Presenter: Narrated

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COURSE OBJECTIVES

* Explain how to perform pain assessment and management, restraint and seclusion procedures, handoff communication methods, and fall and suicide prevention measures.
* Identify patient infections and preventions for catheter-associated urinary tract infections, central line-associated bloodstream infections, and surgical site infections, and recognize ethics of care.

MODULE 1: ASSESSMENT/MANAGEMENT OF PAIN

PAIN ASSESSMENT

Speaker 1: Patients have a right to appropriate pain assessment and management. Continuous, unrelieved pain is a known contributor to adverse outcomes such as post-surgical infections, poor wound healing, deep vein thrombosis, pulmonary embolism, pneumonia, depression, and even suicide. These complications not only affect the patient's health but can also lead to extended lengths of stay, unnecessary readmissions, dissatisfaction with care, and may put clinicians and institutions at risk for legal action.

Assessment of pain is key to effective pain management. Assessment methods and parameters should be guided by facility setting and policy.

Speaker 2: Methods used to evaluate pain should be based on a patient's age, condition, understanding, and written criteria.

Speaker 1: As well as patient ability to understand and respond. Pain should be assessed regularly, and reassessed after each intervention to evaluate effect.
PAIN HISTORY

When collecting and documenting a pain history, it is important to include the following: Previous and ongoing instances and types of pain; previous methods used for pain control that had been helpful and unhelpful; typical coping responses to pain including any psychiatric disorders, depression, anxiety or substance abuse; patient and family preferences, expectations and beliefs about pain and pain treatment; and barriers to communication about pain.

ELEMENTS OF PAIN ASSESSMENT.

Intensity: A number of scales have been validated for assessment of pain intensity. Individual patient characteristics along with institutional policies should drive the selection of the appropriate scale. A scale should be used consistently but should not be used as the sole measure of pain intensity. Visual scales allow patients to point to or otherwise indicate an intensity rating based on a visual series of numbers or pictures. Verbal scales use common words such as mild, moderate, or severe.

Verbal numeric scales allow patients to verbally rate pain based on a series of numbers such a 0 to 10. For patients with limited cognitive ability, non-verbal patients, neonates, infants, and children. Other scales may be available by facility and setting.

Location: When possible, ask the patient to point to or be specific about the location of pain. For example, the patient says he has pain in his abdomen but points to the right lower quadrants or complains of backache but points to the left flank.

Description: Ask the patient to describe the pain. This may help in identifying the cause. Musculoskeletal pain is often described as dull, aching, cramping, stabbing, or throbbing. Nerve-related pain is often described as stinging, shooting, tingling, or like an electric shock.

Impact: The impact of pain on the ability to perform bodily functions, sleep, maintain a healthy mood, and perform activities of daily living are important considerations.

Alleviating and Aggravating Factors: Factors such as position, room temperature, and certain movements that either improve or worsen pain are helpful for identifying cause and appropriate interventions.

Physiological and Behavioral Responses: Physiologic responses such as rapid heart rate, increased respiratory rate, and hypertension may help in identifying the presence and intensity of pain. Grimacing, moaning, crying are sometimes exhibited with pain; however, patients may experience pain without these responses.
ASSESSMENT BARRIERS AND SPECIAL POPULATIONS

Self-reporting is the most accurate means of assessing pain; however, patients may not always be able to report. Caregivers and family members may help. Efforts should be made to overcome barriers in collecting an accurate assessment such as the use of interpreters when language barriers exist, visual tools for the hearing impaired, and verbal tools for the visually impaired.

The Elderly: A variety of medical conditions associated with aging often make it difficult to distinguish acute from chronic pain. Clinicians must use patience and good communication when posting questions and allowing time to respond. Use assessment tools that are sensitive to cognitive language and sensory impairments. Family members or caregivers may provide information about the patient's pain history and response to treatments.

Special rating scales are available for infants and young children that use a combination of behavioral and physiological factors such as crying, facial expression, changes in vital signs, withdrawn behavior, posturing, irritability, restlessness, and an altered sleeping pattern. Family members may assist.

Cognitively Impaired: Both self-reporting and observations are necessary when assessing pain in this population. Assessment tools and rating scales should be carefully selected according to the unique abilities of each individual and should be used consistently over the course of a typical event. Input from family members or caregivers may provide additional insight for establishing baselines and selecting interventions.

PAIN MANAGEMENT RESPONSIBILITIES

An effective pain management plan includes pharmacological and non-pharmacological interventions which are selected based on individual patient characteristics, preferences, safety concerns, and setting. Non-pharmacological interventions include, but are not limited to: relaxation techniques, positioning, compression, splinting, application of heat or cold, massage, and neuro-stimulation.

The synergistic use of different pharmacological analgesics results in the need for lower doses to control pain and fewer side effects. A balanced analgesia plan includes: Non-opioids such as acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs); opioids; adjuvant analgesics that include local anesthetics, antidepressants, and anticonvulsants.

PHARMACOLOGICAL OPTIONS

Pharmacological analgesic selection should be based on: Patient goals and preferences, pain history, and assessment, procedures, surgeries, and activities, potential toxicity based on factors such as age and patient conditions, cost and setting.
The body of evidence on pain management supports the following principles for the use of pharmacological analgesics: A fixed dose schedule around the clock should be used when continuous pain is expected; for breakthrough or activity-related pain, use of a rapid onset analgesic; acetaminophen or NSAIDs are recommended for mild to moderate pain; adjuvants such as anticonvulsants or antidepressants are often used for specific types of pain; opioid administration should begin with a low dose titrated to comfort and safety; assessment of the effect of previous doses including intensity, relief, and side effects should guide modifications. If one analgesic is not providing adequate relief, another in the same class may show better results as patients respond differently to various drugs.

GENERAL SAFETY PRECAUTIONS

The following are general safety precautions:

When administering pain medications that have a sedative effect, use fall precautions. For patient-controlled analgesia or PCA infusions, use systems to double-check drug and dose. For catheter administrations, use initial dose testing and monitor response. Protect skin when applying cold or heat.

SAFE USE OF OPIOIDS

The same binding action of opioids with cell receptors in the nervous system that blocks pain signals can also cause sedation, decreased respiration, reduced blood pressure, nausea, euphoria, and decreased bowel motility. These effects can be dangerous or life threatening. The following are important safety precautions: Screen for respiratory risk factors such as sleep apnea and snoring, morbid obesity, older age, upper abdominal and thoracic surgeries, history of analgesic abuse, or increased opioid dose requirements, longer length of general anesthesia, receiving other sedating drugs, pulmonary or cardiac disease or major organ failure, smoking history. Assess patients for fentanyl patch, implanted drug delivery system, or infusion pump before administering a new opioid. Take extra precautions with those new to opioids. Assess patient response to an initial dose before increasing or prescribing long-term use. Avoid rapid dose escalation above routine levels in opioid-tolerant patients. Take extra precautions during care transitions between units, facilities, and when discharging patients to their home as drug levels may reach peak concentrations during this time. Sedation level and respiratory status are more reliable measures for preventing respiratory depression than pulse oximetry or apnea monitoring. Decreased oxygen saturation is a later sign of impending respiratory depression. Take extra precaution with patients also taking antidepressants or anticonvulsant drugs. As these combinations may cause significant sedative effects.
PATIENT AND FAMILY EDUCATION
The following points provide a guide for educating patients about pain management: Reasonable expectations for pain control; the important of controlling pain before it reaches an intolerable level; responsibilities for reporting pain and changes in pain; both pharmacological and nonpharmacological options for managing pain; minor side effects and ways to manage them; dangerous side effects and what to do should they occur.

MODULE 2: RESTRAINT AND SECLUSION, HANDOFF COMMUNICATION, AND FALL AND SUICIDE PREVENTION

RESTRAINT AND SECLUSION
Physical restraint is any human and or mechanical force that restricts a patient's freedom of movement. It may involve: Tucking in a sheet so tightly the patient's movement is restricted; the use of wrist, ankle, or waist restraint devices; keeping side rails raised to prevent a patient from getting out of bed; holding a patient's body or part of the body against his or her will in a manner that restricts movement.

Chemical restraint is any medication NOT part of the standard treatment of care for the patient's medical or psychiatric condition which is used for the purpose of restricting or managing behavior.

Seclusion is holding or threatening to hold a person in a room or space involuntarily and preventing him or her from leaving.

Restraint or seclusion of any kind should ONLY be used for the management of behavior that jeopardizes the immediate physical safety of the patient, staff, or others. Patients have the right to be free from restraint and seclusion used for any other purpose. They should NEVER be used for: Treatment, punishment, behavior modification or staff convenience.

Only a patient's CURRENT behavior may be used to determine the need for restraints. A history of violence or previous self-harm are NOT enough to justify their use. When indicated, the least restrictive form of restraint necessary to protect the patient and others from harm must be used and should be removed at the earliest possible time.

Restraint does not include: Orthopedically prescribed devices, surgical dressings or bandages, or protective helmets.

Preventive and alternative strategies should be tried before using any form of restraint or seclusion that restricts a patient's movement such as: Providing companionship or extra supervision, placing a patient near a nurse's station, soothing distractors like TV, music, walking,
conversation or books, changing or eliminating bothersome treatments, procedures, or medications when ordered by a provider.

If alternatives have been proven insufficient or ineffective, restraint may be appropriate. When used a provider order must be obtained -- standing orders should NOT be used. Staff applying restraint and seclusion MUST be trained and demonstrate expertise with: The physical application, use, and removal of restraint, implementation of seclusion, monitoring, assessment and care of a patient in restraint or seclusion.

Restraints should be removed ONLY by authorized, trained staff. They should never be tied to the mattress or side rails. Knots must be tied so they may be released quickly in the event of an emergency. Restraints must be removed as soon as the patient no longer displays violent or self-destructive behaviors regardless of the length of time stated in an order.

The use of restraint and seclusion must be documented. Information should include but is not limited to: Clinical justification, type of restraint used, clinical condition, assessment information such as vital signs and behavior, criteria used to continue or stop restraint use, and date and time of application and removal. Laws and standards in most states require a patient in restraints to be evaluated face to face at least every hour; however some may have shorter parameters. The Centers for Medicare and Medicaid Services and other accrediting agencies like The Joint Commission regulate restraints and seclusion. All providers and staff must be familiar with applicable laws, standards, and organizational policies.

HANDOFF COMMUNICATION

An estimated 80% of serious medical errors involved miscommunication during patient handoffs. Handoff, handover, or handoff-of-care communication is an interactive process for passing up-to-date patient information from one clinician or team of clinicians to another for the purpose of ensuring the continuity and safety of the patient's care. Patient care handoffs happen during care transitions such as: Shift or break changes, discharges, transfers, and consultations.

According to the American Medical Association, “handoffs should provide timely, accurate information about the patient's care plan, treatment, current condition, and any recent or anticipated changes. Handoffs should: 1) be standardized and clearly defined; and 2) involve face-to-face exchange between the caregivers involved.”

The verbal handoff may include previous care, treatment, allergies, any current problems, and recommendations for the accepting caretaker. Specific items to be included in handoff communication vary by setting and discipline.
Some effective techniques for handoffs are: Using common language and avoiding medical jargon, confusing words, or unacceptable abbreviations; limiting interruptions and protecting confidentiality; focusing on the important details and avoiding unnecessary information; allowing enough time for complete exchange using read-back or check-back techniques to make sure everyone understands clearly; encouraging questions.

Many accrediting agencies require organizations to standardized handoff communication. There are many established strategies so follow your facility's process and policy. One common interactive tool is SBAR which stands for four categories of communication:

* Situation -- a concise overview of the pertinent issues, patient complaints, and diagnoses are stated.
* Background -- the sender communicates the patient's relevant history and physical assessment pertinent to the problem, treatment, clinical course, and important changes.
* Assessment -- a best assessment of what is happening with the patient and facts which support those judgments are summarized.
* Recommendation -- an explanation of what needs to be done for the patient is shared.

Another common handoff technique is “I PASS the BATON.”

* Introduction -- the sender and receiver introduce themselves and their role or job.
* Patient -- the patient's name, identifiers, age, sex, and location are stated.
* Assessment -- what is happening with the patient and facts which support those judgments are summarized.
* Situation -- a concise statement is made about the patient's current status, relevant changes, code status, and response to treatments.
* Safety Concerns -- critical lab values, allergies, and safety alerts such as fall status are reviewed.
* Background -- the sender goes over co-morbidities, medications, and pertinent history.
* Actions -- actions that have been taken or are required are covered along with a brief rationale.
* Timing -- the level of urgency, explicit timing, prioritization of actions are summarized.
* Ownership -- those responsible for care or actions are listed such as nurse, doctor, team, patient, and family.
* Next -- the plan for what should happen next is covered.
When communicating a patient's condition, the assessment of suicide risk should be included. Patients at risk often have acute depression, anxiety, agitation, or medical problems like chronic pain, illness, or terminal cancer.

Your institution should have a system of screening protocols and procedures in place to address suicide risk. After screening, the patient condition should be communicated rapidly to mental health professionals and all affected personnel.

FALL PREVENTION

Hundreds of thousands of patients fall in healthcare facilities every year. According to The Joint Commission, falls with serious injury are consistently among the top 10 reported sentinel events -- and the majority of those reported since 2009 resulted in death.

All healthcare workers must be alert to the potential for falls and provide a safe environment in order to prevent them. Communication between patients, family members, visitors, and healthcare staff is an important factor for fall prevention.

Some key risk factors for patient falls are: A history of falls. Patients with a history of a fall in the past three months should be considered at higher risk for future falls. Impaired mobility and use of assistive devices such as canes, crutches, wheelchairs, and walkers. Medications that cause drowsiness, confusion, impaired balance, or orthostatic blood pressure changes. Patients with delirium, dementia, psychosis, agitation, or confusion. A history of incontinence or frequent toileting needs. Being tethered to equipment, such as an IV pole, that could cause a patient to trip. Visual impairments that may cause a patient not to see an environmental hazard. Orthostatic hypotension which may cause lightheadedness or fainting when standing. Slippery or wet floors. Obstructed pathways.

Universal fall precautions apply to all patients regardless of fall risk and include the following: Familiarize the patient with the environment. Maintain a call light within reach and have the patient demonstrate use. Keep personal possessions within reach. Keep the hospital bed brakes locked and placed in low position when the patient is resting. Raise to a comfortable height when transferring out of bed. Keep wheelchair locks in locked position when stationary. Keep nonslip, comfortable, well-fitting footwear on the patient. Use night lights or supplemental lighting. Keep floor surfaces clean and dry. Clean up all spills promptly. Keep patient care areas uncluttered. Follow safe patient handling practices.

SUICIDE PREVENTION

Suicide is the 10th leading cause of death in the U.S., and claims more lives than traffic accidents. Patients with suicidal thoughts are often NOT identified; however, most patients receive healthcare services unrelated to mental health during the year prior to death by suicide.
Patients may not disclose suicide ideation voluntarily and clinicians in inpatient and outpatient settings should know how to identify and respond to at-risk patients. Research shows that screening tools are more reliable than clinician judgment in detecting suicide risk. For more information about screening tools, visit Zero Suicide at the website listed on your screen (www.zerosuicide.sprc.org.)

Some suicide risk factors include: Mental or emotional disorders, especially depression and bipolar disorder. Up to 90% of suicide victims suffer from a mental or emotional disorder at the time of death. Previous suicide attempts or self-inflicted injury. The risk is twice as high for one year following a suicide attempt and even higher the first few weeks. History of trauma or loss such as abuse as a child, a family history of suicide, bereavement, or financial loss. Serious illness, physical pain, or impairment, alcohol and drug abuse. Social isolation or a pattern of aggressive or antisocial behavior. Discharge from an inpatient psychiatric setting within the first year and particularly within the first few weeks and months. Access to lethal means coupled with suicidal thoughts.

The Joint Commission recommends the following steps in acute and non-acute healthcare settings: 1) review each patient's personal and family medical history for suicide risk; 2) screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool; 3) review screening questionnaires before the patient leaves the appointment or is discharged. Refer for a secondary assessment of the patient is determined to be at risk. For patients who screen positive for suicide ideation and deny suicide risk or decline treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If a patient declines consent, HIPAA allows these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others.

From this step forward, behavioral health clinicians should be included in the care team by consultation or referral.

4) Using assessment results to determine the level of safety measures needed take the following actions:

- Keep the patient in acute suicidal crisis in a safe healthcare environment under one-to-one observation. Do NOT leave them by themselves. Provide immediate care through an emergency department, inpatient psychiatric unit, or crisis resource. Check patients and visitors for items that could be used to make a suicide attempt or harm others. Keep them away from anchor points for hanging and material that can be used for self-injury such as cords, bandages, sheets, restraint belts, plastic bags, elastic tubing, and oxygen tubing.
* For patients at lower risk, make referrals to outpatient behavioral health and providers for follow-up care within one week of initial assessment rather than leaving it up to the patient to make the appointment.

* For patients with suicidal ideation, give the patient and family members the number to the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), as well as local crisis and peer support organizations.

* Plan safety measures by identifying possible coping strategies with the patient and provide resources for reducing risks. This is NOT a suicide contract which is NOT recommended by experts. Review the plan at every interaction until the patient is no longer at risk.

* Restrict access to lethal means such as firearms, prescription medications, chemicals, and other items, and discuss ways of removing or locking firearms and other weapons away during crisis. Restricting access is important. Many suicides occur with little planning during a short-term crisis and both intent and means are required to attempt suicide.

**MODULE 3: MDROs and Preventing Healthcare-associated Infections**

**Magnitude of the Problem of MDROs (Multi-drug Resistant Organisms)**

Speaker 3: The Centers for Disease Control and Prevention defines multi-drug resistant organisms or MDROs as predominantly bacteria that are resistant to one or more classes of anti-microbial agents. The transmission and lifespan of resistant strains is determined by the prevalence of vulnerable patients, use of antibiotics beyond their evidence-based necessity, large numbers of colonized or infected patients, and implementation and adherence to control efforts.

Patients with underlying medical conditions, severe disease, recent surgery, or indwelling medical devices are especially vulnerable to infection by MDROs. The CDC report, *ANTIBIOTIC RESISTANCE THREATS IN THE UNITED STATES, 2013* lists 15 organisms as serious or concerning threats due to antimicrobial resistance -- and three organisms as urgent threats due to high rates of infection and number of deaths resulting each year from these organisms. Gram-negative bacterial infection are especially concerning as these organisms are almost all or entirely untreatable because they are resistant to most or all currently available antimicrobial agents.

The list of MDROs is growing every year. These are some of the most common organisms:
Speaker 4: Clostridium Difficile also known as C. diff is caused from long-term use of antibiotics. The germ causes the colon to inflame which causes diarrhea.

Speaker 3: It's very contagious, spreading from person-to-person on contaminated equipment, hands, bed linens, bed rails, and bathroom fixtures. Antibiotics can be used to treat C. diff.

Speaker 5: MRSA (methicillin-resistant Staphylococcus aureus) is a staph infection resistant to almost all antibiotic treatment. It spreads usually by person-to-person or on objectives.

Speaker 6: Vancomycin-resistant enterococci or VRE for short attacks people taking the antibiotic vancomycin for a long time. Also those with weak immune systems, those that had a major surgical procedure, and those with medical devices such as catheters.

Speaker 3: Vancomycin-resistant enterococci became resistant to vancomycin -- a powerful antibiotic. This germ lives in the intestinal tract and the female genital tract. It spreads by hand-to-hand contact on objects, by people, but it is NOT airborne like by a sneeze or cough.

Speaker 7: Carbapenem-resistant Enterobacteriaceae or CRE represents bacterial germs that mostly infect patients in healthcare settings -- typically not a healthy person.

Speaker 3: These bacteria is often found in a person's gut but strains can move to other parts of the body. These infections are resistant to almost ALL antibiotics, can spread quickly, and have high death rates. You can get these germs from skin contact with an infected person or contaminated medical equipment. It's a multidrug resistant Gram-negative organism.

**PREVENTION AND CONTROL OF MDROs**

What's being done to prevent and control MDROs? Healthcare facilities perform risk assessments for MDRO acquisition and transmission and educate their staff and licensed practitioners about health associated infections, MDROs, and prevention strategies. The Joint Commission recommends all staff should be trained on transmission routes of MDROs. Knowing how these organisms can spread quickly is important to stopping them. Since MDROs frequently spread by contact and from touching infected items such as bed rails, tray tables, medical equipment, and objects that staff is transporting by hand, hygiene is key to stopping their spread. Some preventive measures include:

* Environment of care measures including decontamination of medical equipment
* Hand hygiene -- ensuring the proper and correct hand washing is done, especially before and after contact with patients with MDROs.
* Contact precautions -- this includes, when possible, giving patients with MDROs their own rooms, own equipment, and own staff; wear personal protective gear when with the patients with MDROs; alert a receiving facility about the transfer of these patients; be aware when a patient with an MDRO transfers to your facility; make sure labs immediately alert clinical and infection prevention staff when MDROs are identified; discontinue devices like urinary catheters as soon as possible.

* Use of antimicrobials -- products to kill or slow the spread of these organisms. The Centers for Medicare and Medicaid Services said C. difficile can survive on floors and around toilets in its spore form for up to six months. Extensive cleaning of these rooms can help prevent transmission of the organism. CMS says a 1:10 dilution of sodium hydrochlorite, which is nine parts water to one part bleach is effective for 24 hours against C. difficile.

The CDC uses four core actions to fight back against antibiotic resistance, a contributing factor to MDROs.

1) Preventing infections and preventing the spread of resistance. Clean shared items and surfaces and thoroughly disinfect rooms of infected patients. Environmental services is essential in preventing infection. Clean hands with soap and water or hand rubs before and after any patient contact and after removing gloves. Around organisms not killed by alcohol hand rubs such as C. difficile, wear gloves and then wash your hands with soap and water after removing them. Always use standard contact precautions. Alert the receiving facility when a patient with an MDRO transfers. When possible, dedicate rooms, staff, and equipment to patients with an MDRO. Remove temporary medical devices such as catheters, and ventilators from patients as soon as possible. Take advantage of available immunizations.

2) Tracking. It’s important to report cases of antibiotic-resistant infections. The CDC tracks the information and looks for risk factors. The National Strategy goal for reporting and tracking emphasizes the need to inform healthcare staff on how to use antibiogram data to optimize therapy and outcomes. Reporting requirements will increase, but so will the ready availability of critical data for practitioners.

This importation may identify specific ways to prevent spreading of the germs.
3) Improving antibiotic prescribing and stewardship. One of the most important actions needed to slow down the spread of MDROs, especially antibiotic-resistant infections is to change the way antibiotics are used. Almost half of the antibiotic use in people is unnecessary and inappropriate. Making a commitment to use antibiotics appropriately and to safely treat disease, to choose the right medication, and to administer the antibiotics in the right way every time is called antibiotics stewardship. Interventions to improve antibiotic prescribing fall into three categories.

- **Broad interventions** – “time out” after 48 hours to reassess continued need and choice of antibiotic based on a clinical data and diagnostic evidence, prior authorization policies that require expert review of antibiotic choice and use before administering, and quality control auditing and feedback.

- **Pharmacy-driven interventions** -- consultation for therapy and dose adjustments, alerts for overlapping therapies, automatic stop orders for time-sensitive antibiotic prescriptions, and monitoring for antibiotic related drug-drug interactions.

- **Infection and syndrome specific interventions** -- protocols for diagnosis and treatment based on culture results, optimized dose and duration based on current guidelines, and to prevent unnecessary antibiotic prescriptions.

4) Developing new drugs and diagnostic tests. Antibiotic resistance happens as part of a natural process in which bacteria change. The bacteria can be slowed but not stopped. So, new drugs and new tests will be needed to keep up with the development of these evolving germs.

**Module 4: Preventing Patient Infections – CAUTIs, CLABSIs, SSIs**

**CAUTIS**

Speaker 1: CAUTI. According to the Centers for Disease Control and Prevention (CDC), Catheter-associated Urinary Tract Infections or CAUTI are the most common and most dangerous preventable healthcare-associated infection (HAI). CAUTIs occur when pathogens enter the urinary tract through a urinary catheter during insertion or while the catheter remains in the urinary tract.

CAUTIs can cause infections of the bladder, blood, epididymis, and prostate. They can lead to septic arthritis, inflammation of the testicles in males, and meningitis. CAUTIs can cause severe discomfort, prolonged hospital stays, increased costs, and even death.
The CDC guidelines for prevention of CAUTIs and appropriate urinary catheter use include these core strategies:

- Insert catheters only for appropriate indications
- Leave catheters in place only as long as needed
- Ensure that only properly trained persons insert and maintain catheters using aseptic technique and sterile equipment
- Clean the skin around the area where the catheter will be inserted
- Following aseptic insertion, maintain a closed drainage system
- Maintain unobstructed urine flow
- Practice hand hygiene and standard (or appropriate) isolation precautions
- Consider alternatives to indwelling urinary catheterization such as condom catheters, penis pouches, incontinence products, and bladder scanners for assessing urine volume

Use proper techniques during catheter maintenance:

- Always use proper hand hygiene before and after touching a catheter
- Avoid disconnecting the catheter and drain tube to prevent germs from getting into the catheter tube
- Secure the catheter to the leg to prevent pulling on the catheter
- Keep the bag lower than the bladder to prevent urine from going back into the bladder
- Empty the bag often, and keep the drainage spout from touching anything.

Most CAUTIs can be treated with antibiotics, catheter removal, or changing of the catheter. Healthcare providers should determine the best treatment for each patient.

**Magnitude of Problem of CLABSIs**

A central venous catheter (CVC), or central line, is a catheter placed in a large vein in the neck, chest, or groin to give medications or fluids or to collect blood for tests. They can remain in place for weeks or months. Examples of CVCs are:

- Nontunneled CVCs (subclavian, jugular)
- Tunneled CVCs (Broviac, Hickman, Groshong)
- Dialysis catheter (Quinton)
A central line-associated bloodstream infection or CLABSI is a serious infection that occurs when bacteria or other germs enter the bloodstream by way of the central line. The CDC estimates 31,000 central line-associated bloodstream infections happen in hospitals each year.

Some risk factors for CLABSIs include: A prolonged stay in the hospital before a catheter is inserted; multiple CVCs and/or multiple lumens; emergency insertion; extended use of catheter on a patient; catheters inserted at the femoral site; poor care of CVCs; receiving total parenteral nutrition.

**Placement and Care of CVCs**

The CDC recommends the following strategies for placement and care of CVCs. For selection of central catheters and sites:

* Weigh the risks and benefits of placing a CVC at a recommended site to reduce infection risk against the risk for mechanical complications.
* Avoid the femoral vein in adult patients.
* Use a subclavian site rather than a jugular or femoral in adults for nontunneled CVCs.
* Avoid the subclavian site for hemodialysis and patients with advanced kidney disease.
* Use a fistula or graft for dialysis in those with chronic renal failure for permanent access.
* If available, use ultrasound guidance to place CVCs.
* Use a minimum number of ports or lumens essential for management of the patient.
* Promptly remove and catheter that is no longer essential.
* When adherence to aseptic technique cannot be ensured (like emergency insertions), replace as soon as possible.

Recommendations for hygiene and aseptic technique for CVC placement are:

* Perform hand hygiene before and after palpating catheter insertions sites as well as before and after inserting, replacing, accessing, repairing, or dressing a CVC. Do not palpate the site after application of antiseptic unless aseptic technique is maintained.
* Maintain aseptic technique for insertion and care.
* Use new sterile gloves before handling a new CVC for guidewire exchanges.
* Use maximal sterile barrier precautions including cap, mask, sterile gown, sterile gloves, and a sterile full body drape during insertion.

Skin preparation recommendations are:

* Use a greater than 0.5% chlorhexidine prep with alcohol before insertion and during dressing changes. If a contraindication to chlorhexidine exist, iodine, an iodophor, or 70% alcohol can be used as alternatives.
* Antiseptics should be allowed to dry according to manufacturer's recommendations.

Recommendations for catheter site dressing regimens are:

* Use sterile gauze or a sterile, transparent, semipermeable dressing to cover the site.
* For patients who are sweating or if the site is oozing, use a gauze dressing until resolved.
* Replace catheter site dressing if it becomes damp, loosened, or visibly soiled.
* Do NOT use antibiotic ointment or creams on the site, except for dialysis catheters.
* Do not submerge the catheter or catheter site in water. Showering should be permitted with precautions to reduce introducing organisms into the catheter.
* Replace gauze dressings used on short-term CVC sites every two days.
* Replace transparent dressings on short-term CVC at least every seven days, except in pediatric patients with a risk of dislodgement outweighs dressing change benefits.
* Replace transparent dressings on tunneled or implanted CVC sites no more than once per week until the insertion site has healed unless the dressing is soiled or loose.
* Ensure catheter care is compatible with catheter material.
* Regularly monitor catheter site visually when changing the dressing or by palpation through an intact dressing depending on the patient’s clinical situation.
For tenderness as the insertion site, fever without obvious source, or other manifestations suggesting local bloodstream infection, remove the dressing for thorough examination.

* Encourage patients to report any change in the site or any new discomfort.

Replacement guidelines for CVCs including PICCs, and hemodialysis catheters are:

* Do NOT routinely replace CVCs, PICCs, hemodialysis catheters, or pulmonary artery catheters to prevent catheter-related infections.
* Do not remove CVCs or PICCs on the basis of fever alone. Use clinical judgment for removal if infection is evidenced elsewhere or if a noninfectious cause of fever is suspected.
* Do NOT routinely use guidewire exchanges for a nontunneled catheter suspected of infection. Use a guidewire exchange to replace a malfunctioning nontunneled catheter if no evidence of infection is present.
* Use new sterile gloves before handling a new CVC for guidewire exchanges.

For replacement of administration sets, the following are recommended:

* In patients not receiving blood, blood products or fat emulsions, replace continuously used administration sets including secondary sets and add-on devices no more than at every 96th hour, but at least every seven days.
* Replace tubing used to administer blood, blood products or fat emulsions within 24 hours of initiating the infusion. Replace tubing used to administer propofol infusions every 6 or 12 hours when the vial is changed per manufacturer's recommendations.

For needleless intravascular catheter systems, recommendations are:

* Change the needleless components at least as frequently as the administration set. There is no benefit to changing more frequently than every 72 hours.
* Change needleless connectors no more than every 72 hours or according to manufacturer's recommendations.
* Ensure all components are compatible to minimize leaks and breaks in the system.
* Minimize contamination risk by scrubbing the access port with an appropriate antiseptic and assessing the port only with sterile devices.
* Use a needleless system to assess IV tubing.
* When needleless systems are used, a split septum valve maybe preferred over some mechanical valves due to increased risk of infection with the mechanical valves.

Other recommendations are:

* Use a 2% chlorhexidine wash for daily skin cleansing.
* Use a sutureless securement device to reduce risk of infection.
* Do NOT administer systemic antimicrobial prophylaxis routinely before insertion or during use of an intravascular catheter.
* Do NOT routinely use anticoagulant therapy to reduce catheter-related infection risk in general patient populations.

SSIs
A surgical site infection or SSI is an infection that occurs after surgery in a part of the body where the surgery took place. Surgical site infections or SSIs develop in one to three out of every 100 patients who have surgery -- about half a million patients a year.

Several factors influence the risk of developing SSIs. Patient risk factors include: age, nutritional status, diabetes, smoking, obesity, other infections, colonization, immunosuppression, and length of preoperative stay.

Operative risk factors are: duration of surgical scrub, skin antisepsis, preoperative hair removal, preoperative skin preparation, duration of operation, antimicrobial prophylaxis, operation room ventilation, inadequate instrument sterilization, retention of foreign material, surgical drains, and surgical technique such as poor hemostasis, failure to obliterate dead space, and tissue trauma.

Core prevention strategies based on high levels of scientific evidence include the following:

1) Administer antimicrobial prophylaxis in accordance with evidence-based standards and guidelines.
   * Begin administration within one hour before surgical incision. Two hours are allowed for vancomycin and fluoroquinolones.
   * Select the appropriate antibiotic based on surgical procedure, the most common pathogens causing SSIs for the procedure, and published recommendations.
* Discontinue antibiotics within 24 hours after surgery -- 48 hours for cardiac procedures.
* Redose antibiotics at three-hour intervals in procedures greater than three hours and when there's excessive blood loss.
* Adjust antimicrobial prophylaxis dose based on the patient's weight in obese and morbidly obese patients.

2) When possible, identify and treat remote infections and postpone the operation until resolved.
3) Do NOT remove hair at the operative site UNLESS it will interfere with the operation. If hair removal is necessary, use clippers or depilatory agent -- NOT a razor.
4) Use the appropriate antiseptic agent and technique for skin preparation.
5) Maintain immediate post-operative normothermia.
6) Keep OR doors closed during surgery except as needed for passage of equipment, personnel, and the patient.
7) Protect the primary wound closure with a sterile dressing for 24 to 48 hours post-op.
8) For colorectal surgeries, mechanically prepare the colon (enemas, cathartic agents), and administer non-absorbable oral antimicrobial agents in divided doses on the day before the operation.
9) For cardiac surgeries, measure the patient's blood glucose at 6 a.m. on post-op days one and two, and maintain at a level below 200 mg/dl.

Other SSI prevention measures include the following:

* Patients should control blood glucose levels and stop smoking for at least 30 days prior to surgeries.
* Do NOT withhold necessary blood products as a means to prevent SSIs.
* The patient's pre-operative hospital stay should be kept as short as possible.
* Surgical teams should perform a pre-operative scrub of hands, forearms, and elbows for at least two to five minutes with an appropriate antiseptic. Clean under each fingernail before the first surgical scrub of the day. After the surgical scrub, keep hands up and away from the body so water runs down from the tips of the fingers toward the elbows. Dry hands with the sterile towel and don proper personal protective equipment immediately.
* Wear a mask that covers the mouth and nose when an operation is about to begin, is underway, or if sterile instruments are exposed. Use a cap or hood to cover hair on the head and face. Use surgical gowns and drapes to protect
against liquids. Change scrub suits that are visibly soiled or contaminated by blood or other potentially infectious material.

* Personnel should report signs of a contagious infectious illness promptly to avoid spreading infection.

* Surgical personnel who have draining skin lesions should be restricted from duty until they receive adequate treatment and the infection is gone.

* When cleaning and disinfecting environmental surfaces, use an EPA-approved hospital disinfectant. Clean the areas before the next operation when visibly dirty or contaminated with blood or other body fluids.

* Sterilize surgical instruments according to published guidelines. Perform flash sterilization only for patient care items that will be used immediately. Do NOT flash sterilize for reasons of convenience or to save time.

* Wash hands before and after dressing changes or any contact with the surgical site during post-operative care. Use sterile methods for all dressing changes. Use sterile dressings for primary closed wounds for 24 to 48 hours after surgery.

* Diagnose and treat infections quickly and effectively.

* Make sure the patient and family understand incision-site care, and symptoms of SSI which may include fever, redness around the surgical site, and drainage of cloudy fluid from the surgical wound.

Accrediting agencies require facilities to implement evidence-based practices for preventing surgical site infections. Know and follow your facility’s SSI guidelines.

Module 5: Ethical Aspects of Care

Ethics

Speaker 1: Ethics involves recognizing right from wrong. Healthcare organizations must always have and follow policies of ethical behavior in care, treatment, and services. They must prevent conflicts of interest and make decisions based on patients’ needs.

Each healthcare worker is responsible for the result of his or her actions or inactions. Failing to speak out when we see unethical behavior is a violation of ethical duty. “Following orders” is never an excuse for unethical acts.

Four basic principles in medical ethics should be followed. First, healthcare workers and institutions should protect all patients’ right to maintain control over their own care. This is called autonomy. Patients must be made aware of their rights and have those rights protected.
Patients must receive truthful information about their diagnosis, prognosis, or therapy and be allowed to make decisions about their care.

Second, patients must be treated with kindness. Healthcare workers should put a patient's best interest first. This is beneficence or the act of doing well.

Male Speaker: The third principle is nonmaleficence. It means to do no harm to patients.

Speaker 1: The last principle is justice. Healthcare workers should make sound decisions based on clear, evidence-based criteria.

Organizations must consistently call for and follow policies of ethical behavior during care, treatment, services, and in business. They must prevent conflicts of interest and make decisions based on identified needs of patients. They must make provisions for ongoing care if services are denied to a patient and they must respect patient rights.

**Religion/Spirituality**

Speaker 3: You have an ethical responsibility to respect a patient's religious or spiritual beliefs and practices, but you MUST not force your beliefs on the patients. Instead, screen for a patient's religious and spiritual beliefs. Failing to provide appropriate spiritual referrals can constitute a form of patient neglect. Ask a patient: “How important are your spiritual or religious beliefs to you? Do your beliefs influence how you care for yourself? Do you want to talk to someone about religious matters?” If they say yes, then contact the chaplain or spiritual leader of their choice.

Should you pray with a patient? It depends. Most guidelines say don't pray with the patient unless you have his or her permission or request and a clergy member isn't available. A safer option is if a patient wishes to pray, ask them to lead the prayer.

Some patients and their family members may have beliefs that include rituals, music, prayer, or sacred narratives unfamiliar to you. It's your job to accommodate these religious and spiritual beliefs and practices. Implicit in that statement is that the requested practice does not cause harm and is not excluded by law and regulation.

**End of Life – Compassionate Care**

The goal of care at the end of life is to prevent or ease suffering as much as possible while respecting the dying person's wishes. Respect the patient and family's cultural beliefs and needs when providing comfort. Each patient has unique ideas, desires, and concerns with respect to the dying process. Having end-of-life wishes followed, whatever they are, and being treated with respect while dying are common wishes among patients. There are four areas of
comfort needed: Physical comfort, mental and emotional comfort, spiritual comfort, and practical comfort.

A dying person can be uncomfortable because of pain, breathing problems, skin irritation, digestive problems, temperature sensitivity, or fatigue.

Patients may NOT be able to share feelings or thoughts in a rational manner during periods of pain. They may not be able to tell you they are in pain so watch for signs like changes in facial expression and unrest. Stay ahead of pain; prevent it, instead of waiting to relieve it. Administer medication on time.

Reassure patients or their families that the focus of pain treatment is to relieve suffering. They don't need to be concerned about drug dependency or addiction at this time. Encourage patients and their families to speak up if pain is NOT being controlled. It may be possible to increase or change medicines.

Shortness of breath is common at the end of life. Try raising the bed, opening a window, using a vaporizer, or having a fan circulate air in the room. A doctor may also prescribe oxygen.

Reassure families the noisy breathing of people near death caused by fluids collecting in the throat or by the throat muscles relaxing is not usually upsetting to the patient.

Skin problems can be very uncomfortable. Skin irritations and dryness of the lips, mouth, and eyes is very common at the end of life. Excessive dryness can make the skin more fragile. Alcohol-free lotion can soften and protect the skin and prevent future discomfort. Oral swabs can help relieve mouth and lip dryness. Use a damp cloth to soothe dry eyes. Watch for irritation or rash on the skin. It's important to turn or reposition a patient every couple of hours to prevent pressure ulcers. Use foam pads on boney areas such as heels, ankles, and elbows. Take extra care to make sure skin is kept clean.

Digestive problems are common with end-of-life patients. Medication can help a patient experiencing nausea, constipation, vomiting or loss of appetite, so encourage patients and their families to tell their doctor about these symptoms.

Offer patients who want to eat but have lost their appetite food in frequent, small amounts. Never force a patient to eat. When possible, support a patient's request to have favorite foods or meals brought from home. Arrange to have comfort food available at the patient’s request, and when the patient has an appetite and wants to eat. Sometimes a patient at the end of life makes a conscious decision to stop eating. You may need to help the family understand and respect this decision.
Dying patients may not be able to say they are too warm or too cold. It's important to watch for this temperature sensitivity. Signs include shivering or pushing blankets away. You can remove blankets, offer extra blankets, and try a fan, a cool cloth on a patient's head, or adjust the room temperature.

Female Speaker: It is common for people nearing the end of life to feel tired and have little or no energy.

Speaker 3: Keep activity simple. Allow rest between care, treatments, and procedures. Cultural differences often play a role in interaction between family members, friends, and patients during this time. Take care to be respectful of these different needs and beliefs.

End-of-life care also includes helping a dying patient manage mental and emotional needs. Be sensitive to their fears and concerns. Depression and anxiety are common -- counseling and medication may help. Encourage family to stay close if the patient wishes it. Explain that pain and fear can impact their loved one's mood and behavior. Most people are not familiar with what to expect at the end-of-life process, and you can help the family understand and ease their fears.

Male Speaker: People nearing the end of life will need spiritual comfort just as much as physical comfort.

Speaker 3: Many people find comfort in their faith. If requested, a visit from a pastor, rabbi, priest, or other spiritual leader can comfort patients and their families. Respect all spiritual needs during this time.

Encourage visitors talk TO -- not about -- the patient, and to identify themselves when they enter the room.

Adjust the physical environment as much as possible to a patient's wishes. It might be possible to introduce some of the ways the patient reduced stress before such as music and soft lighting.

Family and friends are often dealing with grief and much more. They may have extra chores and duties like taking care of the patient's home or business. You or your facility may be able to help. It may be possible to provide a private room where the family can rest during a bedside vigil. Asking about their health and being understanding and supportive can make a big difference to loved ones and family at this difficult time.

Families or patients may need to make a decision about organ donation. Healthcare facilities are responsible for recognizing and evaluating potential donors. The Federal Health,
Resources, and Services Administration embraces three national goals to reduce the organ
donation gap:

1) Hospitals achieve a conversion rate of 75% or greater;
2) organs transplanted per donor increased from 3.6 to 3.75;
3) and 10% or organs are donated after cardiac death.

Organ donation should be considered part of the overall care process. Hospitals are held
accountable by federal regulation for setting the process in motion through timely referrals of
potential donors. This includes using clinical indicators to potential donors, a system which
tracks the timeliness of referrals, and a corrective action plan when referrals are made too late.
Hospitals must work with organ procurement organizations to ensure that staff is educated on
the process.

A hospital will notify its local organ procurement organization (OPO) of every potential
eligible donor. The following steps should take place when a patient is deemed eligible.

1) At the appropriate time, an OPO requestor will work with a hospital staff to plan a
discussion about donation with the family.
2) Together the hospital and the OPO will determine the best way, time, and place to
discuss the donation opportunity with the family.
3) A determination will be made of who should be present during the conversation.
4) Hospitals should ensure the OPO requestor was present and part of the team when
the donation conversation occurs. OPO requestors had been specially trained to talk
to a possible donor or family about donation.

Accrediting bodies issue guidelines to ensure that standards for handling of donor organ
issues meet minimal requirements. Be knowledgeable about your facility's policies and your
accrediting organization’s standards.

You have a responsibility to provide potential donors or their families with support,
compassion, and respect for ANY decision they make, regardless of your own personal
donation beliefs.

Whistleblower, Stark Law

A whistleblower can save lives. They can report fraud, abuse, and protect public health
and safety. You can report wrongdoing to a supervisor, facility management, and state or
federal agencies. You can keep your identity confidential with most agencies.
Female Speakers: Whistleblowers have rights. They're protected by several federal and state laws from retaliation.

Speaker 3: If your employer retaliates against you as a whistleblower, contact the Occupational Safety and Health Administration. Such retaliation actions may include: blacklisting, demoting, denying overtime or promotion, disciplining, denying benefits, failing to hire or rehire, firing or laying off, intimidation, making threats, reassignment to a less desirable job, reducing pay or hours, and suspension.

You must file your complaint within legal time limits – it is 30 days for the Occupational Safety and Health Act. The OSHA act protects works who complain to their employer, OSHA, or other government agencies about unsafe or unhealthy working conditions.

Whistleblowers may be eligible for a reward if they report Stark violations. The stark law prohibits healthcare facility from submitting Medicare claims for items or services resulting from prohibited referrals from a physician. Those prohibited referrals would be when a doctor has a financial relationship with the facility as defined in the statute. Another violation is when a doctor prescribes a health item to a Medicare patient and then refers the supplier to a family member who supplies the equipment, drugs, or services. The law was meant to prevent kickbacks and unnecessary treatments. It was also meant to reduce losses to the Medicare program.

**Cultural Sensitivity**

Speaker 1: Our country is growing more diverse every generation. Understanding and being comfortable with those whose racial, ethnic, socioeconomic, and cultural backgrounds are different from yours can add satisfaction and pleasure to your job, as well as help you do that job better. Be aware of and sensitive to cultural diversity, life situations and other factors that shape a person's identity.

Male Speaker: Culture refers to unified patterns of behavior including language, thoughts, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups.

Speaker 1: Culture can affect the following: How a patient describes symptoms and defines illness; perceived causes of illness; understanding of disease process, treatment expectations, and decision making; patient attitudes and interactions with healthcare workers; selection of treatment; and decision to seek treatment. Culturally sensitive care respects diversity and recognizes that cultural factors such as language, communication styles, beliefs, attitudes, and behaviors can affect healthcare. Cultural sensitivity involves racial and ethnic
groups but also population such as the elderly, people with disabilities, and persons identifying as lesbian, gay, bisexual, transgender, queer or questioning, and or intersex (LGBTQI).

The Office of Minority Health at the U.S. Department of Health and Human Services addresses the needs of helping health equity, improving quality, and ending healthcare differences. This is done in part through the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. These standards cover the need for education and training about respectful quality care and services, diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Accrediting agencies require staff be trained on sensitivity to cultural diversity based on their job duties. Those who provide interpreting or translation services MUST have defined qualifications and skills.

There are two common approaches to educate on cultural differences -- programs that are either group-specific or those that apply generic or universal models. There are some concerns about cultural sensitivity programs that use a group-specific approach to teach about the attitudes, values, and beliefs of a specific cultural group. They fear this approach can lead to stereotyping and oversimplifying the diversity within a specific group. The universal approach on cultural sensitivity training uses reflective awareness, empathy, and active listening techniques. This method examines mental structures contributing to cultural insensitivity or blindness such as implicit biases or stereotypes.

Techniques that can improve your acceptance of cultural differences include: Awareness of your OWN cultural values; awareness of cultural differences; valuing diversity; managing the dynamics of difference; developing cultural knowledge; and the ability to adapt to the cultural context of a case.

Here are some ways to improve cultural sensitivity:

* Identify and address communication needs. This should be done throughout the patient process from administration, treatment, and transfer through discharge.
* Identify the patient's preferred language for discussing healthcare.
* Use an interpreter, if needed. The Joint Commission found that relying on untrained interpreters is more likely to result in misinterpretation, lower quality of care, or could even lead to an adverse event. Untrained individuals such as family members, friends, other patients, or untrained bilingual staff should not be used to provide language access services during medical interviews. It may be okay to use untrained interpreters for social conversations or to convey simple
messages with patients, provided the messages or the use of the untrained person does not violate confidential patient rights.

* Determine whether the patient needs help completing medical forms.
* Identify if the patient uses any assistive devices.
* Ask the patient if there are any additional needs that may affect his or her care.
* Identify patient cultural religious or spiritual beliefs or practices that influence care. Identify patient dietary needs or restrictions that may affect care. Some patients may not eat certain foods based on religious or spiritual beliefs or customs.
* And accommodate patient cultural religious or spiritual beliefs and practices.

Age-Related Competency

A patient's healthcare should be adapted to their needs and some of these needs are impacted by age. Recognizing qualities that age groups often share can sometimes help you improve relationships with patients and their families and meet their specific needs. It will help the patient feel more comfortable and more engaged and active in their own care.

Ages are usually grouped into neonate, infant, toddler, preschool, school age, adolescent, young adult, adult to middle age, and later adult to geriatric.

Neonates are infants from birth to 28 days. They're still developing their very basic body functions such as digestion, temperature regulation, and sleeping. Communication is through touch, voice volume, and voice. Be familiar with issues such as jaundice, nutrition, cord care, fever, and especially sleeping positions that are associated with SIDS (Sudden Infant Death Syndrome).

The next age group is infants and toddlers, between the ages of 28 days and three years old. There are big differences developmentally, physically, and emotionally in this age group. Focus on keeping immunizations and checkups on schedule. Providing proper nutrition, oral care and routine screenings are standard issues.

Children from four to six years-old have some similarities but a lot of differences as well. For most children, growth slows a bit at this stage, but learning and motor skills increase. The U.S. Preventive Services Task Force recommends vision screenings for all children between ages 3 and 5. Screenings may help find conditions such as lazy eye which can be treated effectively if caught early. This group should also keep up with immunizations and checkups.

Children ages 7 to 12 will be close to hitting another growth spurt with adolescence. Some children enter into an adolescent growth spurt a little earlier, at age 10 or 11. Issues of concern in this age group include nutrition, physical activity, and peer pressure.
During adolescence, growth will speed up. This is also a time of sexual maturing with issues of sexuality and substance abuse. This age group also needs assistance with management and assessment of nutrition, physical activity, and peer pressure. Children in this age group also face emotional changes as personal identity development starts.

The next age group is young adults ages 21 to 39. Encourage this age group to think about healthy living choices such as nutrition, exercise, annual checkups, and stress management and educate them on the long-term consequences of bad lifestyle decisions at this age.

The middle adults group is between the ages of 40 and 64. Discuss and encourage screening for health issues that commonly begin to occur at this stage of life. Be supportive and open about issues that may arise apart from physical health that may affect mental or emotional health and can also affect physical health down the road. Among conditions that begin to appear at this age are cardiovascular conditions, osteoarthritis, non-specific chest pain, and back problems. These can often result in hospitalization.

Male Speaker: As people age, they tend to use more hospital services and prescription medicines.

Speaker 1: People 65 and older often experience a decline in physical and mental abilities, though not all do. Nutritional, emotional, health, and safety needs begin to change at this stage. It's important to allow older adults time to discuss their medical concerns and to treat them with respect. Try to avoid rapid-fire questions and confusing medical jargon. Some of the most frequent principle diagnoses for inpatient hospital stays include: congestive heart failure, pneumonia, osteoarthritis, and abnormal cardiac rhythms. Clinical preventive services can prevent disease or detect disease early when treatment is more effective. These services include screenings for chronic conditions, immunizations for diseases such as influenza and pneumonia, and counseling about personal health behaviors.

Awareness of age-related needs helps when caring for patients. While age groups have their own GENERAL characteristics, remember each patient is an individual. Don't stereotype because of age, but DO be aware of issues that might be unique to and heavily impact people at different ages.

Presenter: Narrated

SLP: 040417 (Edited/revised)
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