All MHC's and CNA's who wish to staff shifts must (Sitters/1:1's don't complete)

Review all Study Packets in this Section to prepare for tests.

Do Not Return Study Packets to Fort Logan

COLORADO
Office of Behavioral Health
Department of Human Services
Patrick K. Fox, MD, Acting Director
Christopher Burke, PhD, Hospital Director

HIPAA Student/Supplemental Staff/Contract Staff/Volunteer Orientation

- HIPAA stands for Health Insurance Portability and Accountability Act
- Protected Health Information (PHI) is individually identifiable information that is maintained or transmitted in any form (verbal, written, or electronic). It can relate to the past, present, or future treatment of a patient.
- HIPAA legislation was developed in 1996 as a way of addressing abuse in the release of individual's PHI. The intent of HIPAA is to protect all of us from having individual health information given out to others without our authorization to do so. HIPAA reinforces the Confidentiality practices that we have consistently followed at CMHIFL.
- HIPAA prohibits the use or disclosure of healthcare information that can identify a specific person without the individual's verbal or written authorization unless it is for the purpose of **Treatment, Payment, or Healthcare Operations**, or in the case of a **Medical Emergency**.
- The Privacy provisions of HIPAA went into effect on April 14, 2003. The Security Provisions of HIPAA went into effect in 2005.
- An individual can grant others the right to see their PHI by signing an Authorization for this access. An individual can withdraw his/her permission for access to his/her PHI at **Any Time**.
- The rule of thumb is that only the minimum amount of information necessary to provide for the patient is given out to those within the hospital and those outside of the hospital. For example, our dietary staff definitely need access to a patient's dietary preferences, allergies, and any dietary restrictions. However, the dietary staff should not read a patient's psychological testing report because this is not information they need to provide for the patient's nutrition.
- Patients have the right to review their PHI. This has been a patient right at CMHIFL for many years. There Is a standardized process which is utilized whenever a patient asks to see his/her PHI. If a patient asks you for their PHI refer them to regular CMHIFL staff - Don't give them anything out of their chart.
- Documents/notes including PHI must be shredded - do not throw any documents or notes with patient information on them into a wastebasket. Ask the team staff where the shredding box is and be sure to throw any patient information into this box.

- Violations of HIPAA, i.e., if a patient's PHI is given to another entity, without the patient's authorization can result in sanctions. These sanctions can include monetary fines to the hospital and personnel actions against the individual disclosing (sharing) the PHI. In extreme instances violations of HIPAA can result in incarceration of the individual responsible for the disclosure.

- Please note that under certain circumstances PHI may be released to others without the individual's permission. Laws and formal regulations specify when PHI can be released without an individual's permission. Examples when this might occur would be if there was a suspicion of Abuse or Neglect, to report certain communicable diseases such as tuberculosis or AIDS, or if there was a Court Order to provide specified health information. **Under no circumstances would you be authorized to report any patient information to these agencies - this is the responsibility of the CMHIFL staff.**

- Remember, if you are not sure about sharing some type of patient information ask CMHIFL staff before you say anything!

- The CMHIFL Privacy Liaison can be reached at (303) 866-7876.

CODE RED EMERGENCIES

The purpose of this pre… to prepare CMHIFL perso… participate in the immed… treatment of any patient, st… volunteer, or visitor at CMH… suffering from a life-threateni… emergency, i.e., cardiac and/or… respiratory arrest or other possib… life threatening medical condition…

6/9/2011

OBJECTIVES

- Discuss policies and procedures related to our Code Red Emergency Syste…
- Identify situations where the Code R… System would be initiated.
- Identify the location of the Crash Cart.
- Discuss the contents of the Crash Cart.

6/9/2011

- Identify where the injectable Lorazepam (Ativan) is stored and how to access this medication
- Identify the duties of the "Core Le… Patient Nurse, Cart Nurse, Recorder, … Milieu Manager."
- Describe and demonstrate the procedures operating the oxygen tank, insertion of the oral airway, utilizing the AED, and operating the suction machine.

6/9/2011

Introduction

- Our program is designed to provide basic life support with the use of adjunctive equipment. It is designed to stabilize the patient prior… ambulance transport to a hospital emerge… department.

6/9/2011

- The program is dependent on having the ambulance and paramedics respond within 3-5 minutes.
- If an ambulance is needed within … minutes or less, call a Code Red. Patients are… transported to **Swedish Hospital**.
- For non-emergent medical situations, patients are transported to **Porter's Hospit…** within 20-30 minutes.

6/9/2011

- All requests for an ambulance MUST go through the switchboard, by dialing "0".
- Tell the operator whether you need an Emergency or Non-Emergency Ambulance, the Team, Patient name and reason for transport.

6/9/2011

- If a medical emergency involves an employee, visitor, or volunteer utilize Code Red. For other medical problems, they need to consult their primary physician.

Training

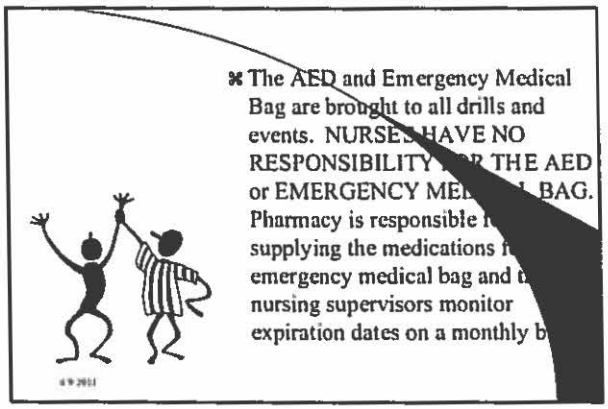
- You are required to have yearly CPR training.
- You are also required to attend a yearly Code Red In-service.

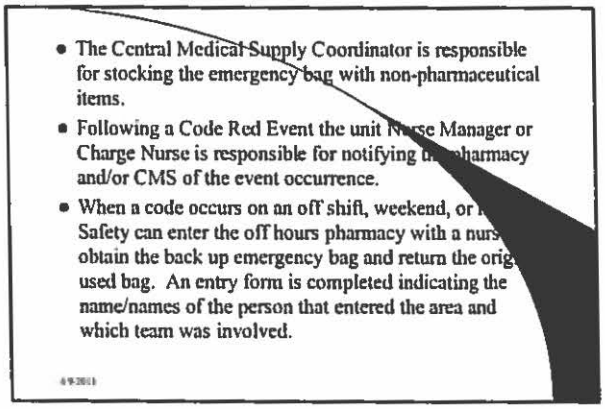
- An RN is expected to respond to Code Red Events.
- The RN may leave the unit with the unit keys in their possession for a Code Red event even if he/she is the only RN on the responding unit.

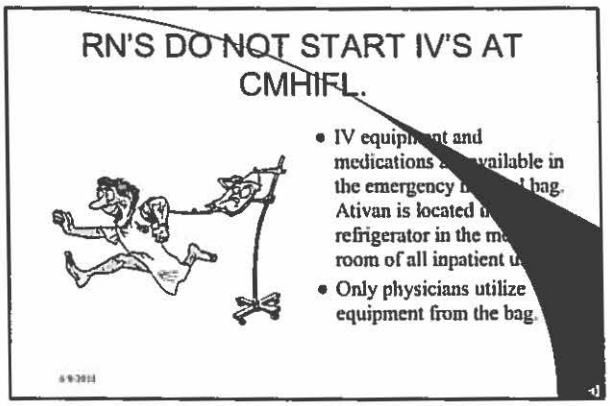
Each inpatient team is required to have 3 drills a year (one for each shift).
Code Red Events are reviewed with those involved in order to evaluate how well they responded, to assess where problems occurred and what necessary changes need to be implemented. It is important to be aware that despite all our best efforts, sometimes patients do not survive.

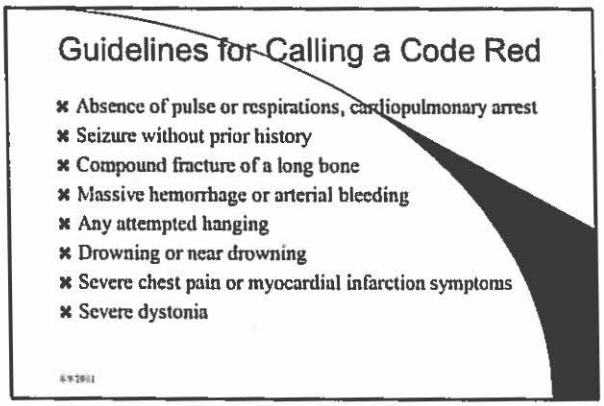
The high level of acuity in the milieu setting is not a reason to decide not to utilize the Code Red Emergency Program. It is designed to have staff respond quickly. Staff are assigned to attend to the milieu in order to allow others to respond to the emergency.

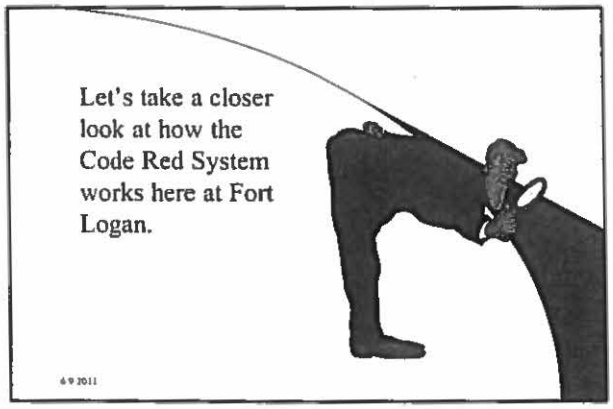
Emergency Medical [illegible]

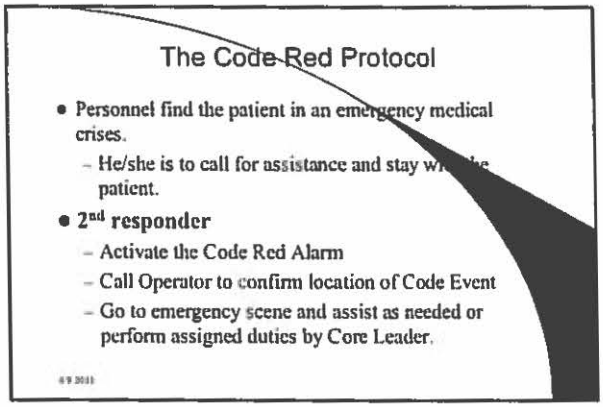

The AED and Emergency Medical Bag are brought to all drills and events. NURSES HAVE NO RESPONSIBILITY FOR THE AED or EMERGENCY MED BAG.
Pharmacy is responsible
supplying the medications
emergency medical bag and
nursing supervisors monitor
expiration dates on a monthly b


The Central Medical Supply Coordinator is responsible for stocking the emergency bag with non-pharmaceutical items.
Following a Code Red Event the unit Nurse Manager or Charge Nurse is responsible for notifying
pharmacy and/or CMS of the event occurrence.
When a code occurs on an off shift, weekend, or
Safety can enter the off hours pharmacy with a nurs
obtain the back up emergency bag and return the orig
used bag. An entry form is completed indicating the name/names of the person that entered the area and which team was involved.


RN'S DO NOT START IV'S AT CMHIFL.
IV equip
nt and
medications
vailable in
the emergency
bag.
Ativan is located
refrigerator in the m
room of all inpatient
Only physicians utilize equipment from the bag.


Guidelines for Calling a Code Red
Absence of pulse or respirations, cardiopulmonary arrest
Seizure without prior history
Compound fracture of a long bone
Massive hemorrhage or arterial bleeding
Any attempted hanging
Drowning or near drowning
Severe chest pain or myocardial infarction symptoms
Severe dystonia


Let's take a closer look at how the Code Red System works here at Fort Logan.


The Code Red Protocol
Personnel find the patient in an emergency medical crises.
He/she is to call for assistance and stay w
patient.
2nd responder
Activate the Code Red Alarm
Call Operator to confirm location of Code Event
Go to emergency scene and assist as needed or perform assigned duties by Core Leader.

Core Leader

- 1st RN that arrives on the scene
- Identifies personnel and assigns duties/roles
- Sends for Crash Cart
- Assign RN to provide patient care (May d to be patient RN) or delegate Core Leader responsibilities to another RN at the scene.
- Assign Cart person.
- Assign recorder
- Assign Milieu Manager
- Assign CPR relief person as necessary

6/9/2011

Core Leader (Cont)

- Assign runner if necessary
- Direct and assist all personnel as necess
- May assume duties of recorder if no other personnel are available.
- Complete (if decided to be patient nurse) or assist/assign the completion of all required documentation following the event.

6/9/2011

Patient Nurse

- Assess patient and institute necessary interventions. (I.e., Assist with insertion of oral airway and/or use of Ambu-bag and delegate bagging of patient, initiate CPR or oversee CPR for efficacy)

6/9/2011

Patient Nurse (Cont)

- Take initial vital signs and repeat ev y 5 minutes.
- Suction secretions PRN.
- Initiate use of AED if needed.
- Assist responding physician and/or paramedic directed.

6/9/2011

Patient Nurse (Cont)

- Complete required paperwork immediately following incident. Place Emergency Medical Record in patient's chart behind nurses' notes of Incident.

6/9/2011

Operator

- Notify Safety
- Notify Physician and Code Red Coordinator by activating Code Red Pagers.
- Call Denver Paramedic Dispatch and state, "This is CMHI at Fort Logan. We need an Emergency (or a Non-Emergency) ambulance to 3520 W. Oxford Ave.

6/9/2011

Operator (Cont)

- Notify Off-Hours Nursing Supervisor a necessary.

Safety

- Transport AED and Emergency Medical Bag to unit. Brings oxygen to non-clinical areas.
- Meet fire/ambulance personnel and escort the unit.
- Assist with Code Red procedure as directed by Leader.

CART PERSON

- Provide to patient nurse equipment requested from Crash Cart.
- Assist with care of patient as requested by Patient Nurse, Core Leader and/or Physician. (Position suction machine, if required, near head of patient. Assist with set-up and/or utilization AED)
- Distribute gloves to staff as requested.
- Only the Cart Nurse will access the Crash Cart to arrange and handle supplies as requested.

Cart Person (Cont.)

- Contact Central Supply to replace items used from Cart.
- If after hours contact Safety to open Central Supply for refill of supplies.
- Once refill completed relock Crash Cart.

Recorder

- Fills in Medical Emergency Record throughout the Code. Remind nurses and others to verbalize what is being done so recording can be completed.
- Note time of the event, time each intervention is initiated) I.e., time CPR initiated, time and results of vital signs (Remind nurse of 5 minute interval), etc.

Recorder (Cont)

- Record events immediately preceding the Code and circumstances of discovery.
- Identify participants and have them complete sign-in sheet.
- Complete Medical Emergency Record with help Nurses/Physician after patient is stabilized.
- Send sign-in sheet to Code Red Coordinator along with copy of Medical Emergency Record.
- Make Medical Emergency Record available to Physician for charting purposes then give to Patient nurse for charting purposes.

Milieu Manager

- Responsible for evaluating and maintaining patient milieu by directing assisting staff as to needs of rest of patients on unit.
- May act as runner or other duties as directed by Core Leader once other patients are secure.
- Obtains patient's chart, if necessary.

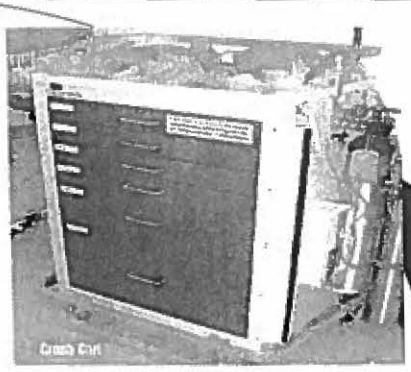
Physician

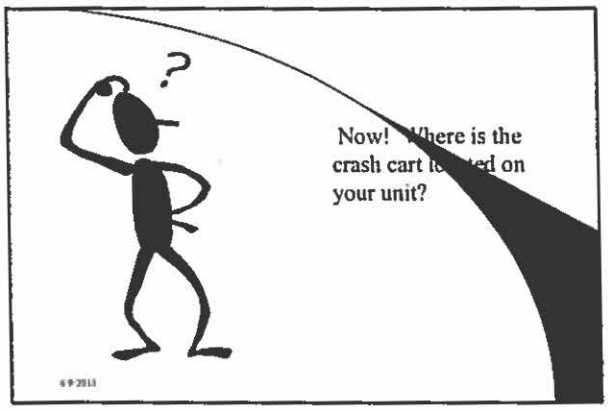
- Respond immediately when Code Red beeper sounds alarm.
- Report to unit and assess patient. Stays in attendance continuing and directing care until patient stable and/or transferred to a general hospital.
- Oversees the use of the AED.
- Notifies receiving facility of condition and imminent arrival of patient.
- Completes comprehensive note regarding patient signs/symptoms, intervention, condition of patient throughout code, condition upon transfer and appropriate physician orders.

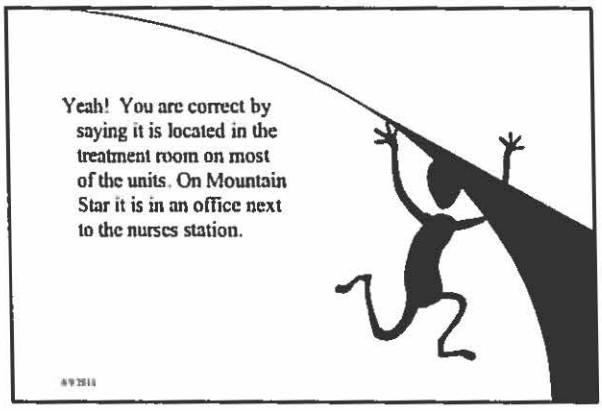
Crash Cart

- Each inpatient unit is equipped with an emergency crash cart. Each of these carts is standardized throughout the hospital. Central Medical Supply and the unit nurse are responsible for checking the contents of the cart.
- The oxygen tank and suction machine located on the Crash Cart is checked weekly by nursing staff and documented.
- The cart and its contents are to be utilized in Code Red Events only.

- An RN and/or Safety can also replace used items from the Crash Cart drawers from Central Medical Supply when the event occurs on an off shift, weekend, or holiday. An entry form is completed indicating which drawers were replaced.
- On the next working day (following unit notification of them), both pharmacy and CMS will review the contents of the Crash Cart and Medical bag, replace if necessary and replace the lock.







THE CART CONTENTS

TOP OF CART

- Res-Q-Flo Masks - Used in Universal Precautions. Can also be located in most fire extinguisher compartments (resusci-shields available in first aid kits)
- Ambu-Bag
- 1 Pair of Scissors

SIDE OF CART

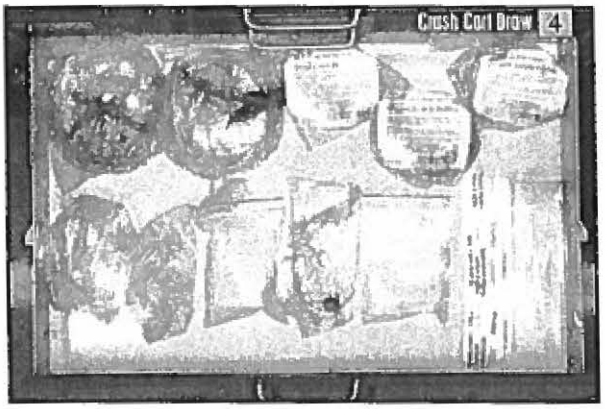
- Oxygen Tank
- Gloves
- Suction Machine
- Sharp Container
- Backboard

Drawers One, Two, Three

- These drawers are empty at the present time.

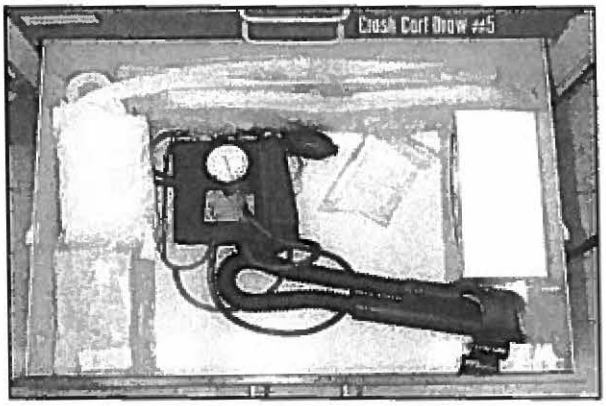
DRAWER FOUR

- 2 oxygen masks, 1 adult, 1 pediatric
- 1 nasal cannula
- 2 oxygen supply tubings
- 1 oxygen connecting tube
- 4 oral airways, various sizes



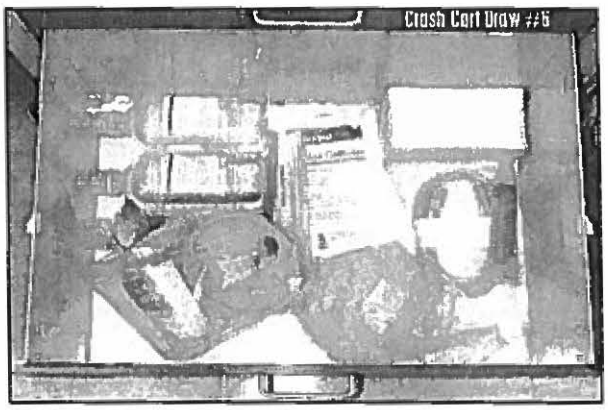
DRAWER FIVE

- Blood Pressure Cuff
- Stethoscopes
- Cervical Collars
- Impervious Gowns and combo masks
- Adhesive Tape
- Penlight
- Snake Light with extra batteries

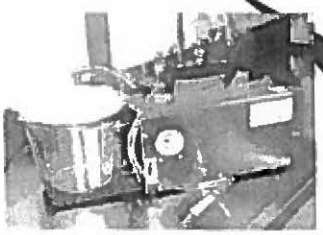


DRAWER SIX

- Suction canister and suction catheter
- Tonsil tip suction tube
- Suction tubing
- 60 cc Cath tip
- Cloth towel and 4x4's
- Sterile water and non latex gloves
- Extra Trash bags



SUCTION MACHINE

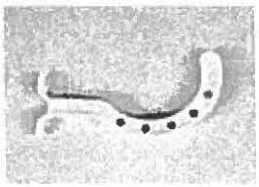


- Unplug the machine before transporting the crash cart. It will remain charged for 45 minutes.
- Place the machine at the head of t patient.
- Turn the unit on and utilize the attach tonsil tip for suctioning.
- Water is available in the bottom drawer if you need to flush the tubing.

OXYGEN

- Turn oxygen key counterclockwis to open the cylinder.
- Turn oxygen on to 8-12 liters when usin ambu bag during resuscitation.
- Adjust oxygen to 2-3 liters when using a nas cannula.
- Adjust oxygen to 5-10 liters when using a mas

ORAL AIRWAY



- Measure plas irway from mouth to e correct size.
- Insert airway with cu toward the tongue.
- Slide over the tongue to open the airway.

IN CONCLUSION

- This program provides you with guidelines in handling a Code Red Event.
- Every emergency situation will have its own unique issues.
- Use your common sense and remember the ABC's of CPR.

CMHI
FORT LOGAN

Assessment and Reporting of Abuse

Please use the 'Page Up' or 'Page Down' keys to move through this presentation.

PHYSICAL ABUSE

Physical Abuse is the non-accidental use of physical force that results in bodily injury, pain, or impairment.

Welcome!

This program was developed by CMHIFL Social Work Discipline

PHYSICAL ABUSE

It includes assault, battery, and inappropriate restraint, or subjection to circumstances that could reasonably pose a serious threat of physical harm or injury.

OBJECTIVES

- **Distinguish between the eleven types of abuse**
- **Identify three possible indicators for each type of abuse**
- **Describe your responsibility and the process for reporting abuse/neglect at CMHIFL**

Physical Abuse Indicators

1. Unexplained or unmentioned fractures, bruises, marks, or trauma (often on back, abdomen, buttocks, or genitals)
2. Unexplained changes in personality or behavior including trembling, panic, hyperventilation, and fearful refusal.

Physical Abuse Indicators

3. Nightmares
4. Unexplained changes in personality or behavior in conjunction with unsupervised caretaker contact, including trembling, panic, hyperventilation, and fearful refusal

Physical Abuse Indicators

The preceding were nine possible indicators for various types of abuse.

However, it is important to remember to use clinical judgment in evaluating individual cases.

Physical Abuse Indicators

5. Exacerbated startle response or flinching
6. Emotional withdrawal/social isolation
7. Stories inconsistent with physical symptoms/evidence

DOMESTIC VIOLENCE

Domestic violence **is the physical abuse or emotional maltreatment perpetrated by a significant other/partner.**

Physical Abuse Indicators

8. Unsolicited defensiveness in relation to partner/significant other
9. Excessive and/or unwarranted fears or worries connected with common events or objects (not explainable or connected to mental illness)

Domestic Violence Indicators

1. Unexplained or unmentioned fractures, bruises, marks, or trauma (often on back, abdomen, buttocks, or genitals)
2. Unexplained changes in personality or behavior including trembling, panic, hyperventilation, and fearful refusal.

Domestic Violence Indicators

3. Emotional withdrawal/social isolation
4. Exacerbated startle response or flinching

NEGLECT

Neglect of basic needs is when the parent or caretaker fails either deliberately or through inability to take those actions necessary to provide a child or senior with adequate food, clothing, shelter, or other essential care.

Domestic Violence Indicators

5. Excessive and/or unwarranted fears or worries connected with common events or objects (not explainable or connected to mental illness

NEGLECT

Indicators of neglect include:

1. Undernourishment
2. Hoarding food or objects
3. Unkempt/inadequate clothing
4. Bedsores (in Geriatric patients)

Domestic Violence Indicators

6. Unsolicited defensiveness in relation to partner/significant other
7. Guilt or remorse in connection with partner/significant other

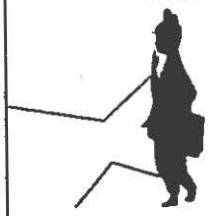
NEGLECT

5. Evidence of physical ailment or condition which has not been treated
6. Painful and noticeable condition which has not been treated
7. Failure to seek or follow through with medical treatment

EDUCATIONAL NEGLECT

Educational neglect is when the parent or caretaker either through action or omission, fails to provide for the child's education and/or school attendance.

ABANDONMENT



Parents or caretakers are completely uninvolved in the life of or refuse to participate in patient's treatment

EDUCATIONAL NEGLECT

An indicator of neglect is beginning or established patterns of school inattendance.

MEDICAL NEGLECT

Medical Neglect is when the child or senior requires medical treatment that the parent/caretaker has not provided, and the failure to provide such care presents a substantial harm to the person at risk.

ABANDONMENT

Abandonment is when the child or senior has no parental support nor available alternate caretaker.

Medical Neglect Indicators

1. Patient presents with physical ailment or condition which has not been treated.

Medical Neglect Indicators

2. Painful and noticeable condition which has not been attended to.

EMOTIONAL ABUSE

The abuse may include but not be limited to:

- frightening,
- humiliating,
- threatening, or
- insulting the person at risk.

Medical Neglect Indicators

3. Failure to seek or follow through with medical treatment.

Emotional Abuse Indicators

1. Excessive criticism/berating of child or elder
2. Isolative behavior
3. Low self-esteem

EMOTIONAL ABUSE

Emotional abuse is when the parent or caretaker's acts or omissions have caused or are likely to cause injury or impairment to the person at risk's psychological capacity or functioning.

Emotional Abuse Indicators

4. Self-deprecating statements
5. Verbal or emotional abuse of others by the child or senior
6. Depression or change in affect

LACK OF SUPERVISION

Lack of supervision is when the person at risk's/child's age and skill level would require a specific level of supervision which did not occur. This omission could or did result in harm to the person at risk.

Child Sexual Abuse Indicators

1. Presence of sexually transmitted disease
2. Excessive/out of context sexualized talk or behavior inconsistent with developmental level or situation
3. Excessive masturbation

CHILD SEXUAL ABUSE

Child sexual abuse occurs when the child has been subjected to sexual intercourse or sexual contact, including touching of the genitals, buttocks, or breasts.

Child Sexual Abuse Indicators

4. Persistent fears or nightmares
5. Sexually inappropriate behavior towards others
6. Disclosure of exposure to material with sexual content (pornography, exhibitionism)

CHILD SEXUAL ABUSE

Sexual abuse also includes actions and behaviors when there is not physical contact, including but not limited to exhibitionism, sexual exploitation, and pornography.

Child Sexual Abuse Indicators

7. Guilt or remorse
8. Fearfulness
9. Unexplained avoidance of a particular person

Child Sexual Abuse Indicators

10. Change in mood or mental status
11. Evidence of physical trauma in the genital area

Sexual Abuse of an Older Person Indicators

5. Change in appetite
6. Fearfulness
7. Unexplained avoidance of a particular person
8. Evidence of physical trauma in genital area

SEXUAL ABUSE OF ADULTS/OLDER PERSONS

Sexual abuse of an older person includes forced sexual contact or sexual contact with an individual who is incapable of exercising consent because of physical or mental impairments.

EXPLOITATION/ FINANCIAL ABUSE

Exploitation is the illegal or improper use of a person's funds, property, or resources for another person's profit or advantage.

Sexual Abuse of an Older Person Indicators

1. Change in mood or mental status
2. Persistent fears or nightmares
3. Excessive or out of context sexualized talk or behavior
4. Guilt or remorse

Exploitation/ Financial Abuse

- Confused older persons are particularly vulnerable to financial abuse.

Exploitation/ Financial Abuse

- A confused older person may be tricked or coerced into signing documents that he or she does not understand.

Exploitation/ Financial Abuse Indicators

4. Inadequate/inferior housing
5. Unwillingness to disclose financial information
6. Confusion around perceived or real loss of assets

Exploitation/ Financial Abuse

- A document signed by someone who was incapable of understanding it at the time of the signing is not legal.

Exploitation/Financial Abuse Indicators

7. Inability to explain changes in assets
8. Disclosure of patient's dependent relationship (releasing funds/assets in exchange for care not provided)

Exploitation/ Financial Abuse Indicators

1. Disclosure of financial agreement
2. Major changes in financial status
3. Movement of funds between accounts

INSTITUTIONAL ABUSE

Any of the above listed types of abuse can be institutional abuse when the incident occurs within an agency setting whose mission is to care for at risk individuals.

REPORTING REQUIREMENTS

It is the responsibility of all staff at CMHI/Fort Logan to report any suspicion of abuse or neglect. You should contact a clinical staff member on the team or the Director of Social Work.

You have completed the Abuse Training! Please click on the button below to access the Abuse Training Post-Test. Print and complete the test and turn it in to your Discipline's Chief's office. It will be graded and sent to your supervisor.

REPORTING REQUIREMENTS

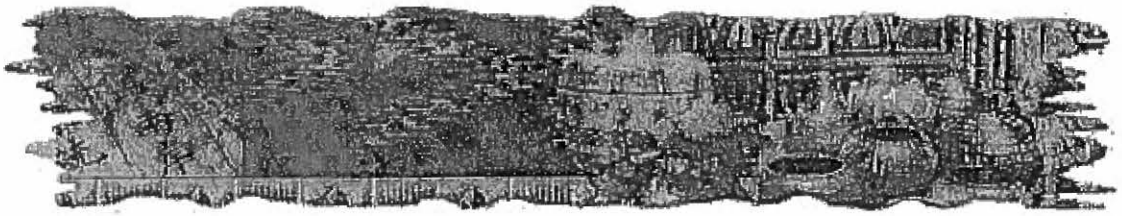
Clinical staff have a responsibility under the law to report any incidents of known or suspected mistreatment of at-risk persons to the mandated agency.

REPORTING REQUIREMENTS

CMHIFL Policy and Procedure 26.40 "Abuse, Neglect, and Mistreatment of Children or Adult Persons at-Risk" explains the reporting process to follow.

CMHI
FORT LOGAN

CMHI-FL Staff Development



Cultural Competency Self Study Module

Please read and then take post-test. Post-test must be returned to Staff Development by May 15, 2006

Rationale for cultural competency in healthcare:

The United States population is increasingly more diverse racially and ethnically. In the 1990s, over 26 percent of the US population constituted of linguistic and cultural minority populations. It is predicted that by 2010, the minority populations will constitute over 30 percent of the population and by 2050, almost 50 percent of the total population will be members of ethnic and racial minorities (US Census 2004).

Research has shown that culture shapes a person's attitudes, beliefs, and practices toward health and disease; culture influences the patient-caregiver relationships; and cultural differences contribute to the health disparities in society.

This course introduces the basic concepts of cultural and linguistic competency, the guidelines and mandates for cultural

competency in practice, the development of cultural competency in healthcare, and basic concepts of culturally competent attitudes, knowledge and skills.

One of the generally accepted descriptions of cultural competency is that it is a developmental process that is developed overtime in order to increase understanding and knowledge of cultural differences that affect the healthcare experience.

According to some sources, the U.S. healthcare profession has not been very well prepared to provide culturally competent care (Surgeon General Report 2005).

1: Objectives of the course

After completion of the module, the participant will be able to:

1. Define culture, cultural competence, and linguistic competence in healthcare.

2. Complete a personal self-assessment of cultural awareness (for your eyes only)

3. Describe culturally competent attitudes, knowledge and skills.

4.List 4 benefits of cultural competence in healthcare.

As Cultural Competence is an ongoing growth experience, this year, the focus will be on Self-Awareness. All exercises are intended to assist this growth, but are not to be submitted to Staff Development. The only documentation needed by Staff Development is the test at the end of the packet. Thank you.
If you have any questions please call Judy Arpaio @ 303-866-7702

Developing Cultural Awareness: Cultural self-assessment

I. Introduction.

"How does a the healthcare provider achieve the requisite knowledge, skills and respect for differences that lead to cultural competence?
The first step is awareness and an honest exploration of one's own
cultural values, beliefs and prejudices against other cultures.
Humility and self-understanding come first before the study of another culture.
(Leonard 2001) (1)

Central to the concept of cultural competency is that it is a ***developmental process that evolves over an extended period***.
In order to respect and acknowledge differences, a person needs to know and accept him or herself as a cultural being.

Self-assessment is not only for individuals, but it also expected of organizations in which individuals belong.

Conducting cultural self-assessments by individuals and organizations is one of the key elements in achieving cultural competence (1,2,3,4,5).
Both organizations and individuals are at various levels of awareness, knowledge and skill acquisition along the cultural competence continuum as self-assessment is an ongoing process, not a one-time occurrence (1,2,3).

First, is a review of the definition of culture.

According to Leininger, culture consists of the learned, shared and transmitted values, beliefs, norms and lifeways of a particular group that guide their thinking, decisions, and actions in patterned ways (2).

Elements of cultural competency:

"The culturally competent system would:

- value diversity
- have the capacity for cultural self-assessment
- be conscious of the dynamics inherent when cultures interact;
- have institutionalized cultural knowledge; and
- have developed adaptations to diversity." (Terry Cross et.al. 1989)(2)

"Practice must be based on accurate perceptions of behavior, policies must be impartial, and attitudes must be unbiased." (Terry Cross et al. 1989.) (2)

Cultural competence terminology

Cultural competence: "The complex integration of attitudes, knowledge, and skills to facilitate communication and appropriate interactions between persons of diverse cultures." (American Academy of Nursing, 1993)
Cultural competence is the ability to work effectively in a multicultural setting. Campinha-Bacote defines cultural competence as "the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client" (family, individual or community) (3).
Cultural competence: "Care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender, and sexual orientation. This care is guided by nursing theories, models, and/or research". (National Academy of Nursing expert panel, 1990)
"Cultural awareness is developing an awareness of one's own culture, existence, sensations, thoughts, and environment without letting them have an undue influence on those from other backgrounds."(Purnell, 2005).
"Cultural awareness is defined as the process of conducting a self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background."

(Campinha-Bacote 2002).

Cultural Sensitivity: Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences (National Maternal and Child Health Center on Cultural Competency, 1997).

Background terminology for cultural competency:

Bias: An inclination of temperament or outlook; especially a personal and sometimes
unreasoned judgment (6).

Stereotypes: Overall impressions based on the assumption that all members of a group possess similar attributes (7).
Stereotypes are the cognitive precursors of prejudice and discrimination (8).

Prejudice: A negative feeling toward a group based on a faulty generalization (9).

Racial identity: Generally refers to physical characteristics of individuals toinclude skin color, facial features, hair, etc; used to define race categories(eg, White, African American, Native American, Asian) (10).

Ethnic identity: refers to how individuals self-identify based not only on physical characteristics, but on religious background, nationality, and cultural experience (10).

Cultural identity is a broader term: people from multiple ethnic backgrounds may identify as belonging to the same culture.

Cultural identity: Any combination of shared historical, linguistic, and psychological factors that influence the perspectives of different cultural groups (7, 10).

One example would be people from Mexico, Guatemala and Columbia may identify with the Latin American culture at the same time identifying with different ethnic cultures. Leininger refers to the different subcultures within the healthcare system: the patient's culture, the care-giver's culture, and the healthcare organization are all part of the larger healthcare system "culture".

Caregivers may have their own ethnic identity, yet self-identify as part of a professional culture, within a specific department's subculture. For example, the psychiatric social worker may have his/her own ethnic identity and still hold a professional identity as a social worker, with a culture that is distinct from an acute care social worker culture.

Values: Ideas held by human individuals or groups about what is desirable, proper, good or bad.

Differing values represent key aspects of variations in human culture. What individuals' value is strongly influenced by the specific culture in which they happen to live? (8)

Worldview: A framework through which an individual interprets the world and interacts in it. A collection of beliefs about life and the universe held by an individual or a group (11)

Almost everything that we experience is shaped by the perceptions provided by our view of the world. Culture filters what we see and what we perceive. Culture determines the generally accepted definitions of social reality (11)

For example, the predominant Technological Worldview of most Western countries, that technology would be able to solve most human disease and illnesses, might be in contrast to a holistic worldview of other cultures.

. Linguistic competence means communicating effectively.

Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences. (Source: NCCC 2004).

The goal of cultural competency is to make healthcare more efficient and more effective.

It is reducing costs of unnecessary tests and procedures, gaining trust and compliance with treatment in order to promote positive outcomes, and respecting and acknowledging that beliefs, practices, and genetic heritage of clients can affect their

treatments and outcomes.

It is *not* learning everything about all the different cultures that you will encounter; it is developing the skills and resources to deal with the differences. It is not learning all the different languages that clients speak, but the knowledge and skills to communicate effectively with and without interpreters.

A *Cultural Sensitivity Manual* is available in all work areas at Fort Logan, which addresses the cultural needs of various groups. You may also contact Staff Development @ 7702 for any further information needed.

Some of the benefits of cultural competence in healthcare (MCC 2005):

- ⇒ Improves communication with patients
- ⇒ Helps with negotiating differences
- ⇒ Promotes disclosure of patient information
- ⇒ Makes more effective use of time with patients
- ⇒ Promotes patient adherence to treatment
- ⇒ Decreases health worker and patient stress
- ⇒ Builds trust in a relationship
- ⇒ Increases patient and provider satisfaction
- ⇒ Meets increasingly stringent government regulations and standards
- ⇒ Positively affects clinical outcomes

Cultural competence: a journey

According to the Campinha-Bacote model, cultural competency is not an end-result to be achieved, but a continuous process of life-long learning and desire, to achieve the ability to work effectively within the cultural context of the client.

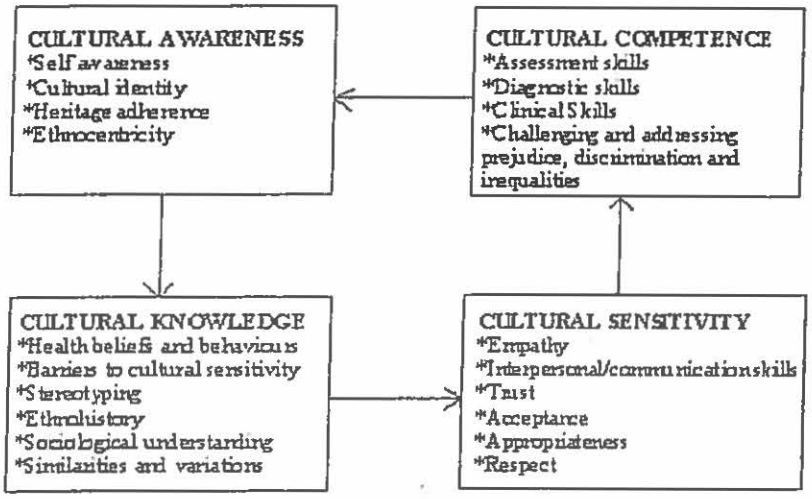
The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence describes a four-stage model that starts with cultural

awareness, to the acquisition of cultural knowledge, to the development of cultural sensitivity and cultural competence (4).

Developing cultural awareness requires self-humility, self-understanding, and self-acceptance of one's own cultural identity. It requires "a life-long commitment to self-evaluation and self-critique...(3)".

Self-awareness must not only be intellectual, it must be emotional or heart-felt to be effective (11). It requires recognition of one's biases and prejudices, and recognizing the limits of one's competence (12).

Source: Papadopoulos, Tilki and Taylor Model
(**www.mdx.ac.uk/www/rctsh/modelc.htm).**



"Cultural identity development is a major determinant of...client attitudes toward the self, others of the same group, and the dominant group".

Self-awareness: Becoming aware of your own worldview

(Adapted from Buhin et al. 2004)

1. Learning About Your Own Culture
2. Understanding Your Personal Worldview
3. Appreciating Your Own Multiple Identities
4. Acknowledging assumptions and biases.

5. Accepting Responsibility and Tolerating Ambiguity
6. Recognizing Limits of Your Competence

1. Learning About Your Own Culture

According to Tervalon and Murray-Garcia, cultural self-awareness requires a life-long commitment to self-evaluation and critique (14). Before entering into a client-caregiver relationship, the individual must become aware of her/his cultural and historical background. By recognizing the different influences from his/her cultural background, the individual will be able to recognize the different influences in the client's background and will be more likely to engage in a sensitive, therapeutic relationship.

Exercise #1: Adapted from http://www.leron-line.com/Cultural_Self_Assessment.htm

(All exercises are for your own personal/professional use.)

Think of yourself as a cultural being whose life has been influenced by various historical, social, political, economic, and geographical circumstances. This exercise will help you become aware of your historical, ethnic and cultural background.

Where were you born?

When were you born?

Where did you grow up?

Where did your parents grow up?

Where did your grandparents grow up?

Where did your great grandparents grow up?

What is your earliest memory as a family?

What is your earliest school memory?

As a family, what events did you celebrate?

Have you traveled or moved as an adult?

Recall on international event that happened before you turned 18. Try to answer the following: Who was involved, what was the event, where did it happen, how did it happen, and why did it happen?

Recall an event that happened in the country where you were born, before you turned 18. Try to answer the following: Who was involved, what was the event, where did it happen, how did it happen, and why did it happen?

What is your earliest recollection as a member of a group?

What was your first job?

As an adult, what events or holidays do you currently celebrate?

2. Understanding Your Own Worldview

Since our perceptions are shaped by our view of the world, the healthcare provider needs to examine and understand how she/he sees the world. One's worldview is learned through socialization, from childhood to adulthood, and constantly reinforced by the culture in which we live. It is the taken-for-granted view of "the way things are" and most of the time unquestioned and invisible.

"To understand worldviews, therefore, we must examine the beliefs/belief systems and the social values that they contain." (LeBaron, M. 2003). An example of a belief system was Social Darwinism, which held that life is a struggle for survival and dominance, and the most competent and hard-working individuals will be most successful, while the incompetent and inferior will be the least successful.

What is your worldview?

One Western worldview is "I am the captain of my soul," which is in contrast to the worldview of "God will provide" which other cultures hold.

When one is blind to his own culture, he will not be able to see the

differences in values between cultures. This could lead to cultural destructiveness, cultural imposition and cultural pain. This stems from cultural ignorance of one's own and other's cultural identities, due to intentional or unintentional isolation or separation. This leads to dehumanizing others with different values than one's own. The greater the difference, the more negative the evaluation of the other culture (16)

"The manner of their living is very barbarous, because they do not eat at fixed times, but as often as they please." Amerigo Vespucci, when he discovered America.

Exercise #2: How do you view the following?

Aspects of Worldview	**What is your worldview?**
Time	(Time is money?)
Space between you and the next person	(When do you start feeling uncomfortable?)
Relationships	(Work relationships vs. personal relationships)
Technology	(How do you see technology?)
Religion or spirituality	(What about religion?)
Honesty	(Tell the truth no matter what.)

3. Appreciating Your Own Multiple Identities

We all live within and identify with multiple identities. Most of us can claim different identities related to gender, age, religion, ethnicity, socioeconomic status, profession, national origin, educational level, etc.

When working with clients from other cultures, the caregiver should examine differences and similarities between herself/himself and the client. The caregiver takes into account "issues related to diversity, marginalization, and vulnerability due to culture, race, gender, and sexual orientation (National Academy of Nursing expert panel, 1990.)

By recognizing one's multiple identities, one is less likely to stereotype others based on minimal information about another person's historical, social, and cultural backgrounds.

What are the shared identities between two 30-year-old men, one is a 30-year-old nurse who works full-time, goes to school in the evenings to work on his master's degree and raises three children and another 30-year-old man who works at two jobs and raises three children?

Exercise # 3. "I am_."

Take a blank sheet of paper and write the numbers 1-10 on the left hand column. Complete the statement "I am_____" using the first words that come to mind.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

What were your first 5 answers? When did you start to slow down in writing your answers?

What were the last 3 answers? Do you feel that your list accurately captures your multiple identities?

4. Acknowledging assumptions and biases

ANA Code of Ethics: Nurse provides care with respect to the inherent worth of the individual. "The nurse establishes relationships and provides care with respect to human needs and values, and without prejudice."(Provision 1.1, 1.2. ANA Code of Ethics.) (17)

"Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows them to acknowledge their own racist attitudes, beliefs, and feelings" (18)

Caregivers are expected to be aware of their own cultural identifications in order to control their personal biases that interfere with the therapeutic relationship. Self-awareness involves not only examining one's culture, but also examining perceptions and assumptions about the client's culture.

Through a self-reflective assessment of their personal values, attitudes, and assumptions about other cultures, and articulating these assumptions and attitudes, the caregiver will gain the ability to sort out or "bracket" the influences of their own cultural background in order to provide respectful and unbiased care. (20)

Exercise # 4: Answer the following questions:

1. What racial group do you identify with?
2. What ethnic group(s) do you identify with?
3. What socioeconomic class do you identify with?
4. What is your earliest memory of belonging in a group (other than your family)?
5. What is your earliest memory of being excluded from a group?
6. What is your earliest memory of excluding someone from a group?

Exercise 5: Adapted from Luckman (1999)

How do you relate to various groups of people in society? Please answer honestly, not as you think might be socially or professionally desirable. Please **do not record** your answers for this exercise.

Level of response:

1. I feel I can genuinely try to help this person without prejudice.
2. Even though I do not agree with this person, I feel I can accept this person as he is and comfortable enough to listen to him/her.

3. I do not feel that I have the background knowledge or experience to help this person.
4. I feel uncomfortable taking care of this person.
5. I feel biased and prejudiced against this person.

Individual	Your Response
Iranian immigrant	
Child abuser	
Mexican American	
Elderly person with dementia	
Prostitute	
Methodist minister	
Gay/lesbian	
Unmarried expectant teen	
White Anglo-saxon American	
Amputee	
Anorexic teenager	
Morbidly obese man in his 30s	
Norwegian	
Person with AIDS	
Person with cancer	
Person who does not speak English	

5. Accepting Responsibility and Tolerating Ambiguity

Caregivers accept responsibility for the continuous process of becoming "aware of their own assumptions about human behavior, values, biases, preconceived notions, personal limitations, and so forth" (Sue et al., 1998, p.38).

Tolerating ambiguity means the caregiver keeps her certainty that "her way is the right way" in check, and will attempt to understand the issues about a client's supposed "non-compliance" with prescribed treatment. Accepting responsibility means the caregiver will not

assume that a failed outcome to treatment stems solely from the client's "non-compliance" with prescribed therapy.

Ethnocentrism is defined as the tendency of human beings "to think that their ways of thinking, acting, believing are the only right, proper, and natural ways" and that beliefs, values and practices that differ from one's own are wrong." (Purnell 1998).

Unexplored assumptions about our biases and preconceived ideas about others will "blind" us to our ethnocentric behaviors and attitudes. Leininger refers to cultural imposition and cultural pain as consequences of ethnocentrism (2)

Ethnocentrism is not an acceptable attitude in health and social care because it deters from relationship building between the professional and the patient (23).

Exercise 6: (Adapted from Luckmann 1999)

Indicate the degree to which you agree to the following statements:

1. People are responsible for their own actions.
2. The outcome of events is beyond our control.
3. It is dishonest to give vague and tentative answers.
4. It is best to avoid direct and honest answers in order not to hurt or embarrass someone.
5. Intelligent, efficient people use time wisely and are always punctual.
6. Being punctual to work or meetings is not as important as spending time with family or close friends.
7. Stoicism is the appropriate way to grieve.
8. Loudly crying and moaning is the appropriate way to grieve.
9. The best way to gain information is to ask direct questions.
10. It is rude and intrusive to ask direct questions.
11. It is proper to call people by their first names to show that you are friendly.
12. It is disrespectful to call people by their first names unless they give you permission to do so.
13. It is rude not to look at a person who is speaking to you.

14. It is rude to engage in direct eye contact with persons of higher status.

6. Recognizing Limits of Your Competence

According to Leininger, having prior knowledge and experience with interaction with different cultures is not sufficient when taking care of clients from different cultures.

Reflective experience needs to be grounded in ethnographically derived holding knowledge, not just on hunches and personal generalizations. The caregiver has the ethical obligation to seek research-based knowledge, training, and education in the care of clients of which she is not familiar (2).

Caregivers should base their practice on evidence or research-based knowledge in order to prevent stereotyping and generalizations.

"All Arab-Americans are Muslims" is a generalization that is not based on fact.

"Mono is a disease of college students" is a generalization based on the fact that the highest rate of the disease occur among college students, but to say that only college students get mononucleosis is inaccurate.

Having personal experience as a member of an ethnic group does not confer expertise on the person without theoretical and research-based background to validate their knowledge.

Expertise in one cultural group does not confer expertise on another group. Having knowledge and experience in working with Hispanic patients does not qualify one to work competently with Haitian patients.

The professional healthcare provider should seek additional education, training and supervision when taking care of clients from unfamiliar cultures. To practice without background knowledge is unprofessional, unsafe, and unethical (2).

Cultural competency is a continuous process of life-long learning and desire (3).It is not accomplished with a one-time session in cultural diversity. It is not accomplished by cultural awareness and cultural knowledge without the desire for face-to-face encounters with others who are culturally different.

Our goal is not attaining merely "cultural competence". The task of self-awareness is not just putting aside and controlling one's own cultural background from influencing the client-caregiver relationship.

It is a process where the caregiver is cognizant of how their self contributes to the experience of themselves and their client, and a process in which the caregiver and the client are enriched by including each other's worldviews in the interaction. It is a site for negotiation and co-creation of new meanings and relationships (20).

"Cultural competence begins with an honest desire not to allow biases to keep us from treating every individual with respect. It requires an honest assessment of our positive and negative assumptions about others.

This is not easy - no one wants to admit that they suffer from cultural ignorance, or in the worst case, harbor negative stereotypes and prejudices. Learning to evaluate our own level of cultural competency must be part of our ongoing effort to provide better health care." National Health Care for the Homeless Council: http://www.nhchc.org/Curriculum/module2/module2D/module2d.htm

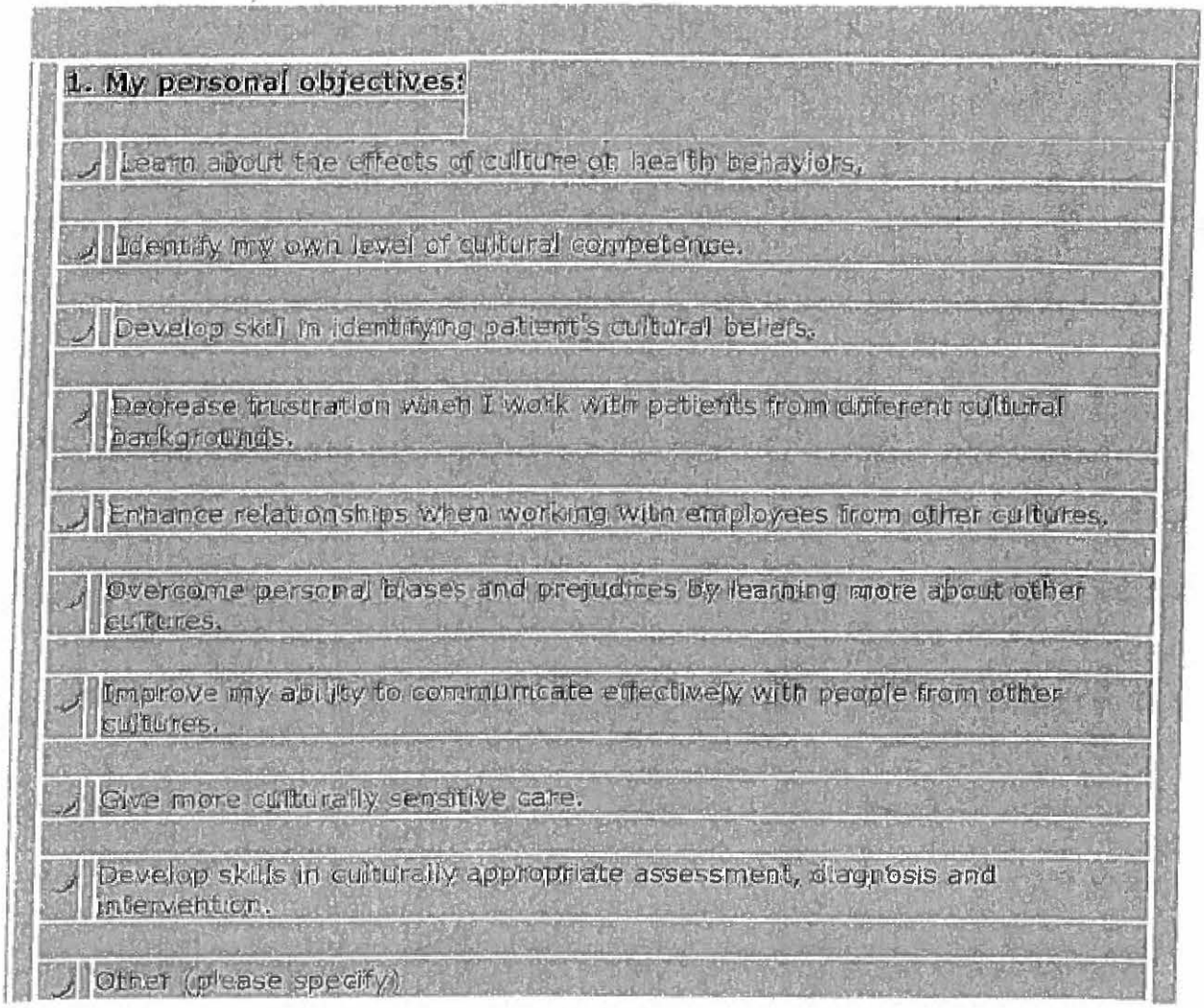
Exercise 7:

How culturally prepared are you to take care of the following clients?

- A married lesbian couple who are wanting to adopt a child
- A 40-year old Caucasian male with AIDS
- Homeless family
- Elderly farmer from Nebraska
- A 50-year old diabetic in prison
- Native American elder
- A Mexican folk-healer
- A Wiccan believer

Exercise 8: To end this module, please complete the following self-assessment :

Assessing your personal objectives.



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(3) Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125.

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