**CAREGIVER**

**ORIENTATION**

**BOOK**

**It is required that all Employees complete a company orientation.**

**Each employee will have an Orientation Checklist completed and placed in the Personnel File.**

**The following are items that are included on the Orientation Checklist.**

* Agency Mission, Vision and Plan
* Types of Care Provided by the Agency Policies and Procedures
* Personnel Policies and Job Description
* Client Rights and Grievance Policy
* Confidentiality of Patient Information (HIPAA)
* Ethics
* Supervision and Evaluation
* Home Safety (Bathroom, Electrical, Environment, Fire and Hazards) Safety Issues in the Home (Including Security and Guns in the Home) Emergency Preparedness Plan/Actions to Take in the Event of Disaster Actions to Take in Unsafe Situations
* Infection Control in the Home/Standard Precautions
* Patient Care Responsibilities
* Mandatory In-services - HIPAA and Infection Control for all staff with additional mandatory in-services of Blood borne pathogens, Medical Device Reporting and Respiratory Disorders/Tuberculosis for employees with direct patient contact.
* Understanding and coping with Alzheimer’s disease and Dementia
* Community Resources
* Cultural Diversity
* Identifying and Reporting Abuse, Neglect and Exploitation
* Fraud, Abuse, and Whistle blowing
* Quality Assurance
* Documentation
* Incident and Occurrence Reporting
* Advance Directives
* Received Photo ID Badge

**Administrative Policy**

**Mission Statement**

The Agency’s mission is to provide professional and paraprofessional services to patients in their homes assisting them to achieve the highest level of potential in their day-to-day self-care activities. We are committed to providing high quality, multidisciplinary care by professionals who recognize the need for comprehensive assessment of needs from both the patient and professional's point of view.

### Vision Statement

We strive to be one of the leading providers of a wide range of quality home health care services, recognized for enduring dedication to provide innovative, professional, and compassionate care to the communities we serve.

**Philosophy**

Our goals and services are based on two fundamental philosophical principles: the belief in the innate worth of the aged and disabled individual; and the belief that each individual, regardless of age, race, color, creed, sex, national origin or handicap(s) is entitled to maximize his potential as a human being and as a member of society.

It is the contention of this Agency that the aging process is a normal state in the development of any individual and that chronic disease and disability are, to some degree, a part of that process. This Agency is dedicated to rehabilitating aged and disabled individuals within the confines of their residence, in order that they may maximize their contributions and fulfill their goals as a family member and member of society with a minimum of conflict. In accomplishing this end, it is felt that the self-respect of the individual can and will be enhanced.

The Agency is also a vital member of its community. As an employer, the Agency practices non-discrimination and strives to provide opportunities for personal and professional growth. As an integral part of the business community, the Agency makes every effort to serve the people with attention to current area practices and specific needs.

**SERVICES PROVIDED Patient Care Policies**

The Agency is dedicated to providing the most qualified personnel to the patient in his/her own home in order to maximize and fulfill his/her goals as a member of the community.

Services are available 24 hours a day, seven days a week using an answering service and on-call procedures after normal working hours, weekends, and holidays. As needed, staff may be assigned to make patient visits after normal business hours.

We offer skilled nursing services and to the extent that appropriate professional staff are either hired or contracted for the additional services listed below will also be available:

**Registered Nurses/Licensed Vocational/Practical Nurses:**

1. Registered Nurses (RNs) provide quality nursing care by the visit or the shift. The highly

trained professionals follow the physician's orders, monitor and instruct the patient

regarding their care. Specialized therapies as IV antibiotics, chemotherapy, and total parenteral

and enteral nutrition are also provided by the RN.

2. The Licensed Vocational Nurse (LVN)/Licensed Practical Nurse (LPN) provides assigned nursing care under the direction of an RN. The LVN/LPN is supervised by the RN at least monthly.

3. All RNs are licensed in the state and follow all regulations and standards of practice required by the State.

4. All LVNs are licensed in the state and follow all regulations and standards of practice required by the State.

5. Our Agency does not provide psycho-active treatments.

**Home Health Aides:**

1. The Home Health Aides (HHA or Aide) provide light housekeeping, meal preparation, shopping and personal care for the patient.

2. These services are provided by the visit or shift.

**Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Worker**

**Services.**

These services are provided as ordered by the physician to enable the patient to receive restorative therapy and social work and nutritional intervention as needed. They are provided through contract or directly.

**This agency does not provide volunteer services. This agency does not have medical delegation.**

**Professional License Verification**

All staff with professional credentials will be verified on hire and at time of their individual license renewal with the appropriate professional Florida Board for RN, LPN, PT, OT, ST, PTA and COTA.

**Physician License Verification** Physician verification/credentialing is conducted at the time of the first patient referral and once yearly thereafter. This is conducted on-line through the State Medical Board.

**COMPLETED POLICIES AND PROCEDURES ORIENTATION**

**(See Policies and Procedures Manuals)**

Personnel Policies

Review of Personal Policy Manual

Job Description (as stated in the policy manual)

Employee Emergency Contact Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT RIGHTS AND RESPONSIBILITIES Administrative Policy**

**Purpose:**

To provide a delineated list of patient rights and responsibilities.

**Policy:**

Patients will be advised at the time of admission and at every re-certification, about their rights and responsibilities regarding the receipt of home care services.

**Procedure:**

1. During the initial visit and every re-certification, the patient is advised of the individual's rights and responsibilities (Bill of Rights & Responsibilities) in the receipt of home care services.
2. The patient is provided with an understandable written explanation of individual rights and responsibilities regarding the receipt of home care services.
3. The Bill of Rights & Responsibilities will be provided to the patient’s legal representative if the patient is unable to comprehend them.
4. Interpreters will be employed as necessary.
5. The patient is given an opportunity to read the written explanation and to ask questions with respect to the Bill of Rights & Responsibilities.
6. The date, signature, and other relevant information with respect to disclosure, discussion and receipt of the patient’s Bill of Rights & Responsibilities will be noted on the Authorization for Services form.
7. Contracts with providers and payers contain a section whereby the providers acknowledge and agree to abide by the Patient’s Bill of Rights & Responsibilities.
8. The patient who feels his rights have been denied or who desires further clarification of his rights or who desires to lodge a complaint about any aspect of service or care should contact the Administrator or supervising nurse, verbally or in writing. The Agency’s grievance procedure shall be followed in handling grievances or complaints.
9. At the time of admission, the patient shall be given in writing the number of the state's toll-free "hot line" and its hours of operation, and the name, address and phone number of the Administrator and supervising nurse.

**CLIENT BILL OF RIGHTS**

**Administrative Policy**

**Patient Care Responsibilities**

**Patient Rights and Responsibilities**

**Statement of Purpose:**It is anticipated that observance of these rights and responsibilities will contribute to more effective care and greater satisfaction for the patient as well as the staff. The rights will be respected by all personnel and integrated into all Home Care programs. A copy of these rights will be given to the patient and their families or designated representative in advance of furnishing service or during the initial evaluation before service is provided. The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the patient are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent. Any legal representative may exercise the patient's rights to the extent permitted by law.

**The Patient has the right:**

1. To be fully informed in writing and knowledgeable of all rights and responsibilities before providing pre-planned care and to understand that these rights can be exercised at any time.
2. To appropriate and professional care relating to physician orders.
3. To choose a health care provider.
4. To request services from the Home Care Agency of their choice and to request full information from their agency before care is given concerning services provided, alternatives available, licensure and accreditation requirements, organization ownership and control.
5. To be informed in advance about care to be furnished and of any changes in the care to be furnished before the change is made.
6. To be informed of the disciplines that will furnish care and the frequency of visits proposed to be furnished and to be served by individuals who are properly trained and competent to perform their duties.
7. To information necessary to give informed consent prior to the start of any procedure or treatment and any changes to be made.
8. To participate in the development and periodic revision of the plan of care/service.
9. To confidentiality and privacy of all information contained in the patient record and of Protected Health Information including the patient or patient’s legal representative’s right under Florida law to access the patient’s clinical records unless certain exceptions apply. The home health agency shall advise the patient or the patient’s legal representative of its policies and procedures regarding the accessibility of clinical records.
10. To information necessary to refuse treatment within the confines of the law and to be informed of the consequences.
11. To treatment with utmost dignity and respect by all agency representatives, regardless of the patient's chosen lifestyle, cultural mores, marital status, political, religious, ethical beliefs, having or not having executed an advance directive and source of payment without regard to race, creed, color, sex, age or handicap.
12. To have his/her property and person treated with respect, consideration and recognition of patient dignity and individuality.
13. To receive and access services consistently and in a timely manner from the agency to his/her request for service.
14. To be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed and to be informed of the agency's limitations.
15. To reasonable continuity of care.
16. To an individualized plan of care and teaching plan developed by the entire health team including the patient and/or family.
17. To be advised that the agency complies with Subpart1 of 42 CFR 489 and receive a copy of the organization’s written policies and procedures regarding advance directives, including a description of the individual’s right under applicable state law and without fear of reprisal whether or not an advance directive is executed, and to know that the Agency will honor the patient’s advance directives in providing care.
18. To be informed of anticipated outcomes of service/care and of any barriers in outcome achievement.
19. To be informed of patient rights regarding the collection and reporting of information.
20. To expect confidentiality of the access to medical records and written information according to State Statutes.
21. To be informed within a reasonable time of anticipated termination of service of plans for transfer to another health care facility/provider and the reason for termination of services.
22. To be informed verbally and in writing and before care is initiated of the organization's billing policies and payment procedures and the extent to which:
    1. Payment may be expected from Medicaid, or any other federally funded or aided program known to the organization.
    2. Charges for services that will not be covered by Insurance
    3. Charges that the individual may have to pay.
23. To be able to identify visiting staff members through proper identification.
24. To be informed orally and in writing of any changes in payment information as soon as possible, but no later than 30 days from the date that the organization becomes aware of the change.
25. To honest, accurate, forthright information, regarding the home care industry in general and his/her chosen agency in particular, including cost per visit, employee qualifications, names and titles of personnel, etc.
26. To access necessary professional services 24 hours a day, 7 days a week.
27. To be referred to another agency if he/she is dissatisfied with the agency or the agency cannot meet the patient's needs.
28. To receive disclosure information regarding ownership and control and of any beneficial relationship the organization has that may result in profit for the referring organization.
29. To education, instruction and a list of requirements for continuity of care when the services of the agency are terminated and information regarding community services available.
30. To be free from verbal, physical and psychological abuse, neglect and exploitation of any kind including agency employees, volunteers or contractors.
31. To privacy to maintain his/her personal dignity and respect.
32. To know that the agency has liability insurance sufficient for the needs of the agency.
33. To be advised that the agency complies with State requirements regarding advance directives and to receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and to know that the Agency will honor the patient’s advance directives in providing care.
34. To receive advance directives information prior to or at the time of the first home visit, as long as the information is furnished before care is provided and to know that the state hotline number may be used to lodge complaints regarding the implementation of the Advance Directive requirement and to know that the agency will follow the patient’s advance directives in the provision of care.
35. To voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect of property by anyone who is furnishing services on behalf of the agency, or recommend changes in policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal and to know that grievances will be resolved and the patient notified of the resolution within 30 days.
36. To not be denied equal opportunity because they or their family are from another country, because they have a name or accent associated with a national origin group because they participate in certain customs associated with a nation origin group, or because they are married to or associate with people of a certain national group.
37. To be informed of the toll-free abuse hot-line number, used to report abuse, neglect or exploitation.
38. To be informed of the toll-free child abuse hot-line number.

**The Patient has the responsibility:**

1. To provide, to the best of his/her knowledge, accurate and complete information about:
   1. Past and present medical histories.
   2. Unexpected changes in his/her condition.
   3. Whether he/she understands a course of action selected.
2. To follow the treatment recommended by the particular handling of the case.
3. For his/her actions if he/she refuses treatment or does not follow the physician’s orders.
4. For accruing that the financial obligations of his/her health care are fulfilled as promptly as possible.
5. To respect the rights of all staff providing service.
6. To notify the agency promptly in advance of an appointment or visit you must cancel.
7. To become independent in care to the extent possible, utilizing self, family and other sources.
8. To pay for care or services not covered by 3rd party payers.
9. To comply with rules and regulations established by the agency and any changes subsequent to the rules

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Signature of patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse/Therapist Signature Date

|  |  |
| --- | --- |
| **PATIENT NAME(Last, First)** | **MEDICAL RECORD No** |

**PATIENT GRIEVANCE PROCEDURE**

**Administrative Policy**

### Definition

A grievance is a concern relating to patient care conditions or to relationships between a patient and the Agency or a caregiver in which the patient believes that he/she has been wronged and wants the wrong corrected. It is regarding problem areas in the delivery of care which appear to threaten the health and well-being of the patient.

The Agency will investigate any complaint made by patient or patient’s family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient’s property by anyone furnishing services on behalf of the Agency. Both the existence of the complaint and the resolution of the complaint will be documented. All complaints/grievances are retained for a minimum of three years.

### Procedure

1. When a patient is admitted to the Agency, he/she is to be given an admission packet that includes a copy of the Agency Bill of Patient Rights and Responsibilities. This policy indicates that grievances are to be filed with the Agency Administrator. The fact that the policy was given to the patient is to be recorded in the clinical record.
2. All grievances and concerns are to be dealt with by the Administrator or his/her designee.
3. When a grievance is received, whether written or verbal, it is to be documented in the patient’s clinical record by the Administrator or his/her designee. It is also to be noted in a log kept by the Administrator.
4. The resolution of the problem is also to be documented in the same manner.
5. Each written grievance received is to be responded to in writing by the Agency within ten (10) days.
6. Grievance received after hours, on weekends and holidays and whenever the office is closed are handled on the next business day.
7. Each written or verbal grievance received is to be responded to in writing by the Administrator within ten (10) days. This information is reviewed by the Administrator and a complaint form is completed by the Administrator. Each person involved is interviewed by the Administrator who then evaluates all collected information.
8. After thorough evaluation, The Administrator makes a determination and formulates a decision notifying all persons involved. All information regarding activities, investigation, analysis, resolution and outcomes are documented in the Administrator's log and in the patient's chart.
9. The response is to explain the decision rendered by the Agency and it is to notify the patient of his/her right to appeal.
10. A copy of the outcome is to be filed in the clinical record and noted in the Administrator's log.
11. If the patient files an appeal, it is to be reviewed and responded to by a member of the Governing Body within thirty (30) days of its receipt by the Agency.
12. The response to the appeal is to be filed in the patient’s clinical record and noted in the Administrator’s log.

**PATIENT GRIEVANCE**

Your complaints or problems are important to the Agency.  We will give full consideration to a problem or complaint and make an effort to resolve the issue in an agreeable manner.  We assure you that you will have the opportunity to voice grievances and recommend changes in services and/or policies without discrimination, coercion, reprisal, or unreasonable interruption of services or reprisal in any manner from the Agency.

If you have a complaint about services or care that is or is not furnished, or about the lack of respect for the client‘s person or property by anyone furnishing services on behalf of the Agency, please:

1. Submit the complaint either verbally or in writing to the Administrator or supervising nurse. If you call after normal business hours, you will be contacted by the Administrator on the next business day.
2. The Administrator or supervising nurse will contact you or your representative and will make every effort to resolve the complaint to your satisfaction. They will documental all activities involved with the grievance/complaint/concern, investigation, analysis and resolution. You will be notified of the Administrator's decision within ten (10) days.
3. If the complaint cannot be resolved to your satisfaction, you may request that the Administrator submit your complaint to the Agency Board of Directors/Governing Body.
4. Please be advised that you may lodge complaints with the state hotline number during its hours of operation.

**THANK YOU FOR SHARING YOUR CONCERNS WITH US**

**Confidentiality of Patient Information (HIPAA)**

**HIPAA – PRIVACY COMPLIANCE**

### Definition:

The HIPAA Privacy ensures that personal medical information you share with physicians, hospitals and others who provide, and pay for, healthcare is protected. The Privacy Rule does the following:

1. Imposes new restrictions on the use and disclosure of personal health information.
2. Gives patients greater access to their medical records.
3. Gives patients greater protections of their medical records.

## Protected Health Information (PHI)

When a patient gives personal health information to a covered entity that information becomes Protected Health Information or (PHI). It includes:

1. Any personal health information that contains information that connects the patients to the information.
2. Information that might connect personal health information to the individual patient including the individual’s name, all geographical identifiers smaller than a state, phone numbers, fax numbers, email addresses, social security numbers, account numbers, certificate/license number, full face photographic images or other comparable images and other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data.

## PHI may be used or disclosed:

1. For treatment, payment and healthcare operations.
2. With authorization or agreement from the individual patient.
3. For incidental uses such as physicians talking to patients in a semi-private room.

## PHI must be released for use and disclosure:

1. When requested or authorized by the individual, although some exceptions may apply.
2. When required by the Department of Health and Human Services (HHS) for compliance or information.

## Signed Authorization from the patient is required if his/her PHI is used for Purposes other than:

1. Treatment
2. Payment
3. Healthcare Operations.

This includes:

1. Use or disclosure of psychotherapy notes (except for treatment, payment or healthcare operations
2. For use and disclosure to third parties for marketing activities, such as selling lists of patients and enrollees
3. Covered entities can communicate freely with patients about treatment options and health-related information.

## Authorization forms must contain:

1. A description of the PHI to be used/disclosed, in clear language
2. Who will use/disclose PHI and for what Purpose
3. Whether or not it will result in financial gain for the covered entity and the patient’s right to revoke the authorization
4. A dated signature of the patient whose records are being used/disclosed
5. An expiration date.

## Authorization Is NOT required as long as there is patient agreement as follows:

1. To maintain a facility’s patient directory.
2. To inform family members or surrogates or notify them on patient location, condition or death.
3. To inform appropriate agencies during disaster relief.

## Other permitted uses/disclosures that do not require patient agreement include:

1. Public health activities related to disease prevention or control.
2. Reporting victims of abuse, neglect, or domestic violence.
3. Conducting health oversight activities such as audits, legal investigations licensure or for certain law enforcement Purposes or government functions.
4. For coroners/medical examiners, funeral directors, tissue/organ donations or certain research purposes.
5. To avert a serious threat to health and safety.

#### In general, use/disclosure of PHI is limited to the minimum amount of health information necessary to get the job done.  This means:

1. Covered entities must develop policies to reduce health information sharing to a minimum.
2. Employees must be identified who regularly access PHI.
3. The type of PHI needed and the conditions presented for access must be monitored.
4. The Minimum Necessary Rule does not apply to use/disclosure of medical records for treatment, since healthcare providers need the entire record to provide quality care.

**Privacy Notice:**

Patients have the right to give adequate notice concerning the use/disclosure of their PHI on the first date of service delivery, or as soon as possible after an emergency.

New notices must be issued when your facility’s privacy practices change.

The Privacy Notice must:

1. Contain patient’s rights and the covered entities’ legal duties.
2. Be made available to patients in print.
3. Be displayed at the site of service, or posted on a web site if possible.

Once a patient has received notice of his or her rights, covered entities must make an effort to get written acknowledgment of receipt of notice from the patient, or document reasons why it was not obtained. Copies must be kept of all notices and acknowledgments.

**Patient Privacy Rights:**

The Privacy Rule grants patients new rights over their PHI, including the following:

1. Receive a Privacy Notice at the time of first delivery of service.
2. Restrict use and disclosure, although the covered entity is not required to agree.
3. Have PHI communicated to them by alternate means and at alternate locations to protect confidentiality.
4. Inspect, correct and amend PHI and obtain copies, with some exceptions.
5. Request a history of non-routine disclosures for six years prior to the request.
6. Contact designated persons regarding any privacy concerns or breach of privacy within the facility or at HHS.

**Privacy Rights of Minors:**

In general, parents have the right to access and control the PHI of their minor children - except when state law overrides parental control. Examples include:

1. HIV testing of minors without parental permission.
2. Cases of abuse.
3. When parents have agreed to give up control over their minor child.

Agency Compliance with HIPAA: In order to comply with HIPAA regulations, the Agency will:

1. Allow patients to see and copy their PHI.
2. Designate a full or part-time privacy official responsible for implementing the programs.
3. Designate a contact person or office responsible for receiving complaints.
4. Develop a Notice of Privacy Practices document.
5. Develop policies and safeguards to protect PHI and limit incidental use or disclosure.
6. Institute employee-training programs so everyone knows about the privacy policies and procedures for safeguarding PHI.
7. Institute a complaints process and file and resolve formal complaints.
8. Make sure contracts with business associates comply with the Privacy Rule.

**HIPAA Educational Training**

Completed HIPAA In-service

**ETHICS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Care Policies**

**ETHICAL ISSUES**

1. The Agency recognizes that issues of an ethical nature related to the patient/client, Agency and the provision of services may develop. Such issues may include but are not limited to:
   1. Informed Consent
   2. Decision making
   3. High technology and medical experimentation
   4. Patient/client safety
   5. Accepting or refusing care
   6. Standards of care
   7. Advance Directives
   8. Confidentiality
   9. Care for persons with inadequate reimbursement for services
   10. Right to freedom of choice, dignity and movement
2. It is the policy of the Agency to:
   1. Provide care within an ethical framework established by the professional disciplines provided by the Agency, established in Agency policy and procedure, and as established by law and standards of care.
   2. Allow the patient/client or his/her representative the right to participate in any discussion concerning ethical issues and to document such involvement.
   3. Have Agency staff and the patient/client’s physician participate in the consideration and resolution of ethical issues.
   4. Furnish staff with education regarding ethics and the mechanisms available to assist them with consideration and resolution of ethical issues.
3. Patient/Client Ethical Issues
   1. Ethical issues for patient/clients include but are not limited to the following:
      1. The patient/client has a Do Not Resuscitate or Do Not Intubate order but there is conflict among the family members.
      2. The patient/client and/or family is participating in and/or conducting rituals, religious healing activities or other behaviors that are disturbing to the employee and/or causing the employee to be concerned for the patient/client's well-being.
      3. The family and physician are concealing from the patient/client true information about his condition.
      4. The physician does not respond to requests for care that the nurse believes is necessary, i.e. an increase or decrease in pain medication, testing for TB, to be seen by the physician, etc.
      5. The patient/client refuses to accept assistance the employee feels is necessary, i.e. bathing, food stamps, companion, homemaker, ALF placement, etc.
      6. The patient/client refuses part of the ordered care (i.e., nursing) but chooses to accept another part of the ordered care (i.e., pharmacy).
      7. There is obvious drug use or other unusual or illegal activity in the patient/client's home which jeopardizes the employee's safety.
   2. The Agency will convene an Ad Hoc Committee of the Professional Advisory Committee to discuss and attempt to resolve ethical issues that arise. This committee will meet once yearly and more often if ethical issues arise.

**The Agency's Medical Advisor and the Agency employees involved in the patient/client's care will be included in the Ethics Committee.**

* 1. The patient/client's physician (or if unavailable, the Agency's Medical Advisor), and the Agency employees involved in the patient/client's care will be included in the Ethics Committee.
  2. The Agency's Quality Improvement Committee or other designated individual(s) or group may serve as a resource to assist in the consideration of ethical issues.
  3. The Governing Body will receive the minutes of the Ethics Committee meetings and may be called upon to take action on issues as required.
  4. Anyone may initiate consideration by notifying the Administrator and/or Director of a potential or actual concern. The Administrator or Director shall present the issues at a meeting of the committee as soon as possible. Minutes shall be kept of the meeting, and as appropriate, staff, the patient/client and the patient/client’s physician shall be advised of the results of the meeting in a manner appropriate to the individual situation.

1. Ethical Issues For Employees
   1. The Agency recognizes that from time to time staff members’ personal values and beliefs enter into their ability to provide care. Such issues include but are not limited to:
      1. Working or traveling on certain religious holidays
      2. Right to life issues
      3. Administering blood transfusions
      4. Respecting an individual decision not to seek medical care because of their religious beliefs
      5. Ethnic and sexual orientation issues for care
      6. Termination of life support systems and participation in certain advanced directive decisions
      7. Conflicting ethical, cultural or religious beliefs
   2. It is the Agency policy that:
      1. Refusal of an individual staff member to participate in certain aspects of care based upon personal values and beliefs will not disrupt the patient/client’s care
      2. When a situation arises for care that is in conflict with individual staff values and beliefs there is an alternative method of care.
      3. Individual performance evaluations will appropriately reflect the manager's consideration of motives related to refusal to participate based upon cultural values or religious beliefs.

**SUPERVISION AND EVALUATION OF STAFF**

**Personnel Policy**

Each clinical staff member, including members that have been contracted on an individual basis, must be supervised on-site periodically by an appropriate supervisor. If a staff member is contracted from an organization, it is that company’s responsibility to perform the supervisory visits.

1. Registered Nurses are evaluated at least annually by the Director.
2. Patients that are receiving LPN visits are supervised at least monthly by a Registered Nurse. Supervision visits are conducted for each patient that is being serviced by the LPN. The LPN is not present during the supervisory visit.
3. Therapists are evaluated annually by the Director.
4. Physical Therapist Assistants, Occupational Therapy Assistants and Social Work Assistants are supervised at least monthly for each patient that they service. Supervision is conducted by the Physical Therapist, the Occupational Therapist or Medical Social Worker depending on the type of therapy being provided to the patient. The therapy assistant does not need to be present.
5. Home Health Aides/Certified Nurse Aides or the paraprofessional providing home health aide services are supervised every two weeks by a Registered Nurse. If only therapy services are being provided, the PT, OT or SLP may perform the supervisory visit. The “supervisory visit” may be conducted with or without the home health aide being present. The supervisory visits are conducted for each patient receiving home health aide services. If only personal care services are provided to a patient, then supervision will take place every 60 days by a Registered Nurse and the paraprofessional providing the service must be present.
6. The supervisory visit shall evaluate the following, but not be limited to these topics alone:
   1. Performance
   2. Organization and time management
   3. Patient care
   4. Documentation
   5. Coordination of services
   6. Other aspects of performance as indicated
7. In addition, staff shall be supervised through their ongoing contact with their supervisor to discuss patient care issues.
8. The supervisory visit will be documented, dated, signed and placed in the patient record. Results of the visit will be reviewed with the employee being supervised.

**SAFETY-PATIENT SETTING** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Care Policies**

### Purpose:

To ensure a safe home environment for the patient/client and his/her family/caregivers as well as for the Agency staff member.

### Policy:

The safety of the home will be evaluated and corrective action taken. Safety education will be provided to the patient/client and family.

### Procedure:

1. A Home Safety Checklist will be completed during the initial home visit. Unsafe conditions should be reported immediately to the Director or designee and a corrective action plan developed with the patient/client and family.
2. Instruct patients/clients and family upon admission and as needed in basic home safety including but not limited to: methods for preventing falls, use of equipment, correct performance of tasks, care and disposal of hazardous waste and fire/emergency safety procedures.
3. Instruct the patient/client to have emergency telephone numbers for the police, fire department, and poison control center along with a neighbor's number readily available near the phone where they can be easily seen.
4. Appropriate emergency back-up systems will be documented and in place as needed, i.e. contacting public utility companies of home ventilator patients/clients.
5. The 24 hour on call telephone number to access Agency staff will be provided to the patient/client and family.
6. Patient/client related safety hazards will be documented in the clinical record.
7. All accidents or injuries will be reported to the Agency Administrator, documented on the Variance Occurrence document and reviewed by the Quality Improvement Committee.

**HOME SAFETY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Care**

**Environmental:**

1. Maintain clear passage ways in every room of your home and on steps.
2. Avoid the use of throw rugs as they contribute to tripping and falls.
3. Keep your home well lit. This practice enhances safety as you move from room to room.
4. Use exterior lights at night. Burglars are least likely to enter your home when outside lights are on.
5. Use a bath mat or other nonskid material in your bathtub to avoid falls. Add grab bars and use bath benches if necessary to aid mobility.

**Emergency Response:**

1. Have a plan in case fire strikes your home. Consider possibilities of fire in various parts of your home. Where will you exit? Where will you meet?
2. Avoid smoking in bed.
3. Keep emergency telephone numbers for fire, ambulances, and police at or on every telephone.

**Electrical Safety:**

1. Cover electrical outlets to prevent children from inserting objects.
2. Check electrical cords for wear. Do not use cords that are frayed or have exposed wires. Be sure to check the junction between the cord and plug.
3. Ground all three-pronged plug adapters.
4. Check heating pads for cracks prior to use. Do not use if present.

**Medication:**

1. Store all medications out of reach of children.
2. Secure all caps on medication bottles.
3. Store syringes behind a closed door and do not talk about the fact that you have syringes in your home.
4. Never expose medications to sunlight. (This precaution also applies to injectable medications, such as insulin)

**Oxygen:**

1. Place a “No Smoking" placards on all entrances to your home. These placards are provided by the oxygen agency.
2. Do not use more than 50 feet of tubing between the oxygen source and the patient/client.
3. Do not place oxygen tanks within 1-1/2 feet of windows or doors.
4. Roll the tubing and carry it to avoid tripping and falling when walking.
5. Do not have open flames, such as pilot lights of gas stoves or water heaters, within 12 feet of any oxygen equipment. (This warning also applies to the tubing.)

Place the number of your Electric Company on or at every telephone. Call if there is a power outage.

**HOME SAFETY ASSESSMENT**

In order to alert the patient/client and caregiver on home safety measures in order to minimize the hazard risk in the home, the Agency performs a home safety assessment which includes environmental mobility and bathroom safety risks as a part of the patient/client’s admission process and annually home safety will be assessed on an ongoing basis.

1. The admitting RN or therapist will explain the home safety assessment to the patient/client and/or caregiver and perform the assessment, including giving any recommendations or comments for improvements.
2. Patient/client handouts discussing home safety measures will be left in the home folder.
3. The home safety assessment will be repeated as needed.

**Safety Issues in the Home**

### Personal Safety of Employees While in the Community

* + - 1. It is important that our staff is safe at all times. To maximize the personal safety of health care professionals working in the community and home setting guidelines have been established.

1. The following precautions should be taken before making visits:
   1. Wear name badges that clearly identify you are from our Agency.
   2. It is recommended that you call patients in advance and alert them to the approximate time of your visit.
   3. If needed, ask the patient/caregiver for further directions to the residence.
   4. Request that pets are properly secured before making visits.
   5. If pets are menacing, back away, never run from animals.
   6. Walk slowly around animals so that you do not frighten them.
   7. Keep change for a phone call on your person.
   8. It is recommended that staff not carry a purse.
   9. Before leaving the Agency, lock your purse in the trunk of your car or cover it with a blanket if it will be visible.
   10. Consider the use of a personal mobile car phone.
2. The following precautions should be taken when traveling by personal or company car:
   1. Keep your vehicle in good working order with plenty of gas.
   2. Store a blanket in your vehicle in the winter and a thermos of cool water in the summer.
   3. Keep a snack in the glove compartment.
   4. Turn on emergency flashers and wait for the police if you have car trouble.
   5. Keep your car locked when parked or driving and keep windows rolled up if possible.
   6. Park in full view of the patient's residence and avoid parking in the alleys or deserted side streets.
   7. Know your route. If you get lost, look for a safe place to get additional directions or view your map.
3. The following precautions should be taken when walking to patient’s homes:
   1. Have your patient care bag/equipment ready when exiting from the vehicle; keep one arm free.
   2. Walk directly to the patient's residence in a professional and businesslike manner.
   3. Cross to the other side of the street, as appropriate, if passing a group of strangers.
   4. Carry car keys in your hand when leaving the patient's residence (the pointed ends of keys between fingers may make an effective weapon).
4. General instructions to staff with respect to precautions that should be taken:
   1. Use common walkways in buildings; avoid isolated stairs.
   2. Always knock on the door before entering a patient's home.
5. If relatives or neighbors become a safety problem:
   1. Make joint visits or arrange for escort services.
   2. Schedule visit time when they are gone.
   3. Discuss closing the case with the supervisor.
   4. Consider working in teams in high crime areas.
6. Defense techniques that can be used include:
   1. Scream or yell "FIRE!"
   2. Kick shins, instep, or groin.
   3. Bite and scratch.
   4. Have a whistle attached to your key ring and blow it.
   5. Use chemical sprays.
   6. Use your nursing bag as a defense weapon.
7. The following precautions should be taken when In neighborhoods with questionable safety or drug/gang related problems:
   1. Make visits in the morning.
   2. Some areas may have to be declared unsafe and therefore not serviced by the Agency.
   3. Regard uniforms and name badges as an important part of identification to the public.
   4. In the event of a robbery, never resist to keep the nursing bag; it can be easily replaced.
   5. Notify the supervisor of any car trouble, auto accident, or incident when personal safety is not secure.
8. After an incident occurs, follow the suggested guidelines regarding documentation:
   1. Complete an incident report within 24 hours to document when personal safety was threatened while you were working.
   2. Animal or human bites must be documented as an incident, and the paperwork should be given to your supervisor within 24 hours.
   3. Seek medical attention as needed.

#### Situations Involving Guns in the Home

1. The safety of staff in the patient’s home is of paramount importance. In any situation which a staff member assesses that there is danger, the employee is to leave the home and notify the office. At no time should care be provided if there is a possibility that a gun could be fired intentionally or unintentionally.
2. Staff members are not to carry firearms, concealed or otherwise, while on assignment for the Agency or traveling to and from the office. To do so will result in disciplinary action.
   1. All firearms in the patient’s home are to be put away before care commences.
   2. The patient/caregiver should be informed regarding the Agency’s safety policies during the initial visit.
   3. If the patient insists on keeping a loaded weapon in the room, the employee should leave the home and contact the supervisor.
   4. All instances regarding guns in the home should be documented thoroughly in the patient's clinical record.
   5. If there are highly unusual circumstances where the employee feels the situation requires the ability to defend oneself, the issue must be discussed within the Ethics Committee and a final decision made by the Administrator of the Agency.
   6. If an above incident occurs, it should be kept confidential within the Agency.

**Emergency Preparedness Plan/Actions to Take in the Event of Disaster** \_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Disaster Policy**

### Know your Agency’s Emergency Preparedness Plan:

1. Know who to report to and procedures to follow.
2. Be prepared to assume tasks/roles out of your ordinary job description.
3. Ensure credentials are up to date and with you.
4. Know how supplies will be procured for patients.
5. Know the Agency’s communication procedures.

### Have the automobile equipped:

1. A full tank of gas.
2. A shovel.
3. Blankets.
4. Portable battery operated or crank flashlight.
5. Portable battery operated or crank radio.
6. A list of gas stations with emergency/backup power.
7. A cell phone charger.
8. Booster cable.
9. A tire repair kit.
10. Bottled water and non-perishable high energy foods, such as granola bars, raisins and peanut butter.
11. Fire extinguisher (5 lbs.; “A-B-C” type).
12. Flares.

### Have alternative communication devices available for use:

1. Charged cell phone.
2. Portable phone.
3. CB Radio (hand held).
4. Satellite phone.

### Establish a family preparedness:

1. Escape routes.
2. Evacuation plan.
3. Have a family communication plan.
4. Have a point of contact that is out-of-town.
5. A plan for pets.

For a laptop computer have a converter that plugs into the cigarette lighter.

**SPECIAL NEEDS CONSIDERATION**

**Hearing Issues:**

1. Have a pre-printed copy of key phrase messages handy, such as:

“I use American Sign Language (ASL),”“I do not write or read English well,” “If you make announcements, I will need to have them written simply or signed.”

1. Consider getting a weather radio, with a visual/text display that warns of weather emergencies.

### Vision Issues:

1. Mark your disaster supplies with fluorescent tape, large print, or Braille.
2. Have high-powered flashlights with wide beams and extra batteries.
3. Place security lights in each room to light paths of travel.

### Assistive Device Users:

1. Label equipment with simple instruction cards on how to operate it (for example, how to “free wheel” or “disengage the gears” of your power wheelchair) and attach the cards to your equipment.
2. If you use a cane, keep extras in strategic, consistent and secured locations to help you maneuver around obstacles and hazards.
3. Keep a spare cane in your emergency kit.
4. Know what your options are if you are not able to evacuate with your assistive device.

**Actions to Take in Unsafe Situations**

**Personnel Policies**

1. Employees shall be provided adequate non-hazardous conditions in which to work in accordance with OSHA regulations.
2. No employee will be required to work in an unsafe situation or atmosphere. While in the field, if conditions are felt to be unsafe, the employee should leave the area, go to a phone in a safe location, and phone the supervising nurse. The employee should await further instructions about notifying the patient and rescheduling the visit.
3. All unusual incidents or circumstances should immediately be reported to the supervising nurse who will determine the plan for providing care and for notifying other employees of the plan.

**INFECTION CONTROL CLIENT HOME ACQUIRED INFECTIONS**

**Infection Control Policies**

The patient receiving home care services may have less clinical “acuity” (i.e.; intensity or degree of care needed) but may have substantial host risk factors, including advanced age, chronic illness, or immunosuppression. Much of home care is provided by family members in a setting that is less structured and controlled than the hospital environment. Plumbing, sanitation and ventilation may be poor or absent.

The Agency shall ensure that patients with potential for occupational exposure will be instructed in the following:

1. Personal hygiene
2. Exposure to blood borne pathogens
3. Infection control procedures
4. Hazards of TB transmission
5. Isolation precautions
6. Signs and symptoms of TB
7. Aseptic technique
8. Medical surveillance and therapy
9. Standard precautions
10. Protocol for tuberculosis care
11. Transmittable infections
12. Other topics as required.

Standard precautions will be followed for all home acquired infections.

Material appropriate in content and vocabulary to educational level, literacy and language of patient shall be used to teach the patient and family the prevention, control, symptoms and treatment of home acquired infections.

1. An accessible copy of the regulatory text of this standard and an explanation of its contents.
2. An explanation of modes of transmission of these diseases.
3. An explanation of the Agency’s exposure control plan.
4. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
5. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment.
6. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.

**Infection Control in the Home/Standard Precautions** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Infection Control Policies**

**EDUCATION/TRAINING**

The Agency shall ensure that health care workers with potential for occupational exposure participate in a training program.

1. All employees and, as indicated, patients/caregivers will be trained in:
   1. Personal hygiene
   2. Exposure to blood borne pathogens
   3. Infection control procedures
   4. Hazards of TB transmission
   5. Isolation precautions
   6. Signs and symptoms of TB
   7. Aseptic technique
   8. Medical surveillance and therapy
   9. Standard precautions
   10. Protocol for tuberculosis care
   11. Transmittable infections
   12. Other topics as required.
2. Employee education shall occur at the time of employment, within 30 days of when changes occur and on an annual basis. Records of such training shall be maintained in accordance with the Agency’s policy for retention of records, but not less than 3 years.
3. Additional training must be provided when changes such as modifications of tasks or procedures affect the employee’s occupational exposure. The additional training may be limited to addressing the new exposures created.
4. The person conducting the training shall be knowledgeable in the subject matter covered by the training outline. An opportunity for questions and answers shall be provided.
5. Material appropriate in content and vocabulary to educational level, literacy and language of employees shall be used.
6. The training program shall contain at least the following:
   1. An accessible copy of the regulatory text of this standard and an explanation of its contents.
   2. A general explanation of the epidemiology and symptoms of blood borne diseases.
   3. An explanation of modes of transmission of blood borne pathogens.
   4. An explanation of the Agency’s exposure control plan and the means by which the employee can obtain a copy of the written plan.
   5. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
   6. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment.
   7. Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment.
   8. An explanation of the basis for selection of personal protective equipment.
   9. Information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
   10. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
   11. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow up.
   12. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident.
   13. An explanation of the signs and labels and/or color coding required.
   14. An opportunity for interactive questions and answers with the person conducting the training session. If the employee is unwilling to attend the training, the name of a person of the Agency, will be provided to the employee. That person should be knowledgeable of the OSHA regulations.
7. Training records must include the following information:
   1. The dates of training sessions,
   2. The contents or a summary of the training session,
   3. The names and qualifications of persons conducting the training, and
   4. The names and job titles of all persons attending the training sessions.
   5. Documentation of the training will be placed in the individual employee’s personnel file.
8. Training records shall be maintained for three years from the date on which the training occurred.
9. The Agency will ensure that all records required to be maintained will be made available upon written request to the Assistant Secretary and the Director for examination and copying.
10. Employee training records required will be provided upon request for examination and copying to employees, to legally authorized employee representatives, to the Director and to the Assistant Secretary in accordance with 29 CFR 1910 (OSHA).

**Infection Control Educational Training**

Completed Infection Control In-service

**Understanding and coping with Alzheimer’s disease and Dementia**

Completed company In-service

**Community Resources**

**Reviewed agency’s Community Resource guide**

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| **COMMUNICATION BARRIERS AND CULTURAL CONSIDERATIONS**  \_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| In order to provide optimal quality care to our patients/clients, the Agency will facilitate communication with sensory-impaired patients/clients and patients/clients with limited formal education. The Agency shall attempt to arrange for bilingual staff members or an interpreter to work with non-English speaking patients/clients.   1. When the Agency assigns a staff member who does not speak the patient/client’s language, the Agency will provide the services of a qualified interpreter at no charge to the patient at any home visit. The Limited English Proficiency (LEP) person may prefer or request to use a family member, friend or significant other. Children and other patients will not be used to interpret in order to ensure confidentiality of information and accurate communication. 2. Interpreters will be used when no one is available in the home to provide interpretive services. 3. Cultural considerations for all patients/clients shall be respected and observed. Where such considerations impede the provision of prescribed health care or treatment, personnel shall notify the supervisor and physician in an effort to accommodate the patient/client. 4. Every effort will be made to obtain the services of an available interpreter when necessary for persons using sign language. The Agency will advise/refer regarding telecommunications devised for the deaf. 5. Educational materials, visual aids and/or special devises will be used as needed to facilitate communication. 6. Written and verbal communication will be at an educational level that the patient/client will understand. 7. When a significant portion of the caseload does not speak English, written materials are provided in a language understandable to patients/clients. 8. Obtaining an outside interpreter if a qualified interpreter on staff is not available. An interpreter will be obtained from one of the following:   Accredited Language Services - 1-800-322-0284  Verbatim Solutions 1-800-575-5702  [www.languageline.com](http://www.languageline.com)   1. Communicating with persons who are deaf or hard of hearing the agency will use the state relay system. |

**Identifying and Reporting Abuse, Neglect and Exploitation**

Domestic: Household or family related

Violence: Implies use of great force, intense vehemence, physical force exerted for the purpose of violating, damaging or abusing people or things

Abuse: Generally carries with it a sense of harm and takes the form of physical, verbal, sexual, psychological and emotional injury. It is generally repetitive and escalating

Neglect: Failure to care for or do, to disregard or pay no attention to. Neglect can be passive (unintentional failure to do care or give attention) or active (intentional failure to fulfill a caretaking obligation to inflict physical or emotional stress or injury)

Child Neglect: Leaving a child in a situation where the child would be exposed to a substantial risk of physical or mental harm, without arranging for necessary care for the child, and the demonstration of intent not to return by a parent, guardian, or managing or possessory conservator of the child

Exploitation: The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with a person using the resources of such person for monetary or personal benefit, profit, or gain without the informed consent of such person.

1. The Agency is cognizant of the increasing occurrence of domestic violence, abuse and neglect in specific population groups in America today. Realizing that victims of alleged or suspected domestic violence, exploitation, abuse or neglect may be admitted to the service of this Agency, appropriate care cannot be provided by the Agency unless these victims are identified and assessed.
2. This organization will:
   1. Educate its staff to the issues, appropriate identification and assessment of domestic violence, abuse, neglect, and exploitation.
   2. Educate its staff to appropriate intervention in response to the identified abuse, neglect and exploitation findings.
   3. Educate its staff to populations at greatest risk for domestic violence, abuse, neglect and exploitation.
   4. Use as the Agency's guide for reporting and intervention processes, the current law and regulations regarding abuse, neglect, exploitation and domestic violence issues.
   5. Establish and maintain a list of referral sources that includes private and public community agencies that provide for, or arrange for, assessment and care of victims of suspected or alleged abuse, neglect or exploitation and establish a referral network with these and other appropriate resources.
   6. Educate staff regarding the referral process with these resources including the referral criteria and implementation of the referral process to the appropriate resources within the network.
   7. Educate staff to appropriately document their assessment and care.
   8. Establish screening guidelines for identification of this Agency's "at risk" population and educate the staff to recognize this Agency's at risk population.
   9. Examples of general population to be considered may include but are not limited to:
      1. Infants and children, especially those within the welfare systems
      2. Women of all ages
      3. Pregnant women, especially pregnant teens
      4. Female psychiatric patient/clients
      5. People with major mental disorders
      6. Severely mentally or physically challenged individuals of all ages
      7. Members of drug and/or alcohol abusing households
      8. Generally abusive relationship households
      9. Dependent elderly requiring continuous or extensive care by family or other caretakers at home
   10. All abusive cases will be monitored and evaluated as part of the overall Agency quality assurance activities.
3. Policies for Reporting all Diagnosed or Suspected Cases of Abuse, Neglect or Exploitation:
   1. Reports of Child Abuse:
      1. Any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report the same promptly to the Department of Health 1-800-800-5556.
      2. Such reports, where possible, shall contain the names and addresses of the child and his parent, guardian, or other persons having custody and control of the child, and if known, the child’s age, the nature and extent of the injuries, abuse or mal-treatment, and any other information that may be helpful with respect to the child abuse and the identity of the perpetrator.
4. Reporting Mechanisms:
   1. Mechanism for coordinating and reporting of suspected cases of child abuse and/or neglect:
      1. All suspected cases will be referred to the Agency Administrator.
      2. The Administrator or his/her designee will determine the appropriateness of referral, collect necessary data, refer the case to the appropriate Child Welfare office, insure follow-up and coordinate both agencies services.
      3. All action taken by Agency staff will be recorded in the clinical record.
   2. Operating Hours
      1. The Agency has a 7 day week, 24 hour answering service. Each staff person is given the number for reporting purposes.
5. Protocols for Identification and Referring Suspected Cases of Abuse and/or Neglect:
   1. Staff members have the opportunity to assess the physical/emotional status of children/families. The following observations may indicate is need for referral:
      1. Primary detection - beginning symptoms of child neglect, e.g., inadequately fed infant, infant rejected, emotional deprivation, inadequate parenting skills, etc.
      2. Secondary detection - definitive symptoms of child abuse, e.g., multiple fractures, circular lesions indicating burns, malnutrition, failure to thrive, welts on body, severe physical illness and/or handicap affecting either children and/or parents, indications of sexual abuse.
   2. Refer to following pages for indicators.
   3. Recording and reporting:
      1. Factual evidence must be accumulated.
      2. Data should be pertinent.
      3. Explicit statements about a child's appearance and family interactions and quoted statements of family members are of value.
      4. Discuss referral with family.
   4. Education and/or Training:
      1. Orientation for new staff includes in-service regarding responsibilities in reporting suspected cases.
      2. In-service education is provided to all appropriate staff regarding the identification and reporting of diagnosed and/or suspected cases of child abuse and/or neglect and regarding the above policies and procedures, on at least an annual basis.
   5. Staff is sent to programs on abuse/neglect sponsored by other agencies, as appropriate.
   6. Board of Directors, through the Administrator is kept abreast of current problems and trends.
6. Policies and Procedures for Elder/Disabled Abuse/Neglect
   1. Same as above (for Child Abuse) with the following changes:
      1. All suspected cases will be reported to administration who will determine referral to an appropriate Agency.
      2. Refer to indicators on following pages.

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| **PHYSICAL AND BEHAVIORAL INDICATORS - ELDER ABUSE AND NEGLECT** | |
| **DIRECT INDICATORS** | **INDIRECT INDICATORS** |
| Injury incompatible with history | Victim reported, or brought to hospital by other than caregiver |
| Injury not properly cared for | Excessive delay between injury/illness and request for treatment |
| Malnutrition and/or dehydration without Illness related injury | History of hospital/doctor hopping, previous unexplained, similar injuries, incidents |
| Lack of personal care | Lack of concern, apathy on part of caregiver |
| Evidence of inappropriate medication administration | Elder is withdrawn, fearful, agitated in presence of caregiver |
| Bilateral or upper arm bruising | Evidence of recent crisis in family |
| Bruising clustered on trunk | Isolation of victim |
| Indications of objects (strap, rope, etc.) used as restraints, | Evidence of alcohol or drug abuse in family |
| Presence of old and new bruises at same time | Excessive feelings of dependence on family or caregivers |
| Other injuries, such as burns (unusual location, type), fractures, etc. | Family or caregiver "blaming" elder or resentful of responsibility |
|  | Evidence of elder's fears, resignation, anger or depression |
|  | Unrealistic expectations of victim by caregiver |
| **Psychological Abuse and Neglect** | |
| Threats |  |
| Insults |  |
| Harassment |  |
| Withholding of security and affection |  |
| Refusing to allow travel, visits by friends, attendance at church, etc. |  |

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| **Financial Abuse, Neglect or Exploitation** | |
| Overdue rent, utility or other bills | Evidence or reluctance to part with elder's Social Security check, other assets to provide for alternative care, even when caregiver/family desire respite |
| Discrepancy between elder's financial resources and condition of housing, level of personal care, nutrition, medical care, clothes, transportation and social opportunities |  |

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| **PHYSICAL AND BEHAVIORAL INDICATORS OF CHIID ABUSE AND NEGLECT** | | | | | |
| **Child's Appearance** | | | **Child's Behavior** | | **Caretaker's Behavior** |
| Bruises and welts (on the face, lips or mouth, in various stages of healing; on large areas of the torso, back, buttocks, or thighs, in unusual patterns, clustered or reflective of the instrument used to inflict them, on several different surface areas) | | | Wary of physical contact with adults | | Has history of abuse as a child |
| Apprehension when other children cry | | Seems unconcerned about child |
| Demonstrates extremes in behavior (e.g. extreme aggressiveness or withdrawal) | | Significantly misperceive child e.g. sees him/her as bad, evil, monster, etc.) |
| Seems frightened of parents | | Misuses alcohol or other drugs |
| Reports injury by parents | | Psychotic or psychopathic |
| Fractures (skull, jaw or nasal fractures, spiral fractures of the long (arm and leg) bones, fractures in various stages of healing, multiple fractures, any fracture in a child under the age of two | | |  | | Offers illogical, unconvincing, contradictory, or no explanation of child's injury |
| Lacerations and abrasions (to the mouth, lip, gums, or eye, to the external genitalia). | | | Attempts to conceal child's injury or to protect the identity of the person responsible |
| **Emotional Maltreatment** | | | | | |
| Emotional maltreatment, often less tangible than other forms of child abuse and neglect, can be indicated by behaviors of the child and the caretaker | Appears overly compliant, passive, understanding | | | Blames or belittles child | |
| Is extremely aggressive, demanding or enraged | | | Is cold and rejecting | |
| Shows overly adaptive behaviors, either inappropriately adult (e.g. parents other children) or inappropriately infantile (e.g. rocks constantly, sucks thumb, is enuratic). | | | With-holds love | |
| Lags in physical, emotional, and intellectual development | | | Treats siblings unequally | |
| Attempts suicide | | | Seems unconcerned about child | |
| **Neglect** | | | | | |
| Consistently dirty, unwashed, hungry, or inappropriately dressed. | | Is engaging in delinquent acts (e.g., vandalism, drinking, prostitution, drug use, etc.) | | Misuses alcohol or other drugs | |
| Maintains chaotic home life | |
| Without supervision for extended periods of time or when engaged in dangerous activities | | Is begging or stealing food | | Shows evidence of apathy or futility | |
| Is exploited, overworked, or kept from attending school | | Rarely attends school | | Is mentally ill or of diminished intelligence | |
| Has unattended physical problems or lacks routine medical care | |  | | Has long-term chronic illnesses | |
| Has been abandoned | | Has a history of neglect as a child | |

**Fraud, Abuse, and Whistle blowing**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Policies**

### Introduction:

Home Health Care Agencies are affected by theft and embezzlement. In addition any staff member that provides services to a client for deals with client billing or client admission must be educated with respect to theft and embezzlement. There is also the problem of employee theft.

Purpose:

The Agency has the responsibility minimize the opportunity for theft in its client dealings, notify appropriate authorities when theft does occur and to notify and assist individuals that may be the victims of theft. Further, the Agency has the same responsibilities if it has reason to believe that personal information relating to Protected Health Information (PHI) or patient personal information is compromised.

The policy of this agency is that in the event that any staff member becomes aware the possibility of theft or embezzlement, that it quickly brought to the attention of the Administrator so that an investigation can take place. If the results of the investigation warrant it, action will be taken in accordance with applicable laws. It is further the policy of the Agency to assure that each of its staff members is adequately trained so that they are able to readily recognize incidents of possible theft or embezzlement.

### Procedure:

When a staff member becomes aware of a possible situation of theft or embezzlement

1. Immediately report it to a supervisor/manager.
2. If a client of the Agency is the potential victim of the theft, the supervisor/manager will advise the client and advise the client that they will be contacted by a another agency representative.
3. The supervisor/manager, preferably, together with the staff member will report the incident to the Administrator.
4. An incident report addressed to the Administrator will be prepared as quickly as possible, and in no evident later than 24 hours after the event. The report will include:
   1. In the event that the incident involved the possible compromise of PHI held by the Agency:
      1. The names and contact information for all individuals that may have had their Personal Information or PHI compromised or unwittingly passed to an unauthorized person
      2. The reasons that led the staff member to believe that PHI and or personal Information may have been compromised
      3. A detailed description of the circumstances of the event
   2. In the evident that the incident involved an attempt by a person to make fraudulent use of information belonging to another person:
      1. The name and contact information of the potential victim of theft
      2. A description of the attempt to defraud and if known, the extent of any potential monetary damages
      3. The information that was being used in the attempt to defraud
      4. A description of the incident itself and what led to its detection
      5. The results of initial contact with the potential victim
      6. Safeguards that had been taken (or had not been taken) to protect the potential victim’s information
5. The Administrator will keep one copy of the incident in a dedicated file and another in the client’s record.
6. The Administrator will make a determination based on the evidence presented as to whether or not suspicion was warranted and the incident could be potentially one of theft.
7. If the Administrator determines that there is the potential that identity theft exists the appropriate law enforcement will be notified within 48 hours.
8. Whether or not the Administrator concludes that is the potential for theft, he/she will contact the potential victim within 48 hours and explain the situation and explain the potential victim’s rights. If the Administrator has decided that there is no need to contact law enforcement, but the potential victim feels otherwise, then Law Enforcement will be contacted as above.
9. If the incident involves the compromise of PHI or Personal Information held by the Agency, the Administrator will, if deemed appropriate after a review of evidence presented:
   1. Contact Law Enforcement
   2. Create a task force to contact each and every client whose personal information may have been compromised
   3. Conduct an investigation as to the scope of the problem that created the incident and the duration of the problem
   4. Notify the Agency’s insurance carrier

## Prevention of Theft and Embezzlement

In an attempt to eliminate theft and embezzlement the Agency will:

1. Prescreen employees
2. Conduct frequent physical inventories
3. Separate bookkeeping functions
4. Personally approve bookkeeping adjustments
5. Control check signers
6. Review monthly bank statements
7. Tighten up on petty cash

**Quality Assurance** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Quality Assessment and Performance Improvement Policy**

### Policy:

It is the policy of this Agency to implement and maintain a Quality Assessment and Performance Improvement (QAPI) Program. This program is designed to have a method of objectivity and systematically monitor and evaluate the quality and appropriateness of patient care. It also demonstrates the Agency’s commitment to continually provide quality health care. The committee members consisting of the Administrator, Director of Nursing, community representative, and, a member from each service discipline the agency offers. The term is three years. This term may be renewed for an additional three years by the Administrator.

None of the information, interviews, reports, statements, memoranda and recommendations produced during or resulting from the agency’s quality improvement program may be admissible as neither evidenced nor be discoverable in any action of any kind in any court, as provided in Article VIII, Part 21 of the Code of Civil Procedure (Medical Studies).

Our company is a private, for-profit, certified and licensed home health Agency providing service to all patients without regard to racial ethnicity, religion, age, gender, sexual orientation, or handicap.

The goal is to continuously improve the quality of services rendered. The responsibility of the QAPI Committee will be to assist in carrying out the objectives and activities of monitoring and evaluating as identified in the QAPI Plan.

The Agency’s QAPI program consists of but is not limited to the following:

1. Program/staff performance assessment activities.
2. Staff recruitment, training, orientation and continuing education programs.
3. Case conferences.
4. Management meetings.
5. Ongoing review of clinical records.
6. Clinical staff peer review activities.
7. Review of records requested by utilization/record review.
8. High volume services, conditions, or diagnoses.
9. Evaluation of systems designed to support clinical operations.
10. Compliance with clinical practice standards and recognized professional standards.
11. Program evaluations based upon measurable objectives, patient outcomes and cost effectiveness.

12. Management systems that support infection control functions.

13. Patient/physician satisfaction assessment.

14. Quality control activities.

15. Annual program evaluation.

16. Orientation/training program.

17. Continuing education.

18. Performance appraisals.

19. Re-prioritization of performance activity.

**OBJECTIVES OF QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM**

1. To administer and coordinate the Agency’s QAPI program which is designed to ensure all quality improvement activities are implemented.
2. To evaluate the delivery of well-coordinated care to patients.
3. To provide and validate comprehensive optimal level of safe and effective care/services at reasonable cost.
4. To improve access to community services.
5. To evaluate the appropriateness and outcome of care provided by staff/contract personnel.
6. To monitor and ascertain compliance with Agency policies and procedures and state and Federal regulations.
7. To identify problems, establish a plan and take action to resolve, reprioritize if necessary and reevaluate results.
8. To evaluate staff performance, delivery of care, documentation and patient outcomes and the Agency’s mechanism for addressing them.
9. To evaluate patient and staff education.
10. To determine patient and physician satisfaction of rendered services.
11. To identify opportunities to improve patient care using ongoing collection and screening and evaluating information about the outcome of customer satisfaction surveys.
12. To minimize risk exposure to staff and/or Agency.
13. To oversee the effectiveness of the program and detection of trends, patterns of performance or potential problems that may affect different areas of the organization.
14. To develop effective information systems to communicate quality assessment and improvement activity outcomes to Agency staff and committees.
15. To ensure patient and staff confidentiality throughout the quality assessment and improvement process.
16. To ensure performance based credentialing for each professional and paraprofessional caregiver.
17. To evaluate the scope, organization and effectiveness of the quality improvement program ensuring that actions taken are within the mission and goals of the Agency.
18. To identify the need for revisions in patient care services, policies and procedures.
19. To identify the extent to which the Agency program is adequate, effective and efficient in the use of all manpower and financial resources.

Documentation - Record Keeping

**CLINICAL RECORD CONTENTS**

The Agency maintains a confidential clinical record for each patient/client admitted to care. Closed or previously discharged records do not become current files if the patient is readmitted to services. The clinical record includes the following information:

1. **Identifying Data**

The identifying data includes:

* 1. the patient's/client's name, address, telephone number, age, sex
  2. next of kin or legal guardian
  3. emergency contact
  4. name of primary caregiver(s)
  5. source of referral
  6. admission and discharge dates from hospital or other institution, if applicable
  7. name of physician responsible for care
  8. diagnosis
  9. physician's order
  10. signed release of information and other documents for protected health information
  11. admission and informed consent documents
  12. assessment of the home, if applicable
  13. initial assessments
  14. ongoing assessments, if applicable
  15. a written plan of service/care, as applicable
  16. advance directive
  17. power of attorney and/or healthcare power of attorney
  18. evidence of coordination of service/care provided by the organization with others who may be providing service/care
  19. physician orders that include medications and dietary treatment and activity orders
  20. signed and dated admission and clinical notes that are written the day the service is rendered and incorporated at least weekly
  21. copies of summary reports sent to physicians
  22. client/patient/family response to service/care provided
  23. discharge summary

1. **Assessment**
   1. Each professional caregiver who is active in a patient/client’s care is responsible for doing an assessment of the patient/client.
   2. An initial assessment is to be done on admission. A copy of the assessment is kept in the clinical record. The initial assessment documentation must be submitted within 48 hours after admission.
2. **Physician's Orders**
   1. A verbal or written physician order is obtained prior to starting care. A verbal order is followed by a written order signed by the physician. When indicated by Agency policy, written physician's orders are obtained and signed by the physician within thirty (30) days after admission to the Agency. These orders are to be renewed as necessary and a minimum of every 2 months for patients/clients receiving skilled care, and every 6 months for patients/clients not receiving skilled care.
   2. Physician's orders are to cover the following:
      1. Name
      2. Prognosis
      3. Treatment
      4. All pertinent diagnoses
      5. Medications
3. **Change of Physician's Orders**
   1. Changes in orders that occur before the orders are renewed are to be documented in the clinical record and a written request is to be sent to obtain the orders in writing. Any changes in orders are signed & in the patient’s chart in the timeframe reference above.
   2. When returned from the physician, the orders are to be filed in the clinical record.
   3. If applicable, a reassessment and renewal of physician's orders are done whenever necessary and at least every 60 days.
4. **Care Plan**
   1. A Care Plan is to be developed by the registered professional nurse doing the initial assessment.
   2. The Care Plan is developed on admission to service and updated and signed by a registered professional nurse as needed and at least every 60 days for patients/clients receiving skilled services.
   3. The Care Plan is to include a description of each service, required treatments and procedures, medications, diet regimens, and frequency of service.
5. **Home Health Aide Care Plan**
   1. Each patient receiving service from a Home Health Aide, or the paraprofessional performing Home Health Aide duties, is to have a care plan developed by the coordinating nurse or professional therapist at the onset of service. It is to be updated as needed and at least every 60 days for patients receiving skilled services.
   2. The plan will specify the scope, frequency and duration of services.
   3. The plan is signed by the RN/therapist and reviewed with the Aide and patient.
6. **Record of Supervision of Aides**
   1. A supervisory note is to be written on admission and every 14 days for Home Health Aides, or the paraprofessional performing Home Health Aide duties, providing service to patients/client.
   2. Supervisory notes are to contain the following:
      1. Patient/client condition
      2. Supervision of Aide
      3. Reference to any pertinent information
      4. Competency of Aide
      5. Problems, interventions, outcome s
      6. On-the-job training
      7. Interaction with patient/client, Aide and family
      8. Evaluation of relationship among patient/client, field staff and family
      9. Review of care plan with patient/client, Aide and family
   3. The notes are to be legible and signed with full name and title.
7. **Progress Notes**
   1. Progress notes are used to record each patient/client visit or phone contact. The notes are to include a summary of patient/client status, response to plan of care and any contacts with family, informal supports and other community resources.
   2. Each caregiver is responsible for recording the care delivered.
   3. Each caregiver signs and dates notes with her/his full name and title, enters the date of the notation, and indicates the type of contact made.
   4. The progress notes are also to be used to record:
      1. Observations and reports made by Aides
      2. The patient/client’s receipt of information regarding his/her rights
      3. Accidents and grievances
      4. Visits made to supervise Aides
8. **Activity Report**
   1. The Aide is to check off those services implemented. Each entry is to be signed and dated by both the Aide and the patient/client.
9. **Release of Medical Information**
   1. The patient/client is to sign a form to authorize the release of medical information to the Agency so that appropriate care can be delivered.
10. **Discharge Summary**
    1. A discharge summary is to be completed on all patients/clients discharged from the Agency. It is to be completed within 30 days of discharge and is to include:
       1. Patient/client status upon discharge
       2. Recommendations and referral for any follow-up care, if needed.
11. **Required Documentation**
    1. All required documentation must be completed and in the patient/client record within fourteen (14) days of service delivery.
    2. In order to assure that the highest quality of coordinated home health care is provided to all patients/clients through direct communication of all involved disciplines, we have established effective interchange, reporting, and coordinated patent/client evaluation through patient/client case conferences.
       1. Patient/client case conferences are conducted every 60 days and as needed. An interdisciplinary case conference can be requested by any member of the staff who identifies a need for in-depth interdisciplinary intervention in order to successfully provide the care that an individual patient/client requires. All individuals involved in the patient/client’s care will be requested to attend, including patient/client/caregivers/family.
       2. The staff member who is the primary nurse is responsible for the initiation, coordination and documentation of the conference.
       3. Subjects discussed in patient/client case conferences include, but are not limited to, the following:
          1. Patient/client assessment of physical status and/or changes in condition,
          2. Patient/client intervention for all disciplines,
          3. Development/implementation of patient/client care plans and teaching plans,
          4. Evaluation of patient/client treatment plans and progress toward goals,
          5. Review of appropriateness of continued delivery of services to patients/clients, and
          6. Discharge planning.
       4. An Interdisciplinary Case Conference form is completed by the primary RN. All identified issues, plans for implementation of correction and the individuals responsible for implementation will be noted on the form.
          1. Original is filed in patient/client’s clinical record.
          2. Copies are given to all who attend the conference.
       5. The physician will be notified of any changes in the patient’s plan of care.
       6. Follow-up and outcomes will be noted by visit staff in progress notes. All clinicians involved in patient/client care, including contract Agency personnel, will have access to the plan of care.
       7. Documentation Errors:
          1. In the event a documentation error occurs, the staff member involved is required to draw one line across the documentation involved being sure that the incorrect documentation can still be read. The word error should be written above the line drawn and initiated. The correct documentation should follow.
       8. Late Entries:
          1. When an entry is made out of sequence, a bracketed (\*) is placed in the margin at the front of the line in which it should appear, along with the location in the record where the late entry may he found.
          2. The late entry is prefixed by the term LATE ENTRY in uppercase letters as well as the page, date, and line of the patient/client record where the entry should appear.
          3. The notation in the patient/client record is signed by the person making it along with the date and time of the entry.
       9. Home Record Contents:
          1. A record will be maintained in the home for all patients. The Record will be clean and orderly and will consist of the following and the home record will have Agency name and appropriate phone numbers on the front of the folder:
             1. Bill of Rights and Responsibilities, including complaint/grievance information (state Hot Line number, hours of operation, who to call)
             2. Home Health Aide care plan
             3. Emergency Plan (state Hot Line number, hours of operation, who to call)
             4. Abuse, neglect and exploitation
             5. Medication Profile (including narcotics forms)
             6. Glucometer log (as appropriate)
             7. Safety information
             8. Wound care order (if appropriate)
             9. Teaching information when appropriate
             10. Vital signs
          2. The patient home record is updated as appropriate.

**Hazardous Device Reporting**

Safety Policy

**MEDICAL DEVICE/SAFETY HAZARDOUS DEVICE REPORTING**

1. Definitions:
   1. Health hazard means a chemical for which there is statistically significant evidence based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed employees.
   2. Safety Data Sheet (SDS) means written or printed material concerning a hazardous chemical (OSHA 500:1131 CH 510 ATT 4 subpart Z). SDS is an OSHA approved method to make readily available to employees, current information and protective measures for chemical health hazards present in the work place.
   3. “MDR reportable events” are the adverse events or problems that the medical device regulation requires to be reported. For facilities, MDR reportable events include patient deaths and serious injuries that medical devices have or may have caused or contributed to, i.e., the devices may have directly caused the events or played a role in the events.
   4. Serious Injury\*-There are three (3) possible types of serious injuries, and they are not mutually exclusive:
2. Life threatening injuries;
3. Injuries that result in permanent damage or impairment; and
4. Injuries that require medical intervention to preclude permanent damage or impairment is defined as irreversible damage or impairment that is not trivial.
   1. Adverse events include:
5. Death.
6. Life-threatening events.
7. Hospitalization-initial or prolonged.
8. Disability.
9. Congenital Anomaly.
10. Required intervention to prevent permanent impairment/damage.
    1. Malfunction is the failure of a device to meet its performance specifications or to perform as intended. A malfunction is reportable when it is likely to cause or contribute to a death or serious injury if it were to recur. The regulation assumes that a malfunction will recur.
11. The Agency chooses to rely upon the evaluation of hazards provided by the chemical manufacturer or importer.
12. Procedures are implemented to document the reporting of medical device safety hazards and the subsequent corrective action taken, or to prevent the reoccurrence of an unsafe act.
13. The Agency understands the importance of communication of hazards for the protection of patients and staff.
14. The reporting of medical device and safety hazards is the specific responsibility of all employees of the Agency. The Administrator has the responsibility for ensuring compliance with reporting requirements.
15. A report is required when the agency has information that reason-ably suggest that a device has or “may have” caused or contributed to a death or serious injury of a patient. If the chance that a device may have caused or contributed to an event is very remote or very unlikely, the event should not be reported.
16. A report is required when a reporting entity receives information that “reasonably suggest” that a device may have caused or contributed to an MDR reportable event. This includes any information such as professional, scientific or medical facts and observations or opinions that would reasonable suggest a device has caused or may have caused or contributed to a MDR reportable event.
17. All medical devices and safety hazards related to patients, personnel and visitors shall be reported immediately to assure that corrective action is taken.
18. An employee report of medical device /safety hazard occurrence should be submitted by an employee as soon as possible, listing the exact location and nature of the hazard. Upon completion, the report should be forwarded to the Administrator.
19. Upon receipt of the employee report of medical device/safety hazard, the Administrator shall conduct an investigation of the reported condition/act and document any action taken or suggested to eliminate the hazard. The manufacturer, if known, will be notified.
20. The Administrator will then forward the report to the Chairman of the QAPI Committee for further review and analysis. Summaries of all such reported hazards shall be documented in the minutes of the committee meeting.
21. All records will be retained for audit and reporting purposes. They will be retained for a minimum of five years.
22. The FDA will be notified by the Administrator when incidents result in serious injury, illness or death or manufacturer unknown. The manufacturer will be notified, if known. Reports must be submitted on FDA Form 3500A (mandatory MedWatch form) within 10 days from the time that any employee or person affiliated with the agency becomes aware that the device may have caused or contributed to a death or injury.
23. The report is to include the following:
    1. Information about the patient.
    2. Type of adverse event.
    3. Description of the event.
    4. Relevant laboratory/test data and patient history.
    5. Manufacturer and identification of the suspect device and certain other information about the device.
    6. Initial reporter of the event.
    7. User facility/distributor name, address and contact.
    8. Event problem codes for the device and patient.
    9. Where and when the report was sent.
24. The following are guidelines for reporting:
    1. Deaths to FDA and Manufacturer within 10 work days.
    2. Serious Injuries\* to the Manufacturer, and the FDA only if the manufacturer is unknown, within 10 work days.
    3. Annual report of deaths and serious injuries to the FDA every January 1.
25. A mandatory in-service on Medical Device/Safety Hazard Reporting is provided on an annual basis with documentation of the date and time of the in-service, a list of attendees and an outline of the training content.
26. Employees will be provided with information and training on hazardous chemicals in the work area during initial orientation and yearly thereafter. The employee orientation will include:
    1. Hazard communication requirements of OSHA.
    2. The presence of hazardous chemicals in the work area.
    3. How to read and interpret labels and SDS.
    4. How to cope with emergency procedures (recognition, reporting, and evacuation).

**SAFETY HAZARDS REPORTING**

### Purpose:

To provide a mechanism for reporting safety hazards.

### Policy:

Agency policy is to document the reporting of Safety Hazards and the subsequent corrective action taken, or to prevent the reoccurrence of an unsafe act.

### Procedure:

1. Reporting of Safety Hazards is the specific responsibility of ALL employees of the Agency.
2. Personnel should report job safety hazards on an employee grievance form and submit to Administrator or the Director, as appropriate.
3. All safety hazards related to patients, personnel and visitors shall be reported immediately to assure that corrective action is taken.
4. The employee report of safety hazard should be submitted by the concerned employee as soon as possible within 24 hours, listing the exact location and nature of the hazard observed.
5. Upon receipt of the employee report of safety hazard, the Administrator and/or Director of Nursing shall conduct an investigation of the reported condition/act and document any action taken or suggested to eliminate the hazard.
6. The report will be forwarded to the Administrator/designee the Safety Committee for further review and analysis. Summaries of all such reported hazards shall be documented in the minutes of the Safety Committee.
7. In the event of the hazard poses an immediate danger, the Administrator must be contacted without delay by the reporting employee for the necessary corrective action to be taken.
8. Reports are filed with the Federal Drug Administration and to the manufacturer according to regulation.
9. All reports are audited by the QAPI Committee.
10. All records are retained for auditing and reporting purposes for seven years.

# CRITERIA FOR REPORTABLE EVENTS

1. Seriousness - Actual documented cases of death or serious injury or serious consequences.
2. Unexpectedness.
3. Vulnerable population - e.g., pediatric or geriatric.
4. Preventability - goal is to prevent recurrence of similar events in various locations. Action should include useful recommendations.
5. Public concern (sometimes called “outrage”) - e.g., lead aprons emitting radiation.
6. Lack of scientific data that could address the issue, especially long term effects.
7. Are product warnings sufficient and effectively translated?
8. There are new hazards.
9. There are long term effects.
10. There are recalls.

# HAZARD COMMUNICATIONS/SDS SHEETS

### Purpose:

To provide policy on communication of hazards for the protection of patients and staff.

### Policy:

Potentially hazardous materials used within the Agency will be identified and documented on Safety Data Sheets (SDS).

### Procedure:

1. The Administrator or Director of Nursing will obtain and maintain current SDS sheets on each hazardous chemical used in the workplace.
2. SDS will be placed at each physical office site in order to be readily available to employees, their designated representatives, OSHA and the National Institute For Occupational Safety and Health.
3. Upon receipt of new or updated SDS, the Administrator or Director of Nursing will review the SDS to ascertain that the sheets are complete and acceptable. Should an incomplete SDS be received, the Agency will document such receipt and return the sheet to the chemical manufacturer or distributor who sent it. If complete forms are not received promptly, OSHA will be contacted for assistance.
4. Employees will be provided with information and training on hazardous chemicals in the work area during initial orientation and yearly thereafter.
5. The orientation will include:
   1. Hazard communication requirements of OSHA standard.
   2. The presence of hazardous chemicals in the work area.
   3. Location and availability of a written hazard communication program including lists of hazardous chemicals and SDS.
   4. How to read and interpret labels and an SDS.
   5. How to cope with emergency procedures (recognition, reporting, and evacuation).
   6. Reading labels for precautions and proper protective equipment to use to guard against injury or illness, such as gloves, goggles, rubber boots and/or a mask.
6. All hazardous chemicals that are shipped to and used in the work place must be labeled and maintained.
7. Most pharmaceutical and "common" household products are exempt from this standard. However careful attention to label instructions must be followed for use and disposal.
   1. Products will not be labeled as hazardous so look for these signal words:
      1. Poison (highly toxic)
      2. Danger (highly toxic, flammable or corrosive)
      3. Warning (moderately toxic)
      4. Caution (slightly toxic)
   2. Use the proper amount and do not mix products.
   3. Store products safely. Cool, dry, well-ventilated areas are best. To help prevent accidents:
      1. Store in original container, if possible
      2. Make sure all products are clearly labeled
      3. Store in secure area away from children and pets
8. Any hazardous chemicals used in the work place that is not in its original container or is missing the label must be labeled with identity of the chemical and hazardous.
9. The labels must include the following:
   1. The chemical used
   2. The common name
   3. Warnings about physical and health hazards
10. A chemical inventory list is to be compiled and placed with SDS binder. The list must be maintained and updated.
11. An SDS notebook or file is to be located when needed where it is accessible to all employees.

Incident Report

PART 1: Patient, Incident & Witness General Information

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location of incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date on which the incident occurred: \_\_\_\_\_\_\_\_\_\_

Time at which incident occurred or was discovered: \_\_\_\_\_\_\_\_\_\_

Witness name/Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness name/Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient condition prior to occurrence** *(select all that apply)*

Alert/oriented Disoriented/confused Sedated/medicated Weak/dizzy Combative/assaultive Senile dementia/Alzheimer’s Unconscious Visually impaired Hearing impaired Walked w/device Walked independently Walked w/person(s) Bed only Chair only

Other *(describe)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART 2: Incident Details**

**Provide a brief narrative description of incident** *(factual information only)*

**Severity of incident**

No apparent injury

Minor (first aid)

Moderate (fracture, sutures)

Severe (hospitalization)

Death

**Description of injury (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Response to incident** *(select all that apply)*

First aid Patient refused treatment Called 911 Admitted to hospital No intervention Unknown

**If you feel it will be helpful, provide further description of the action you took in response to this incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Individuals Notified** *(select all that apply)*

**[ ] Supervisor / manager**

Name of individual notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/ Time notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ] Physician**

Name of individual notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date notified Time notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ] Family**

Name of individual notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date notified Time notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART 3: Type of Occurrence** *(select all that apply)*

**Fall Occurrence** **Observed** **Not Observed**

Found on floor From toilet While ambulating During transfer Out of bed Eased to floor Out of chair Slip/trip Out of wheelchair Other *(describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Miscellaneous Occurrence** **Observed** **Not Observed**

Fire Patient refuses treatment Burn Unplanned absence of caregiver Abuse Caregiver/patient issues Complaints of theft Home care staff/patient disagreement Damage to personal property Safety issue(s) Other *(describe)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Equipment Occurrence** **Observed** **Not Observed**

**Related to:** Fire Patient refuses treatment Equipment malfunction Catheter

Life-sustaining equipment Implanted device Infusion pump Disposable device IV Other *(describe)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Occurrence** **Observed** **Not Observed**

**Related to:** Patient error Caregiver error Employee error Pharmacy error

**Type of medication intake:**

Oral medication IM medication IV medication

Other *(describe)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of medication incident:**

Adverse/allergic reaction Wrong medication Extra dose Wrong time Wrong dose Wrong route

Missed dose Late delivery Mislabeled Other *(describe)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PART 4: Signature of Person Completing this Form**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ADVANCE DIRECTIVES** |

Advance Directives are formulated to make known to all disciplines involved in a patient/client’s care the desires of the patient/client in the event the patient/client is unable to verbalize his/her wishes relating to his/her own medical treatment.

## Medicare Regulation:

132.1 Advance Directive Requirements. Effective December 1, 1991, participating Home Health Agencies must comply with the advance directive provisions of '4206 of OBRA 1990. Therefore, an agreement per '1866 of the Act with a Home Health Agency includes that the Agency must, in accordance with written policies and procedures, for all adult individuals: inform them, in writing of state laws regarding advance directives; inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that state law permits, for a Home Health Agency or any agent of the Agency that, as a matter of conscience, cannot implement an advance directive); document in the individual’s medical record whether the individual has executed an advance directive; not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive (since the law does not require the individual to do so), and educate staff and the community on issues concerning advance directives. (See 42 CFR 484.10(c) (2) (ii).)

### Definitions:

**Adult:** A person 18 years or older, or a person legally capable of consenting to his or her own Medical treatment

**Advance Directives**: A document in which a person states choices for medical treatment, including a Do NOT Resuscitate (DNR) order and a DO NOT Intubate (DNI) order

**Attending Physician:** The physician who is primarily responsible for the medical care of a patient/client while receiving home health care services

**Mental Health:** A Mental Health Treatment Declaration is a legal document which allows you to tell your physical and other health care providers about you preferences and instructions regarding your mental health care treatment, if you are no longer able to make these decisions yourself.

**Treatment:**

Mental health treatment is defined by State law to include:

1. Electroconvulsive or other convulsive treatment
2. Psychoactive drugs
3. Emergency mental health treatment

### Declaration:

**OUT OF HOSPITAL DNR (Do Not Resuscitate)**: Out of Hospital DNR means a legally binding out-of hospital do-not resuscitate order, in the form specified prepared and signed by the attending physician of a person, that documents the instruction of a person or a person’s legally authorized representative and directs health care professionals acting in an out-of-hospital setting not initiate or continue the following life–sustaining treatment:

1. Cardiopulmonary resuscitation;
2. Advanced airway management;
3. Artificial ventilation;
4. Defibrillation;
5. Transcutaneous cardiac pacing; and
6. Other life-sustaining treatment specified by the board under state statute.
7. DNR does not include authorization to withhold medical interventions or therapies considered necessary to provide comfort care or to alleviate pain or to provide water nutrition.

**Patient Self Determination Act:** A Federal Statute enacted as part of the 1990 Omnibus Budget Reconciliation Act (OBRA) (PL 101-508) which requires that a health care facility provide information regarding the right to formulate advance directives concerning health care decisions.

**Surrogate Decision Maker:** A person appointed to make decisions for someone else. This person may be formally appointed (as in a Durable Power of Attorney for Health Care) or in the absence of a formal appointment, may be recognized by virtue of a relationship with the patient/client (such as the patient/client’s next of kin or close friend).

**Terminal Condition:** An incurable condition caused by an injury, disease or illness, which, regardless of the application of life sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life sustaining procedures only postpones the moment of death.

### Agency Policy:

1. The Agency recognizes that all persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care.
2. The Agency will encourage individuals and their families to participate in decisions regarding health care and treatment.
3. Advance Directives, such as Living Wills, Durable Powers of Attorney, and DNR (Do Not Resuscitate) Orders will be followed to the extent permitted and required by law.
4. In the absence of Advance Directives, the Agency will provide appropriate care according to the plan of treatment authorized by the attending physician.
5. Additionally, the Agency will not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.
6. If the Agency is unable to implement the patient/client’s Advance Directives, every effort will be made to facilitate the patient/client’s transfer to an alternate agency that has the capability to facilitate the patient/client’s Advance Directives.
7. The Agency will honor the clients' advance directives and is willing and able to provide all care in accordance with the client's advance directives within the law.

### Procedure:

1. During the admission visit, the admitting qualifying staff member will:
   1. Verify if the patient/client has executed an Advance Directive
   2. Obtain a copy of DNR orders for the chart if they are a part of the Advance Directive
   3. Provide the patient/client with written and verbal information regarding:
      1. State Advance Directive Guidelines
      2. Advance Directive Information Forms
      3. Agency Advance Directive Policy
      4. Policy for Withholding Resuscitative Measures
      5. Policy for Withdrawal of Life Sustaining Equipment (if applicable)
   4. Patients will be encouraged to ask questions regarding the execution of the forms. Documentation of such shall be entered into the medical record. At no time may any staff member either advocate or discourage the execution of an advance directive by the patient/client.
2. The patient/client is encouraged to participate in all aspects of decision making regarding home health care and treatment. Statements by a competent patient/client of his or her desire to accept or refuse treatment shall be documented in the patient/client’s medical record.
3. If the patient/client wishes to initiate and complete the Advance Directive process and the patient/client and/or family is unable to independently make contact with community resources to exercise a Living Will, a referral will be facilitated for medical social worker assistance:
   1. Upon physician referral, the Medical Social Worker will contact the referring/admitting nurse to obtain pertinent medical/psychosocial information
   2. The patient/client and/or family will be contacted by the medical social worker to discuss;
      1. Available options
      2. Witness requirements. Two qualified witnesses are required.
   3. Once an option is decided by patient/client and/or family then the medical social worker will guide and/or assist the individual in contacting available resources.
   4. If the patient/client and/or family requests medical social worker intervention the medical social worker will utilize the Advance Directive form provided by the Agency that is specific to the state in which the patient/client resides.
   5. The RN or the Social Worker will complete the form as necessary with patient/client and family’s involvement and request that patient/client or family inform the physician for orders consistent with the wishes of the of the patient/client and to insure that documentation of the presence of the Advance Directive and its location become a part of the patient/client’s home health care record.
   6. The patient/client will be requested to contact the referring/admitting nurse if any changes or modifications to the Advance Directive are desired, and the procedure will begin from its start above.
4. If it is determined that the patient/client and/or family require more information than the RN or the social worker is able to provide, then the patient/client’s physician will be notified, and the patient/client and/or family will be provided with available community resource listings and guided to consult with their legal counsel for further questioning or for the purpose of executing an advance directive.
5. The admitting qualifying staff member will document in the medical record that the patient/client has executed an advance directive. The attending physician shall be notified of all advance directives, including both written and verbal statements by the patient/client. If the patient/client executes an advance directive after the start of care, notification of the physician will be documented in the patient/client’s medical record on a form reflecting ordered changes.
6. If the patient/client is unable to sign that he/she has received instructions regarding the law, a designated individual must receive the information and sign the appropriate forms. The relationship of that individual to the patient/client must be documented.
7. All staff involved with the patient/client’s plan of care/treatment will be notified by the primary nurse responsible for the care that an Advance Directive was executed.
8. The medical record of any patient/client having an Advance Directive will be flagged with an Advance Directive label.
9. Any changes in the Advance Directive/Living-Will will be documented with a written change of order and in the progress note. Upon recertification the primary nurse will verify that the Advance Directive and Power of Attorney for Health Care are current and have not been revoked.
10. Educational information about Advance Directives and the Agency’s policies and procedures regarding them will be provided to the medical, nursing, allied health professionals, and home health office staff and volunteers during the orientation period. In order to educate the community about Advance Directives, the Agency will participate in community forums, and make available written materials regarding Advance Directives.

#### Health Care Advance Directives – The Patient/Client’s Right to Decide:

All adult individuals in health care facilities such as hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations, have certain rights under state law.

You have a right to fill out a paper known as an "advance directive." The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions that would stop you from telling your doctor how you want to be treated. For example, if you were taken to a health care facility in a coma, would you want the facility's staff to know your specific wishes about decisions affecting your treatment?

**What is an Advance Directive?**

An advance directive is a written or oral statement which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made. Two forms of advance directives are:

**A "Living Will" and Health Care Surrogate Designation”**

An advance directive allows you to state your choices about health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. An advance directive can enable you to make decisions about your future medical treatment.

**What is a Living Will?**

A living will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a "living will" because it takes affect while you are still living. State law provides a suggested form for a living will. You may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way so that your wishes will be understood.

**What is a Health Care Surrogate Designation?**

A "health care surrogate designation" is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent to make medical decisions for you, if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. State law provides a suggested form for designation of a health care surrogate. You may use it or some other form. You may wish to name a second person to stand in for you, if your first choice is not available.

**Which is Better:**

You may wish to have both or combine them into a single document that describes treatment choices in a variety of situations and names someone to make decisions for you should you be unable to make decisions for yourself.

**Do I have to write an Advance Directive under State Law?**

No, there is no legal requirement to complete an advance directive. However, if you have not made an advanced directive or designated a health care surrogate, health care decisions may be made for you by a court appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend in that order. This person would be called a proxy.

**Can I change my mind after I write a Living Will or Designate a Health Care Surrogate?**

Yes, you may change or cancel these documents at any time. Any change should be written, signed and dated. You can also change an advance directive by oral statement.

**What if I have filled out an Advance Directive in another state and need treatment in a health care facility in this state?**

An advance directive, completed in another state, in compliance with the other state's law, can be honored in this state.

**What should I do with my Advance Directive if I choose to have one?**

Make sure that someone such as your doctor, lawyer or family member knows that you have an advance directive and where it is located

1. If you have designated a health care surrogate, give a copy of the written designation form or the original to the person.
2. Give a copy of your advance directive to your doctor for your medical file and keep a copy of your advance directive in a place where it can be found easily
3. Keep a card or note in your purse or wallet which states that you have an advance directive and where it is located.
4. If you change your advance directive, make sure your doctor, lawyer and/or family member has the latest copy.
5. For further information ask those in charge of your care.

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| **Statement of Advanced Directive or Living Will:** | |
| The following is provided to inform you about "Advanced Directives" or "Living Wills: | |
| 1. Every adult has the right to make certain decisions concerning his own medical treatment. The law also allows for your rights and personal wishes to be respected even if you are too sick to make decisions yourself. | |
| 1. You have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment and other procedures that would prolong your life artificially. | |
| 1. These rights may be spelled out by you in a "living will," containing your personal directions about life-prolonging treatment in the case of serious illness that could cause death. | |
| 1. You may also designate another person, or surrogate, who may make decisions for you if you become mentally or physically unable to do so. This surrogate may function on your behalf for a brief time or longer, for a life threatening or a non-life-threatening illness. | |
| 1. Any limits to the power of the surrogate in making decisions for you should be clearly expressed. | |
| 1. Your health care provider will furnish you written information about its policy regarding advanced directives. | |
| **Patient Signature** | **Date** |
| **Signature of responsible party if Patient is unable to sign:** | **MR#** |
| **RN Signature** | |
| **Witness (print name)**  **Signature** | |
| **Additional Information on Advance Directives** | |
| Accident or illness can take away a person's ability to make health care decisions. But decisions must be made. If you cannot do so, someone else will; and sometimes this causes the burden, and expense of court proceedings. You should consider taking steps now to control these decisions so they will reflect your own wishes. | |
| **LIVING WILLS** | |
| A Living Will (or Declaration) is a statement of your wishes regarding the use of life-prolonging treatment if you are terminal. A "Living Will" is different from the Will that disposes of your property after your death. | |
| Generally, a "Living Will" is a statement that you desire to be allowed to die and not be kept alive by medical treatment when your doctors conclude that you are no longer able to decide matters for yourself and that your condition is terminal. If you would not want to be kept alive by use of a feeding tube or other artificial means of providing food and water, specifically state this. | |
| **Surrogate Designation** | |
| 1. If you are too sick to make decisions, close family members or a close friend usually will decide with the doctor and nurses what is best for you. Most of the time that works. But sometimes everyone doesn't agree about what to do, even if you have made a Living Will. One way to help ensure that your wishes will be honored is to name someone you trust who will make medical decisions for you. You may name this person in a Living Will (or Declaration), in which case such person makes only those medical decisions related to serious illness that could cause death. | |
| 1. If you want to name someone you trust to make all other medical decisions for you when you are too sick to do so yourself, you may wish to put this in writing. Remember, if you want this person to also make the decisions about the use of machines and medical treatment that might delay your death when you are hopelessly ill, name the same person in your Living Will. | |
| 1. It is advisable to name a replacement in case the person you have chosen to make decisions for you becomes unable or unwilling to do so. | |
| 1. If you decide to make a Living Will or other advance directive it is recommended that you give a copy to your doctor, relative or friend and any hospital, nursing home or other facility where you are receiving treatment. If you change your mind, make sure that you so advise all those to whom you have given copies. | |
| 1. A Living Will in no way affect life insurance. Also, it cannot be required as a condition for being insured or receiving health care services. Any medical treatment that is used for the purpose of providing comfort care or to alleviate pain will be continued. | |
| A summary like this cannot answer all of your questions or cover every circumstance. If you have questions about your particular legal situation, please talk to a lawyer. Also speak to your health care provider about medical issues. Let those who will be caring for you know what you have decided. | |
| **Patient/ Client Signature** | **Date** |
| **Signature of responsible party if patient is unable to sign** | **MR#** |
| **RN Signature** | |
| **Witness Signature** | |

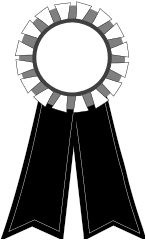
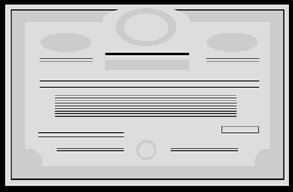
## FEDERAL/MEDICAID REQUIREMENTS FOR ADVANCE DIRECTIVES

Federal law requires that FEDERAL/Medicaid providers notify existing beneficiaries and include information in admission procedure on any new advance directives enacted by the state within 90 days of the day it became effective. Federal/Medicaid providers must have policies and/or procedures in place for all four advance directives (Directive to Physician, Durable Power of Attorney for Health Care, Out-of-Hospital Do-Not-Resuscitate Order, Declaration for Mental Health Treatment) that include the following:

1. Providing information on the advance directives available in the state at the time of the first home health visit before care is provided and documenting that the information has been received.
2. Providing written policies with respect to the implementing of such rights including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience.
3. Providing staff and community education on the issues concerning the advance directives. A provider must be able to document its community education efforts.
4. Procedures for determining and documenting if the patient/client has an advance directive.
5. Placing copies of the advance directives in the patient/client’s medical record and notifying all provider personnel in contact with the patient/client of its existence.
6. Not conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive.
7. Procedures for staff to observe when the advance directive is revoked including documenting the revocation.
8. Procedure Agency staff will follow if it is against Agency policy to comply with an advance directive, notifying the person or persons authorized to make health care decisions on behalf of the person of this policy and taking all reasonable steps to transfer the person to another provider.
9. Ensuring compliance with requirements of state law respecting advance directives.

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| **Notice To Persons Making A Declaration For Mental Health Treatment** | |
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| This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts: | |
| 1. This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, electro-convulsive therapy, and emergency mental health treatment. | |
| 1. This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. | |
| 1. The instructions that you include in this declaration will be followed only if a court believes that you are incapacitated to make treatment decisions. Otherwise, you will be considered able to give or withhold consent for the treatments. | |
| 1. This document will continue in effect for a period of three years unless you become incapacitated to participate in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapacitated. You have the right to revoke this document in whole or in part at any time you have not been determined to be incapacitated. | |
| 1. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED BY A COURT TO BE INCAPACITATED | |
| A revocation is effective when it is communicated to your attending physician or other health care provider. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration is not valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature. | |
| SIGNATURE: | DATE: |

**Achievement**



**Certificate**

**Awarded to:**

**For Completing the**

**Company Orientation Requirements**

Date of completion:

Presented by:

(Signature of presenter)