



**Arkansas  
Children's  
Hospital Allied Health  
Team Playbook**

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## TABLE OF CONTENTS

<b>About this ACH Allied Health Team Playbook</b> .....	4
<b>Letter from the CEO</b> .....	5
<b>History of Arkansas Children's Hospital</b> .....	6
<b>ACH Mission Statement</b> .....	7
Service Theme.....	7
ACH Service Standards.....	7
ACH Behavioral Standards.....	7
ACH Team Philosophy.....	8
ACH Labor Relations Policy.....	8
Equal Employment Opportunity and You.....	9
ACH Non-Discrimination Policy Statement.....	9
Providing a Drug-Free Workplace.....	9
ACH is Smoke Free.....	10
<b>Your Role As An ACH Allied Health Team Member</b>	
Your Supervisor.....	10
Licensure and Certification.....	10
Personnel Policies.....	10
Allied Health Personnel Policy.....	11
Attendance.....	11
Dress Code.....	11
Telephone.....	11
In-House Paging System (Beepers).....	11
Firearms.....	11
Parking.....	12
Guest Relations.....	12
Employee Grievance Procedures.....	12
Personal Information.....	12
Religious and Cultural Differences.....	12
Diversity is Important.....	13
<b>Safety: People, Processes and Setting</b>	
Personnel Files.....	16
Keys and Access to Specific Work Areas.....	16
Corporate Compliance.....	16
ACH Code of Conduct.....	17
Computer Information Security.....	20
Protection of Patient Information.....	20
Reporting Suspected Violations.....	21
General Safety and Accident Prevention.....	21
Security.....	22
Emergency Management.....	24
Hazardous Materials Management.....	25
Fire Safety and Fire Extinguisher.....	26

Equipment Management.....	28
Utilities Management.....	28
Infection Control.....	29
Fire/Disaster Plan in the OR.....	29
Inclement/Severe Weather/Emergency Conditions.....	30
<b>ACH Team Services</b>	
Employee Health Program.....	32
Chapel/Pastoral Care.....	32
Child Enrichment Center.....	32
Employee Fitness Facilities.....	32
Capital Café and Java City.....	33
Playaway Gift Shop.....	33
Volunteer Services.....	33
ACH Medical Library.....	33
<b>Age Specific Information.....</b>	<b>34</b>
<b>Suspected Child/Adult Abuse and Domestic Violence.....</b>	<b>50</b>
<b>Joint Commission National Patient Safety Goals.....</b>	<b>60</b>

## **WELCOME TO ARKANSAS CHILDREN'S HOSPITAL**

### About this ACH Allied Health Team Playbook

This Playbook is provided as a guide to and a summary of the various policies and services available and applicable to ACH Allied Health Team members as of the date published. It also summarizes the rights and responsibilities of Allied Health members. The playbook is intended for informational purposes only. As an ACH Allied Health Team member, you will want to become familiar with the contents of this playbook and with the ACH Policies and Procedures, which are located on myACH.

The policies and services described in this playbook may be changed or discontinued. Documents summarizing various policies and services are issued, amended, and revised from time to time with or without prior notice. Allied Health Team members are encouraged to consult the various booklets, summaries, and governing documents as appropriate, and to contact the Medical Staff Office for more detailed and up-to-date information at 364-4857.

Arkansas Children's Hospital  
Professional Staff Services  
800 Marshall Street, Slot 300  
Little Rock, Arkansas 72202


Dear ACH Team Member:

Over the door of our hospital are the words “Fear not illness, this place of care, love and hope is for you.” Our Team makes these words come true every day. We are pleased that you have joined the ACH Allied Health Team and share our desire to see that every child and family is treated with the same care, love and hope as if they were our children and our family. And of course in a sense they are. The people of Arkansas have given us a very special privilege of caring for their dearest loved ones, a privilege we take very seriously. We serve children and their families with a passion unparalleled in the health care industry.

The ACH Allied Health Team Playbook provides important information to you about Arkansas Children’s Hospital. I hope you will read it carefully and refer to it as questions arise.

ACH employees more than 3,600 personnel, which is one of the largest employers in the State of Arkansas. You are part of a long tradition of excellence going back to 1910. We hope you will find this a rewarding place to work and that you will help us to continue that tradition.

Welcome to the ACH Allied Health Team!



Jonathan Bates, M.D.

President and Chief Executive Officer

## **History of Arkansas Children's Hospital**

### **Yesterday and Today**

Providing world-class pediatric health care is what Arkansas Children's Hospital (ACH) employees do each and every day. Yet, we never forget our humble beginnings, our traditions of excellence.

There was a time less than a century ago when an Arkansas hospital dedicated to care, love and hope of children was the *stuff of dreams*. Could this dream one day grow to become one of the ten largest pediatric hospitals in the nation?

“In your dreams,” many would say.

How right they were. Many dreamers made ACH a reality, but one set the wheels of care, love and hope in motion.

### **Dreamer of Dreams**

Turn back the clock to 1912, a key turning point in the foundation of what would become Arkansas Children's Hospital (ACH). It was 16 years before Sir Alexander Fleming discovered penicillin, five years before the U.S. plunged into World War I and six years before a worldwide influenza epidemic killed millions.

Dr. Orlando P. Christian was a dreamer. A Methodist minister, Dr. Christian struggled growing up in the later part of the 1800s. He survived a childhood of poverty, dire family illness and lack of schooling, but it never held him back. In fact, it inspired him to work with underprivileged children.

The Arkansas Children's Home Society was ACH in its infancy and a branch of the National Children's Home Society. The Arkansas Children's Home Society was established in 1912 to care for Arkansas' orphaned, neglected, homeless and poverty-stricken children. Word of Dr. Christian's prior successes with neglected and orphaned children reached the Society, which recruited Dr. Christian, and he soon began his tenure as superintendent.

Originally located outside of Morrilton, Arkansas, the Arkansas Children's Home Society received a new Little Rock home, which was donated in 1917. In 1918, \$5,000 was donated by a Grand Lake, Arkansas cotton planter to purchase property to be used as a receiving home. That year, Dr. Christian stated, “Our actions will heal the sick, cause the lame to walk, the deaf to hear, the blind to see, and change the menace and liability to an asset and a blessing.”

One year later, the Arkansas Children's Home Society began a campaign to raise \$100,000 to construct the new building for the children's hospital. The dream was a success and approved at a cost of \$200,000.

The dream became a reality when Arkansas Children's Home and Hospital opened the doors to its new facility on March 9, 1926.

### **Still Dreaming Today... Traditions of Excellence**

Today, Arkansas Children's Hospital (ACH) is a private, non-profit institution and the only pediatric medical center in the state and the most comprehensive in the region. Over the past 90 years, we have grown from a two-bed hospital to one of the ten largest pediatric hospitals in the nation (our first, brown-tiled roof hospital remains standing on our 23 city block campus). Team ACH is approximately 500 physicians and 100 residents in pediatrics and pediatric subspecialties supported by more than 3,700 full-time and part-time staff.

Traditions run deep in the heart of each member of Team ACH. We are ordinary people with an extraordinary purpose: to provide care, love and hope to children. Our investment in people, technologies and facilities are testament to our commitment. A commitment to children and continuing the legacy of Dr. Christian and so many dreamers throughout the history of Arkansas Children's Hospital (ACH).

### **ACH Mission Statement**

In order to enhance, sustain and restore health and development of children, Arkansas Children's Hospital provides excellent clinical services, teaching and research. Arkansas Children's Hospital is committed to working with others to achieve high quality, cost-effective, fully accessible services for Arkansas' most precious resource -- our children, without regard to race, religion or inability to pay.

### **Service Theme: Arkansas Children's Hospital...giving care, love and hope.**

The ACH service theme serves three purposes:

- It clearly defines the hospital's purpose
- It communicates our message internally
- It creates an image of the hospital

### **ACH Service Standards**

ACH has established service standards to set the criteria for quality decisions and for measuring the quality of our services. We have identified four service standards that are listed in order of importance to the hospital.

### **Safety, Compassion, Performance and Presentation**

#### **ACH Behavioral Standards**

The eight ACH behavioral standards provide the common expectations that we have for one another and promote a common language that we can all share.

- **Environment:** *Maintain a clean, safe, secure, and comfortable environment.*
- **Respect:** *Treat our patients, families and each other with care, love and hope.*
- **Be Friendly:** *Maintain a family-friendly attitude, smile, make eye contact, and acknowledge others.*

- **Communication:** *Actively listen and communicate in a way that is caring, clear, concise and constructive.*
- **Anticipate:** *Recognize others in need of assistance and offer help, even before requested.*
- **Teamwork:** *Work together so that the needs of others are met.*
- **Confidentiality:** *Respect the confidentiality and privacy of others.*
- **Quality:** *Do your job to the best of your ability, make things better.*
- **Appearance:** *Maintain a neat, clean and professional appearance.*

### **ACH Team Philosophy**

Arkansas Children’s Hospital seeks to have associated with it in every position, the most capable individuals available. The hospital also seeks to orient and train each Team member so that we are increasingly effective in the performance of our jobs.

The hospital has planned its facilities so that you work in a pleasant, safe and orderly environment.

In addition to being provided with knowledge of the hospital’s objectives, goals and plans, you are also given proper lines of communication through the chain of supervision. This communication model allows our recommendations, suggestions, opinions and complaints to be considered in the best interest of the hospital and its Team members.

Arkansas Children’s Hospital wants you to have a sense of pride so that he/she may serve as ambassadors of good will for ACH, telling others about the policies, practices and services provided at the hospital.

The hospital encourages you to participate in self-development programs and to become active in community improvement projects. We will work to promote and maintain harmonious relationships and a cohesive, congenial atmosphere among ourselves and to uphold a mutually cooperative relationship with members of the medical staff, both individually and collectively. The hospital also wishes to maintain a mutually cooperative relationship with all allied health associations.

### **ACH Labor Relations Policy**

Quality patient care is our hospital’s first responsibility. The many services involved in quality care are dependent upon competent personnel working as a Team. Arkansas Children’s Hospital has both the legal and the moral responsibility for the life, health and welfare of its patients. For that reason, organizations or groups that cannot be held legally accountable for quality of service must not be permitted to participate in the hospital’s management decision.

We know that from time to time we will experience work-related problems. However, we also know that we have an excellent history of problem-solving without the interference of outsiders. Our Employee Grievance Policy ensures that you may present any matter of dissatisfaction regarding your association at ACH and have it considered on its merits.

Our Team members possess a broad range of education and skills needed to provide the best possible care to our patients. Because of this diversity among us, we also have many different needs and desires. The management of the hospital recognizes these differences as essential components to the Team we have established and therefore, prefers to deal with the problems directly rather than through a third party.

We recognize that a healthy acceptance of the differences among us will result in harmony among and within our departments. This Teamwork allows us to provide, with unequaled pride in our performance, the most advanced, caring and consistent care of our young patients.

### **Equal Employment Opportunity and You**

Arkansas Children's Hospital is an Equal Employment Opportunity Employer. As an ACH Allied Health Team member, this means that you were approved for privileges on the basis of individual merit. Such factors as race, sex, age, religion, physical or mental disability, and national origin were not considered in evaluating your qualifications for your position. All ACH Team members are treated equally with respect to compensation, opportunity for advancement, and other aspects of employment.

If you believe your rights regarding equal employment have been violated, or if there has been any action that you believe does not conform to these principles, you may appeal directly to the Human Resources Department, or you may choose to follow the Employee Grievance Procedure, HR Policy #435.

### **ACH Non-Discrimination Policy Statement**

In accordance with Title VI and VII of the Civil Rights Acts of 1964 and their implementing regulations, Arkansas Children's Hospital admits and treats all patients without regard to race, ethnicity, gender, national origin, religion or disability. There is no distinction in eligibility for, or in the manner of providing, any patient service provided by the hospital, based upon race, ethnicity, gender, national origin, religion or disability. All programs are available without distinction and rules of courtesy are uniformly applied to all, regardless of race, ethnicity, gender, national origin, religion or disability.

### **Providing a Drug-Free Workplace**

It is the intent of Arkansas Children's Hospital to provide its services within the framework of a drug-free environment. For the safety of our co-workers, our patients and their families, our volunteers, and the public we serve, ACH conducts post-job offer drug testing of all newly hired Team members. Additionally, ACH conducts random drug and "for cause" testing when it is reasonably believed that a Team member may be impaired.

The unlawful manufacturing, distributing, dispensing, possessing, using or being under the influence of a controlled substance or alcohol in the workplace at Arkansas

Children's Hospital is prohibited and may subject the staff member to immediate suspension and disciplinary action up to and including termination.

### **ACH is Smoke Free**

ACH recognizes the mounting scientific evidence of the adverse health effects of tobacco products, and in particular, the health hazards of environmental tobacco smoke. Implementation of a tobacco and smoke-free campus which prohibits use of tobacco products on all ACH owned or leased properties, including parking areas and pathways to and from ACH buildings, eliminates the possibility of exposure to environmental tobacco smoke, thereby contributing overall to a healthier work environment, staff, patients, families and visitors. Effective April 22, 2005, ACH became a totally tobacco and smoke free campus. This applies to all ACH Team members and others assigned to work on the ACH campus, all patients, families, and visitors.

### **YOUR ROLE AS AN ACH ALLIED HEALTH TEAM MEMBER**

#### **Your Supervisor**

You should look to your supervisor for guidance in relation to the quality and quantity of your work, for information about work procedures, and for job training and work coordination within your department. Your supervisor also determines your work schedule. If you have any questions or problems regarding your work, or ACH policies, please talk to your supervisor.

#### **Annual Performance Reviews**

While performance is evaluated on a day to day basis through observation, skills validation and training, you will receive an annual evaluation of your performance. The ACH Allied Health Review Committee will review all yearly evaluations at its annual meeting. You will need to complete the following preparation:

1. Reappointment Application
2. Evaluation completed by your sponsoring physician
3. Practice Agreement
4. License
5. CPR Certification for all nurses (CPR is recommended for all Allied Health Personnel)
6. Malpractice Insurance
7. TB Skin Test

#### **Licensure and Certification**

Team members in positions that require professional licenses will be required to keep your license in active status and meet the practice requirements as authorized by your licensure.

#### **Personnel Policies**

ACH Personnel Policies and Procedures establish uniform policy and procedures for Arkansas Children's Hospital Team members. These policies are established to guide

supervisory and Team members in the day-to-day administration of the personnel programs. These written policies are intended to promote communication and understanding of the Hospital personnel policies, reduce the need for personal decisions on matters of hospital-wide policy and help to ensure the uniform application of the policies throughout the organization.

The Personnel Policies and Procedures undergo periodic revisions as the Hospital's needs change. The Hospital reserves the right to make necessary revisions, additions or deletions to these policies and procedures. As revisions, additions or deletions are made, they will be communicated through customary ways used at ACH. (OA, Vital Signs, and departmental communications) For questions concerning any policy, please contact Employee Relations at ext. 4-7288.

### **Allied Health Personnel Policy**

The Allied Health Personnel Policy is available upon request at the Medical Staff Office at 364-4857.

### **Attendance**

Allied Health Personnel are expected to be at work on time for their scheduled shifts. Allied Health Personnel are also required to inform his/her supervisor of any absence during his/her scheduled shift, preferably prior to the beginning of the shift.

The Attendance Policy provides general guidelines for attendance and absences. In addition, your department will have a specific attendance policy which applies to personnel in the department. You should review both the general material in the ACH Personnel Policy and discuss any departmental attendance policy with your supervisor.

### **Dress Code**

If uniforms are not specified, business dress is the customary attire.

### **Telephone**

To call an outside number, you must first dial 9, Personal local phone calls should be kept to an absolute minimum and no personal long-distance calls are to be made from hospital phones. Cell phones are not to be used in restricted areas – see your supervisor if you have questions about this. The emergency number to call inside the hospital for any reason is 88.

### **In-House Paging System (Beepers)**

Dial 555, then you will hear a message to enter the pager number.

### **Firearms**

None are permitted except those carried by hospital security officers and law enforcement personnel.

### **Parking**

All parking is free and temporary employees are allowed to park in employee lots. Please do not park in patient lots. If you have a current disabled permit and need more accessible parking, please contact Employee Health. The hospital provides a shuttle service between 6 a.m. and 8 p.m. Monday-Friday. Exceptions are snowy/icy weather days and holidays. The shuttle always stops at the North and South Shuttle Lots and the “Sunshine” lot. The driver will make a stop on request at or near any of the parking lots.

The North and South Shuttle Lots have handicapped parking spaces next to the covered bus stop. One shuttle bus also has a wheelchair lift. Call 364-4353 for a security escort. There is an emergency phone in each parking lot. Do not walk alone to the lots after dark.

A lot designated for students is on the southwest corner of 10<sup>th</sup> and Summit streets. A covered shelter with a call box directly across 10<sup>th</sup> Street can be used to call the shuttle. Students are asked not to park in employee lots unless the student lot is full or unless it is a weekend.

### **Guest Relations**

As a student or temporary employee, you will be perceived by patients, parents and visitors as representing Arkansas Children’s Hospital. Please greet them cordially and assist them in every way possible if you can, such as giving directions, etc.

### **Employee Grievance Procedures**

Everyone is encouraged to discuss concerns and/or problems about work related situations with his/her immediate supervisor or department manager. Should these communications prove unsatisfactory, ACH Allied Health members will be provided with an opportunity to present his/her complaints and appeal decisions by management through a formal grievance procedure as outlined in Personnel Policy No. 435. For questions related to the grievance process you may contact the Medical Staff Office at 364-4857.

### **Personal Information**

You must notify the Medical Staff Office when you have a change in name, address, telephone number, emergency contact, licensure, certification or registry.

### **Religious and Cultural Differences**

It is extremely important to recognize that people have religious and cultural backgrounds that may be very different from yours. It is important to remain nonjudgmental, as you will encounter people with different customs, values and child-rearing practices. These differences need to be respected.

The Employee Notification for Conflicts in Patient Care Policy serves as a guideline for employees where cultural, ethical and/or religious conflicts arise in relation to patient care. Arkansas Children's Hospital is committed to providing quality health care services to all patients without regard to race, religion, or inability to pay or the nature of the

health care problem. When patient care situations arise that create cultural, ethical and/or religious conflict with an employee and expectations of the delivery of patient care, the hospital will consider a request by the employee not to participate in certain aspects of care. Procedures for making a request are outlined in Personnel Policy No. 461.

### **Diversity is Important**

Diversity is the condition of being different, or variety. Someone who is different is not bad or less important. Stereotyping is making assumptions directed to all persons who belong to a group. Stereotyping assumes that all people in a particular group are alike. No two people are exactly alike. Someone who is different is not bad or less important.

Diversity is important:

- To our patients and families. Patients and families of all cultures come here. They deserve respect and concern for their traditions. Children will be more comfortable and responsive to care when offered in a familiar and supportive environment.
- To Children's Hospital. Our hospital will thrive and grow as we are able to meet the needs of a diverse population.
- To volunteers, employees and Allied Health Personnel. Volunteers, employees and Allied Health Personnel from diverse backgrounds deserve respect and understanding. They are better able to perform their responsibilities in a supportive atmosphere. If we were all alike, we would have the same strengths and the same weaknesses. Diversity brings a variety of perspectives and strengths to the workforce.

As a volunteer or employee who works here, I must:

- **Avoid assuming** that a person in a particular category or group has the characteristics often attributed to that group.
- Realize that I may be biased, so **ask questions** to clarify behavior or appearance that may be different from what I am familiar with.
- **Refrain from comments or jokes** at all times on the job about groups of people who are different.
- **Communicate honestly** about how I want to be treated if I am offended by something which is said or done in the workplace.
- **Use internal resources** if I am unable to communicate successfully with a patient of another culture or resolve a cultural conflict or misunderstanding with a coworker.

Suggested resources available from ACH Staff Development, Ext. 3513:

"Overcoming Cultural Barriers in Healthcare" (OA self study article)

"Cultural Diversity in Healthcare" (video)

"Diversity in the Workforce" (video)

"Hispanic Growth in Arkansas" (OA self study article)  
"Meeting the Needs of our Hispanic Patients & Families" (video of Grand Rounds presentation)

**ACH SAFETY  
MANAGEMENT PROGRAMS**

## **Safety of People, Processes and Setting**

### **Personnel Files**

You have a confidential Allied Health personnel file which is maintained in the Medical Staff Office. The file contains your Allied Health application, performance evaluations and other records related to your ACH status. You may review the contents of your Allied Health file during the regular business hours of the Medical Staff Office (8 a.m. to 4:30 p.m. Monday through Friday).

### **Keys and Access to Specific Work Areas**

Some Allied Health Team members may be issued keys or granted access to specific work areas. It is the responsibility of the Team member to safeguard the keys issued to them in order to maintain adequate security. The duplication of keys and/or allowing unauthorized access to work areas is strictly prohibited. If your job requires you to have keys, you will be asked to sign for them. If you transfer to another department or leave ACH, you are expected to return the keys entrusted to you.

## **CORPORATE COMPLIANCE PROGRAM**

### **Why A Corporate Compliance Program?**

ACH has established a Corporate Compliance Program to help protect against fraud and abuse in our organization. More than anything else, Corporate Compliance means good business practices and signifies our intent to always conduct business in an ethical manner, ensuring the best interest of all our customers.

### **The Federal Government and Corporate Compliance:**

- Corporate Compliance is relatively new to healthcare but has been around in other industries for some time.
- In the simplest terms, it means "businesses must follow the rules and do what is right."
- In 1984, the Sentencing Reform Act created more uniform sentencing for those violating federal laws. It rewarded organizations for preventing and reporting their own violations.
- In 1995, U.S. Attorney General Janet Reno and the Justice Department began combating health care fraud and abuse.
- The Office of the Inspector General (OIG) is now aggressively investigating reports of fraud and abuse within healthcare organizations.
- Those found guilty of wrong doing (intentional or unintentional) are penalized with severe fines, sometimes involving millions of dollars.
- Corporate Compliance Programs are a way for institutions to police themselves and help prevent violations and fines from occurring.

## **ACH's Role in Corporate Compliance**

- In 1998, the ACH Board established the ACH Corporate Compliance Program and named Phil Gilmore as the Corporate Compliance Officer (ACH phone number 320-4368).
- ACH has always conducted business in an ethical manner, and has not been accused of any wrongdoing.
- The Corporate Compliance Program is a proactive step to ensure that ACH maintains our current ethical, correct business practices at all levels. This, in turn, allows us to continue to do what we do best - take care of the children of Arkansas.
- Some of the major areas of focus for the Corporate Compliance Program are:
- Correct billing of services and avoiding common errors:
  - billing for services that were not done
  - incorrect coding of procedures/ charges
  - duplicate billing
  - billing outpatient charges during inpatient stays
- Providing and billing ONLY medically necessary patient services
  - MD must order specific items needed by that patient
  - All MD orders must be accurately & promptly transcribed & carried out
- Accurate and complete medical records documentation which confirms those items being billed (NOT DOCUMENTED = NOT DONE!)
- In teaching hospitals, the need for attending physician supervision of residents and correct documentation and billing by the attending (supervising) physician
- Avoiding violations of any federal or state statute or regulation (i.e., Drug Enforcement Agency Narcotics Control Regulations, COBRA antidumping, antitrust, no kickbacks or conflict of interests, etc)
- Accurate processing of all financial contracts
- Cost-effective practices which avoid inflation of patient charges

## **THE CODE OF CONDUCT**

- ACH has a Code of Conduct that applies to every employee, physician, volunteer, vendor and other agents that work with ACH.

- Corporate Compliance education is mandatory for all ACH employees at the time of employment (New Employee Orientation) and on an annual basis.
- The Code of Conduct serves as a written commitment from ACH to always do what is ethical and proper, ensuring the best interests of all of our customers.
- All employees, physicians, volunteers, vendors and other agents of ACH will be given a copy of the Code of Conduct and a form to sign acknowledging they have received the document.
- While no one is expected to memorize the Code of Conduct, everyone is responsible for being aware of the contents of the Code of Conduct.
- It is everyone's responsibility to abide by the Code of Conduct as it relates to your role within the institution.

**The ACH Code of Conduct:**

1. We are committed to the ethical treatment of those to whom we have an obligation.
2. We obey the law.
3. We work safely.
4. We promote a positive work environment.
5. We safeguard the privacy rights of our patients, their families, and employees.
6. We use our Organization's assets wisely.
7. We keep accurate and complete records.
8. We avoid conflicts of interest.
9. No illegal gifts, favors or kickbacks are given or received.
10. We make use of the reporting systems when we observe or suspect that this Code is not being honored.
11. We follow through on all compliance related complaints.

**ACH COMPLIANCE HOTLINE**

- Anyone who knows of or suspects unethical, illegal or questionable activity is obligated to report such activity for the good of the institution and those we serve.
- Ideally, anyone who has something they feel they need to report should do so to their supervisor or manager.
- An individual can also report to the Corporate Compliance Officer or Director of Corporate Compliance.
- However, if an individual is not comfortable making a report in person, a telephone hotline has been established to make reporting easier.
- The Compliance Hotline is operated by an independent company, located outside of Arkansas, which specializes in Corporate Compliance Hotline services.
- Calls to the Compliance Hotline are toll-free. The number is 1-877-384-4275.

- The Compliance Hotline operates 24 hours a day, seven days a week.
- Calls will always be answered by a live person.
- All calls are confidential (calls are not recorded and cannot be traced) and callers may remain anonymous. You do NOT have to identify yourself by name or the department you work in.
- There will never be any retaliation for calling the Compliance Hotline.
- All calls to the Compliance Hotline are reported back to ACH within 24 hours (if the call requires immediate attention, the Director of Corporate Compliance is notified immediately).
- The Corporate Compliance Office will investigate all calls made to the hotline.
- Callers may call back to the Compliance Hotline to find out how their call was handled (the hotline operator will give the caller a call back date and a unique code if the caller remains anonymous).

## **CORPORATE COMPLIANCE EXECUTIVE COMMITTEE**

The Corporate Compliance Executive Committee assists the Corporate Compliance Officer direct investigations and advises on issues as necessary.

This committee meets once a month, or more often, as needed.

### **\*\*SPECIFIC IMPLICATIONS \*\***

#### *1. Billing*

- All billing and charge sheets for ACH service rendered must be done accurately.

#### *2. Documentation*

- All documentation related to clinical and other services rendered must be accurate and complete as this validates that we actually provided the services.
- Documentation should be consistent throughout the medical record and with any other existing ACH records (i.e., MD order for medication on 7/8/98 should be reflected in nursing documentation with medication starting 7/8 and in the pharmacy documentation for drug dispensing).

#### *3. Narcotic Practices and Documentation*

- All narcotics should be administered only with appropriate physician's orders.
- All narcotic security practices must be followed exactly as written in ACH policy and procedure.
- All documentation must be filled out accurately and in accordance with ACH policy and procedure (this includes documentation of administration on

MAR's/flowsheets and documentation of all wastage in accordance with ACH policy and procedure)

*4. Accuracy of order transcription and processing*

- All orders must be transcribed exactly as written by the M.D.
- All orders placed into the computer system must be entered exactly as written by the M.D., including any specific reasons noted for the test or procedure, and done in accordance with that department's procedures. This is essential when dealing with diagnostic testing, including all laboratory testing, radiology, and other services, as it relates to "providing services which are medically necessary".

*5. Specific issues involving special regulatory statutes or financial contracts for services*

- Many areas have specific issues related to a particular federal or state laws (i.e., Emergency Department and COBRA) or may be involved with special non- ACH contractual services.
- Employees in these departments must practice in compliance with these laws or specific contractual terms. For questions about these issues, seek help directly from your manager or administrator.
- Managers and administrators should seek assistance from Legal Affairs, Financial Services, and/ or the Corporate Compliance Office prn for existing issues and as new issues arise.

\*\*Refer to the following policies/procedures for additional information:

**ACH Administrative Policies**

**ACH Personnel Policies**

**Pharmacy/Nursing:** Controlled Substances - Diagnostic Areas and Emergency Department, Controlled Substances - Non-CII Variable Doses, Controlled Substances - Inpatient Floor Stock Procedures, Medication Security, Medication Administration Record, and Medication Security

**Nursing Policies:** Diagnostic and Therapeutic Orders: Acknowledging, Coordinating, and Implementing

**Computer Information Security**

It is your responsibility to protect your password(s) which authorizes your access to Meditech and the ACH network. Additionally, information obtained, used or stored through your access must be protected and shared only with persons who have a "need to know" the information or have authority for the sharing of information.

**Protection of Patient Information**

ACH has implemented steps to comply with the Administrative requirements of the HIPAA Privacy Regulations. The designated Privacy Officer has also been designated as the contact person for receiving complaints concerning violations of the ACH Privacy Policies and as the person from whom additional information may be obtained concerning any of the issues discussed in the ACH Notice of Privacy Practices.

**Reporting Suspected Violations**

ACH will address any complaints by an individual that involves a potential violation of such individual's privacy rights. Any complaint regarding the privacy of protected health information is to be made in writing to:

Arkansas Children's Hospital  
Attention: Regulatory Affairs  
800 Marshall Street  
Little Rock, AR 72202-3591  
501-364-4368

**The Corporate Compliance Hotline is open 24 hours a day and the call is free (1-877-384-4275). Your call is confidential and you may remain anonymous.**

### **No Intimidation or Retaliatory Acts**

ACH will not intimidate, threaten, coerce, discriminate against or take any retaliatory action against any individual: (1) exercising any right provided for in the HIPAA Privacy Regulations; (2) for filing a complaint alleging that his privacy rights have been violated; (3) assisting, testifying or participating in any compliance review or other proceeding concerning an alleged violation of the HIPAA Privacy Regulations; or (4) opposing any act not allowed under the HIPAA Privacy Regulations.

### **GENERAL SAFETY AND ACCIDENT PREVENTION**

The Safety and Emergency Manual contains program descriptions and policies for all aspects of Safety management. The manual can be found on the MYACH web page under ACH policies. Critical safety policies can be found in the red binder in your department/unit. A quick reference guide can be found on the MYACH website page. Note the location of the red Safety and Emergency Manual which contains critical safety policies, department specific safety policies, and material safety data sheets. *All general safety policies are available on the My ACH webpage (pull up on computer screen).*

In addition to the campus wide policies described in the manual, all departments are required to develop departmental specific safety policies which describe procedures which relate specifically to that department. At a minimum, departments should develop and maintain written plans for the following: Fire Safety; Evacuation Procedures; External Disaster; Internal Disaster; Tornado Disaster; Equipment Training; and Hazardous Materials. Other policies may be developed as necessary. Review your departmental specific safety policies, and (if applicable) the green binder OSHA specific safety checklists that was given to certain high-risk areas.

All ACH employees sick, injured, or exposed should report to Employee Health for treatment. The Employee Notice of Injury form should be completed. Employee Health is located in the basement (north end) of the Dennis Building, one block east of the main hospital. Hours of operation are: Monday-Friday 7:30 am to 4:00 pm. *In 2005, the leading injury to employees was exposure to communicable diseases.* Ask your manager what the most common types of injuries for your department for the past year.

OSHA specific information and training may be necessary for your area. Please review the binder (listed above) or contact the EHS Department (ext. 43800) if you have questions.

### **PROTECTIVE MEASURES**

Review specific job hazards or operations in your department (e.g. infectious, chemical, physical, mechanical, thermal, radioactive, etc.) *A written hazard assessment must be on file with the EHS Dept. describing types of hazards and personal protective equipment and clothing necessary to protect the employees.* This PPE must be worn - not just available. Employees must receive the following training concerning PPE:

1. When PPE is necessary
2. What PPE is necessary
3. How to put it on, take off, and wear properly
4. Limitations of the equipment
5. Proper care, maintenance, useful life, and disposal procedures

### **ACCIDENT REPORTING**

Note the location and types of reporting forms in your department.

- Employee Notice of Injury (Form N) - send to Employee Health
- Safety Committee Incident Report - send to Safety Department
- Quality Assurance Occurrence Report - send to Risk Management

All employees are encouraged to report safety hazards to their supervisor or to the Environmental Health and Safety Department (EHS) at extension 43800 or by OA/e-mail to the Safety Officer – Richard James. The EHS "representative" on call can be reached at pager #0075 for emergencies. In addition, staff may contact Maintenance at extension 41222 or Security at extension 44353.

### **SECURITY**

All employees of ACH are required by policy to obtain and wear an ACH identification badge. Students are also required to wear a form of ID. Badges are issued by the Security Department, and ACH Security Officers are required to check all employees entering the hospital for an ID badge. If an employee forgets or loses their ID badge, it is his/her responsibility to get another. Please do not put stickers and decals on the ID badge so our families can readily identify our staff.

If your department or unit has panic buttons review their location with your manager or safety coordinator.

All ACH employees and students are also required by ACH policy to have a parking decal on their vehicle. Parking decals are also issued by the Security Department. The decal is to be placed on the left rear side of the vehicle glass, so it is visible. The Security Department issues parking citations to those employees who park illegally, and to employees who do not have parking decals.

Security Dispatch is manned 24 hours a day, 7 days a week. If an emergency arises and assistance is needed, contact Security at extension 44353. If Security assistance is needed on the parking lots, employees should utilize the emergency call boxes installed on all lots except the patient lot. These boxes connect directly to Security Dispatch.

Please secure your personal valuables and encourage or patients to do the same.

Employees are discouraged from parking on the city streets around the campus of ACH. The parking lots are monitored by CCTV cameras, and patrolled by outside Security Patrol.

Visitors coming to the Emergency Department will pass through a metal detector for the detection of potential weapons. Employees wearing their ID badges will not have to pass through the detector.

### **CODE ADAM**

Code Adam is a tool to notify staff in the event a patient is missing. When the Code is announced, staff should look in his/her area for the patient described in the announcement.

Patients that are an elopement risk should be wearing an orange striped arm band. Patients leaving the unit must be escorted by an employee wearing their ID badge or another adult also wearing an orange arm band. If staff sees a patient wearing an orange arm band that is not accompanied by either of the above, contact the Security Dispatch at extension 44353.

### **WORKPLACE VIOLENCE**

Violence in the health care industry is widespread. Although it is increasing in severity and frequency, violence against employees in areas such as psychiatric facilities, community mental health clinics, infirmaries in corrections departments, pharmacies and community care facilities has been a serious problem for many years. Health care workers are at risk for both fatal and non-fatal violence-related injuries. Between 1980 and 1990, 106 occupational violence deaths occurred among the following health care workers: 27 pharmacists, 26 physicians, 18 registered nurses, 17 nurses' aids, and 18 health care workers in other occupational categories.

Whenever patients or visitors display aggressive or hostile behavior, supervisors or managers should be notified as well as staffing providing care; then necessary protective measures must be taken.

All hostile or aggressive behavior shown by a fellow staff member should be reported to the supervisor.

Staff should be made aware of engineering controls available in the departments such as panic alarms, controlled access devices, and means of emergency communication.

All staff needs to be trained on departmental specific risks associated with the areas they work. As a safety coordinator, please contact Security if you have any questions regarding your specific department.

If a staff member becomes aware of domestic or personal situations involving threats or actual acts of violence to a fellow staff member, this information should be communicated to the supervisor.

### **EMERGENCY MANAGEMENT**

The following is a summary of emergency plans at Arkansas Children's Hospital:

Code Green - External Disaster (*victims from the community*)  
Code Echo - Internal Disaster (*utility outages, water damage, etc*)  
Severe Weather Alert - Severe weather threatening the hospital  
Code Tango – Tornado  
Code Blue - Medical Emergency  
Dr. Red - Fire  
S-Team - Bomb Threat

#### ***To report any emergency Dial "88"***

The Tango policy has changed which incorporates a Severe Weather Alert when weather deteriorates. The Severe Weather alert will be announced overhead so that staff can begin getting prepared to move patients and families in the event of a Code Tango (tornado). A Code Tango will be announced when a tornado threatens the facility.

When a medical emergency occurs involving employee and patients within the hospital & or out buildings, dial 88 for assistance. The ACH operator will notify emergency services and direct them to you.

Emergency management policies are found in the Safety and Emergency Manual or on the MyACH web page.

### **HAZARDOUS MATERIALS MANAGEMENT**

There are four major programs covering hazardous materials at ACH consisting of the following:

1. Hazard Communication
2. Laboratory Chemical Hygiene
3. Hazardous Materials Disposal, and

#### 4. Hazardous Materials Spill Response.

The Hazardous Communication Program informs the user about various safety and health aspects of chemicals used at ACH. The Laboratory chemical hygiene program is essentially the same but designed for laboratory operations only.

If a container has a warning on the label with warning (e.g.; Warning, Danger, Caution, Toxic Flammable, Caustic, Irritant, Poison, etc.) then the material is considered hazardous and must be included in the requirements of the Hazard Communication Program or Laboratory Chemical Hygiene Plan.

Only infectious materials should be placed in red bagged containers. All other trash should be placed in normal trash containers.

#### LABELS

Labels are required on all containers of hazardous materials. Damaged labels should be replaced. Extra containers (e.g.; small bottles filled with a stock solution) should also be labeled like the original container.

#### MSDS

Material Safety Data Sheets must be available to employees and legibly written. **The user is required to obtain a MSDS.** *Material Safety Data Sheets may be obtained by using the “MSDS” button on the MY ACH web page. Type the name of the chemical and print the MSDS from the manufacturer used by ACH. If the MSDS is not found, notify the EHS Department, extension 43800, and a request will be forwarded to include this in the selection.* The first aid section of the MSDS is very important for employees.

MSDS's are USUALLY kept in the red Safety and Emergency Manual. However, if there is too much material to fit in the book, another designated book may be used **IF ALL EMPLOYEES KNOW HOW THIS BOOK IS LABELED AND WHERE THE IT IS KEPT.**

#### INVENTORY

A chemical inventory must be maintained for departments which use hazardous materials. The inventory is kept in the red Safety and Emergency Manual. *This is updated annually on the eReq system by the Safety Coordinator.*

#### TRAINING

Departments which use hazardous materials must provide annual training to employees. Training includes specific hazards of the chemicals, unusual job tasks involving chemicals, and wearing personal protective equipment (e.g.; gloves, glasses, etc.).

1. Location of the chemical inventory.

2. Location of Material Safety Data Sheets. (*Located at the last blue tab in the Safety and Emergency Manual*).
3. Labels on all containers should be replaced if destroyed or missing.
4. OSHA Hazard Communication Standard and appendices and the ACH hospital policy are available to employees.
5. Location/operations where hazardous chemicals are used and stored.
6. Physical and health hazardous of the chemicals used (flammable, toxic, caustic, etc.).
7. Protective clothing and equipment location and requirement to wear.
8. Methods of detecting the hazardous chemicals (odors, color, etc.).

Disposal of chemotherapy, chemicals, infectious waste, sharps, and radioactive material is regulated. The hospital policy "Hazardous Materials Disposal Policy" should be followed.

### **CHEMICAL SPILL**

If there is a chemical or radioactive material spill the user must clean up the chemical spill – NOT Environmental Services. If the chemical is toxic or very large or is a radioactive material contact the Environmental Health and Safety Department (EHS) at extension 43800 or pager 0075. If the user cleans up the spill, remember exposure precautions, wear safety equipment and clothing, move people away from the spill, and the spilled material is hazardous and must be disposed of properly.

### **BIOLOGICAL OR INFECTIOUS SPILL (Blood or body fluids)**

If blood or a body fluid is spilled and the user needs help, contact Environmental Services at ext. 41170 or page the supervisor.

### **FIRE SAFETY AND FIRE EXTINGUISHER**

Dr. Red is the designated announcement for a fire alarm in the main hospital or Sturgis building.

Reinforce the acronym R.A.C.E. constantly.

- R** Remove or Rescue
- A** Alarm (activate fire alarm pull station and dial "88")
- C** Contain
- E** Extinguish

A fire alarm pull station activates the entire fire alarm system and is the fastest way for all of us to get help in the event of a fire or possible fire. All employees need to know the location of the pull stations in their immediate areas. Make sure everyone understands that in conjunction with activating the pull station, they also need to dial "88".

When we talk about CONTAINING, we need all doors closed, not just patient rooms. When fire doors are closed and latched they provide a minimum of 2 hours protection from fire smoke.

For operation of a fire extinguisher teach employees the P.A.S.S. acronym:

- P** Pull the pin
- A** Aim the nozzle
- S** Squeeze the handle
- S** Sweep at base of fire

Ensure that access to fire extinguishers is always free of any obstruction. You may need to get to one very quickly. Routes of egress also need to be clear of all items. Time can make a difference and you may not have enough time to move things to evacuate or get to your fire extinguisher.

Employees need to know the location of their closest fire extinguisher. ABC extinguishers are for use on all types of fires. Remember that carbon dioxide and water extinguishers are found in the Critical Care Area. ***We are currently in the process of switching CO2 and water extinguishers for a single clean agent called Halatron.*** For those of you in sprinkled areas, no storage of materials is allowed within eighteen inches below the head of the sprinklers across the plane of the room. This is true for the entire area that has sprinklers. Keep items off of top shelves and away from sprinkler heads. Life Safety Code prohibits the use of any items to block doors open.

In the event of evacuation, units/departments within the hospital will first move horizontally from their area through corridor smoke/fire doors into an adjacent smoke compartment. If the situation deteriorates, a vertical evacuation via elevators will be performed. ***Look for corridor doors with a red label which indicates a smoke and fire separation which provides a safe haven for staff and patients.***

#### PROHIBITED EQUIPMENT

Electrical heaters, cheater plugs, and extension cords are not allowed at ACH. Prohibited breakroom appliances include toaster ovens, coffeemakers with hotplates, and microwaves over 900 watts. If combustible materials get too close to these heaters ignition of material can occur and cause a fire.

#### STORAGE

No temporary or permanent storage is allowed in the corridor. If equipment or supplies carts are in active use then they are allowed in the corridor. In addition, equipment is not allowed to temporarily stored in the corridor to charge.

#### **EQUIPMENT MANAGEMENT**

Clinical Engineering is responsible for testing, repairs, and inventory of all medical equipment used for patient care. If equipment is suspected of malfunctioning, contact Clinical Engineering at extension 41463. Each department utilizing medical equipment has a written backup plan for medical equipment malfunctions. Direct your questions to your department director.

***All new and loaned medical equipment should be tested by Clinical Engineering PRIOR to being used in patient care.***

In the past, patient care equipment has been marked with colored stickers. This practice is no longer used. Staff may receive information regarding equipment status, preventative maintenance history and other pertinent information by contacting Clinical Engineering at extension 41463. Equipment that does not require periodic testing will be marked with an "EXEMPT" sticker placed on the equipment.

Users must receive specific training on the proper operation and safety of equipment if it could cause physical harm. The following criterion dictates the need for required training:

- New equipment
- New employees
- New procedures
- Equipment with a trend of accidents
- As required by the department manager

Review care of batteries for patient equipment. Contact Clinical Engineering (ext. 41463) with questions.

#### **UTILITIES MANAGEMENT**

**Emergency electrical power is provided within 10 seconds to all critical areas, red emergency power outlets, exit egress lighting, and designated equipment.** In addition, the hospital's turbine generators can be brought on line within an hour and will carry the balance of the hospital's electrical load. Emergency electrical outlets are identified by the color red. Emergency electrical outlets may be used during non-emergency times for patient care equipment.

**Backup telecommunication devices are the beige Meridian telephones and the black Nortel Networks telephones associated to toggle switches that are located in designated areas.** When the toggle switch is activated (switch forward) these phones are intended to serve as an emergency backup system in case the regular phone system is out of service. The black phones will also say "Emergency Mode" on the display when the toggle is activated. **It is important to note that the red phones, previously used and replaced by the phones with toggle switches, are the secondary backup system and have limited capabilities.** Unlike dialing a 5 digit internal extension, the red Plexar phones can be reached by dialing a 7 digit telephone number. The Plexar (red phone) directory is listed in the Meditech System.

Medical gas valves must only be operated by Respiratory Care staff. At times, the Maintenance Department will perform preventive maintenance or replacement of parts on the valves. Employees should be aware of the location of medical gas shut-off valves.

During times of construction, staff may only enter a construction / renovation area when approved and escorted by staff from Physical Facilities. Otherwise, this is a violation of hospital policy and Occupational Safety and Health Administration (OSHA) requirements.

### **INFECTION CONTROL**

Infections within the hospital are transmitted by direct contact; therefore hand disinfection is the most effective method to prevent transmission. Our hand hygiene consists of washing with soap/water; use of alcohol gel/foam and use of lotion. There are multiple choices for hand disinfection/hygiene available at ACH.

Isolation precautions for diseases such as pertussis, meningitis, or RSV bronchiolitis are found in the Infection Control Manual available on My ACH web page, ACH policies, under Infection Control. For resistant isolates look under the Significant Pathogen Precaution section for isolates such MRSA and resistant gram negative bacilli.

Patients in the intensive care units are at the greatest risk of developing hospital related infection- called nosocomial infections (ventilator pneumonia) - secondary to exposure to devices such as ventilators, central venous catheters and urinary catheters. Prevention of nosocomial infections is part of the ACH Patient Safety Program. The most common nosocomial infection in pediatric patients is a bloodstream infection.

Employee protection programs include the Bloodborne Pathogen and Tuberculosis Control. Protective measures such as safe handling of sharps/needles and TB skin testing of employees are parts of these programs. Manuals for these programs are available on the MY ACH web page/ACH policies or contact Infection Control at extension 41322 or 43722.

### **FIRE/DISASTER PLAN IN THE OR**

1. Remove any patient in immediate danger beyond the 2-hour fire wall located outside the OR #12 or West to Express Care or East to PACU.
2. Hospital evacuation will only be called by the Hospital Administrator on call and/or by the Fire Authorities. Hospital evacuation will be by the stairwell adjacent to PACU.
3. Activate the alarm system located: 1) next to stairwell by OR #1, 2) next to stairwell from PICU elevator, and 3) in hallway to the left of the oR lounge by the door leading to the RED elevators.
4. Dial "88" to give operator exact location.
5. Contain the fire or smoke by closing doors.
6. Extinguish fire, if possible.
7. Turn off all gases and electrical equipment.
8. The OR Director/Assistant Director/Shift Coordinator will ensure patients are evacuated to appropriate areas and that all doors are closed.

9. All surgeries in progress will expedite the procedure as appropriate to evaluate as necessary.
10. No surgery will be started until an “ALL CLEAR” has been announced.

### **INCLEMENT/SEVERE WEATHER/EMERGENCY CONDITIONS**

It is the policy of ACH to maintain essential services and operations during any severe weather or emergency condition while providing for the protection, safety and health of all patients, Team members, medical staff and visitors. Essential services include maintaining hospital operations and providing necessary support and administrative services.

Because of the essential services ACH provides to the community at large and our responsibility to support and care for patients, we are not at liberty to cease operations during severe weather and emergency conditions. ACH and its Team members must be prepared to safely operate and serve during these extraordinary conditions.

Every ACH Team member performs important services and work. During extraordinary times of severe weather or emergency conditions, some positions require on-site presence to continue operations of patient care, support and operational functions. To ensure continuous operations during these conditions, all jobs are categorized into one of three service levels in support of the policy.

Essential Service: jobs that are required to maintain essential services and operations during any severe weather or emergency condition while ensuring for the safety and health of all patients, Team members, medical staff and visitors.

During Severe Weather/Emergency Conditions or when a State of Emergency has been issued, **essential service Team members**:

- Report to or remain at work
- Transportation services provided for essential staff
- Childcare services provided
- Meal service and sleeping arrangements provided as needed

The Administrator on Call or President/CEO will determine whether to activate or terminate the severe weather/emergency conditions policy and authorize communication as early as possible before the start of each shift. Once activated, the policy provisions will remain active for the duration of the work shift.

## **ACH TEAM SERVICES**

### **Employee Health Program**

The nurses in Employee Health maintain Employee Injury Reports on all on-the-job injuries and exposures to infectious diseases. If you are injured on the job, you should complete an Employee Injury Report and bring it to Employee Health Services within 24 hours of the injury. Physician referral will be arranged if needed. The Employee Health Nurse will see that you receive proper medical treatment and assist you in filing a claim for Workers' Compensation as required by law.

Routine immunizations such as TB, MMR, Hepatitis B vaccine, Flu vaccine, and TB evaluations are available in Employee Health.

### **Chapel/Pastoral Care**

Devotional services are held every day of the year in the Pamela Friday Freeman Chapel at 9:30 a.m. The chapel is located on the second floor of the main hospital building near the cafeteria. Patients, family and hospital staff are invited to attend the services. Memorial services and other special religious observations are occasionally held in the chapel

The chapel is open and available around the clock as a place for prayer, Scripture reading or meditation. Persons of all faith backgrounds are welcome to use the chapel. Arrangements for special services can be made through the Pastoral Care Office, ext. 4-1823.

A chaplain is available 24 hours a day to assist patients, families and hospital staff with religious and spiritual concerns. To contact a chaplain, ask the hospital operator to page the chaplain on-call or call the Pastoral Care Office at ext. 4-1824.

### **Child Enrichment Center**

ACH operates a well supervised and equipped Child Enrichment Center for the convenience to ACH Team members and medical staff. The center is staffed by caring professionals and is located in the East Campus building within walking distance of the hospital. For more information contact the Child Enrichment Center at ext. 3566.

### **Employee Fitness Facilities**

ACH offers you and your family members have access to two on-site fitness facilities. The Main Hospital Center is located on the first floor across from the Eye Clinic and is open 24 hours, 7 days per week.

The East Campus facility is open 7 days a week. Hours are Monday through Friday - 5:30 a.m. to 8:00 p.m.; Saturday - 8:00 to Noon and Sunday - 1:00 to 5:00 p.m. This center offers an indoor track, gymnasium, 2 racquet ball courts, state-of the art equipment, personal trainers and fitness instructors, and a number of fitness classes. Memberships include individual, employee plus one, and family memberships.

### **Capital Café and Java City**

Excellent hot meals at reasonable prices are available in our attractive café 7 days a week. Main meal service is from 6:00 a.m. to 10:30 a.m. (breakfast), from 11:00 a.m. to 1:45 p.m. (lunch), and from 5:00 p.m. to 7:00 p.m. (supper). Team members who present their ACH ID badge at the time of purchase will receive a 20% discount on their food purchases in the Capital Café.

Java City is located in the lobby of the main hospital and is open 7 days a week for your convenience. They provide gourmet coffees and beverages and food items.

### **Playaway Gift Shop**

The Gift Shop is located in the atrium of the hospital. It is an attractive, well supplied shop staffed by several full-time employees and volunteers. It is operated for the convenience of our patients, families, Team members, medical staff and visitors.

Since its beginning in 1982, the gift shop has been the flagship of the Hospital Auxiliary and all profits are given to the hospital by the auxiliary. A 10% discount is given with the presentation of an ACH badge to ACH Team members and medical staff on purchases. A 25% discount is offered during the calendar week of your birthday on one eligible item.

### **Volunteer Services**

ACH has an active volunteer program to enhance and extend services to patients. Approximately 500 volunteers serve in the Gift Shop, Child Life, Admissions, Foundation, Clinics, Patient/Family Services, Ambulatory Surgery, Public Relations, Rehabilitation, Library and elsewhere. About 200 junior volunteers, ages 14 and over, are serving in the hospital. ACH staff volunteer for special projects and in various departments within the hospital. Interested staff can call Volunteer Services at 364-1825 to get involved.

### **ACH Medical Library**

The Medical Library is located on the first floor of the Sturgis Building. The pleasant, quiet study area contains books, medical journals and tapes. Access to the Medline, nursing and Psychological Abstract databases is also available. Please contact the librarian for more information at 364-1801.

The Family Resource Library, located inside the Medical Library, has a wide variety of books, magazines, pamphlets and videos to promote good health for children with information that helps the child and family understand health conditions and their care. Materials in this collection are selected to serve people of all ages.

## **AGE SPECIFIC INFORMATION**

## AGE-SPECIFIC INFORMATION

### Introduction

- Arkansas Children's Hospital cares for children and adults of all ages.
- All patients are unique and need contact that is appropriate for their respective ages.
- Read the following characteristics of different age groups including some suggestions for interacting with people of different ages in appropriate, caring ways.

### Patterns of development

Growth and development are marked by relatively predictable events. To understand the events related to this process, the patterns of development and the sequencing and rate of growth must be considered.

Growth and development occur in **regular related patterns**.

1. Each system **has critical periods of development**.
2. Each is reflective of physical development and maturation of neuromuscular function.
3. The directions are:

### Cephalocaudal

- development begins at the head
- the head is large and complex and the lower end is simpler and develops later

### Proximodistal

- "near-to-far" concept or "midline-to-proximodistal" concept
- CNS develops prior to peripheral nerves

### Differentiation

- simple occurs first and is followed by complex (i.e., the child rolls over, crawls, creeps, stands, walks, and finally runs)
- broad global behaviors are followed by more specific and refined behaviors (i.e., an infant will "palm" an object while trying to pick it up before being able to use the thumb and forefinger in a "pincer" grasp to pick up a small object)

### **Sequencing and rate of growth**

1. There is a predictable sequence for all dimensions of growth.
2. Each stage is affected by all preceding and following stages.
3. Does not occur at the same rate for all children.

### **Factors adversely affecting growth and development:**

1. Genetic Factors
2. Physical Factors
3. Environmental Factors
4. Social, Cultural and Affective Factors

### **NEONATES (Birth - 1 month)**

#### **General Considerations**

1. Major stressor - physical immaturity.
2. Remember - limited cerebral cortical pathway - connections not fully established
3. Behavior is largely reflex in nature

#### **Physical Considerations**

1. Position is one of flexion
2. Metabolic rate about 2 times adult's with body surface area 3 times adult's - therefore, predisposed to excessive heat loss
3. Also have difficulty in dissipating extra heat - therefore, risk of hyperthermia
4. Greater risk for acidosis due to high metabolic rate
5. Rate of fluid exchange twice that of adult with greater percentage of extracellular fluid
6. Immature kidneys can't concentrate urine - therefore, higher risk for overhydration
7. Head is 70% of eventual body size
8. Skeletal system contains large amounts of cartilage. Fontanelles are open because six skull bones are soft and not yet joined.
9. Eyes can detect movement, colors, changes in brightness, and visual patterns
10. Hears very well - knows mother's voice by 3 days of age

11. Has well developed sense of smell and can recognize caregivers by smell

### **Psychosocial Considerations**

1. Major developmental task is bonding with primary care giver
2. Development of trust essential during this period

### **Safety**

1. Obligatory nose breather
2. Vulnerable to aspiration due to proximity of respiratory & GI passages, immature cardiac sphincter, small stomach capacity
3. Vulnerable to temperature changes due to inability to sweat in response to heat and shiver in response to cold
4. Substantial fluid losses may occur from nose breathing, insensible losses through skin, limited ability to concentrate urine, warm environment, fever, GI losses, high metabolic rate
5. Limited inflammatory response and antibody production caused by immature immune and liver functions

### **Interventions to promote Growth and Development**

1. Touch and motion are essential to normal growth and development
2. Promote the idea of the infant as an individual with unique behavioral characteristics
3. Swaddling promotes sleep and maintains body temperature
4. Intermittent, vertical rocking promotes bright-alert behavior, while continuous horizontal rocking induces more drowsy behavior (Whaley and Wong, 1995, p. 293).

### **INFANTS (1 month - 12 months)**

#### **General Considerations:**

1. Time of rapid growth and development
2. Changing physically and socially and learning about the environment

#### **Physical Considerations**

1. Growth is very rapid, particularly during the first 6 months of life
2. Birth weight has doubled by 5 months and tripled by 1 year

3. Length has increased by 50% by 1 year of age
4. Head circumference increases by 33% by 1 year of age
5. Brain weight has increased two and a half times by 1 year of age
6. Visual acuity increases from about 20/100 to 20/40
7. Vital signs change - heart and respiratory rates slow and blood pressure increases
8. Thermoregulation becomes more efficient and increased adipose tissue is laid down by 6 months to provide insulation
9. Continues to have a greater proportion of extracellular fluid (ECF)
10. Digestion is maturing, but solids may still pass through undigested
11. Tongue becomes smaller in relation to rest of oropharynx and mature swallow reflex develops. Extrusion (tongue thrust) reflex fading by 4 months of age.
12. Teeth develop (number of teeth expected is figured by taking the age of the child - 6. In other words, a 9 month old child would be expected to have 3 teeth [9 - 6 = 3])
13. Fine motor development:
  - Can voluntarily grasp an object by 5 months
  - Can hold bottle and feed self a cracker by 6 months
  - Can transfer objects from one hand to the other by 7 months
  - Neat pincer grasp in place by 11 months

### **Gross motor development**

1. Can lift the head and front portion of chest approximately 90 degrees by 4 months
2. Has well established head control by 6 months
3. Rolls from abdomen to back purposefully by 5 months and from back to abdomen by 6 months
4. Sits alone by 7 months using hands for support; sits unsupported by 8 months
5. Crawls (moving forward with belly on floor) by 6 - 7 months
6. Creeps (moving forward with belly off floor) by 9 months
7. Pulls into standing position by 9 months
8. Walks supported by hand holding or by hanging on to furniture by 11 months
9. Walks with one hand held by 1 year and may walk unsupported by this time

## **Psychosocial Considerations**

1. Bonding with parents requires touching, talking, and playing
2. Needs to develop intrafamily relationships with siblings, grandparents
3. Responds more to mother than others, but continues to respond to "mothers" whether familiar or no at 8 - 12 weeks
4. Show preference for mother at 6 months of age
5. Begin to show attachment to other family members about 1 month after beginning to show attachment to mother
6. Begin to protest when mother leaves at about 6 months (although may not notice at first if involved in play)
7. Begin to protest mother leaving before she leaves by 11 - 12 months
8. Stranger anxiety develops between 6 and 8 months
9. Stressors: loud noises, bright lights, sudden environmental changes
10. Cognitive abilities depend on age in months
11. Reactions move from reflexive to intentional
12. Language development:
  - vocalizes by 5 - 6 weeks
  - makes single vowel sounds by 2
  - makes some consonant sounds, coos, gurgles, and laughs out loud by 3 to 4 months
  - imitates sounds and makes additional consonant sounds by 8 months
  - understands the meaning of words (including "no") and follows simple commands by 10 - 11 months of age
  - can say 3 - 5 words by one year
13. By 8 months the infant begins to coordinate two or more actions
14. Can play simple games by 6 months, imitate actions and noise by 7 months, imitate sounds by 8 months, and play pat-a-cake and peekaboo by 10 months

## **Safety**

1. Vulnerable to URIs and aspiration due to small airways, limited ability to chew, proximity of respiratory and GI passages, immature cardiac sphincter, and small capacity of stomach
2. Greater proportion of ECF and continued immaturity of renal structures places infant at continued risk for dehydration
3. Respiratory failure possible because of poorly developed accessory muscles of respiration and limited diaphragmatic excursion

4. Unable to distinguish dangers
5. Aspiration is the leading cause of fatal injury in children < 1 year
6. Motor vehicle injuries are the leading cause of accidental death in children < 1 year
7. Other risks include suffocation, poisoning, burns, drowning, and other bodily damage
8. Keep siderails up at all times
9. Have bulb syringe available for suctioning

### **Interventions to Promote Growth and Development**

1. Major fear: separation from primary caregiver
2. Parental anxiety may be transmitted to child
3. Mistrust may be evidenced as failure to thrive
4. To decrease anxiety:
  - allow child to keep parents in line of vision
  - have familiar objects available
  - cuddle and hug the infant
  - distractions such as pacifiers, bottles, and toys may help when assessments and interventions are performed
1. The greater the lack of harmony between the child's temperament and the parent's ability to deal with it, the greater the risk for parent-child conflicts (Whaley and Wong, 1995).
2. Stranger anxiety may be lessened by talking softly, meeting the child on his/her level, maintaining a safe distance, and avoiding sudden gestures or sounds.
3. Anticipatory guidance including immunizations, injury prevention, and strategies to promote growth and development should be discussed with families
4. when teaching procedures to parents, provide opportunities for return demonstration

### **TODDLERS (1 - 3 years)**

#### **General Considerations**

1. Slowed physical growth but continued systems maturation
2. Striving for independence and self-assertion

## **Physical Considerations**

1. Birth weight quadrupled by 2 1/2 years of age
2. Average weight gain is 1.8 - 2.7 kg/year
3. Average height at 2 years is 86.6 cm (34 inches) and is about half of adult height
4. Height increases about 3 inches/year and is mainly seen in the lengthening of legs
5. Head circumference increases about 2.5 cm in 2nd year then slows to about 1.25 cm/year by 5 years. Head and chest are approximately equal in size until after second year.
6. Visual acuity is about 20/20 and other senses are well developed
7. Respiratory and heart rates slow and blood pressure rises
8. Begins to have some control over elimination processes
9. Major gross motor skill is development of locomotion
10. Major fine motor skill is increased manual dexterity

## **Psychosocial Considerations**

1. Giving up dependence in exchange for control, independence, autonomy
2. May attempt to exert control through negativism
3. Has rapid mood swings
4. Becomes verbal
5. Tolerates separation from parent/caregiver
6. Interacts with others in a decreasingly egocentric manner and begins to act in a "socially acceptable" way
7. Acts in a ritualistic manner, which provides comfort
8. Engages in parallel play (plays along side other children but not with them)

## **Safety**

1. Injury is the leading cause of death
2. MVA's cause of most accidental deaths followed by drowning, burns, poisoning, and aspiration/suffocation
3. High risk for dental caries (nursing caries) if continuing to drink from bottle

## **Interventions to promote Growth and Development**

1. Any invasive procedure (even nonpainful) may evoke an exaggerated avoidance response
2. Hospital environment, strangers and procedures may evoke terror response
3. Separation anxiety may be intense
4. Short attention span and limited memory capability
5. Magical thinking may lead to perceiving machines as "monsters" or to feeling responsible for illness
6. Tend to falsely reason that when any two events occur together, that one has caused the other
7. Behavior can be very ritualistic; upset by changes in environment and daily activities
8. Low tolerance for frustration or pain; exaggerated responses to both
9. Responds better to visual than spoken cues

## **PRESCHOOLERS (3 - 6 years)**

### **General Considerations**

Considered critical for emotional and psychological development

### **Physical Considerations**

1. Weight gain is about 2.3 (5 lbs.)/year and height increases by about 2.5 - 3 inches/year
2. Gross and fine motor skills continue to develop
3. Body systems are mature

### **Psychosocial Considerations**

1. Learning to play in groups
2. Major fears: fear of the unknown, of the dark, of mutilation, bodily injury, of being left alone
3. May perceive procedures as mutilation or as punishment
4. Able to tolerate brief separation from parents with little protest if given explanations of where parents are and when they will return

5. May have difficulty differentiating reality from fantasy but moving toward understanding of cause and effect
6. Verbal expressions of pain and discomforts not always reliable
7. Critical period for speech development occurs between 2 and 4 years.
8. Failure to master results in stuttering or stammering

### **Interventions to promote Growth and Development**

1. Explain procedures (be honest) and unfamiliar objects
2. Demonstrate use of equipment, let child play with the equipment if possible/safe
3. Use of dolls/puppets for explanations when performing procedures may alleviate anxiety
4. Involve the child whenever possible
5. Provide rest periods during long procedures, testing, therapy
6. Assess and manage pain (distractions may help for short term pain during a procedure)
7. Allow child to choose site for an injection
8. Offer stickers or other rewards for cooperation

Do not restrict child's movement, unless necessary for safety reasons

### **SCHOOL-AGE CHILDREN (6 - 12 years)**

#### **General Considerations**

1. Great social and cognitive change
2. Maturation from biological and physiological standpoints
3. Gross motor skills organized and purposeful
4. Exhibit competition, learning styles, and great sense of humor

#### **Physical Considerations**

1. Grows about 2 inches/year and will double weight by age 12 years
2. Girls surpass boys in both height and weight by end of this period. Growth spurt for girls begins about 10 years and boys about 2 years later
3. Become slimmer with lower center of gravity. Fat decreases and muscle mass increases.

4. Will lose all primary teeth during this period
5. Enters prepubescence during the last 2 years
6. Gross and fine motor ability and coordination increase

### **Psychosocial Considerations**

1. Decrease in egocentricity
2. Prefers socializing with peers and friends vs. family
3. Wants some control over privacy
4. Can be reasoned with - increased concept of right and wrong
5. Likes reward systems
6. Great fears of the unknown: of bodily injury, mutilation, separation, death
7. May perceive hospital treatments as punishments
8. Can reason systematically about tangible or familiar objects and use logic to analyze relationships and implications of events
9. Able to describe discomforts in some detail
10. May have little understanding of anatomy, body functions, and illness

### **Safety**

1. Ideal time to begin to be responsible for own health
2. Begin to engage in risk taking behavior
3. Major sources of accidental injuries include MVA, bicycles, skateboards, and skates
4. Injury prevention directed toward education as well as provision of safe play areas

### **Interventions to promote Growth and Development**

1. Explain procedure in advance, use correct terminology
2. Explain equipment, let child touch equipment and try it out if safe
3. Allow child to have some control, offer choices if possible provide privacy
4. Assess and manage pain; may understand the use of a PCA or parent
5. May control analgesia; schedule medication to prevent pain (may need around-the-clock meds)

6. Assess response to pain medication prior to and after each dose to be sure patient is receiving enough to control pain
7. Define and reinforce behavior limits; use visual aids; be concrete and specific

## **ADOLESCENTS (12 - 18 years)**

### **General Considerations**

1. Longest period of development - becoming more "adult"
2. May have great change and turmoil
3. Characterized by biologic, cognitive, psychological, and social change (Whaley and Wong, 1995, p. 857)

### **Physical Considerations**

1. Biological changes constitute period called puberty
2. Become sexually mature as well as fertile
3. Final 20 - 25% of linear growth achieved and up to 50% of ideal body weight is gained
4. Lean body mass increases in both sexes and fat mass increases in girls but declines in boys
5. Neural system continues maturation as reflected in increased cognitive abilities
6. Skeletal growth is faster than muscle growth, thus allowing for incoordination

### **Psychosocial Considerations**

1. Move from concrete thinking to abstract, hypothetical type thinking
2. Separating themselves from parents and other authority figures and relationships with peers become more important
3. Body image: may be extremely self conscious with body changes, appearance, perceived flaws
4. Behavior may be inconsistent, unpredictable, moody, regressive; strongly influenced by peers
5. May be hypersensitive/hyperreactive to pain
6. Need time to adjust and cope with events
7. May need but not request adult support to cope effectively
8. Develop ability to think more abstractly, deductively, and to form their own opinions

## **Safety**

1. Risk taking behavior is common
2. Accidents are the single greatest cause of death
3. MVA's cause approximately 2/3 of all accidental deaths and alcohol is involved in the majority of these
4. Homicide is the second leading cause of death and first for black adolescents. Firearms are involved in > 70% of homicides.
5. Suicide is 3rd most frequent cause of death in this age group

## **Interventions to promote Growth and Development**

1. Discuss sensitive issues (such as sexuality) in private
2. Explain procedures and supplement with reasons
3. Privacy is very important
4. Involve patient in planning and decision making as much as possible
5. Allow adolescent to maintain as much control as possible
6. Provide essential teaching based on how the individual learns the best (auditory, visual, etc)
7. Provide information on pain control methods, assessment scale, schedule for pain management, need to ask for pain medication as soon as pain starts, need for them to provide information on degree of pain relief
8. Always address the patient when you are discussing them in their presence; if need for conversation about the patient with parents or other staff arises hold the conversation away from the patient (out of ear shot)

## **ADULTS**

### **General Considerations**

- Divided into three groups:
  1. early adulthood (20 - 29 years)
  2. young adulthood (30 - 44 years)
  3. middle adulthood (45 - 59 years)

### **Physical Considerations**

1. Growth stops, but physical strength increases

2. Body functions begin to diminish in efficiency and continue throughout adulthood
3. Body appearance begins to change as adulthood progresses
4. Basal metabolic rate decreases by 30% in middle adulthood
5. Decrease in amount of sleep needed as age
6. Cells begin to atrophy and body begins to shrink

### **Psychosocial Considerations**

- Early (ages 20 - 29):
  1. Period of change and new beginnings - living away from home, work, marriage, beginning a family, etc.
- Young Adult (ages 30 - 44):
  1. Develop adult roles at home, work, community
  2. Feelings of "now or never" in regard to achieving life goals
  3. Tasks related to managing household, child rearing, career development
- Middle Adulthood (ages 45 - 59)
  1. Time of "change in life"
  2. Tasks related to managing home, career, and role changes as well as improving quality of life for the young
  3. Often caring for both their children and their parents
  4. Major stressors for all groups includes loss or separation from meaningful work or social relationships

### **Safety**

1. Major causes of death for early adult are all related to violence: MVA, suicide, homicide, and other accidents.
2. Major causes of death for young adult are heart attack, stroke, cirrhosis (related to lifestyle).
3. Major causes of death for middle adult are heart attack and stroke.
4. All age groups need to be aware of risks related to drugs, alcohol, smoking, poor nutrition, and casual sexual behavior.

### **Interventions to promote Growth and Development**

1. Involve individual/significant other in plan of care
2. Explore impact of illness/hospitalization on career, family, body image
3. Be aware of body language which may give clues about unexpressed feelings
4. Assess and manage pain based on patients needs and response
5. Allow choices

6. Encourage as much self care as possible
7. Promote positive, health behaviors
8. Assist with lifestyle changes and stress management

## **GERIATRICS (60 years and above)**

### **Physical Considerations**

1. Losing hearing acuity to high pitched sounds
2. Decreased appetite due to decreased taste and smell
3. Decreased peristalsis
4. ROM decreased and reaction time slowed
5. Body systems continue to decrease in efficiency
6. Lose collagen and subcutaneous fat
7. Decreased sensory acuity: auditory, tactile, taste, visual
8. Take longer to fall asleep, sleep more lightly, awaken more often, shorter Stage IV and REM sleep may cause fatigue

### **Psychosocial Considerations**

1. Suffer many personal losses such as loss of spouse or other relatives and friends, loss of employment, loss of health and lifestyle and control over decision making
2. Coping with adjustments necessitated by advanced age, illness, disability
3. Fears: declining health, social isolation, loss of relevance, loss of independence or increased dependency on others

### **Safety**

1. Vulnerability to injury due to slower decision-making and responses to stimuli, reduced visual and auditory acuity, reduced balance and equilibrium
2. The three most common problems of the geriatric patient are incontinence, falls and drug reactions related to aging

### **Interventions to promote Growth and Development**

1. The older adult may need a referral to a mental health provider to explore the feelings of loss
2. Explore possibility of related existing conditions
3. Involve family with care if possible

4. Provide adequate nutrition
5. Monitor bowel elimination every 24 hours
6. Continue pain assessment and management (narcotics with long half lives may cause problems with confusion and constipation as well as other side effects)
7. Apply lotion to skin after bathing
8. Patient may need a warmer environment
9. Assess skin integrity frequently; use tape sparingly
10. May need to divide sleep up between day and night
11. Reposition every 2 hours without fail
12. Assess resources for discharge

**SUSPECTED CHILD/ADULT ABUSE AND  
DOMESTIC VIOLENCE**

## SUSPECTED CHILD/ADULT ABUSE AND DOMESTIC VIOLENCE

### OBJECTIVES:

1. To review the objective criteria for identifying and assessing possible child/adult victims of abuse and or neglect.
2. To apply the criteria to observable evidence and not on allegation alone in the following situations or suspected situations:
  - a. Physical assault
  - b. Rape or other sexual molestation;
  - c. Domestic abuse; and
  - d. Abuse or neglect of elders and children
3. To be able to make appropriate referrals to the ACH Social Work Department (ext.1406) regarding any ACH patient that is a suspected victim of abuse and or neglect.

### CONTENT:

Protection of children and impaired or endangered adults from maltreatment/abuse and domestic violence is the role of every responsible adult. Arkansas Children's Hospital (ACH) respects each patient and family's right to privacy. ACH also observes any and all laws pertaining to the mandatory reporting of suspected abuse and/or domestic violence.

ACH has two Administrative Policies which cover the mandatory and legal responsibility of the hospital doctors, nurses and social workers to report suspected child maltreatment/abuse or neglect, adult abuse and domestic violence.

Both policies state that the hospital Social Work Department is responsible for coordinating and officially reporting for the hospital any suspected case of abuse, neglect or domestic violence to outside agencies.

Outside of work, recognition and reporting of suspected child maltreatment/abuse, adult abuse and domestic violence, will help children and impaired or endangered adults in your community stay safe too. To report suspected abuse, look in the front of your phone book for these numbers:

**For a Child**, call the Child Abuse Hotline (1-800-482-5964) or Child Protective Services or the Police.

**For an Adult**, if the adult is a resident of a long-term care facility (impaired or endangered) call the Office of Long-term Care at 682-8487

For all other adult reporting, call the Department of Human Services Adult Protective Services hotline 1-800-482-8049.

## **OVERVIEW OF ACH ADMINISTRATIVE POLICY M1**

"Suspected Child Abuse - Physical, Sexual, Emotional or Neglect"

What is child maltreatment/abuse?

Arkansas law says child maltreatment is physical abuse, sexual abuse and/or neglect of a child or any person under 18 years of age.

The Administrative Policy - M1 Suspected Child Abuse- Physical, Sexual, Emotional or Neglect states that it is the legal responsibility of the hospital doctors, nurses and social workers to report suspected child maltreatment/abuse or neglect. The ACH Social Work Department is responsible for coordinating and officially reporting suspected child.

Abuse or neglect for the hospital to outside protective agencies.

This policy says that Child maltreatment is: "abuse, sexual abuse, neglect, sexual exploitation, or abandonment as defined below.

Abuse is:

Any of the following acts by a caregiver, or by any person that is legally responsible for the child's welfare, or by any person or agent (i.e. public or private school/home) entrusted with the juvenile's care.

- Extreme and repeated cruelty
- Any sexual abuse or physical or psychological abuse that is on purpose, neglectful, and without good reason.
- Any act or behavior that could cause death, illness, injury (lasting or temporary) to the mind or body of a child.
- Any injury to a child's body or mind that was not an accident.

Suspected Abuse

- Suspected when an injury that looks suspicious or does not match the history given (the injury does not match the explanation of how the injury happened).

Examples of observable suspicious injuries that may warrant reporting are:

\* Fractures \* Burns \* Cuts

\* Dislocations \* Welts \* Human bites

\* Sprains \* Extensive bruises \* Bruises of different ages

\* Subdural Hematomas \* Clustered bruises indicating repeated contact with a hand or instrument,

\* Bruises in the pattern of: slap (imprint of fingers), ruler, belt buckle, coat hanger, electrical cord, human bites.

Abuse is NOT:

Discipline of a child that is reasonable and moderate and not excessive and is used to correct a child or to keep a child from harm.

When deciding to report an injury as suspicious, remember to follow these guidelines:

You have reason to believe that the injury resulted from one of the following:

- a. A direct, non-accidental action of the caregiver or adult responsible for the child's welfare.
  - a. The failure of the caregiver or adult responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in the injury.

Sexual Abuse of a child/juvenile includes:

1. Solicitation or participation in sexual activity with a child/juvenile.
2. Any offense relating to sexual activity, abuse or exploitation including rape and incest.

Examples of sexual abuse include the following acts:

Any non-penetrative act of sexual gratification, specifically:

1. Touching, directly or through clothing, of the sex organs, buttocks, or anus of any child or the breast of a female child
2. Encouraging, forcing, or permitting the child to touch parts of someone else's body in ways that are part of sexual activity.
3. Sexual use of a child for sexual arousal, gratification, advantage or profit; exposure of sexual organs to a child, forcing a child to watch sexual acts or self-masturbating in the presence of a child.

Physical Evidence/Suspicious for sexual abuse:

1. A witness sees a child being sexually abused
2. A child has very specific physical injuries on their body
  - o Genital bruising or bruising caused by restraint of child's mouth, wrists, or legs
  - o Lacerations around genitalia

- Fissures - small cracks around anal opening - may be visible in sodomy cases
  - Skin tags - flaps of skin around anal area - caused by repeated rectal penetration - sphincter muscles become damaged and stretched.
  - Bite marks - may be visible around breasts or genital area
3. Suspicious stains, blood or semen are noted on child's diapers, clothing or body
  4. Presence of sexually transmitted disease
  5. Difficulty urinating (burning, frequent urination or retention) or excreting (pain when excreting or retention of feces)
  6. Early unexplained pregnancy (girls who have reached puberty)

### **Behavioral Indicators of Child Sexual Abuse**

Behavior of a child that may suggest sexual abuse has occurred includes:

- Hinting, talking about or acting out age-inappropriate detailed sexual activity
- Overly compliant behavior
- Pseudo-mature behavior
- Persistent and inappropriate sexual play with peers or toys or themselves, or sexually aggressive behavior with others
- Poor peer relationships or inability to make friends
- Lack of trust, particularly with significant others
- Non-participation in school and social activities
- Inability to concentrate in school
- Sudden drop in school performance
- Extraordinary fears of males
- Seductive behavior with males
- Running away from home
- Serious sleep problems
- Regressive behavior; withdrawal
- Clinical depressed
- Suicidal feelings

Neglect is:

Those acts or omissions of a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, custodian guardian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible under state law for the juvenile's welfare which constitute:

1. Failure or refusal to prevent the abuse of the child when the person knows the child is or has been abused

2. Failure or refusal to provide the necessary food, clothing, shelter and education required by law, or necessary medical treatment (including failure to follow the prescribed treatment plan for a condition that could become serious enough to harm the child unless the plan is followed) except when it is because of financial inability and no services for relief have been offered or refused
3. Failure to take reasonable action to protect the child from abandonment, abuse, neglect, or parental unfitness when such a condition was known or should have been known
4. Failure or irremediable inability to provide for the essential and necessary physical, mental or emotional needs of the juvenile
5. Failure, though able, to assume responsibility for and to provide for the juvenile's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care or to participate in a plan to assume such responsibility
6. Medical diagnosis of Failure to Thrive when due to one of the above.

Examples of neglect:

- Not enrolling child in school, prevents child from attending school, or does not take reasonable action to ensure the child is regularly attending school
- The child's person, clothing or living conditions are unsanitary to the point that the child's health is in significant danger of impairment
- Non-organic failure to thrive

Medical neglect examples:

- Lack of medical or dental treatment for a health problem or condition which, if untreated, could become severe enough to constitute serious long-term harm to the child
- Lack of follow-through on a prescribed treatment plan for a condition which if untreated, could become severe enough to constitute a serious long-term harm to the child if the plan goes unimplemented.

Abandonment is the failure of the caregiver to provide reasonable support or maintain regular contact (in person or other means) with the child without just cause, for a period of one year.

Severe Maltreatment:

- Sexual abuse/sexual exploitation.
- Acts or failing to act that may or does cause a child to die.
- Abuse with a deadly weapon.

- Acts or omissions that cause substantial and observable change in behavior/demeanor of child.

Examples of severe maltreatment in addition to sexual abuse include:

- \* Bone fracture \* Internal injuries \* Burns,
- \* Immersions \* Suffocation \* Abandonment,
- \* Failure to thrive \* Mental abuse.

**PROCEDURE:**

I. When child maltreatment/abuse is reported to and or discovered by a physician, or the physician is told about the suspicion of abuse, the physician shall:

- A. Immediately notify the Social Work Department
- B. Document all the information, physical and verbal history on the required forms
  - 1. Physical abuse, neglect and emotional abuse on the "Suspected Child Physical Abuse Medical Record"
  - 2. Sexual abuse on the "Suspected Child Sexual Abuse Record", and complete the "Sexual Assault Victim Reimbursement form (code R)"
- C. The physician shall obtain appropriate consents for treatment
  - 1. See ACH Administrative Policy K2
  - 2. AR Code Ann. 12-12-508 gives permission for the medical exam without consent when there is reasonable cause for suspicion resulting in the need for an examination as part of the evaluation process.
- D. Consult with the Team for Children at Risk (TCAR) for all inpatients suspected of child abuse or neglect.

II. When child maltreatment/abuse is discovered by a Social Worker, or the Social Worker is told about the suspicion of abuse the Social Worker shall:

- A. Follow departmental protocols regarding Social Work intervention in suspected abuse cases.
  - 1. Appropriately assess for emergency medical evaluation or possibility of deferring medical exam to the Arkansas Children's House (ARCH). See attached ADDENDUM for guidelines for deferment protocol to ARCH.

If the medical exam is to be deferred Social Work shall:

- 1. Confer with the appropriate physician involved in determining if exam can be deferred.

2. Make all necessary reports at the time of the initial contact with patient/family.
3. Complete a Minimal Data Base and provide it to appropriate staff/agencies (e.g. TCAR, DHS, ASP).
4. Assume responsibility for providing detailed follow-up instructions to patient/family prior to leaving ACH (e.g. follow-up appt. time/date/location; future contact phone numbers; etc.)
5. Notify the Child Abuse Hotline (1-800-482-5964) and the law enforcement agency in the county in which the incident occurred.
6. If the child is placed on a 72 hour hold, follow the guidelines as set forth in the Administrative policy J-23 72 Hour Hold.

III. Any other hospital employee who has cause to suspect a patient has been or is a victim of abuse should contact the Social Work Department immediately for assistance. Hold policy (J-23) and follow the recommended guidelines.

### **OVERVIEW OF ACH ADMINISTRATIVE POLICY K13**

"Interventions in cases of Suspected Adult Abuse or Domestic Violence"

Adult abuse/domestic violence is: abuse, maltreatment or exploitation. This means willful or negligent acts by a caregiver responsible for an impaired individual or by the impaired individual which result in:

- o neglect
- o sexual abuse
- o unreasonable physical injury
- o emotional abuse
- o unjust or improper use of an adult for one's own advantage (e.g. sweat shops)
- o failure to provide necessary treatment, attention, food, clothing, shelter or medical services
- o a situation or that poses an imminent risk of death

Who is considered an "endangered adult"?

A person 18 years of age or older, in or out of a Nursing Home or long term-care facility, who is found in a situation or condition that poses risk of death or serious bodily harm to that person and the person is unable to understand the nature and results of staying in the risky situation or condition.

Who is considered "an impaired adult"?

A person 18 years or older who has a mental or physical disease or defect and is unable to protect him or her self from abuse, neglect, or exploitation.

## **PROCEDURE:**

The following guidelines are recommended in the recognition, identification, assessment, management and referral of such patients/family members.

- An impaired adult or a patient over the age of 60 who demonstrates through actions, verbal communication, or physical findings (e.g. bruises, other suspicious marks) that they may be a victim of abuse by a caretaker or family member.
- Parents/caretakers of patients who appear to have been physically battered (e.g. black eye, suspicious bruising on face, arms or legs).
- Adult patient who present to the Emergency Department with injuries suspicious of domestic violence or who present with a history of an altercation.

All ACH staff should be alert to family members or adult patients who may be victims of domestic violence or adult abuse.

What should you do if you suspect a family member or adult patient may be a victim of domestic violence or adult abuse?

Any clinical discipline who becomes aware of an adult patient suspected of being abused should document their findings or information in the patient's medical record along with documentation of actions taken to address the identified concern.

Once a victim of suspected adult abuse or domestic violence is identified, a Social Work consult should be requested (call ext. 1406).

Social work will follow departmental guidelines to assess the suspected victim of abuse or domestic violence, paying particular attention to the alleged victim's rights as an adult such as:

- The right to privacy
- The right to refuse help or treatment
- The right to seek legal assistance

Social Work will document in the patient's medical record relevant information pertaining to adult abuse issues within the confines of patient/client confidentiality and the right to privacy.

The social worker will provide crisis counseling to adult patients or visitors suspected of being a victim of abuse. The Social Work Department will maintain resource materials and information relevant to domestic violence assistance, shelters, advocacy and support groups, etc. to provide to patients or visitors

If an adult visitor appears to be a victim of abuse, and appears to be in need of urgent medical attention, the Social Worker will consult with the appropriate physician to make recommendations for seeking treatment. Social Work will assist in facilitating the visitor's access to an adult care facility if the adult is receptive to seeking medical treatment.

As mandated reporters and according to AR Code 5-28-205, photographs of the area of visible trauma may be taken, and, if medically indicated, X-rays performed. These will be made available to the Department of Human Services upon request.

Social Work will not make reports to law enforcement agencies or to the Department of Human Services (DHS) with out consent of the adult victim unless the situation is reportable by law:

- AR Code 12-12-602 - "Report of treatment required",
- AR Code 5-28-203 - "Persons required to report abuse",
- AR Code 5-28-204 - "Report of death caused by abuse".

In a mandated reported situation DHS, law enforcement or hospital may take an endangered adult into emergency protective custody if the situation presents imminent danger to his/her health or safety. Emergency protective custody shall not exceed three working days, and the probate court and DHS shall be notified immediately upon taking such adult into protective custody.

#### REMEMBER:

The ACH procedure regarding suspected child maltreatment/abuse, adult abuse and domestic violence is: the doctor and social worker are responsible for gathering information and social work is responsible for giving this information to the appropriate outside agency.

ACH does not investigate child maltreatment, adult abuse and domestic abuse however we must help the investigating agencies by giving them information to help them decide if the person has been a victim of abuse or neglect.

#### RESOURCES:

1. ACH ADMINISTRATIVE POLICY "M1 SUSPECTED CHILD MALTREATMENT/ABUSE"
2. ACH ADMINISTRATIVE POLICY "K13 - Interventions in cases of Suspected Adult Abuse or Domestic Violence"
3. November Update CAMH 98 Copyright 1998 JCAHO SECTION I/ASSESSMENT OF PATIENTS PE.1.1\PE.1.8

# 2008 National Patient Safety Goals Hospital Program

[2008 National Patient Safety Goals Manual Chapter](#)  
(Includes Rationales and Implementation Expectations)

Note: Changes to the Goals and Requirements are indicated in **bold**. Gaps in the numbering indicate that the Goal is inapplicable to the program or has been “retired,” usually because the requirements were integrated into the standards.

**This year’s new requirements (3E and 16A) have a one-year phase-in period that includes defined expectations for planning, development and testing (“milestones”) at 3, 6 and 9 months in 2008, with the expectation of full implementation by January 2009. See the Implementation Expectations for milestones.**

- Goal 1 Improve the accuracy of patient identification.
  - 1A Use at least two patient identifiers when providing care, treatment or services.
- Goal 2 Improve the effectiveness of communication among caregivers.
  - 2A For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.
  - 2B Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.
  - 2C Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
  - 2E Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.
- Goal 3 Improve the safety of using medications.
  - 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.
  - 3D Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

- 3E Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.**
- Goal 7 Reduce the risk of health care-associated infections.
- 7A Comply with current **World Health Organization (WHO) Hand Hygiene Guidelines** or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- 7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.
- Goal 8 Accurately and completely reconcile medications across the continuum of care.
- 8A There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.
- 8B A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.
- Goal 9 Reduce the risk of patient harm resulting from falls.
- 9B Implement a fall reduction program including an evaluation of the effectiveness of the program.
- Goal 13 Encourage patients’ active involvement in their own care as a patient safety strategy.
- 13A Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.
- Goal 15 The organization identifies safety risks inherent in its patient population.
- 15A The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals—NOT APPLICABLE TO CRITICAL ACCESS HOSPITALS]
- Goal 16 Improve recognition and response to changes in a patient’s condition.**
- 16A The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient’s condition appears to be worsening. [Critical Access Hospital, Hospital]**