. Power strips which contain an internal breaker are not extension cords and may safely be used.
5. When unplugging an electrical cord, never pull on the cord itself, grasp the plug firmly and disconnect. Do not touch the metal prongs.
6. Avoid touching any equipment or surfaces which may carry electricity when touching a patient with the other hand. Example: turning on a light or TV while checking a patient's pulse.
7. Avoid shocks. Never touch any equipment or electrical cords with wet hands. DO NOT use any electrical equipment which has been exposed to a liquid spill.
8. Red outlets indicate emergency power is available when normal power is not.

Notify Engineering

1. Any Electrical problems requiring immediate attention must be reported to Engineering by calling the:

**Operations Support Center at x6293
Any time Day or Night**

2. Report the following by calling the Operations Support Center;
 - Evidence of overheating – smell or touch
 - Frayed or worn wires or cords
 - Damaged plug
 - Loose or malfunctioning switch
 - Loose or malfunctioning controls
 - Any manner of shock
 - Any evidence of malfunction
 - Non-hospital owned appliances or equipment that does not have an Engineering inspection sticker
 - Any improper or unsafe use of extension cord or electrical equipment.

2010 Required Education



Princeton HealthCare System

Fire Safety

Person Discovering a Fire

- R Rescue patients in immediate danger
 - A Alarm – pull alarm to report the fire
 - C Confine the fire – close all doors and windows to reduce the spread of smoke and fire
 - E Extinguish – react smoothly and quickly by using the closest proper fire extinguisher
- OR
- Evacuate – remove all persons to adjacent fire compartments

General Information

When an alarm is active and sounded the following will happen:

1. Strobes will flash and bells or horns will sound (at Merwick they will sound a pattern “code” giving the location of the fire).
2. Elevators, located in the area of the fire only will return to the ground floor and doors will open.
3. Operator will announce “Code Red” – followed by the location over the public address system.
4. A response team, consisting of the Hospital Fire Marshall and employees from Engineering and Security, will respond to the unit, evaluate and handle the situation.
5. Termination of the Emergency will be announced by the operator over the public address system by the term “Code Red All Clear.”

How to Use a Fire Extinguisher

- P Pull the pin (seal will be broken)
- A Aim the extinguisher nozzle at the base of the fire
- S Squeeze the operating lever and handle together
- S Sweep the nozzle back and forth at the base of the fire

Types of Extinguishers and Fires

- A Water: For ordinary combustible fires, paper, wood, cloth
- B Foam: For flammable liquids, alcohol, acetone
- C Carbon Dioxide: For electrical circuits or equipment
- BC Dry Chemical: For flammable liquids and electrical equipment
- ABC Multi-Purpose Dry Chemical: For combustible, flammable, liquid and electrical equipment.
- Halon For computer fires
- K Wet Chemical: For kitchen and grease fires

Responsibilities of Unit Personnel IF an Alarm Has Sounded

In Your Area

1. Prior to any alarms, read and understand your departmental plan. Locate and remember pull stations, fire extinguishers, and oxygen shut-off valves within the department.
2. Follow “RACE” (printed on the back of your ID badge).
3. Evacuation – if required by “RACE” evacuate patients Horizontally to another fire compartment and away from the fire and then, if necessary, vertically downward. (Note: patients not in immediate danger should not be moved without approval from the person in charge).
4. Disconnect Oxygen and/or shut Oxygen shut-off valves, **only with approval of the Nurse in Charge!**

Outside Your Area

1. Prior to any alarms, read and understand your departmental plan. Locate and remember pull stations, fire extinguishers, and oxygen shut-off valves within the department.
2. Follow “RACE” (printed on the back of your ID badge).

2010 Required Education

HAZCOM- Hazard Communication

“The Right to Know”



Princeton HealthCare System

The Hazard Communication Program is in place to ensure that employees are aware of all hazardous materials, drugs, and chemicals that are in the workplace environment under normal conditions.

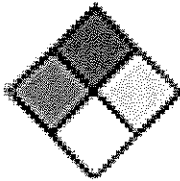
Chemical Hazards- there are 2 kinds of hazards

1. **Physical** – a sudden violent reaction, such as, an explosion or fire
 - a. Flammable
 - b. Explosive
 - c. Reactive
2. **Health** – the ability of a chemical to affect your health either quickly or over a long period of time
 - a. Acute- occurs quickly and harms your body after a single exposure
 - i. Acute effects include: burning, irritation, and immediate damage to your internal organs
 - b. Chronic- occurs over time, usually through repeated low exposures over a long period of time.
 - i. Chronic effects include: liver disease, cancer
 - c. Types of Health Hazards
 - i. Carcinogen- a substance that may cause cancer
 - ii. Corrosive- a substance that destroys or changes your tissues on contact
 - iii. Highly Toxic- A substance that can kill you quickly
 - iv. Toxic- similar to highly toxic, but it takes a larger exposure to kill you
 - v. Irritant- a substance that harms your skin at the site of contact
 - vi. Sensitizer- a substance that causes an allergic reaction that can get worse with each exposure
 - vii. Target Organ- a substance that damages a specific body organ or system.

Labels -All containers must be labeled at PHCS

2 Common types of Labels:

HEALTH	<input type="checkbox"/>
FLAMMABILITY	<input type="checkbox"/>
REACTIVITY	<input type="checkbox"/>
PERSONAL PROTECTION	<input type="checkbox"/>



Exposure Time – exposure limits are set by the government and scientific groups and measure how much of a substance you can work around without being overexposed.

- 1) **PEL-** Permissible Exposure Limit
 - a. The limit that you may not exceed when averaged over an 8-hour work day
- 2) **TLV-** Threshold Limit Value
 - a. Another name for the amount that you may not exceed when averaged over an 8-hour work day.

Controlling Exposure

PHCS tries to keep exposure below the PELs and TLVs through engineering controls, such as, Lab hoods. But for some chemicals and job tasks you may also have to wear Personal Protection Equipment (PPE).

1. Types of PPE includes:
 - a. Gloves
 - b. Safety shoes/boots
 - c. N-95 respirator

Material Safety Data Sheets (MSDS) - located in books in each area or on Citrix. Each MSDS provides information on:

- Physical characteristics- smell, color, appearance, flash point, and vapor pressure
- Physical hazard-explosion, fire, violent reaction
- Health hazard- how a chemical can harm your health, including the signs and symptoms
- Route of entry- inhalation, ingestion, and dermal
- Safe Handling and Use-precautions and protective measures needed when using the substance or cleaning up spills
- Control measures-list of suggested engineering controls, work practices, and PPE
- Exposure limits-the amount of exposure that is considered safe
- Emergency and first aid procedures-the proper methods for dealing with fire, spill or leak and what do if you are exposed

In case of a hazardous chemical spill:

Barricade the area.

Wear appropriate PPE to avoid exposure.

Call Environmental Services for cleanup.

Identify the material spilled and size of spill.

Find the MSDS.

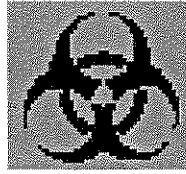
Complete Accident Report Form if injured, and report to Occupational Health during day shift or to the Emergency Department after hours.

Complete Hospital Incident Report Form and submit to Environmental Services.

Reference: (M: Drive)

See Administrative Standards Policies: AS H-1.1, AS H-1.2, AS H-1.3, AS H-1.7

ITEMS TO GO IN RED REGULATED MEDICAL WASTE CAN



Biohazard INFECTIOUS WASTE

(Must be saturated/caked with body fluid)
SATURATED items drip if lightly
squeezed.

BODY FLUID: blood amniotic cerebrospinal
peritoneal pleural pericardial
semen synovial vaginal

IF visible blood: tubing urine feces
sputum vomit

NOT: Wrap Package Glove
Exam Table Paper

Unsaturated: Dressing Pad Drape
Bedpan Urinal Basin
Foley IV Bag Tube
Diaper

The above applies to Isolation as well. 1

2010 Required Education



Princeton HealthCare System

BIOMEDICAL EQUIPMENT

Princeton HealthCare System uses a yellow inspection sticker to indicate when Biomedical Engineering has last inspected the device. Since not all devices require routine inspections the "Inspection Due" area might give other information about the device such as "Rental", "Loaner", "Demo", or "Check Once" if the device does not require routine inspections. Since devices are sometimes dropped or banged into door jams it is important to visually inspect a device for damage before using it to treat a patient.

If you suspect a device is not working properly an orange "Defective" tag should be attached to the device to ensure no one else tries to use it. Since some problems can be subtle (Example: Infusion Pump missing the drug library) it is important to provide a brief description of the problem on the orange defective tag. This will assure the problem is addressed and avoid unnecessary re-processing.

The yellow inspection tag has a field labeled "Inspection Due". If the month and year that appear on this line are in the past the device is overdue and should be reported to Biomedical Engineering.

2010 Required Education



Princeton HealthCare System

Security Department

Violence in the Workplace Fact Sheet

Stop Workplace Violence Before It Starts

When you hear the words "disgruntled employee," you may recall newspaper headlines describing the aftermath of violence in a factory, post office or local business, or even recall something that has happened in your own workplace.

The fact that the workplace is no longer a "safe haven" is hard for most of us to accept. Have you or do you know someone in your organization who has seen someone intimidate another employee with threats? Slash tires of cars in the parking lot? Send threatening letters to a person in the organization? Not all workplace violence is comprised of punches, guns, knives or bombs. Some "violence" may take a while to come to light, such as sabotage of files, computers or other office equipment. This article concentrates on physical violence.

Causes of Violence at Work

Many things may contribute to a person's becoming violent at work -- being suspended or fired, rejected romantic advances, perceived mistreatment on the job, mounting bills, job pressure, a grievance of some sort, personality conflicts with a person or people at work, even personal problems such as a divorce or death.

Warning Signs

Potentially violent employees may change their usual behavior, display anxiety, irritability or depression, withdraw or even make comments about suicide when they have been patient, talkative and more social before. They may make unwanted sexual advances toward another employee. They may be incapable of accepting criticism and hold a grudge over a disciplinary act; promotion or other perk they feel should have gone to them. They may intimidate fellow employees or make threats. They may exhibit paranoia and think management or another employee is "out to get" them. They may start talking about problems, physical complaints or difficulty sleeping. They may test the limits of rules and regulations. Most important, and most common, they blame others for their problems.

Examples of workplace violence also include shouting, throwing objects, verbal threats, physical altercations, damaging property, or bringing a weapon to the workplace.

All personnel need to be aware and learn to recognize relevant behavioral changes. Protecting confidentiality of reports and early intervention are the keys to handling potential problems.

Prevention

A very important rule of thumb for management to remember when disciplining employees is the Golden Rule, "Treat your employees as you would like to be treated." This applies to any form of discipline, layoff or termination. Don't give employees the idea that they are a dime a dozen or deal with a problem employee from a parent/child stance instead of an adult/adult one. Never discipline the problem employee in front of others. Don't humiliate them or strip them of their

dignity.

Sensitivity training can be helpful in firing employees. In many cases, employees are terminated after their small performance problems are ignored. Supervisory inaction, therefore, allows poor performance or inappropriate behavior to become potentially serious. Often, in the case of employee misbehavior, the original problem was caused by poor supervision. The best antidote for workplace violence is good management.

Some internal controls that can help assure a safe working environment are:

- Perform random drug screens.
- Encourage employees, especially females, to advise management if they are experiencing violence at home.
- Deny former employees access into company facilities unless specifically authorized by management.
- Provide employees experiencing problems with sources of help.
- Institute a "zero tolerance" policy.



CODE TRIAGE

The Emergency Management Plan for Princeton Healthcare System describes how the institution establishes and maintains a program to ensure effective response to disasters or emergencies affecting the environment of care. This plan addresses four phases of emergency management activities:

1. Mitigation
2. Preparedness
3. Response
4. Recovery

A Disaster is a natural or man-made event that significantly disrupts the environment of care, such as damage to the buildings and grounds due to a severe weather incident. It may also encompass an event that disrupts care and treatment of patients such as a loss of utilities, civil disturbances, accidents, or other emergencies within PHCS or the surrounding communities.

In a time of crisis or disaster PHCS will be prepared to meet the following objectives:

1. Alleviate suffering and loss of life through emergency care of casualties
2. Utilize in the fullest capacity existing facilities of PHCS so that it may accommodate an unusual patient load during a disaster situation
3. Mobilize personnel and specific hospital departments necessary to cope with a disaster
4. Ensure a set period of predictable behavior by the majority of the staff directly following an emergency situation
5. Provide specific guidelines for staff in the event of an emergency
6. Conform to all appropriate federal, state, municipal laws, and accrediting agency regulations on the safety and care of patients and employees during a disaster situation
7. Create an inventory of resources that may be needed in an emergency
8. Maintain an ongoing planning process
9. Educate staff
10. Implement organization-wide drills

2010 Required Education



Princeton HealthCare System

Emergency Management – Incident Command Center:

What You Need to Know

1. The Command Center, located in Ground Floor Conference Room B, is part of our overall Emergency Operations Plans for Princeton HealthCare Systems. The establishment of a Command Center is a requirement of the National Incident Management System (NIMS) and our participation in NIMS is necessary for many reasons including compliance with Joint Commission standards and eligibility for NJDHSS Grants.
2. The Command Center is a central location for the healthcare system where we can collect information on an incident and make decisions based on that information. It allows us to put all the necessary individuals in one location where we can pull resources together and coordinate activities across departments and across off-site service locations.
3. Those that staff the Command Center are typically given specific titles and duties to perform. These titles and duties correspond with all other agencies and organizations that are using NIMS based systems which allow us to better coordinate efforts throughout the region and throughout the state.
4. Common terminology is essential in the Incident Command structure as all other agencies and organization that we may deal with do not use our specific codes or jargon. Common terminology helps to ensure that we are all speaking the same "language" during an incident.
5. The Command Center can be open for any incident or emergency including Code Triage (activation of the emergency operations plan), Code Purple (surge conditions), severe weather, power outages, IT failures, communication failures, or any situation that requires additional resources and organization to quickly return to a normal operations status.
6. A Code Triage and the activation of the Command Center can only be authorized by the Nursing Supervisor, the Administrator on Duty/Call, the Emergency Management Coordinator, or the Emergency Department Physician. The operator will announce overhead "Code Triage".
7. The Security Department and/or the Engineering Department are responsible for setting up the Command Center. This takes approximately 15 minutes.
8. Upon activation of a Code Triage, only VPs, Department Directors, and Nurse Managers will report to the Command Center. Staff should remain on their posts and await further instruction from a manager or director. At no time should staff report to the Command Center or Emergency Department unless directed to do so.
9. Staff will be kept updated on emergency situations by phone, radio, scheduled meetings, or any available means during the incident.
10. When the situation is resolved and normal operation can resume, an announcement of "Code Triage – All Clear" will be made by the operator.

2010 Required Education



Princeton HealthCare System

EMERGENCY INFORMATION LOCATED ON YOUR PHCS ID BADGE

In case of a security emergency, dial ext. 4444

The security non-emergency page number at UMCP is #801

Extinguisher Use:

- P – Pull Pin
- A – Aim
- S – Squeeze
- S – Sweep

In case of fire:

- R – Rescue
- A – Alarm
- C – Confine
- E – Extinguish/Evacuate

The New Jersey Healthcare Emergency Codes are:

- Code Red – Fire
- Code Blue – Adult Medical Emergency
- Code White – Pediatric Medical Emergency
- Code Amber – Infant/Child Abduction
- Code Yellow – Bomb Threat
- Code Gray – Security Emergency/Patient Elopement
- Code Silver – Hostage Situation
- Code Orange – Hazmat Situation
- Code Triage – Disaster Situation
- Code Clear – the situation has been cleared

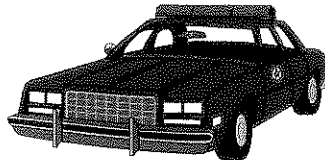
Should you need a NJ Healthcare Emergency Code card, please call the Department of Education at ext. 4460.

2010 Required Education



Princeton HealthCare System

Princeton HealthCare System Security Department



Bomb Threat Fact Sheet

- **Bomb Threat Procedure**

Upon receiving a threatening phone call alleging the presence of an explosive device in the hospital, the switchboard operator should attempt to keep the caller on the line for as long as possible in order to gain as much information about the caller as possible.

Immediately after ending the call, the operator will do the following:

- A. Notify the nursing supervisor on call.
- B. Notify the administrator on call to contact the police.
- C. Notify the Security Department
- D. Notify ER physician, attending physician and residents, and surgical services so that they may begin evaluating patients for possible transfers.

- **What if I receive a bomb threat?**

If anyone other than the switchboard operator receives a threatening call, they should try to obtain as much information about the caller and the background that the call is coming from. Try to remember the following:

1. Is the caller male or female?
2. Can you approximate an age, race, or ethnicity based on their voice?
3. What does the background sound like (i.e. inside, outside, factory, hospital, or residence)?
4. What does the connection sound like (i.e. payphone, cell phone, speakerphone, static, etc)?
5. What state of mind did the caller sound to be in (i.e. laughing, yelling, crying, whispering, serious, etc)?

This information should be immediately relayed to the Nursing Supervisor or Administrator on call. Remember consider any threat that you receive as legitimate and report it immediately.

- **What if I find a suspicious package?**

If, during the course of a bomb threat, a suspicious package or device is discovered, remember the following guidelines:

1. The item should not be moved or touched in any way.
2. Secure the area surrounding the device and do not permit anyone to approach it.
3. Contact the Nursing Supervisor and/or Administrator and advise them of the situation.
4. Assume nothing. Consider any unusual package or item to be a threat until it is proven otherwise.
5. Remember the Color Code for a bomb threat is "Code Yellow".

Think Safety First

Remember to always report any suspicious activity to the Nursing Supervisor or Administrator on call.

- **What to do if you receive a bomb threat**

1. Stay calm and do not panic. Do not hang up the phone. Try to get as much information as possible.

2. Do not hang up the phone.

3. Do not touch or move anything that looks suspicious.

2010 Required Education



Princeton HealthCare System

Princeton HealthCare System Security Department Infant/Child Abduction Fact Sheet

Who is an Infant/Child Abductor

Statistically, an abductor may meet the following criteria:

1. Is usually an overweight female, age 14 - 44.
2. Has planned the abduction but not selected a specific infant. Whenever possible, an abductor will target a child of similar race.
3. Typically acts alone, but the possibility of accomplices should never be ruled out.
4. May have a history of miscarriages or infertility.
5. May have previously faked being pregnant, or be presenting herself as pregnant.
6. May seem emotionally immature, suffer from low self esteem, or have a history of depression.
7. Is usually married or in a relationship that is troubled and sees the presence of a child as a means of saving the relationship.
8. Is familiar with layout of hospital and hospital employees. The abductor may be frequently seen at the facility before committing an abduction. Often, abductors disguise themselves as employees.

From a security perspective, an abductor has no age, sex, race, or background. Never dismiss someone acting suspicious because they do not meet the "typical" abductor profile. It can be anyone, anywhere, at any time. Recognizing suspicious behavior, and the characteristics of the typical abductor is the first step to protecting children.

What is Suspicious Behavior

Suspicious behavior must be taken on a case by case basis. However, there are some warning signs that are universal to infant abductions that should be noted.

1. Look for someone making repeated visits to areas that have infants. Phrases like "I just wanted to see them"; or "I couldn't keep myself away" may be used to hide an abductors true intentions.
2. Watch for anyone that asks questions regarding facility/security procedures or floor layout. An abductor will be interested in security measures, shift times, procedures for moving children, the location of stairwells, elevators, or locations that are not normally monitored.
3. Take note of someone with large or bulky items such as heavy coats (especially if the weather does not require one), duffel bags, boxes, items wrapped in a blanket or towel, or an item that seems to be heavier for the person to carry than it should be. These are all possible transportation devices for abducted children.
4. Someone dressed in hospital scrubs that does not have proper ID.

What to do if an Abduction Occurs

If you suspect an abduction has occurred, or receive word of an abduction report it to your supervisor immediately. The switchboard operator will be notified so that administration, security, and local law enforcement can begin to take action and form a response team. All exits leading out of your department and out of the facility from your department should have an employee stationed at them. The primary responsibility of employees watching these exits is to

notify security and law enforcement of anyone seen with the infant or of anyone acting in a suspicious manner. At no time should an employee act alone in confronting an abductor or possible abductor; this could put the employee or the child at risk. Instead, keep the subject in sight and notify members of the response team of your location and the direction of the suspect.

Remember; the Color Code for infant/child abduction is "Code Amber".

Knowledge and use of these preventive measures can help save a child and family from becoming victims of abduction.

Information for this Fact Sheet was obtained from the National Center for Missing and Exploited Children

2010 Required Education



Princeton HealthCare System

Occupational Medicine Services

Formerly Employee Health Services

Hours of Operation:

Monday – Friday 7:30 AM- 4:30 PM

609- 430-7121/430-7122

Worker's Compensation

- For your protection, the Princeton Health Care System carries Worker's Compensation Insurance on all employees.
- If you are injured while at work, report your injury, no matter how minor, to your Manager immediately.
- **If your injury is not reported immediately, you may not be eligible to collect benefits under the Worker's Compensation Insurance coverage.**

After Reporting your Injury to your Manager:

- Fill out an Accident Report and Treatment Form (ART)
- Report to Occupational Medicine Services

If you have a sharp injury or body fluid exposure

- Report this immediately to your manager
- Fill out the Sharp Injury, Blood/Body Fluid Exposure form along with the ART form
- Report immediately to Occupational Medicine Services

If the Occupational Medicine Services is closed

- You must go PHCS Emergency Department and call Occupational Medicine Services on the next business day.
- In all Workers' Compensation cases, you are required to see the physician in Occupational Medicine Services and may not treat with your own physician.

Modified Duty Program

- If you are placed on modified duty, so that you cannot perform your regular duty job, an Employee Modified Duty Program is in place to provide **temporary** work during this time.
- You are required to accept the modified duty position and perform it acceptably as a condition of continued employment.
- If you experience any difficulties while working in the modified duty position contact Occupational Medicine Services for re-evaluation.
- Participation in the Modified duty program does not exceed 12 weeks

Prevention of Bloodborne Pathogen Exposure

Princeton HealthCare System
Occupational Medicine Services
(609) 430-7121 & (609) 430-7122

Program Objectives

- Identify Potential Causes and Risks of Bloodborne Pathogen Exposure.
- Identify Methods of Prevention
- Identify Methods of Compliance
- Identify Appropriate Post Exposure Treatment and Follow- Up


Who is OSHA?

OSHA is the Occupational Safety and Health Administration that was created by the Department of Labor OSH Act of 1970.

OSHA's Bloodborne Pathogen Standard prescribes safeguards to protect workers against the health hazards from exposure to blood and other potentially infectious materials and to reduce their risk from this exposure.


Who Does the OSHA Standard Cover?

- The Standard covers all employees who could reasonably anticipate to face contact with blood or other potentially infectious materials.
- Those at risk: EMTs, First responders, Firefighters, Law enforcement personnel, Healthcare personnel, Waste Management workers, Morticians, and Good Samaritans.



Background

- OSHA estimates that 5.6 million workers in healthcare and other workplaces are at risk for Exposures to Blood borne Pathogens
- If precautions for safety are taken for exposure related events in the workplace, the chances of an exposure occurring are significantly reduced.



OSHA Requires Training

- Modes of Transmission
- Symptoms
- Epidemiology
- Warning signals indicating exposure
- Procedures to follow if exposure occurs
- Work practices to reduce exposure
- Use of personal protective equipment (PPE)
- Information on biohazard labeling

Modes of Transmission

- ❑ A pathogen is a disease producing organism that enters the body (germ)
- ❑ Most infectious diseases are caused by one of 6 pathogens- usually bacteria or virus
- ❑ The immune system relies on skin to limit the amount of pathogens that enter the body

How Do Exposures Occur?

- ❑ Needle sticks
- ❑ Cuts from other contaminated sharps. (scalpels, suture needles, razors, etc.)
- ❑ Contact of mucous membranes (eye, nose, and mouth).
- ❑ Contact of broken, cut or abraded skin with blood or other potentially infectious materials.

Hepatitis B

- ❑ According to the CDC, Hepatitis B carries the largest risk to a susceptible individual after exposure to infected blood.
- ❑ The risk ranges from 6-30% depending on the hepatitis B e antigen status of the source individual (CDC, 2003).
- ❑ Hepatitis B can cause chronic infection including cirrhosis of the liver, liver cancer, liver failure and death (CDC, 2003).
- ❑ Hepatitis B can live in a dry environment for at least 7 days. Once the virus is dead – it is dead.

Hepatitis C

- ❑ Hepatitis C is transmitted primarily through exposure to blood and blood products.
- ❑ Hepatitis C affects approximately 4 million Americans.
- ❑ Hepatitis C is the most common cause of chronic hepatitis, cirrhosis, and hepatocellular cancer in the world (Porth, 2005).

Hepatitis Signs and Symptoms

- ❑ Flu-like symptoms
- ❑ Fatigue
- ❑ Abdominal pain with nausea/vomiting
- ❑ Loss of appetite
- ❑ Jaundice
- ❑ Liver ailments- cancer, cirrhosis

HIV/AIDS

- ❑ Acquired immunodeficiency disease (AIDS) can occur from exposure to blood or body fluid of someone infected with Human Immunodeficiency Virus (HIV).
- ❑ 25 million people worldwide affected (CDC)
- ❑ HIV disease is associated with immunosuppression, opportunistic infections, malignancies, wasting, and central nervous system degeneration (Porth, 2005).

HIV/AIDS Symptoms

- Fever
- Night sweats
- Weight loss
- Diarrhea
- Severe fatigue
- Shortness of breath
- Lesions

Healthcare Personnel with Documented and Possible Occupationally Acquired HIV Infection, by Occupation, as of December 2002

Occupation	Documented	Possible
Nurse	24	35
Laboratory Worker (clinical & non-clinical)	19	17
Physician (non-surgical)	6	12
Housekeeper/maintenance worker	2	13
Surgical Technician	2	2
Embalmer/morgue technician	1	2
Health aide/attendant	1	15
Respiratory Therapist	1	2
Dialysis Technician	1	3
Dental Worker, including dentist	-	6
Emergency medical technician/paramedic	-	12
Physician, surgeon	-	6
Other technician therapist	-	9
Other healthcare occupation	-	5
Total	57	139 (CDC,2003)

Methods of Prevention

- Exposure Control Plan
- Engineering Controls
- Work Practice Controls
- Personal Protective Equipment
- Housekeeping
- Labeling
- Hepatitis B Vaccination

Exposure Control Plan

- Requires employers to identify in writing tasks and procedures as well as job classifications where occupational exposure to blood occurs
- Must set a schedule of implementation
- Plan must be accessible to employees and to OSHA

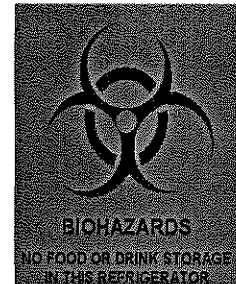
What are Engineering Controls

- Engineering controls reduce the employees exposure by removing the hazard or isolating the worker.
- Examples: sharp disposal containers, needle less systems, and other sharp safeties



What are Work Practice Controls

- Work Practice Controls reduce the likelihood of an exposure by altering how a task is performed.
- Examples:** No recapping contaminated needles, Do not bend or break sharps, wash hands before and after glove removal, no food or drinks in work areas where blood or infectious materials are present.



Methods of Compliance

- Mandates Universal Precautions
- Treat all exposures as if Bloodborne
- Emphasize engineering controls
- Work place controls
- Specifies methods of Sharp use and disposal- Safety needles
- Procedures for hand washing
- Regulates waste and handling of contaminated linen
- Labeling of Infectious or Contaminated Items- Red Bags and Biohazard labeling

Hazard Communication

- Warning Labels
- Red Bags
- Disposal Containers
- Restricted Areas



Personal Protective Equipment

- Always Wear PPE
- PPE's provide a barrier between the worker and potentially infectious materials
- Gloves, Masks, Gowns, Eye Protection, Face Shields, Mouthpieces and resuscitation devices

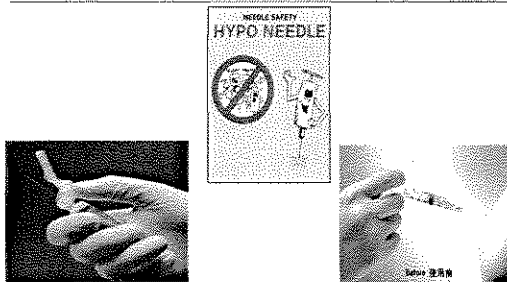


Handwashing

- Handwashing is the preferred method of infection control
- Handwashing facilities should be accessible to employees
- Wash with soap and water
- Wash before and after glove removal
- Waterless antiseptic



Sharp Safety



What to do if Exposure Occurs

- Immediately wash affected area with soap and water
- Flush splashes to nose, mouth or skin with water
- Irrigate eyes with water or saline
- Immediate medical evaluation, treatment and follow-up
- Medical laboratory tests, and confidential reporting
- Post exposure prophylactics (time sensitive)
- Counseling
- Evaluation report from treating physician within 15 days of completed medical provider assessment.
- All treatment provided at no cost to the employee

OSHA's Training Requirements

- Bloodborne Pathogen Training should be provided to employees at time of initial assignment to a job with occupational exposure and at least annually thereafter.
- Training records should be maintained for 3 years.

If you have any questions please call
Occupational Medicine Services
609-430-7121 or 609-430-7122
Hours of Operation
Monday- Friday 7:30am-4:30pm

2010 Required Education



Princeton HealthCare System

Body Mechanics & Injury Prevention

Cumulative Trauma

- Cumulative micro-trauma can lead to macro-trauma. Getting hurt a little bit at a time can eventually lead to a larger injury.
- Many injuries occur from repetitive stress rather than a single occurrence.

Protecting Your Back

Lifting Objects

- Bend your knees.
- Keep the object close to your body.
- Don't twist your body, move your feet.
- If you have to do a task while bending forward, then afterwards, bend backwards.
- Know your limits and if the object/person is too heavy to lift by yourself, then get help or use mechanical devices.

Protecting Your Shoulders

- Avoid repetitive lifting overhead
- Avoid sustained holding your arms overhead
- Use a step stand to put or get items from a high shelf.
- Know your limits and if the object/person is too heavy to lift by yourself, then get help or use mechanical devices.

Protecting Your Knees

- Avoid sustained squatting, especially with your toes in front of your knees.
- Avoid twisting, pick up your feet and turn your whole body when moving items.
- If you must kneel, use knee pads.
- Using gel inserts in shoes can help to absorb some of the impact of being on your feet all day.

Protecting your Hands/Wrists and Neck

- When typing have your elbows even with the keyboard.
- The first line of print on the monitor should be even with your eyes.
- Your feet should be in contact with the floor. If they are not, then you need a footrest.
- Take a 1-3 minute break every 20-30 minutes to move your hands, fingers, neck, shoulders and back. Also look into the distance to refocus your eyes.

Prevent Injuries

- Stay flexible. When you do stretches, hold the stretch for 30 seconds and repeat 2-3 times daily.
- Do exercises to maintain the strength of the body especially your trunk muscles.
- Do exercises to keep the endurance of the muscles high such as bicycling, walking, or swimming.

What to Do if You are Injured

- Report the injury to your supervisor and fill out an Accident Reporting and Treatment Form.
- Go to Occupational Medicine Services.
- If after hours, go to the Emergency Room and then to Occupational Medicine Services the following day.
- Don't delay in treating injuries. It is easier to treat an acute rather than a chronic problem.

2010 Required Education



Princeton HealthCare System

Safe Patient Handling

Why do we have a Safe Patient Handling Program?

Injuries related to patient handling occur frequently among healthcare workers. Nationally, we have the highest work related musculoskeletal disorders resulting in an average of 6 days away from work which is much higher than even construction workers. Also this can be a career threatening injury with 12% of nurses leaving their profession due to back injuries and 52 % of nurses complaining of chronic back pain. Safe Patient Handling is a program brought to the Medical Center to promote safe practices and reduce injuries from lifting and moving of patients.

Why do health care workers get musculoskeletal injuries?

We perform tasks such as transferring patients, lifting patients, repositioning in bed, bathing in bed, dressing in bed and tasks that require long period of bending and stooping. Inpatient units have a high proportion of patients who are dependent, requiring full assistance, for activities of daily living. So the activities that lead to injury are frequent, unpredictable and assistance can be limited. Patients can be asymmetrical and often weigh more than 50 lbs which is the maximum weight recommended for safe lifting.

How will we be able to perform patient positioning and transferring with out injuries?

Direct patient care staff will assess patient mobility and plan handling tasks prior to patient handling to determine the safest way to accomplish them. In the past two decades, strategies to reduce back injuries have focused on body mechanics education, and training in lifting techniques. These have been largely unsuccessful and injury trends are on the rise. Currently the strategies recommended are use of mechanical lifting equipment and or other approved patient handling aids to be used to prevent the unsafe lifting and handling except when absolutely necessary such as in a medical emergency.

What will we do next?

In the next few weeks equipment will be brought in for staff to trial and based upon the response we will select several devices that will be maintained on the floors for staff to use when there are difficult and unsafe patient handling tasks. Direct patient care staff will be trained on the selected equipment. A policy with an algorithm will also be developed to assist all in the correct techniques and strategies to use when faced with a difficult handling task.

2010 Required Education



Princeton HealthCare System

*When You Don't Know What to Do Next...
We Can Help*

Employee Assistance Program
1000 Herrontown Road
Clock Building
Princeton, NJ 08540



EAP

Completely confidential
Voluntary
Personal

Available to all PHCS employees & their household members *at no charge*
Professional help from qualified, licensed clinicians

EAP Services Include:

Short-term Counseling
Legal Consultations
Resource and Referral Information
24/7/365 Crisis Services
Quarterly Workingwell Newsletter
Supervisor/Manager Consultations
Trauma Response/Critical Incidents

Employee Assistance Program
1.800.527.0035

2010 Required Education



Princeton HealthCare System

All staff should understand the difference between religious and spiritual concerns:

Religious Beliefs: An individual's commitment to a particular system of beliefs, values, rules of conduct, and rituals.

Examples:

Jewish Beliefs regarding Dietary Laws: "Kashrut": not only are pork and shellfish forbidden, so is the mixing of milk and meat

Muslims: pray five times a day: dawn, noontime, afternoon, sunset, night; and must be facing east toward Mecca when doing so

Jehovah's Witnesses believe to transfuse blood is to break God's law and therefore it is forbidden.

It is important for a Roman Catholic patient to receive the Sacrament of the Anointing of the Sick (formerly known as Last Rites or Extreme Unction). It is administered to bring spiritual and even physical strength during an illness, especially near the time of death.

Areas that may have religious significance: diet; hygiene practices; time constraints; days of rest; attire; prayer attitude and rituals; gender of caregiver

Spirituality: The dynamic process in which a person establishes an awareness of the meaning, purpose and values in life usually in relationship to a Higher Power.

Spiritual Distress: An individual experiences a disturbance of a value system that provides strength, hope, and meaning to life.

Spiritual care: Allowing the individual to explore the need for meaning, purpose, fulfillment in life, suffering and death. It also allows the individual to explore the need for hope, belief in self, others, and a power beyond oneself.

Spiritual well being: An individual experiences affirmation of life in relationship with a higher power (as defined by the person), self and community and therefore feels nurtured and able to celebrate wholeness.

Spiritual concerns of hospitalized patients: disappointment or anger with God; concern about the after-life; dying; grief; inner conflict about beliefs; moral or ethical issues of medical plan of care; pain; suffering; guilt; forgiveness

Competencies for Providing Religious and Spiritual Care:

The health care professional provides for spiritual and religious support of the patient and family through demonstrating the following seven competencies:

1. Assesses patients and families for spiritual and/or religious beliefs that have implications for recovery and care.
2. Documents assessment of spiritual and religious beliefs or practices.

3. Includes in plan of care any spiritual and or religious considerations, which may have an impact on the patient's course of treatment or illness.
4. Implements a plan of care that includes spiritual and religious needs.
5. Avoids value judgments and creates an environment of acceptance,
6. Allows the patient to express fears and beliefs without fear of recrimination.
7. Listens to concerns and avoids statement such as, "You shouldn't feel that way," and "Don't say that," or "Don't think like that."

Spiritual and Religious Care of the Patient

Spirituality: The dynamic process is which a person establishes an awareness of meaning, purpose and values in life usually in relationship to a Higher Power.

Religion: An individual's commitment to a particular system of beliefs, values, rules of conduct, rituals

Differentiation of Beliefs: Distinguish between our own beliefs and our patients' beliefs.

Respect and support the customs, beliefs and rituals of our patients

Religious Practices Seen in the Health-Care Setting: Visitation by chaplains and clergy; Religious symbols in the room (Cross, Star of David, icons, Bibles, Koran, prayer cloths); Prayer; Communion; Sacraments

Spiritual Practices in the Health-Care Setting: Meditations, Music, Relationships, Solitude, Nature, Prayer

Indicators of Spiritual Needs: Loss of meaning in life and/or hope; Anger towards staff, family, God or higher power; Disappointment in God; Concerns about suffering, dying, the afterlife; Anticipatory Grief; Moral and ethical issues regarding care; Expression of guilt and/or need for forgiveness.

Responses to Spiritual Needs: Allow patient to share and to discuss beliefs and issues; Contact the chaplain or patient's clergy; Provide privacy for visits of chaplain or clergy; Handle religious belongings respectfully.

Responsibilities of the Interfaith Chaplains include:

- Caring for patients of all religions
- Participating as part of the healthcare team
- Calling a patient's clergy representative; if the patient request this

TO CONTACT A CHAPLAIN: EXT. 4231 or Dial OPERATOR

The following policy is available on the M Drive via the following pathway:

- M Drive/Patient Care Services folder/Patient Care Policies folder/General Policies and Procedure folder/"Current" folder/PCS S-3.1 "Assessment of Spiritual Needs".

2010 Required Education



Princeton HealthCare System

PERFORMANCE IMPROVEMENT

Why Performance Improvement (PI)?:

Healthcare is continually changing making it necessary for Healthcare organizations to evaluate their processes to go along with these changes. Improving services offered requires institutions to measure their own achievements in order to understand and improve current systems.

Results are achieved through a systematic process that considers the institutional context, describes desired performance, identifies gaps between desired and actual performance, identifies root causes, selects, designs and implements interventions to fix the root causes, and measures changes in performance.

PI is a continuously evolving process that uses the results of monitoring and feedback to determine whether progress has been made and to plan and implement additional appropriate changes.

What is the Goal of PI?:

- The goal is to enhance the quality of care that we provide to our patients as well as increase efficiency.
- Sustain goals achieved and further improve on them.
- In an era marked by increased emphasis on results and greater accountability, PI is dedicated to improving performance to bring about those results.

2010 PHCS Performance Improvement Priorities:

- Core Measures: AMI, HF, PN, SCIP, Stroke
- Patient Experience
- Mortality
- Length of Stay
- National Patient Safety Goals
- Patient Safety Indicators (Agency for Health Research and Quality-AHRQ)

How are You Involved?:

Progress can be achieved through improvements in the ways people perform their work; understanding the role each healthcare professional must play to help patients get well is key to the provision of quality care.

For our goals to be realized, Directors, Managers, and Staff have to actively participate.

Your daily activities relating to patient care that involves Performance Improvement includes but is not limited to:

- Hourly rounding
- Hand hygiene
- Appropriate patient identification
- Safe medication administration
- Initiatives to reduce falls
- Initiatives to reduce pressure ulcers
- Patient satisfaction
- Appropriate discharge instructions given to CHF and Stroke patients

What Method is Used at PHCS to Effect Change?

The rapid-cycle improvement method identifies, implements, and measures changes made to improve a process or system:

P- Plan a change of improvement

D- Do what was planned

C- Check the results to measure effectiveness

A- Act on the check



For questions, please call The Center for Clinical and Organizational Performance Analysis (Performance Improvement) at x4160 or 4053

Center for Clinical and Organizational Performance Analysis (Performance Improvement) | 1000 Walnut Street, Princeton, NJ 08540 | 609-681-4053

Center for Clinical and Organizational Performance Analysis (Performance Improvement)

Center for Clinical and Organizational Performance Analysis (Performance Improvement) | 1000 Walnut Street, Princeton, NJ 08540 | 609-681-4053

2009 Required Education

Healthcare Incident Report Form



Princeton HealthCare System

Incident Reporting: for any occurrence that is not consistent with routine operations or situations

Completing the form:

- Use a ballpoint pen.
- Complete the check-off boxes within the Nature of Incident categories:
 - Anesthesia related
 - Article in Patient
 - Burn
 - Emergency Department Related
 - Equipment Related
 - Fall (and "Circumstances" in the fall section)
 - IV/Blood Related
 - Medication Related
 - Obstetrics Related
 - Patient/Resident Induced
 - Surgery Related
 - Treatment/Procedure Related
 - Other
- Complete:
 - Type of person involved
 - Incident/report date and time
 - Department involved
 - Location
 - Injuries (and Site of injury, Severity of injury, Nature of injury, Patient/Resident condition prior to injury)
 - Disposition (and Seen by, Did patient/resident receive treatment, Most significant treatment received)
 - Doctor's findings (if applicable)
 - Reporter's comments
- Complete for person to which incident occurred (if visitor, complete with visitor demographic information, not patient)

Procedure:

- Form is completed by employee who observes or first learns of occurrence.
- Notify appropriate department immediately for corrective actions to begin (for example, call Environmental Services for spillage, Engineering for malfunctioning bed, etc.)
- Only report objective facts.
- If appropriate, notify physician for further treatment.
- Report must be signed by person completing form and Department Manager, or designee.

Risk Management:

- Incident reports are confidential.
- Do not release report to patient or other person.
- Do not make copies of report.
- Do not place form in medical record, nurses' station, or any vicinity where it can be viewed by unauthorized persons.
- Do not reference in medical record that incident report was completed.
- Do not staple any additional papers to form (use paper clip if you want to attach additional documentation).

The following policy is available on the M Drive via this pathway:

- M Drive/Administration folder/Administrative Standards/AS I – 2.6 Incident Reporting

2010 Required Education



Princeton HealthCare System

IDENTIFYING VICTIMS OF ABUSE

In addition to legal requirements, The Joint Commission requires that hospitals educate staff on identifying victims of abuse, neglect, and exploitation. Staff should understand that victims may seek medical treatment through a variety of services and may present complications that do not appear to be the direct results of physical assault. Effective treatment cannot be rendered unless the underlying cause is identified.

Forms of abuse are frequently misdiagnosed:

1. **Neglect** – victims of neglect include elders, children, disables and anyone who is dependent of a caretaker. The caretaker may be failing in their role for a variety of reasons either purposeful or unintentional.

Suspect Neglect if you see:

- malnourishment
- failure to thrive
- dehydration
- inappropriate dress and/or poor physical hygiene
- caregiver, parent, or guardian under the influence of alcohol/drugs
- lack of supervision
- contractures
- delay in medical treatment

2. **Emotional Abuse** – the victim may be an elder, a spouse, or child. It is often the underlying cause of other ailments and victims seek medical help for non-specific complaints.

Symptoms may include:

- headaches
- backaches
- fatigue
- insomnia
- poor eye contact
- depression
- fearful behavior
- abandonment
- social isolation

3. **Violent Physical Abuse** – the first indicator is unusual injuries

The signs of possible assault that should raise suspicion are:

- the unusual injuries
- non-consensual sex
- unusual behavior
- unexplained bruising, lacerations or fractures
- use of restraints

4. **Sexual Abuse**

- sexual transmitted disease in a minor
- bleeding or itching in child's genitals
- an implausible story

5. **Exploitation** – is the practice of taking selfish or unfair advantage of a person or situation, usually for personal gain. The victim may be an elder, a spouse, or child. Exploitation could be, but is not limited to, financial, labor or sexual in nature. Financial/labor exploitation occurs when a vulnerable individual's funds, assets, property or labor are used for the benefit of someone other than the vulnerable individual. This could include:

- unauthorized sale or transfer of property
- unauthorized taking of personal assets
- negligent failure to effectively use a vulnerable adult's income or assets for their care.
- misuse of powers of attorney.
- child labor

Sexual exploitation could include, but is not limited to, prostitution or pornography.

Interview the Patient

- *Conduct the interview in a private and safe location
- *Don't blame the victim
- *Don't interview the patient with a suspected abuser present
- *Don't interview children about abuse unless you are trained
- *Don't encourage adult victims to make hasty or unplanned departures from the abuse
- *Don't confront the abuser

Plan for Safety

- If there is any possibility of violence – notify the Security department and the Police immediately. If there is a child involved notify The Department of Children and Families immediately.
- Avoid any confrontation with the suspected abuser
- The law permits notification of the police only when:
 - The patient requests to file a complaint or make a police report
 - The victim is a child
 - The injury resulted in or could have been expected to result in serious physical harm
- Provide the victim with phone numbers of appropriate referral services

Document ONLY THE FACTS:

History and physical assessment

Agency referrals and reason for referral

That help from the police was refused if the adult patient refuses to allow notification of the police & the indication for notification are present – using the AMA form

Report:

Notify Social Service department, if applicable

Notify appropriate protective agencies, if applicable

STATE LAW requires notification of The Department of Children & Families (1-877-652-2873) if the victim is a child

State Ombudsmen must be notified (1-877-582-6995) if the victim is a resident of a nursing home or boarding house – State-wide Domestic Violence Hotline (1-800-572-7233)

Adult Protective Services: Report Elder Abuse for patients over 60 and 18-59 if the patient is disabled

References: M Drive PCS: A1.1, A1.3, D1.2

2010 Required Education



Princeton HealthCare System

Age Specific Care

Birth to 1 year:

Physical:

- Birth weight doubles by 4-6 months, triples by one year
- Teething begins, 8 teeth by 1 year
- Oral activities are soothing (pacifier, thumb sucking)

Motor/Sensory Adaptation:

- Progresses to raising head, turning, rolling over, and bringing hand to mouth toward middle of year
- Repeats actions to fine tune learning

Cognitive:

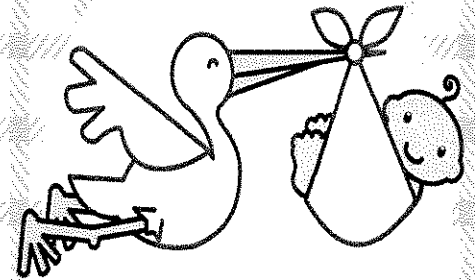
- Manipulates objects in the environment
- Learns by imitation

Psychosocial:

- Develops a sense of trust and security if needs are met consistently and with predictability
- Smiles and repeats actions that elicit response from others

Implications for Healthcare Providers:

- Keep crib side rails up
- Use infant/child security device; check ID bands on both child and parent
- Do not leave infant unattended on changing table, bed, etc.
- Never leave small objects within an infant's reach
- Allow parents/caregivers to remain with the infant; do not allow bed sharing
- Place infant on back to sleep
- Manipulate the environment to reduce stress on the infant
- Be sensitive to clues that infant is over-stimulated: closing of eyes, fretting, turning away, change in color, hyper-alertness
- Encourage parents to bring toys from home or provide colorful, appropriate toys
- Keep parents/caregivers in infant's view
- Use distraction (pacifier, bottle, toy, etc.)
- Use soft, calm voice to speak to the infant



2010 Required Education



Princeton HealthCare System

Toddler (1-4 years)

Physical:

- Decreased appetite and growth
- Learning bowel and bladder control

Motor/Sensory Adaptation:

- Development of manual dexterity
- Loves to experiment

Cognitive:

- Sees things only from own point of view
- Able to group similar items
- Short attention span

Psychosocial:

- Discovers ability to explore and manipulate environment
- Asserts independence and develops sense of will; temper tantrums common
- Plays simple games, enjoys being read to, plays alone

Implications for Healthcare Providers:

- Watch child closely; maintain safety at all times
- Use child security devices, check ID bands
- Allow and encourage parents to remain with child
- Provide age-appropriate toys, including objects from the hospital environment for creative/imaginative play
- Keep side rails up
- Allow mobility and control
- Allow the child to help with procedures
- Speak and play with the child to reduce stress; distract with puppets, games, blowing bubbles
- Allow choices wherever possible
- Emphasize aspects that require the child's cooperation
- Provide favorite, age specific food



2010 Required Education



Princeton HealthCare System

Pre-School (4-6 years)

Physical:

- Baby fat becomes muscle tissue
- Begins to lose baby teeth

Motor/Sensory Adaptation:

- Roller skates, learns to ride a bike
- Dresses/undresses independently

Cognitive:

- Questions "why?"
- Major cognitive skill is conversation

Psychosocial:

- Significant persons are parents, siblings, peers
- Increasing independence and beginning to assert self
- Likes to boast and tattle
- Masters new tasks and acquires new skills
- Learns social manners

Implications for Healthcare Providers:

- Explain procedures and unfamiliar objects
- Keep explanations short, simple and logical
- Use attentive listening and interested facial expressions
- Maintain safety at all times
- Use child security devices, check ID bands
- Allow and encourage parents to remain with child
- Use comforting objects from home
- Involve the child wherever possible
- Praise for good behavior
- Focus on one thing at a time
- Give permission and encourage child to express feelings



2010 Required Education



Princeton HealthCare System

School Age (6-12 years)

Physical:

- Growth is slow and regular
- Pubescent changes start

Motor/Sensory Adaptation:

- Draws and paints
- Assists in household chores
- Likes quiet and active games

Cognitive:

- Capable of logical operation with concrete thought
- Increased attention span and cognitive skills
- Functions in the present
- Rule bound

Psychosocial:

- Prefers friends to family
- Works hard to be successful
- Belonging and approval of peer group is important
- Behavior controlled by expectations, regulations and anticipation of praise or blame

Implications for Healthcare Providers:

- Explain procedures in advance using correct terminology
- Keep instructions simple
- Use books and visual aids
- Repeat information as many times as necessary
- Provide privacy
- Allow parents and peers to visit as much as possible
- Teach general safety as appropriate (use of protective sports equipment)
- Allow child to have some control
- Promote independence



2010 Required Education



Princeton HealthCare System

Adolescent (13-18years)

Physical:

- Rapid growth of skeletal size, muscle mass, adipose tissue and skin
- Development of primary and secondary sex characteristics

Motor/Sensory Adaptation:

- Awkward in gross motor activity
- Easily fatigues
- May need more rest and sleep

Cognitive:

- Increased ability to use abstract thought and logic
- Internal growth of self-esteem
- Does not like to ask questions; afraid to appear "stupid"

Psychosocial:

- Interested in and confused by own development
- Often critical of own features
- Socialization derives from peer interaction
- Belonging to peer group is important
- May criticize parents
- Identity is threatened by hospitalization (concern for bodily changes)
- Think they are invincible and nothing bad will happen to them
- Behavior not predictable

Implications for Healthcare Providers:

- Present explanations in a logical manner, supplement with rationale
- Provide instructions away from peers, roommates and parents
- Encourage questions regarding fears or concerns
- Promote and enhance self-image
- Use proper medical terminology
- Provide privacy
- Allow adolescent to maintain control
- Involve in decision making and care
- Encourage visits from family and friends; friends should visit whenever possible
- Encourage interests and hobbies which can be pursued in the hospital



2010 Required Education



Princeton HealthCare System

Early Adult (18-29years)

Young Adult (30-44years)

Middle Adult (45-65years)

Physical:

- Health problems and risks, preventative behavior and response to illness are influenced by gender and lifestyle in the early adult
- Senses become less acute and muscle mass begins to decrease in middle adulthood

Cognitive:

- Focused on time constraints and only wants to learn what is practical
- May have fixed attitudes
- Learning occurs in adults of all ages

Psychosocial:

- Young adult focuses on independence, personal responsibility, selecting a mate
- Early adult focuses on family, Middle adult introspection, life review, new interests
- May be dual caretaker (parent and children)
- Suicidal tendencies, alcoholism, drug abuse, eating disorders, and tobacco abuse may surface

Implications for Healthcare Providers:

- Explain the benefits of adhering to the treatment plan
- Involve patient and family in care and education
- Focus on preventative care
- Call bell always in reach
- Promote recreational and personal safety habits
- Provide for privacy
- Provide informed consent
- Consider ethnic, religious, or cultural factors affecting patient care



2010 Required Education



Princeton HealthCare System

Older Adult (65years and beyond)

Physical:

- Decreased tactile sensation of heat and cold, resulting in increased risk for injury
- Diminished organ functioning
- Slower healing

Motor/Sensory Adaptation:

- Decreased balance
- Muscle atrophy
- Increased response time
- Reduced visual acuity
- Hearing loss
- Decrease in restorative sleep

Cognitive:

- Brain atrophy
- Decreased short term memory
- More time needed to learn new things

Psychosocial:

- Concern for health increases
- Acceptance of death
- Shrinking social networks
- Concern related to limited income, children leaving home, decreased abilities

Implications for Healthcare Providers:

- Keep instructions simple and direct
- Involve family as necessary
- Provide for privacy
- Keep room clutter free
- Remind patients to use call bell for assistance and keep it within reach
- Frequently assess room temperature to patient comfort
- Consider additional lighting at night
- Promote use of assistive devices (cane, walker, wheelchair)
- Monitor and report signs of elder abuse
- Utilize proper procedures in patient identification
- Encourage familiar items from home



References: "M" Drive Policies PCS-P-1.5, PCS-S-2.3, PCS-V-1.6, PCS-A-1.5, LDRP-N-1.1,

LDRP-P-1.0



Ethics Consultation Service at Princeton HealthCare Systems

When you or a loved one is in the hospital, it can be a confusing time. During the course of treatment, concerns and conflicts may arise about what patients want from their care, the goals of treatment, benefits of a particular treatment plan, and more. To provide an added resource during difficult times, Princeton HealthCare System offers assistance to patients and family members through Ethics Consultations, a service of our Biomedical Ethics Committee.

What is an Ethics Consultation?

It is a discussion between you and a member of the Biomedical Ethics Committee, to review unresolved questions and concerns about patient care for you or your loved one. It is designed to bring about communication between the physician and patient (or person making the care decisions) and come to a solution to the problem.

Who requests it?

Anyone involved in a particular patient's care may request a consultation. Primarily, the patient and his or her physician are the main decision-makers in treatment, so it may be best to start by asking the patient's primary physician. However, any staff member, patient or family member also can request a consultation by asking the patient's nurse, or by contacting the on-call nursing supervisor through the hospital operator. The nursing supervisor has access to a consultant at all times.

How does it work?

Once a consultation is requested, the consultant will meet with you to review your situation and talk with your healthcare professionals. In some instances, a larger multidisciplinary committee (e.g., nurse, physician, chaplain, social worker) may become involved to provide you with additional advice and assistance. You may be assured that you are under no obligation to either request a consultation, nor to follow the advice that results from this meeting; it is an entirely **OPTIONAL** service. Any final decisions on care remain with the patient – or his or her healthcare representative – in conjunction with the physician. However, experience has shown that these consultations usually help resolve the issue.

Examples of Situations/Questions that Might Involve a Consultation:

- Who makes healthcare decisions?
- How do patients and family members handle disagreements with the treatment plan?
- How does one change treatment goals from life-sustaining to supportive care?
- How might medical staff respond to an unexpected refusal of treatment?
- Who is available to talk through medical choices when there is a breakdown in communication?
- How is this case unusual and what guidelines are available to help plan for the future?