NC Department of Health and Human Services

Patient Rights and Reporting Annual Training 2021

ADVOCACY DEPARTMENT

Division of State Operated Healthcare Facilities

Central Regional Hospital

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OBJECTIVES

- Rights Infringement & Reporting
- Rights Infringements – A, N, & E
- Grievance & Advocacy Department
- Human Rights Committee

Central Regional Hospital

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ADVOCACY DEPARTMENT . . .

The Advocacy Department investigates allegations, concerns and and right infringements on behalf of patients/clients who reside in state operated healthcare facilities. These facilities are operated by the NC Department of Health and Human Services (DHHS), Division of State Operated Healthcare Facilities (DSOHF).

Advocacy functions as an investigative team of the division that conducts interviews, collects documents and evidence and prepares investigative reports for Facility, DSOHF and DHHS.

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ADVOCACY

NCGS §122C-3 A Client Advocate is a person whose role is to monitor the protection of client's rights or to act as an individual advocate on behalf of a particular client.

NCGS §122C-53 "Internal client advocate" means a client advocate who is employed by the facility or has a written contractual agreement with the Department or with the facility to provide monitoring and advocacy services to clients in the facility in which the client is receiving services.

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ADVOCACY Department Values:

COMMUNICATION: We actively listen to others, non-judgmentally to gain an account of the facts relating to issues arising from a situation.

INFORMATION: We seek facts through systematic examination of information, to form a cohesive and logical picture of a given situation.

APPROACHABLE: We are always available for the patients, residents, students and healthcare services providers.

ENGAGEMENT: We work forthwith to help patients, residents, students and members of the healthcare team to protect clients' rights.

ACCOUNTABILITY: We perform with transparency and integrity, demonstrating respect, honesty, fairness, equality and uncompromising adherence to strong ethical behaviors.

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ADVOCACY – Contact Information

STAFF may Call

- ✓ CRH Operator: (919) 764-2000
- ✓ Advocacy On-Call Cell: (919) 698-5005
- ✓ Direct Office Number: (919) 575-7802
- ✓ Director's Office: (919) 575-7800

Patients/Residents Contact

Advocacy Voicemail: (919) 575-7485

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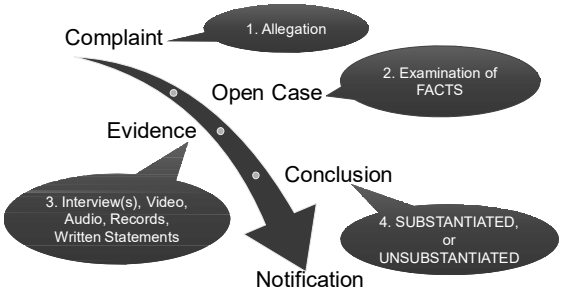
INVESTIGATION PROCESS



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Allegations

Investigations

- **Physical Abuse**
- **Emotional Abuse**
- **Verbal Abuse**
- **Sexual Abuse**
- **Exploitation**
- **Neglect**
- **Rights Violation**

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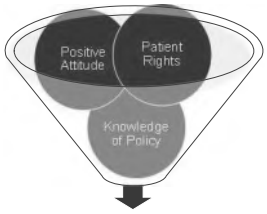
Interaction must blend. . .



TO GIVE
DIGNITY AND RESPECT TOWARD PATIENTS

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PATIENTS/RESIDENTS RIGHTS

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FEDERAL LAW

U.S. Code, Title 18
§ 242 – Deprivation of Rights Under Color of Law

It is a crime for any person acting under color of law, statute, ordinance, regulation, or custom to willfully deprive or cause to be deprived from any person those rights, privileges, or immunities secured or protected by the Constitution and laws of the U.S.

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Federal: Title 42 CFR – Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

- § 483.10 Resident Rights
- § 483.12 Freedom from Abuse, Neglect & Exploitation
- § 483.15 Admission, Transfer & Discharge Rights
- § 483.24 Quality of Life
- § 483.25 Quality of Care
- § 483.60 Food & Nutrition Services

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FEDERAL: Bill of Rights

- Free to exercise: Religion, Speech, Press & Assembly
- Free to petition the government for Redress of Grievances

Cornell Law School. (2020). *Bill of Rights. https://www.law.cornell.edu/constitution/billofrights*

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STATE LAW (NCGS)

§ 122C, Article 3 - Clients' Rights

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to **DIGNITY, HUMANE CARE** and freedom from **MENTAL AND PHYSICAL ABUSE, NEGLECT AND EXPLOITATION**.

North Carolina General Statute § 122C, Mental Health, Development Disabilities and Substance Abuse Act of 1985

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PATIENT'S NOTICE OF RIGHTS

- Patients are informed of their rights at admission.
- A written explanation is provided in patient handbooks, notices or brochures.

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STATE LAW (NCGS)

Patients' Rights

- To Be Informed of Patient Rights
- Dignity, Privacy & Humane Care
- Freedom from Discrimination
- Freedom from corporal punishment
- Freedom from A, N, & E
- Civil Rights
- Confidentiality
- Treatment/right to refuse treatment

North Carolina General Statute § 122C, Mental Health, Development Disabilities and Substance Abuse Act of 1985

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STATE LAW (NCGS)

Patients' Rights

- Annual physical & dental exam
- To be informed of treatment risk(s)
- Access to Laundry & Clothing
- File a Grievance
- Balanced & Nutritional Diet (3 a day)
- Consult with Legal Counsel, Private Health Professionals
- Right to consult with Advocate
- Send/receive sealed mail

North Carolina General Statute § 122C, Mental Health, Development Disabilities and Substance Abuse Act of 1985

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STATE LAW (NCGS)

- To be addressed by staff in a RESPECTFUL Manner

North Carolina General Statute § 122C, Mental Health, Development Disabilities and Substance Abuse Act of 1985

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STATE LAW (NCGS) – Can Be Restricted

- Confidential Telephone Calls
- Visits
- Social Interaction
- Off-Campus Visits
- Time outdoors
- Access to Facilities/ Equipment for Physical Exercise
- Personal Clothing & Possessions
- Participation in Religious Worship
- Keep/spend Money
- Retain a Drivers License
- Access to Storage for Private Use

North Carolina General Statute § § 15A, 20, 35A, 122c and GSAC 10A NCAC (APSM 95-1)

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ADMINISTRATIVE CODE (NCAC)

10A, 28A 28D - Mental Health, State Operated Facilities and Services

The purpose of the rules in Subchapters 28A, 28B, 28C and 28D is to set forth regulations governing human rights for clients in state facilities.

North Carolina Administrative Code
28A – Committees & Procedures; 28B – General Rights; 28C – Dignity & Respect; 28D – Right to Treatment

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Resource: APSM 95-1: Human Rights for Clients in State Facilities

DHHS, (2020), *https://www.ncdhhs.gov/document/apsm-95-1-human-rights-clients-state-facilities*

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POLICY - DHHS Directive Number III-5

Reporting Abuse, Neglect and Exploitation in DHHS Divisions, Facilities and Schools

It is the **policy of the DHHS** that whenever there **is cause to suspect** the **ABUSE, NEGLECT or EXPLOITATION o**f a person in the custody of or receiving services from a DHHS division/facility/school, the matter in investigated as **required by law** (G.S. 7B, Subchapter I; G.S. 108A, Article 6; and G.S. 122C-66) and **department policy**.

Department of Health and Human Services (DHHS) Policy
GS 7B – Juv. Code; GS 108A – Social Svc; GS 122C-66 – Protection from Abuse & Exploitation; Reporting

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POLICY – DHHS Directive Number III-5

Client Rights Policies, Rights of Client

- Requires all allegations involving minors to be reported to the Department of Social Services (DSS) – Child Protective Services
- Also requires the reporting of abuse, neglect, exploitation that involves disabled adults, who are in continued need of protection.

Department of Health and Human Services (DHHS) Policy DirIII-05

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POLICY – DSOHF – 136-AL(3)

Protecting Patients/Residents/Students from Rights Infringements

- Rights Infringements are strictly prohibited
- Must promptly report to immediate supervisor & advocate
- Advocacy Investigates

State Operated Healthcare Facilities (SOHF) Policy 136-AL (3)

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BOTTOM LINE UP FRONT (BLUF)

- Abuse, Neglect or Exploitation of a client will not be tolerated
- No tolerance for a failure to report
- Any DHHS employee found to have violated any abuse, neglect and exploitation policy or reporting requirement may be disciplined up to and including dismissal

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POLICY - Local

CENTRAL REGIONAL HOSPITAL

- CPM-A.0005, ANE or Other Rights Infringement of Patients, Events Occurring After Admission
- CPM-P.0030, Patient Rights Summary – Minors
- CPM-P.0025, Patient Rights Summary – Adults

Abuse, Neglect, Exploitation (ANE)

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RIGHTS INFRINGEMENTS

(*including, but not limited to, abuse, neglect and exploitation*)

of patients/residents/students in all DSOHF facilities are strictly prohibited and shall not be tolerated.

A / N / E

DSOHF Policy, 136-AL (3), (11/25/2015)

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ABUSE defined 42 CFR § 483.12 . . .

- The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

CORNELL LAW SCHOOL, Legal Information Institute (2020), https://www.law.cornell.edu/cfr/text/42/483.12

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ABUSE defined 10A NCAC 28A.0102. . .

- "ABUSE" means THE INFLICTION of physical or mental PAIN or INJURY by other than accidental means; or unreasonable confinement; or the DEPRIVATION by an employee of SERVICES which are NECESSARY to the mental and physical health of the client.
- Temporary discomfort that is part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse.

10A NCAC 28A.0102, Definitions (emphasis added)

29

ABUSE.. . .

DSOHF 131-AL(3) Policy

- The INFLICTION of physical or mental PAIN or INJURY by other than accidental means; or UNREASONABLE CONFINEMENT; or the DEPRIVATION by an employee of SERVICES which are NECESSARY TO THE MENTAL AND PHYSICAL HEALTH of the patient/resident/student.

DSOHF Policy, 131-AL(3) (11/15/2015) , *Protecting Patients/Residents from Rights Infringements*

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ABUSE (Physical) . . .

Types of physical abuse:

- Assault: hitting, slapping, punching, kicking, hair-pulling, biting, pushing
- Rough handling
- Scalding and burning
- Physical punishment
- Inappropriate or unlawful use of restraint

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ABUSE (Physical) . . .

Types of physical abuse – cont'd:

- Making someone purposefully uncomfortable (e.g. opening a window and removing blankets)
- Involuntary isolation or confinement
- Misuse of medication

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ABUSE (Verbal) . . .

- THE USE OF WORDS TO INFLICT EMOTIONAL HARM[1].
- Can be the act of forcefully criticizing, insulting, or denouncing a patient/resident/student.

[1] **DSOHF Policy, 136-AL(3), (12/25/2015),** *Protecting Patients/Residents from Rights Infringements*

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ABUSE (Verbal) . . .

- Words that Demean
  - Cause a loss in the dignity of and respect for
- Words that Frighten
  - Cause a feeling of being afraid or anxious
- Words that Control
  - Behaviors Used Intentionally To Control or Manipulate Others
- Words that Alarm
  - Behaviors Used To Cause An Anxious Awareness of Danger or ill-will

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ABUSE (Sexual) . . .

SEXUAL ABUSE

Engaging in <u>ANY</u> form of Sexual Activity towards <u>OR</u> with a patient/resident/student.

DSOHF Policy, 136-AL(3), (12/25/2015), *Protecting Patients/Residents from Rights Infringements*

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ABUSE (Sexual) . . .

CONTACT Examples:

- Genitalia, anus, groin, breast, inner thigh, or the buttocks of a patient/resident/student, excluding contact incidental to a professional action.
- Between the mouth and any body part as an attempt, threat, or request by a staff member, contractor, or volunteer to engage in sexual activities.
- Staff member, contractor, or volunteer <u>SHOWS THE INTENT</u> to abuse, arouse, or gratify sexual desire from client.

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ABUSE (Emotional) . . .

EMOTIONAL ABUSE

Abusive verbal or nonverbal interactions with or in the presence of patient(s)/resident(s)/student(s) that may result in destress, fear or a negative reaction

DSOHF Policy, 136-AL(3), (12/25/2015), *Protecting Patients/Residents from Rights Infringements*

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EMOTIONAL Abuse . . .

BEHAVIOR MAY INCLUDE:

- Verbal Aggression
- Intimidation
- Manipulation
- Threats
- Menacing
- Cowing
- Making Fun of
- Jibes
- Snub
- Taunting/Baiting
- Insults
- Sarcasms
- Put-Downs
- Humiliation
- Goading
- Teasing
- Glaring
- Non-Verbal eye-roll

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EXPLOITATION . . .

The USE of a PATIENT/RESIDENT/STUDENT or his/her RESOURCES including borrowing, taking or using personal property with or without his/her permission for another person's profit, business or advantage.

The misuse of a patient's/resident's/student's identity will also be considered exploitation.

DSOHF Policy, 136-AL(3), (12/25/2015), *Protecting Patients/Residents from Rights Infringements*

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EXPLOITATION . . .

- Action or Fact of:
  - Treating a client UNFAIRLY in order to benefit from them personally
  - Making use of and BENEFIT from a client's resources
  - Deliberate MALTREATMENT, manipulation of power and excessive control over a client
  - Taking ADVANTAGE of a client or situation for personal gain

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NEGLECT . . .

The FAILURE to provide Care or Services NECESSARY to maintain the Mental and Physical health of the Patient/Resident/Student.

DSOHF Policy, 136-AL(3), (12/25/2015), *Protecting Patients/Residents from Rights Infringements*

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NEGLECT . . .

Staff member's action, or inaction that deprives a client of the care or services necessary to maintain the client's physical or health status

DSOHF Policy, 136-AL(3), (12/25/2015), *Protecting Patients/Residents from Rights Infringements*

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NEGLECT . . .

Neglect examples:

- Failure to execute observation protocols
- Failure to deliver a meal
- Failure to provide necessary clothing
- Ignoring medical/physical care needs
- Withholding necessities life (nutrition, medication, heating)
- Ignoring a client's cries for help

DSOHF Policy, 136-AL(3), (12/25/2015), *Protecting Patients/Residents from Rights Infringements*

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GRIEVANCE SYSTEM 42 CFR 483.10

- The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal.

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GRIEVANCE: NCGS 150b-22 . . .

It is the policy of this State that any dispute between an agency and another person that involves the person's rights, duties, or privileges, including licensing or the levy of a monetary penalty, should be settled through informal procedures.

North Carolina General Statute § 150b-22, Settlement; contested case

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GRIEVANCE 10A NCAC 28B.0203

PROCEDURE & REPORTS

Each state facility shall have a written procedure to process clients' formal grievances in a fair, timely and impartial manner. The grievance procedure shall specify that it is not intended to cover informal verbal expressions of dissatisfaction or discontent which can be resolved informally.

North Carolina Administrative Code
10A NCAC 28B.0203, STATE FACILITY GRIEVANCE PROCEDURES AND REPORTS

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GRIEVANCE Process . . .

- **Informal Resolution** — Usually the patient reaches out to a treatment team member for assistance or resolution
- **Formal Process** — Advocate or either the patient submits (verbally or written) the complaint for formal review
- **Appeal Process** — If the patient is not satisfied, they may appeal to the Facility CEO for resolution

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GRIEVANCE Allegations

- Privileges
- Environmental
- Food
- Legal
- Mgt. Issues
- Medical Care
- Treatment
- Medication
- Personal Possession
- Property Access
- Staff Interaction
- Telephone
- Unit Rules
- Other

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Reviewers . . .

FACILITY and EXTERNAL

- Facilities' respective Risk Mgt. Teams
- Law Enforcement (Criminal Matters)
- Disability Rights North Carolina (DRNC)
- NC DHHS Healthcare Personnel Registry
- NC DHHS Division of Social Services
- Human Rights Committee

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HUMAN RIGHTS COMMITTEE

TO PROVIDE AN ADDITIONAL SAFEGUARD FOR PROTECTING THE HUMAN, CIVIL, LEGAL AND TREATMENT RIGHTS OF CLIENTS.

A human rights committee shall be established at each state facility to provide an additional safeguard for protecting the human, civil, legal and treatment rights of clients who, due to impairments resulting from mental retardation, mental illness or substance abuse, may be less able to articulate and exercise their legal entitlements than those not impaired.

10A NCAC §§28A MENTAL HEALTH, STATE OPERATED FACILITIES AND SERVICES

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HUMAN RIGHTS COMMITTEE

THE COMMITTEE SERVES AS INDEPENDENT BODY

- REVIEWS FACILITY'S COMPLIANCE WITH HUMAN RIGHTS LAWS AND RULES
- REVIEWS EXISTING AND PROPOSED METHODS AND PROCEDURES FOR PROTECTING CLIENTS
- REVIEWS ALLEGATIONS (GRIEVANCES AND INVESTIGATIONS)
- REVIEWS HUMAN RIGHTS PROGRAMS AND SERVICES
- REVIEWS OTHER CONCERNS BROUGHT FORWARD

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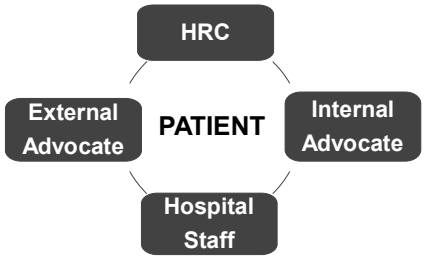
HUMAN RIGHTS COMMITTEE



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Questions

When you blend your professional practice with positive attitude and knowledge of Patient Rights and Policy you are more likely to _____?

a) Know when you are doing a good job.
b) Treat patients/residents/students with Dignity and Respect
c) Remember everything that you are supposed to do each day
d) Treat patients the same as you would treat a stranger you meet on the street

It is a federal crime to willfully deprive or cause to be deprived from any person those rights, privileges, or immunities secured or protected by the Constitution and laws of the United States? (True or False)

It is the policy of North Caroline to assure the basic human rights to each client of a facility (True or False)

The patient's/client's right to be addressed in a respectful manner by staff is only a policy of the Hospital? (True or False)

Patients/clients have the right to voice grievances? (True or False)

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Central Regional Hospital

At Central Regional Hospital we provide psychiatric care to North Carolinians

- We treat children, adolescents, adults, and the elderly.
- We stabilize those in crisis
- We assess our patients and provide medical care
- We provide psychiatric treatment and counseling
- We help our patients plan for their discharge and to make connections with the community.

1

CRH Executive Staff

Robyn Carr
Chief Executive Officer

Brian Grover, Psy. D
Director of Clinical Programming

John Witt, RN
Chief Nursing Officer

Alan Cook, MD
Chief Medical Officer

Charles Cox
Director of Advocacy Department

Ariana Nesbit, MD
Deputy Chief Medical Officer

Vidya Kumar, RN
Associate Chief Nursing Officer

Kim Newton
Director of Quality Management

Mark Quinnan
Director of MIS

Pam Richardson
Deputy Chief Operating Officer

Anne Stephenson, MD
Director of Medical Services

Katherine Williamson
Director of Human Resources

Aaron Thornton
Chief Operating Officer

John Tillery
Assistant Attorney General

Vacant
Deputy Chief Medical Officer

Jody Webster
Associate Chief Nursing Officer

2

Characteristics of Screening Admissions Unit (SAU)

3

Common Considerations During the Admission Process For All Age Groups

- Almost **95%** of our patients are here **involuntarily**.
- This is a **stressful event**
- Patient can be in SAU for several hours.
- Many patients are angry or fearful
  - may be expressed in a form of agitation or withdrawal

How can you help?

- Respond with an understanding of cultural diversity
- Answer the patient's questions honestly and to the best of your ability
- Offer reassurance, comfort, and support at all times

4

Mission Statement for SAU

Central Regional Hospital's Screening and Admissions Unit (SAU) provides compassionate, efficient, and safe clinical evaluation of patients presenting for admission.

Serving the Central Region of North Carolina, CRH provides treatment for individuals diagnosed as having an acute problem with a psychiatric and/or substance abuse disorder, who cannot be managed safely as outpatients in the community.

5

SAU Philosophy

A prospective patient makes their initial contact with Central Regional Hospital in the Screening and Admissions Unit

- The first personal contact with the hospital clinical team should be **positive,** as this contact has a lasting impact upon the treatment process
- **Professionalism, kindness, and compassion** are essential to start the treatment process
- Serving patients with **respect and dignity** is the cornerstone of care provided by SAU staff

6

Age Specific

Every patient is admitted through SAU

- SAU admits to every patient care unit (PCU) in CRH
- Forensics Evaluation and Admission is a branch of SAU
  - admits individuals on court orders requiring competency evaluations and other forensic issues directly to the Forensic Service Unit

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Age Specific

Every patient is admitted through SAU

- Chronological age does not always determine the level of functioning of the individual
  - our approach must be determined by the specific needs of the patient
- A patient's level of functioning may be decreased when:
  - an individual is acutely psychotic
  - has a lower than normal IQ
  - has a developmental disability such as autism
  - is acutely intoxicated

8

Characteristics of the Child and Adolescent Unit (CAU)

9

Who Are the Patients?

- Two Coed Age Groups:
  - Ages 5 - 11
  - Ages 12 – 17

- Many of the patients have a history of:
  - abuse, neglect, many out of home placements
  - ADHD, PTSD, depression
  - school failure, poor social skills, delayed language

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Admissions to the Child and Adolescent Unit

Concerns may include:

- Disrupted family life
- Substance abuse
- Legal involvement
- Out-of-home placements
- Failed relationships
- Difficulties managing anger
- Self-harm

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Collaborative Proactive Solutions

- Core CPS belief: *Kids do well if they can*.
- Treatment focuses on skill development.
- Consistent with CPS, unit expectations are:
  - *Participate*
  - *Be safe*
  - *Respect yourself and others*

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Typical Activities

- Community meetings
- Individual, family, and group therapy
- Therapeutic school
- Structured activities on the PCUs and in the CAP Malls
- Patient employment for older adolescents
- Special events and field trips

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Understanding CAU patients

- Kids on CAU lack skills in problem-solving, flexibility and frustration tolerance.
- Many of them:
  - Are very active & react quickly
  - Express feelings intensely
- Often, they can't:
  - Regulate themselves or their emotions
  - Understand their own feelings
  - Tell you what is wrong

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CAU Staff Must DOs

- Remember - the patients are **children,** not adults
- Skills needed to help them are therapeutic - **NOT** parental
- Interact, engage, and talk therapeutically with the kids during all activities
- Smile and praise frequently

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If a patient starts to become upset…

- Respond early - don't wait until behaviors escalate
- Stay calm and be kind
- Remember: Kids aren't difficult on purpose, they just have skill deficits
- Distract the patient
- Offer to "talk about it"
- Follow individualized treatment plan

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Points to Remember

- CAU patients are **children**
- Kids learn through teaching, not punishment
- Encourage and assist kids to participate
- Staff should always **model** the behaviors they expect from the kids
- CAU can be like any other group care setting for children with:
  - Spills, accidents, & noise
  - Shoes that need to be tied
  - Children who need attention, reminders, & lots of recognition for doing a good job

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Characteristics of Adult Admissions Unit (AAU)

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Admissions to Adult Admission Unit

- Patients age 18 – 64
- Many have multiple diagnoses - including medical problems and substance abuse
- This may be a first admission or a repeat admission (some have been hospitalized over 20 times)
- Many have a history of trauma, are involved with the legal system, or are distrusting for other reasons

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Acute Psychiatric Care for Adults

- These adults are in psychiatric **crisis** and **need** hospitalization
- The three most common diagnoses on AAU:
  - Schizophrenia/Schizoaffective Disorder
  - Bipolar Disorder
  - Major Depression
- The majority of patients will be taking psychiatric medications
- Most common reason adults go into psychiatric crisis
  - Not taking prescribed psychiatric medications when living in the community

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Typical Symptoms for AAU Patients

- Irritability
- May sleep or eat too much or too little
- May not be able to control their behavior
- May talk to persons not seen by others
- May not attend to hygiene needs
- May try to hurt self/others/property
- May appear confused or be unable to communicate their thoughts

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Acute Psychiatric Care for Adults

Mental health treatment goals for the acute psychiatric adult population:

1. Stabilization of mental and physical health
2. Return to living in the community
3. Living as independently as possible

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Adult Person-Centered Care

- We **give** adult patients the opportunity to be involved in decision making for their care
- We **collaborate** with, **NOT** dictate to our patients
- We **provide** information that the patient can understand
- We **respect** the wants, needs, and concerns of patients, even if we cannot meet them
- We **support** the patient in their quest for healing
- The focus is on **wellness** - not on the illness
- **Listening** to and learning about our patient's life experiences may make them feel more understood
- Show genuine interest while maintaining a **non-judgmental** attitude
- Provide **honest** answers and do not make promises you cannot keep

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Trauma-Informed Care for Adults

- Patients need to be respected, informed, connected, and hopeful regarding their own recovery
- Patients need to feel physically and emotionally safe in their care, and we need to be responsive when they are not feeling safe
- It is common for patients who have experienced trauma to have problems with depression, anxiety, substance abuse, and eating disorders
- We need to work in a collaborative way with patients, family and friends of the patient, and other providers in a manner that will empower the patient

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Providing Culturally Competent Care to Adult Psychiatric Clients

- **Be aware** of your own cultural biases and prejudices
- **Know** your own beliefs about mental health and mental illness
- **Acknowledge** the client's personal beliefs, concerns, and fears about the mental illness
- **Collaborate** with the patient to address cultural beliefs

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Providing Culturally Competent Care to Adult Psychiatric Clients

- Understand that beliefs and values can be different for each person within a certain culture
- The role of the family member may be different from culture to culture
- Adult patients should have interpreters if they prefer not to speak English and should be given written information in their preferred language

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Characteristics of Community Transition Unit (CTU)

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CTU Patients

The Community Transition Unit (CTU) patient population

- Adults ages 18 - 64
- Diagnosed with a severe mental illness.

Patients are rarely admitted directly to CTU from Screening and Admission Unit (SAU).

Patients are usually transferred from Adult Admission Unit (AAU) for long term treatment of their mental illness.

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CTU Patients

Typically:

- Chronic and persistent symptoms of their illness
- History of repeated admissions to psychiatric facilities
- Often homeless
- Limited or no source of income
- Lacking a support system (home and community)
- Inadequate coping and problem solving skills.

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CTU Treatment

Treatment efforts are aimed at:

- Reducing and managing symptoms while
- Strengthening life skills needed to successfully return to community living.

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CTU Treatment

There are three specific goals of the unit:

1. To **EMPOWER** each patient through their personal journey of recovery by helping to increase their acceptance, understanding, and motivation for treatment of their illness.

1. To **ENCOURGE** each patient to help them develop and/or improve skills needed to effectively manage their illness, reduce troubling and persistent symptoms, and minimize episodes of relapse.

2. To **ENHANCE** each patient's sense of personal responsibility and hope by supporting their efforts and gains in treatment.

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CTU Treatment

CTU operates on a concept of **recovery principles** and committed to **providing care** that is:

- patient-centered and
- age specific.

Treatment includes:

- Management of symptoms of the illness through a combination of medications and care
- Supportive treatment environment to convey a sense of hope for a satisfying life
- Psycho-education to help patients gain knowledge regarding their illness and treatment options
- Encouragement to empower them through their personal journey for a successful recovery

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STAR PROGRAM

Success in **Transition And Recovery** Program
Developed as a guide to help patients through steps of the recovery principles.

A **core element** of the program is that it **"empowers"** patients to achieve their goals

- Through promoting and offering skill development for living in the community.
- The program also serves as a pathway for person centered care.

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CTU Life Skills

Essential life skills are facilitated by allowing patients to:

- Participate in work activity
- Receive independent privileges on and off campus with minimum staff supervision
  - e.g.- going on shopping trips and eating at restaurants.
- Participate in trips into the community with the Social Worker and Nursing Staff to look at places in the community to live after discharge

34

CTU Life Skills

These opportunities help patients to:

- Apply new knowledge and practice skills learned from going through the steps of the **recovery principles**
- Experience a less restrictive environment and encourage self-expression
- Build self-esteem
- Have input into the decision of where they will live after discharge
- Develop a sense of hope, support, and achievement that is important to recovery
- Define personal goals and develop the skills needed to achieve them

35

Characteristics of Patients on the Geropsychiatry Service Unit (GSU)

36

Admissions to Geropsychiatry

- Most patients are age 65 and older
- Often have multiple medical issues
  - Some are at risk for falls and aspiration
- May be confused and disoriented but not always
- May be adapting to losing independence
- May come from nursing homes or other residential settings
  - e.g. private residence, assistive living facility, or group home
- A goal of the Gero Unit is to improve and preserve function, making the most of the patient's remaining abilities

37

GSU Patients

- Some may be younger adults admitted due to early onset of dementing illness and issues relating to their safety on other units
- Most common reasons for patients to be admitted from the community:
  - medication non-compliance leading to exacerbations
  - aggression and unpredictable behavior
  - resistance to activities of daily living (ADL)
  - Behavioral disturbances of dementia and delirium
  - Poor self care and resistance to care

38

Common Admitting Diagnoses

- Deliruim
- Dementia
- Depression
- Schizophrenia
- Schizoaffective Disorder
- Bipolar Disorder
- Personality Disorder
- Traumatic Brain Injury

39

GSU Patient Behaviors

Agitation

Aggression

Confusion

Withdrawal

Wandering

Intrusiveness

Forgetfulness

Sun-Downing
(days and nights mixed up)

40

Patient Functioning

- Don't assume that all older adults are frail, dependent, and confused. Level of function ranges tremendously from patient to patient.
- Patients are at various levels of care when performing ADLs (Activities of daily living skills)
  - Independent
  - Assist
  - Total Care

41

GSU Patient Safety

- Increase in safety risk due to:
  - Sensory decline with age
  - Mobility impairments
  - Changes in ability to chew, swallow, eat
  - Risk of cognitive impairments and dementia
  - May be unable to recognize dangers and may be at increased risk for falls
- Assess for environmental hazards & problems of mobility
- Assess for aspiration risk
- Assess for confusion and/or agitation-increase may indicate an acute medical issue
- Be aware of some common problems that can occur more often with age

42

GSU Activities

Monday - Friday
All patients are required to attend Group Activities.
Some activities take place in the various treatment malls.
Some may attend unit based groups.

- Typical groups that our patients attend
  - art
  - reminiscence
  - music
  - exercise
  - coping skills
  - stress management
  - healthy living
  - work activities

Alternate age appropriate groups are offered on rotating cycles.

43

GSU Programs

- E1 STAR Behavioral Milieu Program
  - Most patients with severe mental illness such as major depression, bipolar disorder, schizophrenia, schizoaffective disorder
  - May also have some degree of cognitive impairment
  - Can earn points and privileges for safe and responsible behavior and engagement with treatment
- F1 Dementia Care Unit
  - Most patients with moderate to severe dementia with behavioral disturbances
  - Dementia Capable Care given to support patients' remaining strengths

44

GSU Patient Teaching

- The older adult may be facing:
  - Diminished memory
  - Slower processing speed
  - Hearing or reading difficulties due to sensory changes
  - Limited ability to communicate
- Present information:
  - In a slow and understandable manner
  - Keep sessions short
  - Avoid distractions
- Allow time to repeat desired skills frequently until goal is achieved
- Use large print, simple pictures & drawings
- Allow the patient to express their concerns

45

GSU Patient Nutrition

- **Many require Aspiration Precautions**
  - May need assistance when eating
  - Some have to be fed
- "Interventional Feeding Table"
  - A special group seating
  - Utilized to monitor and provide prompts
  - Provide reminders toward patients at risk for aspiration.

46

GSU Patient Nutrition

- Factors that may improve nutrition:
  - Upright sitting position
  - Specialized adaptive equipment for feeding such as:
    - Controlled flow cups
    - Adaptive feeding spoons
    - Mini-spoons
  - Offer smaller, more frequent portions
  - Adjust food intake to activity level
  - May need pureed foods and supplements

47

Medical Psychiatric Unit (MPU)

48

Characteristics of Patients on MPU

Admissions:

- **may come from within CRH**
  - **have unstable medical conditions that can't be managed on the "home" unit.**
- **directly from outside facilities or community**
  - **home, hospitals, nursing homes, assisted living facilities, group homes, jail or correctional facilities**

49

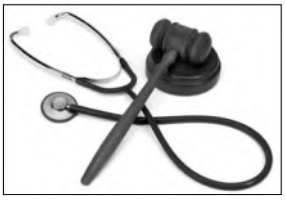
Characteristics of Patients on MPU

- **Many patients require 1:1 observation to promote compliance with medical interventions such as:**
  - **IV therapy**
  - **Telemetry monitoring**
  - **Tube or catheter maintenance**
  - **Isolation precautions etc.**

- **Depending on physical condition and tolerance level patients are expected to attend group activities.**
- **The age specific competencies required depend on the patient's "home" unit.**

50

Characteristics of Forensic Services Units (FSU)



Forensic Services Unit (FSU) provides court-ordered forensic services all counties in the entire State of North Carolina.

51

FSU Pre-Trial Evaluation Admissions Unit (PTA)

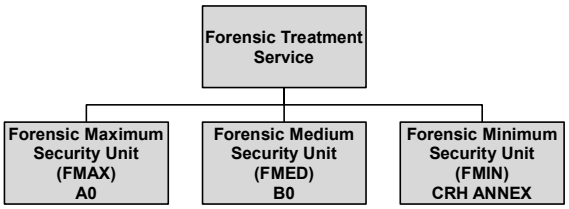
- Consists of 8 beds
- Evaluating of males and females of all ages.
- Provides forensic inpatient evaluation services for the State of North Carolina.
- Criminal defendants undergo evaluations of
  - their capacity to proceed
  - criminal responsibility
  - other questions as ordered by the court.

Serves a limited number of defendants who may require

- more intensive observation
- evaluation services due to being at high risk
- medically complicated

52

Forensic Service Units



53

Forensic Maximum Security Unit FMAX (A0)

- Consists of 22 male beds
- Have court orders for admission to the unit.
- Have unit restrictions for safety and security.

54

Forensic Medium Service Unit FMED (B0)

- Consists of 24-beds and houses both male and female patients.
- Patients must have court orders for admission to the service
  - females are admitted directly to B0.
  - Male patients transfer from FMAX.
- Have unit restrictions for safety and security.

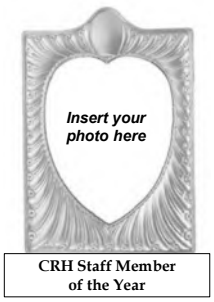
55

Forensic Minimum Security Unit (FMIN)

- Consists of 30 patient beds.
- Have male and female patients.
- Patients transferred from B0.
- Patients have unit restrictions for safety and security.
- Patients can participate in off-campus activities with court orders.

56

Your Role at CRH



CRH Staff Member of the Year

Your work at CRH is **critical** to successful patient outcomes.

You are the patient's strongest advocate

report any changes you observe with a patient.

Your quick and professional response can make all the difference!

Thank you!

57

Computer Use

based on the CRH HIPAA Acceptable Use Policy

Annual Update Training

1

Users

Central Regional Hospital Users (defined as employees, volunteers, guests, vendors and contractors) are expected to use the Intranet (e.g., H drive, I drive, S drive) and Internet (www…) responsibly and professionally.

2

Use of Intranet/Internet

Users make no intentional use of the Intranet/Internet services in an illegal, malicious, or obscene manner as described in NC General Statute (GS) 14-190.1.

3

Use of Intranet/Internet

Users will not stalk others; post, transmit, or originate any unlawful, threatening, abusive, fraudulent, hateful, defamatory, obscene, or pornographic communication or any communication where the message, or its transmission or distribution, would constitute a criminal offense, a civil liability, or violation of any applicable law.

4

Use of Intranet/Internet

All Users of CRH's Information Systems are advised that their use of these systems may be subject to monitoring and filtering.

5

Computer Access

Users will not access or attempt to gain access to any computer account to which they are not authorized.

- Users **are not** to share userids/usernames and passwords with other staff members.
- Users **are not** to let other Users work under their own account

6

SOCIAL MEDIA

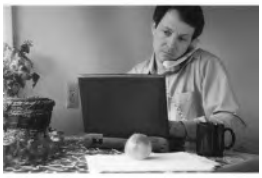
- Social Media is not permitted to be used by staff while at a DHHS facility.
- When employee's use personal social networking sites they should remain personal in nature and not be blurred with their professional life.
- Confidential or non-public information should never be shared.
- The release of sensitive information over Social Media can harm the organization's reputation, violate HIPAA and other regulations.

7

7

Remote Computer Access

Remote access to the CRH Intranet and CRH data resources is by Executive Team & MIS approval only.



8

Relocation of Equipment

Computer hardware, including desktops, laptops, printers, or other devices, are not be moved without MIS approval.

Computer hardware and software are not to be removed from the Central Regional Hospital (CRH) without specific written permission from the Hospital Executive Team.

The theft of computer resources, including computer software/hardware, is illegal!

9

Security

When unattended, computers are not to be left in a state where someone could come behind the user and access data resources or the intranet/internet.

Pressing the Windows button on the keyboard in combination with the letter "L", locks the screen.

10

Security

Laptops must be physically secured when the User has taken the laptop out of a secure area.

11

Security

Users must report all information security violations to the CRH IT Security Officer (located in Aiken X52553) including any incidents of misuse, theft or loss of data.

12

Installations and Alterations

Hardware and software installations and alterations are managed by CRH MIS Department or MIS-designated contractors **only**.

Personally owned devices, such as: diskettes, CDs, USB Flash Drives, PDAs, laptops, etc, are **not** allowed on the CRH campus without approval by Executive Team and the IT Security Officer.

13

Computer use is a privilege.

Do your part to keep the equipment, information and system safe.

14

CONFLICT MANAGEMENT

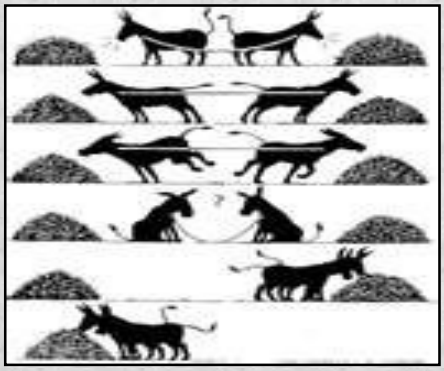
Staff Development
Central Regional Hospital

1

What is Conflict?

A disagreement through which the parties involved perceive a threat to their needs, interests or concerns

2



3

We Assume It's Bad …

But is it, really?

It's natural and will happen; Conflict is a fact of life as are the emotions that go along with it.

4

Conflict Can Be Beneficial

Most conflict begins with a simple misunderstanding that grows and grows and grows….

To prevent misunderstandings it is important to be aware of your personal communication style – we all have one.

Are you:

Non-assertive?
Directly aggressive?
Passive aggressive?
Indirect?
Assertive?

5

Which Style Are You?

- ***Non-assertive styles:*** an unwillingness or inability to express thoughts or feelings in conflicts often resulting from a lack of confidence. May show avoidance or reluctant accommodation to another in conflicts.
- ***Directly aggressive styles:*** expressed criticism or demands that bullies or belittles the person to which the communication is directed. It may take the form of character attacks, competence attacks, teasing, threats, swearing, or non-verbal gestures. Leaves the receiver feeling embarrassed, humiliated or inadequate.
- ***Passive aggressive styles:*** result in the expression of hostility in an obscure, not obvious way. It occurs when people have feelings of anger, resentment, or rage that they choose not to express directly. May leave the receiver feeling confused, angry or feeling manipulated.

6

Which Style Are You?

- ***Indirect conflict styles:*** trying to give a message in a roundabout way so as not to hurt someone's feelings. Often the goal is to get someone to do what the person wants without making them upset. Can lead to mixed messages and confusion.
- ***Assertive styles:*** people expressing needs, thoughts, and feelings clearly with respect for others.

7

"Communication is the response you get from the message you sent regardless of its intent."

Author Unknown

8

Communication and Errors

According to Sentinel Event (SE) data compiled by the JCAHO, ineffective communication is identified as the third leading cause of reported errors in the client care setting.

- Have you experienced a situation involving a breakdown of communication?
- What are some examples and their precipitating factors?

9

Listening & Clear Messages

In conflict, we need to want more than just to be heard, but to also be open to what is being said.

Make sure your message is clear and focuses on the problem not the personality.

10

Conflict Resolution

All conflict is not bad. We have to be good at resolving the conflict.

Let's review conflict resolutions styles and when they are best used.

Keep in mind this is not one size fits all, you have to match the conflict with the conflict resolution style.

11

Thomas and Kilmann's Conflict Resolution Styles

Competitive:

People who tend towards a competitive style take a firm stand, and know what they want. They usually operate from a position of power, drawn from things like position, rank, expertise, or persuasive ability.

This style can be useful when there is an emergency and a decision needs to be made fast; when the decision is unpopular; or when defending against someone who is trying to exploit the situation selfishly. However it can leave people feeling bruised, unsatisfied and resentful when used in less urgent situations.

12

Thomas and Kilmann's Conflict Resolution Styles

Collaborative:

People tending towards a collaborative style try to meet the needs of all people involved. These people can be highly assertive but unlike the competitor, they cooperate effectively and acknowledge that everyone is important.

This style is useful when you need to bring together a variety of viewpoints to get the best solution; when there have been previous conflicts in the group; or when the situation is too important for a simple trade-off.

13

Thomas and Kilmann's Conflict Resolution Styles

Compromising:

People who prefer a compromising style try to find a solution that will at least partially satisfy everyone. Everyone is expected to give up something, and the compromiser him- or herself also expects to relinquish something.

Compromise is useful when the cost of conflict is higher than the cost of losing ground, when equal strength opponents are at a standstill and when there is a deadline looming.

14

Thomas and Kilmann's Conflict Resolution Styles

Accommodating:

This style indicates a willingness to meet the needs of others at the expense of the person's own needs. The accommodator often knows when to give in to others, but can be persuaded to surrender a position even when it is not warranted. This person is not assertive but is highly cooperative.

Accommodation is appropriate when the issues matter more to the other party, when peace is more valuable than winning, or when you want to be in a position to collect on this "favor" you gave. However people may not return favors, and overall this approach is unlikely to give the best outcomes.

15

Thomas and Kilmann's Conflict Resolution Styles

Avoiding:

People tending towards this style seek to evade the conflict entirely. This style is typified by delegating controversial decisions, accepting default decisions, and not wanting to hurt anyone's feelings.

It can be appropriate when victory is impossible, when the controversy is trivial, or when someone else is in a better position to solve the problem. However in many situations this is a weak and ineffective approach to take.

16

Interest-Based Relational (IBR) Approach

In resolving conflict using this approach, you follow these rules:

- **Make sure that good relationships are the first priority**
- **Keep people and problems separate**
- **Pay attention to the interests that are being presented**
- **Listen first; talk second**
- **Set out the "Facts"**
- **Explore options together**

http://www.mindtools.com/pages/article/newLDR_81.htm

17

Whenever you're in conflict with someone, there is one factor that can make the difference between damaging your relationship and deepening it. That factor is attitude.

-William James

18

Summary

Most of us try to avoid conflict at all cost. It is important to keep in mind that by resolving conflict successfully, you can solve many of the problems that it has brought to the surface, as well as getting benefits that you might not at first expect:

- *Increased understanding*
- *Increased group cohesion*
- *Improved self-knowledge*

However, if conflict is not handled effectively, the results can be damaging. Conflicting goals can quickly turn into personal dislike. Teamwork breaks down. Talent is wasted as people disengage from their work. And it's easy to end up in a vicious downward spiral of negativity and recrimination.

19

Questions?

20

Covid-19

What You Should Know About SARs-CoV-2 and the Pandemic Illness affecting NC, the USA and the world.

Training Presentation for workers in the NC Division of State Operated Healthcare Facilities. Produced by NC DHHS, Chief Medical Office for Behavioral Health and IDD, February 2020 Version for Direct Care Workers

1

Coronavirus

- The information in this presentation is based on guidance from the Centers for Disease Control and Prevention (CDC), the North Carolina Division of Public Health (NC DPH) and the North Carolina Division of State Operated Healthcare Facilities (DSOHF).
- The information is current as of September 2020.
- This is a new virus and guidance may change frequently as more information is known about the virus.

2

What is Coronavirus?

- Coronaviruses commonly occur among humans and cause mild illness, like the common cold.
- The virus occurring now is new. It's called SARS-CoV-2 and it has caused a Pandemic (world wide person to person infectious outbreak).
- COVID-19 is a name of the illness caused by this novel coronavirus.
- Because it is new, we are still learning about the virus.
- As we learn more about COVID-19, ways to protect our patients/residents, visitors, and ourselves may change.

3

What are the symptoms?

Covid-19 illness can be asymptomatic, mild, or moderate to severe and can lead to death.

Symptoms can include:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Symptoms may appear 2- 14 days after being exposed to the virus.

4

How does COVID-19 spread?

- The virus spreads person to person. This means someone who is sick with COVID-19 can spread the virus to other people.
- As an employee, it's important for you to stay home, and away from other people, when you are actively sick.
- Patients/residents who are actively sick will be isolated from patients/residents who are not sick.

5

What does person to person contact mean?

Person to person contact means the virus can spread if:

- You are in close contact with another person who is infected (within about 6 feet)
- When an infected person coughs or sneezes- the droplets can land in the mouth, nose and eyes.
- It may be possible to get COVID-19 by touching a surface or object that has the virus on it and then touching your own mouth, nose, or eyes.

6

How can I prevent or slow the spread of COVID -19 at work?

- Use **STANDARD PRECAUTIONS** during all patient care.
- **COVER coughs and sneezes.**
- Perform **HAND HYGIENE** frequently and before and after patient contact.
- Routinely clean and **DISINFECT** frequently touched surfaces.
- STAY HOME or go home when you develop symptoms of respiratory illness (fever, cough, shortness of breath). Contact your supervisor and follow your facility call in procedures for absences.

7

How can I prevent or slow the spread of COVID -19 in my community?

- WEAR a face covering at all times when around people that are not members of your household.
- **Avoid crowds, parties, weddings, funerals, services, bars and dine in restaurants.**
- Perform **HAND HYGIENE** frequently throughout your day.
- **DISINFECT** frequently touched surfaces before and after contact.

8

Standard Precautions

Standard Precautions are infection control practices that healthcare workers should apply when working with **all patients**.

Always use these precautions with individuals with suspected or confirmed COVID-19.

Standard Precautions are:

- Hand Hygiene
- Use of Personal Protective Equipment (PPE)
- Safe Injection Practices
- Respiratory Hygiene/Cough Etiquette

9

Hand Hygiene

Hand Hygiene is one of the most effective ways to prevent the spread of infectious diseases. You should always:

- Perform Hand Hygiene with ABHR=alcohol-based hand rub (preferred) or wash with soap and water
  - before and after every patient contact.
  - when hands are not visibly soiled.
  - after touching the patient's immediate environment.
  - after removing gloves.
- Always wear gloves when contact with blood, mucous membranes, or non-intact skin could occur.
- Always remove gloves after caring for a patient.
- Do not wear the same gloves with more than one patient.
- Wash hands with soap and water
  - when visibly soiled.
  - before eating.
  - after using the bath room.

10

Use of Personal Protective Equipment (Also known as PPE)

Every healthcare worker is expected to choose and use the appropriate PPE when there is potential for contact with blood or body fluids or other potentially infectious materials (e.g. changing sheets, handling contaminated linen, etc)

PPE choices include (but are not limited to):

- Gowns
- Gloves
- Face shields
- Goggles
- Surgical Mask
- N-95 Respirator

11

Transmission Based Precautions

- Transmission Based Precautions are used when caring for patients who are known or suspected to be infected with COVID-19.
- Contact
- Droplet
- Airborne
- **Special Airborne Contact for COVID-19**
- When a patient/resident is placed on transmission precautions, follow your facility policy regarding patient placement, signs to be posted, and other restrictions.

12

PPE and COVID-19:

If your facility has a patient/resident with suspected or confirmed COVID-19, the following PPE is required:

All healthcare workers entering the room must use Special Airborne Contact precautions.

This includes gown, glove, eye protection (e.g. goggles or face shield) and N95 mask. Safety glasses are not a substitute for goggles or face shield.

Airborne precautions includes use of fit-tested N95 mask or higher. (This is not a regular surgical mask).

13

Special Airborne Contact Precautions

Airborne Infection Isolation Rooms (AIIR)
Or
Room with door closed

Gown
N-95 Respirator
Eye Protection
Gloves

14

Proper Way to Don (Put On) PPE

Perform hand hygiene before putting on any PPE.

General approach to putting on this PPE combination for respiratory viruses:

Gown

N95 Respirator

Goggles or face shield

Gloves

15

Proper Way to Doff (Take Off) PPE

General approach to removing PPE for respiratory viruses:

- Gown
- Gloves
- Goggles or face shield
- Respirator

Important Reminders:

- Remove gown and gloves at doorway or in anteroom
- Perform hand hygiene
- Exit room
- Remove respirator and eye protection after leaving patient room and closing door. Careful attention should be given to prevent contamination of clothing and skin during process of removing PPE
- Perform hand hygiene after removing all PPE

16

Respiratory Hygiene/ Cough Etiquette: Always Cover Your Cough

Cover your mouth and nose with a tissue when you cough or sneeze

OR

Cough or sneeze into your upper sleeve, not your hands

Put your used tissue in the waste basket

You may be asked to put on a surgical mask to protect others

OR

Clean your hands after coughing or sneezing

Content on this slide from "Cover Your Cough" poster available for download from: Minnesota Department of Health

17

Disinfect Surfaces

It's important to vigorously maintain cleaning protocols that include disinfection.

Patient Rooms

Common Areas such as dayrooms, dining rooms

Treatment Rooms

Admissions Office

Activity Areas

Patient/Resident Equipment such as blood pressure cuffs, stethoscopes, pulse oximeters, etc.

Frequently touched surfaces such as handrails, elevator buttons, door handles

18

Disinfection Procedures

With COVID-19, cleaning/disinfection procedures should include the following:

Use EPA-registered Disinfectant appropriate for coronavirus in healthcare settings. (PDI Super Sani-Wipes is acceptable. This may be referred to in your facility as the "purple top" wipe).

Use standard FDA-approved hospital hand hygiene agent effective against coronavirus

Check your facility's protocol for the approved disinfectant to use for widespread cleaning

For suspected or confirmed COVID-19, it is best to use separate medical equipment for the patient/resident, instead of sharing items such as stethoscopes. If you have to share, clean and disinfect equipment between patients/residents.

19

Social Distancing

Coughs, Sneezes, Hugs and Handshakes are ways viruses can spread.

Social distancing is designed to limit the spread of a disease by reducing the opportunities for close contact between people.

Ways to eliminate close contact include:

- Avoiding close contact (6 ft) with all persons who are not members of your personal household.
- Use touchless social greetings
- Conduct meetings and interviews by phone or video
- Avoid dine-in restaurants, parties, weddings, funerals, crowds.

20

Immediate measures if patient/resident is suspected to have COVID-19

If a patient/resident is suspected to have COVID-19, implement the following measures immediately:

1. Place a surgical mask over the patient/resident's nose and mouth.
2. Educate the patient/resident about respiratory hygiene and cough etiquette (e.g. covering their cough, disposing of tissue in trash can and washing their hands.)
3. Isolate patient/resident in a private room with the door closed. Use an Airborne Infection Isolation room if available.
4. The patient/resident needs to stay in the room. If medically necessary transport is required, the patient/resident must use a surgical mask. Patient/resident must be transported using predetermined routes which minimize exposure for staff, other patients and visitors.
5. All healthcare personnel entering the room are to use Special Airborne Contact precautions, including gown, N95, eye protection and gloves.

21

Immediate measures if patient/resident is suspected to have COVID-19

6. When possible, limit the number of visitors and healthcare providers to minimize exposures.
7. Notify your medical provider and infection control personnel.
8. Do not perform aerosol generating procedures.
9. Use disposable or dedicated patient care items such as stethoscopes, blood pressure cuffs, if possible.
10. Maintain log of all persons (including visitors) who enter the room or care area for the patient/resident.
11. Once the patient/resident is no longer infected, move the patient/resident and clean/disinfect the room. Allow ample time for air exchanges before terminal cleaning and disinfection of the room.

22

How have we prepared?

COVID-19 Plan	Facility has a plan for early identification and management of patients/residents with acute respiratory infection. Plan includes how to minimize chance for exposure.
Signage at Entrances	Post respiratory hygiene/cough etiquette signage at all facility entrances; provide respiratory hygiene supplies- alcohol based hand sanitizer, tissues, no touch trash receptacle, face masks
N-95 Fit Testing	Confirm an adequate group of health care workers, who will provide resident care for COVID-19 patients, have been medically cleared and are fit tested.
PPE	Maintain an adequate supply of PPE and other medical supplies
Contingency Plan for Curtailing Services	Identify what essential services can be curtailed if required
Limit Visitors	Visitation is curtailed for certain levels of infection in the community and if allowed it will involve education, screening and specific limitations.

23

How do we prepare?

Precautionary Measures	Instruct patients with symptoms of respiratory infection to adhere to respiratory etiquette and wear a mask covering the nose and mouth.
Workforce	Review HR Communicable Disease Emergency Policy and be prepared to implement if required
Current Information	Stay up to date with changes by reviewing guidance and instructions from the CDC, NC DPH and DSOHF
Patient/Resident Education	Educate patients/residents about respiratory hygiene/cough etiquette. Confirm respiratory hygiene supplies are available to patients/residents.

24

Resources

Additional information about COVID-19 can be found at the following websites:

- CDC.gov
- publichealth.nc.gov

25

CENTRAL REGIONAL HOSPITAL

1

CENTRAL REGIONAL HOSPITAL

Mission

The mission of Central Regional Hospital is to provide **high quality**, **integrated**, **person-centered** treatment to children, adolescents, and adults with psychiatric disorders with a **focus on safety** while promoting **wellness** and offering **support** to patients and their families consistent with the **principles of recovery** and **trauma informed care**.

Vision

Central Regional Hospital seeks to be a model state hospital using evidence based practices, research, education and technology to provide quality clinical care in the safest environment.

2

CENTRAL REGIONAL HOSPITAL

CRH Executive Team

Chief Executive Officer
Assistant Hospital Director
Chief Medical Officer
Deputy Medical Director
Deputy Chief Medical Officer
Deputy Chief Medical Officer
Medical Services Director
Chief Operating Officer
Deputy Chief Operating Officer
Chief Nursing Officer
Associate Chief Nursing Officer
Associate Chief Nursing Officer
Advocacy Director
Director Human Resources
Director Quality Management
Director of Psychosocial Treatment
MIS Director
Business Officer
Assistant Attorney General
President Medical Staff

3

CENTRAL REGIONAL HOSPITAL

Unit Management Teams

Unit Administrative Director- UAD

Unit Clinical Director- UCD

Unit Nurse Director- UND

Unit Social Work Chief

Unit Chief Psychologist

4

CENTRAL REGIONAL HOSPITAL

Unit	Current Beds	Ages
Acute Adult Unit (AAU)	148 beds	18+ yrs
Community Transition Unit (CTU)	76 beds	18-64 yrs
Geriatric Services Unit (GSU)	40 beds	64+ yrs
Medical Psychiatric Unit (MPU)	14 beds	All ages
Forensic Services Unit (FSU)	84 beds	All ages
Child and Adolescent Unit (CAU)– Child	10 beds	5-11 yrs
Child and Adolescent Unit (CAU)– Adol	26 beds	12-17 yrs

5

CENTRAL REGIONAL HOSPITAL

A2 24 - m	B2 24 - m	C2 24 - f	D2 24 – m	E2 24 - f	F2 14 - coed
A1 26 - coed	B1 27 - coed	C1 23 - coed	D1 18 - m	E1 24 - coed	F1 14 - coed
A0 30 – m Pre-Trial & FMAX	B0 24 – coed FMED	C0 10 – coed Intensive Support PCU	D0 12 – coed	E0 13 – m	F0 13 – f

CRH Annex

393
30 – coed
FMIN

Community Transition Unit (CTU) with ages 18-64 yrs = 76 beds
Acute Adult Unit (AAU) with ages 18+ = 148 beds
Medical Psychiatric Unit (MPU) with all ages = 14 beds
Geriatric Services Unit (GSU) with ages 64+ = 40 beds
Forensic Services Unit (FSU) with all ages = 84 beds
Child and Adolescent Unit (CAU) Child with ages 5-12 yrs; 14 beds
Adol with ages 13-17 yrs; 24 beds= total 38 beds

6

CENTRAL REGIONAL HOSPITAL

CRH Catchment Area

Adult Psychiatric Services

7

CENTRAL REGIONAL HOSPITAL

N.C. State Psychiatric Hospitals

8

CENTRAL REGIONAL HOSPITAL

Forensics Catchment Area (entire state)

9

CENTRAL REGIONAL HOSPITAL

Child/Adolescent Catchment Area

10

CENTRAL REGIONAL HOSPITAL

CRH Clinical Services

- Psychiatry
- Medicine
- Nursing
- Social Work
- Psychology
- School (Child & Adolescent Unit)
- Chaplain Services
- ECT Services
- Psychosocial Treatment
  - Main Street & Commons
  - Community Living Program
    - Work Therapy and Work Crews
    - Community Living Center

11

CENTRAL REGIONAL HOSPITAL

CRH Medical Clinic

- Employee Health
- Clinics
  - Podiatry
  - Optometry
  - Neurology
  - Gynecology
- Dental
- Radiology
- Respiratory Therapy
- Speech & Language Therapy
- EMS/Transportation

12

CENTRAL REGIONAL HOSPITAL

CRH Hospital Support Services

- Staff Development
- Health Information Management
- Patient Advocacy
- Quality Management
- Utilization Review
- Infection Control
- Plant Operations
- Volunteer Services
- Pharmacy
- Lab
- Interpreter Services
- Human Resources
- Business Office
- Environmental Services
- Reimbursement
- Purchasing
- MIS/Telecommunications
- Warehouse
- Timekeeping
- Physical Therapy
- Occupational Therapy
- Nutritional Services

13

CENTRAL REGIONAL HOSPITAL

CRH ANNEX

- **Staff Development**
- **Plant Operations**
- **IT Programmers**
- **Sewing Room**
- **Biomedical Storage**
- **Advocacy**
- **Purchasing**
- **Timekeeping**
- **Whitaker PRTF**
- **Community Living Program**
- **Forensic Minimum**
- **Seating Repair Shop**
- **Storage**

14

CENTRAL REGIONAL HOSPITAL

<u>Main Street</u>

3 Commons
Music Room
Gym
Fitness Room
Art Room
Computer Lab
Library
Cashier's Office
Training Kitchen
Beauty/Barber Shop
Dining

15

CENTRAL REGIONAL HOSPITAL

The End

16

CULTURAL SENSITIVITY & WORKPLACE DIVERSITY

YOUR JOURNEY TO CULTURAL COMPETENCE

Human Resources, Central Regional Hospital

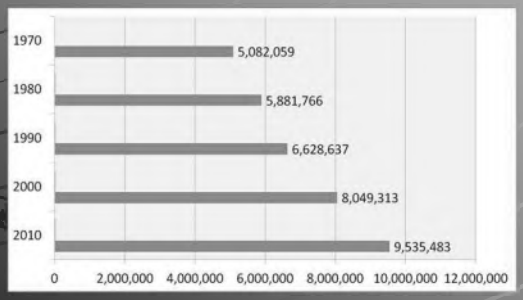
1

State of North Carolina

Quick Facts

2

North Carolina Population 1970 to 2010



Source: Census 2010

3

Working Definitions

What is meant by ***"culture"***?

CULTURE refers to learned and shared beliefs, assumptions, and values about the "right" way to think and act.

What is meant by ***"diversity"***?

DIVERSITY refers to recognizing, appreciating, valuing, and utilizing the unique talents and contributions of all individuals.

4

Why should *I* learn about cultural sensitivity?

- Because … you never want to underestimate the importance of human relations skills. And because …
- Cultural diversity and awareness training is helpful in allowing you to handle sticky situations gracefully and sensitively
- The key is developing and nurturing mutual respect for each other

5

Types of Culture

- **Nationality**
- **Ethnicity**
- **Regional**
- **Gender**
- **Sexual orientation**
- **Socio - economic**
- **Educational**
- **Religion**
- **Age**
- **Physical ability**
- **Industry/Workplace**
- **Organizational**
- **Department/Professional**

We all have multi-layered cultural identities

6

Most Cultures Share…

- A Love value
- A Truth value
- A Fairness value
- A Freedom value
- A Unity value
- A Tolerance value
- A Responsibility value
- A Respect for Life

Source: Rushworth Kidder, "Shared Values in a Troubled World"

7

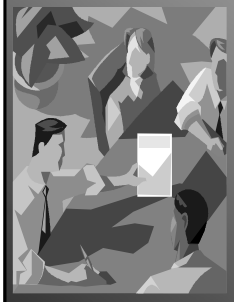
Cultures Vary In Their…

- Beliefs & attitudes
- Mental processing & learning styles
- Work habits & practices
- Values & norms
- Relationships
- Time & time awareness
- Sense of self and space
- Communication & language
- Dress & appearance
- Food & feeding habits

Source: Harris & Moran, "Managing Cultural Differences"

8

Subtle Non-Verbal Differences



- ***Kinesics*** – "Body Movement"
- ***Proximics –*** "Interpersonal Space"
- ***Chronemics –*** "Verbal exchange timing"
- ***Oculesics –*** "Eye Contact"
- ***Haptics –*** "Interpersonal touching"

9

Developing Cultural Competence

- Heighten sense of respect
- Slow yourself down
- Listen for assumptions you make
- Check out the assumptions you make
- Listen and reflect back
- Identify your strengths
- Utilize all resources

10

Barriers – Affecting Cultural Competence

- Making assumptions about similarities
- Language differences
- Non-verbal misinterpretations
- Preconceptions and stereotypes
- Tendency to evaluate
- High Anxiety
- Tension
- "Culture Shock"

11

Creating a Culturally Competent Workplace and Providing Culturally Competent Care

1. Start with what you know about you
2. Learn about the different cultures, traditions, values on the patients and families you serve
3. Look for existing barriers to providing culturally competent care
4. Participate in identifying possible strategies for overcoming the barriers you identify
5. Prepare staff at all organizational levels
6. Evaluate the results of your efforts
7. Be Objective & flexible in your thought process

Source: The Institute for Family-Centered Care

12

Cultural Sensitive Programming

- Be aware of the culture in which you are operating
- Demonstrate respect
- Show patience
- Be inclusive
- Avoid value judgments
- Use language sensitively
- Assume the role of facilitator
- Know your adversaries
- Find common ground
- Accentuate the positive
- Nurture partnerships
- Never give up

Source: Guide to Working from Within: 24 tips for Culturally Sensitive Programming

13

14

Fire Safety

Hospital Orientation

1

CRH Fire Response Strategy

CRH is a "**Defend-in-Place**" facility:

CRH was designed to accommodate the defend-in-place strategy, whereby occupants are relocated to a safe location in the building rather than being evacuated. The safe locations are created by subdividing the floors of the building into two or more smoke compartments or fire compartments, separated by specially constructed walls designed to limit the transfer of smoke or restrict the spread of fire from one side to the other.

Most CRH staff and patients will "relocate" vs "evacuate".

2

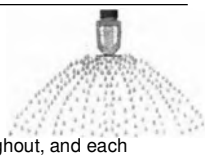
Keys and ID

Because CRH is a locked facility, it very important that you have your hospital keys and your ID badge with you at all times.

Patients and visitors **do not** have keys and therefore can not relocate. They depend on you for their safety.

3

Sprinklers



CRH Main Hospital is fully sprinkled throughout, and each sprinkler head activates separately.

Please **do not** store items within 18" of sprinkler head/ceiling. Items stored high enough can disrupt the spray pattern and cause the sprinkler to be ineffective.

CRH Annex Campus, does not have sprinklers, therefore items may not be stored within 24" of the ceiling.

4

Emergency Floor Plans

The emergency floor plans are located on the walls throughout CRH. The floor plans include:

- Pull Stations
- Fire Extinguishers
- Exits
- Tornado Shelter Areas
- Crash Carts
- Medical Gas Shut-offs
- Relocation Area

5

Emergency Floor Plans

Observe the Items or symbols identified on upper-left of floor plan…

Each corresponding Items or symbols are strategically identified on the floor plan of each unit or department.

6

Wayfinding at CRH

Picture Theme

At CRH the purpose of each picture theme is to uniquely identify that particular floor level.

3 Level = Space
2 Level = Sky
1 Level = Earth
0 Level = Sea

Inter-Connector Theme

All three inter-connectors theme are uniquely identified on the treatment mall, level-1.

Sunflower
Dogwood
Tulip

7

Wayfinding at CRH

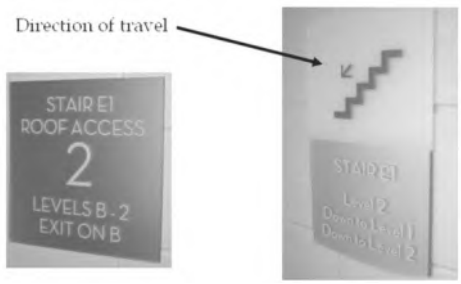
Example: Location of the letter and numbering system at CRH

Location
E = Section
2 = Floor Level
018 = Room Number

Location
K = Section of Tulip inter-connector
2 = Floor Level
034 = Room Number

8

Stair Signs: Entrance



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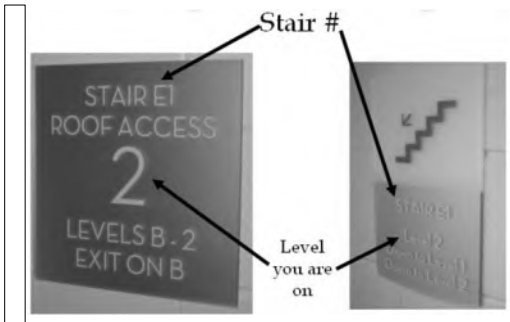
Stair Signs: Entrance



10

Incident Command System

The **Incident Command System** (ICS) will be used during emergencies. A Hospital Command Center (HCC) may be established.

It is the same ICS used by **ALL EMERGENCY** agencies such as:

Butner Public Safety

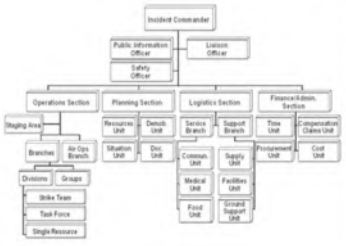
Granville County Emergency Management

FEMA

11

Incident Command System

- If you have a role in the Hospital Incident Command Staff that would activate in an emergency, then you will be trained on the responsibilities of that role.
- Positions expected to serve in this capacity can be identified in the Emergency Management Plan, on the CRH Intranet.



12

Fire Alarm Zones

The fire alarm is divided into 32 different fire zones. **ONLY** the alarm in the affected zone will activate the audible (tone & voice) & visual (strobes) devices.

Each Patient Care Unit (PCU) is a separate fire zone.

The fire alarm will **NOT** be heard throughout the building.

An alert will automatically be sent to the operator room, fire panel and to Butner Public Safety.

A fire truck will be dispatched to the location.

A prerecorded voice message will instruct occupants to relocate to another zone.

A Hospital Command Center (HCC) may be established.

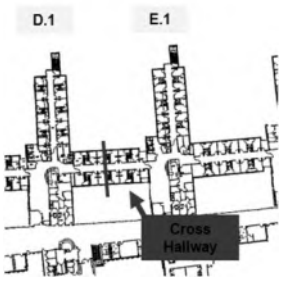
13

Fire Alarm Zones

When you start working in your PCU/department you will receive training on where to relocate when the fire alarm is activated.

Several units have "Cross Hallways". Cross Hallways are areas located in your PCU/Fire Zone that may have patient rooms or employee offices that belong to a connecting PCU. It's important that these areas are checked and evacuated if the fire alarm is activated.

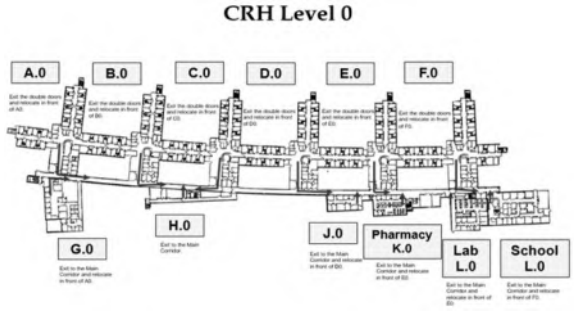
Fire drills are conducted every quarter on every shift in patient care areas.



14

Fire Alarm Zones

Relocation areas vary depending in where you work. PCUs will typically relocate to the Main Corridor.



15

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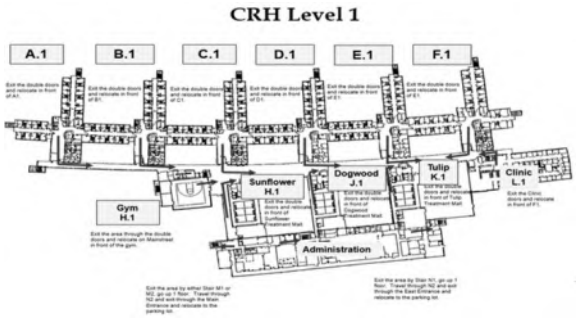

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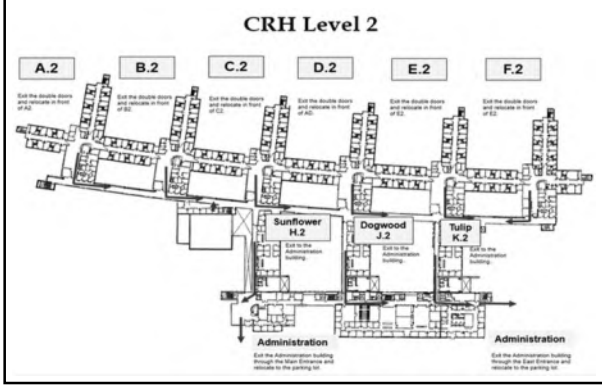
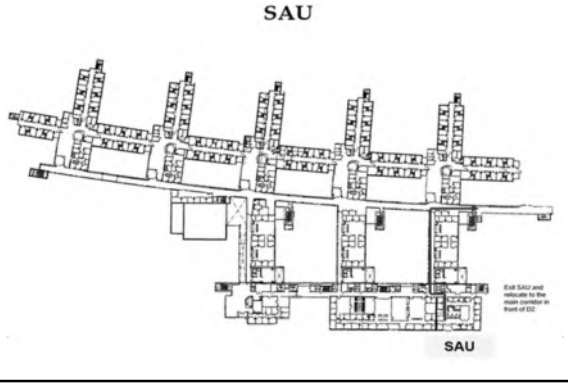
Fire Alarm Zones



17

Fire Alarm Zones



18

R.A.C.E.

Central Regional Hospital uses an acronym called **RACE** to help us remember what to do in the event of a fire. Each letter identifies a portion of the process as described below:

Remove Person(s)

Activate Alarm

Confine fire/Close door

Extinguish Fire/Evacuate you should extinguish fire **ONLY** if safe to do so

19

Know Your Relocation and Staging Area

All units and departments **must know** their designated relocation or staging areas.

The location of the relocation or staging area depends on the location of the danger.

Make sure all **staging areas** are checked for a proper headcount.

The **relocation area** is a safe area in another zone.

You will learn your relocation area once you're assigned to your unit/department.

20

Remember

A headcount must be conducted to ensure the safe evacuation of all persons in the immediate danger area and in adjoining **potentially dangerous areas.**

Be sure to **check all rooms** for persons who may have been unable to evacuate or who did not hear the alarm.

21

Activate the Alarm

22

Activate the Alarm

If there is a fire and you must go to the immediate rescue of someone

***SHOUT* - "Code Red!"**

If you hear someone shouting **"Code Red"**
Activate the fire alarm by pulling a pull station
- Dial 55 and give a report

23

Activate the Alarm

55 is the CRH version of "911"

Dialing **55** at the CRH Butner Campus **gets** the **hospital operator**. The hospital operator will:
- Summon external and internal resources
- Call Butner Public Safety to ensure alarm was received

While you may dial 911 to summon help, help may arrive faster if you **Dial 55.**

24

Contain/Close Doors

Doors must be closed in the event of a fire, open doors increases the amount of oxygen, leading to a larger fire.

Staff should never prop a door open with any type of obstruction. Doors are not allowed to be propped open at any time.

Shut doors to office areas when you leave – doors with magnetic hold-open devices will close automatically.

Fire Shutter Doors are rolling steel doors designed to close automatically in the event of a fire or alarmed event.

25

26

27

Fire Extinguishers

Each person must use their assigned key to open a fire extinguisher box to access the extinguisher.

28

Flammable Liquids

- **It is a liquid** [other than a solution containing less than 24 percent alcohol by volume and at least 50 percent water by weight] **that has a flash point less than 140 °F.**
- Flash Point is the lowest temperature at which a liquid gives off enough vapors to form an ignitable mixture with air.

29

Categories of Flammable Liquids

Category 1: Flashpoint below 73.4 degrees F and boiling point below 95 degrees F

Category 2: Flashpoint below 73.4 degrees F and boiling point above 95 degrees F

30

Categories of Flammable Liquids

Category 3: Flashpoint is between 73.4 and 140 degrees F

Category 4: Flashpoint is between 140 and 199.4 degrees F

31

Storage of Flammable Liquids

- The cabinet must be obviously labeled: "Flammable"
- No more than 60 gallons of category 1, 2, or 3 shall be stored at any one time or 120 gallons of category 4 at any one time.

32

A-B-C Fire Extinguishers

Extinguishing agents in a fire extinguisher are based on the products to be extinguished.

A-B-C fire extinguisher will contain dry chemical powder to extinguish **A**-**B** or **C** fires.

CRH only uses **A-B-C** Fire extinguishers.

33

Categories of Fire

A: Solid combustible (wood, vegetation, paper)

B: Flammable liquids (gas, paint, propane, oil)

C: Electrical sources (wiring, fuse boxes)

34

Important Safety Features

DO NOT BLOCK

- Fire Extinguishers
- Alarm Pull Stations
- Electrical Panels
- Exit Doors

Furniture, plants, files, boxes, etc. are **not** allowed to be placed or stored in front of these safety items.

These areas **must always be accessible** in the event of an emergency.

35

Small Fire vs. Large Fire

Your actions in a fire situation will depend on the size of the fire.

Small fire
determined to be within your control to try and extinguish

Large fire
beyond your control **not able** to extinguish

Both kinds of fires should be addressed using the **RACE** formula.

36

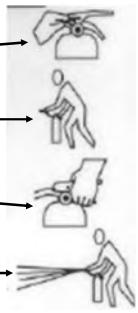
Using a Fire Extinguisher : PASS

Pull the pin

Aim at base of fire

Squeeze trigger

Sweep back and forth



37

Other Factors To Remember

Always check the door for heat with the back of your hand before opening the door to a potentially dangerous fire.

Smoke rises, so crawl or stay near the floor for safety.

Know the location of fire extinguishers in your area and how to use them properly.

Know the meaning of, and safely practice P-A-S-S!

38

Other Factors To Remember

Know the location of alarm pull stations in your area.

At the time of an emergency, you do not want to lose precious time searching for an alarm station.

Do not enter a fire area if the heat, smoke or fumes are too intense.

Always report the fire, large or small, to your supervisor and **Dial 55.**

All discharged fire extinguishers must be replaced.

39

Questions?

If you have questions related to Fire Safety, please review the policy manual or contact the Safety Department:

EOC Coordinator, CRH
764-7319
Reba Duke, Safety Officer, CRH
764-7221
Allison Edwards, Safety Officer, CRH Annex
575-7689

40

The End

You will now have an **assessment**, you **must pass** with a competency of **80%** in order to receive credit for taking the class.

41

Central Regional Hospital: 4 Core Principles

1

Partnering with Patients for Safety and Recovery

- Patients who are actively involved in contributing and carrying out their own treatment plan are more likely to improve and be successful in the community.
- Providing opportunities, encouragement, and support that help patients get more involved in their treatment is partnering with patients for recovery.
- Patients actively involved in various treatment activities with supportive staff are less likely to become aggressive to themselves or others, which is how staff partner with patients for safety.
- The 4 Core Principles were developed to provide guidance on how to partner with patients for safety and recovery.

2

What are the 4 Core Principles?

1. How Can I Help You?
2. It's All About Relationships
3. What You See is Not Always What's There
4. Wellness Begins with YOU

3

1. How Can I Help You?

- A primary purpose of CRH staff is to serve patients by helping them improve the quality of their lives both in and out of the hospital. Knowing the answer to "How can I help you?" is key to aiding patients with having more rewarding lives. It is important for all staff to come to work with this attitude and question on their minds.
  - An attitude of "How can I help?" will bring clarity to your job no matter what department you work in.
- Sometimes asking a patient "How can I help you?" or "What do you need?" is a simple process that can lead to responses like the following:
  - More chocolate milk
  - A place to live when I leave the hospital
  - Different medication
  - More blankets
  - Gardening group
  - Anger management classes
  - Help with a medical problem

4

1. How Can I Help You? (continued)

Sometimes patients may not be able to clearly answer the question or state that they don't need help even when they do.

- However, it is still important to keep the "How can I help?" principle on your mind and use it to inform your interactions with patients. Patients refuse medication, placement assistance, grooming help and groups even when they could benefit from these services. Helping patients in these situations requires creativity, using various approaches.
- We have patients who refuse classroom groups, but will become involved in other events or activities and even jobs when we try to understand their preferences and strengths.

Helping others through understanding their spoken and unspoken healthy needs and goals is a major step in providing quality care and treatment.

The "How can I help?" and "What do you need?" mindset and attitude is key to patient and staff success. Feel free to use the above mindset and attitude with other staff members. You just may make someone's day.

5

2. It's All About Relationships

Positive relationships are crucial to many successful endeavors in life with family, friends and work.

- We all know that people respond better to a request when they have a supportive relationship with the person making the request. Our patients have the same need for positive, supportive relationships and will respond better to us if we have positive, helping relationships with them.

A therapeutic relationship is the type of positive relationship that hospital staff should form with patients.

- A therapeutic relationship is a helping relationship, not a friendship.
- The goal of a therapeutic relationship is to help patients solve problems, learn skills, improve their lives, and feel supported during their stay in the hospital. It is not a relationship where the staff shares their problems or too much about their personal lives with patients. Forming therapeutic relationships is a skill which some people do naturally and others can learn.

6

2. It's All About Relationships (continued)

The following are some qualities of a therapeutic relationship:

- ▶Patients feel valued because staff listen.
- ▶Patients feel safe to express themselves because staff keep information confidential, by only informing other treatment team members.
- ▶Patients have a sense of trust about the relationship because staff use the relationship to help the patient.
- ▶Patients feel respected because they are addressed in a caring and respectful manner.
- ▶Patients feel supported because staff respond in helpful ways to ensure patient requests for basic needs and comforts get positive action.

Quality therapeutic relationships with patients and quality working relationships with colleagues will make CRH a more enjoyable and rewarding place for patients and staff.

7

3. What You See is Not Always What's There

- ❖ **Patients in psychiatric hospitals often experience feeling unsafe, scared and fearful. Patients frequently have trouble thinking clearly and do not know what is going on around them. A person who is confused in a strange situation where they perceive that someone is going to hurt or mistreat them is likely to become threatening or violent.**
  - ▶ Working directly with someone who is in an agitated state, who is not thinking clearly, is difficult and can be scary. The challenge of working with agitated people is not to get into a cycle of fear, misunderstanding and aggression. This can be accomplished by realizing that you are working in a hospital and not encountering a threat on the street along with understanding that the agitated patient is most likely scared and afraid.
- ❖ **The vast majority of psychiatric patients have a personal history of trauma, which means that they have been abused and mistreated many times in their life.**
  - ▶ Past abuse and mistreatment can cause patients to think you are going to be abusive to them. They, at times, respond to this fear and misperception with hostility. People who have been hurt by others tend to see others as being likely to hurt them again, even if you are trying to help them.

8

3. What You See is Not Always What's There (continued)

- ▶ **When working with patients, it is important to maintain professional, therapeutic boundaries at all times.**
- ▶ **We can not allow our cognitive biases or emotions to drive our interactions with patients. We need to respond to each patient and each situation with objectivity, empathy, and a high level of professionalism.**
- ▶ **Being professional means not using labels when discussing patients, never minimizing a patient's feelings of pain (psychological or physical), and never assuming a patient's complaint is false.**

9

3. What You See is Not Always What's There

A safe caring environment where patients feel respected will reduce patients' fears and hostile reactions. Psychiatric patients report the following helps them to feel safe and secure when hospitalized:

- ▶*Listen to what we say*
- ▶*Talk with us about what is going on*
- ▶*See us as individuals, not our diagnosis*
- ▶*Respect our potential for growth and healing*
- ▶*Be aware of our personal histories*
- ▶*Be aware of early warning signs of distress and offer support before things get more difficult; offer soothers and alternatives*
- ▶*Use de-escalation rather than physical interventions whenever possible*

Understanding that we all feel vulnerable sometimes helps us remember that when a patient is being angry and aggressive, they many also be scared and hurting.

10

4. Wellness Begins with YOU

Work can be more difficult for people who are struggling with their health and various life stresses. Workers who are healthy and calm perform best.

- ▶ **This is particularly important for a work setting like CRH given the importance of therapeutic communications with patients who are struggling with serious psychiatric disorders. Healthy, calm staff are more likely to enjoy their work and be effective treating and caring for patients.**

Supporting co-workers will also contribute to reducing stress at CRH.

- ▶ **Aiding and relieving co-workers when they are in tense situations with patients is a way we can all reduce stress at CRH. A true team approach is when we all help each other at the most difficult times.**

11

4. Wellness Begins with YOU (continued)

The hospital offers some programs to help staff with their health and well being:

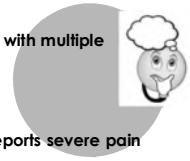
- ▶Staff Support Program (SSP) 919-764-2239, 919-764-2241. or 919-764-5219
- ▶Employee Assistance Program (EAP) 1-800-633-3353 A confidential counseling and referral program for personal and family problems
- ▶Health and Wellness Resources are offered by the NC State Health Plan
- ▶CRH Wellness Committee (Plans specific activities for staff)

Jobs at CRH can be demanding and stressful.

It is important that managers, supervisors and staff **work together** to reduce stress, increase wellness, and support each other while providing quality care and treatment. The equation is win-win. A healthy, balanced staff is ready to offer their best support to patients. A culture of wellness reflects support and value of the staff and highlights what is needed to work positively with patients: **Your best self ready to offer support, patience and respect to our patient population and to our co-workers.**

12

How could you use EACH of the 4 Core Principles in these situations?



- Seeing a familiar face on Main Street
- Entering a PCU in the afternoon (after PST groups) with multiple patients in the day room
- Getting to know a new patient
- Working with an uncooperative patient
- Working with a patient who frequently falls and reports severe pain and injury after each incident
- Working with a patient who makes frequent suicidal threats and/or gestures
- Working with a patient who just received bad news

13

General Safety

Hospital Orientation Training

1

General Safety

This topic has been identified as a hospital-wide competency. You will be tested on the material at the end of this course.

2

Proximity Cards : Name Tags

A **Proximity Card** looks like an identification badge that has a barcode on the back of the card. It identifies you as a Central Regional Hospital Staff Member

3

Proximity Cards : Name Tags

Loss of a proximity card should be reported **immediately** to your supervisor to protect the hospital from unauthorized entry of non-hospital staff

They work as a key to certain areas of the hospital

They identify nursing staff providing for medication administration purposes

If proximity card does not work, use your key

If you do not have your badge and keys when you come to work, **you will not be allowed to work** and must return with them.

4

Keys

Loss of a keys should be reported **immediately** to your supervisor to protect the hospital from unauthorized entry of non-hospital staff and prevent patient elopement.

5

The Globally Harmonized System (GHS) for Hazard Classification and Labeling

Worldwide System for Hazard Communication

~~MSDS~~ now SDS

MSDS is no longer in use

6

What is the GHS?

- It is a **common worldwide approach** to defining and classifying hazards, and communicating information on labels and safety data sheets.
- Currently different countries have their own requirements for hazard definitions as well the as information to be included on a label or the material safety data sheet that we currently use.
- With the GHS system all requirements will be the same worldwide so everyone will be able to use and understand them.

7

The GHS Elements

Classification Criteria

- Health and Environmental Hazards
- Physical Hazards
- Mixtures

Hazard Communication

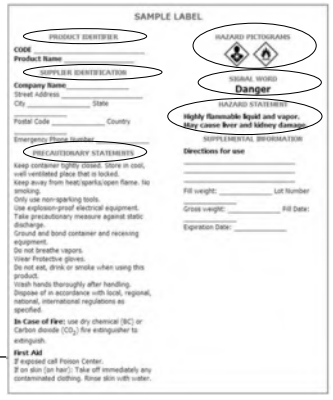
- Labels
- Safety Data Sheets

8

Hazard Communication – Labels

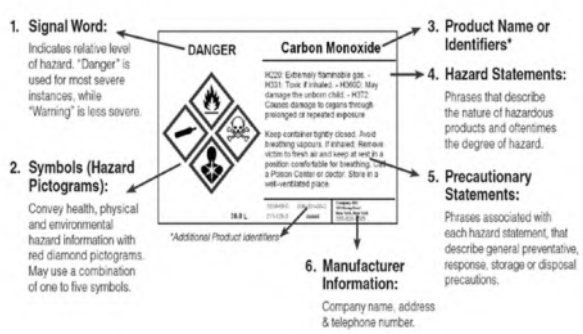
There are several new label elements:

- Product Identification
- Supplier/Manufacturer Identification
- Precautionary Statements
- Symbols called "Pictograms"
- Signal Words
- Hazard Statements



9

Six Elements of the GHS Label



10

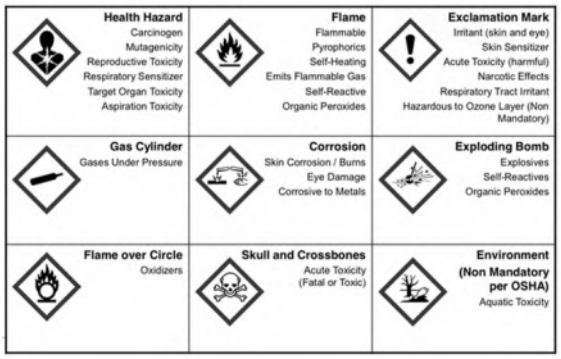
Elements of the GHS Label : Signal Words

"Danger" or "Warning"

These words are called signal words, and are used to emphasize hazards and discriminate between levels of hazard.

11

Elements of the GHS Label : GHS Pictograms



12

GHS Pictograms by Category

Chemical/Physical Risks
1. Explosives
2. Flammables
3. Oxidizers
4. Gases Under Pressure
5. Corrosives

Health Risks
1. Severe Toxics
2. Acute Toxics
3. Health Dangers
4. Corrosives

Environmental Hazard Class*

*OSHA does not regulate the Environmental Hazard Class, however the EPA is expected to incorporate this element of GHS into their standards.

13

Primary and Secondary Containers

When a chemical is purchased the container it is in is a **primary container** and typically will already be have an appropriate label, any container that the chemical is transferred to from the primary container is a **secondary container**. Both primary and secondary containers need to be labeled properly.

14

OSHA Training Requirements for SDS

Initial training on MSDS and hazardous communication **(completed in hospital orientation)**

Site specific training on SDS within 10 days of reporting to unit/department

Once employees are trained initially in SDS, they continue to be trained in this area as part of Annual Training **(like what you are completing now)**

Specific SDS training when a new product is introduced or if an employee misuses the product **(Generally occurs on unit or in department in which you work)**

15

SDS Training Records

All training must be documented in your online training record

Review your training transcript online or contact Staff Development if you have questions

16

Hazardous Drugs/USP 800

Hazardous drugs (HDs) are sometimes used at Central Regional Hospital during the treatment of patients.

Handling HDs includes, but is not limited to, the receipt, storage, compounding, dispensing, administration, and disposal of sterile and nonsterile products and preparations.

Employees shall follow all CRH policies and procedures to comply with the USP <800> standard regarding handling hazardous drugs.

17

Safety Data Sheets (SDS)

Powered by MSDSonline®

- Beginning in 2016 you will be able to access a SDS online.
- Departments may request to add a new chemical SDS online and have it placed in their eBinder.

18

Location of MSDSonline

MSDSonline is located in the Staff Portal.

19

Lockout/Tagout (LOTO)

What is Lockout/Tagout?

Answer: A mechanical device that physically prevents the transmission or release of energy. Plant Operations uses this procedure when repairing equipment.

20

How does LOTO affect me?

- If you see LOTO devices on equipment
  - Do not attempt to use that equipment
  - Do not attempt to remove LOTO devices

21

Compressed Gas Cylinders

What type of compressed gas cylinders do we have at CRH?

- **Fire Extinguishers, Welding Tanks Oxygen, Acetylene**
- **Medical Use Tanks Oxygen**
- **Propane Tanks Forklifts, Grills**

22

Compressed Gas Cylinders Safety Precautions

- **Cylinders should be handled by trained personnel;**
- **Cylinders must be properly labeled and color coded;**
- **Never attempt to repair cylinder, valves, or safety relief devices;**
- **Cylinders containing compressed gas should not be exposed to temperatures above 125 F;**
- **Leaking cylinders should be taken outside to vent;**
- **Cylinders; containing flammables should be placed in a safe area and identified;**
- **Cylinder valve should be closed when not in use;**
- **Transport and store cylinder properly, use hand truck, roll platform, chains, etc...**
- **Never drop cylinder, use valve protection.**

23

Personal Protective Equipment (PPE)

Personal Protective Equipment is provided at no charge to the employee. Types of PPE include:

Safety Goggles: protect the eyes from chemicals that could splash in the eyes

Gloves: protect hands from chemicals that could cause burns or irritation to the skin

Masks: protect face/mouth from chemicals that could splash on the face

Respirators: offer protection from chemicals that have harmful fumes or dust

24

Personal Protective Equipment (PPE)

Face Shields: protect the face from chemical splashes

Safety shoes: protect the feet in situations that require the moving of heavy objects

Apron/gowns: protect clothes in case of chemical splashes

Hard hats: prevent head injuries due to falling objects, as in construction areas

25

Personal Protective Equipment (PPE)

Always wear the appropriate PPE for the specific tasks you are performing.

When using PPE, consider the following:
- Where you are
- Risk of exposure
- To what you might be exposed to

Check SDS for specific PPE required

26

Slips, Trips and Falls

- They're the second-leading cause of workplace injuries.
- Slips involve materials or substances flat on the walking surface.
- Trips involve materials protruding from the walking surface.

27

Take Action

Take responsibility for yourself and your coworkers. If you see a problem or unsafe condition you can:

- Take care of the problem
- Report it to supervisor
- Report it to maintenance or environmental services
- Report it to Safety

28

How You Can Prevent Trips & Falls

- Slips and falls may not be spectacular but they account for a major portion of workplace injuries.
- You can help avert slips and trips by watching for/marking hazards and being sensible in the way you go about your work.
- Make slip/trip avoidance personal by speaking up about your own practices and those of others.
- Always notify your supervisor & safety officer so they can support you and make a difference.

29

LIFTING AND BACK SAFETY

Back Injuries can be prevented with proper lifting techniques.

30

Back Injury Prevention

- Use proper lift procedures . . . follow these steps when lifting . . . .
- Take a balanced stance, feet shoulder-width apart.
- Squat down to lift, get as close as you can.
- Don't lift, if it's too heavy

31

Back Injury Prevention

- Get a secure grip, hug the load.
- Lift gradually using your legs, keep load close to you, keep back and neck straight.

32

Back Injury Prevention

- Once standing, change directions by pointing your feet and turn you whole body. Avoid twisting at your waist.
- To put load down, use these guidelines in reverse.

33

Medical Equipment

Important
All staff are responsible for reporting equipment problems

- Employees must be trained to use equipment
- Equipment must be inspected prior to use
- Report equipment problems to your supervisor
- Supervisor completes *Equipment Incident Management Report*

34

Medical Equipment

In the event of a medical equipment malfunction or failure, staff members are instructed to ensure the safety of the patient as follows:

1. The staff member will cease using the malfunctioning medical equipment immediately and ensure safety of the patient by following medical emergency procedures if indicated (i.e. MedStat, Code Blue).
2. Employees shall notify their supervisor/charge nurse of the malfunctioning medical equipment for patient and situation assessment. If question of patient safety or potential injury, staff shall not leave a patient unattended- call for assistance by either yelling or using your whistle.
3. Malfunctioning medical equipment must be labeled as "out of order", dated and timed, and placed in a locked room away from patient care. Your Immediate Supervisor/Charge Nurse shall be notified who will subsequently assist in placing a work order for repair.

35

Hospital Beds

Central Regional Hospital has three types of beds.

- Institution Bed (Fixed or Non-Movable)
- Mechanical Bed (Non-Electrical)
- Electrical Bed

Electrical beds are inspected during bi-monthly unit inspections to ensure:

1. the electrical cord does not exceed 12 inches, except in MPU F2,
2. there is no damage to the cord, plug or outlet,
3. there is no manipulation to the components of the bed by the patient.

Employees who work in units where electrical beds are located should be trained in their operation.

36

MRI Safety

Magnetic Resonance Imaging (MRI) uses a **powerful magnetic field** and a computer to determine if an injury or disease is present.

- Any metal object brought into the magnetic field may become a projectile and have a missile effect.
- Implanted devices (in the employee or patient) may twist when entering the magnetic field and could cause internal damage.
- The magnetic field in the MRI is always on (even when the machine is not scanning and the department is closed).
- The magnetic field is so strong it can:
  - Pull large and small metal items into the machine (O2 cylinders, wheelchairs, floor machines, wrenches, screwdrivers, etc.).
  - Pull metal objects out of the employee/patient (aneurysm clips, pacemakers, hearing aids, etc.).

37

MRI Safety

Safety Precautions:

- **ALWAYS** consult with MRI staff before going into the area.
- Even in an emergency, **DO NOT** rush into the area with equipment or without making yourself safe to enter.
- Staff members must empty their pockets of any loose metal objects (hair/safety pins, coins, keys, ID badges, wallets, credit/banking cards, lighters, scissors, stethoscopes, hemostats, hearing aids, etc.) before entering the magnet room.
- Patient related equipment not allowed in the MRI area:
  - Oxygen cylinders, wheelchairs, beds, stretchers, IV poles, medication pumps, some patient implants, pacemakers, aneurysm clips, diabetic pumps, rods, screws, other implants.

"The objects pulled into the MRI Scanner or out of the patient/employee may cause injury or death"

38

Eyewash Bottles & Eyewash Stations

39

The eyewash bottle will be stored on the Environmental Services Cart and in the Nurses Station.

1. To open, twist cap in the direction of the arrow.

2. If foreign bodies are in the eye it may be best to lean your head forward and rinse.

3. Hold the eye cup to the affected eye(s). Squeeze the bottle to control the flow of solution and flush the eye.

40

After flushing with the eyewash bottle get to a permanently affixed eyewash station.

- Permanently fixed eyewash stations are located in the clean utility room on the PCU's and in identified environmental services closets.

41

Activate the eyewash station by pushing on the yellow paddle.

- The protective caps will pop off automatically.
- Place your face over the water stream and hold both your eyelids open with your fingers.
- Move your eyes around to ensure that they are properly flushed.

42

Flush for 15 minutes and then go straight to the clinic for medical assistance

- **Flush for 15 minutes.**
- **Go straight to the clinic for medical assistance.**
- **As soon as possible let your supervisor know and fill out an occupational injury/illness report** .

43

Emergency Announcements

To report a disaster or emergency at CRH, dial 55

If an emergency situation is declared, the hospital operator will announce, ***"Attention, Attention! Emergency Response Required! Staff report to…"***

Operator will announce the location designated by the Incident Commander

44

Weather Emergencies

Central Regional Hospital is a **24 hour** operation and **must remain open** regardless of adverse weather conditions

Adverse weather may necessitate the implementation of emergency measures to ensure sufficient staffing resources to provide continuity of care for services to our patients. CRH Hospital is a 24-hour operation and must remain open regardless of adverse weather conditions. **Therefore, closing decisions will not impact on the operation of the hospital and should be disregarded by staff.**

Facilities are made available for staff to stay on campus during adverse weather

45

Severe Weather Emergencies: Watches Vs. Warnings

WATCH
means conditions are favorable for severe weather

WARNING
means severe weather is happening or is going to happen

Examples:
Tornado Watch means conditions are favorable for the formation of tornados.

Tornado Warning means a tornado has been seen near by

Hospital operator will announce the tornado warning over the overhead page followed by "**this is not a drill**".

46

What Do You Do During a Tornado "Watch"?

Return patients to the PCU's and stay alert to weather changes

Cancel any offsite appointments

Plan what to do if the **"Watch"** is upgraded to a **"Warning"**

Be prepared to move to the tornado shelter. Gather any supplies needed

Do not leave your work site without notifying your supervisor

If you work in a patient area, make note of the location of the patients in your area and be prepared to move them if a **"Warning"** is announced

47

What Do You Do in a Tornado "Warning"?

This means that a tornado has been sighted or indicated on radar

Move employees, patients, students and visitors to the tornado shelter areas as indicated by the signage in the PCU's or yellow areas shown on the emergency floor plan

Stay in these areas until an "**ALL CLEAR**" announcement is made by the hospital operator

Remain calm!

48

CRH Adverse Weather Planning

Stage I: Planning & Activation
Stage I should be considered when weather predictions indicate conditions are highly likely for adverse weather conditions in the area surrounding CRH. This stage should be considered as a notification to hospital staff and key personnel that some type of adverse weather is expected.

Stage II: Emergency Implementation and Activation
Stage II should be considered as a notification to hospital staff and key personnel that some type of adverse weather will affect CRH's ability to maintain normal operations and/or will pose a significant hazard to the hospital's patients, staff and visitors

49

Stage I: Planning & Activation: What Happens?

Hospital staff and key personnel are notified that some type of adverse weather is expected & implement pre-planning

Activation: Operator will announce **"*CRH has implemented the Adverse Weather Plan Stage 1*"**

Direct care staff and support staff should be prepared to remain on duty due to possible critical staffing shortages or adverse weather conditions causing travel to and from work to be exceptionally hazardous

Off-duty staff are encouraged to contact their supervisor in case they are needed to work on another shift

Staff reporting for duty should bring personal items that will allow them to remain on duty for an extended period of time

50

Stage II: Emergency Implementation & Activation: What Happens?

Adverse weather or other significant weather emergency **will/or has occurred** and will affect CRH's ability to maintain normal operations

Activation:
Operator will announce **"CRH has activated Stage II of the Adverse Weather Plan"**

Supervisory personnel are to immediately implement the pre-planned option

Staff may be expected to remain on duty beyond their normal shift. Staff reporting for duty should bring extra personal items

51

Disasters/Emergencies

The first person at a disaster/emergency scene may begin rescue if it is safe to do so

Remove persons from danger area (if this can be accomplished safely)

Never enter an unsafe area!

Call hospital operator by dialing **55** & make a report **(Do not dial 0 to report emergencies)**

Notify your supervisor immediately

52

Disasters/Emergencies

When an emergency has been declared, you should:

- Follow announced instructions
- Know your unit or department relocation area
- Heighten your awareness of your surroundings
- Conduct a head count of patients and staff

53

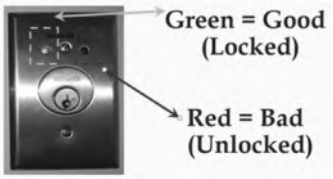
Door Security

- When using your badge or keys to enter or exit any door, all staff are responsible for ensuring that the door securely closes and locks before leaving the area.
- All staff are also responsible for not allowing anyone to enter or exit through a secured door or onto the elevators if the person is not wearing a CRH badge.
- If you identify a door that is not working properly, please notify a supervisor immediately in order to have the issue evaluated by Plant Operations.

54

Door Security

- A majority of the doors in the hospital can be unlocked using our badge. These doors also have the option of using a key to lock and unlock the door.
- It is safer to use your badge on this type of door since it will automatically lock. If you use your key on these doors you must remember to lock the door back.



55

Disasters/Emergencies

What is an Active Intruder?

An active intruder is a person who appears to be actively engaged in physically harming or attempting to physically harm someone in or at CRH. In most cases, active intruders use a firearm(s) and display no pattern or method for selection of those being attacked. In some cases, the assailant will use other weapons and/or improvised explosive devices to cause additional harm or to impede police and emergency responders.

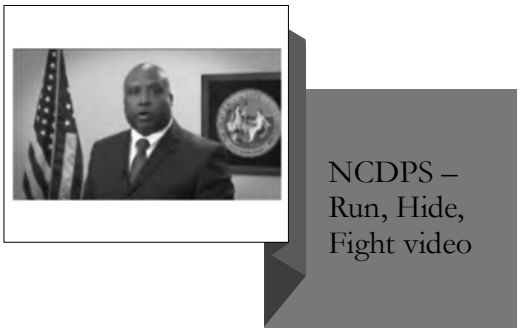
56

Disasters/Emergencies

Notifying Others and Maintaining Personal Safety

- All employees, upon witnessing/learning of an active intruder incident, should determine if they should RUN-HIDE-FIGHT. Employees may decide to use any combination of RUN-HIDE-FIGHT depending on the situation.
- If an employee is caring for patients, then the employee should decide the best RUN-HIDE-FIGHT option for themselves and their patients.
- When safe as possible, employees will call 55 (from a CRH phone) and report the incident. Dial 911 to report the incident if the 55 call does not connect or the employee is using a non-CRH phone.

57



NCDPS – Run, Hide, Fight video

58

Disasters/Emergencies

When an Active Intruder emergency has been declared, you should:

RUN!

- Have an escape route and plan in mind.
- Leave your belongings behind.
- Keep your hands visible.
- Evacuate quickly and quietly, as not to attract the attention of the intruder.
- Help patients and others while escaping

HIDE!

- Hide in an area out of the active intruder's view.
- Lock/barricade the door and turn out lights if possible.
- Block entry to your hiding place and lock the doors.
- Remain quiet and remember to silent cell/VOIP phones and pagers.
- Identify possible weapons to FIGHT the intruder if necessary.

FIGHT!

- As a last resort and only when your life is in imminent danger.
- Attempt to incapacitate the active intruder utilizing any means necessary.

59

Emergency Codes

Code **Red** = Fire
Code **Blue** = Medical Emergency
Code **Green** = Incident Command Activation
Code **Orange** = Chemical Emergency
Code **Gray** = Severe Weather
Code **Brown** = Security Emergency/Lockdown
Code **Black** = Utility Failure

60

Hospital Security

- Security Lockdown Policy is in the Safety Manual in the CRH Intranet (This response procedure can be activated anytime a credible threat of violence is made towards CRH).
- Be alert and notify your supervisor if a threat of violence is made towards yourself or the hospital.
- If a lockdown occurs, an announcement will be made overhead and an emergency one-call alert will be sent to those who signed up.
- Exterior doors to the hospital will lose card access at the main campus and all exterior doors will be locked at the Annex Campus.
- Depending on the emergency, employees may or may not be able to exit the building.
- Outdoor activities will be immediately terminated
- When the threat is concluded, an "All Clear" message will be announced overhead and through One-Call.

61

CRH Tobacco Free Environment

CRH prohibits smoking or the use or sale of any tobacco product on all CRH properties. This policy applies to all employees and persons on CRH grounds.

Purpose

CRH is committed to providing a safe and healthy treatment and work environment for all patients, staff, visitors, and business associates. Policy #APM-T.008

62

CRH Tobacco Free Environment

Procedure: Prohibits all employees on CRH properties from…

- Smoking or using other tobacco or nicotine delivery products while on grounds.
- Using tobacco or tobacco and nicotine delivery products at off-campus patient related activities or facility-sponsored events.
- Smoking or using other tobacco or nicotine delivery products in their private vehicles while the vehicles are on the facility's grounds.

Policy #**APM-T.008**

63

CRH Tobacco Free Environment

- Tobacco or Nicotine Delivery Products include (but are not limited to): cigarettes, pipes, pipe tobacco, tobacco substitutes (e.g. clove cigarettes, chewing tobacco, snuff, cigars and e-cigarettes).
- Nicotine Replacement Products include gum, patches, lozenges and inhalers. Nicotine replacement products are not considered tobacco or nicotine-delivery products and are allowed for purposes of this policy.

Policy #**APM-T.008**

64

CRH Tobacco Free Environment

Assistance for those wanting to quit

- Quitting support services of the North Carolina Tobacco Use Quitline at 1-800-QUIT-NOW (1-800-784-8669).
- Employees are also encouraged to talk to their health care provider about quitting and ask about appropriate pharmacotherapy available through their health insurance plan.

65

Tobacco Free Environment
Policy Number: APM-T.008

Failure To Comply

- Disciplinary Action, up to and including dismissal, for unacceptable personal conduct.
- Non-complying contractors, volunteers, visitors, and other covered individuals may be asked to leave.

66

Weapons

Weapons and firearms **are not allowed** on either campus of Central Regional Hospital

Violators may be subject to dismissal and criminal prosecution

67

Drugs

Alcohol and illegal drugs **are not allowed** on the campus of CRH Hospital

Violators may be subject to dismissal and criminal prosecution

68

Vehicle and Parking Lot Safety

Lock your vehicles while at work

It is in your best interest and those of our patients to lock your vehicles while on campus

If you drive open-bed vehicles, (like pick-up trucks) please remember not to bring items in your truck which may be used as a weapon or tool by our patients to injure themselves or others

69

Vehicle and Parking Lot Safety

Potentially harmful items include:
- Gas cans
- Garden utensils
- Rope
- Sharp objects
- Glass

If you have a handicap placard, register it with the safety office.

And remember…**Always park in designated parking areas only! Vehicles may be towed at owners expense.**

70

Potential Safety-Related Events That Should be Reported to your Supervisor

Medical Equipment Problems

Hazardous Material or Waste Spills

Any Threatening or Violent Behavior

Suspicion of an Individual having firearms or weapons

On-the-job accidents, injuries or occupational illness

Restraining Orders employees obtain against another individual must be reported to their supervisor and a copy provided that will go to HR and Safety.

71

Always Report a Safety Concern

You are encouraged to report ***all*** safety concerns

You can do so without fear of:
- Harassment
- Retaliation
- Intimidation

You **may** report concerns **anonymously**

You can report safety concerns without fear of retaliation!

72

Reporting Hazards

You have several ways to report a hazard.

- Inform your supervisor
- Contact the Safety Officer
- Contact a member of the EOC/Safety committee
- To make reporting hazards easier for employees, OSHR is also implementing a new web-based reporting tool. The tool will keep a record of hazard reports and responses for ongoing data analysis by OSHR.

73

WORKERS' COMPENSATION

A program designed to help YOU!

74

Workers' Compensation

- Report on-the-job accidents to your supervisor before the end of your shift.
- Complete *Occupational Injury/Illness Report* as soon as possible, preferably before the end of your shift.

75

Workers' Compensation

- Be specific as to type of injury, how injury occurred, and date/time of accident.
- Report to the CRH Clinic for first aid and medical consultation.

76

Workers' Compensation

- First 7 days after accident employee must use personal leave
- Workers' Comp pay = 66 2/3 % of monthly salary.

77

Workers' Compensation

- CRH Clinic, Workers' Comp representative or Key Risk Management Services MUST authorize additional medical treatment. Do not go to personal physician, clinic or specialist -- these appointments will not be paid.

78

The End

You will now have an **assessment** which will consist of
10 questions.

You **must pass** with a competency of **80%** in order to receive credit for taking the class.

79

HIPAA/CODING RELATIONSHIP

CENTRAL REGIONAL HOSPITAL

GENERAL ORIENTATION

HIPAA TRAINING

Crystal Marsico-Wood, RHIT, CCS
CRH HIPAA PRIVACY OFFICIAL

David Ayscue
CRH HIPAA SECURITY OFFICIAL

MISSION CONFIDENTIAL

1

Presentation Outline

- What is HIPAA?
- What is Patient Confidentiality?
- Where is PHI at CRH?
- Types of CRH PHI
- HIPAA Privacy Rules
- Importance of Privacy
- Privacy Safeguards
- CRH Privacy Contact Information

2

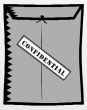
What is HIPAA?

Health Insurance Portability and Accountability Act

It is Federal legislation to ensure *confidentiality, privacy & security* of a patient's health information

3

What is Patient Confidentiality?



Keeping information about a patient PRIVATE and not sharing the information with anyone who doesn't need to know.

Maintaining confidentiality:

- Protects the patient, employee & hospital
- Is a responsibility of everyone at CRH - employees, physicians, students, & volunteers

4

What is Confidential?

Protected Health Information (PHI)

Any information pertaining to a patient that may be used to identify the patient.

- Name
- Address
- Date of Birth
- Social Security Number
- Medical Record Number
- Phone Number
- Email address
- Account Number
- Certificate Number
- Photograph
- Medical Record
- Billing Information
- Relative's name

5

Where is PHI at CRH?

Everywhere!

There are three types of PHI at CRH:

Oral

Written

Electronic

6

HIPAA/CODING RELATIONSHIP

Oral PHI

- Meetings
- Conversations
- Telephone contacts

7

Written PHI

- Medical Record
- White Board
- Reports
- Billing Forms

8

Electronic PHI

Any patient information stored as electronic data

Computers **Flash drives**
Email **Web Sites**
Servers **Networks**
PDAs (Personal Digital Assistants)

Some Data Examples

- Electronic patient care programs (Pharmacy, Labs)
- Master Patient Index
- On-line dietary requisitions
- HEARTS

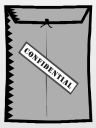
9

Why is Privacy Protection Important?

- It's the law & written policy at CRH
  - NC Mental Health Statutes (§122C, Article 3, Part 1)
  - NC Administrative Code (10A NCAC 26B)
  - Federal Substance Abuse Law (42 CFR, Part 2)
  - Federal Privacy Law - HIPAA (45 CFR, Parts 160 & 164)
- Civil & criminal penalties for violations
- Confidentiality is a *PATIENT RIGHT*
- Protection against discrimination
- To ensure & maintain a therapeutic environment

10

HIPAA Privacy Rules



1. Defines how CRH may use & disclose PHI
2. Establishes safeguards for the protection & privacy of PHI
3. Ensures accountability by providers & payers through civil & criminal penalties

11

HIPAA Privacy Rule

Notice of Privacy Practice (NPP)

- Required under HIPAA
- Distributed to patients upon admission to CRH
- Advises patient of their PHI rights at CRH
- Directs how CRH will use patient's PHI
- Gives CRH permission to disclose PHI for Treatment, Payment, and Operations (TPO) without a separate consent
- Patient has right to revoke consent to TPO

12

HIPAA/CODING RELATIONSHIP

HIPAA Privacy Rule

Who has the right to access PHI at CRH?

- Treatment providers
- Insurance company to facilitate payment for services
- Guardian/Power of Attorney
- Family/significant others - *with the patient's consent*
- Patient

CRH must protect PHI from accidental or intentional disclosure, alteration, destruction or loss at all times.

13

Remember!

All information about a CRH patient, even the fact that they are here, is private & confidential, and cannot be disclosed to anyone without the patient's permission.

14

Phone Call Response

"Due to Federal Regulations, I cannot confirm or deny if we have a patient by that name. I can take down your name and number and if there is a patient by that name, your information will be given to that individual. Contact with you is at the discretion of the individual".

15

HIPAA Privacy Rule

The trash is private!

PHI is discarded separately from "routine trash". Any documents with PHI must be shredded at CRH.

16

Shred Containers at Central Region Hospital

Shred Container at Annex

Shred Container at CRH

17

Privacy Safeguards

CRH Privacy/Protection Safeguards

- Environmental safeguards
  - Conversations in private areas
  - Location of medical records, documents, etc.
- ID badges for employees & visitors
- Sign in/out procedures for visitors
- Limited access to PHI - locked areas / electronic access
- Log-in Monitoring & Password Management
- Password protected electronic environments
- Encrypted transmission of PHI
- Secured Printing & Faxing locations
- Secure destruction methods - shredding
- Employee "need to know" access

18

Privacy Safeguards

SOCIAL MEDIA

- Social Media is not permitted to be used by staff while at a DHHS facility.
- When employee's use personal social networking sites they should remain personal in nature and not be blurred with their professional life.
- Confidential or non-public information should never be shared.
- The release of sensitive information over Social Media can harm the organization's reputation, violate HIPAA or other regulations, and lead to breach notifications and hefty fines.

19

Privacy Safeguards

CELL PHONES

- Cell phones are not permitted in any patient care area at CRH unless approved by management.
- Staff should never take "selfies" in the workplace.
- Cell phones are not secure, they can be called into evidence in a court of law if ordered into evidence by a judge.

20

HIPAA Safeguards

Establishes accountability

Helps to limit …
- Civil Penalties
- Criminal Penalties

21

What do you do if you see an inappropriate use of PHI?

- *Contact supervisor immediately*
- *Notify CRH Privacy Official at ext. 47611 (Crystal Marsico – Wood)*
- *Document circumstances*

22

THE END

23

Infection Control

Central Regional Hospital Hospital Orientation

Who is responsible for CRH Infection Control Program?

Infection Preventionists
Kim Perry, BSN, RN
Barbara Geercken, RN

Dr. Anne Stephenson is CRH's Medical Director & Director of the Infection Control Program

1

Who else is responsible for preventing the spread of infection at CRH?

WE ALL ARE!

- Infection Control is the hospital's program established for the prevention and control of the spread of infections to patients, visitors and healthcare workers. The infection control program will provide you with the education now and annually to carry out this important responsibility – to participate in the Culture of Safety.
- There are Infection Control Policies on the CRH Intranet to help guide you.

2

Where will you come in contact with germs?

EVERYWHERE!

For example:
Door knobs
Keyboards
Furniture
Phones
Bathrooms
Trashcans
Vending
Laundry

When providing direct patient care:
- Taking vital signs
- Giving medications
- Restrictive interventions
- Obtaining Lab specimens (blood, urine or throat cultures)
- Patient education
- EMERGENCIES



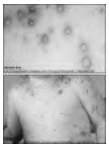

3

What are some infections that CRH patients could have?


COVID-19

Methicillin-Resistant Staph aureus (MRSA) skin and wound infections
Clostridium difficile (C. diff) gastrointestinal infection
Herpes simplex (cold sores)
HIV
Varicella zoster (shingles)
Varicella (chickenpox)
Hepatitis C virus infections
Lice
Colds
Influenza
Pneumonia


HIV


Chickenpox

Urinary Tract Infection- CAUTI (Catheter associated urinary tract infection)
CLABSI-Central line bloodstream infection
Conjunctivitis or eye infection

4

HOW DOES CRH PROTECT STAFF FROM INFECTIONS?

- CRH conducts testing for protective immunity for certain infections on all new employees, free of charge.
- CRH gives free and safe vaccinations to all employees who need them for Hepatitis B virus, chickenpox, measles, mumps, influenza and TDAP.
- CRH identifies infection risks and puts up proper signage to identify special precautions.
- CRH will test you if you have evidence of exposure to tuberculosis.
- CRH provides the training and equipment (PPE) you need to protect yourself from contact, droplet or airborne infections.
- Alcohol based hand sanitizers and soap are available throughout CRH for hand hygiene.
- CRH will screen staff and contractors as determined by mgmt.

5

Examples of PPE

What is PPE? Specialized clothing and equipment worn to protect against exposure to infectious materials.


Gloves


Mask


Ambu Bag


Hair cover
Face shield
Goggles


Gown


N95 Respirator

6

CRH employees must anticipate exposure to potential sources of infection and put on the Personal Protective Equipment (PPE) that is indicated.

Examples:

- Drawing blood
- Handling urine or stool specimen
- Changing dressing
- Cleaning up a blood spill
- For a large blood spill
- Assisting with patient restraint when the patient has a bleeding injury





7

PPE Locations in hospital

PPE is located in these areas:	PPE is located HERE
PCUs, Treatment malls X-ray PT Lab Pharmacy Laundry Food & Nutrition Schools Grill SAU EEG Beauty & Barber Shop Ambulances / Transportation	Exam rooms Medication Rooms Nourishment Rooms Clean Utility Rooms Dirty Utility Rooms Code Carts Spill Kits Green Bags Blue Bags Central Supply

8

What is the single most important measure to prevent the spread of infection?

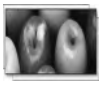
Hand Hygiene!!

>> video

If your hands are visibly dirty or visibly soiled with blood or body fluids, wash your hands with **soap and water**.

Everyone must use **SOAP AND WATER** to perform hand hygiene:

Before **EATING** or **Handling FOOD** &
After using the **RESTROOM.**



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How to wash hands with soap and water:

- **Wet hands first with water (avoid hot water)**
- **Apply soap to hands**
- **Rub hands together vigorously for at least 20 seconds**
- **Rinse**
- **Dry thoroughly**
- **Use TOWEL to turn off faucet**

10

USE ALCOHOL BASED HAND SANITIZER:

- When hands are not visibly soiled.
- Before and after direct contact with patients.
- After contact with body fluids, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled.
- After contact with inanimate objects in the immediate vicinity of the patient.
- After removing gloves.

*Note: **All staff are responsible to monitor the expiration dates on their personal and desk hand sanitizers. Discard prior to expiration date. Every department has a process to audit for and discard personal & desk sanitizers prior to expiration date.**

Apply product to palm of one hand and rub hands together covering all surfaces of hands and fingers until dry.

11

Important Hand Hygiene Reminders

- Do not use one pair of gloves to care for more than one patient
- Use hospital provided lotion to reduce cracking and drying due to frequent hand hygiene
- Keep nails to ¼ inch in length or less

12

Standard Precautions (Universal Precautions)

1. Hand Hygiene 
2. PPE (Personal Protective Equipment)
3. Safe Injection Practices 

4. Respiratory Hygiene/Cough Etiquette

Based on the principle that all:

- Blood
- Body fluids (except sweat)
- Non-intact skin
- Mucous membranes

May contain Blood-borne Pathogens or other potentially infectious materials (OPIM).

13

CRH
Modified Standard Precautions Guidelines

- For a Patient diagnosed with a Multi-drug resistant organism (MDRO) - either colonized (carrier) or minor infections that can easily be covered or contained in a continent patient.
- Allows patients to receive treatment unhindered.
- Multidrug resistant organisms like MRSA, VRE, ESBL, CRE, C-Diff are antibiotic resistant.
- MRSA is methicillin-resistant Staph aureus and is harder to treat, but **is not** more contagious.
- Patient is provided dedicated medical equipment (i.e. blood pressure cuff).
- Patient's do not share rooms with others unless they have the same condition (roommate criteria).

14

There are 3 Basic Isolation Precautions

Contact
Droplet
Airborne

These are called:

Transmission-Based Precautions

Transmission-Based Precautions are used to prevent the spread of germs for which the risk of spread requires additional precautions beyond Standard Precautions.

15

Contact Precautions

Did you know that 80% of infections are transmitted by direct or indirect contact .

- **Direct**: person to person transmission (*body fluid from a patient contacting your mucosa or non-intact skin*)
- **Indirect**: environmental surface to person transmission *(patient infecting objects which then are touched by staff*)

Contact Precautions are used for:

- Lice
- Conjunctivitis
- Scabies
- MRSA draining wound

*Post this sign on patient's door on MPU only

16

Droplet Precautions

Droplet Precautions are used for:

- Respiratory Illness such as Influenza
- Strep Throat
- Viral Syndromes with a fever

Germs are **spread** through close contact with respiratory secretions of a patient with respiratory infection (Spreads 3-6 feet)

Encourage patients to:

- Stay in room
- Have meals in room
- Wear mask when out of room
- Perform good hand hygiene
- Perform cough etiquette

*Post this sign on door of patient's room on MPU only.

PPE: always wear a **Mask** when you are within 6 feet of the patient. (and wear gown, gloves and goggles when indicated)

17

Influenza Information

Influenza is a serious viral disease characterized by *abrupt onset of fever, muscle pain, fatigue, non-productive cough, sore throat, and runny nose* (rhinitis)

- Spreads from person to person through coughing or sneezing
- Can cause pneumonia and death
- At risk: Over 65, infants and immunocompromised
- Influenza spreads very easily by coughing and sneezing

Once infected:

- takes 1-3 days to get sick – during these days you are spreading the flu and you do not know it.

Annual Flu vaccine is mandatory for CRH employees and is provided at no cost.

The deadline to have proof to your supervisor is November 1.

18

Respiratory Hygiene and Cough Etiquette

19

✈Airborne Precautions

Germs that remain **suspended** in the air (aerosolized) for long distances and can spread to others.

These patients are placed in negative pressure rooms in the Medical unit (MPU).

Airborne Precautions are used for:

- Tuberculosis
- Measles
- Chickenpox (varicella)

PPE: always wear N95 respirator when you are in the patient's room (and wear gown, gloves and goggles when indicated)

The patient **must**:
-stay in room
-have meals in room
-wear a mask when out of room
-encourage good hand hygiene and cough etiquette

20

STOP

Please see the Nurse in Charge

before entering this room.

Thank you.

***Post this sign on Patient's Door when on TBP except MPU**

21

CRH also uses the following Precautions:

- Contact - Special Enteric:
  - When patients have C. diff (Clostridium difficile) diarrhea or gastroenteritis (diarrhea).
  - Patients are transferred and treated on the Medical unit (MPU).
  - Staff must wash their hands with **Soap and Water**.

- Special Airborne/Contact:
  - Avian Flu
  - Coronavirus 2019 (COVID-19)

- **Staff must wear**: N95 Respirator, **wear gown, gloves, and goggles when you are in the patient's room**

22

Occupational Safety and Health Administration OSHA

Occupational Safety and Healthcare Act of 1970 requires that employers ensure a safe and healthful workplace.

OSHA is the federal agency that inspects workplace settings to ensure compliance with federal law.

CRH has a Exposure Control Plan to ensure we are compliant with law and our workplace is safe.

23

Blood-borne Pathogen Exposure Prevention: measures used by the Hospital to minimize or eliminate occupational exposure to Blood borne Pathogens or other potential infectious materials.

- **OSHA Blood-borne Pathogen Standard (29 CFR 1910.1030)**
- **CRH posts the CRH Blood-borne Pathogen Exposure Control Plan**
- The Infection Control Policy Manual is available on the CRH Intranet…

24

What are CRH Exposure Control Measures?

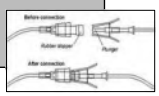
- Personal Protective Equipment (PPE)
- Hand Hygiene
- Tags, Labels, Bags
- Safe Injection Practices
- Laundry Practices
- Housekeeping Practices
- Handling Specimens
- Regulated Waste
- Hepatitis B Vaccine
- Post-Exposure Prophylaxis

25

Engineering Controls

Sharps Containers:
- Puncture Proof
- Leak Proof

Needleless systems for IV lines and IV administration of medications



Work Practice Controls

PPE

Hand Hygiene

Safe Injection Practices

Used Needles may not be recapped, bent, broken, sheared.

Do not eat, drink, smoke, apply cosmetics, handle contact lens where you might be exposed to infection.

Do not keep food in locations where specimens or blood/body fluids might be.

26

What is OSHA Regulated Waste?

- **Liquid or semi-liquid blood or other potentially infectious materials (OPIM). (e.g., human body fluids).**
- **Contaminated items that would release blood or other potentially infectious materials if compressed.**
- **Items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling.**
- **Contaminated Sharps (by facility policy)**
- **Pathological and microbiological wastes containing blood or other potentially infectious materials.**

27

How does CRH communicate Biohazard?

Tags
Bags
Labels

The tags are red/orange.

The labels contain the word Biohazard or the Symbol

and state the biohazard present.

Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious materials.

- Refrigerators
- Freezers
- Specimen Coolers
- Specimen Bags
- Specimen Boxes
- Contaminated Laundry containers

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OSHA Regulated Waste Disposal

Biohazard

- Bags with a red/orange biohazard symbol are used for the disposal of OSHA Regulated Waste
- These are located in treatment rooms and medication rooms.
- Staff must wear gloves when handling OSHA Regulated Waste or any other contaminated material.

29

CRH Sharps' Disposal

- **DO NOT DISPOSE OF SHARPS' CONTAINERS IN THE HOSPITAL DUMPSTERS.**
- WHEN FILLED **(3/4 FILL LINE)** DESIGNATED STAFF ARE TO:
  - CLOSE AND SNAP LID FIRMLY
  - BAG USING THE RED BIOHAZARD BAGS
  - PLACE IN THE DESIGNATED CONTAINER IN THE **BIOHAZARD STORAGE AREA** in Room N1032 Located Across from Central Supply
  - REPLACE WITH A FRESH CONTAINER RIGHT AWAY

- **THE KEY TO ROOM N1032 BIOHAZARD STORAGE AREA** CAN BE OBTAINED from **CENTRAL SUPPLY** DURING BUSINESS HOURS
  IF CENTRAL SUPPLY NOT AVAILABLE DURING BUSINESS HOURS > PHARMACY, **HOUSE COORDINATORS** FOR ALL AFTERHOURS, WEEKENDS AND HOLIDAYS

PLEASE HELP KEEP ALL HEALTHCARE PROVIDERS and WASTE MANAGEMENT WORKERS SAFE!

30

Laundry Practices

- All laundry is considered contaminated.
- Handle as little as possible.
- Gloves are always worn.
- Wear gown if needed.
- Use fluid resistant bags for contaminated laundry.
- Place in covered contaminated container.
- Do not allow container to overfill.
- CRH does not sort laundry.
- Wash your hands after removing gloves/handling contaminated laundry.

31

Housekeeping Practices
Decontamination

All surfaces that become contaminated must be cleaned and disinfected as soon as possible.

CRH uses EPA-approved disinfectant and this must be used according to label directions.

Spill kits are available on each PCU usually in the treatment/exam rooms.

Spill kits contain:
- Gloves
- Fluid Resistant Gowns
- EPA approved disinfectant
- Face Shields
- Mask
- Paper towels

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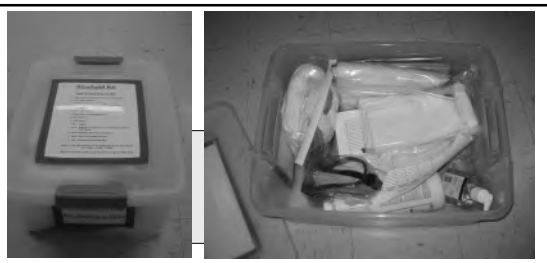


Blood Spill Kits

Contains PPE and cleaning / disinfecting supplies for larger clean-ups of blood or other potentially infectious materials.
For replacement items contact Environmental Services at X(4)7030.

33

Handling of Specimens

Laboratory Specimens (e.g., blood, urine and throat cultures) will be placed in a plastic bag with a biohazard symbol attached.

Laboratory Specimens will be transported in a puncture resistant, leak proof container that has a biohazard symbol attached.

34

Cleaning / Disinfection of Medical Equipment

- Noncritical medical equipment: Medical equipment that may come in contact with intact skin but not mucous membranes or non-intact skin.
- Ex. BP cuffs, stethoscopes, bedside commodes, glucometers, wheelchairs, etc.

35

Cleaning / Disinfection of Medical Equipment

- Visible contamination or soil must be cleaned with soap and water **prior to disinfection**.
- When the medical equipment is **not visibly soiled**, a one-step cleaning/disinfecting method may be used, using hospital approved disposable disinfect wipes.
- Patients with **non-intact skin or on isolation precautions** should be given disposable BP cuffs that are dedicated for that patient's use and properly discarded when no longer functional or needed.

36

Safe Injection Practices

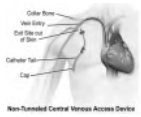
>> Video

CRH staff will adhere to basic aseptic technique for the preparation and administration of parenteral medications:

- Do not administer medications from one syringe to multiple patients.
- Use fluid and administration sets for one patient only. Needles, tubing and syringes are single use items.
- Use single dose vials for parenteral medications whenever possible.
- Do not administer meds from single dose vials to multiple patients or combine leftovers for later use.
- If multi-dose vials must be used, the needle (or cannula) and syringe must be sterile.
- Do not keep multi-dose vials in the immediate vicinity of a patient treatment area; discard if sterility is questionable.

37

CLABSI Prevention



A **central venous catheter** (**CVC**), also known as a **central line**, **central venous line,** or **central venous access catheter**, is a catheter placed into a large vein. This includes peripherally inserted central catheter known as **PICC** lines.

CRH Implements evidence-based practices to prevent central line associated bloodstream infections know as a **CLABSI. CLABSIs** result in thousands of deaths each year and billions of dollars in added costs to the U.S. healthcare system, yet **these infections are preventable**.

Prevention of CLABSIs at CRH:

- requires education to patients and to clinical staff about the importance of infection prevention.
- by using **hand hygiene** & removing nonessential catheters when possible.
- by implementing policies and practices aligned with evidence-based standards.
- by conducting periodic risk assessments, monitoring compliance, & evaluating effectiveness of prevention efforts.

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CAUTI Prevention

A urinary catheter, which is a tube inserted into the bladder through the urethra to drain urine.

CRH Implements evidence-based practices and guidelines to prevent catheter associated urinary tract infections known as a **CAUTI**.

Prevention of CAUTIs:

- requires education to patients and to staff about CAUTI prevention
- by using **hand hygiene** & removing indwelling catheters when no longer needed.
- by implementing policies and practices aligned with evidence-based standards for appropriate placement criteria, maintenance, monitoring, and evaluating effectiveness of prevention.

39

What are Blood-borne Pathogens and how are they transmitted?

- Disease-causing germs (viruses or bacteria) carried in the bloodstream AND other body fluids.
- They are transmitted from person to person OR person to object to person by CONTACT.

Major Blood-borne pathogens are the viruses:

Human Immunodeficiency Virus (HIV)
Hepatitis C virus (HCV)
Hepatitis B virus (HBV)

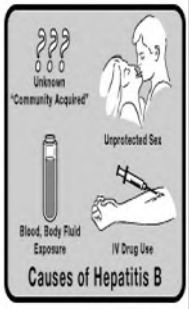
In addition to blood these viruses can be transmitted through contact with other body fluids.

- **semen**
- **vaginal**
- **cerebrospinal**
- **synovial**
- **pleural**
- **peritoneal**
- **amniotic fluid**
- **saliva (dental procedures)**

40

Most common routes of transmission of Hepatitis B Virus (HBV) - Hepatitis C Virus (HCV) and HIV

- Accidental puncture from contaminated needles, broken glass or other sharps
- Contact between broken or damaged skin and infected body fluids
- Contact between mucous membranes and infected body fluids
- Sexual Contact
- Needle sharing by drug addicts
- Splashing of contaminated body fluids into eyes, nose or mouth.
- From mothers to babies at birth



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HIV
Human Immunodeficiency Virus

- HIV infection causes a weakening of the body's immune system leading to progressive wasting and serious infections unless treated.
- It circulates in the blood at very high levels if untreated.
- It cannot be cured but it can be controlled with medications.

Symptoms of HIV

- "Flu" symptoms early then few symptoms for years
- Fevers
- Fatigue
- Large Lymph Nodes
- Weight Loss
- Infections (lungs, skin, brain)

42

Viral Hepatitis

Hepatitis is a general term for inflamed liver and has many causes. HBV and HCV are two viruses that are blood borne and cause hepatitis. Hepatitis B vaccine is free of charge in Employee Health Services.

When hepatitis is caused by:
-Hepatitis B Virus (vaccine available) or
-Hepatitis C Virus (no vaccine)

It can cause progressive liver damage and lead to liver failure (cirrhosis) or liver cancer.

Symptoms of HCV and HBV Hepatitis
- No symptoms early
- Fatigue
- Nausea
- Jaundice (yellow skin and eyes)
- Abdominal Pain

43

What will you do to prevent workplace injury due to blood borne pathogen exposure??

- Follow Standard/Universal Precautions 100% of your work time.
- Be aware of and alert for any possible or actual exposure to blood or body fluids or other infectious material.
- ONLY dispose of sharps in properly labeled and secured sharps containers.

- ONLY dispose of OSHA Regulated Waste in a biohazardous labeled container.

44

What if you think you have had a blood-borne pathogen exposure?

- Wash the exposed area well with soap and water
- Flush any exposed mucous membranes (eyes, nose, mouth)
- Report the exposure to your supervisor
- Report to Employee Health (Clinic during first shift, Medical Unit during second and third shift)

CRH has a Post-Exposure Evaluation and Care Plan

45

Post Blood-borne Pathogen Exposure Evaluation

- An immediate and confidential medical evaluation is conducted by Employee Health.
- Testing will be performed on the source individual, if known, and on the employee.
- Treatment will be offered based on results of testing and circumstances. Some "exposures" turn out to have no risk of infection associated with them.

You have access to:

- **Blood-borne Pathogen Exposure Control Plan**
- **CRH Post Exposure Prophylaxis for Employees policy**

In the CRH IC Policy Manual on the CRH Intranet

46

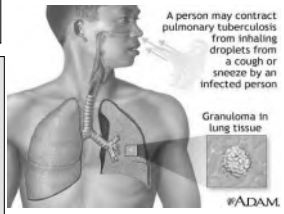
What is Tuberculosis?

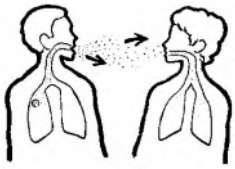
Tuberculosis is an airborne disease caused by bacteria, Mycobacterium tuberculosis.

The germ primarily affects the lungs, but can also affect other organs.

Once the TB germ is inside a person's body, the body's immune system can suppress its growth, resulting in inactive or latent TB infection, which does not make the person feel sick and cannot be spread to others.

If not properly treated with a course of preventive antibiotics, TB infection can develop into active TB disease.

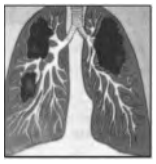




47

What are the symptoms of Active Tuberculosis Disease?

- Cough more than three weeks
- Fever more than three weeks
- Night sweats more than three weeks
- Weight Loss
- Blood in sputum



CRH Patients at Risk for TB

- Immigrants to the US from high TB areas
- Homeless persons
- Injection Drug Users
- HIV patients

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At risk employees for TB exposure are those who are immunocompromised, for example those receiving chemotherapy or with HIV infection.

If you develop symptoms of active Tuberculosis,

- Persistent cough
- Fever
- Night sweats
- Weight loss

Seek medical attention immediately!

Tuberculosis is a curable disease when medications are taken as directed.

49

How does CRH protect Patients and Staff from getting Tuberculosis?

All employees are required to get the TB skin test when they are hired.

All patients coming into CRH are evaluated for signs and symptoms of Active TB by history and physical exam.

Patients that have signs or symptoms of TB will have a mask placed on them and have stat CXR to rule out active TB.

Patients that are felt to possibly have TB:

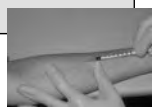
- Are placed on Airborne Precautions in the Medical Unit
- Staff will wear a N95 respirator mask
- Staff will remove the mask after leaving the room
- Patient movement from room will be limited
- Patient will wear a surgical mask whenever out of isolation

Patients that have an indication for routine TB skin testing can get that done while at CRH.

50

How to perform and interpret the skin test for TB

Place 0.1 cc PPD intradermally with needle bevel up.



Read in 48 to 72 hrs. as ordered.
Measure only induration, from lateral to medial

Positive if
≥ 5 mm or more in HIV or other immunosuppressed
≥ 10 mm in long term care facilities, health care workers
≥ 15 mm in persons with no risk factors

51

Employee Skin Test
What can I expect if my skin test for TB turns positive?

- Confidential referral for CXR and consultation with the local health department.
- When your skin test is positive and your CXR shows **NO** signs of active lung TB, this is called **LATENT TB**.
- This means you have been exposed to the TB bacteria and should take medication to prevent the development of active TB.
- This evaluation and treatment will be provided to you free.

Healthcare Worker Responsibility:

Seek prompt medical evaluation if PPD conversion occurs.

Notify Employee Health if you are diagnosed with Active TB or have symptoms of Active TB.

52

The CRH Antibiotic Stewardship Program Strives To:

Provide an organized multidisciplinary approach (pharmacy, MDs, IPs, RNs, Lab, QM) to optimize antimicrobial use in our patients:

- Reduce possible adverse effects from antimicrobials (like the development of C. difficile gastroenteritis)
- Ensure bacterial infections are treated with the correct dose of med for the correct bug for the correct amount of time
- Ensure that non-bacterial infections are not treated with antibacterial meds

THEREBY:

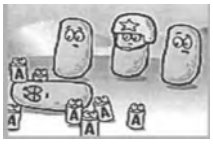
- Reducing the risk antimicrobial resistance to antibiotics

Antimicrobial Stewardship + Infection Control Program = Limits the emergence and transmission of Antimicrobial Resistant Bacteria.

53

HOW DOES ANTIBIOTIC RESISTANCE DEVELOP?

- **BACTERIA DEVELOP RESISTANCE WHEN THEY ARE EXPOSED TO ANTIBIOTICS**
- **BACTERIA MUTATE TO PROTECT THEMSELVES FROM THE ANTIBIOTICS THAT THEY ARE EXPOSED TO**



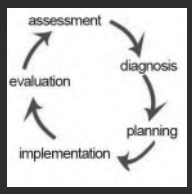
54

Prevention Is Primary!

- The Infection Control Preventionists are available for Support.
- Thank you for your participation in the Culture of Safety!
- Protect your patients and their visitors, protect yourself and coworkers and your family.
- **Infection Preventionists**
  - **Kim Perry, BSN, RN 4-2118**
  - **Barbara Geercken, RN 4-2119**

55

Person-Centered Treatment Planning



1

What do you think this means and why should we do it?

2

Reasons to Engage in Person Centered Treatment Planning

- Research is in early stages, but shows that person-centered planning increases:
  - Patient satisfaction with services
  - Patient motivation and adherence to treatment regimens
- Accrediting bodies (e.g., Joint Commission) and federal laws (e.g., Civil Rights of Institutionalized Persons Act) are requiring this model of service delivery.

3

Main Theme 1
It is a Partnership between the Patient, Family, and Team

4

The plan is a contract between the patient/family and team

- Educate the patient and family about the purpose and process of the plan.
- Include the patient and family in all treatment planning meetings, when possible.
- Write the plan in the patient and family's words where possible.
- When the team's words are included, use language that the patient and family understands.

5

Main Themes 2 and 3

- Assessments are highly individualized, comprehensive, and culturally sensitive.
- They provide data about the patient and family's needs, strengths, and goals.

6

Main Theme 4: Gear the plan and services toward discharge

- What individualized goals can we help patient meet to leave the hospital and remain in the community.
- What is required for discharge is informed by the patient and family's goals.
- Focus on the patient's strengths and assets.
- Write goals that reflect positive steps.
- Devise a plan of interdisciplinary services that work in coordination toward the patient's goals.

7

Main Theme 5

- Services are evidenced-based, when possible, but always individualized and reflective of a coherent and coordinated approach

8

CRH Treatment Planning Policy

- The Master Treatment Plan (MTP) is completed by day 10 of admission.
  - Initial Treatment Plan within 72 hours of admission
- If a patient is re-admitted within 14 days of discharge
  - New MTP is not required
  - Can use MTP from prior admission but must be updated to reflect changes.
- Planned Transfers:
  - When a patient moves from one unit to another (example AAU to CTU), the plan is reviewed or redone within 5 days of transfer
- Emergency Transfers:
  - When a patient transfers to another unit or PCU because of patient management issues and the patient is assigned to a new treatment team, the MTP is reviewed or redone within 1 business day

9

Who is on the Treatment Team?

- The patient and/or family or guardian
- Attending physician
- Nurse
- Social worker
- Staff members from other disciplines are important participants (though not required to attend for meetings to occur):
  - Psychologists
  - Psychosocial Treatment staff
  - Rehab Therapy staff
  - Therapeutic Support Specialists (TSS), Youth Program Education Assistants (YPEA), Nutritionists, Physical Therapists (PT), Teachers, etc.

10

The MD as the Team Leader

- As the team leader, the MD ensures that:
  - Person-centered planning occurs by fostering an interdisciplinary planning process
  - The plan is guided by assessments
  - The patient and family's needs and wishes are the focus of the plan
  - All team members are actively involved in the development of the plan
  - The planning process is focused and efficient

11

Treatment Plan Meeting Do's and Don't

- Do:
  - Come to the meeting with completed assessments
  - Participate in the discussion and encourage others to do so
  - Include the patient/family in the discussion when possible
  - Write a plan that is consistent with the patient's wishes and strengths
- Don't:
  - Repeat assessment findings that have already been discussed
  - Do interviews or interventions with the patient in the meeting
  - Put the patient on the spot

12

Structure of the Treatment Plan Meeting – Beginning Steps:

- Prepare for the meeting.
  - Discuss the meeting with the patient ahead of time
  - Invite family or significant community supports to the meeting when possible
- Bring the patient into the meeting, when possible.
  - Do a round of introductions
- Have each team member present assessment data.

13

Structure of the Treatment Plan Meeting : Treatment Planning Components

- Problems
- Assets (strengths)
- Long-term Goals (LTG)
- Short-term Goals (STG)
- Interventions (Services)
- Patient's Needs Upon Discharge

14

Let's Learn About our Patient Meet Mr. Smith

25 year old Caucasian male who was admitted to CRH after hitting and kicking staff at his group home and at the mall. It was reported by group home staff that he had been refusing his medications and there had been an increase in his aggression and he frequently made comments that people were out to do him harm. They do not feel like he can return.

Behavior problems begin in adolescence as he had trouble in school, non compliant at home, and was smoking marijuana and drinking alcohol. He has had two prior hospitalizations which were due to paranoia, hearing voices, and aggression. Mr. Smith carries a diagnosis of Paranoid Schizophrenia.

By history, Mr. Smith has demonstrated sustained periods of stability when taking medications, but he does not like medicine and has trouble remembering to take it or simply refusing.

Mr. Smith has a sister in the area who is supportive but she is unable to have him live in her home. He has not been able to maintain employment, but he does have Medicaid.

Mr. Smith never finished school but when stable talks about wanting to get a GED, work, and trying to have a place to live where he can have a dog.

Upon admission, Mr. Smith denied any reason for being hospitalized, saying that he fought back when people were trying to kidnap and poison him. He has been observed responding to voices and has argued with staff about why they took him from home and are keeping him here.

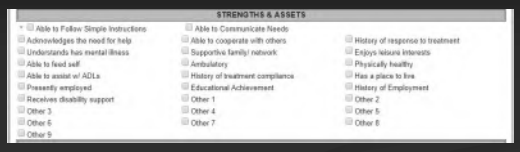
15

The Patient's Assets

- **All patients have some resources or positive attributes**
- **Identifying them may help a patient:**
  - **respond to treatment**
  - **prepare for discharge**
  - **remain in the community after discharge**

16

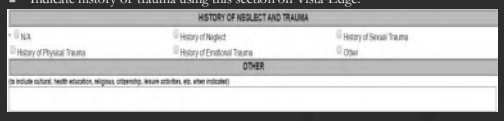
The Asset List on the Master Treatment Plan (MTP)



17

History of Trauma

- CRH is required to report *Patient History of Neglect and Trauma* on the Master Treatment Plan.
- Indicate history of trauma using this section on Vista Edge:



- Note that until permanent changes are made in Vista Edge, only new/annual MTPs will have this template. For all renewed plans without the template, use the "Other" section above to write one of the following: "h/o neglect", "h/o sexual trauma", "h/o physical trauma", "h/o emotional trauma" or "no h/o neglect or trauma" or "h/o neglect or trauma not known"

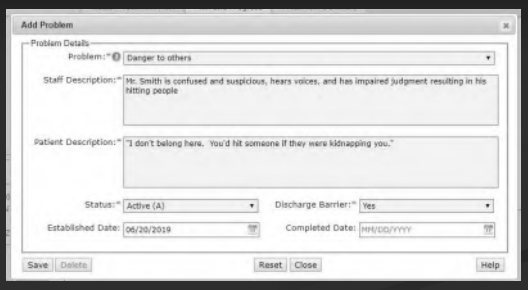
18

Problems to be addressed on the Master Treatment Plan (MTP)

- During the treatment team meeting, the team and patient/family decide on the problems to be addressed in the treatment plan.
- Usually, two or three problems are chosen as the focus of intervention.
- The problems are described in the patient's words and the team's words, when possible.
- Always include repeat admissions, substance abuse, intellectual disability, any CRH-required medical issues, and high risk behavior as problems, if identified

19

An example of a problem to be addressed on the MTP



20

Long-term Goal

- **One global statement that captures what the individual needs to do to remain in the community.**
  - When possible, this goal could be written in the patient's words and should always be written as something the patient will achieve.
  - If the patient/family cannot articulate a goal, the team may help. Even if written in the team's words, the goal should reflect the patient's wishes.
  - The goal should be written in lay language.

21

Examples of Long-term Goals

- **"There's nothing wrong with me." (patient's initial statement).**
  - **I want to understand my symptoms better so I can get help when I need it (combined patient/team goal).**
- **"I want to get a dog." (patient's initial statement).**
  - **I need a place to live and a plan to stay healthy and out of the hospital (combined patient/team goal)**

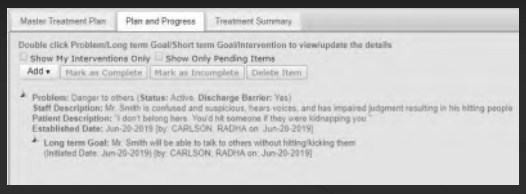
22

More Examples of Long-term goals

- I will learn ways to remember to take my medication so I can stay out of the hospital.
- I will learn ways to deal with my anger so that I won't start fights and have to come to the hospital

23

Example of Long Term Goal on the MTP



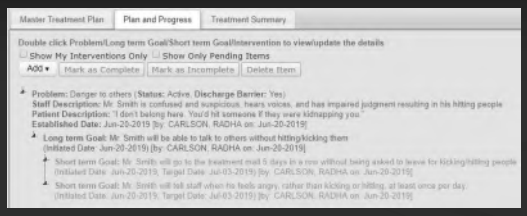
24

Short-term Goals

- Outcomes that are small, logical steps toward the long-term goals.
  - Observable
  - Measurable
  - Achievable
- "Mr. Smith will state two ways to stay calm when irritated by noise."

25

Examples of Short Term Goals on the MTP



26

Interventions

What staff members provide to the patient to assist him/her in reaching short term goals.

- Medications
- Nursing treatments
- Group therapy
- Individual therapy
- Positive behavioral support
- Educational opportunities
- Quality of life activities

27

Interventions: What the staff members do, not what the patient does

"Prescribe Prozac …",
"Nursing staff will offer patient …"
"Social Worker will meet with the patient…"
"Provide DBT group….."
NOT
"Patient will…"

28

Interventions are NOT Job Descriptions

Nursing will administer meds and monitor for SEs.

MD will prescribe medication and monitor for effectiveness.

SW will meet with the patient to develop a discharge plan.

29

Interventions Must Specify:

- Who: **Psychologist, nurse, MD, etc. (by name)**
- What: **Calm, Cool, Collected group …**
- How often: **5 x week for 45 minutes**
- Why: **for Mr. Smith to learn ways to express his angry feelings without hitting people or destroying property.**

30

Interventions on the MTP

- Are developed through team discussions
- Include a mix of interdisciplinary and multidisciplinary interventions
- Are known by all team members, regardless of who is providing them.

31

Interventions: A Mix of Interdisciplinary and Multidisciplinary

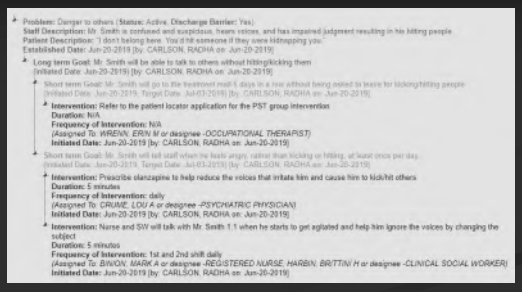
STG: Mr. Smith will state 3 actions he can take to prevent readmission to the hospital.

Interventions:

- **MD and nursing staff (named)…will talk with Mr. Smith about his medication and how taking it correctly can help prevent readmission. (Interdisciplinary)**
- **Psychology and social work staff (named)…will meet with Mr. Smith to help develop a crises plan to prevent readmission. (Interdisciplinary)**
- **RT (named)….will provide Recovery Resources group to help Mr. Smith identify services and supports that will help him remain in the community. (Multidisciplinary)**

32

Examples of Interventions on the MTP



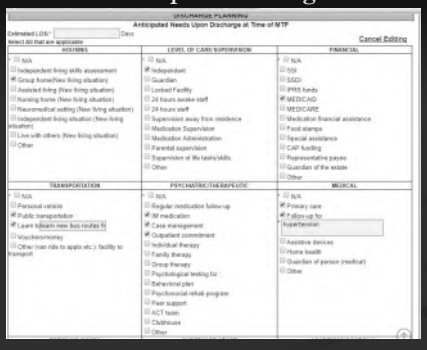
33

Needs Upon Discharge

- Needs upon discharge are identified at the MTP meeting
- Patient and family should provide input
- What is checked on the list includes things the patient needs to obtain in order to succeed outside of the hospital.

34

Needs Upon Discharge



35

Needs Upon Discharge cont.

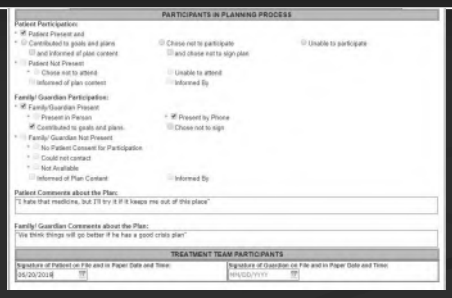
36

Required Problem: Frequent/Rapid Re-Admission

- Patients who have had frequent re-admissions to CRH defined as any of the following:
  - Re-admission within 30 days of discharge from CRH
  - 3 or more admissions to CRH in the 12 months preceding the current admission
  - 10 admissions to any NC state psychiatric facility
- Must have frequent re-admissions prevention plan in their MTP.

37

Signatures (Top part of page)



38

Signatures Cont.

TREATMENT TEAM PARTICIPANTS		
Signature	**Printed Name**	**Date**
Patient : *John Smith*	John Smith	7-12-10
Family:		
Guardian:		
Psychiatrist: *Joe Miller, MD*	Joe Miller, MD	7-12-10
Nurse: *Mary Chase, RN*	Mary Chase, RN	7-12-10
Social Worker: *Renee Jones, LCSW*	Renee Jones, LCSW	7-12-10
Rehabilitation Liaison: *Gail Smith, LRT*	Gail Smith, LRT	7-12-10
Psychologist: *Robert Mason, Ph.D.*	Robert Mason, Ph.D.	7-12-10
Other:		

39

MTP is just the beginning

40

Treatment Plan Reviews

- Treatment Plan Reviews are done to update the Master Treatment Plan and ensure that it reflects current patient goals, diagnoses, interventions, discharge plans and so forth.
- There are two types of Treatment Plan Reviews:
  - *Scheduled*: Periodic reviews of the MTP linked to length of stay (see policy for times)
  - *Special Reviews*: Done within 1 business day of an event that triggers a special review

41

Schedule of Treatment Plan Reviews

- Reviews are held as frequently as clinically indicated, but not less than:
  - 14 days after the Master Treatment Plan meeting
  - Every 14 days until 60 days after admission (3 reviews)
  - Every 45 days between day 60 and 1 year
  - Every 60 days after one year
- Long-term unit policy:
  - The plan is reviewed every 60 days. A new Master Treatment Plan is developed at the beginning of each year of admission after the first year

42

Reviews triggered by significant events

- Must be completed within 1 business day of notification
- Special Treatment Plan Review (STPR)
  - Require Attending Physician with notification of nursing
- Restrictive Intervention Prevention Review (RIPP) and Behavior Aggression Review (BAR)
  - Require Attending Physician, Nurse, Psychologist

43

Behaviors and Incidents that Trigger Special Treatment Plan Reviews

- Patient incidents resulting in moderate/major injury (other than from self-injurious behavior or assault)
- Any use of mechanical restraints
- First assault after admission and first assault after 90 days assault-free
- 2 falls in 30 days
- Start of forced meds
- Elopement
- Victims and perpetrators of non-consensual sexual activity
- At request of hospital administration

44

RIPPs and BARs

- **Restrictive Intervention Prevention Plan**
  - Three or more restrictive interventions any 4 week period
  - 40 + hours cumulative in any 4 week period
  - 24 hours of continuous seclusion
- **Behavior Aggression Review**
  - Three or more assaults within 30 days (5 for latency age patients)
  - Assaults resulting in a moderate/major injury
  - Self-Injurious behavior resulting in a moderate/major injury
  - Three or more episodes of self-injurious behavior within a 30 day period (regardless of injury level)
  - Self-Injurious behavior that involves: cutting, strangling, handing or ingestion

45

Questions

46

Central Regional Hospital Annual Training

(1) Performance Improvement
(2) Risk Management, Patient Safety Events & Patient Safety Organization (PSO)
(3) Patient Incident Reporting
(4) Policies and Procedures
(5) Joint Commission/NPSG
(6) Surveys
(7) Ethics
(8) EMTALA
(Emergency Medical Treatment and Labor Act)

1

1

What is Performance Improvement?

An ongoing effort to improve the hospital's ability to safely provide quality care to all patients

2

2

What Principles Guide Performance Improvement at CRH?

- Performance Improvement:
  - supports the hospital's mission
  - is hospital wide
  - is interdisciplinary and collaborative
  - is responsive to our customers
- Performance Improvement looks for a weakness in how we carry out an activity, NOT in the performance of an individual staff person.
- Remember - Performance Improvement is everyone's job!

3

3

How are CRH PI Priorities Identified?

- Customer expectations
- Staff suggestions
- Processes that are:
  - high risk (e.g. Seclusion & Restraint, ECT, Code Blue)
  - high volume (e.g. treatment planning)
  - prone to problems
- Standards/regulations/directives
- The PI Committee organizes PI Teams when necessary to address high priority areas in need of improvement

4

4

Where do the Standards come from?

- Federal Regulations
- State Laws
- Division & CRH Policies
- Professional Organizations/Licensing Boards
- Accrediting Body Standards
- Education / Research

5

5

CRH Performance Improvement Approach: the "PDCA" Cycle

- Plan
- Do
- Check
- Act

6

6

PDCA - Break it Down

- PLAN
  - Define the problem; collect data; identify potential causes
- DO
  - select a solution; implement the solution on a trial basis
- CHECK
  - Collect data; monitor results; get feedback; review results
  - if unsuccessful, return to PLAN phase
- ACT
  - Identify training needs; implement the change; monitor the results

7

7

Risk Management, Patient Safety Events and Patient Safety Organization

8

8

What is Risk Management ?

- Risk management is a goal-directed, interrelated series of processes of which the primary goal is to provide a safe, functional and effective environment for patients, staff and other individuals in the hospital. These processes are crucial to providing patient care and achieving good outcomes.
- Steps in Risk Management
  - ✓ Identify Risk
  - ✓ Analyze Risk
  - ✓ Control Risk

9

9

What types of events does the facility review?

Patient Safety Events: Events, incidents or conditions that could have resulted or did result in harm to a patient.

A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure or human error.

Patient safety events include:

1. Adverse events- patient safety events that result in harm to a patient.
2. No harm events- patient safety events that reach the patient but do not cause harm.
3. Close call/near miss- patient safety events that do not reach the patient.
4. Hazardous (or unsafe) condition(s)- circumstances (other than the patient's own disease process or condition) that increases the probability of an adverse event.

10

10

Sentinel Events

The most serious types of events are referred to as Sentinel Events. Sentinel events are patient safety events (not primarily related to the natural course of the patient's illness or underlying condition) that reach the patient and results in any of the following:

- ✓ Death
- ✓ Permanent harm or
- ✓ Severe temporary harm

Examples of Sentinel Events includes:

- ✓ Unexpected deaths
- ✓ Suicide or serious suicide attempts
- ✓ Accidents that result in loss of limbs or permanent loss of functioning
- ✓ Rape
- ✓ Elopements resulting in harm
- ✓ Abductions

11

11

What happens during the review of pt safety events?

- Interviews are conducted with staff and patients to determine if systems issues exist or if the event if related to a human error.
- Documentation is reviewed (medical records, applicable policies and procedures, etc.).
- If the incident occurred in an area equipped with video cameras, video is reviewed.

What should you do if you identity a potential pt safety event?

- Notify your immediate supervisor.
- Follow the established reporting procedures given the nature of the event (document the incident in the medical record, complete an incident report, etc.) given your role/position.
- Discuss the incident in an open, honest way with leadership and risk management staff.

12

12

What is a Root Cause Analysis (R.C.A.)?

- RCAs are used to review the most serious types of incidents.
- It involves the process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
- RCAs generally produce various actions plans that identify follow-up actions intended to help prevent a similar occurrence and improve overall systems of care.

What departments are involved in RCAs and the review of pt safety events?

- Senior leadership is involved in reviewing all serious events that occur at the facility.
- Additionally, Pt Safety/Risk Management assists in the review of pt safety events, as well as, Nursing, Psychiatry and other staff members who have first hand knowledge of the event.
- If the event involves suspected abuse/neglect, Pt Advocacy will be involved in the review.

13

13

Patient Safety Organization (PSO)

What is a Patient Safety Organization?

- ✓ PSOs were formed from federal law that seeks to reduce healthcare errors by learning from pt safety events.
- ✓ As part of a PSO, CRH has it's own Patient Safety Evaluation System (PSES) in place.
- ✓ Part of the federal law requires that discussions about pt safety events remain confidential.

What types of information has to be kept confidential when a pt safety event occurs?

- ✓ Conversations and interviews with management about the event.
- ✓ All notes and minutes related to the review.
- ✓ Discussions from the RCA and
- ✓ All oral, written or recorded information generated by the event analysis process.

14

14

How can I help maintain confidentiality when being interviewed by those outside of our Patient Safety Evaluation System?

- When being interviewed by those outside of our Patient Safety Evaluation System (PSES), advocates, surveyors, etc.:
  - Provide information that is true and factual
  - Staff can share what they directly observed or overheard during the incident
  - Do not provide speculation or opinions about why an event occurred
  - Information obtained from analysis within the PSES cannot be shared with those outside of the PSES

Improving our system of care and reducing risk is everyone's job!

15

15

RL6 – QM System
Patient Incident Reporting System

- CRH has a computer based patient incident reporting software.
- Allows staff to report incidents in the moment and users to have access to information immediately.
- System allows us to aggregate data, analyze trends, provide alerts to designated staff for specific incidents, provide follow up to incidents, provide reports to units with "real time" data and information.

16

16

Patient Incident Reporting

- How do I report a patient incident/occurrence?
  - If you witness an incident, give ALL details to the RN so that it can be entered into the Quality Management System.
  - All incidents should be completed prior to the end of the shift.
  - Prior to submitting an incident in the QM System, staff should review all of the information entered for accuracy.

17

17

General Incident Types

- Behavioral Restraint
- Seclusion
- Time Out/ETO
- Aggression/Assault
- Falls
- Accident
- Elopement/Wondering
- Unwitnessed Injury
- Suicidal Behavior
- Clinical
- Self Injurious Behavior
- Contraband/Search
- Code Blue/Med Stat
- Sexual Activity
- Medication Variance
- Other
- Seizure
- Adverse Drug Reaction
- Fire setting
- Nutrition
- Pressure Ulcer

18

18

Where can you find information on Policies and Procedures?

CRH REFERENCE LIBRARY
http://intranet.crh.dhhs.state.nc.us/index.htm

- Clinical Care Manual
- Administrative Policy Manual
- Human Resource Manual
- Safety Manual
- Infection Control Manual
- Department Manuals

19

19

The Joint Commission

BEE Ready!

20

20

Joint Commission

- Unannounced surveys and surveys at least every 3 years
- Focused Standards Assessment
- "Tracer" Methodology
- National Patient Safety Goals
- ORYX
- FMEA

21

21

Focused Standards Assessment

- Self-assessment of compliance with all Joint Commission standards
- Requires evidence of compliance (audits, tracers, data tracking etc)
- Non-compliant standards require a plan of action, implementation of the plan and resolution
- Due annually

22

22

Tracer Methodology

- Traces an individual through the organization in the sequence they receive care
  - A patient is referred to as a "tracer".
  - Tracers will be randomly selected and followed by a surveyor through the organization in the sequence they receive care.
  - Gives the surveyor the chance to examine components of a system and how different components work together.
- The surveyor may issue a recommendation if problems are identified. The organization has 60 days to submit evidence of compliance.

23

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National Patient Safety Goals (NPSG)

- What are National Patient Safety Goals?
  - They are goals set by the Joint Commission
  - All accredited health care organizations – including CRH - are required to meet these goals

The Joint Commission

24

24

2020/2021 National Patient Safety Goals

1. Improve the accuracy of patient identification
   - 2 identifiers are required at CRH when giving medications, collecting specimens and other treatments/procedures:
     - **1st identifier**: Patient name stated by a reliable/capable patient, wristband, on photo ID, in medical record with photograph
     - **2nd identifier**: Date of birth, barcode on wristband or medical record number
     - For administering medications: name and scanned barcode on wristband. If no wristband – name and DOB as stated by the patient or on the photo ID
   - Label all specimens in the presence of the patient
2. Improve communication among caregivers
   - Ensure that patient care information is communicated accurately
   - Timeliness of reporting test results and values (30 minutes at CRH)
3. Improve the safety of using medications
   - All medications are labeled
   - Anticoagulation administration is guided by policy and procedure to reduce errors

25

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2020/21 National Patient Safety Goals

- Accurately and completely reconcile medications across the continuum of care
- Patients' medications are documented and reconciled at admission and discharge.
- The list of patients' discharge medications is provided upon any transfer, to the next caregiver, and to the patient at time of discharge
- Discuss with the patient the importance of managing medication information is discussed with the patient.

4. Reduce the risk of health care associated infections
   - Hand hygiene training and resources are provided to staff, patients and visitors
5. Identify safety risks in the patient population
   - CRH conducts ongoing environmental risk assessments to identify and mitigate potential ligature risks and safety hazards.

26

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2020/2021 National Patient Safety Goals

- All patients are screened with a validated tool for suicide risk at admission. Ongoing clinical assessments are performed to assess and identify patients at risk for self-harm or suicide and to determine most appropriate level of observation and interventions for the Plan of Care.
- All staff are trained to identify and respond to patients at risk.

6. Universal Protocol to prevent errors in performing procedures
   - Pre-procedure verification (2 patient IDs)
   - Time out is taken prior to the procedure
   - Marking of the procedure site prior to the procedure
7. Reduce the harm associated with clinical alarm systems
   - Make improvements to ensure clinical alarm effectiveness
   - For example: cardiac monitors, IV machines

Posters with NPSGs are posted throughout the Hospital.

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FMEA
(Failure Mode and Effects Analysis)

- FMEA provides a systematic method of identifying and preventing product and process problems before they occur.
  - Involves identifying all the steps in a process, identifying failures that could occur at each step, and implementing strategies to reduce or eliminate high risk failures
- Join Commission requires Hospitals ;to perform at least 1 FMEA annually
- FMEA for 2017/18 – Process for Securing Environmental Services Supplies and Tools on the Patient Care Units
- FMEA for 2019/20 – Improve processes related to Unit transfers to reduce errors.

28

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Benefits of Accreditation

- Assists organizations in improving their quality of care
- May be used to meet certain Medicare certification requirements
- Enhances community confidence
- Provides a staff education tool
- Enhances recruitment of medical staff and other health professionals
- Often fulfills State licensure requirements

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Surveys

- CRH is surveyed by various agencies:
  - Joint Commission
  - Department of Health Service Regulation (DHSR)
  - Federal Centers for Medicare and Medicaid Services (CMS)
  - Federal Department of Justice (DOJ)
  - Others

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What to Expect When Surveyors Come to Your Area

- Surveyors will always be accompanied by staff from Management or Unit/Department Heads
- Sometimes Surveyors come to evaluate our compliance with standards or regulations; other times they come to investigate complaints or specific incidents

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What to Expect When Surveyors Come to Your Area

- Surveyors may want to:
  - review written or electronic records
  - interview staff, patients or family members
  - observe patient care
  - tour the area
  - review meeting minutes
  - review employee files
  - attend treatment team meetings etc.

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What to Remember when Surveyors Arrive in your Area

- Greet them and make them feel welcome
- Answer questions honestly
- Keep your answer on track with the question asked
- Respond quickly to requests made by the surveyor or their escort
- **Do not ignore your patient care responsibilities.**
  - If you have to complete a patient care task, explain this and let the surveyor and escort know you will return as soon as the patient care need is met
- Communicate with and help your co-workers as needed to get the information the surveyor needs
- Keep a positive attitude!

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Patient Safety & Quality of Care Concerns

The CRH Management Team is committed to working with all employees to address concerns related to patient safety and quality of care. Staff who have concerns are encouraged to communicate and resolve these issues by talking with their supervisor or Department/Unit Director. Employees may also contact the Hospital Director's Office (764-7300) with their concerns.

Staff who feel their concerns have not been addressed may choose to contact the Joint Commission . Concerns submitted to the Joint Commission can be sent anonymously or name kept confidential:

By mail: Office of Quality Monitoring/Joint Commission
One Renaissance Blvd, Oakbrook Terrace, IL 60181
Or
by Fax 630.792.5636
E-mail complaint@jcaho.org
Phone 800.994.6610
** CRH will not take any disciplinary actions against employees who contact the Joint Commission. **

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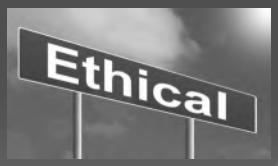
Ethical Considerations: Working With Psychiatric Patients



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Legal and Ethical Issues: Sources of Guidance

- HIPAA/Confidentiality
- North Carolina Psychology/Psychiatry/Nurse/Social Work/Pharmacy/Rehabilitation Therapy Practice Acts
  - Statutes
  - Codes of Conduct
  - Rules
- Various guidelines and best practices documents
- CRH Ethics Committee

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CRH Ethics Statement

- Employees will follow the CRH Code of Ethics and comply with any specific ethical codes of their professions
- The welfare and safety of patients is our highest priority
- We treat all patients, co-workers and any others we encounter with respect and courtesy
- We treat patients in a manner appropriate for their developmental stage, age, background, culture, religion and heritage

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CRH Ethics Statement (continued)

- We do not intentionally harm patients
- We report any evidence of impairment or unethical conduct in co-workers
- We avoid any activity that could be perceived as taking advantage of patients or using our position for personal gain
- We accept responsibility to maintain competencies to function effectively

38

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CRH Ethics Committee

- CRH maintains an Ethics Committee to:
  - Provide case consultation in matters of patient care when ethical dilemmas arise
  - To serve as a forum for discussion of ethical issues
  - To provide education on approaches to resolve ethical issues
  - To develop policy recommendations to the CRH Management Team

39

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Organizational Ethics

- Conflicts of interest
  - A conflict of interest may arise when an employee's activities, associations, or positions outside of CRH conflict with the appropriate discharge of duties as a hospital employee.
- Please discuss potential conflicts with your supervisor to prevent undue influence of outside interests.

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EMTALA

The Emergency Medical Treatment and Labor Act

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What is EMTALA?

EMTALA is a Federal law that governs how a patient suspected of having an emergency medical condition is:
(1) evaluated
(2) how treatment at a state psychiatric hospital may be appropriately refused, and
(3) how a patient is stabilized and/or transferred if that individual is determined to have an emergency medical condition.

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What is an Emergency Medical Situation?

- A medical condition with acute symptoms (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) so severe that the absence of immediate medical attention could reasonably be expected to result in:
  - placing the health of the individual in serious jeopardy;
  - serious impairment to any bodily functions; and/or
  - serious dysfunction to any bodily organ or part.

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Medical Screening Examination

- The process required to determine whether a medical emergency does or does not exist.

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Stable for Transfer: What does this mean?

- The treating physician has determined that the patient is expected to be transferred to another facility with no significant worsening of his/her condition, or that the benefits of transfer outweigh the risks.
- The transferring facility has stabilized the patient to the best of their ability and the patient requires more specialized care from the receiving facility, and
- The receiving facility confirms that they have the capacity to treat the individual and will accept them for admission.

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- All pertinent medical records generated at CRH, the request for/consent to transfer, and EMTALA certification forms must be transported with the patient

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It is required that the EMTALA process be completed for any:

1. Non-admitted patients in the Screening and Admissions Unit being transferred to another hospital
2. Persons with emergency medical conditions including:
   - Visitors
   - Employees
   - Contractors
   - Passersby on our hospital grounds.

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EMTALA

- Medical screening cannot be denied or delayed due to concerns about payment
- CRH is required to report suspected violations of EMTALA

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- If you have Questions, contact Quality Management at 4-7310

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NURSING ANNUAL REVIEW

RESTRICTIVE INTERVENTIONS

1

CRH RESTRICTIVE INTERVENTIONS PHILOSOPHY

- To prevent and reduce the use of seclusion and restraint.
- To prevent emergencies that may lead to physical interventions.
- Non-physical techniques (e.g. redirection, de-escalation) are preferred and are to be attempted or considered first.

2

RESTRICTIVE INTERVENTIONS INCLUDE:

- Time Out and Exclusionary Time Out
- Manual restraints/physical holds
- Seclusion
- Mechanical restraints
  - Leather/cuff restraints
  - Restraint chair (not to be used for Child/Adolescent or pregnant patients)
  - Geri-chair with locked table top
  - Soft ties (cloth restraints)
  - Ambulatory

3

DEFINITIONS OF RESTRICTIVE INTERVENTIONS

- Time Out:
  - the removal of a patient from other patients within the same activity area.
  - duration of the time out must be more than **1 hour** to be considered a restrictive intervention.
- Exclusionary Time Out:
  - the removal of a patient to a separate area from which the entrance is not blocked.
  - duration of the ETO must be more than **15 minutes** for it to be considered a restrictive intervention.

4

DEFINITIONS OF RESTRICTIVE INTERVENTIONS (CONT'D)

- Seclusion:
  - **involuntary** confinement of a patient in a designated room (locked or unlocked).
  - the patient is prevented from leaving the room.
  - staff must provide constant supervision.

5

DEFINITIONS OF RESTRICTIVE INTERVENTIONS (CONT'D)

- **Restraint**:
  - Any method (manual, mechanical, use of a device, materials or equipment) that immobilizes or reduces the ability of the patient to freely move arms, legs, body or head.
  - Staff must provide constant supervision.

2 Types of Behavioral Restraints

- **Manual (Physical Hold) -** A manual restraint is any situation where a staff person places his/her hands on a patient to get the patient to do something that the patient does not want to do. This could involve moving (walking or carrying) the patient from one location to another or it could involve stopping the patient from doing something.
- **Mechanical** – requires permission/approval of the Chief Medical officer or Deputy Chief Medical Officers prior to initiation.

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UNACCEPTABLE USES OF S & R

- Restrictive Interventions may not be used:
  - as coercion, punishment, or retaliation.
  - for the convenience of staff (e.g. inadequate staffing).
  - in a manner that causes harm or pain.
  - solely due to verbal abuse.
- S & R is not to be used until non-restrictive or less restrictive interventions are attempted or considered.
- Seclusion and Mechanical Restraint are interventions of the last resort to be used only in an emergency situation where the patient is in imminent danger of causing injury to self or others.

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LEAST TO MOST RESTRICTIVE INTERVENTIVE TECHNIQUES

- De-escalation techniques (least)
- Time Out
- Exclusionary Time Out
- Manual Restraint
- Seclusion
- Mechanical Restraint (most)

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BEHAVIORAL VS MEDICAL RESTRICTIVE INTERVENTIONS

- The primary distinction between the two is in the intent of the intervention
  - Behavioral Interventions
    - used for behavioral modification (manual restraints) or safety of self or others (mechanical restraints).
  - Medical Restraints
    - used to facilitate care and treatment of a patient's medical or physical condition.
    - e.g. to reduce risk of falls or to prevent a patient from pulling out an IV or NG tube.

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SPECIAL CONSIDERATIONS WHEN CONSIDERING MECHANICAL RESTRAINT

- Every effort should be made to avoid Mechanical Restraints, particularly when the patient:
  - has medical conditions (including cardiac and respiratory problems), predisposition to fracture, or has a current fracture
  - is vomiting
  - has a history of sexual abuse/rape while restrained
  - is medically unstable
  - is pregnant

o The MD ordering a Mechanical Restraint should call the medical provider when the patient has any of the above conditions.

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STAFF RESPONSIBILITIES DURING THE USE OF SECLUSION AND RESTRAINT

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MD ORDERS FOR RESTRICTIVE INTERVENTIONS

- MD orders for Seclusion or Restraint must not exceed: (duration of the intervention is by age a group)
  - 2 hours for adults and children age 9-17
  - 1 hour for children under the age of 9
- **Every** restrictive intervention requires a MD Order.
- The RN must notify the MD and initiate the verbal order in VistA for the Restrictive Intervention as quickly as possible but no later than the end of the shift.
- The MD must review and sign the order in VistA.
- It is ultimately the MD's responsibility to make sure the order is entered into VistA and with all the correct information.

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NURSING RESPONSIBILITIES

- **When staff members engage in a restrictive intervention they must notify the Charge Nurse/designee immediately with a clear description of the event and restrictive intervention used.**
- **The Charge Nurse/designee will notify the psychiatrist as soon as possible following the use of the restrictive intervention.**
- **The RN must initiate the verbal order for the restrictive intervention as soon as possible in VistA.**
- **The RN must enter the restrictive interventions into the patient incident reporting system – RL6.**
- **The RN must assess the patient within 15 minutes**
  - determine whether the intervention is justified
  - check restraint cuffs (if applicable)
  - Include visual observation of the patient's condition

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NURSING RESPONSIBILITIES (CONT'D)

- **The RN must assess the patient within 15 minutes**
  - determine whether the intervention is justified
  - check restraint cuffs (if applicable)
  - Include visual observation of the patient's condition
- The RN must evaluate the patient periodically – but **at least every 30 minutes** – to determine the need for continuing the procedure.
- The patient must be released from the restrictive intervention when he/she meets the criteria for release specified in the Physician order.
- If a patient verbalizes pain after a restrictive intervention, the RN must assess the physical complaints of the patient and notify the Medical Provider immediately based on assessment.

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MONITORING REQUIREMENTS FOR NURSING STAFF

- Observation and care of patient is documented **every 15 minutes.**
- **Every 2 hours or less**, staff must:
  - offer patient fluids/food (food if during regular meal or snack time)
  - offer use of the toilet
  - release patient cuffs for range of motion
  - offer oral hygiene after food

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MONITORING REQUIREMENTS (CONT'D)

- For incidents lasting **more then 8 hours**, the following must be completed:
  - RN must take patient's vital signs
  - offer patient oral hygiene
- If the incident lasts **more than 24 hours**, the patient must be given the opportunity to bathe.

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DOCUMENTATION OF MONITORING

- Staff must note all monitoring activities on the Restrictive Procedures Form.
- If the patient is too agitated or it is unsafe to provide the required care (e.g. toileting) this must be noted.
- **If it's not written down, it is assumed that it did not happen!**
- Quality Management performs audits at least monthly to measure S & R documentation compliance.
- Nursing also performs audits on restrictive intervention documentation on each unit.

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DEBRIEFING AFTER THE INTERVENTION

- A debriefing of the intervention with the patient must occur within 24 hours of discontinuation of the procedure. This debriefing is generally done immediately after the intervention.
- As many participants in the intervention as possible should be involved in the debriefing.
- Staff should also debrief after the incident.

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PURPOSE OF DEBRIEFING

- Identify what led to the incident and what might have been done differently.
- Is an effort to reduce recurrent use of these interventions.
- Ascertain the patient's post intervention physical well being and psychological comfort.
- Counsel the patient for any trauma that may have resulted from the episode.

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Team Building:
Developing Successful Work Teams

1

"Team" Defined

Group(s) of people working together toward a common goal for a common purpose…

Hold themselves mutually accountable for the outcome.

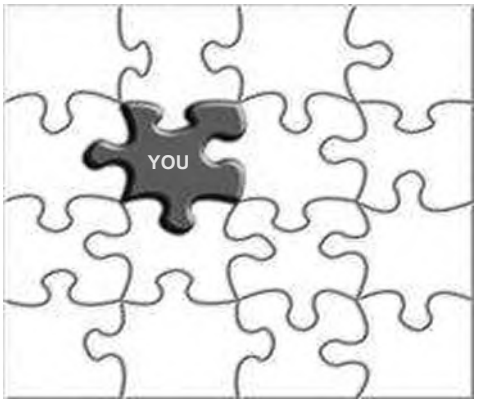
2

Why Teams?

Missions and Goals for which:

- **Tasks are high in complexity**
- **Consists of many interdependent subtasks**
- **Requires cooperation and collaboration**
- **Requires diversity and inclusion**

3



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TEAMS… Promoting Diversity and Inclusion!!!

- Creates an open and inclusive workplace culture
- Aligns diversity initiatives with organizational strategies
- Promotes diversity in leadership among all employees
- Empowers the strength of our diverse employees to promote the health and wellness of our members and communities

5

"***Teamwork is the fuel that allows common people to attain uncommon results.***"

- Unknown

6

Team-Centered Environments

In team-centered environments, each person works together to contribute to the overall success of the goals.

Although each employee has a specific job function and belongs to a specific department, we must work together within the organization to accomplish the overall objectives.

7

The bigger picture (mission & goal) drives your actions (work); your function exists to serve the bigger picture!

8

Purpose of Teams

The purpose for creating teams is to increase the ability of employees to **participate** in planning, problem solving and decision making to better serve customers.

9

Increased Participation Promotes:

- **Better understanding of the how & why of decisions**
- **Support and participation in implementation plans**
- **Willful contribution to problem solving and decision making**
- **Ownership of processes and changes.**

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Team: Stages of Growth

Form - A group of people come together to accomplish a shared goal *(ex. care for our patients)*

Storm - Disagreement about mission, vision, and approaches combined with the fact that team members are getting to know each other can cause strained relationships and conflict *(ex. work practices are different)*

Norm - The team has consciously or unconsciously formed working relationships that are enabling progress on the team's objectives. *(ex. communication during shift change is improved)*

Perform - Relationships, team processes, and the team's effectiveness in working on its objectives are synching to bring about a successfully functioning team. *(ex. team works well together and handles conflict appropriately)*

11

Team: Team Dynamics

The team's movement from one stage of growth to another will vary from team to team and is really a process of getting to know each other and maturing as a team.

While the stages may be somewhat predictable the transition can only occur when concerns, issues and conflict are put on the table and talked through.

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Team Dynamics Issues

Identity within the group
- *How do I fit in?*
- *Am I an "insider" or an "outsider"?*

Influence and Control
- *Who's calling the shots here?*
- *How much influence will I have?*
- *Will I be listened to, allowed or able to contribute?*

Getting Along
- *How will I get along with the others?*
- *What are their expectations of me?*
- *How formal or informal will we be?*
- *Can I be open in what I say? Will they?*

Loyalty
- *How does membership in this group relate to my other roles and responsibilities?*

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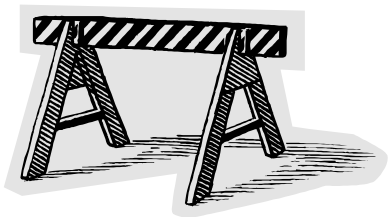
Barriers to Team Performance



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Characteristics of Effective Teams

- Team members share success and failure with each other
- Teams have established goals and objectives that are accepted by each team members
- Teams allow disagreements to occur and have effective ways of resolving problems and group conflicts
- Team trust exists
- Teams have members of various backgrounds and perspectives
- Leadership roles are shared
- Team decisions are made by consensus considering all options

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Characteristics of Effective Teams

- Teams foster a comfortable working atmosphere
- Team members are engaged, committed, alert
- Team members listen to everyone and provide useful feedback
- Teams encourage and value constructive criticism through respectful tone
- Team members' individual contributions are recognized
- Teams are results-driven
- Teams use resources effectively
- Distribute and assign work thoughtfully

16

Teamwork

Supporting a team format requires building a culture of teamwork with individuals that value cooperative collaboration.

In a teamwork environment, staff believe that planning, decisions and actions are better when done together.

17

"The ratio of We's to I's is the best indicator of the development of a team."

Lewis B. Ergen

18

“none of us is as good as all of us.”

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Trauma-Informed Care

Developed by: Leslie Hite, RN, CPRP
Mental Health Recovery and Trauma-Informed Care Nurse Consultant
DHHS: Cherry Hospital
Goldsboro, NC

1

By the end of this learning experience, attendees will be able to:

- Discuss the definition of trauma including prevalence and effects
- Discuss how to apply SAMHSA's principles of Trauma-Informed Care
- Discuss how to build resiliency and protective factors
- Discuss the importance of self-care to prevent compassion fatigue, vicarious trauma, and burnout
- Discuss ideas about how to implement self-care

2

Sections

I. Understanding Trauma
II. Trauma-Informed Care Principles
III. Resiliency and Protective Factors
IV. Self-Care

3

Rated E: Emotional Content AHEAD!

- *Content includes discussion about trauma and images to enhance discussions*

4

3

4

Section 1

Understanding Trauma

5

Definition of Trauma

"An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, or spiritual well-being".

6

(SAMHSA, 2014)

6

Types of Trauma

Acute
Single traumatic event limited in time
Examples: Accidents, medical treatment, natural disaster, death of loved one, assault

Chronic
Experience of multiple traumatic events
Examples: Domestic violence, neglect, community violence, war

Complex
Exposure to chronic trauma with long-term effects
Example: Aggression in a individual with a history of exposure to domestic violence

Historical
Personal or historical event that continues to impact several generations
Examples: Slavery, the Holocaust, genocide, or forced relocation

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7

The Effects of Trauma

- Impairs memory, concentration, new learning, and focus
- Correlated with physical illness including heart disease, addiction, and autoimmune disorders
- Impairs ability to trust or develop healthy relationships
- Disrupts ability to control emotions and distinguish between what is safe and unsafe
- Shapes belief about self, others, and future

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Section 1.1

Adverse Childhood Experiences (ACEs)

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The ACE Study Video

If the above video does not play, click here to view:
https://youtu.be/ccKFkcfXx-c

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(Crawford County Human Services, 2016)

10

ACE Study in North Carolina

In 2012, 10,383 adults responded to the questions based on the ACE study in the NC Behavioral Risk Factor Surveillance (BRFSS) survey.

57.6% reported at least one ACE

The most common reported ACEs:

- 27.4% parental separation or divorce
- 26.8% substance abuse in household
- 23.7% emotional abuse

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(Austin & Herrick, 2014)

11

- *ACEs disrupt neurological development or a person's "wiring" and this leads to social, emotional, and cognitive impairment or what we see as people who have difficulty socializing, emotional difficulties, or thinking through a situation.*
- *The person may then adopt unhealthy behaviors or take risks that could may lead to disease, disabilities, and social problems and early death. (Examples of health risk behaviors include: smoking that may lead to COPD or lung cancer, gambling that may lead to financial and family difficulties, risky sexual behavior that may lead to STDs)*
- *We may know someone who may have had many adverse childhood experiences and never see these effects. This person most likely is very resilient or had protective factors in their life. Tie ACE Trauma factors to Resiliency factors to demonstrate how trauma experienced by multiple individuals may impact each of them differently.*

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

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(CDC, 2016)

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Section 1.2

Shift from Symptom to Adaptation

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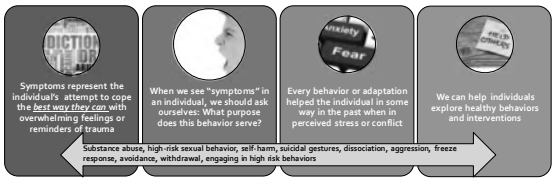
Trauma "Symptoms" as Adaptations



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Problems or Adaptations?

Fight	• We might say: Non-compliant or Combative • What they are demonstrating: Attempting to regain or hold on to personal power
Flight	• We might say: Treatment-resistant or Uncooperative • What they are trying to do: Disengage or emotionally withdraw
Freeze	• We might say: Passive or Unmotivated • What they are trying to demonstrate is: Giving in to those in power

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Section 1.3

The Brain and Trauma

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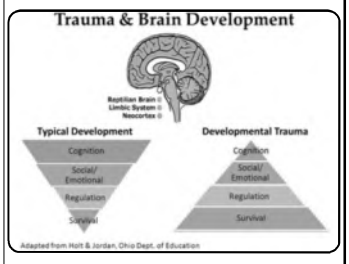
- Our brains develop from the bottom up from this area of orange, to green, to blue.
- Look at this upside down triangle representing typical development. When we are born, we need to survive and we are born with this orange part of our brain controlling our survival such as breathing, and heart rate. Quickly we start to develop the limbic part of the brain or this green area with caregiver responses and connections forming healthy connections in our brain through healthy interactions learning to regulate our emotions, behavior, motivation, and we gain memory skills based on experience and new knowledge. Our memories are associated with emotional events here in the limbic system.
- In later childhood around the age of 10 or 12, our neocortex or blue part of the brain development takes off where analytical and rational thinking begins to develop so we can think through a situation and develop logic and reasoning. Before this, we were just concrete thinkers. This part of our brain continues to grown into our 20's.
- When we experience stress or trauma, the neocortex or thinking brain is wired to shut down to make sure we focus on survival and that is why it is hard to think when something really stressful or what we perceive as trauma is happening. The area of brain responsible for speech (Broca area) also shuts down and that is why when we ask what is wrong, and the person may have difficulty thinking or speaking on what to say or how you can help. When the threat is over, we may return to the upside down triangle when we feel safe.
- Child abuse and neglect disrupt healthy brain architecture and can result in this triangle on the left. their brain may be stuck in survival mode with fight, flight or even freeze responses always or in environments that mimic traumatic events or the past.
- To help, we must assist the individual feel safe first so they don't need to fight, flight, or freeze and this may begin with just being there and developing what we call a therapeutic rapport to understand how to help individuals feel safe



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Section 1.4

Prevalence of Trauma

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Trauma in Children

- Up to 92% of youth in residential mental health treatment have experienced multiple traumatic events
- Up to 93% of children in juvenile justice systems have experienced trauma
- 60% children and adolescents exposed to violence annually
- 3 million children neglected every year
- 1 in 4 girls and 1 in 6 boys sexually abused before adulthood
- Children growing up in poverty are 7 times more likely to develop schizophrenia

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Trauma in Adults

Statistics

- 51-98% of public mental health individuals with severe mental illness, have been exposed to childhood physical and/or sexual abuse and most with multiple experiences.
- 50% of female and 25% of male individuals have experienced sexual assault in adulthood

Facts

- Clients with a history of child abuse have earlier first admissions, more frequent and longer hospital stays, more times in seclusion/restraints, more medication use, and more severe symptoms.
- Content of hallucinations and delusions is often based on memories of childhood trauma

Substance Abuse

- Up to 2/3 of men and women in substance abuse treatment report childhood abuse/neglect
- 92% + of homeless mothers have chronic trauma histories and have 2 x the rate of drug and alcohol dependence
- Almost 1/3 of all veterans seeking treatment for substance use have been diagnosed with PTSD

IDD

- People with history of IDD may experience greater exposure to adverse events than general population related to cognitive limitations and vulnerabilities

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Hospitalization and Trauma

Trauma Reminders Related to a Hospitalization:

- Loss of freedom
- Loss of privacy
- Loss of power or control of discharge or treatment
- Loss of stress management and coping techniques (smoking, self injury, support, substance use, etc.)
- Restraint/Seclusion
- Caregiver tone of voice and nonverbal communication
- Caregiver use of labeling language: manipulative, needy, attention-seeking

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Reminders of Trauma


Bedtime


Dental appointments/medical appointments


Food


Room checks


Large men


Yelling


Crowds

22

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Section 2

Trauma-Informed Care Principles

23

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Trauma-Informed Care Organizations

1. Realize the prevalence of trauma
2. Recognize trauma adaptations
3. Integrate knowledge about trauma into polices, procedures and practices
4. Seek to resist re-traumatization

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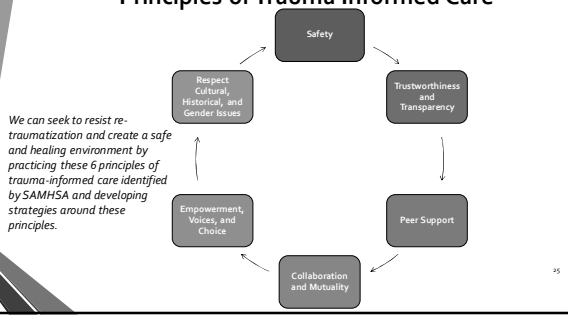
SAMHSA's Principles of Trauma Informed Care



We can seek to resist re-traumatization and create a safe and healing environment by practicing these 6 principles of trauma-informed care identified by SAMHSA and developing strategies around these principles.

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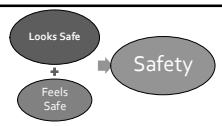

Environment **looks** and **feels** safe

Environment promotes a sense of safety **(looks safe)**

- Access to doorways, exits, seating and personal space
- Lighting

Interpersonal interactions promote a sense of safety (**feels safe**)

- Nonjudgmental approach
- Interactions without shame or embarrassment
- Welcoming environment
- Respectful language
- Meeting basic needs
- Privacy for communication

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Trust and Transparency

Our goal is to build and maintain trust among individuals and their family and support systems

- Maintain clear and appropriate boundaries
- Honor confidentiality policies
- Be clear, be consistent, and predictable
- Explain and assist people with their options

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Peer Support

- Peer = individuals with experiences of trauma (trauma survivors)
- Purpose: Develop authentic mutual relationships
- Helps to establish safety and hope
- May be family or caregivers in the home
- Peer Support Specialists in inpatient
- Peer groups in community

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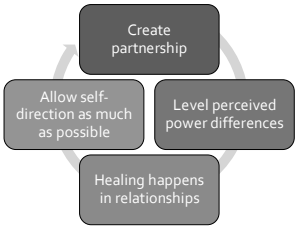
Collaboration and Mutuality



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Empowerment, Choices, and Voice

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Cultural, Historical, and Gender Issues

- Provide opportunities for engagement in cultural practices
- Use interventions respectful of cultural backgrounds
- Move past cultural stereotypes and biases
- Recognize and address historical trauma

Cultural factors influence how people identify, interpret, and respond to traumatic events

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Section 2.1

Responding to Trauma Reminders

32

In Fight, Flight, or Freeze Situations: Responding to Emotional Reminders

33

33

Healing happens in relationships: The Power of Empathy by Brene Brown

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https://youtu.be/KZBTYViDPIQ

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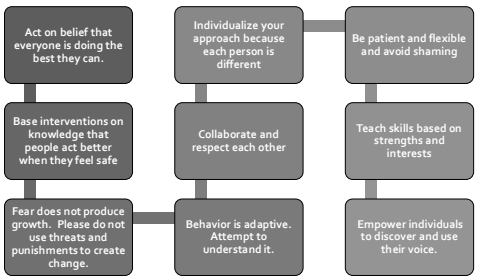
Actions that Create Trauma Informed Care



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"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
Maya Angelou

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Section 3
Resiliency and Protective Factors

37

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Resilience Defined

Ability to "bounce back" or adapt to adversity, trauma, or stress

Promote resiliency through development of skills to adapt to sources of stress

Reflective of protective and risk factors

Involves behaviors, thoughts, and actions in the face of stress adversity

Can be learned regardless of age, adversity, challenges, or trauma

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Resiliency Factors

Resiliency Factors:

- Caring and supportive relationships
- Sense of self and self worth
  - Acceptance, achievements, praise, strengths
  - What is important to and for you?
- Communication and problem-solving skills
- Management of impulses and emotions

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Protective factors are important in helping reduce the risk for adverse effects of trauma

Additional Protective Factors:

- Availability of food and water
- Income
- Stable housing
- Social connections including safe and healthy relationships
- Education about health and wellness
- Access to health and emergency services
- Policies and laws to prevent crime and violence

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Section 4
Self-Care

41

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Prevents looking like this....

"Mental health is not an easy field to work in and it is important to incorporate self-care into your routine to prevent burnout. Know you are valued and if you can take time for yourself to do things you enjoy, your job satisfaction is proven to increase." -*Caleb Mol, MS, LMFT, Outpatient Mental Health Therapist*

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Working with individuals with a History of Trauma can lead to…

Vicarious Trauma, Compassion Fatigue, or Secondary Trauma

- Compassion Fatigue
  Emotional, behavioral, and physical stress symptoms from helping individuals
- Vicarious trauma or Secondary Trauma:
  Cognitive changes from repeated exposure to hearing about horrible stories of trauma from individuals
- Effects can be similar to PTSD including intrusive images , nightmares, emotional numbing, dissociation, and exaggerated startle response
- May result in feeling unsafe, increased negativity, low morale, low productivity, and increased job turnover
- Can be prevented and treated through identification and knowledge about support and resources

Burnout:

A severe state of emotional exhaustion, depersonalization and reduced feelings of personal accomplishment resulting in negative and cynical attitudes towards individuals

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An Example of Compassion Fatigue

"We're encouraging people to become involved in their own rescue."

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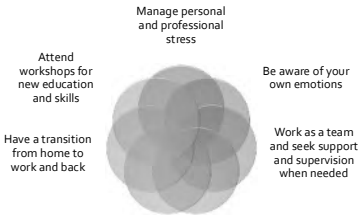
Trauma-Informed Self-Care



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Employee Ideas to Build Support and Teamwork

- Potluck or theme days at work
- Walking groups
- Comfort box with sensory items
- Yoga or stretching in the morning
- Break room ideas
  - Inspirational quotes
- Feelings thermometer

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VICARIOUS TRAUMA

Vicarious Trauma results from empathic engagement with traumatized others and their reports of traumatic experiences.

Vicarious Trauma can affect at every level of our being and leave us feeling out of balance. See below for ways to rebalance.

Six dimensions of Vicarious Trauma and how to manage

- Physical
- Psychological
- Spiritual
- Emotional
- Personal
- Professional

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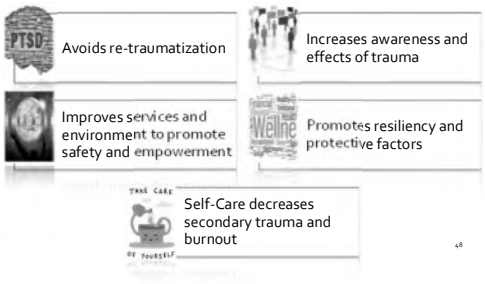
How Trauma-Informed Care Helps:



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TREATMENT TEAM PROCESS

Health Care Technician
Role and Responsibilities

1

>> Click anywhere on the screen to advance forward in this presentation

1

Rationales for HCT Education on the Treatment Team Process

- Central Regional Hospital is an inpatient psychiatric facility that provides treatment and services for persons with mental illness
- The Health Care Technician is a valuable member of the Health Care Team and plays an important role in the patient's treatment
- Education on the Treatment Team Process will help the HCT be better prepared to participate as an effective member of the team

2

Objective

- To provide the HCT with the general knowledge of the following:
  1. Members of the Treatment Team
  2. Purpose of the Treatment Plan
  3. HCT Role and Responsibilities in the Treatment Planning Process
  4. How to Read a Treatment Plan
  5. How to Document Towards Treatment Goals in the Progress Note

3

Goals

- The HCT will understand the Treatment Team Process
- The HCT will be better prepared to participate in the Treatment Team Process
- The HCT will be prepared to write a Progress Note directed towards the Treatment Plan Goals

4

Teamwork

The work of a group of people in order to achieve a common goal

5

5

Members of the Treatment Team

- Patient
- Psychiatrist
- RN
- Social Worker
- Rehabilitation liaison
- HCT
- Psychologist
- Other disciplines (occupational therapy, dietician, physical therapy, etc)

6

6

Treatment Plan

- The purpose of a Treatment Plan is to provide a guide for any staff member to use to know how to help the patient achieve his treatment goals
- The plan is written during a scheduled meeting, but the plan can be changed whenever needed by the team

7

7

Treatment Planning
6 guiding principles

1. **Treatment planning** *involves team members from different departments (Psychiatry, Nursing [RN,LPN,HCT], SW, Psychology, Rehab Therapy, etc) and includes patient participation*
2. **Treatment plans** *are written for each patient as an individual*
3. **Treatment Plans** *are based around the problem that brought the patient into the hospital or what is keeping them from being discharged*

8

8

Treatment Planning
6 guiding principles

4. **Patient** *is a member of the team and is part of making his/her treatment plan*
5. **Treatment planning** *uses the assessments completed by the Psychiatrist, RN and Social Worker*
6. **Treatment plans** *work towards patient's discharge*

9

9

Responsibilities of HCT in Treatment Planning Process

- **Act as the patient's main support while in the treatment team meeting**
  - **Before the meeting**
    1. Talk with the patient about what happens in the meeting
       - Example: *"Mr. Stevens, You're going to meet with your doctor, nurse, social worker and other people on your treatment team today. This is a chance for you to talk with everybody to tell us why you think you came into the hospital and ways we can help you so you can be discharged."*
    2. Have the patient ready and located close to the team meeting room (in the dayroom)
    3. Escort patient to the meeting at the scheduled time and place

10

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Responsibilities of HCT in Treatment Planning Process

- **During the Meeting**
  1. Support the patient and help make sure he/she understands what is happening
     - *Sit beside him/her if you think this will make them feel more comfortable*
  2. Inform the treatment team members how this patient is doing on the unit, if it is different than what other people have said
  3. Provide suggestions for interventions if you have found certain things that work best with the patient

11

11

Responsibilities of HCT in Treatment Planning Process

- **After the Meeting**
  1. Share important information with other staff members on the unit so everybody will do the same things while working with the patient
     - *Pass on information to any person taking over responsibility of pt (especially at shift change)*
     - *Make sure HCT card is current with goals, interventions, etc (ask RN)*
  2. Talk with patient about the plan and make sure he/she understands

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Responsibilities of HCT in Treatment Planning Process

3. Follow Plan of Care
   - *Always know what the patients' goals and interventions are (Look at treatment plan and HCT card)*
4. Document patient responses to care
   - *How did the patient respond to the interventions you used to help him with his/her goal*
5. Notify RN if interventions are or are not working and make suggestions for new interventions

13

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HCT Responsibilities regarding care of all Assigned Patients

1. Read the Treatment Plan for all assigned patients
2. Make sure you have an updated HCT card with goals and interventions on it (Ask the nurse if you don't)
3. Follow the Plan of Care
4. Document patient's responses to care
5. Inform RN of interventions that are not working and provide suggestions

14

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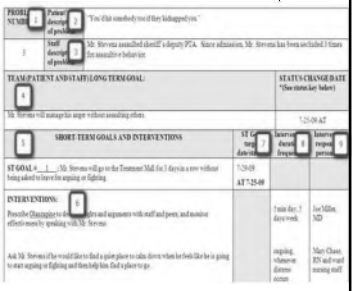
Understanding how to read a Treatment Plan

1. Problem number
2. Patient's description of problem
3. Staff description of problem
4. Long term goal (LTG)
5. Short term goal (STG)
6. Interventions
7. STG target dates
8. Intervention duration / frequency
9. Intervention responsible person / title



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Nuts and Bolts of Progress Notes

1. **Purpose of the Progress Note**
   - The progress note is a place for all staff to describe the progress the patient is making towards reaching his/her treatment goals
2. **When to Document**
   - Per hospital policy or more frequently depending on your unit requirements
   - As needed – When something happens that provides important information about the patient and his/her progress toward their goals
3. **How to Document**
   - Progress notes should be related to the problems on the patient's Treatment Plan
   - *Example: In the subject column, write: HCT; P#3; STG#1*

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Information to include in Progress Notes

1. **A description of the patient problem(s)**
   - *Chart only what you observe (just the facts)*
   - *What the patient did or said*
2. **A statement of the treatment interventions used**
   - *What intervention did you use, or what did you say or do*
3. **A description of how the patient responded and progress toward the specific treatment goals**
   - *How did the patient respond to what you said or did*
4. **A description of how well the intervention worked**
   - *Was the intervention effective*
   - *Was the goal met or not met*

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Master Treatment Plan for Problem #3, Goal #1

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Example of Documentation in Progress Note (#1)

- During Tx Mall today, pt became upset at another peer, Mr. RB, for interrupting him in class. Mr. Stevens kicked Mr. RB on the leg. Instructor asked Mr. Stevens to leave class. Writer notified RN and escorted pt back to the unit. Pt stated "I'll be ok. I just want to go to my room and calm down."

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Example of Documentation in Progress Note (#2)

- Mr. Stevens attended Tx Mall today with no behavioral problems. He sat quietly in all of his classes. Writer praised pt for not arguing or fighting and talked with him about what he enjoyed today in class. He stated he liked his Community-Reentry group because they told him about things he could do when he was discharged. This was the 1st day pt has been able to stay in tx mall all day without being asked to leave because of his behavior.

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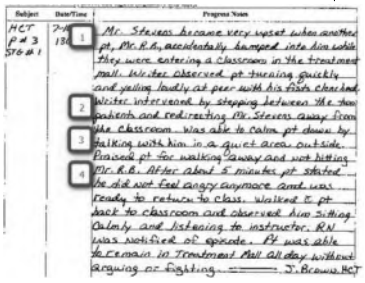
Example of Documentation in Progress Note (#3)

1. Description of problem or behaviors
2. Interventions used
3. Patient's response
4. Effectiveness of treatment interventions (Progress towards goal)



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WORKPLACE VIOLENCE

Central Regional Hospital
Orientation/Annual Training

1

OBJECTIVES

- Define workplace violence
- Explore CRH's Culture of Safety and approach to the prevention of Workplace Violence
- Recognize violence risk factors and warning signs
- Understand the steps employees should take if a violent event occurs and response to emergency incidents
- Review requirements and processes for reporting workplace incidents and concerns

2

WORKPLACE VIOLENCE DEFINITION
The Joint Commission

- An act or threat occurring at the workplace that can include any of the following: nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying, sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors.

3

TYPES OF WORKPLACE VIOLENCE

- Type I: Criminal Intent/Perpetrator with no relationship to organization
- Type II: Involves a client or patient
- Type III: Employee-on-Employee
- Type IV: Perpetrator who has a relationship outside of the organization with an employee

4

TYPES OF WORKPLACE VIOLENCE

- Threat: The expression, directly or implied, of intent to cause physical or mental harm. An expression constitutes a threat without regard to whether the party communicating the threat has the present ability to carry it out.
- Bullying: Unwanted offensive and malicious behavior which undermines an individual or group through persistently negative attacks. There is typically an element of vindictiveness, and the behavior is calculated to undermine, patronize, humiliate, intimidate, or demean the recipient
- Cyber-Bullying: Uses technology to intentionally harm others through hostile behavior, as well as threatening, disrespectful, demeaning, or intimidating messages. This is bullying that occurs via the Internet, cell phones, or other electronic devices (e.g., emails, IMs, text messages, blogs, pictures, videos, postings on social media, etc.)

5

TYPES OF WORKPLACE VIOLENCE

- Domestic Violence: The use of abusive or violent behavior, including threats and intimidation, between people who have an ongoing or prior intimate relationship.
- Stalking: Involves harassing or pestering an individual, whether in person, in writing, by telephone, or through an electronic format. Stalking also involves following an individual, spying on them, alarming the recipient, or causing them distress, and may involve violence or the fear of violence.
- Intimidation: Includes, but is not limited to, stalking, bullying, or engaging in actions intended to frighten, coerce, or to induce duress.
- Property Damage: Intentional damage to property which includes property owned by the State, employees, visitors or vendors.
- Physical Attack: Unwanted or hostile physical contact such as hitting, fighting, pushing, shoving, biting, choking, spitting or throwing objects.

6

RATES OF WORKPLACE VIOLENCE

- Approximately 2 million people become victims of workplace violence each year
- Most injuries caused by workplace violence happen in the healthcare industry
- Consequences:
  - Low staff morale/decreased job satisfaction
  - Burnout
  - Other physical/psychological consequences
  - Lawsuits
  - High worker turnover
  - Negatively impacts patient care

7

CULTURE OF SAFETY

- The physical and psychological safety of the staff and patients is CRH's #1 priority
- CRH has a zero-tolerance policy for violence
- CRH is committed to a blame-free environment where individuals can report errors or near misses without fear of reprimand or punishment
- CRH encourages collaboration between disciplines and leadership and frontline staff to seek solutions to safety concerns

8

WORKPLACE SAFETY COMMITTEE

- Provides oversight of the Workplace Violence Prevention Program
- Multidisciplinary and includes front line workers and leadership
- Identifies issues and improvements related to workplace violence
- Reviews and evaluates environmental designs, response to events/staff, training, reporting processes, and best practices

9

WHO IS RESPONSIBLE FOR MAINTAINING A SAFE WORKPLACE?

- EVERYONE is responsible and has a role to prevent workplace violence
- Responsibilities include:
  - Being aware of warning signs
  - Responding appropriately to incidents to ensure safety
  - De-escalation and nonphysical/physical intervention skills when appropriate to training and situation
  - Alerting others in an emergency (whistles, TRT, 55, 911)
  - Reporting incidents
  - Addressing potential environmental risks (e.g., contraband, broken furniture, unsecured doors)

10

UNIVERSAL SAFETY PRECAUTIONS

- Assaults are not an expectation of employment at CRH
- However, violence is sometimes unpredictable. ALL patients are therefore considered to be at risk for injury to self or others
- It is everyone's responsibility to utilize "Universal Safety Precautions" at all times for every patient
- Universal Safety Precautions means that it is everyone's responsibility to identify, address, and report potential risks, hazards, and changes in patient behavior

11

VIOLENCE BY PATIENTS

12

INDICATORS OF POTENTIAL PATIENT VIOLENCE

- Best predictor of future violence?
  - History of violence
- Hostile attitude, irritability
- Threats of violence
- Intoxication
- Attacks on objects/property damage
- Poor "therapeutic alliance" (e.g., not cooperating with an assessment)
- Physical restlessness
- Delirium/confusion
- Muscle tension/clenched fists
- Raised voice
- Sleep problems
- Severe psychotic symptoms (e.g., hearing voices telling them to hurt someone else)

13

TYPES OF AGGRESSION

- Impulsive ("hot blooded")
  - Most common on inpatient units
  - Many causes, including mania, PTSD/trauma history, personality disorders
  - Spontaneous, unplanned, usually after being told "no"/losing control over one's environment
- Psychotic
  - Patient misunderstands or misinterprets environmental stimuli and feels threatened
  - E.g., paranoid delusions ("my nurse is poisoning me")
- Predatory ("cold blooded")
  - Planned, goal-directed, lack of remorse
  - Least common on inpatient units

14

WHY DO PATIENTS BECOME VIOLENT?

- In one study, 70% of inpatients said they attacked a staff member either because:
  - They perceived the staff member to be patronizing and/or disrespectful; or,
  - They perceived they were told "no" without receiving an adequate explanation
- Take away?
  - EVERYONE, regardless of their position, can reduce the likelihood of violence by responding to patients respectfully, patiently, and explaining their reasoning, especially when setting limits; this approach is consistent with Trauma Informed Care (TIC) and will help to de-escalate potentially volatile situations, keeping patients and staff safe

15

PREVENTING PATIENT VIOLENCE

- Stay alert to your surroundings
- Notice and report even subtle changes in patient behavior (e.g., restlessness, appearing more withdrawn)
- Be mindful of environmental risk factors. For example:
  - Do not leave objects (e.g., pens) that could potentially be used as weapons in patient care areas
  - Adhere to Dress Code Policy (e.g., note that neckties and scarves can be hazardous) and always have a whistle
  - Be very cautious about being in a room with a patient alone. If you do, ensure that you always have access to an exit.

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PREVENTING PATIENT VIOLENCE

Crisis Prevention Institute's (CPI's) Top 10 De-Escalation Techniques

1. Empathic and non-judgmental statements
2. Respect personal space
3. Use non-threatening non-verbals
   The more distressed a person becomes, the fewer words they can process. Tone, body language, and facial expression can have a profound impact.
4. Focus on feelings
   Acknowledge the fact that what they are feeling, although perhaps irrational to the outside world, is profoundly real to them.
5. Avoid overreacting
6. Ignore challenging questions and focus on true needs of the person
7. Keep limits simple, clear, reasonable, and enforceable
8. Choose wisely what you insist on
   You might need to say "no" about one thing, but what can you say "yes" to?
9. Allow silence for reflection
10. Allow time for decisions
    Anxiety can momentarily separate someone from their ability to make rational choices. A quiet moment can help a situation correct its course.

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RESPONSE TO PATIENT VIOLENCE

- Make sure that everyone is in a safe location
- Use whistle
- Call "55"
  - Therapeutic Response Team (TRT): Crisis management team with advanced skills in verbal de-escalation and advanced Applied Physical Techniques (APT)
  - Butner Public Safety (BPS) is available as back-up in extreme circumstances (e.g., if there is a lethal weapon and/or imminent risk) and with permission of the Chief Nursing Officer/Designee or House Coordinator

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REPORTING PATIENT VIOLENCE

- Immediately report to the charge nurse and your supervisor
- Give all details to the charge nurse so that appropriate assessments/interventions can be taken for prevention and patient/staff safety, and so the incident can be entered into the RL6-Patient Incident Reporting System by the end of shift
- Document thoroughly in the medical record as appropriate for your role/position

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FILING CRIMINAL CHARGES

- The hospital may file criminal charges against a patient when alleged criminal behavior has occurred and the treatment team, after consultation with the Unit Clinical Director and Chief Medical Officer, agree that the behavior was volitional and/or premeditated and that such an action is considered a therapeutically appropriate consequence
- Individual employees and/or patients who are victims may, at any time, as independent agents, apply to the magistrate for the filing of charges after notification of their supervisor

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VIOLENCE BY EMPLOYEES/ OUTSIDE PERPETRATORS

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INDICATORS OF POTENTIAL EMPLOYEE VIOLENCE
U.S. Department of Homeland Security

- Increased use of alcohol and/or illegal drugs
- Unexplained increase in absenteeism; vague physical complaints
- Noticeable decrease in attention to appearance and hygiene
- Depression/withdrawal
- Resistance and overreaction to changes in policies and procedures
- Increasingly talking about problems at home or with finances
- Threats of violence
- Increase in mood swings
- Noticeably unstable, emotional responses
- Explosive outbursts of anger or rage without provocation
- Suicidal; comments about "putting things in order"
- Paranoia ("everybody is against me")
- Identification with violent individuals
- Increase in unsolicited comments about weapons
- Talk of previous violence

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HOW TO PREVENT EMPLOYEE VIOLENCE

- Effective, clear communication between employees is a key factor in prevention
- Seek supervision early when disputes occur
- Report early warning signs (e.g., arguments, emotional instability, signs of substance abuse or burnout) to your supervisor to help assess the situation and obtain help
- Talk with your supervisor or contact EAP if you are feeling overwhelmed, stressed, or are otherwise noticing signs of burnout

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HOW TO PREVENT OUTSIDE PERPETRATOR VIOLENCE

- Do not allow anyone to enter/exit through a secured door or onto the elevator if the person is not wearing a CRH badge
- Immediately report safety concerns/hazards to your supervisor. For example:
  - Lost keys/badge
  - Doors that do not secure properly
  - Suspicion of an individual having a firearm or weapon
  - Any threatening or violent behavior, including verbal threats

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RESPONSE TO EMPLOYEE/ OUTSIDE PERPETRATOR VIOLENCE

- Make sure that everyone is in a safe location
- Use whistle if needed
- Call "55" or 911 if there is any difficulty reaching the hospital operator
  - The perpetrator may be removed from the premises with the assistance of Butner Public Safety

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REPORTING EMPLOYEE/ OUTSIDE PERPETRATOR VIOLENCE

- You must immediately report to your supervisor any threats against you or another employee, whether you heard it directly or another employee tells you of the threat
- Supervisors are responsible for immediately notifying Human Resources and Hospital Leadership to ensure appropriate actions are taken for everyone's safety
- Employees reporting in good faith will not be subject to retaliation or harassment based on their report
- If you have any type of court order against anyone (e.g., protective order), you must report it immediately to your supervisor, who will report it to HR
- All reports are held in the strictest confidence

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REPORTING EMPLOYEE/ OUTSIDE PERPETRATOR VIOLENCE

- Employees are required to report any arrest, criminal charges, or criminal convictions to include criminal drug and alcohol violations, as well as any protective orders entered against them or any confirmed finding of abuse or neglect against them to their supervisor no later than (5) five calendar days after such occurrences

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RESPONSE TO VICTIMS

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RESPONSE TO PATIENT VICTIMS

- Any employee who observes an unsafe incident will immediately intervene, within the scope of their ability, to protect the health and safety of the patient
- Patient victims of verbal or physical aggression will be evaluated by an RN and psychiatrist to determine whether additional support/management is required
- Patients who have been physically assaulted will be evaluated by a medical provider
- If at any time an incident causes staff to suspect abuse, neglect, or exploitation, staff should ensure that their supervisor and Patient Advocacy are notified

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RESPONSE TO STAFF VICTIMS

- On-site immediate medical evaluation/treatment is available through Employee Health Services (EHS) or the MPU after hours
- Staff Support Program (SSP) provides employees with assistance from trained co-workers following stressful events (919-764-2239)
- NC Employee Assistance Program (EAP) provides a needs assessment by an experienced, licensed clinician who will either resolve the problem or refer for additional support (1-800-633-3353)

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SUMMARY

- The physical and psychological safety of the staff and patients is CRH's #1 priority
- CRH has a zero-tolerance policy for violence
- Universal Safety Precautions means that, because violence is sometimes unpredictable, it is everyone's responsibility to identify, address, and report potential risks, hazards, and changes in patient behavior
- Always immediately report to your supervisor any allegations, suspected, or witnessed incidents of workplace violence to ensure everyone's safety

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