Required Orientation Clinical Topics for Clinical Staff

I acknowledge that I have received a copy of "Required Orientation Clinical Topics for Clinical Staff" including the following content areas:

- ❒ Needs of the Dying Patient
- ❒ Pain Management
- ❒ Abuse, Neglect and Exploitation
- ❒ Organ Donation
- ❒ Population Served
- ❒ Fall Reduction
- ❒ Restraints and Seclusion
- ❒ Reporting a Change in Patient Condition
- ❒ Impairment in the Workplace
- ❒ Infection Control

I agree that it is my responsibility to:

- ❒ **Read** this packet of information.
- ❒ **Ask questions** if I need additional information regarding any information covered in this packet.
- ❒ **Abide by** and observe any policies and procedures of The Johns Hopkins Hospital which are generally outlined in this packet.

Name (Please print)

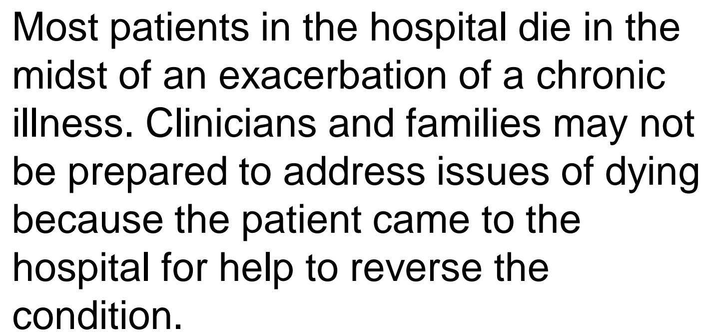
Signature Date

This packet includes basic information on many important topics relevant to working at The Johns Hopkins Hospital (JHH). Where possible, references are provided. It is not meant to be an all-inclusive study. Your department, office or unit may require more extensive education in any of the above areas. Please see your manager for more information.

2016 version

Needs of the Dying Patient

Overview



Most patients in the hospital die in the midst of an exacerbation of a chronic illness. Clinicians and families may not be prepared to address issues of dying because the patient came to the hospital for help to reverse the condition.

Careful symptom management and attention to psychosocial and spiritual issues will help both the patient and the family who will live out their lives with these final memories of their loved one.

Goals May Change

A patient may be admitted with the goal of curing or reversing a condition. As the illness progresses, however, the goals may change. New goals may include:

- rehabilitation
- prolonging life so the person may see a grandchild marry or graduate
- not prolonging dying
- or providing comfort in dying

Once these new goals are established, the particular treatments to meet the goals are decided in discussions between the team and the patient and family. Goals for cure and for palliation (i.e., symptom management) can be simultaneous.

Resources for Establishing Goals

Sometimes there are conflicts among clinicians or with clinicians and families regarding the goals of care. There are JHH resources to help address such conflicts.

- Adult Pain and Palliative Medicine Service referrals can be ordered through EPIC or Ping. Pediatric Palliative Care consultation is available via PING.
- The JHH Ethics Service can be paged for assistance when conflicts arise. The Ethics Service pager is 3-6104.

Assisting Caregivers and Staff

JHH has developed the protocols below to assist care givers and other staff. The links work if you are within the Hopkins network.

- Establishing Goals of Care
- Medically Ineffective or Futile Treatment
- Palliative Care for the Hospitalized Patient with End-of-Life Needs

About the Dying Process

The dying process can take days or even weeks. Some patients tend to linger in their dying while others have a sudden and swift decline. The uncertainty of a timeline can cause family distress. Educating the family about the normal dying process can help ease their distress.

Signs of Each Stage

Signs of the Early Stage	• Bed bound • Loss of interest and ability in eating and drinking • Changes in cognition • Hypoactive delirium • Hyperactive delirium • Increasing sleepiness
Signs of the Mid Stage	• Mental status continues to decline • Upper airway secretions that patient is unable to clear (“death rattle”) • Fever can be present with unidentifiable source
Signs of the Late Stage	• Comatose • Cool, mottled extremities from shunting blood to vital organs • Change in respiratory pattern: fast, slow or uneven breathing • Fever • Pain and other symptoms

Comfort for Dying Patients

Many patients will have pain, shortness of breath, delirium and fatigue as they are dying. Patients may also experience emotional and spiritual distress. These symptoms can and should be managed to relieve distress at the end of life.

Collaboration with pastoral care, palliative care, social work and Child Life will help in addressing these symptoms. For the dying patient, interdisciplinary care from nursing, clergy, social work, medicine, nutrition, and other therapies is needed to meet the needs of both the patient and family.

For more information, contact the JHH palliative care services.

Pain Management

Overview

- Pain is defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage."
- Pain can be defined operationally as “what the patient says hurts” and it exists when the patient says it does. The “right” to be free of pain exists for all patients regardless of age or underlying disease process. Relief of pain and suffering is integral to the mission of JHH, and pain is considered the “5th vital sign.”

The Experience of Pain

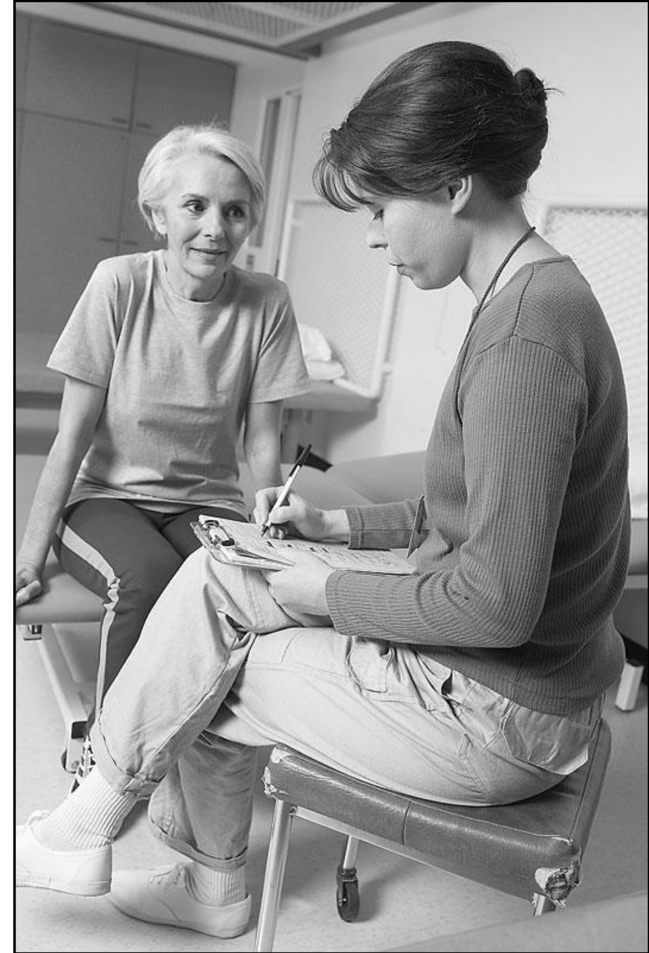
The physiology of pain is well established. Following an injury or disease, nerves transmit impulses to the brain which as they reach consciousness will be interpreted as pain.

However, pain is much more than that. It is impossible to assume how much pain a patient is experiencing. Many factors determine pain and how a patient will respond to it, such as:

- Age
- Culture
- Socio-economic factors
- Previous pain experience
- Fear and/or helplessness
- Sleep deprivation
- Time and place
- Anxiety

How You Can Help

- Hospital staff can act as patient advocates. If any new pain or change in pain is noticed, or if it appears that interventions are not working, the nurse or doctor should be notified.
- Non-nursing staff are often in a position to notice symptoms that are not seen by MDs or RNs.



ABC's of Pain Management

The following are the ABCs of pain management:

A Assess pain at regular intervals using a self report measure if possible

B Believe the patient

C Choose the appropriate therapies

D Deliver therapy in a logical, coordinated fashion

E Empower and Education patients to control their pain

F Follow-up

For more information, see the JHH Pain Protocol.

(*You must be within the Hopkins' intranet to access this document*.)

Assess

Assess the pain at regular intervals.

At JHH, nurses and unlicensed assistive personnel (UAPs) screen every patient for pain on the following occasions:

- On admission
- At every outpatient encounter
- Before *and* after any surgical procedure

For non-nursing roles, your part in pain management would be to notify the RN if the patient reports any pain to you. You should also report if you observe obvious signs of pain when you are with the patient (for example, while doing a PT treatment or transporting a patient).

Believe

Believe the patient.

When assessing pain, use a patient reported measure when possible. There are various rating scales that may be used for screening based on the patient's age and communication abilities. These scales can be found in the Pain Management protocol referenced in this lesson.

Choose

Choose the appropriate therapies.
Pain may be managed most effectively using a combination of medications and non-pharmacological approaches.

Pharmacological
There are a number of medications that are effective in managing a patient's pain. Selecting the appropriate pharmacological intervention is a collaborative decision making process that involves authorized prescribers, pharmacists, and care givers along with the patient's input.

Non-pharmacological
Non-pharmacological interventions should be considered based on patient preference and the degree of pain relief obtained. Options include heat or cold, massage and vibration, distraction (music, videos, games), relaxation techniques such as imagery, acupuncture, self-hypnosis, and transcutaneous electrical nerve stimulation (TENS).

Choose (continued)

Complications

Pain management may be complex in some patient populations.

Special attention should be paid to the following high risk patient groups:

- Infants & children
- Elderly
- Women in labor
- Non-English speaking patients or patients from other cultures
- Patients with substance abuse background
- Patients with communication difficulties

Deliver – Empower and Educate – Follow-up

Deliver therapy in a logical, coordinated fashion.

When pain occurs on a regular basis, medication should be given on an around-the-clock (ATC) schedule to ensure adequate pain relief.

Empower and Educate patients to control their pain.

Non-pharmacological interventions should be taught to the patient. Options include heat or cold, massage and vibration, distraction (music, videos, games), relaxation techniques (imagery), acupuncture, self-hypnosis, and transcutaneous electrical nerve stimulation (TENS).

Follow-up

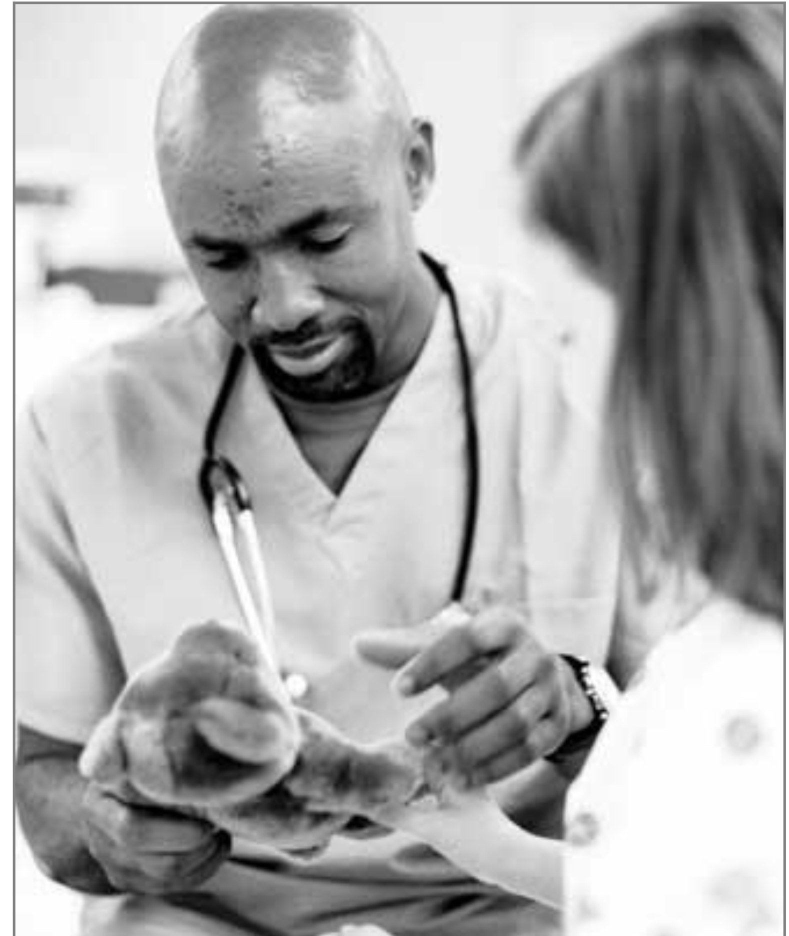
Follow-up with the patient to determine if his or her level of pain relief is adequate, after therapies are initiated.

Abuse, Neglect and Exploitation

Overview

Healthcare practitioners are in a unique position to provide early detection and intervention of abuse and neglect. They tend to be the first or only professionals to whom victims of abuse or neglect may turn.

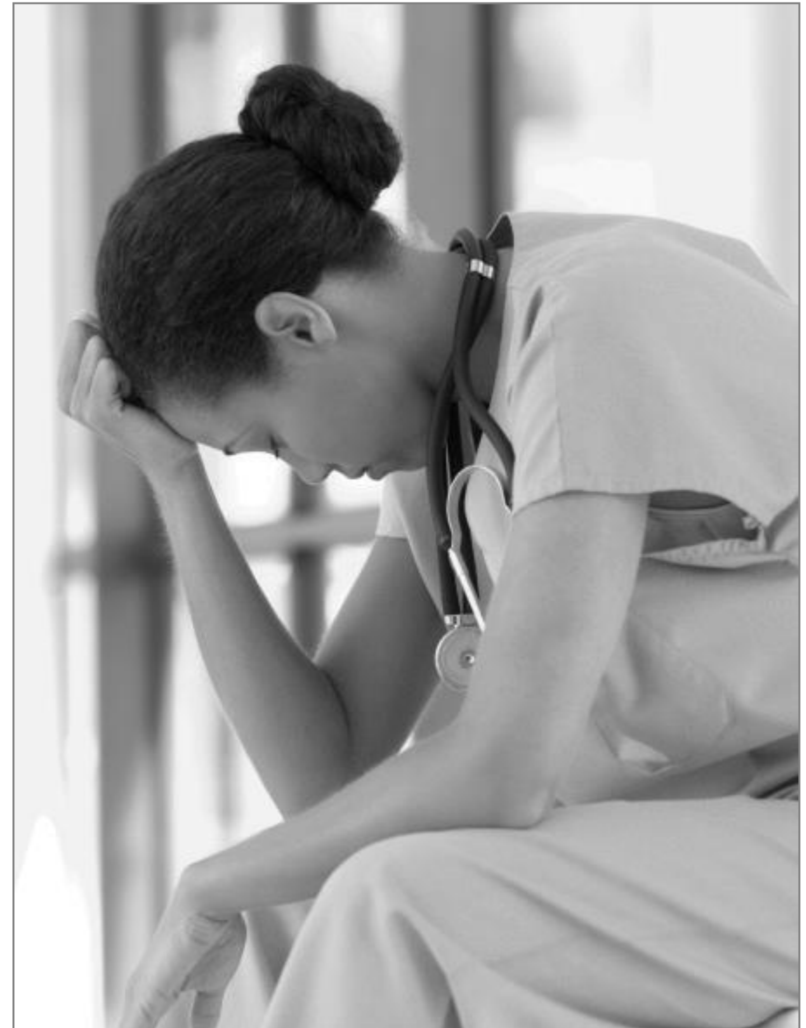
It is important for healthcare workers to be aware of the signs of abuse and neglect and to know what to do issues of abuse or neglect are suspected. Assessment of abuse and neglect should be a routine part of all care.



Use FASAP

If you suspect that a co-worker is a victim of abuse please speak with the individual and encourage him or her to seek assistance from the Faculty and Staff Assistance Program (FASAP).

Contact your supervisor or FASAP for assistance. For more information about FASAP, go to www.fasap.org or call 443-287-7000 or 443-997-7000.



Part 1: Intimate Partner Abuse and Domestic Violence

Background

Domestic abuse or violence is a pattern of coercive behavior characterized by the control of one person over another, usually by an intimate partner.

This may occur through physical, sexual, emotional, verbal or economic abuse. It occurs in all levels of society and all communities. Abuse or violence occurs in all racial, ethnic and socioeconomic backgrounds.

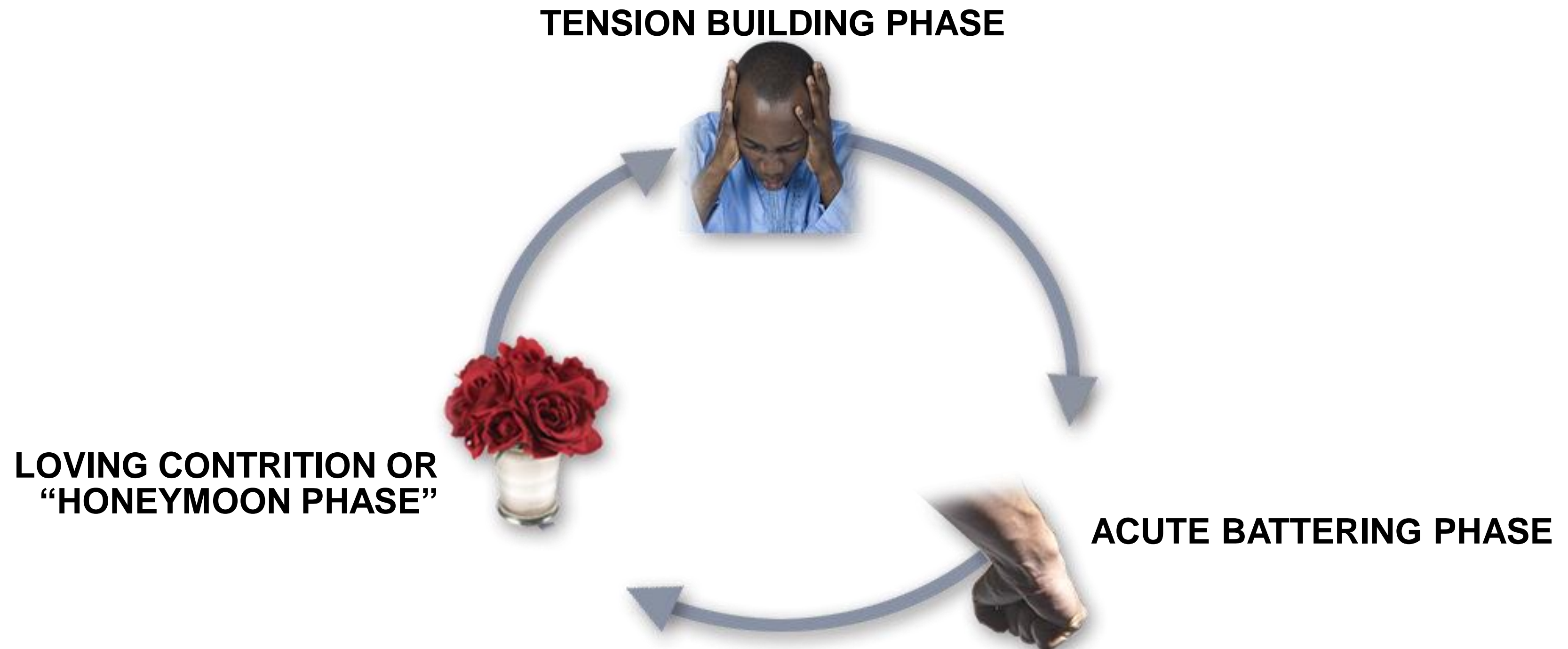
Prevalence Rates

Women are most likely to be abused, with a prevalence rate of 85-95%. One out of every four American women will report being a victim of domestic abuse or violence at some point in her life.

Child abuse is reported to occur in 30-60% of families where domestic violence occurs.

The Cycle of Violence

A repeating cycle of violence is common and consists of these three phases:



The most dangerous period in an abusive or violent relationship is when an individual decides to leave.

Definitions and Indicators of Partner Abuse

TERM	DEFINITION	INDICATORS
Physical Assault and Battery	An act that causes serious bodily harm. Un-permitted touching or the threat of harm with the ability to carry it out.	Bruising; fractures; lacerations; reports of pushing, punching, slapping, choking, kicking; reports of using weapons or hurting children
Sexual Assault/Rape	Non-consensual sexual contact of any kind. Forcing sexual acts against someone's will or attacking sexual parts of the body.	Bruises around breasts, genital area or thighs; unexplained venereal diseases or infection; unexplained vaginal or anal bleeding
Psychological/ Verbal Abuse	Fear induced by intimidating looks, actions, gestures, loud voices, or threats. Unkind or harsh statements affecting ones self-esteem.	Isolation, stalking, criticism, humiliation, threats or other intimidation, harassment, lying, jealousy, possessiveness, manipulation, controlling of activities, monitoring calls or visitors, abusing pets/property

What You Should Know About Partner Abuse

Employees who have contact with patients should be aware of the legal aspects of partner abuse and how to respond to individuals who may be victims.

Legal Requirements:

- Maryland has no law mandating the reporting of domestic violence. Disclosures of intimate partner abuse or domestic violence are confidential unless a child or a "vulnerable adult" is in suspected danger or a victim of abuse (see definition in next topic).
- Should an individual choose to do so, a formal report of events can be made to local law enforcement. Victims also have the right to file for an Ex Parte order (a civil court order which directs the abuser to refrain from further abuse and refrain from further contact with the victim).

What You Can Do:

- **Make Referrals**

  The most important thing you can do is to refer all reports of domestic violence to the hospital social worker or other members of the healthcare team. The social worker is responsible for creating a detailed assessment, counseling support, planning for the victim's safety, and referring the victim to appropriate community resources.

- **Provide Reassurance**

  It is important to reassure victims. Tell individuals that you believe them and that they are not alone. Tell them that they do not deserve abuse or mistreatment and that the violence is not their fault. Tell them that domestic violence is a crime and that there is help in the community.

What You Should Know About Partner Abuse (Continued)

RADAR

RADAR is a helpful domestic violence intervention:

R = Routinely Screen Female Patients

A = Ask Direct Questions

D = Document Your Findings

A = Assess Patient Safety

R = Review Options & Referrals

Ask Questions

Incorporate routine questions related to domestic violence into daily practice. For example, "Because violence is so common in many women's lives, I've begun to ask about it routinely."

- Interview patients alone (without significant other or children present)
- Sit eye-to-eye with a patient; provide positive eye contact
- Ask direct questions such as:
  - "Are you in a relationship where you have been physically hurt or threatened?"
  - "Have you ever been hit, punched or slapped by your partner?"
  - "Are you afraid of anyone at home?"
  - "Do you feel safe at home?"

Part 2: Elder/Vulnerable Adult Maltreatment and Exploitation

Neglect is the most common form of maltreatment reported in the elderly and vulnerable population. Statistics show that adult children are the most frequent abusers of the elderly followed by other family members and spouses.

Many victims of abuse feel:

- Embarrassed or ashamed
- Frightened of retaliation
- Guilty for being dependent, imagining they are "causing" abuse to occur
- Afraid the abuser will be prosecuted

As a result adult maltreatment tends to be greatly underreported. It may be hidden as a "family secret."

Overview of Vulnerable Abuse

Who are vulnerable adults?

A "vulnerable adult" is described as an adult over the age of 18 who lacks the physical or mental capacity to provide for his or her daily needs. Abuse or maltreatment of elderly or vulnerable adults happens to almost 2 million adults per year from all racial, ethnic and socioeconomic backgrounds. It is most prevalent toward women. Incidents may occur in patient homes or in institutions.

Risk factors for elder/vulnerable abuse include:

- A family history involving abusive relationships
- Mental illness or alcohol/drug dependence in patient or caregiver
- Extreme caregiver stress
- Social isolation of patient
- Declining physical or mental capacity of the patient accompanied by increasing care needs
- Economic pressures

Definitions and Indicators of Elder/Vulnerable Abuse

TERM	DEFINITION	INDICATORS
Physical Abuse	The use of physical force that may result in bodily injury, physical pain, or impairment.	• Bruises, welts, lacerations, black eyes • Broken bones, joint dislocations • Untreated injuries in various stages of healing
Sexual Assault	Non-consensual sexual contact of any kind, including sexual contact with individuals incapable of giving consent.	• Bruises around breasts, genital area or thighs • Unexplained venereal diseases or infections • Unexplained vaginal or anal bleeding
Neglect	The refusal or failure to provide life necessities such as food, water, clothing, shelter, personal hygiene, medication, comfort/pain management and personal safety or supervision. Neglect can be intentional or unintentional.	• Dehydration • Malnutrition • Untreated wound • Poor personal hygiene • Untreated health problems • Hazardous or unsanitary living environments

More Definitions and Indicators of Elder/Vulnerable Abuse

TERM	DEFINITION	INDICATORS
Self Neglect	Behaviors of an elderly or vulnerable person that threatens his or her own health or safety. These behaviors generally involving life necessities such as food, water, living environment, personal hygiene, and required medications. Self-neglect does not include older adults who are mentally competent and can fully understand the consequences of his or her actions.	• Dehydration • Malnutrition • Untreated medical conditions • Hazardous or unsanitary living environments
Financial Exploitation	Illegal or improper use of an elder or vulnerable adult's funds, property, or assets. This may include such actions as cashing checks without permission; forging signatures; stealing money or possessions; and coercing or deceiving an individual into signing documents.	• Sudden bank account changes • Abrupt changes in a will • Unexplained disappearance of funds or possessions • Sudden appearance of uninvolved family claiming their right to funds or possessions

What You Should Know About Elder/Vulnerable Abuse

Employees who have contact with patients should be aware of the legal aspects of elder and vulnerable adult abuse and how to respond to individuals who may be victims.

Legal Requirements:

Under Maryland law health practitioners, police officers and human service workers are required to report suspected elder/vulnerable adult abuse and neglect. It is the responsibility of city, county and state agencies to investigate reports of suspected abuse or neglect.

The investigating agencies include:

- Department of Social Services, Adult Protective Services: investigates alleged elder/vulnerable adult maltreatment in domestic or community based settings.
- Department of Aging, Long Term Care Ombudsman Program: investigates alleged elder/vulnerable adult maltreatment in nursing home and long-term care facilities.
- Department of Health and Mental Hygiene, Office of Health Care Quality: investigates alleged elder/vulnerable adult maltreatment in all licensed and federally certified facilities such as nursing homes and hospitals.
- Department of Health and Mental Hygiene, Office of Health Care Quality: investigates alleged elder/vulnerable adult maltreatment in all licensed and federally certified facilities such as nursing homes and hospitals.
- Local law enforcement: investigates alleged elder/vulnerable adult maltreatment in all settings, including community and institutional.
- Office of the Attorney General, Medicaid Fraud Control Unit: investigates and prosecutes incidents of abuse and neglect of elder/vulnerable adults residing in facilities that receive Medicaid funds.

What You Should Know (Continued)

Use questions routinely

Incorporate routine questions related to elder/vulnerable adult maltreatment into daily practice. Interview patients and caregiver separately.

Ask direct questions such as:

- "Has anyone at home ever hurt you?"
- "Are you afraid of anyone at home?"
- "Has anyone ever touched you without your consent?"
- "Has anyone ever failed to assist you when you needed help?"
- "Are you alone a lot?"
- "Have you ever signed any documents that you didn't understand?"

What you can do:

The most important thing you can do is to report any suspected maltreatment or indicators of maltreatment to the hospital social worker or other member of the healthcare team.

The hospital social worker is responsible for completing a detailed assessment and reporting any suspected maltreatment to the appropriate community investigating agency.

If you feel a patient has been abandoned at the hospital this should also be reported to social work for early intervention.

Part 3: Child Abuse and Neglect

Background

- Child physical abuse, sexual abuse, and neglect constitute an alarming medical and social problem in the United States. Statistics show that the overall rate has declined by only a small percentage (2012).
- The majority of cases in Maryland involve neglect.

Definitions and Indicators of Child Abuse and Neglect

<table>
<tr><th>TERM</th><th>DEFINITION</th><th>INDICATORS</th></tr>
<tr><td>Physical Abuse</td><td>Any injury to a child in which a child’s health or welfare is at harm or at-risk of harm, caused by a parent, household or family member, or one who has responsibility for supervision of the child.</td><td rowspan="3">There are many indicators of child physical abuse, sexual abuse, and neglect. Signs and symptoms can range from injury that may or may not be visible to behavioral indicators. You may see: bruising, broken bones, or failure to gain weight.

Some studies show that there are medical findings in only 4% of sexual abuse cases. There are usually multiple factors present that would lead someone to suspect abuse.

Medical professionals will look at all of the injuries and behaviors and determine if they are consistent with the story the family or caretaker provides. Ultimately, if there is an injury or behavior that causes suspicion one should take it seriously. You should report the injury or behavior and leave it to the professionals to determine if the child has suffered abuse or neglect. Always give the benefit of the doubt to the child.</td></tr>
<tr><td>Sexual Abuse</td><td>Any act that involves sexual molestation or exploitation of a child, whether injuries are sustained or not, by a parent or other person who is responsible for the supervision of a child.</td></tr>
<tr><td>Neglect</td><td>A minor child who is suffering, or at risk of suffering, physical or mental harm or injury from being left unattended or from a failure to give proper care and attention to a child.</td></tr>
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What You Should Know About Child Abuse and Neglect

What You can Do:

If you suspect child abuse or neglect and are unsure how to proceed, contact the JHH Social Worker assigned to the floor, outpatient clinic or medical team.

What can you do in a public place when a child is being mistreated by an adult?

- Avoid negative remarks. This can increase the adult's frustration and make things worse.
- Start a conversation with the adult to direct attention away from the child, such as "She seems to be trying your patience. Is there anything I can do?" or "My child has gotten upset like that too."
- If the child is misbehaving, divert the child's attention by talking to the child.
- Praise the child and parent at the first opportunity.

Employees who have contact with patients should be aware of the legal aspects of child abuse and neglect, and how to respond to individuals who may be victims.

Legal Requirements:

- Any person who has reason to believe that a child has been subjected to abuse or neglect shall contact the local Child Protective Services in the city/county where the maltreatment is suspected to have happened.
- Or call local law enforcement agency.
- Reporting only requires suspicion of abuse or neglect. Reporting to Child Protective Services can be done anonymously. If done in good faith there is no liability for making such a report.

Key Points

- Routinely assess patients for abuse and neglect.
- Contact your supervisor or FASAP if you believe a co-worker is a victim of abuse or encourage the co-worker to contact FASAP at:
  - 443-287-7000
  - 443-997-7000
- **Domestic Violence**: refer all reports of domestic violence to the hospital social worker or physician
- **Elder/Vulnerable Adult Abuse**: under Maryland law health practitioners are required to report **suspected** elder/vulnerable adult abuse and neglect. Contact the patient's social worker or physician.
- **Child Abuse**: Any person who has reason to believe that a child has been subjected to abuse or neglect must contact the local Department of Child Protective Services or local law enforcement agency.

Organ Donation

Overview

In Maryland, there are currently over 3600 people waiting for organ transplants. The majority are waiting for kidneys, livers, and lungs.

As a Level 1 Trauma Center, JHH is often in the position to identify and refer potential organ and tissue donors to the Maryland Donor Referral Line. The Maryland Donor Referral Line (410-242-1773) is a 24 hours referral center that activates the local Organ Procurement Organization, the Living Legacy Foundation.

Staff should be prepared to answer questions or refer family members to experts.

Types of Donors

Organ donors are classified into three types:

- Organ donation following brain death
- Organ donation following cardiac death
- Tissue donation

Types of Donors: Following Brain Death

- Patients must have severe cerebral impairment that meets the criteria for a Glascow Coma Scale 3.
- Patients are on artificial life support (ex: mechanical ventilation) and end organ perfusion continues despite neurological death (patient still has organized cardiac activity).
- Organs and tissues can be recovered.
- It is important that staff do not discuss donation options with families until a consult with the Living Legacy Foundation has been made. The Living Legacy Foundation determines donation suitability.

Types of Donors: Following Cardiac Death

- Patients with severe acute irreversible central nervous system injury who do not meet the criteria for brain death and for whom the family or surrogates have decided to withdraw life-support.
- The degree of neurological injury should in all cases necessitate the need for mechanical ventilation.
- The liver, pancreas, and kidneys may be recovered.
- It is important that staff do not discuss donation options with families until a consult with the Living Legacy Foundation has been made. The Living Legacy Foundation determines donation suitability.

Types of Donors: Tissue Donation

- Tissue donation can occur when either brain death or cardiopulmonary death has been declared.
- Each potential tissue donor is evaluated on an individual basis.
- One tissue donor can enhance the lives of over 100 recipients.
- It is important that staff do not discuss donation options with families until a consult with the Living Legacy Foundation has been made. The Living Legacy Foundation determines donation suitability.

Protocols

JHH has several resources to help assist families and caregivers with this process.

To support ethical organ and tissue donation and to meet the spiritual and emotional needs of families, JHH has three interdisciplinary protocols. You can view these if you are within the Hopkins' network.

- Organ Donation following Brain Death: http://www.insidehopkinsmedicine.org/hpo/policies/39/145/policy_145.pdf
- Organ Donation following Cardiac Death: http://www.insidehopkinsmedicine.org/icpm/MEL011-donation_cardiac_death.pdf
- Death, Care After: http://www.insidehopkinsmedicine.org/hpo/policies/39/16/policy_16.pdf

Resources

Maryland Donor Referral Line, the Living Legacy Foundation

Web site: www.theLLF.org; Phone: 410-242-1173

Family Advocate

The Family Advocate is a JHH chaplain who has received special training for this role. The Family Advocate serves as a 24 hour dedicated resource for providing impartial emotional, spiritual and crisis intervention support to the family of any patient with severe neurological injury. This support is available irrespective of the likelihood of subsequent organ donation. He or she is available by paging 410-283-6000.

Transplant Coordinator

The JHH Donation Program Coordinator is responsible for supporting the donation process, education of hospital staff, data collection and monitoring of family and staff satisfaction with the organ donation process. This person may also serve as a family advocate and may be reached on beeper 410-283-6667.

Population Served

Differences Through the Ages

Welcome

At Johns Hopkins, our highest priority is the care we provide to patients. This care should be individualized to meet the needs of each person. One aspect of meeting a patient's needs is to understand the unique characteristics of their age group including:

- Developmental highlights
- Safety considerations
- Service considerations
- Additional tips

In this course, you will learn about the differences and similarities of all age groups beginning with birth and ending with late adulthood. Knowing this information will help you adjust your behavior and communication to meet the unique needs of the age group with whom you are interacting.

Birth to 4 Weeks

Developmental Highlights

- Smiles randomly
- Enjoys being held, cuddled, touched, talked to and smiled at
- Cry is strong when hungry or uncomfortable

Safety Considerations

- Car seat required

Service Considerations

- Do not approach newborn directly or too quickly
- Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises

4 to 8 Weeks

Developmental Highlights

- Makes noises with throat
- Moves eyes
- Begins to smile in response to stimulation
- Begins to follow objects with eyes
- Responds to and enjoys:
  - Mobiles
  - Human faces
  - Being held, rocked, and cuddled

Safety Considerations

- Car seat required

Service Considerations

- Do not approach newborn directly or too quickly
- Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises

2 to 4 Months

Developmental Highlights

- Smiles in response to another's smile
- Looks around in search of speaker
- Responds differently to familiar vs. unfamiliar
- Responds to and enjoys:
  - Increased contact with family members
  - Rattles
  - Easily grasped objects
  - Free-play with hands

Safety Considerations

- Car seat required
- Do not leave baby unattended on the floor or any other surface
- Remove all objects that could be eaten if the baby is on the floor
- Remove all cords and other objects that the baby could use to strangle him or herself

Service Considerations

- Smile and talk to infant
- Do not approach newborn directly or too quickly
- Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises

4 to 6 Months

Developmental Highlights

- Recognizes familiar objects
- Laughs aloud
- Babbles, coos, and gurgles when talked to
- Enjoys having other people around and being talked to
- Responds and enjoys increased contact with family, physical movement, copying others, soft toys, large toys, plastic rings, banging toys, and block toys

Safety Considerations

- Car seat required
- *Baby-proof* the environment
- Remove all objects that could be harmful to the baby (e.g. cords, ropes, objects small enough to be eaten, chemicals)

Service Considerations

- Smile and talk to infant
- Do not approach newborn directly or too quickly
- Approach primary caretaker(s) with a smile and make an appropriate comment about the newborn if the situation arises.

6 to 9 Months

Developmental Highlights

- Lets you know his/her feelings through sounds, crying, cooing
- Babbles
- Demonstrates excitement
- Vocalizes syllable sounds like *Ma, Da,* etc.
- Imitates adult sounds
- Responds to own name by vocalizing or stopping activity
- Turns head to side on hearing sounds
- Shows fears and is afraid of being separated from caretaker(s)
- Shows signs of frustration

Safety Considerations

- Car seat required
- *Baby-proof* the environment
- Make sure objects that could be swallowed are moved
- Make sure that all objects (physical, chemical, electrical, etc.) are removed

Service Considerations

- Call infant by name if known
- Make sure that the infant always has an eye on the primary caretaker(s) to avoid a strong cry (separation anxiety)

Age-Specific Care

- Involve child and caretaker(s) in the child's care during feeding, diapering, and bathing
- Encourage child to communicate; smile
- Speak softly
- Help educate the caretaker(s)

9 to 12 Months

Developmental Highlights

- Copies sounds; says *Ma-Ma* and *Da-da*
- Responds to own name
- Imitates gestures and facial expressions
- Plays peek-a-boo
- Shakes head for *No*
- Responds when asked to do something simple
- Stops activity in response to *No!*
- Shows fear of strange voices
- Shows emotions such as anger, joy, affection, jealousy

Safety Considerations

- Car seat required
- Put small or sharp objects out of reach
- Make sure the environment is *crawl*- and *walk*-proof
- If baby is in danger, say *No* or *No-No* firmly

Service Considerations

- Play peek-a-boo with hands
- Ensure infant always has an eye on the primary caretaker(s) to avoid a strong cry (separation anxiety)
- Do no get upset if baby cries when you show up or when you talk to the infant (may show fear of strangers)

Caretaker Tips

Caretaker may experience a degree of stress while child is ill. Signs of this type of stress:

- Anger or hostility toward the staff
- Rude, uncooperative, and/or demanding behavior
- Suspicious behavior as though staff is hiding something from them

12 to 15 Months

Developmental Highlights

- Knows 2-3 words
- Jabbers expressively
- Recognizes the meaning of *No, No-No*
- Shows emotion, e.g. joy, anger, frustration
- May indicate when diaper is wet
- Imitates simple acts
- Understands names of people

Safety Considerations

- Car seat required
- *Baby-proof* the environment
- Make sure baby changing areas are clean and functional
- Make sure baby does not run out into the street, parking lot, on escalators, or on elevators

Service Considerations

- Smile and talk to baby
- Use a strong *No!* if the child is in danger; is likely to respond

Caretaker Tips

- Stay calm when caretakers express anger, hostility, or indifference
- Show flexibility by making changes or modifying care to help ease the pressure of the caretakers
- Say, “I realize this must be upsetting for you.” Show your understanding
- Honor the caretaker as a partner in the child’s treatment

15 to 18 Months

Developmental Highlights

- Knows 2-3 words
- Uses jargon
- Shakes or nods head to *Yes* and *No* questions
- Comprehends up to 50 words

Developmental Highlights (continued)

- Responds to and enjoys:
  - Solitary play and watching others play
  - Running
  - Water play
  - Riding toys
  - Outdoor activities
  - Throwing
  - Scribbling
  - Looking at books
  - Repetitive songs and toys
  - Push-and-pull toys

Safety Considerations

- Car seat required
- *Baby-proof* the environment

Service Considerations

- Smile and talk to baby

18 to 24 Months

Developmental Highlights

- Talks in two-word combinations
- Vocabulary of about 300 words
- Imitates speech
- Points correctly to body parts
- Verbalizes needs
- Obeys simple commands
- Fears parents leaving
- Has a strong sense of *Mine!*
- May become less willing to do what you ask
- May throw temper tantrums
- Does not readily ask for help

Safety Considerations

- Car seat required; *baby-proof* the environment
- Make sure that the baby does not take any object that is harmful
- Repeat command if baby refuses to obey
- Provide help if you notice that a safety issue is at hand
- Tell baby to behave safely (e.g. crossing the street)
- Protect from harm if a tantrum is thrown
- Be aware that you could get bitten, scratched, or kicked during a tantrum
- Protect property if a tantrum is thrown

Service Considerations

- Smile and talk to baby
- Make sure that baby is reassured that primary caretaker(s) will return if separated

Caretaker Tip

- Use words that caretakers will understand. Explain medical terms.

2 to 4 Years

Developmental Highlights

- Speech is 50-75% intelligible
- Talks in 3-4 to 4-6 word combinations
- Knows first and last name
- Understands long and complex sentences
- Knows physical needs
- Uses play to learn, express self, and work out fears
- Temper tantrums and negative behavior may continue

Safety Considerations

- Car seat required (state laws may vary)
- Explain in simple terms why certain behaviors or objects are dangerous and harmful (while removing objects from child)

Service Considerations

- Ask child if he or she wants certain foods and drinks
- Lean down and forward when interacting with child
- Honor requests to place foods in certain places, e.g. nothing touching on the plate

Caretaker Tip

Caretakers want to know what their alternatives are. They can be good partners in care if they know their choices and the consequences of each. It will help them make the best decisions for the patient.

5 Years

Developmental Highlights

- Vocabulary of 1500-2100 words
- Speech is 90-100% intelligible
- Can count to 5 -10
- Comprehends *cold, tired,* etc.
- Uses play to learn, express self, and work out fears; pretends
- Plays with peers; marches and swings
- Enjoys rhymes and riddles

Safety Considerations

- Seat belt required
- Protect child from fantasies and pretend behavior that is dangerous

Safety Considerations (continued)

- Explain simply to child the differences between *safe* and *unsafe* behaviors and the consequences of dangerous behavior
- Help caretaker(s) teach child safety rules

Service Considerations

- Lean forward and interact with child
- Recognize peers of child as important
- Call child by first name, by last name if appropriate, or both
- Let child make food choices
- Use toys and games to teach child and to reduce fears
- Encourage child to ask questions, play with others, talk about feelings

Caretaker Tip

Take advantage of possible teaching opportunities. Promote safety and healthy habits with 5-year-olds, such as good nutrition, personal hygiene, bike helmets, and safety belts.

6 to 8 Years

Developmental Highlights

- Uses language correctly
- Begins reading, writing, adding, and subtracting
- Attention span lengthening
- Tells time by hour
- Gives address
- Cooperative family member
- Has a concept of death

Developmental Highlights (continued)

- Enjoys:
  - Same-sex peers
  - Outdoors; competitive games
  - Board games
  - Songs; riddles and rhymes
  - Imitative play
  - Arts and crafts
  - Books and stories

Safety Considerations

- Seat belt required
- Alert child to stay focused when doing any activity, particularly outdoor activities
- Protect children who are naturally drawn to dangerous situations

Service Considerations

- Call child by name
- Interact with child and peers if it seems appropriate

8 to 10 Years

Developmental Highlights

- Can name from memory and describe differences between objects
- Participates fully in conversation with adults
- Begins separation from family
- Learns by doing
- Understands *past, present,* and *future*
- Understands death as permanent, biological, and universal
- Becomes extremely critical of parents
- May glorify another family

Developmental Highlights Continued

•May be independent, disobedient, defiant; rejects discipline

•Tries to be more grown up

Safety Considerations

•Seat belt required

•Repeat directions firmly to protect child

•Needs to be reminded of dangerous situations

•Explain the consequences of dangerous behaviors, even those resulting in actual physical death

Service Considerations

- Interact with child as you would with an adult
- Honor their striving for independence

Caretaker Tips

Don't ignore the patient while talking to the caregiver(s). Don't give painful or complicated information hurriedly or abruptly over the phone. Don't use inappropriate humor or words aimed at the patient or caregiver(s). Don't give false hope.

10 to 12 Years

Developmental Highlights

- Very verbal
- Can verbalize feelings, but privately
- Understands humor

- Enjoys interacting with peers of both sexes
- Appearance becomes important
- Copies teenage dress and slang
- Continues to be self-conscious
- May worry and exhibit nervous behavior
- Awakening interest in world beyond home and community
- Can be assisted to make logical decisions

Safety Considerations

- Seat belt required
- No smoking under age 18
- No drinking under age 21
- Explain safe behavior using logical explanations and reasoning
- Be cautious of risky behavior when in a crowd because of peer pressure
- Model appropriate male/female relationships

Service Considerations

- Interact with honesty and respect
- Honor the fact that appearance and self consciousness are important to child
- Provide comfort and assurance if you notice worry or nervous behavior
- Humor can go a long way to developing a relationship

12 to 15 Years

Developmental Highlights

- Able to interpret social classes and emotional state of others
- Able to gain and maintain attention in socially acceptable ways
- Beginning interest in dating
- Increasing concern of physical appearance
- Need for privacy continues
- Extremely idealistic
- Able to consider potential alternatives to situations not yet experienced
- Interested in making independent decisions

Developmental Highlights Continued

- Reasons through trial and error
- Difficulty understanding consequences of their own behavior

Safety Considerations

- Seat belt required
- No smoking under age 18
- No drinking under age 21
- Explain safe behavior using logical explanations and reasoning
- Be cautious of the increasing impact of peer pressure
- Clearly communicate the immediate consequences of engaging in unsafe behavior

Service Considerations

- Interact with respect
- Pay attention to the increasing emphasis on physical appearance
- Respect the need for privacy

15 to 18 Years

Developmental Highlights

- Decisions continue to be influenced by peers and significant adults though becoming increasingly independent
- May question authority figures and seek out ways to change a situation which seems unfair
- Need for privacy continues
- Formulates sex role identity
- Experiences mood changes and unpredictable reactions; being unable to make decisions is common
- Experiments with adult behavior

Safety Considerations

- Seat belt required
- No smoking under age 18
- No drinking under age 21
- Model appropriate male/female relationships
- Enforce limits using strategies other than parental power; instead use reasoning, explanation, and self protection

Service Considerations

- Interact with respect and dignity
- Make certain not to refer to person as *child, boy, girl,* etc.
- Respect need for privacy
- Pay attention to increasing emphasis on physical appearance

Early Adulthood (18 to 29 Years)

Developmental Highlights

- Establishes personal identity and a residence
- Develops intimate relationships outside the family
- Establishes a personal set of values and a career that provides satisfaction, security, and a feeling of contribution

Safety Considerations

- Seat belt required
- No drinking under age 21
- Emphasize the consequences of being an adult from a legal perspective
- Focus on the fact tat pre-teens (10-12 years) model their behavior based upon what Early Adults do

Service Considerations

- Interact in a way that respects the other
- Anticipate a need and meet the need
- Listen to concerns and respond

Young Adulthood (30 to 44 Years)

Developmental Highlights

- Continues work on the developmental tasks of early adulthood
- Manages a household, possibly some children, and a career
- Maintains friendships

Safety Considerations

- Seat belt required
- No drinking and driving
- Clearly communicate the rules and the consequences of violation the rules

Service Considerations

- Interact in a way that respects the other
- Anticipate the need and meet the need
- Listen to concerns and respond
- Be patient due to the multiple demands and priorities of managing a household, a career, friends, and maybe children

Middle Adulthood (45 to 65 Years)

Developmental Highlights

- Discovering and developing new satisfaction
- Helping growing and grown children
- Creating a pleasant, friendly, and comfortable home
- Balancing work with other roles
- Accepting that they are now having to take care of their aging parents
- Achieving social and civic responsibility
- Accepting and adjusting to physical changes of middle adulthood

Safety Considerations

- Seat belt required
- No drinking and driving
- Watch out for role overload and doing too much with too few resources

Service Considerations

- Interact in a respectful manner
- Be patient with the pressures of managing multiple priorities and perhaps caring for kids and aging parents (*Sandwich Generation*)

Late Adulthood (65+ Years)

Developmental Highlights

- Adapting to physical changes that accompany aging
- Redirection of energy and talents to new roles and activities
- Development of a personal view of death

Safety Considerations

- Seat belt required
- No drinking and driving
- Be alert for disorientation due to early signs of confusion and forgetfulness (dementia) or the mixing of prescribed medications
- Be alert to preventing falls and slips that might result in breaks and cuts

Service Considerations

- Interact in a way that shows respect for person, age and wisdom
- Speak in a normal volume unless you know the patient has a hearing impairment
- Walk at a normal rate unless you know that an ambulatory problem exists
- Make sure printed materials are in large print

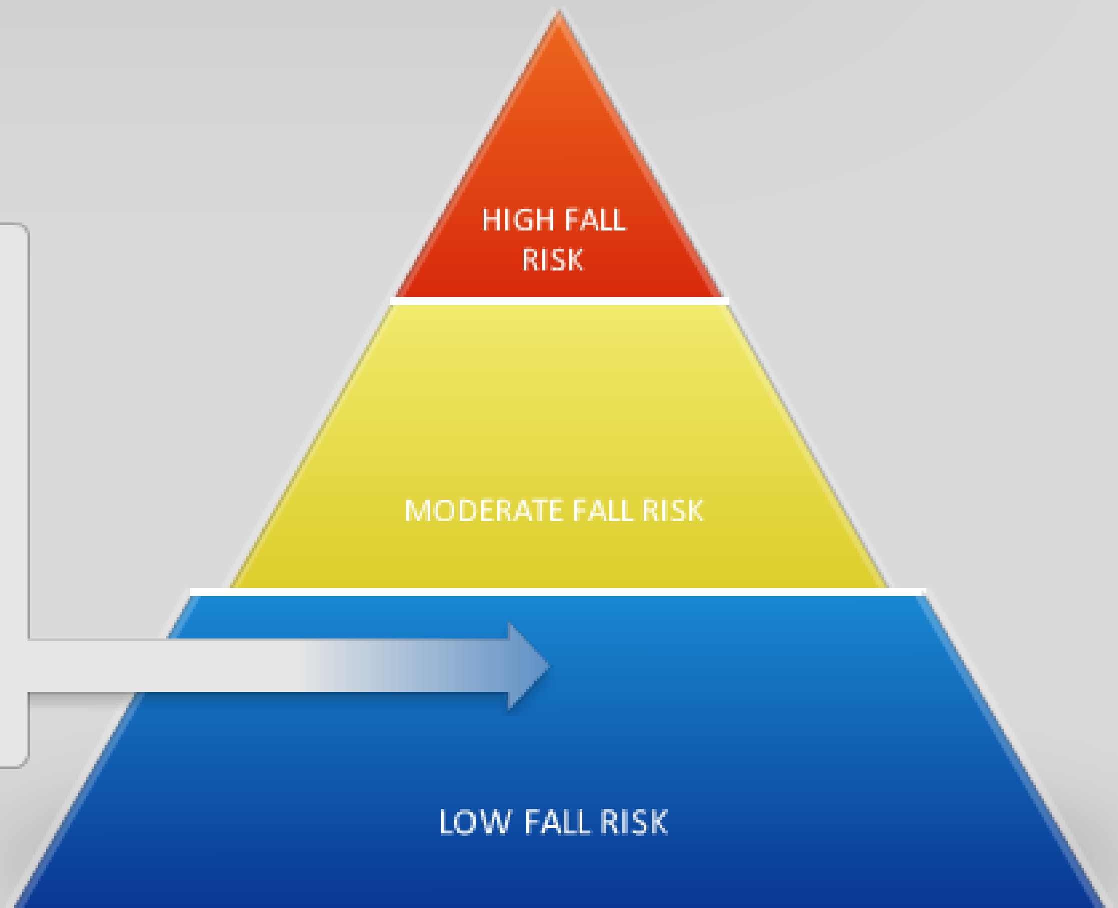
Fall Reduction

Adult Fall Risk Categories and Interventions

LOW FALL RISK

Criteria:
Risk assessment tool score of 0 to 5

Interventions:
Initiate basic fall safety interventions

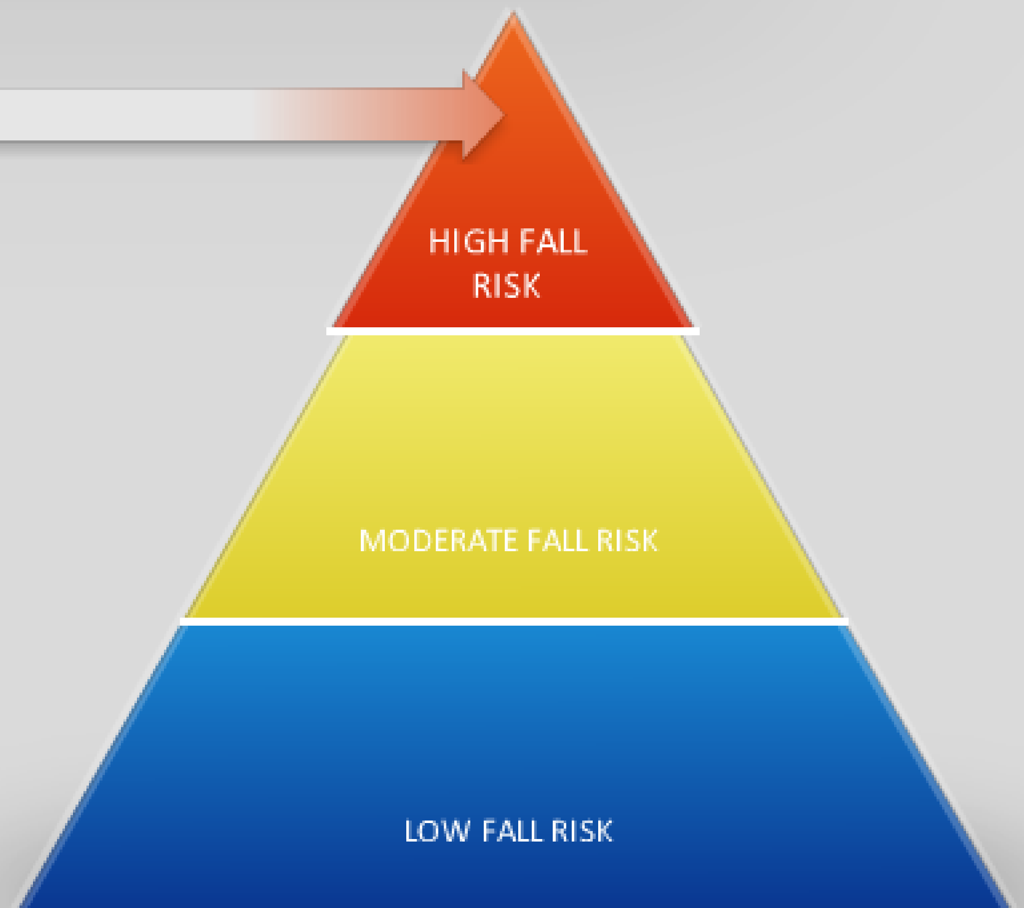


Adult Fall Risk Categories and Interventions

HIGH FALL RISK

(Red Flag)
Criteria:

- Risk assessment tool score of >13
- Automatic high risk per fall history (a fall during this hospitalization or more than 1 fall in 6 months prior to

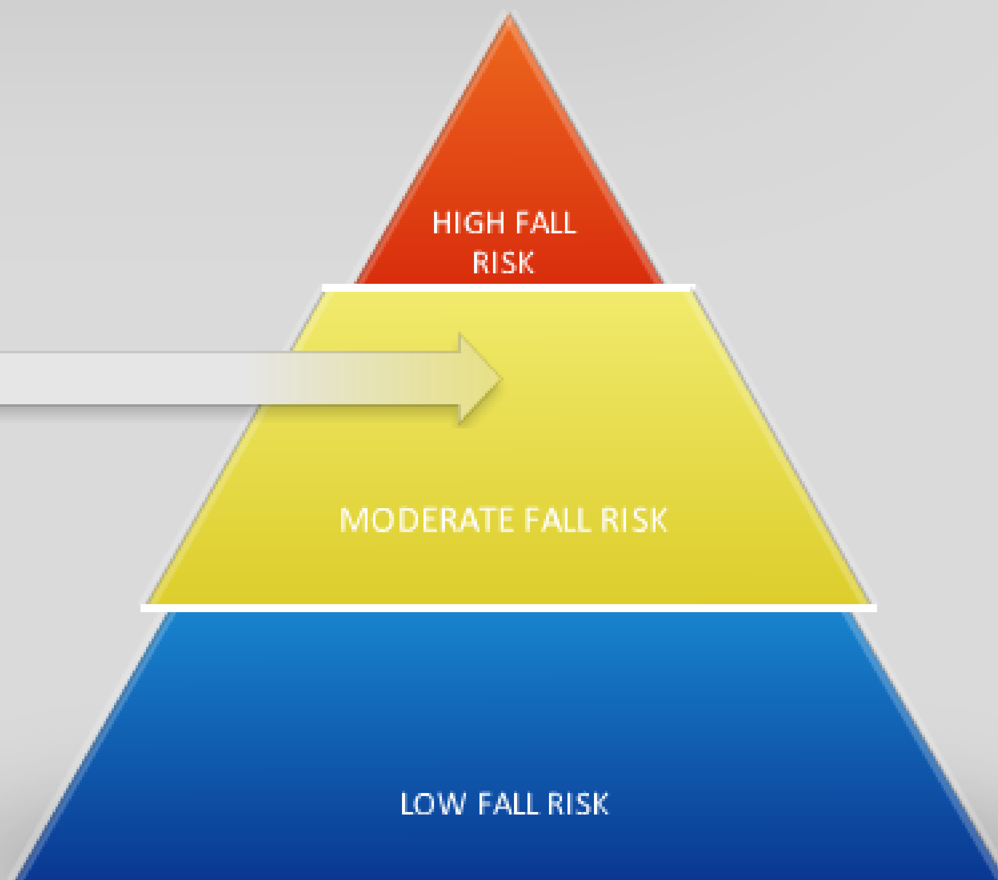


Adult Fall Risk Categories and Interventions

MODERATE FALL RISK

(Yellow Flag)
Criteria:
Risk assessment tool score of 6 to 13

Interventions:
Initiate basic and additional fall safety interventions

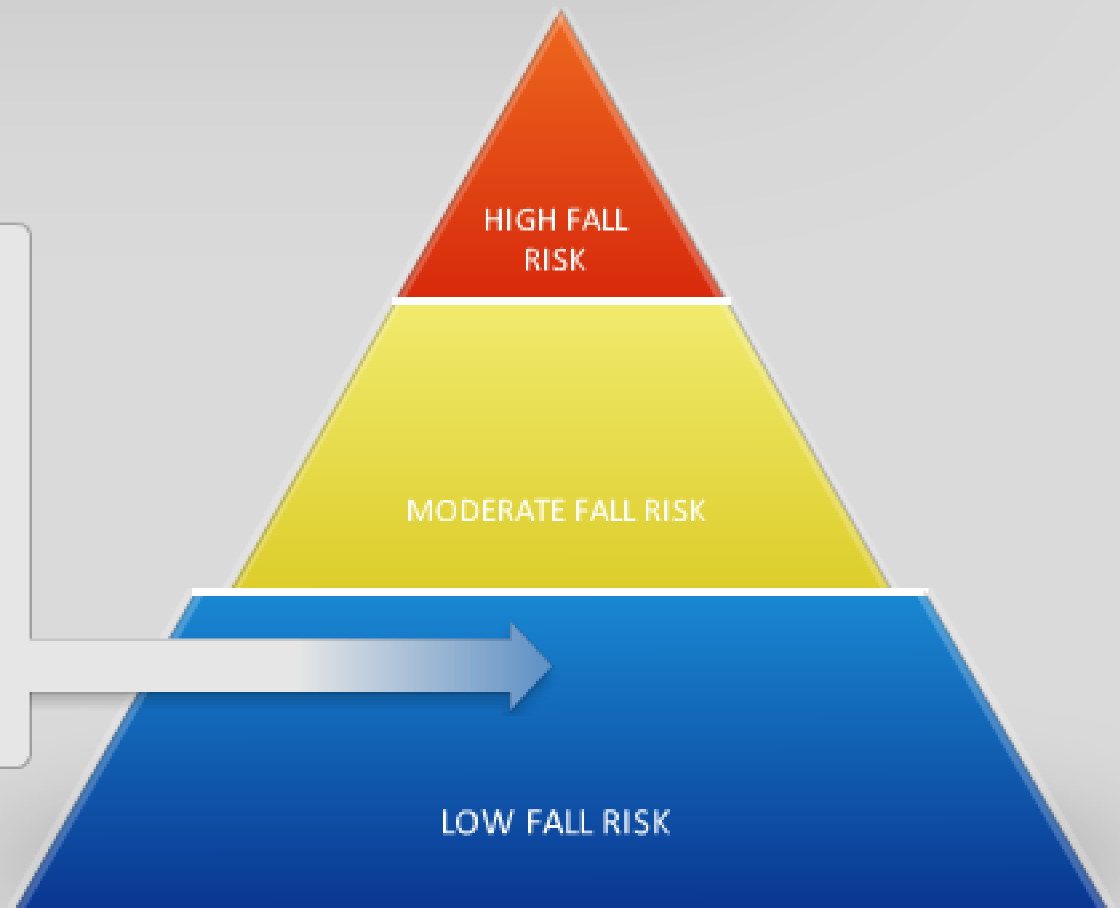


Adult Fall Risk Categories and Interventions

LOW FALL RISK

Criteria:
Risk assessment tool score of 0 to 5

Interventions:
Initiate basic fall safety interventions



How to Reduce Falls—1

ASSIST & ASSESS THE PATIENT

- Orient patient to surroundings
- Place call light and frequently needed objects within patient reach
- Encourage patients and their families to remain attentive and to call for assistance when needed
- Display special instructions for vision and hearing
- Assure adequate lighting
- Complete a fall assessment on outpatients at least once per year

BEDS, CHAIRS, STRETCHERS

- Keep bed/crib in lowest position during use unless impractical
- Keep 2-3 bed side rails up as needed to assist with bed mobility
- Keep side/crib rails up at all times
- Secure locks on beds, stretchers and wheelchairs

SPILLS

- Clean spills immediately and place “Danger - Wet Floor” signs promptly
- Use properly fitted, nonskid footwear

CLUTTER

- Remove excess equipment, supplies and furniture from rooms and hallways
- Keep floor clutter-free
- Secure excess electrical and telephone wires

Remember to include the family in fall safety education.

How to Reduce Falls–2

The Falls Risk Reduction poster advises patients to:

- Let staff members know about any recent fall history.
- Let staff members know if they need help going to the restroom, down the hall or to their car.
- Let staff members know if they feel lightheaded or dizzy.
- Avoid bending or reaching to pick up items.

How to Prevent FALLS with Us

Did you know?

- One in three adults over 65 fall each year.
- About one-third of patients who fall suffer an injury.
- Injuries from falls can lead to hospitalizations.
- Falls are more likely in an unfamiliar environment. You may need help here even though you may not need help at home.

Our goal is to keep you safe and active.

Here's what you can do:

- Let staff members know about your fall history or if you have had a recent fall.
- Let us know if you need help going to the restroom, down the hall or to your car.
- Let staff members know if you have any lightheadedness or dizziness.
- Avoid bending or reaching to pick up items out of reach.

If you have questions ask a staff member.

JOHNS HOPKINS MEDICINE

Pediatric Risk and Interventions–1

- All pediatric patients are at some risk for falls in the hospital setting. Safety and fall prevention strategies should be considered for all patients.
- Assessment of fall risk in pediatric patients is done through the use of the **Humpty Dumpty Fall Risk Assessment Tool©** following the Fall Risk and Safety Protocol in Pediatrics. It can be used in ambulatory, ED, and inpatient settings.
- There are 7 parameters for calculating fall risk using this tool. Minimum score is 7 and the maximum score is 23. A score of 12 or above is considered "high risk." Download Fall Risk and Safety Appendix B from the Resources tab in the upper right. It provides definitions and characteristics for each of the parameters being scored.

Pediatric Risk and Interventions–2

Standard Fall Prevention Strategies to be used for all pediatric patients:

- Orientation to room
- Personal items and call bell (if appropriate)
- Bed in lowest position, brakes on
- Offer assistance to bathroom if appropriate
- Monitor patient's medications, especially those having hypotensive, tranquilizing or sedation effects
- Monitor parent's ability to set appropriate behavioral activity limits for child
- Bed and stretcher side rails will be kept in raised position for preschool children and as indicated for older children based on developmental age or clinical conditions (e.g., seizures, sedation, etc.)
- Crib rails will be kept in raised positions unless direct care is being provided
- Maintain a safe room environment
- For ambulating patients, use of non-skid footwear, appropriate sized clothing to prevent risk of tripping, and adequate supervision when ambulating, secure equipment tubing, catheters etc. to minimize tripping or fall risk.
- Use safety belts when positioning patients in infant seats, high chairs, strollers, and walkers

Pediatric Risk and Interventions–3

High Fall Risk Prevention Strategies (patients with score of 12 or above); in addition to standard interventions:

- Institute flagging system to include High Risk Falls sticker on patient's chart and High Risk for Falls sign on the door
- Accompany patient during ambulation
- Assess need for hourly rounding
- Assess need for increased supervision (e.g., Patient Safety Attendant)
- Assess need for bed alarm
- Assess need for enclosed bed

Patient/Parent education is critical for all pediatric patients to include fall risk and interventions to prevent falls

Resources

Johns Hopkins provides several important resources regarding fall risk that you can download.

- Fall Risk Assessment: Prevention and Management (for Adults)

  See Appendices for:

  - Assessment Tool
  - Intervention by Risk Category
  - Patient Education on Preventing Falls in Hospital
  - Patient Education on Preventing Falls at Home
- Pediatrics Safety and Falls Prevention

Restraints and Seclusion

Introduction

What constitutes restraint and seclusion? You should understand these important definitions and the types of restraint protocols:

Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move his/her arms, legs, head or body freely. A restraint is designed so that it cannot be easily removed by the patient.

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

Restraints can be used for either **non-violent or violent behaviors.** The policies are different; with different indications, monitoring, and documentation requirements.

- **Non-violent** behaviors typically involve patient attempts to remove medical equipment or non-compliance with activity restrictions. The use of the restraint is to support healing in the presence of non-violent behavior. Check Hopkins Policies Online (HPO) for *Restraint to Support Healing in the Non-Violent Patient*.
- **Violent behaviors** typically include combative behaviors, kicking, biting, hitting or engaging in self-harm. The use of restraints is to protect the patient or others from aggressive or threatening actions that present an immediate or serious danger or safety threat. Check Hopkins Policies Online (HPO) for *Restraint and Seclusion, Management of Violent or Self Destructive Patient Behavior*.

Overview

The decision to use restraints is a difficult one involving complex issues that pose significant risks to patients and to the hospital. When using restraints or seclusion, the practitioner must strike a balance between patient safety and the patient's dignity and well-being.

Failure to correctly use restraints and monitor patients who are in restraints can lead to serious injury or even death. On the other hand, hospitals have also been sued for false imprisonment when patients were restrained against their wishes.

A hospital may be sued for negligence if adequate precautions are not taken to protect those at risk of harming themselves or others. Hospitals are responsible for protecting impaired, elderly, incapacitated or unstable patients.

When Is It Appropriate to Use Restraint or Seclusion?

- Joint Commission and Medicare/Medicaid (CMS) standards are in place to ensure that **patients' rights** include that they have the right to be free from the use of restraints or seclusion as a means of coercion, convenience, or retaliation.
- Preventive strategies and alternatives to restraint and seclusion must be attempted **before** instituting restraints or seclusion.
- "**When**" alternatives are deemed ineffective and restraints or seclusion are clinically justified, the least restrictive measures should be used. (Refer to Restraint Policies, Alternatives and Least Restrictive appendices.) The **goal** is to discontinue use as soon as the patient behavior indicates restraint or seclusion is no longer necessary.

How Do We Ensure the Safety of a Patient in Restraints or Seclusion?

The following key points should be followed:

- Restraints or seclusion should only be used when other non-physical methods have been proven ineffective.
- When restraints or seclusion are clinically indicated, the least restrictive measures appropriate for the patient condition should be used.
- The appropriate policy and plan of care should be selected based on patient behavior, not care location.
- The patient/family should be educated about why restraint or seclusion is in use and what behaviors will determine when it can be discontinued.
- A provider order is required for restraints or seclusion. The policy specifies the order frequency, the evaluations and documentation the provider must complete.
- Staff trained to care for the patient must complete and document all observations and care at the frequencies per the appropriate policy.
- Safety is the focus of patient care and the goal is discontinuation as soon as the behavioral changes indicate restraint or seclusion is no longer necessary.

Who Can Apply Restraints or Place Patients in Seclusion?

Only staff who receive **special training** may apply restraints or place the patient in seclusion. Specialized training includes:

- The use of non-physical skills to manage patient behaviors to prevent the use of restraint or seclusion
- Identifying events and factors that may trigger behaviors that require the use of restraints or seclusion
- Safe application of restraints and how to recognize and respond to signs of distress
- Changes that indicate restraint or seclusion is no longer necessary
- Monitoring the physical and psychological well-being of the patient in restraint or seclusion

If you have not received special training on restraints, you should never attempt to tie or untie a patient's restraints without asking for RN assistance.

Reporting a Change in Patient Condition in the Inpatient Setting

Rationale for Reporting Changes

Did you know that a significant number of critical inpatient events are preceded by warning signs?

According to the Joint Commission, an early response to changes in a patient's condition by specially trained individual(s) may reduce cardiopulmonary arrests and mortality.

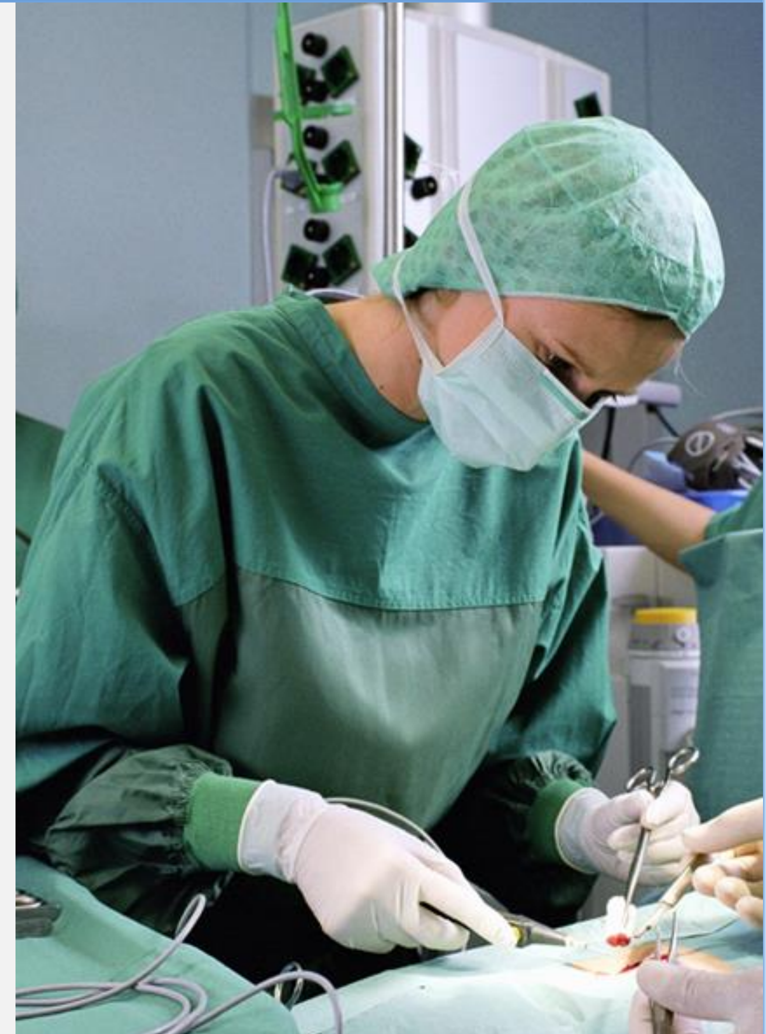
Note: If you work in an ambulatory setting, different procedures apply. Please see the Special Topics for Outpatient Clinicians Module.

JHH Teams

The Johns Hopkins Hospital maintains several different teams that respond to medical emergencies.

For example, there are:

- Adult Code Teams
- Adult Rapid Response Team or RRT (used in inpatient areas only)
- Ambulatory Code/RRT Team
- Pediatric Rapid Response Team (also responds to codes)
- Adult Difficult Airway Response Team (DART)
- Pediatric Difficult Airway Response Team (pDART)
- Intubation/Anesthesia Only Team (for Adult ICUs/ED only)
- Neonatal Resuscitation Team



Contact all teams by calling 410-955-4444 (on campus: 5-4444)

Emergency Medical Response in the Inpatient Setting

- Each team consists of individuals with specific training to deal with different kinds of medical emergencies.
- Staff must be aware of the existence of these different teams, their geographical boundaries and types of emergencies for which each team responds.
- Click on the link below to review the list of teams available (you must be on the Hopkins Intranet).

Available Teams

How do I get the right team?

Call the Hospital's emergency number: **5-4444.** Let the dispatcher know the 4W's:

What kind of emergency?

Medical, fire, or security?

Where is help needed?

Building, floor, room number, name, phone number.

Who needs help?

Adult, child, neonate? Inpatient?

If there is ever doubt about which team to call, call the Adult Code Team for an adult patient and the Pediatric Rapid Response team for a child.

Which emergency team is needed?

- Medical emergency (Code team)
- Urgency (RRT)
- Adult Difficult Airway Response Team (DART),
- Pediatric Difficult Airway Response Team (pDart)
- Pediatric patients (Pediatric RRT—same team responds to code calls and RRT calls)

Activating Rapid Response Teams

Introduction

Here are important answers to questions about the JHH Rapid Response Teams. Click on each question below.

- What are the suggested criteria for activating Adult RRT calls?
- Who should activate the Adult Rapid Response Team?
- What are the suggested criteria for activating Pediatric RRT calls?
- Who should activate the Pediatric Rapid Response Team?
- When and how should the Neonatal Rapid Response Team be called?
- When do I activate an Adult or Pediatric Difficult Airway Response Team (DART)?
- How do I activate a DART call?

Activating Rapid Response Teams

Introduction

What are the suggested criteria for activating Adult RRT calls?

- General concern (from patient, family or staff) that the individual "just doesn't look or feel right"
- Change in mental status and/or level of consciousness
- HR <45 or >130
- Systolic blood pressure <85 or >200 mmhg
- RR <8 or >30
- O2 saturation <90% despite 60% O2
- New seizure or prolonged seizure
- In Neuroscience population, Na+ <130 or >155

Who should activate the Adult Rapid Response Team?

What are the suggested criteria for activating Pediatric RRT calls?

Who should activate the Pediatric Rapid Response Team?

PREV NEXT

Activating Rapid Response Teams

Who should activate the Adult Rapid Response Team?

- Any staff member can activate the adult RRT
- Patients and families should be encouraged and educated to seek assistance if the patient's condition changes or worsens
- In Adult units, the RN can assist the patient and family with the notification of the appropriate RRT team

What are the suggested criteria for activating Pediatric RRT calls?

Who should activate the Pediatric Rapid Response Team?

When and how should the Neonatal Rapid Response Team be called?

When do I activate an Adult or Pediatric Difficult Airway Response Team (DART)?

How do I activate a DART call?

Activating Rapid Response Teams

What are the suggested criteria for activating Pediatric RRT calls?

- General concern (from patient, family or staff) that the individual "just doesn't look or feel right"
- Change in mental status and/or level of consciousness
- Worsening respiratory status (e.g., significant change in respiratory pattern and rate, increased oxygen requirements, decreased saturations)
- O2 saturation <90% despite 60% O2 supplementation (if no cyanotic heart disease)
- Seizure with apnea
- Circulatory compromise (e.g., hypotension, poor perfusion, decrease in urine output)
- Administration of the following drugs:
  - Adenosine
  - Emergent load of amiodarone
  - Intra-muscular Epinephrine
  - Flumazenil
  - Naloxone
  - Insulin for treatment of hyperkalemia
  - Hypertonic saline
  - Glucagon
  - Emergent use Mannitol
- Acute pain not resolved with current resources

Who should activate the Pediatric Rapid Response Team?

PREV NEXT

Activating Rapid Response Teams

Who should activate the Pediatric Rapid Response Team?

- Pediatric RRT responds to both urgent (RRT) and emergent (code) situations
- Any staff or family member can activate the pediatric RRT
- Families should be encouraged and educated to seek assistance if their child's condition worsens
- Families can directly activate the Pediatric RRT Team
- Directions for activating the team are posted in all pediatric patient rooms or they can ask their RN for assistance

REMEMBER: Pediatric RRT responds to both urgent (RRT) and emergent (code) situations.

When and how should the Neonatal Rapid Response Team be called?

When do I activate an Adult or Pediatric Difficult Airway Response Team (DART)?

Activating Rapid Response Teams

Who should activate the Pediatric Rapid Response Team?

When and how should the Neonatal Rapid Response Team be called?

- This team would get called anytime a baby is being born outside of the delivery room.
- The Neonatal RRT responds to both urgent (RRT) and emergent (code) situations in newly born infants.
- This team is not for other infants or children who are covered by the Pediatric RRT.
- Activate the Neonatal RRT by calling 5-4444 (or 410-955-4444) and letting the dispatcher know that you have a newborn infant that requires the Neonatal RRT.

When do I activate an Adult or Pediatric Difficult Airway Response Team (DART)?

How do I activate a DART call?

Activating Rapid Response Teams

When and how should the Neonatal Rapid Response Team be called?

When do I activate an Adult or Pediatric Difficult Airway Response Team (DART)?

These teams are used for emergency airway situations such as:

- A patient who cannot be ventilated following standard intubation algorithms or loss of airway (e.g., failed intubation attempts, self-extubation on patient with a difficult airway band)
- Known or suspected difficult airways (e.g., patients with a short, thick neck, severe obesity, prior neck surgery or tumor, receding jaw, and facial trauma, craniofacial surgery or abnormalities)
- Bleeding compromising airway visualization
- Any procedure where maintenance of an airway may be compromised

The teams use special equipment and/or can provide a surgical airway if needed, **and are activated by a single call.**

Do not confuse the DART team with the "Anesthesia Only" calls made by the ICUs and EDs. They are not the same thing!

PREV NEXT

Activating Rapid Response Teams

How do I activate a DART call?

EARLY ACTIVATION OF THE TEAM IS THE KEY TO ITS SUCCESS:

- Call 5-4444 to activate a team. Tell them you need the Adult DART or Pediatric pDART.
- If the initial intubation is unsuccessful during any emergent airway situation, nursing staff can prompt the responding provider by asking, “Do you want me to call the DART or pDART Team?”
- If a patient arrests in non-ICU areas or procedural areas and has a **known difficult airway**, request the DART Team at the same time as the Code Team.
- For ICU patients with a known difficult airway requiring emergent intubation, request the DART team or pDART.

A FEW KEY REMINDERS:

- Each area needs to know if they are required to retrieve a cart during an airway emergency, or if it will be delivered to their area by one of the units housing a cart (check the **Difficult Airway Response Team Policy, Appendix C**)
- When a cart is used, palace the patient’s I. D. on the DART Cart Count sheet (for infection control tracking purposes)
- Some areas have airway carts on their units- the nursing staff in those areas should verify that the cart is not expired, that the locks are intact, that they match the lock numbers on the Dart Airway Count Sheet and Tracking Sheet. Any issues, use the number posted on the cart to page the Critical Care Technologist

PREV NEXT

Stroke Care at JHH

TIME IS BRAIN SO KNOW THE SIGNS and ACT IN TIME

What are the Signs and Symptoms of a Stroke?

Warning Signs

- Sudden onset of numbness or weakness
- Sudden onset of confusion or difficulty speaking
- Sudden onset of vision loss
- Sudden onset of dizziness or imbalance
- Sudden onset of severe headache

How to Activate the Brain Attack Team (BAT)

- Outside of hospital, call 911.
- Within JHH in a Clinical area:
  - Contact the BAT and the Primary Team **immediately** at x5-9444
  - All others and JHOC immediately call the Code Team at x5-4444
- Within JHH in a non-clinical area:
  - Call x5-4444 to activate the Code Team

Note: If the BAT Team is delayed in responding **(longer than 6 minutes)**, please contact HAL again at x5-9444. Ask to speak with the Stroke Attending on call.

Primary team should start the “tPA initial eval” order set in the electronic medical record.

Activation Summary

Situation	Appropriate Team	Important Note
Adult Patients from outpatient, testing, and procedure areas **Adult Visitors, Parents, or Staff** who need emergent help (even in the Children's Center)	**ADULT CODE TEAM** responds to medical emergencies	Note: JHOC has their own Ambulatory Code/RRT Team
Adult Patients in need of urgent medical assessment and/or intervention, but not an imminent threat to life	**ADULT RRT**	• Used in inpatient areas only • Imminent threat to life use Adult Code Team
Pediatric Patients	**PEDIATRIC RRT** for both rapid response and codes	Make sure to specify that you have a pediatric emergency and request the Pediatric RRT.
Neonatal Patients (any delivery outside of the delivery room)	**NEONATAL RRT**	
Stroke Signs and Symptoms	**BRAIN ATTACK TEAM**	
Emergency Airway Situations	• **ADULT DIFFICULT AIRWAY RESPONSE TEAM** (DART) • **PEDIATRIC DIFFICULT AIRWAY RESPONSE TEAM** (pDART)	Ensures airway experts, information, and equipment are immediately available for the management of difficult airway patients.

The Johns Hopkins Hospital Stroke Center

- Stroke is the nation's fourth leading cause of death.
- Currently the Johns Hopkins Hospital (JHH) is designated as a Joint Commission and Maryland Institute for Emergency Medical Services Systems (MIEMSS) Comprehensive Stroke Center.
- Stroke education is an important mission of the center. Early recognition of stroke symptoms is imperative so the patient is treated promptly.
- Brain Attack Teams have been established to emergently treat patients with stroke.

Signs and Symptoms of Stroke

It is important to recognize these sudden changes which may indicate stroke:

- Numbness or weakness of face, arm or leg
- Confusion, trouble speaking or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

Stroke

- If signs and symptoms of stroke are present outside of the hospital, call 911 immediately.

Brain Attack Team

- In the event the patient has signs and symptoms of stroke within a JHH non-clinical area (e.g., hospital lobby, cafeteria, or Outpatient Center), call x5-4444.

Brain Attack Team

- In the event the patient has signs and symptoms of stroke within a JHH clinical area, contact the BAT and Primary Team **immediately**.
- TO NOTIFY THE BRAIN ATTACK TEAM (BAT), call HAL (Hopkins Access Line) at x5-9444.
  - If the BAT Team is delayed in responding (longer than 6 minutes), please call the HAL Line <u>again</u> at x5-9444, and ask to speak with the Stroke Attending on call.

Summary

- TIME IS BRAIN SO KNOW THE SIGNS AND ACT IN TIME.

Impairment in the Workplace

Overview

Risk Factors and Background Indicators

- Family history of addiction
- History of frequent job changes
- Jobs with limited supervision
- Prior medical history
- Home/family problems

Signs and Symptoms on The Job

Job performance changes:

1. Attendance issues such as absenteeism or tardiness
2. Job shrinkage/getting less done
3. Inability to meet deadlines
4. Illogical or sloppy documentation
5. Excessive errors in judgment in patient care decisions
6. Increased on the job injuries
7. Increased patient complaints
8. Changes in behavior with colleagues, staff, patients
9. Changes in personal hygiene

Additional Signs and Symptoms

Personality changes

- Irritability
- Withdrawal
- Mood swings

Behavioral changes

Mental status changes

Physical changes

Social changes

- Increased isolation
- Decreased interest in outside activities

Overview of Managing Narcotics

- Substance abuse among healthcare professionals is a problem in the U.S.
- Access to prescriptive medications make use and abuse an issue.
- Report rates vary from:
  - ANA reports 6% - 8% rate
  - Other rates reported as high as 32% with emergency, oncology and administrative nurses at the high end.
  - Others report 10% per the job force as a whole

Requirements for Achieving Narcotic Safety

Regulatory Requirements

- Chain of custody
  - Requires a trail from delivery to administration
- Required by law to report loss of narcotics
  - Includes theft and prescription fraud

Policy and Procedures

Operational policies direct personnel to handle controlled substances in a manner that reduces temptation and ease of diversion

Oversight and supervision by managers

- Recognize signs and symptoms of impairments
- Assess practice in the current work environment
- Make the practice environment safe for staff to report concerns early

Technology

Automated dispensing machines (ADMs)

Responsibility of staff members

- Report concerns of impairment in peers
- Follow narcotic control policies

Signs of Diversion Activity

- Charting errors and omissions increase
- Patients complain of unresolved pain during the employee's shift
- Patients may have more documented PRN pain medication during an employee's shift
- RN volunteers to take patients with prescribed pain medications
- Has excessive waste or has no waste of narcotic
- No orders for documented narcotic medications
- May arrive at work outside of scheduled hours

Help and Resources

If you have concerns about a co-worker or staff member, report this using your chain of command. Remember to keep this information confidential.

Organizational resources:

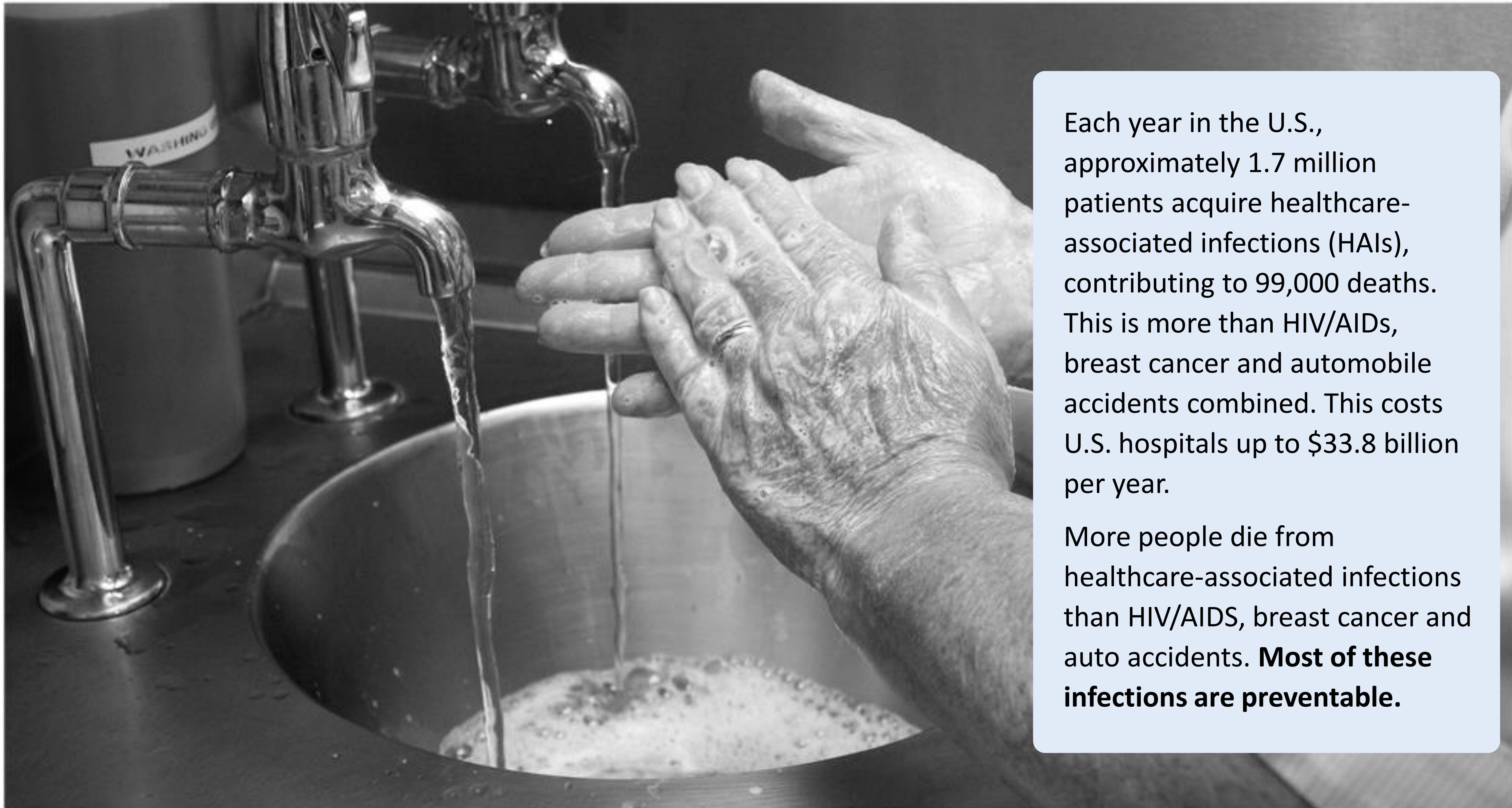
- **FASAP: 443-997-7000**
- **Compliance Reporting Line: 1-877-We Comply (1-877-932-6675)**
- **NPAC (Nursing Professional Assistance Committee): 410-614-2961**

  Support for depression, anxiety and other mental health issues; alcohol, substance abuse and other addictions; grief and loss; family and relationship difficulties; adjusting to physical illness and disability
- **RISE Team (Resilience in Stressful Events): Page 410-283-3953**

  Free, confidential peer support program available 24/7 during or after stressful patient-related events

You have a legal and ethical obligation to report.

Infection Prevention and Control



Each year in the U.S., approximately 1.7 million patients acquire healthcare-associated infections (HAIs), contributing to 99,000 deaths. This is more than HIV/AIDs, breast cancer and automobile accidents combined. This costs U.S. hospitals up to $33.8 billion per year.

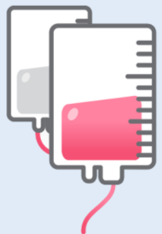
More people die from healthcare-associated infections than HIV/AIDS, breast cancer and auto accidents. **Most of these infections are preventable.**

Hospital-Associated Infections (HAIs)

In the U.S., if you are admitted to a hospital, you have a 5% chance of contracting an HAI

2 million people per year get an HAI during a hospital stay

Of these, **>99,000** people die annually from HAIs



30% of Intensive Care Unit patients develop an HAI

$28-33 billion per year in healthcare costs

Hand Hygiene Prevents the Spread of Disease–1

Waterless Hand Sanitizers (Purell)

When to Use

- Upon entering & leaving a patient's room/environment
- Between patients
- Before & after using gloves
- When moving from a contaminated to a clean body site
- Before & after handling an invasive device
- After contact with body fluids, excretions, mucous membranes, non-intact skin or contaminated items
- Before handling food or oral medications
- As needed after coughing or sneezing

How to Sanitize Hands

Dispense a thumb-sized amount of sanitizer into the palm and briskly rub over all surfaces of both hands until dry.

Use only hospital-approved skin lotion to main skin integrity. No artificial nails; no chipping fingernail polish; natural nails less than ¼ inch long.

Hand Hygiene Prevents the Spread of Disease–2

Soap and Water

When to Use

- Before eating
- After using the restroom
- Anytime hands are visibly soiled
- After caring for patients with spore-producing organisms (For example: *Clostridium difficile or Norovirus)*
- When there is significant build-up of waterless hand sanitizer

How to Wash

- Wet hands with water
- Apply soap
- Vigorously rub together all surfaces of both hands for 15 seconds
- Thoroughly rinse hands under a stream of water
- Dry hands with a paper towel
- Turn off faucet using a paper towel

We Take Hand Hygiene VERY Seriously

Person observed not practicing hand hygiene?

- Feedback from observer
- Recorded in accountability database
- Reported to Manager/FUD/Department Chair by email
- Manager/FUD/Department chair determines appropriate action for 1st offense
- Increasing levels of action after 1st offense
- **Suspension or termination** on 5th offense

Standard Precautions and Why They Matter

Treat all blood and body fluids as though potentially infectious. Apply Standard Precautions to all patients to protect yourself.

Perform hand hygiene before and after patient care (remind yourself of the moments for hand hygiene).

If touching blood, body fluids, secretions, excretions, and/or contaminated items is likely, wear gloves.

If your clothing might be contaminated during procedures and/or during patient care, use a gown.

If sprays/splatters are possible, add a fluid shield mask with eye protection.

Transmission-Based Precautions

Apply Transmission-Based Precautions to patients who are known/suspected to be colonized/infected with multidrug resistant organisms (MDROs) & other epidemiologically significant organisms. See the chart below for each type of precaution. Remember, Standard Precautions still apply.

Contact Precautions
(e.g., MRSA, VRE, or C. difficile)

Droplet Precautions
(e.g., Influenza or Respiratory syncytial Virus)

Airborne Precautions
(e.g., tuberculosis, measles, shingles/ chickenpox)

Tuberculosis

The Basics

At-risk Populations:
People who are HIV positive, homeless, incarcerated, immunocompromised or from countries with a high-incidence of tuberculosis.

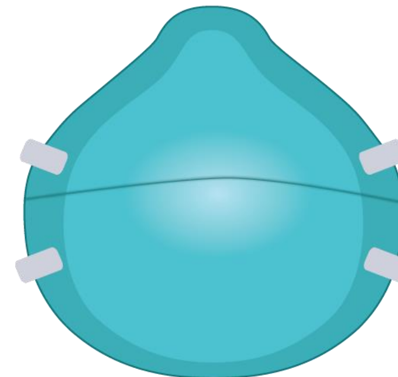
Signs and Symptoms:
Cough, new infiltrate, fever, night sweats, weight loss, hemoptysis, and/or fatigue.

Policies

- Annual TB Testing is required for all Hopkins' employees engaged in patient care or who enter patient care areas.
  TB Hospital Policy
- Only HEIC can remove a patient from airborne precautions,
  call: 5-8384
  pager: 410-283-3855

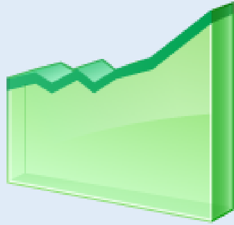
Infection Control Strategy:
Place the patient on airborne precautions upon admission.

Negative pressure room, PAPRs or Fit-tested N95 respirator



Provide surgical mask (not PAPR) to the patient if out of his/her room

About Flu and Respiratory Viruses



Epidemics of influenza and RSV occur each winter. Influenza alone causes ~36,000 deaths and >200,000 hospitalizations annually.

Timing is variable so surveillance is conducted to determine when to institute prevention and control measures.

The Respiratory Virus Policy (IFC022) provides guidance on prevention and control measures.

Additional information relevant to the specific season is posted on the HEIC website.

Prescription for Preventing the Spread of Respiratory Viruses

To keep yourself healthy and to prevent the spread of respiratory viruses to and between your patients, follow this prescription.

℞

1. Receive influenza vaccine each year. It is available free of charge from Occupational Health. Influenza vaccination is mandatory for all staff.
2. Stay home if you have a fever and respiratory symptoms. You must be cleared by Occupational Health before returning to work.
3. Cough or sneeze into your sleeve.
4. Wear a mask for patient care if you have respiratory symptoms but no fever.
5. Always practice good hand hygiene.

The Path For Patient Care

START HERE

You must assess all inpatients and ED patients for respiratory viruses.

Respiratory testing varies for immunocompromised and immunocompetent patients.

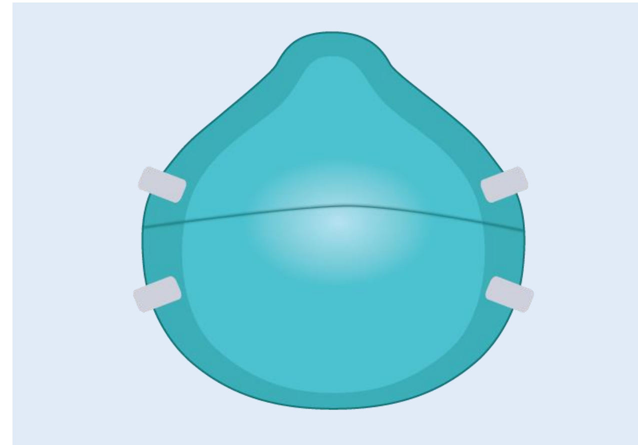
Patients suspected of having a respiratory virus must be placed on droplet precautions and tested.

All patients who test positive for Influenza, RSV, Adenovirus, Parainfluenza, rhinovirus or Human Metapneumovirus must remain on droplet precautions until asymptomatic. Some patients also require a negative test.

Call HEIC to remove patients from droplet precautions.

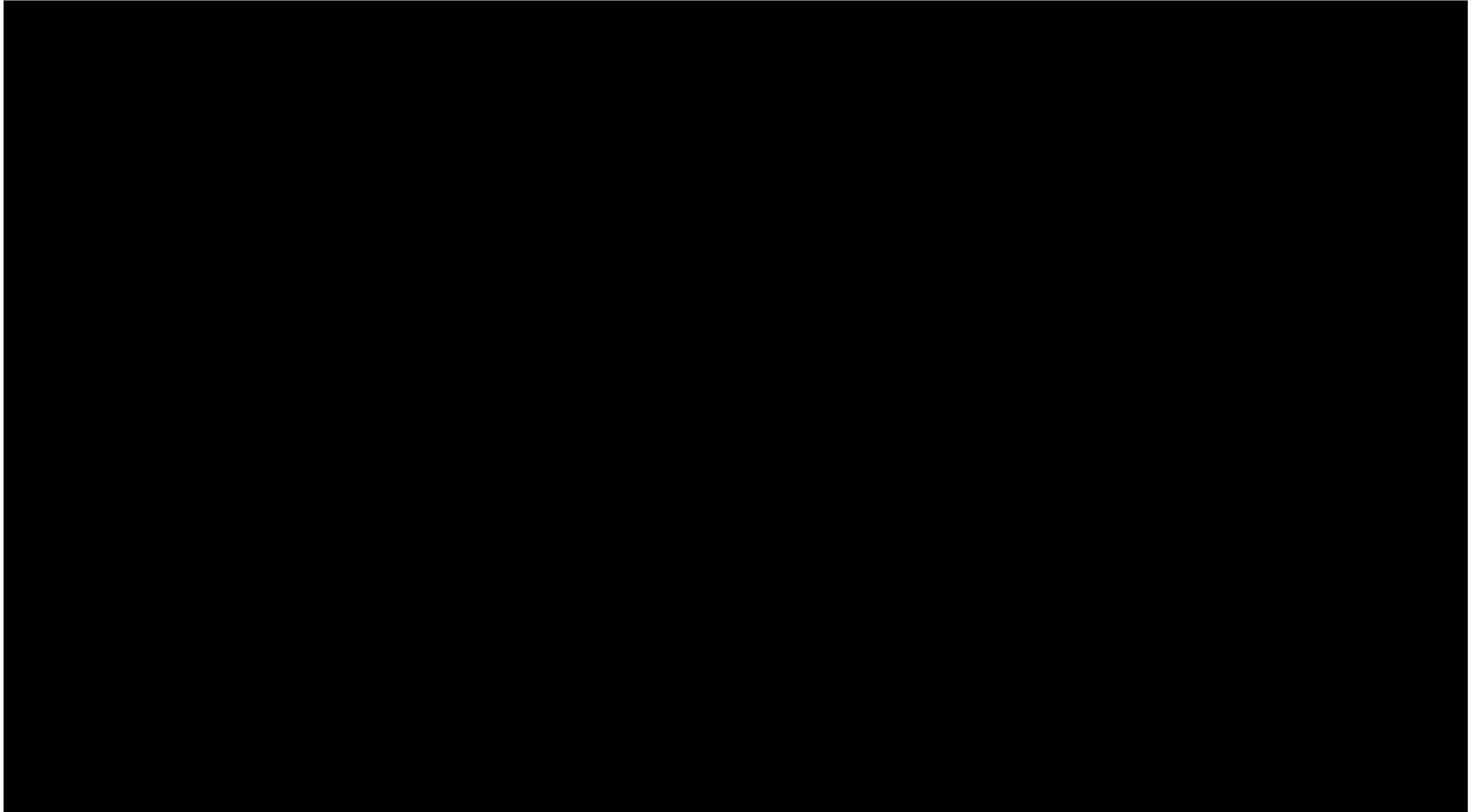
PAPR and N95

PAPR


N-95

- Respirators, such as PAPRs (Powered Air Purifying Respirators) and N-95s, are used in the hospital to protect staff from exposure to airborne infectious agents, like TB, and from aerosolized drugs, like Ribavirin.
- The decision to use N-95s is unit specific; check with your Nurse Manager for more information. Staff using N-95s must be fit-tested annually. Fit-testing is scheduled with HSE via the Nurse Manager.
- In the Outpatient Center, PAPRs and Hepa filters are stored on JHOC 2nd floor, room 2084, near the Administration suites.

Training on Use of the PAPR



Click the play button. This video will provide your annual training on the use of the PAPR.

You are required to watch the entire video before moving to the next slide.