# TRAIN FOR SUCCESS INC.
# PROFESSIONAL CONDUCT AND CODE OF ETHICS 10 HR

Professional conduct and Code of Ethics 10 Hr

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## PURPOSE:

The purpose of this course is to provide a review of ethical – code of conduct, standards and practices to assist individuals in developing and maintaining the highest level of ethical decision-making skills, to continue to provide care and services as a desirable model, implementing strategies for effective communication, strategies to manage communication issues in the workplace, specific ways to integrate effective interpersonal communication skills in the day to day decision making, appropriate and accurate Documentation; reviewing documentation guidelines that are required in the clinical settings as well as other sites where patient care is being done. The course is designed for Nurses: LPN, RN, ARNP and other the health care professionals, Occupational Therapists, Physical Therapists, Massage Therapist, Guardians, Certified Nursing Assistants (CNA), Home Health Aid (HHA) as well as other individuals and students.

## OBJECTIVES

At the end of this course, the reader will be able to:

1. Discuss principles of the Code of Ethics
2. Discuss ethical issues in the workplace
3. Define ethical behavior for the healthcare team and other Professionals.
4. Describe the role of the professionals in the ethical practice of health care
5. Describe ethical decision making skills
6. List specific ways to integrate ethical considerations in the day-to-day decision-making.
7. Discuss strategies for effective communication.

8. Discuss principles of the effective communication

9. Discuss strategies to manage communication issues in the workplace

10. Describe the forms of communication

11. List specific ways to integrate effective interpersonal communication skills in the day to day decision making.

12. Describe the importance of completing accurate and complete documentation within the patient's medical record

13.Discuss the Health Insurance Portability and Accountability Act, Privacy Rule.

14. Describe various factors to consider in documentation.

# Unprofessional Conduct

According to 64B9-8.005 of the F.A.C. unprofessional conduct shall include:

(1) Inaccurate recording;

(2) Misappropriating drugs, supplies or equipment;

(3) Leaving a nursing assignment without advising licensed nursing personnel;

(4) Stealing from a patient;

(5) Violating the integrity of a medication administration system or an information technology system;

(6) Falsifying or altering of patient records or nursing progress records, employment applications or time records;

(7) Violating the confidentiality of information or knowledge concerning a patient;

(8) Discriminating on the basis of race, creed, religion, sex, age or national origin, in the rendering of nursing services as it relates to human rights and dignity of the individuals;

(9) Engaging in fraud, misrepresentation, or deceit in taking the licensing examination;

(10) Impersonating another licensed practitioner, or permitting another person to use his certificate for the purpose of practicing nursing;

(11) Providing false or incorrect information to the employer regarding the status of the license;

(12) Practicing beyond the scope of the licensee's license, educational preparation or nursing experience;

(13) Using force against a patient, striking a patient, or throwing objects at a patient;

(14) Using abusive, threatening or foul language in front of a patient or directing such language toward a patient.

(15) Accepting a gift from a patient the value of which exceeds the employer's policy regarding gifts.

(16) Knowingly obtaining or using or attempting to obtain or use a patient's property with the intent to temporarily or permanently deprive the patient of the use, benefit or possession of the funds, assets or property, or to benefit someone other than the patient.

## ETHICS- RULES OF CONDUCT

Ethics - defined as rules of conduct; the branch of philosophy that deals with morality. Ethics is concerned with distinguishing between good and bad in the workplace, schools and overall in the society / in the world. Ethics involves distinguishing between right and wrong human actions, and between virtuous and non-virtuous characteristics of individuals.

Ethics involves moral principles that govern an individual's behavior or a group's conduct or behavior. All professionals, Nurses: License Practical Nurses, Registered Nurses, Advanced Registered Nurse Practitioners, and other the health care professionals, Occupational Therapists, Massage Therapists, Certified Nursing Assistants (CNA), and Home Health Aid (HHA) need to follow the ethical principles and code of ethics that are in place.

Ethics provides a guideline or a set of standards for behavior that assists the individuals to decide how he/ she behave or conduct themselves in various situations. Ethics involves making choices or decisions and provides reasons why individuals should make these choices.

# PRINCIPLES OF ETHICS

The Principles of Ethics are model standards of exemplary, flawless, professional behavior /conduct that should be demonstrated by all professionals; representing the best.

# PROFESSIONAL RELATIONSHIPS

In all professional relationships, work and /or services should be practiced with compassion, recognizing human dignity and value that is present in each client, co-worker/ each individual. All professionals need to maintain the highest regard for the standards of one's profession/ position and;

Avoid actions that are based on prejudice,

Avoid behavior/ actions that are threatening of others,

Avoid actions that brings harassment to others,

Provide fair treatment to others, and

Maintain relationships that are caring.

## RESPECT FOR HUMAN DIGNITY

Respect for human dignity requires that the professional is aware of, acknowledge and understands that the clients/patients have specific rights (will review later in this course).

## HONESTY

Honesty is the quality of being honest,

Honesty reflects uprightness of character or action,

Honesty means being trustworthy, fair, loyal and sincere,

Honesty implies a refusing to lie, steal, or deceive in any way,

Fairness or uprightness of character or actions,

Honesty reflects a part of one's moral character and reflects positive, virtuous attributes for example:  truthfulness, integrity, and straight forwardness.

## PROVIDING CARE/ SERVICES

In the provision of care and services, the professionals should respect the beliefs, values and customs of each individual, the family and community.

## RELATIONSHIPS TO CLIENTS/PATIENTS

The professional establishes therapeutic relationships with the clients/ patients and administers care and services taking into consideration the individuals' lifestyle, religious beliefs and values. Effective communication should always be employed to ensure that the clients / patients' needs are met at optimum levels of care.

## RESPECT VALUES AND BELIEFS

The professionals should always respect the values and beliefs of the clients/ patients and avoid enforcing their personal values and beliefs on the clients/patients.

Regarding:

THE NATURE OF THE /PATIENTS/ CLIENTS STATUS

HEALTH PROBLEMS

SOCIAL STATUS

ECONOMICAL STATUS

The professional does not allow the functional status of the clients/ patients, diagnosis or any disabilities to determine the client's/patient's worth.

The professional also respects the clients' rights, dignity, and values regardless of their socio-economic status.

## RESIDENTS' RIGHTS

Rights are often defined as legal, ethical or social principles of entitlement or freedom; which involves normative rules about what is allowed of people or what is owed to people or a legal or moral entitlement to obtain or have something or to act in a certain way.

Within the nursing home setting, residents' rights are the moral and legal rights of the residents of a nursing home. There are legislations that exist in various jurisdictions to help to protect such rights. In 1980 the Florida statute was enacted to protect such rights; Florida statute 400.022, commonly known as the Residents' Rights Act.

All individuals who work with residents must be aware of the rights of the resident, so that they can adhere to the legal /ethical principles, respect the residents' rights and also follow the standards of practice.

(See your State Resources on website for more information)

FLORIDA STATUTES 400.022 RESIDENTS' RIGHTS — NURSING HOMES AND RELATED HEALTH CARE FACILITIES states that:

(1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights.

(b) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened correspondence, access to a telephone, visiting with any person of the resident's choice during visiting

hours, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, outof-town visitors and working relatives or friends.

Unless otherwise indicated in the resident care plan, the licensee shall, with the consent of the resident and in accordance with policies approved by the agency, permit recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy access to the facility during visiting hours for the purpose of visiting with and providing services to any resident.

(c) Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident. The resident has the right to deny or withdraw consent to access at any time by any entity or individual. Notwithstanding the visiting policy of the facility, the following individuals must be permitted immediate access to the resident:

1. Any representative of the federal or state government, including, but not limited to, representatives of the Department of Children and Families, the Department of Health, the Agency for Health Care Administration, the Office of the Attorney General, and the

Department of Elderly Affairs; any law enforcement officer; any representative of the State Long-Term Care Ombudsman Program; and the resident's individual physician.

2. Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident.

The facility must allow representatives of the State Long-Term Care Ombudsman Program to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law. (d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to

governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal.

This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents.

(e) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents.

(f) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents.

(g) The right to examine, upon reasonable request, the results of the most recent inspection of the facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility.

(h) The right to manage his or her own financial affairs or to delegate such responsibility to the licensee, but only to the extent of the funds held in trust by the licensee for the resident. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident or the person responsible for the resident. The facility may not require a resident to deposit personal funds with the facility. However, upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

1. The facility must establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

2. The accounting system established and maintained by the facility must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

3. A quarterly accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident.

4. Upon the death of a resident with personal funds deposited with the facility, the facility must convey within 30 days the resident's funds, including interest, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, or, if a personal representative has not been appointed within 30 days, to the resident's spouse or adult next of kin named in the beneficiary designation form provided for in s. 400.162(6).

5.The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

(i) The right to be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility.

(j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.

(k) The right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide

informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1).

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter.

Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice.

A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes.

Admission to a nursing home facility operated by a licensee certified to provide services under Title XIX of the Social Security Act may not be conditioned upon a waiver of such right, and any document or provision in a document which purports to waive or preclude such right is void and unenforceable. Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver from a resident or potential resident shall be construed to have violated the resident's rights as established herein and is subject to disciplinary action as provided in subsection (3). The resident and the family or representative of the resident shall be consulted in choosing another facility.

(q) The right to freedom of choice in selecting a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act; and to obtain information about, and to participate in, community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record.

If a resident chooses to use a community pharmacy and the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides

service delivery, and stocks the drugs normally used by long-term care residents. If a resident chooses to use a community pharmacy and the facility in which the resident resides does not use a unitdose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents.

(r) The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician. If clothing is provided to the resident by the licensee, it shall be of reasonable fit.

(s) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents.

(t) The right to receive notice before the room of the resident in the facility is changed.

(u) The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement.

Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it is medically determined by the agency that the resident will not need it or will not be able to return to the nursing home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization.

(v) For residents of Medicaid or Medicare certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under 42 C.F.R. s. 483.12.

(2) The licensee for each nursing home shall orally inform the resident of the resident's rights and provide a copy of the statement required by subsection (1) to each resident or the resident's legal representative at or before the resident's admission to a facility. The licensee shall provide a copy of the resident's rights to each staff member of the facility. Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section. The written statement of rights must include a statement that a resident may file a complaint with the agency or state or local

ombudsman council. The statement must be in boldfaced type and include the telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the numbers of the local ombudsman council and the Elder Abuse Hotline operated by the Department of Children and Families.

(3) Any violation of the resident's rights set forth in this section constitutes grounds for action by the agency under s. 400.102, s. 400.121, or part II of chapter 408. In order to determine whether the licensee is adequately protecting residents' rights, the licensure inspection of the facility must include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards and consultation with the State Long-Term Care Ombudsman Program.

(4) Any person who submits or reports a complaint concerning a suspected violation of the resident's rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint shall have immunity from any criminal or civil liability therefor, unless that person has acted in bad faith, with malicious purpose, or if the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party (See your state for more information).

All professionals have to make sure that they are aware of these rights and provide care / services to the clients/ patients, ensuring that the rights of the clients/ patients are being honored and there are no violations.

# COMMUNICATION

Communication is defined as the act or process of using words, sounds, signs, or behaviors to exchange or express information or to express ones thoughts, ideas and feelings to someone else or a message that is given to someone such as in telephone call or in a letter.

**TYPES OF COMMUNICATION**

1. Non-Verbal communication.
2. Written communication.
3. Verbal (Oral) communication.

(1) Verbal communication - you listen to individuals to understand their meaning

(2) Written communication - you read their meaning

(3) Nonverbal communication - you observe others and infer meaning.

## COMMUNICATION WITHIN THE WORK ENVIRONMENT

Effective communication in the workplace can:

➢ Increase employees' knowledge and awareness of a health issue, problem, or solution

➢ Influence beliefs, perceptions, and attitude

➢ Increase employees' knowledge of a problem or solution

➢ Reinforce beliefs, perceptions, and attitude

➢ Refute myths

➢ Illustrate health promoting skills

➢ Refute misconceptions

➢ Prompt action

➢ Demonstrate health promoting skills

➢ Show the benefits of behavior change

➢ Strengthen organizational relationships

➢ Realign the social rules or standards for workplace behavior.

## COMMUNICATION WITH CLIENTS/ PATIENTS

Interpersonal skills are very important in establishing and maintaining an effective and productive and rewarding relationship with the clients/patients.

## EFFECTIVE INTERPERSONAL RELATIONS

Effective interpersonal relationships involve:

Maintaining open communication,

Being a good listener

Being honest

Being sincere

Being courteous,

Being patient

Being hopeful.

Developing trusting and supportive relationships with clients/ patients by being trustworthy and supportive.

Encouraging clients/ patients to express their feelings.

Respect each client/ patient as a unique individual with their own behavior patterns.

## APPROPRIATE STEPS TO STARTING A CONVERSATION

If the client/patient is in a private room with door closed, knock on the door before entering.

Identify yourself by name and title and greet client/ patient by their name.

Greet the client/patient in a courteous manner

Approach the client/patient in a calm manner.

Explain what you are going to do.

Explain the procedure to the client/ patient

Encourage the client/ patient to participate as needed.

## SPEAKING/ ATTENTIVE LISTENING

It is recommended that you get the client's /patient's attention before speaking.

Always use courtesy when you are communicating.

Use normal tone of voice and adjust your volume to the individual client's/ patient's needs.

Listen and respond appropriately to the clients/ patients

Keep conversations brief and concise

Avoid using slang while communicating.

Speak slowly (avoid the rush tone)

Avoid mumbling and speak clearly

Employ positive messages by using praise, encouragement, smiles and other methods that are acceptable to the client/ patient.

Your verbal and nonverbal message should match

Be attentive and listen to what the client/ patient is saying.

Give/ receive feedback and/or request feedback as appropriate to make sure the communication is understood.

## AVOID BARRIERS TO CONVERSATION

Avoid discussing or talking about your own personal problems and the problems of other patients or co-workers with the client/patient.

Avoid expressing your own opinions if it involves passing judgment

Avoid interrupting the clients/ patients when they are speaking

Avoid changing the subject.

Avoid personal phone calls while client/patient is speaking with you.

## COMMUNICATING WITH CLIENTS / PATIENTS WITH HEARING LOSS (HARD OF HEARING)

Avoid startling the client/ patient.

Stand comfortably close to the client/ patient in a good light and face him/her while you are speaking.

Speak at a normal or only slightly increased volume, so that you avoid shouting.

Write down key words if necessary or use other communication assistive devices such as communication boards if applicable.

Utilize short words and sentences.

Always clarify client's/ patient's understanding and rephrase message if applicable.

Eliminate as much as possible, any distracting background noise and /or activity.

Assist the client/ patient to use a hearing aid as applicable.

If the client/ patient hears better in one ear, then stand on the preferred side.

Speak slowly and distinctly/ clearly.

Avoid chewing gum or covering your face with your hands while speaking.

Avoid conveying negative messages by the tone of voice or even by your body language.

If the client/ patient use sign language, try to locate an individual who knows sign language to interpret.

## COMMUNICATING WITH CLIENTS/ PATIENTS WITH LOSS OF VISION

Always identify self by name and title as you enter room to avoid startling the client/ patient.

Encourage and assist patient to keep glasses clean and to wear them (as applicable).

Ensure there is good light in the room and face client/ patient when you speak.

Speak in a normal tone of voice.

Give explanations of what you will be doing and what is expected of the client/ patient.

Clarify client/ patient's understanding as appropriate.

Remember not to rearrange the environment without the client's/ patient's knowledge.

If rearrangement is necessary, always replace items to their original location in the client's /patient's room.

Always inform the client/ patient when you are finished and when you are leaving.

## COMMUNICATING WITH PATIENTS WHO HAVE PROBLEMS WITH SPEECH /SPEAKING

Try to keep conversation short as much as possible.

Ask direct questions if client/ patient can answer - Yes or No.

If you are unable to understand the words or uncertain, validate what you think the patient is saying.

Allow the client /patient adequate time to respond.

Employ attentive listening (listen carefully).

Emphasize positive aspects.

Take the time and complete every conversation, to avoid conveying any impatience.

Assist the client /patient to point, write or use assistive devices for communication for example word boards or picture board as appropriate.

Encourage the client /patient to nod as appropriate.

Monitor body language to make sure you are not giving negative messages.

## NON-VERBAL COMMUNICATION

Non- verbal communication is also an important aspect of communication. Gestures, nodding of head, waving of hand all convey a message; therefore, it is vital for the professionals to be aware that effective non-verbal communication is also needed while working with the clients/patients and other colleagues.

**Non- verbal communication has several functions:**

Non- verbal communication is sometimes a substitute for verbal message such as gestures or facial expressions.

Non- verbal communication is frequently used to accent verbal messages.

Non- verbal communication is sometimes used to repeat the verbal message for example pointing in a direction while giving directions.

Non- verbal communication often complements the verbal message.

Non- verbal communication often regulates interactions for example non-verbal cues may indicate when the other person should respond or not respond.

## CONFLICT OF INTEREST

Conflict of interest may be frequently encountered while working with or providing services to clients/ patients. The professional should not exploit the client/ patient for any kind of personal gain.

All professionals have to consider their personal beliefs/values, the beliefs/ values of the clients/ patients and others who are involved while they are providing care /services.

Whenever you are guiding the clients/ patients in making decisions, you have to consider the beliefs/ values of the clients/ patients and make sure that the clients/patients' values are honored.

## CONFLICT / TEAM BUILDING

Conflicts may also arise among members of the team. Some ways to form a collaborative work relationship and a strong and effective team with diverse members of the team is by:

Setting expectations

Providing guidance

Providing supervision

Defining responsibilities of each members of the team

Communicating the expectations to each member of the team so they are aware of what they are accountable for.

Meeting regularly to keep the lines of communication open

Meeting as needed to address any team-building issues that exist.

Strengthening work relationships; staff appreciation group awards etc.

Meeting regularly to find out if they have any concerns or issues that needs to be addressed

Meeting regularly to assess personal development

Meeting regularly to develop future goals.

# TYPES OF CONFLICTS

o Intrapersonal conflict

o Interpersonal conflict,

o Intragroup conflict,

o Intergroup conflict.

**Intrapersonal conflict**

o Intrapersonal conflict occurs within the individual (within the mind).

Interpersonal conflict

o Refers to conflict which occurs between two people.

Intragroup conflict

o Intragroup conflicts refers to conflicts that happens among individuals within the group

Intergroup conflict

Intergroup conflict refers to conflicts that take place among different teams within an organization.

## CONFLICT RESOLUTION

## 5 STYLES OF MANAGING CONFLICT

A tool that has been developed is the Thomas-Kilmann Instrument (TKI). TKI identifies 5 different styles that people frequently use when facing a conflict;

1. Accommodating with a goal to yield harmony and relationships.

2. Collaborating is the process of 2 or more individuals or organizations works together to realize mutual goals.

3. Compromising is defined as a settlement of differences by mutual concessions or an agreement reached by adjustment of conflicting

4. Avoiding conflicts – it is recommended that avoidance should only be used when the issue is not of great importance especially if the potential damage of having a confrontation outweighs the benefits.

5. Competing is often a negative way to manage conflict with a goal of winning whatever the cost.

# CONFIDENTIALITY

All professionals have to continually remind themselves of the importance of keeping client/ patient information private. Safeguarding the rights of the clients'/ residents' personal health information is a legal and ethical obligation as healthcare workers, other professionals and providers.

The trust between the clients/ patients can be compromised by unnecessary disclosure of medical information.

Confidentiality is defined as a set of rules or a promise that limits access or place restrictions on certain types of information. Within the health care setting, confidentiality is a major issue in patient/resident care. Nurses, social workers, Therapist, Physicians, Certified nursing assistants as well as everyone else who works with the patient has to maintain confidentiality of patient information. For example: you cannot talk about the patient with others who are not working with the patient and you cannot leave patient's chart at the bedside for unauthorized personnel to view. Legally, you can be fined or imprisoned; if you talk about the patient or share patient information. HIPAA laws must be followed and maintained.

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Confidentiality of patients' information

HIPAA violations involve both civil and criminal penalties which include fines and imprisonment. The fines can range from $100 for each violation of the law to a limit of $25,000 per year for multiple violations. For misusing or disclosing any of the patient's information, criminal sanctions carry fines of 50,000 to 250,000 and one to ten years imprisonment.

Always maintain confidentiality of patients' information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules:

The Office for Civil Rights enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

The HIPAA Privacy Rule provides Federal protections for individually identifiable health information held by covered entities and their business associates and give the patient an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it allows the disclosure of health information needed for patient care and other important purposes.

## Protected Health Information (PHI)

The HIPAA Privacy Rule protects most “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form; electronic, on paper, or oral. The Privacy Rule calls this information protected health information (PHI). Protected health information is information, including demographic information, which relates to:

- the person’s present, past, or future physical, mental health or condition,
- the provision of health care to the individual, or
- the present, past, or future payment for the provision of health care to the individual, and that identifies the person, or for which can be used to identify the individual.

Protected health information includes many common identifiers such as name, address, Social Security Number, date of birth when they can be associated with the health information.

A medical record, hospital bill or laboratory report, would be Protected health information because each document would contain a patient’s name and the other identifying information associated with the health data content.

According to an article from the American Nurses Association, the issue of health care reform brings ethical issues of justice to the forefront, as communities, individuals and the legislature struggle with how to provide quality health care to several individuals without sacrificing the basic rights of the few. The June 2012 Supreme Court decision that upheld the constitutionality of the Patient Protection and Affordable Care Act (PPACA), first enacted in 2010, provides some guidance to employers, states,

consumers and insurers about what they were required to do by 2014 (OJIN 2012).

Provisions in the Patient Protection and Affordable Care Act are designed to expand insurance coverage, control costs, target prevention; with one of the primary target being adults aged 19-64, because their use and access to health care / health services deteriorated between 2000 and 2010, especially among those individuals who were not insured.

The Patient Protection and Affordable Care Act include but not limited to reforms such as:

 Expanding Medicaid eligibility,

 Subsidizing premiums for insurance

 Allowing incentives for various businesses to provide health care benefits
 Prohibiting insurance companies from denying coverage for pre-existing condition etc.

It is very important for nurses and other health workers/ professionals to consider how the implementation of the Patient Protection and Affordable Care Act (PPACA) relates to their role in understanding and trying to rectify conditions of injustice in health care. Through our education, practice and interactions with various segments of society, we are able to gain a unique perspective of what constitutes injustice in health care and which groups and individuals are especially disadvantaged. “Through understanding how certain human contexts and conditions erect and maintain barriers to the improvement of well-being, nurses and other health professionals can make important differences in helping to provide the human good of health to both individuals and societies” (OJIN 2012).

## CODE OF ETHICS – NURSING

Providing the highest quality healthcare services is a major function for nurses. Therefore the Code of Ethics for Nurses was developed as a guide

for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession (ANA 2016).

As required for all other professionals, so the nurses also have to:

o Avoid actions that are based on prejudice,

o Avoid behavior/ actions that are threatening of others,

o Avoid actions that brings harassment to others,

o Provide fair treatment to others, and

o Maintain relationships that are caring.

## RESPONSIBILITY AND ACCOUNTABILITY

Nursing practice involves actions that include providing treatment, medications, and care to patients. Other task involves teaching, research, delegation, management and supervision. Nurses are responsible for the care that their patient receives and their own practice therefore the nurse has a responsibility to follow the standards of care at all times.

Accountability is the acknowledgment and assumption of responsibility for actions, to account for one's actions. Therefore, the nurse has to follow the standards that are in place.

According to the Florida Administrative Code and Florida;

64B9-8.005 Unprofessional Conduct

Unprofessional conduct shall include:

(1) Inaccurate recording;

(2) Misappropriating drugs, supplies or equipment;

(3) Leaving a nursing assignment without advising licensed nursing personnel;

(4) Stealing from a patient;

(5) Violating the integrity of a medication administration system or an information technology system;

(6) Falsifying or altering of patient records or nursing progress records, employment applications or time records;

(7) Violating the confidentiality of information or knowledge concerning a patient;

(8) Discriminating on the basis of race, creed, religion, sex, age or national origin, in the rendering of nursing services as it relates to human rights and dignity of the individuals;

(9) Engaging in fraud, misrepresentation, or deceit in taking the licensing examination;

(10) Impersonating another licensed practitioner, or permitting another person to use his certificate for the purpose of practicing nursing;

(11) Providing false or incorrect information to the employer regarding the status of the

license;

(12) Practicing beyond the scope of the licensee's license, educational preparation or nursing experience;

(13) Using force against a patient, striking a patient, or throwing objects at a patient;

(14) Using abusive, threatening or foul language in front of a patient or directing such language toward a patient.

Check your state for more information.

## ETHICAL DECISION-MAKING

Ethical decision-making involves a process of assessing /evaluating the situation and choosing among the alternatives in a manner that is consistent with ethical principles.

When making ethical decisions, it is necessary for the professional to perceive and eliminate choices or options that are unethical and choose the best ethical alternative.

With regard to ethical decision-making, professionals have a duty to have respect for the values of others and make sure that they are not giving opinions or making decisions that place them in the position of crossing professional boundaries.

When the professionals are presented with situations that the values, actions or beliefs, are personally or socially unacceptable, the professional should provide skilled professional care and provide care or services in a respectful manner.

Various situations may cause the nurse, healthcare worker or other professionals to respond or act in ways which are a violation of the values of the profession/ violation of the code of ethics. All professionals have a duty to retain the integrity of their profession. Healthcare team members are obligated to preserve patient safety. Healthcare workers cannot abandon their patients. Resident’s rights have to be honored and maintained.

## Appropriate and accurate documentation

Documentation is a set of documents that is used as a form of communication. Documentation can be provided on paper, online or on digital or analog media such as audio tape or CDs. It is becoming less common to see paper (hard-copy) documentation. Documentation can be distributed via the website, software products, and other on-line applications. Within the health care setting, documentation is a form of communication that provides information about the healthcare that the patient receives. Accurate and complete documentation of patient care is required by the facilities/institutions providing services to patients/residents, accreditation agencies, reimbursement agencies, federal and state governments; Medicare and Medicaid.

Some of the purposes of documentation include:

- Fulfilling professional responsibility and establishing accountability
- Legal standards
- Compliance with standard of practice
- Communication among the health care team and providing education to staff
- To provide continuity of care
- Providing information for research
- For reimbursement.

## A COMPLETE MEDICAL RECORD

A complete medical record must have an accurate and complete representation of the actual care/experience of the resident/patient in the facility. It needs to have enough information to demonstrate that the institution knows the status of the resident/patient, has care plans identified to meet the resident's/patient's conditions, and provides enough documentation of the effects of the care provided. Documentation should provide a picture of the resident /patient and the results of treatment and the resident's/ patient's response to the treatment. Documentation should also show the changes in status or condition of the resident/patient and any changes in orders or treatments.

## THE CERTIFIED NURSING ASSISTANT (CNA)

THE SCOPE OF PRACTICE FOR THE CERTIFIED NURSING ASSISTANT (CNA)

Check with your state to detail your role as a CNA/HHA. The Florida Statutes describe below, provides specific guidelines regarding the role of the nursing assistant within the long term and home health care settings.

The Florida Statutes 400.211 Persons employed as nursing assistants; certification requirement: (1)To serve as a nursing assistant in any nursing home, a person must be certified as a nursing assistant under part II of chapter 464, unless the person is a registered nurse or practical nurse licensed in accordance with part I of chapter 464 or an applicant for such licensure who is permitted to practice nursing in accordance with rules adopted by the Board of Nursing pursuant to part I of chapter 464.

Chapter 464 of the Florida Statues

(5) “Practice of a certified nursing assistant” means providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with:

 personal care,

 maintaining mobility,

 nutrition and hydration,

 toileting and elimination,

 assistive devices,

 safety and cleanliness,

 data gathering,

 reporting abnormal signs and symptoms,

 postmortem care,

 patient socialization and reality orientation,

 end-of-life care,

 cardiopulmonary resuscitation and emergency care,

 residents’ or patients’ rights,

 documentation of nursing-assistant services, and other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse.

## LEGAL DOCUMENTATION

Certified Nursing Assistant (CNA)

Legal documentation involves:

 Careful and accurate charting, never document a task if it was not done, this too is illegal (always notify the nurse for assistance as needed),

 Never document for another CNA, this is illegal,

 Always document the facts,

 Do not place personal feelings in the chart

 If you observe something abnormal with the patient, do not just write it down; make sure the charge nurse is notified so that the patient can be assessed,

 only document care when it is given,

 Avoid using abbreviations, Potential for errors (refer to the Do not use list)

 Make sure hand writing is clear and can be read by others of the health care team, everything that you document, or chart can be used in court and the lawyers and everyone involved in the legal team must be able to read it.

**Members of the Health care Team**

As previously mentioned, it is very important to complete appropriate documentation within the patient's medical record because other members of the healthcare team will also be reviewing and reading the document. Therefore, always provide information about the patient that is current, accurate, factual, complete, and it reflects a picture of the resident/patient while under the care of each health care worker (nurse, CNA, physician etc.).

**Goal of Documentation**

The overall goal of the nursing documentation is to:

 Ensure that there is documented timeline for the care that the patient receives. Every entry that is completed by each nursing staff or members of the healthcare team has to be coordinated. This coordinated documentation will allow members of the health care team and other who

need to review the chart, to see the patient's status at specific times and assist the health care team in determining if changes have occurred within the patient and at what time the changes were observed, reported and documented.

 Always remember that documentation is considered a legal document which reflects the care the patient received and should reflect that patient care was given in accordance with appropriate standards of care.

**Personnel completing the documentation**

As a health care worker, you are also documenting for your own purpose. When you have appropriately documented, this documentation will be available for you to access as needed, if you need to recall complete details of what did for the patients. If there is a lawsuit or claim filed within a year or more, you might not remember all the details of care given to that patient or even the time that care or medications were administered therefore your complete and accurate documentation will be useful at that time. See your state for the statute of limitation (time frame); within some states, the statute of limitations allows lawsuits within 2 years or more of the date of the event resulting in a claim. The timeframe may be extended as much as 20 years if the patient involved is a minor. Everyone within the health care team must document and the documentation should be at the time of patient care so that the information is accurate and complete. Never leave your shift without documenting; never say "I will come back in the morning and document."

**Lawyers, consultants, Judge and Jury**

When there is a lawsuit, all of the documentation of the patient's medical record will be reviewed by the lawyers, consultants, nurses and other experts involved. The team will look for what was not done per standard of care, what could have been done better, what was not accurately done,

what was not done that should have been completed etc. The documentation will be read by the jurors involved in the case.

Follow the nursing process

The nursing process should always be followed. The nursing process requires :

- Assessment,
- Nursing diagnosis,
- Planning,
- Implementation, and
- Evaluation.

**Assessment**

Assessment is the first step in delivering nursing care. Nursing assessment is defined as the gathering and analyzing of information about a patient's physiological, economic, psychological, sociological, cultural and spiritual status.

**Diagnosis**

The nursing diagnosis is the nurse's clinical judgment about the patient's response to actual or potential health status/conditions.

**Planning**

Based on the assessment and diagnosis, the nurse establishes measurable and achievable short- and long-term goals and expected outcomes for the patient. The information is placed in the plan of care.

Implementation

Implementation involves carrying out the nursing care according to the plan of care.

**Evaluation**

Ongoing evaluation is completed to check the patient's status and the effectiveness of the nursing care. The care plan is then modified as needed.

State nurse practice acts may vary from state to state so follow the established guidelines for documentation. Some tips for accurate and complete documentation are listed below:

 Always write clearly (legibly), everyone within the health care team needs to be able to read what you have documented. This is vital to accurate and continuity of care for the patient. It is good to use block printing if your handwriting is illegible.

 Avoid charting in advance, this too is illegal and can lead to devastating errors.

 Always complete your documented entry using a chronological documentation format. This will provide separate entries for each narrated item because you want to provide a clear picture of the events and times surrounding the care that was provided for that patient.

 Document timely; charting should be done every 1-2 hours for routine care. Medication administration and other interventions or changes in condition should be documented immediately.  If medications are not recorded in a timely manner, there is a possibility that the patient may receive that medication again.

 When standard time is used, always include AM or PM with notations. Some healthcare facilities use military time to reduce errors.

 Your Signature is very important. The healthcare worker must always sign for every notation in the patient's medical record.

 If you are to assess the patient's baseline mental status, document it because if there is a change or deviation noted from baseline this could indicate an injury or an acute illness.

 If you completed a task or an intervention, always document the intervention followed by an evaluation; did the intervention help the patient, was it effective? If intervention was not effective, what was done? Was the physician updated, all basis covered? Patient's needs met?

 Also document any complaints of the patient and/ or family and ensure follow up is done with the supervisor, with timely resolution and documentation.

 If you document a body system abnormality, always note the details because over a period of time the abnormality may become worse.

 Always accurately document how your assessment was done. For example, if you watch the chest of the patient rise and fall, you cannot document that the patient has normal breath sounds unless you have used the stethoscope to listen to the lungs.  Do not use abbreviations unless they are approved, acceptable and included in your facility's policy and procedure. Therefore, if you are unable to complete an entry on that page, do not shorten the word (do not make up your own word) move to the next page; follow your facility's policy and procedure for continuing an entry on the next page.

 Do not use slangs within the patient's medical record. As mentioned before the patient's medical record is a legal document. All documentation should be in Standard English with accurate grammar. Accurate spelling is

also required because misspelled words may lead to different interpretations.

 Writing must be done using permanent ink pen (dark ink, blue or black) and writing needs to be neat and legible. Do not use pencil or pen that can be erased. Check your facility policy, some only allow black ink.

 Always assess the patient at the time of admission, transfer and discharge. You need to know the status of a patient when he/she enters your care and before he/she leaves.

 Avoid leaving spaces in charting. If blank spaces are left, this will allow others to make additions to the patient's medical record, to your notation. Make a straight line through any empty space.

 Make sure if you have to complete a late entry, always follow your facility's policy. Late entries must indicate the date and time they were actually entered into the patient's medical record, and you have to include the notation -Late entry; followed by the date and time of the event.

 When medications or treatments are delayed, the healthcare worker must document in the patient's medical records, noting the reason for the delay. For example, the patient may be completing a diagnostic examination and has not yet returned to the unit. If aware that the patient is scheduled for the examination, prioritize and make plans to complete the treatment before the patient leaves for the examination; if possible.

 When you have to continue notes from one page to another, make a notation that the entry is continued on the next page, this is to indicate that the note is not complete. Then document also on the next page to indicate that it is a continuation. Both of the pages have to contain your signature. (Follow your facility's Policy).

 When making corrections in the medical record, the error cannot be white-out, erased, scratched out to make illegible. The error can be corrected by drawing a line through the text and writing the word “error.” sign your name and date the cross off. Follow your facility policy.

**Always remember !!**

- Writing has to be legible –clear for others to read and understand
- Use dark ink pen on the patient’s medical records.
- Whenever you make an error, use your pen and cross it off with one thin line. Write error, sign your name and date the cross off.
- Do not try to cover up the mistake with marker or scribble.
- Do not rewrite over the error; just one straight line through the error.
- White out cannot be used when you make a mistake.

**Documentation Variations among health care institutions**

Healthcare workers often work in various settings. Physicians, nurses, CNAs and other healthcare personnel often work in more than one facility at the same time. Therefore, it is very important to understand the basic formats for effective documentation.

Appropriate and accurate documentation requires the nurse to have an understanding of the nursing process and nursing diagnosis.

NANDA International (formerly the North American Nursing Diagnosis Association) is a professional organization of nurses standardized nursing terminology that develops, researches, disseminates, refines the nomenclature, criteria, and taxonomy of nursing diagnoses.

NANDA International sets the standards for nursing diagnoses with a taxonomy that includes domains, classes, diagnoses, based on health patterns; domains such as:

Activity/Rest Comfort Coping/Stress Tolerance Elimination Growth/Development Health Promotion Life Principles Nutrition Perception/Cognition Role Relationships Safety/Protection Self-perception Sexuality

**Nursing Interventions Classification (NIC) and Nursing Outcomes Classification (NOC)**

Nursing Interventions Classification; a standardized list of several of different interventions and activities needed to implement the interventions. The patient outcomes related to the nursing interventions classification are detailed in the Nursing Outcomes Classification (NOC), which contains several outcomes, each with measures to determine if outcomes are met.

NANDA International Nursing Diagnoses: Definitions and Classification 2015-2017 is available and approved by NANDA-I. The new 2015-2017 edition has been updated and revised throughout. There are 235 diagnoses presented and are supported by definition, defining characteristics, related factors, or risk factors. The new / revised

diagnosis is based on latest global evidence, and approved by expert nurse diagnosticians, educators and researchers.

## Computerized documentation systems

Computerized documentation systems often incorporate nursing diagnoses into the system, which produces lists of interventions and expected outcomes. More institutions are utilizing computerized systems for documentation. These computerized systems however vary from one facility to another; however, security is a common factor for all systems. Training has to be provided for the staff, which usually include securing patient information from unauthorized persons whether the computer is at the nurses' station or at the bedside, security of password information; no one is allowed to share their password with their co-worker etc. Computer systems usually track the use of the system, therefore it is documented who is logged on and time and date. There has to be training regarding how to correct errors when an entry error is made.

Computerized documentation systems have many advantages, including but not limited to:

- Eliminates handwritten orders,
- The records are legible; no need to worry about unclear handwriting,
- Enters signatures automatically,
- Security of patient information; need password to log in to access patient information,
- Orders can be automatically transmitted to pharmacy and medication is ordered quickly,
- Reduction in errors,
- Prevents tampering of the medical record,
- Difficult to delete information from the record.

**Computerized documentation systems may include:**

### Electronic medical record (EMR)

Electronic medical record is the computerized patient medical record. With the use of the computerized documentation system, computer terminals may be located in the patient's room, therefore healthcare providers / workers, professionals have to be educated/ trained regarding the importance of logging off the computer system so that persons who are not authorized will not be able to access and view the patient's information. The computerized documentation system usually has computerized physician order entry, clinical decision support system; therefore, the notes can be entered electronically.

### Clinical decision support system (CDSS)

Clinical decision support system refers to the interactive software systems which has evidence based medical information. Clinical decision support system can be used for different purposes such as providing diagnosis and treatment options when the symptoms are imputed into the computer system. Clinical decision support system may also monitor the orders and the treatments to prevent repetitions or duplications.

### Computerized physician or provider order entry (CPOE)

Computerized physician or provider order entry (CPOE) refers to the interactive software application that automates ordering for medications or treatments. Orders must be entered in a prompted format that eliminates many errors. These systems usually include Clinical decision support system to provide alerts if there is an inaccurate dose or duplication order. Computerized physician or provider order entry eliminates handwritten orders and the information is automatically transmitted to the pharmacy, reducing errors and medication is ordered quickly.

## Documentation Formats

Many institutions utilize the narrative format when documenting in the clinical record. Healthcare workers must utilize the system that is in place / follow the policy and procedures of the facility that they work in.

Some of the formats that are available include:

- Narrative format
- Focus
- Charting by exception (CBE)
- Problem Oriented medical record (POMR)
- Flow Sheet, Assessment, Concise, Timely (FACT)
- Problem/ intervention/ Evaluation (PIE)
- Core.

## Narrative format

Narrative format is used in most of the institutions. Narrative charting involves recording data using progress notes, with the flow sheets supplementing the notes. Narrative charting does not follow a specific outline and follows the thought process of the healthcare worker who is documenting.

### Focus

Organized into patient centered topics, the Focus system encourages integrating assessment data to evaluate the patient's condition on an ongoing basis. The Focus system is best used where the procedures are

repetitive and is utilized primarily in acute care settings. Progress notes are written utilizing the DAR (Data, Action, and Response) format.

**Charting by exception (CBE)**

Charting by exception requires the development and use of practice standards or protocols for each body system. The forms utilized in the documentation are developed following specific guidelines. Developing the standards and forms eliminates the need to document in narrative format standard nursing care. The healthcare worker checks off the areas on the flow sheet through which the patient has met the established standard,

then writes a narrative note when the patient's condition deviates from the established standard.

**Problem Oriented medical record (POMR)**

Problem oriented medical record (POMR) is utilized in many health care institutions. The POMR system follows a problem list format, identifying all areas (both positive and negative) that are impacting the patient. The notes and all the documentation refer back to the problem list, using the Subjective, Objective, Assessment, Plan (SOAP), the Intervention, Evaluation (SOAPIE) and/or SOAPIER (Revision) format.

**Flow Sheet, Assessment, Concise, Timely (FACT)**

Flow Sheet, Assessment, Concise, Timely (FACT) developed to help eliminate repetitive notes, irrelevant data, inconsistency and to reduce amount of time required to complete documentation. Flow sheets are

designed to address the redundant activities in caring for a resident. The narrative documentation utilizes the Data, Action, Response (DAR) format of the Focus charting system.

### Problem/ intervention/ Evaluation (PIE)

Problem/ intervention/ Evaluation (PIE) organize information according to the patient's problems to simplify the documentation system. Problem/ intervention/ Evaluation (PIE) utilize flow sheets which have been developed for daily documentation supplemented with structured narrative documentation. This system also integrates the care plan into the daily documentation.

### Core

Core focuses on the nursing process. The Core framework utilizes the data base, flow sheets, care plan, progress notes, discharge summary to chart the patient's needs and progress. Progress notes follow the data, action, evaluation/response (DAE) for each of the problems.

### Use of abbreviations

Abbreviation is a shortened form of a word or phrase. Abbreviations can lead to some serious or life-threatening errors, therefore there are guidelines in place. The Joint Commission has set guidelines and rules; all healthcare settings have to standardize abbreviations, acronyms and symbols that they are using. They are also required to adhere to a Do Not Use list.

The Do Not Use List includes some of the following:

Do Not Use u, or for unit. Mistaken sometimes for zero. You must write "unit" Do Not use iu for international unit. Mistaken for IV. Write "international unit" Do Not Use Q.D., QD, q.d., qd (Daily). Mistaken for each other. Write "Daily". Do Not Use Q.O.D. QOD, q.o.d., qod (every other day). Write "every other day"

See the complete Do Not Use List (The Joint Commission http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf)

**Timely Documentation**

Time is a very crucial factor within the nursing process. Healthcare workers; Physicians, Nurses, CNA have to document the time of all interventions and notations. For example, the patient complains of severe pain to the fractured extremity, the nurse administered the pain medication prior to leaving the shift; no notation was completed. The patient reports pain to the oncoming nurse, who is aware that patient has a fracture and will experience pain, therefore administers the pain medication; within the hour the patient has received pain medication twice. Another scenario; the CNA obtained vital signs at 7am at 2:30pm the patient reports feeling ill, flushed and experiencing severe headache; the CNA gives the nurse the results of the vital signs assessment which was documented as completed 2:30pm this may lead to inappropriate interventions and inaccurate reporting to physician regarding patient's status.

**Documentation /Physician orders**

Telephone order and Verbal order

Always follow the institution's Policy when noting orders on the physician order sheet. When the nurse receives a telephone order (the physician telephones and gives an order) then it has to be documented as a

## Telephone Order (T.O.)

The telephone order should indicate a telephone order with the time, date, physician's name and that the order has been repeated to the physician, also Verbal orders, must be documented as V.O. and must be written exactly as dictated and then verified.

## Vital Information

Some information such as allergies/ sensitivities, Patient's identification; name and other identifying information should be on every page of every document in the patient's medical record.

## Notation of Medications and treatments

When medications and treatments are administered, the healthcare worker has to document in the patient's medical record. Also, if the wrong medication or treatment is administered, this also has to be documented. The nursing note has to indicate all treatments and medications given to the patient, even if it was the wrong medication or treatment. The individual who administers the wrong medication or treatment has to document the:

- Name of the medication
- the dose of medication,
- Name of physician notified
- time the physician was notified,
- Nursing interventions or physician orders to prevent or treat adverse effects,
- Patient's response to treatment.

Follow the facility policy and procedure regarding with medication and treatment errors. An incident report will also be completed.

## NURSES

Nurses need to know their state law, the policies and the professional standards that relates to the specialty in which they are practicing. If there is any doubt or lack of knowledge consult with a supervisor or an expert to assist.

## THE NURSE PRACTICE ACT

The Florida Statues 464 states:

464.018 Disciplinary actions

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(a) Procuring, attempting to procure, or renewing a license to practice nursing or the authority to practice practical or professional nursing pursuant to s. 464.0095 by bribery, by knowing misrepresentations, or through an error of the department or the board.

(b) Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or to the ability to practice nursing.

(d) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, any of the following offenses:

1. A forcible felony as defined in chapter 776.

2. A violation of chapter 812, relating to theft, robbery, and related crimes.

3. A violation of chapter 817, relating to fraudulent practices.

4. A violation of chapter 800, relating to lewdness and indecent exposure.

5. A violation of chapter 784, relating to assault, battery, and culpable negligence.

6. A violation of chapter 827, relating to child abuse.

7. A violation of chapter 415, relating to protection from abuse, neglect, and exploitation.

8. A violation of chapter 39, relating to child abuse, abandonment, and neglect.

9. For an applicant for a multistate license or for a multistate licenseholder under s. 464.0095, a felony offense under Florida law or federal criminal law.

(e) Having been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence as defined in s. 741.28.

(f) Making or filing a false report or record, which the nurse knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the nurse's capacity as a licensed nurse.

(g) False, misleading, or deceptive advertising.

(h) Unprofessional conduct, as defined by board rule.

(i) Engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part.

(j) Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon

General's designee that probable cause exists to believe that the nurse is unable to practice nursing because of the reasons stated in this paragraph, the authority to issue an order to compel a nurse to submit to a mental or physical examination by physicians designated by the department. If the nurse refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the nurse resides or does business. The nurse against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A nurse affected by this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of nursing with reasonable skill and safety to patients.

(k) Failing to report to the department any person who the nurse knows is in violation of this part or of the rules of the department or the board. However, a person who the licensee knows is unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

(l) Knowingly violating any provision of this part, a rule of the board or the department, or a lawful order of the board or department previously entered in a disciplinary proceeding or failing to comply with a lawfully issued subpoena of the department.

(m) Failing to report to the department any licensee under chapter 458 or under chapter 459 who the nurse knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the nurse also provides services.

(n) Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the nurse is not qualified by training or experience.

(o) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(p) For an advanced practice registered nurse:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing on Schedule II in chapter 893.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine, a sympathomimetic amine drug, or a compound designated in s. 893.03(2) as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term “muscle building” does not include the treatment of injured muscle. A prescription written for the drug products identified in this subparagraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: “This prescription may be filled at any pharmacy of your choice.”

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced practice registered nurse’s professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the advanced practice registered nurse by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a substance designated in s. 893.03(2) or (3) as a substance controlled in Schedule II or Schedule III, respectively, in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03 as a controlled substance.

(q) For a psychiatric nurse:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing in Schedule II of s. 893.03.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine, a sympathomimetic amine drug, or a

compound designated in s. 893.03(2) as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term “muscle building” does not include the treatment of injured muscle. A prescription written for the drug products identified in this subparagraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: “This prescription may be filled at any pharmacy of your choice.”

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced practice registered nurse’s professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the psychiatric nurse by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a substance designated in s. 893.03(2) or (3) as a substance controlled in Schedule II or Schedule III, respectively, in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03 as a controlled substance.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or nurse who is found guilty of violating subsection (1) or s. 456.072(1).

(b) The board may take adverse action against a nurse's multistate licensure privilege and impose any of the penalties in s. 456.072(2) when the nurse is found guilty of violating subsection (1) or s. 456.072(1).

(3) The board shall not reinstate the license of a nurse, or cause a license to be issued to a person it has deemed unqualified, until such time as it is satisfied that such person has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of nursing.

(4) The board shall not reinstate the license of a nurse who has been found guilty by the board on three separate occasions of violations of this part relating to the use of drugs or narcotics, which offenses involved the diversion of drugs or narcotics from patients to personal use or sale.

(5) The board shall by rule establish guidelines for the disposition of disciplinary cases involving specific types of violations. Such guidelines

may include minimum and maximum fines, periods of supervision or probation, or conditions of probation or reissuance of a license.

### Sexual misconduct in the practice of nursing

According to F.S. 464.017 regarding Sexual misconduct in the practice of nursing;

The nurse-patient relationship is founded on mutual trust. Sexual misconduct in the practice of nursing means violation of the nurse-patient relationship through which the nurse uses said relationship to induce or attempt to induce the patient to engage, or to engage or attempt to engage the patient, in sexual activity outside the scope of the practice or the scope of generally accepted examination or treatment of the patient. Sexual misconduct in the practice of nursing is prohibited.

## Conclusion

In all professional relationships, work and /or services should be practiced with compassion, recognizing human dignity and value that is present in each patient, client, co-worker and each individual. All professionals need to maintain the highest regard for the standards of one's profession/ position.

# Bibliography

www.nursingworld.org (2018) Healthy Work Environment. Retrieved from https://www.nursingworld.org/practice-policy/work-environment/

www.nursingworld.org (2018) Ethics and Human Rights. Retrieved from https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/

www.flrules.org (2017) Unprofessional Conduct. Retrieved from https://www.flrules.org/gateway/ruleno.asp?id=64B9-8.005

www.leg.state.fl.us (2018) Nurse Practice Act. Retrieved from http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0464/0464PARTIContentsIndex.html

www.leg.state.fl.us (2018) 464.018 Nursing - Disciplinary Actions. Retrieved from http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0464/Sections/0464.018.html

www.leg.state.fl.us (2018) 464.017 - Sexual misconduct in the practice of nursing . Retrieved from http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0464/Sections/0464.017.html

www.asha.org (2019) Documentation in Healthcare. Retrieved from https://www.asha.org/Practice-Portal/Professional-Issues/Documentation-in-Health-Care/