Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

Employee Name/ Print

Field Staff Job Description

Organizational Relationship:
Direct clinical oversight provided by the Clinical Operations Manager.
Scheduling and compliance oversight provided by the Operations Manager.

- □ **Registered Professional Nurse**
- □ **Licensed Practical Nurse**

Section 6902 of Article 139 of the Education Law distinguishes between the legal definitions of RNs and LPNs as follows:
"The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen."

"The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations."

Responsibilities:

Competencies and Job Performance Standards

- Function within the scope of the Nurse Practice Act
- Establish a "hands off" communication with client / caregiver, including the opportunity to ask and respond to questions.
- Follow the Plan of Care [485] for each individual client assigned.
- Perform a head-to-toe evaluation each shift.
- Assess the environment of care each shift.
- Obtain vital signs, deliver treatments and administer medications as ordered.
- Perform all tasks essential for the client's health and comfort.
- Support client's therapeutic discipline(s) [PT, OT, ST, Special Ed, Feeding Specialist and other auxiliary support]
- Initiate and/or reinforce client / caregiver teaching requirements.
- Continually evaluate client / caregiver educational needs
- Assure Physician Orders are accurate and complete.
- Maintain the client's E-chart for completeness and accuracy.
- Ensure that client records are kept in a secure and confidential manner consistent with Health Department policies and procedures, and HIPAA standards.
- Educate clients / families on their rights related to privacy of medical information.
- Support Agency Clinical and Administrative Policies & Procedures

Employee's Signature_____Date_____

Employee Name/ Print

Communication and Teamwork Standards

- Communicate with Agency Clinical Department regarding changes in client's condition or Plan of Care in a timely manner.
- Communicate scheduling availability to the Scheduling Department
- Maintain a good rapport with the client, family and Agency staff.
- Notify Agency immediately of client / caregiver complaints.
- Notify Agency immediately of any incident/unusual occurrences related to client during shift.
- Report patient infections immediately to the Clinical Department
- Report employee infections immediately to the Scheduling Department
- Notify the Scheduling Department of any deviation(s) to the schedule, and if planned, in advance of the change.
- Submit required documentation to the Agency in a timely manner.

Customer Service Standards

- Conduct oneself professionally at all times.
- Dress in appropriate attire [scrubs preferred]
- Be respectful and courteous at all times.
- Adhere to scheduled assignments.
- Represent Agency in a positive manner to clients / families / staff / public at all times.

Requirements

- Professional Nursing License; maintain licensure requirements.
- Professional Liability Insurance preferred.
- CPR Certification
- Reliable transportation
- Valid Email Address
- Smart Phone
- Computer Skills

Medical Requirements

- PPD w/in last 12 mos. **(If +, need proof of chest x-ray)**
- Initial Physical – Current within 1 year; maintain health requirements yearly
- Immunization Records: Rubella, Measles – Serological Evidence
- Documentation of vaccination against Influenza

Employees's Signature_____Date_____

Employee Name/ Print:

Employment Qualifications:

Education: Possession of licensure from an accredited nursing program to practice as a Registered / Licensed Practical Nurse in the State of New York.
Experience: Preferred one year of nursing experience in a community health, public health, or home care setting, or be clinically competency-tested for specific case assignments.
[The qualifications listed are intended to represent the minimum skills and experience levels associated with performing the duties and responsibilities contained in this job description. The qualifications should not be viewed as expressing absolute employment or promotional standards. The organization will conduct an annual supervision of the performance and effectiveness of all personal including onsite visit]

Physical Requirements/ Functional Abilities:

- Must be able to hear and speak in a manner understood by most people.
- Must be able to read English.
- Must exhibit good phone skills.
- Must have good interpersonal skills to work with the professional clinical staff.
- Must be able to stoop and bend effectively.
- Must be computer literate.

Environments of Care: Clients' homes, schools and or other settings as directed.

☐ I have read the requirements of this position and understand what is expected of me.

Employee's Signature_____Date_____

Since 1985

J&D ULTRACARE

A Professional Home Care Nursing Agency

EMPLOYEE HANDBOOK

Revised January 2024

J&D Ultracare is proud of the quality nursing care delivered to our clients, by RNs and LPNs who demonstrate clinical expertise and an unparalleled commitment to home care.

Our in-house and field-based staff work tirelessly to ensure positive patient outcomes and satisfaction, while continuously supporting individual professional growth and development opportunities.

J&D Ultracare has achieved recognition as a leader in the pediatric and adult health care community through our connections with various insurers, Medicaid and school districts. We have also earned our reputation as a respected resource, especially for those professionals new to the field of nursing and/or the home care industry.

This Handbook is designed to acquaint you with J&D Ultracare and provide you with information about the Agency and its policies, practices and guidelines that affect your employment. The information contained in this Handbook applies to all employees of J&D Ultracare; adherence to such is a condition of continued employment. You are responsible for reading, understanding, and complying with the provisions of this Handbook.

This Handbook supersedes all previous Employee Handbooks that may have been issued. However, since the needs of the Agency are subject to change, we reserve the right to change, interpret, suspend, cancel or dispute - with or without notice – any part of this Handbook.

We rely upon the accuracy of information provided in your employment application and all data presented throughout the hiring process and employment.
Any misrepresentations, falsifications or material omissions of information may result in termination of employment.

This Handbook does not modify the employment relationship this Agency has with each of its staff members. Employment with J&D Ultracare is "at will", and therefore entered in voluntarily. The Agency and its employees may terminate the employment relationship at any time.

Employment Practices

J&D Ultracare is an Equal Opportunity Employer. We recruit and select the most qualified candidates to fill job openings. Consideration and selection are made without regard to an individual's sex, race, religion, color, creed, national origin, citizenship, age, disability, marital status, or any other characteristic protected by federal, state or local law.

In accordance with the U.S. Equal Employment Opportunity Commission [EEOC], J&D Ultracare strictly adheres to this policy in all aspects of employment including hiring, promotion, transfer, termination, recruitment, compensation, training, and general treatment during employment.

In the event there is a lapse in active compliance on the part of an employee, reactivation is required. The reactivation process includes submission of current documentation to establish compliance with NYS DOH and Agency requirements.

Pre-Employment Background Check (Effective 3.1.2024)
J & D Ultracare will conduct pre-employment criminal background checks on all new applicants upon becoming active with the agency and prior to placement on a case, in accordance with all applicable federal and state laws. This applies only to those applicants who will have direct patient contact. Employees will be required to provide written consent authorizing the agency to conduct such checks and all employees will be provided with a copy of the report.

Reasonable Accommodation & Religion
Upon introduction to a potential work assignment, an employee will be given information regarding the job requirements. A staff member has the right to decline any work assignment that may conflict with his/her cultural values or religious beliefs.

The law requires an employer to reasonably accommodate an employee's religious beliefs or practices, unless doing so would cause difficulty or expense for the employer.

Reasonable Accommodation & Disability
The law requires an employer to provide reasonable accommodation to an employee or job applicant with a disability, unless doing so would cause significant difficulty or expense for the employer.

A reasonable accommodation is any change in the workplace or in the way things are usually done, to help a person with a disability apply for a job, perform the duties of a job or enjoy the benefits and privileges of employment.
www.eeoc.gov/laws/practices

Job Descriptions
Upon hire and as appropriate thereafter, each employee shall be presented with his/her respective job description. Employees will be asked to provide written acknowledgment of their receipt of the document and confirmation of his/her understanding of the responsibilities contained within.

The Management Team may conduct periodic reviews of all job descriptions to ensure that they accurately reflect each position's functions, duties, responsibilities, purpose, working conditions, and reporting relationships as well as the knowledge, skills, and abilities required of current and new employees.

HIPAA Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all medical records and other individually identifiable health information used or disclosed by this Agency in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives our patients significant rights to understand and control how their health information is used.

HIPAA provides penalties for covered entities that misuse personal health information. We have prepared this "Summary Notice of HIPAA Privacy Practices" to explain how we are required to maintain the privacy of our patients' health information and how we may use and disclose their health information.
A Notice of HIPAA Privacy Practices containing a more complete description of the uses and disclosures of health information is available upon request.
We may use and disclose patients' medical records for the purposes of treatment, payment and health care operations.

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **PAYMENT** means such activities as obtaining payment or reimbursement for services, billing or collection activities and utilization review.
- **HEALTH CARE OPERATIONS** include managing Electronic Medical Records to facilitate diagnostic medical consultations with participating physicians, conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Corporate Compliance

This Agency has established compliance standards, policies and procedures that are reasonably capable of reducing the prospect of conflicts of interest and/or unacceptable conduct.

Through its hiring and retention practices, this Agency utilizes internal and external processes and systems reasonably designed to detect misconduct by its employees, including but not limited to verification of identity, verification of professional licensure, disciplinary action thereto and professional references.

Upon hire and annually thereafter, you will be apprised of the appropriate method whereby you may report criminal or inappropriate conduct encountered during your professional assignments.

Standards of Conduct

There are certain Standards of Conduct that we all must observe as good citizens and employees. Through implementation of Agency-wide Standards, employees are encouraged to perform at the peak of their abilities, while observing company culture and adhering to Agency policies, protocols and guidelines.

While it would be impossible to list all examples of misconduct, the following is representative of those that may result in discipline, up to and including termination. This Agency strictly adheres to all guidelines offered by the New York State Office of the Professions. Please refer to the Office of the Professions' Nursing Guide to Practice for further guidance on this topic. **www.op.nysed.gov**

Examples include:

- Violation of professional standards of patient care
- Violation of Patients' Rights
- Falsification of records (including but not limited to time sheets, patient care notes, job applications and professional references)
- Release and/or use of confidential or proprietary Agency and patient information.
- Removing records or materials from Agency premises without permission.
- Poor work performance
- Poor attendance including excessive tardiness
- Unauthorized / careless use of, destruction/damage to client or Agency property
- Possession, use, sale or reporting to work under the influence of intoxicants/drugs
- Insubordination
- Violation of the solicitation and distribution rules
- Carrying weapons or other hazardous devices
- Disorderly conduct, fighting, abusive or threatening language
- Violation of established smoking regulations
- Violation of established safety regulations
- Violation of the Agency's harassment policies
- Any conduct that is dishonest, unethical or illegal

Please be advised that while the Agency has a defined employee discipline process ranging from verbal consultation to termination, the Agency's Management Team reserves the right to make disciplinary decisions on a case-by-case basis, factoring individual and situational circumstances, severity and frequency of violations into their determination. Clients and their families will be notified of any potential disruptions in their schedules, if appropriate, as a result of disciplinary action taken against you.

Agency Standards of Conduct will be monitored regularly through employee observations, annual evaluations, supervisory visits and communication with clients and/or their families, peers and employees of community-based care settings.

Any concerns regarding the subjects contained within this policy can be reported anonymously, and without fear of reprisal, to:

J&D Ultracare's Corporate Compliance Officer @ 845-357-4500, NYS Office of the Medicaid Inspector General @ 877-873-7283 or www.omig.ny.gov; or The Joint Commission @ 1-800-994-6610 or complaint@jcaho.org

Additionally, this Agency is committed to maintaining a workplace free from all types of harassment, including but not limited to sexual, physical and/or mental abuse or harassment, offensive behavior, an intimidating or hostile environment or discrimination based on religion, age, race, sex, or disability.

This policy applies to all employees, applicants for employment, interns, whether paid or unpaid, contractors and persons conducting business, regardless of immigration status, with J&D Ultracare. For purposes of this section, the term "employees" refers to this collective group.

Workplace harassment is illegal and will not be tolerated. Any employee or individual covered by this policy who engages in harassment or retaliation will be subject to remedial and/or disciplinary action (e.g., counseling, suspension, termination).

All employees are encouraged to report any behaviors that violate this policy, either by filing a complaint internally to J&D Ultracare or externally with a government agency or court under federal, state, or local antidiscrimination laws. J&D Ultracare will provide a complaint form for employees to report harassment and file complaints.

Retaliation Prohibition:

- No person covered by this Policy shall be subject to adverse action because the employee reports an incident of harassment, provides information, or otherwise assists in any investigation of a harassment complaint.
- J&D Ultracare will not tolerate such retaliation against anyone who, in good faith, reports or provides information about suspected harassment.
- Any employee of J&D Ultracare who retaliates against anyone involved in a harassment investigation will be subjected to disciplinary action, up to and including termination.
- Any employee who believes they have been subject to such retaliation should inform a supervisor, manager, or Agency Officers.

All forms of harassment constitute a violation of our policies, are unlawful, and may subject J&D Ultracare to liability for harm to targets of harassment. Harassers may also be individually subject to liability. Employees of every level who engage in harassment, including managers

and supervisors who engage in harassment or who allow such behavior to continue, will be penalized for such misconduct.

J&D Ultracare will conduct a prompt and thorough investigation that ensures due process for all parties whenever management receives a complaint about harassment, or otherwise knows of possible harassment occurring. J&D Ultracare will keep the investigation confidential to the extent possible. Effective corrective action will be taken whenever harassment is found to have occurred. All employees, including managers and supervisors, are required to cooperate with any internal investigation of harassment.

Managers and supervisors are **required** to report any complaint that they receive, or any harassment that they observe or become aware of, to Agency Vice President or President.

Conflict Of Interest

- As an employee of J&D Ultracare, you are expected to act in the Agency's best interests and to exercise sound judgment unclouded by personal interests or divided loyalties.
- Both in performing your duties at the Agency and in your outside activities, you should **avoid the appearance as well as the reality of a conflict of interest**.
- A conflict of interest exists if your circumstances would lead a reasonable person to question whether your motivations are aligned with the Agency's best interests.

The Agency shall define potential Conflicts of Interest including but not limited to those that affect, or have the potential to affect:

- Patient and staff safety
- Quality of patient care, treatment and services
- Laws, regulations and standards that govern our work
- The Agency's integrity and sustainability
- The Agency's financial status, business relationships, or reputation.

In matters involving a potential Conflict of Interest, all employees have a professional duty to disclose information regarding why a particular action or inaction may not be in the best interest of the Agency, its patients or employees.

Should a situation arise that is considered an actual or potential Conflict of Interest, please contact a member of the Agency's Management Team.

Disciplinary Action

Progressive or corrective discipline gives employees the opportunity to improve their performance, attendance or behavior to meet Agency standards.
This Agency's progressive discipline process shall document each warning / counseling provided to an employee for an identified behavior or action.

- **Verbal Reprimand:** As soon as the Agency has identified a performance deficiency, an Agency representative will contact the employee to discuss the concern and corrective action. A detailed account of the discussion will be written and filed in the individual's employment chart.
- **Written Warning:** Should the problem persists (or additional concerns emerge), the Agency will again discuss the issue with the employee, followed with written documentation detailing the objectionable behavior, corrective action, Agency expectations, policy and/or protocol, defined timeline and consequences. The document will be signed by both the Agency representative and employee and filed in the individual's employment chart.

Once progressive discipline has been initiated for an employee, continuous monitoring of the employee's performance will occur. Should the employee fail to meet outlined expectations during the defined timeline, a final discussion with the employee will occur during which a thorough accounting of the employee's performance will be presented.

The Agency representative shall clearly explain that the individual's failure to meet Agency standards has resulted in his/her termination.

The Agency's Management Team is responsible for the oversight of the progressive discipline process. The Team is responsible for ensuring that any employee terminated as the result of sub-standard performance was treated fairly and in accordance with Agency policy, job responsibility, review, and evaluation.

Staffing & Scheduling

The Agency's regular office hours are 8:30am-4pm, Monday through Thursday, and 8:30am – 3pm on Fridays.
The Agency's offices are closed for most accepted holidays (see below) and may close on an ad hoc basis with or without notice. [Severe weather events for example]

Additionally, our On-Call staff provides clinical and scheduling support after hours and on weekends. By dialing 845-357-4500, the Agency's On-Call staff is accessible to address "time of the essence" issues that cannot wait until regular business hours.

We work on our schedules a month ahead of time. Your availability to be scheduled for the upcoming month **must be received by the 5th of the current month**, giving us the opportunity to produce the most complete schedules possible. It is your responsibility to review your monthly schedules as soon as they

are received. If you find inaccuracies or need to make changes, you must contact the Staffing Department immediately.

- Our Scheduling Department will make every effort to accommodate your preferences. You may however be asked to consider other dates and times if there is an urgent need to find staff for a particular shift or visit.
- It is NOT permitted for an employee to make any alternate arrangements directly with patients, families, or nurses. Self-scheduling is strictly prohibited.
- The Agency requires at least 24-hour notification of a cancellation. We understand that unexpected events or crises may occur preventing you from fulfilling your commitments. Last-minute cancellations are very difficult to fill, and our clients and families are counting on you to honor your schedule.
- Three successive cancellations for the same illness / injury will require a physician's note providing medical clearance for you to return to work.
- Excessive cancellations are reviewed by the Management team and will result in employee counseling or disciplinary action.
- Communication between you and our scheduler is very important. If there is a change to your contact information, such as cell / home phone numbers, email, or home address, **please notify us immediately**. It is imperative that we always have a valid phone number on file for you.
- The Agency utilizes mass communications via email, Kantime Office Communication, and Kantime texting. It is expected that employees check their Kantime Communications frequently (including when not on a scheduled shift).
- Shift offers will be sent via office communication and text. Employees are expected to respond.
- **Opt "IN" for text notifications** to ensure immediate communication from the Agency.
- Clock-in and Clock-out times must match the hours for which you have been scheduled to work by the Agency. If there is a change in your scheduled time you must notify the Agency.
- Cell phone use should be limited while on duty and ANY use of cell phones or other technology to take pictures or videos is strictly prohibited.
- Nurses are **not** permitted to sleep on duty.
- Nurses will wear comfortable, respectful clothing; uniforms are not required.

- Employees will provide a picture for identification purposes to Agency HR staff. Picture IDs via EMR profile must be readily available to be presented on shift.
- Smoking is strictly prohibited in any office or during any patient visit.
- This Agency and our employees are given the opportunity to participate in the care of our clients at the request of their families. Please keep in mind that we are in each home by invitation and as such you are expected to demonstrate respect and professionalism toward our patients, their families, personal belongings and preferences for care and treatment.
- Should a patient require transport, his/her caregiver is responsible for making appropriate transportation arrangements.
- If your assignment specifically includes patient transport to / from a school or day care setting, the Agency will provide a Plan of Care directing the care provided during such time.
- Should a patient require emergency medical attention, Agency employees are required to call 911.
- Nurses are not permitted to operate a vehicle to transport patients but may accompany a patient in a vehicle (operated by others) at the nurse's discretion.

Holidays

The Agency observes the following 6 holidays for which the office is closed:

New Year's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Christmas Day

On-call Scheduling and Clinical are available.
Field Staff who work the above holidays will be paid at **1½** times their corresponding case rates.

Payroll Protocols

J & D Ultracare's workweek begins Sunday at 12:00am and ends the following Saturday at 11:59pm. There is a Chromebook in each patient's home for EMR documentation in our Kantime system (Electronic Medical Records).

- Field Staff are required to Clock-in and Clock-out of all shifts using either the Agency-issued device in the home OR their personal cell phone.
- Field Staff are required to Clock-in and Clock-out in order to be paid for hours worked.

- Field Staff are required to submit Nurses Notes/Documentation using the agency-issued Chromebook or their personal device. If documentation is incomplete and does not match clock times, a delay in payroll may occur.

All properly completed paperwork will be processed for payroll. All employees will be required to participate in Direct Deposit. Paychecks will be deposited into the provided account on Fridays at 12:00am (Thursday night). (Bank holidays may affect regularly scheduled deposits). Shortened work weeks or systems issues beyond our control may cause us to alter this timetable. Paper Pay Stubs will be mailed out every Friday.

Notice of Pay

In accordance with Section 195.1 of the New York State Labor Law, the Agency is required to provide all employees with a written notification of pay. You will receive one at the time of hire, and if there are any decreases in case pay rates. Any increases will be reflected in your pay stub.

Employee Benefits

J&D Ultracare offers all eligible employees the opportunity to enroll in our medical, dental, and supplemental benefit[s] plans. Length of employment and minimum weekly work hours may apply for each benefit. If you choose not to enroll when you first become eligible, you may enroll during our annual open enrollment period. Please contact our Human Resources Coordinator with questions.

401K

You may elect to enroll in our 401K plan after completing one year of employment with the Agency. You must have worked a minimum of 1000 hours during that year in order to be eligible.

Requesting Time Off

J&D Ultracare is committed to providing our patients with the greatest levels of staffing available. Therefore, requests for days off must be coordinated with the Staffing Department.

We require that you provide **advance, written notification** of your request[s] thus allowing sufficient time to accommodate your request and ensure appropriate levels of staffing in your absence. Written notification may be faxed or emailed to the Staffing Department.

NYS Paid Sick Leave

Effective 01.01.2021 all Agency Field Staff are entitled to accrue and use a maximum of 56 hours of paid sick time within a calendar year. Sick time accrues at the rate of 1 hour earned for every 30 hours worked. The calendar year is the 12-month period from January 1st to December 31st.

An employee may request to use this benefit when informing the office stating an inability to perform a scheduled shift / work assignment due to personal illness or that of an immediate family member according to the permitted uses described below. Family members are defined as child, spouse, domestic partner, parent, sibling, grandchild, grandparent, as well as the child or parent of a spouse or domestic partner.

Sick pay may only be accessed in blocks of 2 or more hours. The rate of pay for sick time used will be the equivalent of that on the corresponding missed shift(s) / work assignment(s).

Unused accrued sick time will carry over to the following calendar year, however an employee may not utilize more than 56 hours in a calendar year even if the total accrued exceeds this limit. Unused sick time is not eligible to be paid out at any time during or upon separation from employment.

Permitted Sick Leave uses include for a mental or physical illness, injury, or health condition, regardless of whether it has been diagnosed or requires medical care at the time of the request for leave; or for the diagnosis, care, or treatment of a mental or physical illness, injury, or health condition; or need for medical diagnosis or preventive care.

Safe Leave is also a permitted use of this time for an absence from work when the employee or employee's family member has been the victim of domestic violence as defined by the State Human Rights Law, and as it relates to a family offense, sexual offense, stalking, or human trafficking. Please see the Fact Sheet link below for a complete list of applicable situations.
https://www.ny.gov/sites/ny.gov/files/atoms/files/PSL_FactSheet_General.pdf

For more information on the program in general, please visit the NYS Dept. of Labor website which may be accessed with the following links.
https://www.ny.gov/programs/new-york-paid-sick-leave

References

All requests for employment verification must contain the employee's signature authorizing the release of information. J&D Ultracare only provides dates of employment and positions.

Complaints

J&D Ultracare makes every effort to ensure that all employees are provided with adequate means to present their complaints, free from interference, coercion,

discrimination, or reprisal. All ethical concerns and/or complaints shall be treated with confidentiality as appropriate.

The following provides an overview of our procedure. If you have questions or need to file a complaint, please contact J&D Ultracare directly at 845.357.4500.

- Each reported concern shall be treated with consideration, respect and full recognition of the individual's dignity and individuality.
- Employees have the right to express themselves without interference, coercion, discrimination, or reprisal.
- Reports of any type may be lodged with any Manager or Officer of the Agency.
- Responses to an ethical concern or complaint shall be rendered within 15 days of receipt by the Agency.
- This Agency will examine all reported ethical concerns and complaints. Receipt, investigation, and resolution of any concern, including an appeal of such, will be documented appropriately.

Should you have concerns regarding patient care and safety that have not been satisfactorily resolved through the Agency you may contact:

NYS Department of Health Home Care and Hospice Complaints Hotline @ 1-800-628-5972; 10am - 4pm on all State business days.

- OR -

The Joint Commission's Office of Quality Monitoring @ 1-800-994-6610 or complaint@jcaho.org.

PERSONNEL SAFETY TIPS

Safety in the Community:
It is very important to this Agency that our staff remains safe at all times. Should you perceive a situation to be unsafe, **first** take appropriate steps to ensure your safety and then **immediately** call the Agency.

The following guidelines have been established to assist you in maintaining your safety:

- Wear your name badge at all times.
- Carry a charged cell phone at all times.
- Call patients' homes in advance to alert them to your estimated time of arrival.
- Know your route. If you get lost, look for a safe place to stop and ask / call for additional directions.
- If needed, ask the patient / caregiver for further directions to the home.
- Request that pets are properly secured before your arrival. If pets are known to be menacing, back away. Never extend your hand out to the pet; never run from animals. Walk slowly around animals so that you do not frighten them.
- Do not carry a purse. Lock your purse in the trunk of your car or hide it from visibility in your car.
- Have your nursing bag/equipment ready before exiting from the vehicle. Keep one arm free.
- Keep your vehicle in good working order and ensure it has sufficient gas.
- In the winter, store a blanket in your vehicle; in the summer, a thermos of cool water.
- Keep a snack in the glove compartment.
- If you have car trouble, turn on the emergency flashers, call for assistance and wait for the police.
- Keep your car locked when parked or driving. Keep windows closed.
- Cross to the other side of the street when passing a group of strangers [if you are uncomfortable].
- Carry car keys in your hand. The pointed ends of the keys between your fingers may make an effective weapon.
- Park in full view of the patient's residence. Avoid parking in alleys or deserted side streets.
- Walk directly to the patient's residence in a professional and business-like manner.
- Use common walkways in buildings. Avoid isolated stairwells.
- Always knock on the door before entering a patient's home.
- Notify the Agency immediately if you encounter any incident that may jeopardize your personal safety.
- Seek medical attention as needed.
- If you feel that you are in imminent danger, **dial 911.**
- In the event of a robbery, never resist theft of the nursing bag.
- If patient's relatives or neighbors become a safety problem, notify the Agency immediately of the hazard.

Sexual Harassment Policy:
Upon Hire and annually Employee's will complete Mandatory Sexual Harassment Training
Sexual Harassment toward or by any Agency employee will not be tolerated. This Agency has a zero tolerance for Sexual Harassment. Any employee who feels that he/she has been sexually harassed should report this immediately to their Manager/Supervisor. An investigation of the allegation will ensue.

Violence in the Workplace:

1. No Weapons Policy:

- Agency personnel are strictly prohibited from carrying a weapon of any kind to a patient's home or to the Agency's office, regardless of whether you are licensed to carry said weapon.
- If a weapon / gun is present in the patient's home, request that the weapon be moved to a locked location during the visit / shift.
- If the weapon / gun poses a threat to you, the patient or caregiver, and the person will not remove the weapon, discontinue the visit / shift. Inform the person of your reason for leaving.
- After leaving, call the Agency immediately.
- If the person, patient or caregiver is willing to move the weapon / gun to a safe location, you must establish a verbal or written agreement that he/she will continue to store the gun elsewhere during your shifts / visits. Contact the Agency immediately regarding this agreement.

2. Domestic Violence:

All employees providing home care should be aware of the potential for domestic violence.

If domestic violence is observed:

- Remove yourself and the patient to a safe room.
- Call 911 for assistance if necessary.
- Notify the Agency and the patient's physician of the situation.
- If an Order of Protection is in place, notify the Agency. If that person comes to the patient's home, you are not permitted to allow him / her to enter. Request that s/he leaves. If s/he refuses, call 911 for assistance and notify the patient's emergency contact person of the situation.
- If an employee of the Agency has an Order of Protection against someone, s/he must notify the Human Resources Manager of the Agency. If that person arrives at the Agency, s/he will be asked to leave. If that person refuses, the Agency has the right to seek assistance.
- The Agency will not provide any employee's or patient's telephone number or home address to anyone not authorized to receive such information.

An Unusual Occurrence Report must be completed for any weapons / domestic violence incidences.

Office Safety:

J&D Ultracare will maintain a safe office environment. The front and back entrances of the office building will be locked at all times, and only authorized personnel will have access to the lock combinations. These combinations will be changed after termination of any office employee.

All Agency personnel will make safety a priority in their daily responsibilities. Any unsafe situations must be reported to a manager immediately. If the manager cannot resolve the issue, s/he shall convene a meeting of the Safety Committee to discuss and resolve the safety issue. If the Safety Committee cannot resolve the safety issue, the PAC members [or any appropriate outside entity] may be called to intervene or resolve the issue.

The following safety precautions will be taken in J&D Ultracare's office environment:

- Floors will be maintained to assure good footing; non-slip surfaces will be provided.
- Aisles and exits will be free of debris to provide easy movement and exit from facility.
- Handrails will be provided on all steps.
- Stairwells will be well lit.
- Heavy machines will be properly installed and maintained.
- Electrical equipment will be grounded properly.
- Electrical cords, plugs and switches will be in good working order.
- Desk and file drawers will operate easily. Drawers will be kept closed when not in use.
- Scissors, knives, push pins, razor blades and other sharp objects will be stored safely.
- Smoke alarms will be maintained. Battery operated smoke alarms will have their batteries changed as appropriate.
- Fire extinguishers will be checked as required by manufacturer.
- Employees will be trained in the use of fire extinguishers.
- Fire drills will be conducted at least annually.
- Flammable materials / products will be stored per manufacturers' recommendations.
- Evacuation / floor plan of the Agency will be posted for easy viewing by all employees and/or visitors.
- Heating elements, coffee makers, electric heaters will be used properly and maintained in good working order.
- Hazardous materials will be properly disposed of.
- All employees will be oriented to the OSHA Ergonomics regulations upon hire and annually thereafter.
- Employees will be instructed in proper lifting and handling techniques.
- Office employees will be issued proper chairs and workstations.

POLICY AND PROCEDURE

PRE-EMPLOYMENT BACKGROUND CHECK

REQUIREMENT

The Agency will conduct a pre-employment criminal background check on all new applicants prior to becoming active with the agency and in accordance with all applicable federal and state laws. This requirement will apply to all new applicants having direct patient contact.

IMPLEMENTATION

During the onboarding process with the Agency as part of their compliancy, the agency will conduct a criminal background check before placing any new employees on a case.

Prior to initiating the criminal background check, all potential employees will be required to provide written consent authorizing the Agency to do so. Once written consent is received by HR, the background check will be performed by a contracted third party as permitted by federal and state laws. Refusal to participate in the pre-employment background check will terminate the hiring process.

Once the report is received, the applicant will be made aware of the findings and provided with a copy of the report. HR, in conjunction with the Agency Management team, will review the results to determine if they will proceed with the hiring process.

In the event the agency learns of a criminal history based on information received in the background check report, the applicant will be afforded an opportunity to refute the report and clarify any discrepancies or inaccuracies prior to the Agency making a final hiring decision.

The Agency retains the right to make the final determination on hiring. If it is determined that the hiring process will not proceed, the applicant will be notified in writing.

Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

POLICY AND PROCEDURE

CORPORATE COMPLIANCE: P7A
EFFECTIVE: 01 / 1999; REVISION 02/2024

REQUIREMENT

This Agency has implemented a Corporate Compliance Program to provide guidelines for ensuring that we maintain responsible corporate citizenship at all times.
Primarily, our Corporate Compliance Program serves to ensure that all employees:

- Act in accordance with the laws, regulations and standards that govern our work.
- Help detect and deter conflicts of interest and/or compliance violations [by Agency employees or other agents] that could potentially:
  - affect the provision of care, treatment, and services.
  - expose the Agency to civil or criminal liability.
  - damage its financial status, business relationships, or reputation.
- Promptly report any situation or activity that may violate the law to an immediate supervisor or the Agency's Compliance Officer.

Further, all employees are expected to adhere to the Agency's requirement that any and all knowledge or information obtained in the course of employment is to be utilized solely in the pursuit of Agency business and for no other purpose, **and will be forever held inviolate and be concealed from any competitor and all other persons,** including but not limited to:
The Personal Health Information (PHI) of Agency clients and; the conduct and details of the Agency, it's personnel & agents and; the secret processes, formulas, intellectual property,
client / employee information and lists used by the employer in its course of business and; any knowledge regarding Agency personnel professional and/or personal information;

Secondarily, this Program is maintained to ensure this Agency exercises due diligence in seeking to prevent and detect criminal and/or inappropriate conduct by its employees and other agents for which it is responsible or encounters in our course of business.

IMPLEMENTATION

This Agency has established compliance standards, policies and procedures that are reasonably capable of reducing the prospect of conflicts of interest and/or unacceptable conduct, and outline methods for resolving such issues including but not limited to modes of discipline for individuals responsible for an offense. Such standards, policies and procedures are explained to Agency employees at the time of hire and are reviewed by all employees annually thereafter as mandated by this Agency. This Agency's Governing Body shall assume oversight responsibility for compliance with such standards and procedures.

Through its hiring and retention practices, this Agency consistently utilizes internal and external processes and systems reasonably designed to detect misconduct by its employees and other agents, including but not limited to verification of identity, verification of professional licensure and any disciplinary action thereto, verification of professional references, OMIG and OIG exclusion checks, and criminal background checks.

Should this Agency detect an offense, the organization shall make all reasonable efforts to respond appropriately to the offense and to prevent further similar offenses. These efforts shall include any necessary modifications to the Corporate Compliance Program in order to prevent and detect future violations of all applicable laws, regulations, etc.

Upon hire and during mandatory review of information annually, employees are apprised of the appropriate method whereby criminal or inappropriate conduct by all those encountered during the performance of your professional assignments may be reported.

The Agency has established billing practices that are in keeping with current acceptable standards of accounting and has implemented various protocols for purposes of patient financial information verification and auditing. **[See policy S17A Billing For Services]**

AGENCY STANDARDS OF CONDUCT

There are certain Standards of Conduct that we all must observe as good citizens and employees. Through implementation of Agency-wide Standards, employees are encouraged to perform at the peak of their abilities, while observing company culture and adhering to Agency policies, protocols and guidelines.

While it would be impossible to list all examples of misconduct, the following list is representative of those that may result in discipline, up to and including termination. In addition to any and all guidelines contained herein, this Agency strictly adheres to all guidelines offered by the New York State Office of the Professions. Attached please find pages 66 and 67 of the Office of the Professions' Nursing Guide to Practice for your review and reference.

Examples include:

- Violation of professional standards of patient care
- Violation of Patients' Rights
- Falsification of records (including but not limited to time sheets, patient care notes, job applications and professional references)
- Release and/or use of confidential or proprietary Agency and patient information.
- Removing records or materials from Agency premises without permission.
- Poor work performance
- Poor attendance including excessive tardiness
- Unauthorized and/or careless use of, destruction or damage to client or Agency property
- Possession, use, sale or reporting to work under the influence of intoxicants or drugs
- Insubordination
- Violation of the solicitation and distribution rules
- Carrying weapons or other hazardous devices
- Disorderly conduct, fighting, abusive or threatening language
- Violation of established smoking regulations
- Violation of established safety regulations
- Violation of the Agency's harassment policies
- Any conduct that is dishonest, unethical or illegal

Please be advised that while the Agency has a defined employee discipline process ranging from verbal consultation to termination, the Agency's Management Team reserves the right to make disciplinary decisions on a case-by-case basis, factoring individual and situational circumstances into their determination.

Agency Standards of Conduct will be monitored regularly through employee observations, supervisory visits and communication with clients / families, peers and employees of community-based care settings.

Any concerns regarding the subjects contained within this policy can be reported anonymously, and without fear of reprisal, to:

J&D Ultracare's Corporate Compliance Officer @ 845-357-4500;

NYS Office of the Medicaid Inspector General @ 877-873-7283 or www.omig.ny.gov; or

The Joint Commission @ 1-800-994-6610 or complaint@jcaho.org

POLICY AND PROCEDURE

CONFLICT OF INTEREST: P1A

EFFECTIVE: 11 / 1994; REVISION: 03/2020
Reviewed 2/2024

REQUIREMENT

The Agency shall define potential Conflicts of Interest including but not limited to those that affect, or have the potential to affect:

- Patient and staff safety;
- Quality of patient care, treatment and services;
- Laws, regulations and standards that govern our work;
- The Agency's integrity and sustainability; and/or
- The Agency's financial status, business relationships, or reputation.

The Agency shall uphold its procedure[s] for identifying and resolving conflicts as they arise.

The Agency's Governing Body shall use ethical principles to guide patient, employee, and business-related decisions.

IMPLEMENTATION

Any situation that may present a Conflict of Interest, whether or not directly related to patient care, shall be discussed with Agency Management, Governing Body, Professional Advisory Committee members and/or Ownership as deemed appropriate.

In matters involving a potential Conflict of Interest, all employees have a professional duty to disclose information regarding why a particular action or inaction, may not be in the best interest of the Agency, its patients or employees.

Agency employees are prohibited from engaging in any activities or practices that may be considered a Conflict of Interest.

The following list represents examples of situations that may be viewed by the Agency as potential Conflicts of Interest:

- Acceptance and/or discharge of a patient to / from Agency service for reasons that may be detrimental to the patient, Agency or both.
  [See policies N1A Patient Admission/Retention/Transfer and Discharge].
- An employee's failure to disclose knowledge of or participation in any activity that may pose a conflict to the business of the Agency.
- Governing Body's unauthorized decision to engage in a business relationship that poses a Conflict of Interest to the business of the Agency.
- An employee's acceptance of assignment to an Agency client either independently or through a competitor, without prior authorization from the Agency.
- Acceptance of money or expensive gifts given or received in connection to an individual's Agency employment.

Should a situation arise that is considered to be an actual or potential Conflict of Interest, the Agency shall implement protocols outlined in policies **G1A Employee Grievances, D3A Patient Grievances and P7A Corporate Compliance** in an effort to examine and resolve all concerns brought to the Agency.

Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

CLINICAL POLICY AND PROCEDURE

C 31 Safe Patient Lifting, Transfer and Repositioning

REQUIREMENT

The Agency will take appropriate steps to manage safety risks and address safety concerns as necessary. To ensure maximum safety, comfort and quality of care within a safe lifting, transfer and repositioning environment.

POLICY:

1. All direct care staff are required to review this policy document describing safe lifting practices and associated guidelines. Demonstrated competencies are required to indicate the caregiver's/nurse acceptance of responsibility to adhere to safe lifting practices at all times.
2. The Agency will adopt a "Zero Lift" policy. However, when there is no mechanical lift equipment or clinical circumstances prevail, safe lifting technique may be utilized .Manual lifting of patients is discouraged in all but exceptional medical emergencies or life threatening situations. Caregivers/nurses will assume first responsibility for using mechanical lifts or repositioning aids during all high risk tasks except when absolutely necessary(medical emergency or life threatening situation).
3. All patients will be evaluated during the initial assessment visit for lifting and/or transfer needs. Patients, caregivers and Agency staff will be informed of our policies regarding safe lifting and potential use of mechanical lifts and transfer aids.
4. Lifting and/or transfer needs of the patient will be documented on the "Home Health Certification and Plan of Care, (485).
5. The patient, caregiver and Agency staff will be instructed on proper safe lifting and transfer techniques.
6. The Field Nursing Supervisor will reassess the patient's safe lifting and/or transfer requirements at the time of each reassessment visit. Changes will be added to the Plan of Care. The patient, caregiver and nurses on the case will be educated on any changes and/or new equipment.
7. Nursing staff will receive instructions on proper Safe Lifting and transfer techniques on orientation. These instructions/protocols will be reviewed at time of each reassessment visit or more frequently if necessary.
8. Caregiver, patient, and Agency staff will follow manufacturer's instructions as it pertains to specific lifting device.
9. Any injury resulting from patient lifting or repositioning, including sprains, strains, or any other musculoskeletal injuries, must be reported to the Agency within 24 hours.

IMPLEMENTATION

Upon admission to this Agency and during each reassessment, a basic safety assessment is performed to identify and address potential safety hazards during patient lifting, transfers and repositioning.

Provide education to patient / caregiver and staff in proper safe lifting and transfer techniques to meet the patient's assessed needs.

Patients / caregivers are informed that they should report any patient care-related safety concerns to the Agency. They are also informed that they may report their concerns to the New York State Department of Health and/or The Joint Commission.

If safety concerns cannot be satisfactorily resolved with the patient, caregiver, family or Agency staff, the issue will be presented to the Agency's Safety Committee for review. The Safety Committee will be comprised of the Governing Body and other appropriate staff as determined by the President.

Attachment to Clinical Policy and Procedure - C-31

FIRST find out the person's strengths and weaknesses. Often one side of the body is stronger. The stronger side should be transferred first. When lifting, transferring, or carrying a physically restricted person, observe the following principles of body mechanics. Practicing them will help prevent possible strain or injury to your lower back, and will insure a safe lift for the person you are lifting.

I. LIFTING:

A. First, plan the job.

B. Make sure ample room is available for good footing, and the path is cleared for the carry.

C. Stand so you will not have to twist as you lift.

D. If the weight of the person is more than one-fourth of your body weight, you should get someone to help you. Also, get assistance if lifting the person is awkward.

E. Your back should be kept as straight as possible.

F. Lift by straightening your legs in a steady upward thrust and, at the same time, move your back to a vertical position.

G. The weight of the person should be kept close to your body and over your feet.

II. CARRYING:

A. Carry the person as close to you as possible.

B. Keep your back straight, not arched.

C. Do not twist. Change direction by taking small steps and turning the whole body at once.

III. LOWERING:

A. Spread your legs to hip width, and lower the person between your feet.

B. Hold your back straight and steady, even when you lean forward.

C. Lower in a slow and even manner while bending your legs.

D. Do not twist your body. To turn, move your feet.

IV. TRANSFERRING:

Although some individuals who use a wheelchair have sufficient arm strength and coordination to transfer into and out of their chair by themselves, many will need assistance. Various types of transferring techniques can be used to move someone from one place to another when carrying is not necessary. The individual's weight and physical ability to help, as well as your own strength, are important factors in deciding which technique will be most appropriate.

V. WHEELCHAIRS:

A. Make sure the chair is locked when removing or seating the person.

B. Pull the wheelchair backwards up steps or curbs.

C. Adjust the height of the foot pedals so the person is sitting at a 90-degree angle at the hip and knee.

D. When removing or seating the person, the following procedure is suggested as easy for you and most comfortable for the person:

Before you begin, make sure you have put up the foot pedals or swung them out of the way. Place your arm around the person under his or her arm at the armpit. Place your other arm under the person's knees. Or face the person in the chair. Secure a hold under each arm, and lift the person out of the chair.

VI. LIFTING AND MOVING (from bed to wheelchair):

A. Always begin the lifting procedure by moving the person to the edge of the bed. First, move the upper trunk, then the legs one at a time. Repeat this until the person is near the edge of the bed. Repeated movement of the trunk and legs is easier than lifting the person as a whole all at once.

B. Remember, bend from your knees, not from your waist. If you must bend from the waist, tighten your stomach muscles while bending and lifting. This reduces pull on the back muscles. Keep your back straight at all times. The following are step-by-step procedures, which will make lifting and transferring safer and easier.

VII. THE ONE-PATIENT TRANSFER:

A. Prepare for the lift.

1. Place a belt around the person's waist.

2. Place wheelchair at a slight angle to the side of the person's bed.

3. Lock both brakes on the wheelchair.

4. Remove the armrest of the wheelchair on the side next to bed, if possible. This helps prevent bumping the person's hips or buttocks and allows for lifting without lifting too high.

5. Swing away the leg rests of the chair. If leg rests will not swing away, lift the pedals to avoid interference during the transfer.

6. If the person is connector to any equipment, feeding tubes, ventilator, infusion pumps etc. secure all lines allowing for enough slack for safe transfer

7. Stabilize the bed, so it will not move.

B. Steps in the one-person transfer.

1. Place the person's legs over the side of the bed with the knees near the bed's edge.

2. Place the person's hands in his or her lap.

3. Place your arms under the person's armpits and around the back.

4. Raise the person to a sitting position on the side of the bed. Do not let go unless the person can sit alone without support.

5. Gradually slide the person forward until the person's feet are flat on the floor. Place your feet in a "v" on both sides of the person's feet for support. Have your feet far enough apart to give you a good base of support. Your knees should be on each side of the person's knees.

6. Have the person lean forward. If possible, place the person's arms around your shoulders. Allow the person to reach with an outside arm for the far wheelchair arm.

7. Bend your hips and knees while keeping your back straight. Place your arms around the person's waist. Grip the person's belt

on both sides toward the back with your hands. (If the person is not wearing a belt, a safety belt may be put on during the preparation stage.)

8. Keep the person's knees stabilized. Count 1-2-3, and then pull forward on the belt to lift the person.

9. When the person is high enough to clear the armrest or chair surface, turn by taking small steps. Be sure to keep the person's knees blocked with your own knees.

10. When turned, bend your hips to squat and lower the person to the chair's seat.

11. Replace the footrests, then the armrest.

12. Remove the belt, if necessary.

13. Fasten the seat belt on the chair.

14. Repeat the procedure from steps 5 to 11 when transferring from a chair to the bed or other areas. Remember if the person is connector to any equipment, feeding tubes, ventilator, infusion pumps etc. secure all lines allowing for enough slack for safe transfer

C. Alternate lifts: use only to lift a very small person.

1. Prepare for the lift by following the same procedure as outlined in steps 1-6 in the one-person transfer. 2. If the individual is totally incapable of assisting you and you are alone without another's assistance, follow the procedure listed below. (If the person is more than one-fourth of your body weight, try not to lift the person by yourself.)

a. Move the person to the side of the bed in a lying position.

b. Fold the person's arms across his or her chest.

c. Place your feet far enough apart to give you a good base of support.

d. Bend your knees slightly.

e. Place one of your arms under the person's neck.

f. Place the other arm under the person's knees.

g. Using the strength in your legs, draw the person close to your body and lift up while keeping your back stralght.

h. Take small steps to the wheelchair. Remember to keep your knees bent. Carefully place the person in the seat of the chair.

i. Check on the person's sitting position and adjust the wheelchair seat belt.

j. Fasten the seat belt.

k. Repeat the procedure to lift an individual from a wheelchair to another area (e.g., to a bed or couch).

VIII. THE TWO-PERSON TRANSFER:

A. Prepare for the transfer.

1. Know where you are going to move the person.

2. Prepare the wheelchair, tub, or bed prior to starting to lift the person.

3. Be sure the wheelchair brakes are locked.

4. Remove the wheelchair's armrest, which is closest to the destination point.

5. Swing away or remove the leg rests or lift pedals, if possible.

6. If the person is connector to any equipment, feeding tubes, ventilator, infusion pumps etc. secure all lines allowing for enough slack for safe transfer

7. Stabilize the surface from which you are lifting the person.

B. Steps in a two-person transfer.

1. The taller lifter should stand at the back of the person.

2. The shorter person should stand on one side of the person.

3. The lifter at the back should put his or her arms under the person's shoulders and around the person's chest with arms folded across the person's chest.

4. The taller lifter at the back should then widen the base of support by spreading feet apart and bending slightly at the hips and knees. (Remember to not bend the back, but to use the strength in the hips and knees.)

5. The shorter lifter at the side places both arms under the person's thighs in order to support the buttocks and lower legs. Clasp one hand to wrist for firm grip.

6. The shorter lifter should also widen the base of support by spreading feet apart.

7. Bend knees and hips slightly before lifting.

8. Be sure the person being lifted keeps elbows next to the body or place arms and elbows in that position, if necessary.

9. The taller lifter counts to three after which both lifters should straighten their hips and knees to lift the person in unison. Both lifters step to the transfer surface and place the person there. If the individual is being put in bed, repositioning for comfort may be necessary.

IX. ACTIVE TRANSFERS:

❶ ***Individuals who need little or no assistance perform the following transfers.*** This type of transfer is known as an "active" transfer. The three commonly used active transfers for the aged and handicapped are the side, the walker, and the cane transfers. Procedures for these transfers are as follows:

A. ***The side transfer:*** used by a person who is weak in the lower extremities. (This technique is described for a person moving from a wheelchair to the toilet, but may be used for bed to chair, chair to bed, or chair to tub seat.)

❶ ***The person:***

1. Approaches the toilet at a 90-degree angle, or so the wheelchair makes an "I" with the toilet.

2. Locks the brakes on the chair.

3. Raises the pedals of the chair.

4. Places both feet flat on the floor about 12" apart.

5. Places both hands on the armrests of the chair and leans slightly forward over the knees.

6. Assumes a partially standing position by pushing with both hands.

7. Grasps the left grab bar with the left hand, or the right grab bar with the right hand, depending upon the angle of approach. (A grab bar should be available either on the toilet seat or on the wall beside the toilet.)

8. Takes small steps and turns slowly until standing with back to the front of the toilet.

9. Stabilizes before leaning forward and lowering to the toilet seat.

- ***Transfers should be made toward the strongest side or to the side without an encumbrance, such as a cast.*** Improper transferring to the wrong side could cause falling and injury.

- ***An elevated toilet seat can help a person who has difficulty in transferring from a toilet to a wheelchair.***

- ***In a bathroom with limited space, the person may be required to have the wheelchair facing the toilet.*** The person must, therefore, turn halfway around before sitting down.

B. The Walker Transfer:

- ***Many aged persons need the aid of a walker for stability.***

- ***To rise, the person:***

1. Secures the wheelchair by backing it against a wall, if possible, and locking the brakes.

2. Raises or swings the footrests out of the way.

3. Places the walker in front of, and as close as possible to, the wheelchair.

4. Moves forward to the front half of the wheelchair seat.

5. Places both hands on the armrests of the chair. (Under no circumstances should the person take hold of the handles of the walker until fully upright. The walker will tip backwards easily.)

6. Places feet flat on the floor and spreads them apart about 12" for a good base of support.

7. Leans forward with shoulders directly above knees.

8. Pushes with arms and legs to a standing position.

9. Takes hold of the walker using one hand at a time. (Only after standing should the person reach to take hold of the walker.)

10. Stabilizes prior to walking.

- ***To sit, the person:***

1. Approaches the chair from the side. (If using a wheelchair, the brakes need to be locked.)

2. Turns until his or her back is facing the chair. (Only a quarter turn is required for the person to have his or her back to the chair. The person's strong side should be closest to the chair.)

3. Backs up until the backs of the knees come in contact with the front of the seat.

4. Reaches back with one hand at a time to grasp the wheelchair's armrests.

5. Leans forward, bending the hips and knees to lower self into the chair.

C. The Cane Transfer:

- ***Many aged persons use a cane for increased stability.***

- ***To rise with a cane, the person:***

1. Stabilizes the chair (especially a wheelchair) against a wall and locks brakes.

2. Raises footrests or swings them out of the way.

3. Places the cane in the hand of the strongest side.

4. Holds the cane in the hand while grasping the armrest by the same hand. (If the hand opposite the cane is usable, the person grasps the armrest with it, also. When someone does not have the use of the arm opposite the cane, the person should lean forward over the knee on the side of the cane.)

5. Moves forward in the chair to the front half of the seat.

6. Spreads feet about 12 inches apart.

7. Leans forward to shift weight.

8. Pushes with arms and legs to stand.

9. Brings cane up from the armrest.

10. Stabilizes with the cane before proceeding to walk.

- ***To sit with a cane, the person:***

1. Approaches the chair with the cane, placing the cane in front of the chair. This places the strongest side toward the chair.

2. Turns until the back is fully to the chair.

3. Backs up until the backs of the knees touch the front of the seat.

4. Reaches back with both hands, if possible, and grasps the armrests.

5. Holds cane with the armrest.

6. Leans forward over both knees, provided both arms could be used. The person should lean over the knee on the cane side if only that arm is usable.

7. Bends hips and knees to sit down.

- ***Please remember that each individual situation is unique when applying these basic steps in transferring.***

Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

POLICY AND PROCEDURE

EMERGENCY PREPAREDNESS PLAN - C1A

EFFECTIVE: 08/08/94
Revised 01.2020

REQUIREMENT

This Agency shall maintain a written emergency plan including procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation to all employees to their responsibilities in carrying out this plan.

Annually, a Hazard Vulnerability Analysis shall be completed to evaluate the Agency's level of risk and preparedness for a variety of hazardous events. This assessment will serve as the foundation for emergency planning for this Agency.

This Plan is intended to address emergencies as identified by the Agency's Hazard Vulnerability Analysis.

IMPLEMENTATION

During the initial orientation of new staff and annually thereafter, all employees shall be oriented to the Agency's Emergency Preparedness Plan and their individual responsibilities in carrying out the Plan.

The Plan shall be reviewed at least annually by the Agency's Management Team and approved by the Governing Body. All Agency staff shall be notified when there are changes to the Plan.

If the Plan has not been activated in the previous 12 months, it shall be activated as a planned exercise.

The Agency will maintain a current Health Provider Network [HPN] account with the New York State Department of Health, which has been established as a mechanism to accurately disseminate information regarding public health concerns, disasters and/or emergencies.

The Agency's designated HPN Coordinator will maintain the HPN account and notify staff of any applicable occurrences.

The Agency shall maintain an electronic roster of office staff, active field staff and active patients (which includes TALS designation and identification of patients dependent on use of electricity for healthcare needs and/or ventilator dependence). These rosters reflect system changes and remain in real time and may be printed for reference at any time. The Agency's Call Down list will be maintained for internal office staff and updated as necessary to reflect changes. On-Call Staff and Clinical Care Coordinators shall ensure their secure access to these lists at all times.

The Agency will participate in community-wide disaster drills and exercises as required, including but not limited to, collaboration with the designated Regional Resource Center at Westchester Medical Center. The Agency will strictly adhere to guidelines set forth by the Regional Resource Center as they pertain to the Agency's role in a community-wide emergency management plan.

The Agency shall collaborate with county health departments, state and local emergency management agencies, and other health care delivery systems, as necessary and appropriate.

As a contingency for admission to this Agency, each client will be assessed to ensure that s/he meets the NYSDOH definition of a **Level 3 Low Priority** client. [Policy N1A Admission and Retention]

The following definitions are in accordance with NYSDOH regulation:

Level 1 – High Priority. Patients in this priority level need uninterrupted services. The patient must have home care. In case of an emergency, every possible effort must be made to see this patient. The patient's condition is highly unstable and deterioration or inpatient admission is highly probable if the patient is not seen. Examples include patients requiring life sustaining equipment or medication; those needing highly skilled wound care; and unstable patients with no caregiver or informal support to provide care.

Level 2 – Moderate Priority. Services for patients at this priority level may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. The patient's condition is somewhat unstable and requires care that should be provided that day but could be postponed without harm to the patient.

Level 3 – Low Priority. The patient may be stable and has access to informal resources to help them. The patient can safely miss a scheduled visit with basic care provided safely by family or other informal support or by the patient personally.

- Upon admission to this Agency, potential emergency / risk factors will be identified for each client and appropriate emergency plans will be discussed with the client and his/her responsible caregiver. An Emergency Resource List including the name and telephone number of at least one emergency contact will be obtained.

Surge Plan

In the event of a community-wide disaster, this Agency will collaborate with inpatient facilities within its service area to determine the Agency's ability to assist with patient care, should emergency plans include the need for increased home care services.

This Agency has limited resources to support an influx of new patients during an emergency. However, should this Agency be called upon to support a surge in home care referrals, the Governing Body will evaluate the Agency's ability to safely increase admission capacity, facilitate rapid transfers and/or discharges, and/or identify appropriate nursing staff.

Emergency Response Procedure:

- When an emergency occurs, the President or his/her designee shall initiate the Call Down List to ensure proper notification to office staff, active field staff and patients / caregivers.

  To the greatest extent possible, office and field staff are expected to report to work unless otherwise directed by the Agency. If appropriate, office staff will be directed to report to an alternative location. If field staff are unable to report to their scheduled assignments, patients and caregivers will be notified of cancellations, and the Agency will make diligent efforts to fill the open shifts. Caregivers will be instructed to arrange for alternate care.
- The President and/or Incident Commander shall direct receipt and dissemination of all information regarding, and during an emergency. All efforts will be made to maintain patient confidentiality, so long as such efforts do not interfere with or prohibit the Agency's emergency response procedure.
- The President and/or Incident Commander shall direct the activities / responsibilities of all Agency employees and take appropriate action to ensure the Agency's ability to continue operating while maintaining the integrity of pertinent client and financial data during an emergency.
- To the extent possible, effective communication with patients, field staff and primary / alternate caregivers will be maintained. In the event of a medical emergency or should the patient's home become unsafe for delivery of care, 911 shall be accessed.

Emergency Evacuation Protocols

COMMUNITY EVACUATIONS

Mandatory Evacuation Orders

Upon admission to service with this Agency and no less often than annually thereafter:

- All patients will be assessed to determine their Transportation Assistance Level [TAL]; and
- All patients, caregivers and Agency staff will be educated regarding potential mandatory evacuations and this Agency's protocol[s] for adherence to such, including the potential risks associated with sheltering in place.
- Patients, their caregivers and Agency field staff will be advised of the Agency's requirements for field staff during a mandatory evacuation order and ongoing communication throughout the duration of the emergency.

Should a patient's home be subject to a mandatory evacuation order:

Patient / Caregiver is evacuating: Agency field staff should assist caregiver[s] with preparing for evacuation, call 911 if warranted and notify the Agency of the patient's plan. Agency field staff are required to adhere to the order and leave the premises. In order to assure patient safety, a trained caregiver must be present prior to staff departure.

Patient / Caregiver is refusing to evacuate: In the event that an ordered evacuation is refused by the patient / caregiver, Agency field staff will hand-off care to a trained caregiver and leave the premises, or in the absence of a trained caregiver, Agency field staff will evacuate with the patient via 911 assistance. Agency field staff are required to adhere to the evacuation order and leave the premises once care is assumed by a trained caregiver. Staff must notify the Agency of the patient's location / plan.

To the extent possible, documentation during an emergency shall be thorough and complete. Activities will be documented as an Unusual Occurrence and included in the QI reports for that quarter.

OFFICE EVACUATION

To ensure the safety of all office staff and visitors, the Agency's Incident Commander or his/her designee shall organize and direct all staff activities including evacuation as appropriate during an emergency.

Employees and visitors will be alerted to the need for evacuation either by internal smoke or carbon monoxide detector alarms or by a loud-speaker announcement.

REASONS TO EVACUATE

- Visible fire, smoke or carbon monoxide alarm
- Weather related emergencies- hurricane, flooding, tornado, winter storms
- Indian Point Emergency
- Local Town / State or Agency Declared Emergencies
- Prolonged computer, internet and/or phone outages

Ready®

Preparing Makes Sense for People with Disabilities and Others with Access and Functional Needs. Get Ready Now.

1. Get a Kit of emergency supplies.

Be prepared to improvise and use what you have on hand to make it on your own for **at least three days**, maybe longer. While there are many things that might make you more comfortable, think first about fresh water, food and clean air.

Recommended Supplies to Include in a Basic Kit:

- ✓ **Water**: one gallon per person per day, for drinking and sanitation
- ✓ **Non-perishable food**: at least a three-day supply
- ✓ Battery-powered or hand crank **radio** and a NOAA Weather Radio with tone alert and extra batteries for both
- ✓ **Flashlight** and **extra batteries**
- ✓ **First aid kit**
- ✓ **Whistle** to signal for help
- ✓ **Filter mask** or cotton t-shirt, to help filter the air
- ✓ **Moist towelettes, garbage bags** and **plastic ties** for personal sanitation
- ✓ **Wrench** or **pliers** to turn off utilities
- ✓ **Manual can opener** if kit contains canned food
- ✓ **Plastic Sheeting** and **duct tape** to shelter-in-place
- ✓ **Important family documents**
- ✓ **Items for unique family needs,** such as daily prescription medications, infant formula, diapers or pet food

Include Medications and Medical Supplies: If you take medicine or use a medical treatment on a daily basis, be sure you have what you need on hand to make it on your own for at least a week and keep a copy of your prescriptions as well as dosage or treatment information. If it is not possible to have a week-long supply of medicines and supplies, keep as much as possible on hand and talk to your pharmacist or doctor about what else you should do to prepare. If you undergo routine treatments administered by a clinic or hospital, or if you receive regular services such as home health care, treatment or transportation, talk to your service provider about their emergency plans. Work with them to identify back-up service providers within your area and other areas you might evacuate to.

Include Emergency Documents: Include copies of important documents in your emergency supply kits such as family records, medical records, wills, deeds, social security number, charge and bank accounts information, and tax records. It is best to keep these documents in a waterproof container. If there is any information related to operating equipment or life-saving devices that you rely on, include those in your emergency kit as well. If you have a communication disability, make sure your emergency information list notes the best way to communicate with you. Also be sure you have cash or travelers checks in your kits in case you need to purchase supplies.

Additional Items: If you use eyeglass, hearing aids and hearing aid batteries, wheelchair batteries or oxygen, be sure you always have extras in your kit. Also have copies of your medical insurance, Medicare and Medicaid cards readily available. If you have a service animal, be sure to include food, water, collar with ID tag, medical records and other emergency pet supplies.

Consider two kits. In one, put everything you will need to stay where you are and make it on your own. The other should be a lightweight, smaller version you can take with you if you have to get away.

2. Make a Plan for what you will do in an emergency.

The reality of a disaster situation is that you will likely not have access to everyday conveniences. To plan in advance, think through the details of your everyday life.

Develop a Family Emergency Plan. Your family may not be together when disaster strikes, so plan how you will contact one another and review what you will do in different situations. **Consider a plan where each family member calls, or e-mails, the same friend or relative in the event of an emergency.** It may be easier to make a long-distance phone call than to call across town, so an **out-of-town contact** may be in a better position to communicate among separated family members. Depending on your circumstances and the nature of the attack, the first important decision is whether you stay put or get away. You should understand and plan for both possibilities. **Watch television and listen to the radio for official instructions as they become available.**

Ready®

Preparing Makes Sense for People with Disabilities and Others with Access and Functional Needs. Get Ready Now.

Create a Personal Support Network: If you anticipate needing assistance during a disaster, **ask family, friends and others to be part of your plan**. Share each aspect of your emergency plan with everyone in your group, including a friend or relative in another area who would not be impacted by the same emergency who can help if necessary. Include the names and numbers of everyone in your personal support network, as well as your medical providers in your emergency supply kit. Make sure that someone in your personal support network has an extra key to your home and knows where you keep your emergency supplies. If you use a wheelchair or other medical equipment, show friends how to use these devices so they can move you if necessary and teach them how to use any lifesaving equipment or administer medicine in case of an emergency. Practice your plan with those who have agreed to be part of your personal support network.

Inform your employer and co-workers about your disability and let them know specifically what assistance you will need in an emergency. Talk about communication difficulties, physical limitations, equipment instructions and medication procedures. Always participate in trainings and emergency drills offered by your employer.

Create a Plan to Shelter-in-Place: There are circumstances when staying put and creating a barrier between yourself and potentially contaminated air outside, a process known as sheltering-in-place and sealing the room can be a matter of survival. **If you see large amounts of debris in the air, or if local authorities say the air is badly contaminated, you may want to shelter-in-place and seal the room. Consider precutting plastic sheeting to seal windows, doors and air vents.** Each piece should be several inches larger than the space you want to cover so that you can duct tape it flat against the wall. Label each piece with the location of where it fits. Immediately turn off air conditioning, forced air heating systems, exhaust fans and clothes dryers. Take your emergency supplies and go into the room you have designated. Seal all windows, doors and vents. Understand that sealing the room is a temporary measure to create a barrier between you and contaminated air. **Listen to the radio** for instructions from local emergency management officials.

Create a Plan to Get Away: Plan in advance how you will assemble your family and anticipate where you will go. **Choose several destinations in different directions** so you have options in an emergency. **Become familiar with alternate routes as well as other means of transportation** out of your area. If you do not have a car, plan how you will leave if you have to. If you typically rely on elevators, have a back-up plan in case they are not working. **Talk to your neighbors about how you can work together.**

Consider Your Service Animal or Pets: Whether you decide to stay put or evacuate, you will need to make plans in advance for your service animal and pets. Keep in mind that what's best for you is typically what's best for your animals. If you must evacuate, take your pets with you, if possible. However, if you are going to a public shelter, make sure that they allow pets. Some only allow service animals.

Fire Safety: Plan two ways out of every room in case of fire. Check for items such as bookcases, hanging pictures or overhead lights that could fall and block an escape path.

Contact Your Local Emergency Information Management Office: Some local emergency management offices maintain registers of people with disabilities and other special needs so you can be located and assisted quickly in a disaster. Contact your local emergency management agency to see if these services exist where you live. In addition, wearing medical alert tags or bracelets that identify your special needs can be a crucial aid in an emergency situation.

3. **Be Informed** about what might happen.

Some of the things you can do to prepare for the unexpected, such as assembling an emergency supply kit and making an emergency plan are the same regardless of the type of emergency. However, it's important to stay informed about what might happen and know what types of emergencies are likely to affect your region. Be prepared to adapt this information to your personal circumstances and make every effort to follow instructions received from authorities on the scene. Above all, stay calm, be patient and think before you act.

HOME CAREGIVER GUIDE TO

Nuclear Biological & Chemical Emergencies

This brochure is intended to help you, the caregiver, understand and prepare for emergencies that might endanger you, your patients, and your community. Be sure to write important phone numbers on the end leaf of this flyer, tear it off and keep it with you.

HOME CARE ASSOCIATION of New York State, Inc.

194 Washington Avenue, Suite 400, Albany, New York 12210
518.426.8764 FAX 518.426.8788 www.hcanys.org

This brochure was created by the Home Care Association of New York State, Inc., with funding from the New York State Department of Health

EMERGENCY PREPAREDNESS CHECKLIST

MAKE SURE:

- ✓ You have an emergency plan in place for all your family for different times of day, including pets;
- ✓ You and your family understand basic emergency response terms such as "shelter-in-place" and evacuation, and you have enough emergency food and supplies on hand for three days;
- ✓ You keep personal protective equipment with you at all times;
- ✓ You know your employer's emergency plans and contacts;
- ✓ Your patients have adequate supplies, including medications, for three days, and you know their emergency plans and contacts;
- ✓ You've planned with babysitters and loved ones to meet family responsibilities if someone needs to work, or can't get home from work;
- ✓ You keep a list of emergency contact numbers, radio stations, and other important names, places, and numbers with you at all times;
- ✓ You keep up to date on daily news;
- ✓ You and your patients have "Go" bags in case you need to evacuate;
- ✓ You know where nearby shelters are located, and have a map available.

TALK TO YOUR SUPERVISOR AHEAD OF TIME SO YOU ARE AS READY AS POSSIBLE FOR AN EMERGENCY SITUATION.

RECOGNIZING BIOTERRORISM RELATED ILLNESS

Signs that might indicate an act of bioterrorism, or intentional use of disease to cause harm to humans or animals, are:

- Unusual numbers of sick or dying people and/or animals;
- Sudden illness in previously healthy people;
- Outbreaks of disease such as cold or flu "out-of-season";
- Outbreak of a rare disease such as smallpox or plague;
- Unusual spraying activities.

...ely agents: anthrax, smallpox and plague. ...ny illnesses have flu-like symptoms, and not be noticed at first.

RECOGNIZING CHEMICAL TERRORISM RELATED ILLNESS

Most chemical agents work very fast. For a chemical weapon to cause harm, it must come in contact with the skin or mucous membranes, be inhaled, or swallowed. Signs that might indicate a chemical attack are:

- Mass casualties, or many illnesses within a small area OR in groups of people;
- Many people choking, with skin blisters, rashes, nausea, disorientation or convulsions;
- Many dead insects, animals, birds, fish or unusual dead trees and plants at the same time;
- Unusual liquid droplets or wet areas; unexplained odors; low lying cloud or fog.

RECOGNIZING RADIATION RELATED ILLNESS

Effects of exposure to radiation can take days or weeks to be noticed. Most immediate injuries will be from the explosion itself. Some symptoms might be similar to those for chemical exposure. Specific symptoms of radiation poisoning or sickness, which may take up to 2-3 weeks to be noticed, are:

- Unexplained burns or skin lesions;
- A tendency to bleed and/or hair loss;
- Symptom clusters such as:
  - -Headache, fatigue, weakness
  - -Skin damage, and ulceration
  - -Nausea, vomiting, diarrhea
  - -Bruising, infections

WHAT IS BIOTERRORISM?

Bioterrorism is the intentional use of disease to attack humans, plants, or animals. An important thing to know about bioterrorism is that it can create symptoms that are similar to naturally occurring illnesses such as flu, colds or chickenpox. Examples of how bioterrorism has been used to make people sick are:

- In Colonial Days British soldiers gave Native Americans blankets infected with smallpox. Entire tribes died as a result.
- Following 9/11, anthrax was sent through the mail, causing five deaths and widespread terror.

Sometimes, even experts have a difficult time telling what might be bioterrorism, and what might be the result of nature. In 1993, the water in Milwaukee, Wisconsin was contaminated, making hundreds of thousands of people sick, and causing many deaths. It was not terrorism, but a naturally occurring waterborne disease called cryptosporidium, which is resistant to chlorine.

WHAT IS CHEMICAL TERRORISM?

Chemical terrorism is the use of a chemical to harm or kill people. Most chemicals work very fast, often within seconds. Some chemicals have colors and odors, but others are completely unnoticeable. For a chemical to cause harm, it must come in contact with the skin or mucous membranes, be inhaled, or swallowed.

Many hazardous chemicals are used in industry. Others are found in nature (for example, poisonous plants). Some can be made from everyday items such as household cleaners. Sometimes hazardous chemicals are accidentally released in an industrial or even a traffic accident. Recent examples of how chemical poisons have been used intentionally to make people sick are:

- In 2003 the coffee at a church social in Maine was poisoned with arsenic; and
- A supermarket employee in Michigan poisoned 200 pounds of ground beef with insecticide.

Chemical spills can be devastating too. In 1984 the accidental release of poisonous gas at a pesticide factory in India resulted in the deaths of 28,000 people.

WHAT IS NUCLEAR or RADIOLOGICAL TERRORISM?

Nuclear or radiological terrorism is an intentional act by terrorists using an explosive device (such as a nuclear warhead, suitcase bomb or dirty bomb) that releases radiation. A radiological emergency could also be an accident caused by a leak at a nuclear power plant.

In most cases, there will be no immediate symptoms of radiation exposure or contamination outside the immediate blast area. Most injuries will be from the explosion itself. Signs of radiation "sickness" may take weeks to appear.

If there is a nuclear or chemical release incident, you may be told to "shelter-in-place," which means making wherever you are as safe as possible until it is safe to go outside.

Ask your supervisor what you should know about decontamination.

QUESTIONS TO ASK IF YOU SUSPECT SOMETHING IS WRONG

- Are others ill? What's on the news?
- Have there been any unusual events or accidents?
- Has the patient been traveling or had guests from overseas?
- Is it a possible food-related illness?
- Does the patient have pets that roam outside? Are the pets sick?
- Are there a lot of mosquitoes or rodents in the house or yard?
- Has anyone else noticed anything?
- What does my supervisor think?

Any of the signs listed on the other side of this flyer might indicate an attack by terrorists, or they might be the result of an accidental chemical spill, radiation leak, food poisoning, or naturally occurring infectious disease outbreak. All might be dangerous!
REPORT ANYTHING UNUSUAL TO YOUR SUPERVISOR!

TEAR THIS OFF AND KEEP WITH YOU FOR HANDY REFERENCE

IMPORTANT PEOPLE & PLACES

Shelter:
Directions to Shelter:

Baby Sitter:

School:

Place to meet:

Out of State Contact:

Family numbers:

IMPORTANT NUMBERS

Poison Control: 1-800-222-1222

Terrorism Tip Line
Upstate: 1-866-SAFE-NYS
NYC: 1-888-NYC-SAFE

Local Red Cross:

Fire Department:

Police Department:

IMPORTANT NUMBERS

Supervisor:
(pager)

Agency:

Emergency Contact Number:

Back Up Number:

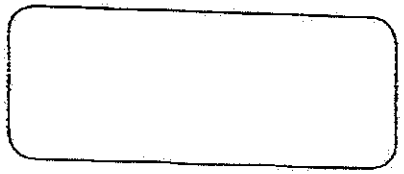
Emergency Broadcast Radio or TV Station:

Local Emergency Office:

ex[illegible] what they think are the s[illegible]oms of flu: headaches, fatigue, nausea, and dizziness. These are actually symptoms of CO poisoning as well.

some recover... some die

Why?



Smell anything?
CO is odorless.

What is carbon monoxide (CO)?

Carbon monoxide is a poisonous gas that can kill you if inhaled. You can not see it, smell it, or taste it. It is sometimes called the "silent killer" because it can take your life without warning. Most people that die in home fires die at night, while they are asleep. They don't wake up because the CO puts them into a deeper sleep. They are unable to respond and escape.

Why is it deadly?

When air containing CO is inhaled, it displaces oxygen in the bloodstream. It reduces the blood's ability to carry oxygen to vital organs such as the heart and brain. In addition to flu-like symptoms, it can cause vomiting, loss of consciousness, brain damage and/or death. Unborn babies, infants, senior citizens, and people with heart and breathing problems are at an especially high risk.

ALWAYS R[illegible]EMBER YOUR COMPREHENSIVE HOME FIRE SAFETY PROGRAM:

Have working smoke detectors.
Have and practice a home escape plan.
Get out! Stay out!

David A. Paterson
Governor
State of New York

Lorraine Cortés-Vázquez
Secretary of State
Department of State

Floyd A. Madison
State Fire Administrator
Office of Fire Prevention and Control

NYS Department of State

OFFICE OF
FIRE PREVENTION
& CONTROL

One Commerce Plaza
99 Washington Avenue, Suite 500
Albany, NY 12231-0001
Phone: 518-474-6746
Fax: 518-474-3240
E-mail: fire@dos.state.ny.us
Website: www.dos.state.ny.us/fire

carbon monoxide is a stealthy killer

[illegible] symptoms of CO poisoning?

The symptoms of CO poisoning are flu-like, including headache, fatigue, nausea, dizziness, and confusion. Prolonged exposure can result in vomiting, blackouts, and, eventually, brain damage and death. The amount of CO inhaled and how long you are exposed to it determines the effect.

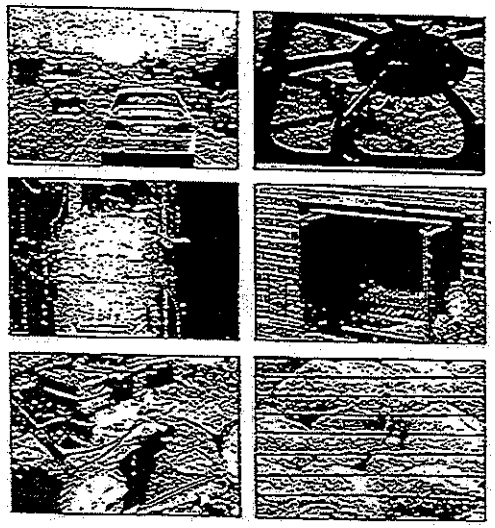
What can be done to prevent CO poisoning?

- Make sure appliances are installed according to the manufacturer's instructions and by professionals.
- Have heating systems inspected and serviced at least once a year.
- Make sure chimneys and vents are checked for blockages, corrosion, and loose connections.
- Open flues completely when fireplaces are in use.
- Use proper fuel in space heaters.
- Never burn charcoal or a barbecue grill inside a home or enclosed space.
- Never use portable fuel-burning camping equipment inside a home, garage, vehicle, or tent.
- Never leave a car, mower, or other such item running in an attached garage, even with the garage door open.
- Never operate unvented fuel-burning appliances in any room where people are sleeping.
- Never use the kitchen range for heating a house.
- Never run a gas powered generator in a garage, basement, or near any overhang on the home. Keep it at a distance.

Where does CO come from?

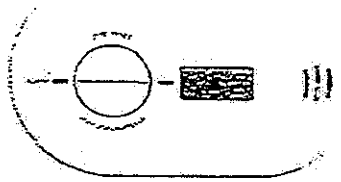
CO is a product of incomplete combustion. Any fuel-burning device has the potential to produce dangerous levels of CO gas. Examples of common devices that may emit CO include:

- Fuel-fired furnaces (not electric)
- Gas water heaters
- Fireplaces and wood stoves
- Gas stoves
- Non-electric space heaters
- Gas dryers
- Charcoal grills
- Lawnmowers, snowblowers, etc.
- Automobiles
- Gas powered generators



How can I tell if CO is present in my home?

Since carbon monoxide is colorless, odorless, and tasteless, the best way to alert your family is to install a carbon monoxide detector/alarm to warn of the gas's build-up.



A Common Home CO Detector

Where should CO detection be installed?

CO is almost identical in weight to air and thus mixes freely in it. For this reason, alarms may be installed at any level in a room.

If the detector is being mounted on a ceiling, it should be installed away from existing smoke alarms in order to be able to distinguish between the CO and smoke alarms in an emergency.

Every home should be equipped with at least one CO alarm near the sleeping area. For maximum protection, additional alarms should be located on each level of your home.

What should I do if the CO alarm sounds?

Stay calm. Most situations resulting in activation of a CO detector are not life threatening and do not require calling the fire department. To determine if emergency services should be called, ask everyone in the house:

"Do you feel ill? Do you have flu-like symptoms of headache, nausea, or dizziness?"

If the answer to these questions by anyone in the house is "yes," evacuate the house and have someone call the fire department. Failure to get out immediately may result in prolonged exposure, worsening effects from the CO. The best initial treatment for CO exposure is fresh air.

If the answer to the questions, by everyone, is "no," the likelihood of a serious exposure is much less and you may not need to call the fire department. Instead, turn off all fuel-burning devices, ventilate the area, and attempt resetting the alarm. If the alarm will not reset or resounds, call a qualified technician to inspect, service, and/or repair your fuel-burning device. If at any time during this process someone begins to feel ill with the symptoms described above, evacuate everyone from the building to a safe location and call the fire department.

Infection Control Plan

This Agency's Infection Control Plan is an organization-wide integrated process designed to minimize the risk of development of health care-associated infections [HAIs]. The Plan includes strategies for the identification, prevention and control of infections among patients, caregivers and employees in all programs, services and settings. Additionally, this Plan shall facilitate performance improvement activities as they relate to patient and employee safety, environmental safety and equipment management.

Based upon the geographic location and community environment[s] of our patients, the services provided, the characteristics inherent in our population, and the results of the analysis of our infection prevention and control data, this Agency evaluates and reassesses risks for the acquisition and transmission of infectious agents on an ongoing basis.

The current prioritized risks for our organization include the following:

Community: Due to the fact that many of our patients attend school, or have school-age siblings residing with them, this Agency's priority risks include all ***upper respiratory infections, such as Pneumonia and RSV, MRSA and Conjunctivitis***. Therefore, specific surveillance activities include monitoring patient exposure and taking appropriate, proactive action in order to minimize or mitigate the risk of infection transmission.

Analysis of Results of Previous Infection Control Data: Based upon analysis of historical data, this Agency has included the following infections in its priority risks: ***Tracheitis, Stoma Infections and Otitis Media***. These infections are common among our current patient population and therefore require continual monitoring and intervention. This organization's Performance Improvement program provides a planned systemic, organization-wide approach to evaluating and where necessary, improving the appropriateness of its systems and the quality of patient care.

Geography / Environment: Given the geographical location of the Agency, its service area and population, our patients, their families and Agency staff are susceptible to the measles and seasonal infections such as ***Influenza***.

Addendum to the Infection Control Plan 2020

J & D Ultracare has been closely monitoring the recent outbreak of Novel Corona (COVID-19) virus.
More cases of COVID-19 are likely to be identified in the coming days, including more cases in the United States. It's also likely that person-to-person spread will continue to occur, including in communities in the United States. It's likely that at some point, the widespread transmission of COVID-19 in the United States will occur.
Effective immediately, any nurse who has traveled recently must report to the agency the location they traveled. J & D will be notifying your patient's family of any such travel. It will be the sole discretion of the individual family to decide if you may return to their home immediately, or whether they will ask for a clearance period.
If you are exhibiting any symptoms of sickness or have been exposed to anyone who has traveled, we ask that you inform the office immediately and stay at home until symptoms subside and fever free for 48 hours.
As an agency, we are implementing a two-week clearance period if the nurse has traveled to areas deemed a Level 3. During that initial two weeks, we are asking our nurses to conduct all necessary business with the office remotely. If you need help in doing so, please reach out.

Precautions the Agency has implemented:

- We have taken inventory of all of our PPE on hand and made attempts to secure additional supplies.
- Staff and families should access information on COVID-19 provided by the CDC and World Health Organization Websites.
- We have added important COVID-19 updates to our website.
- Our Policies can be accessed via EMR through Attachments; Resource Folder:
- Infection Control Policy and Hand Hygiene for both nurses and families.
- We will continue to identify both families and nurses who have traveled recently.
- We have started to conduct an emergency preparedness survey with both families and nurses.
- We have updated, revised and tested our emergency preparedness plan.

STATEMENT OF GOALS and OBJECTIVES:

Our organization's Infection Control goals for this year are:

- To limit unprotected exposure to pathogens. Assure referrals from discharge planners or primary physicians address the presence of communicable diseases. Notification to staff going into the home if precautions beyond standard precautions are indicated.
- To improve hand hygiene. Increasing compliance assuring hand hygiene materials are accessible. Alcohol-based rubs, soap, and paper towels should be in easy access for the healthcare worker at point of care. Goal for 2020 set for 92% compliance rate.
- To minimize the risk of transmitting infections associated with the use of medical equipment, appropriate storage, cleaning and disinfecting as per manufacturer guidelines.
- To improve response [to infection control strategies] through education and training for all patients, caregivers, staff, and the community as appropriate. Educational pamphlets and education Respiratory Hygiene Etiquette.
- To improve in employee health-related issues; screening, handling of infections exposures and influenza vaccination program.
- To identify potential infectious situations quickly and take appropriate action. Notification to physician for treatment plan, notification to other family members and staff to take appropriate precautions.

STRATEGIES FOR IMPLEMENTATION:

In accordance with New York State Department of Health and Joint Commission guidelines, and all other applicable laws and regulations, this Agency shall implement, at a minimum, the following strategies for infection prevention and control:

- Upon hire and at least annually thereafter, orientation for all staff shall include proper infection control guidelines, Hand Hygiene Precautions and guidelines for the appropriate storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment, and the reuse of equipment designated by the manufacturer as disposable.
- Agency shall perform unannounced supervisory visits of field staff in order to monitor compliance with Infection Control protocols and provide opportunities for positive reinforcement, education on the spot and tracking of missed opportunities for compliance.
- Agency shall provide additional education opportunities for field staff as deemed necessary.
- Agency shall encourage all field staff to receive flu vaccines, as appropriate, and shall provide such.

- Agency shall mandate that all field staff be tested for TB annually, and shall provide such testing. **CDC Division of Tuberculosis Elimination Guidelines**
- Agency shall offer all staff the Hepatitis B vaccine.
- In accordance with NYS DOH regulations, Agency shall require all employees to provide proof of an annual health assessment and immunizations [upon hire].
- Agency shall prohibit any nurse with a health condition that may interfere with the safe provision of direct patient care, including but not limited to communicable infections, conjunctivitis, open wounds, exudative lesions or weeping dermatitis, from administering patient care and from handling patient care equipment until s/he receives physician clearance to resume patient care.
- Should this Agency identify staff as potentially having an infectious disease or risk of infectious disease – regardless of how the exposure occurred - the Agency shall direct said staff to his/her physician for appropriate assessment, testing, treatment, as indicated and any further follow up deemed necessary by the physician.
- Agency shall provide patients, caregivers and staff with non-sterile latex free gloves. Additionally, alcohol-based waterless hand cleanser will be provided to all field staff.
- Agency shall provide field staff with appropriate personal protective equipment. The employee shall use protective equipment when s/he is at risk of exposure to blood and/or bodily fluids.
- Agency staff shall use universal precautions at all times, and shall implement transmission-based precautions as indicated.

Employee Safety and Health Guidelines

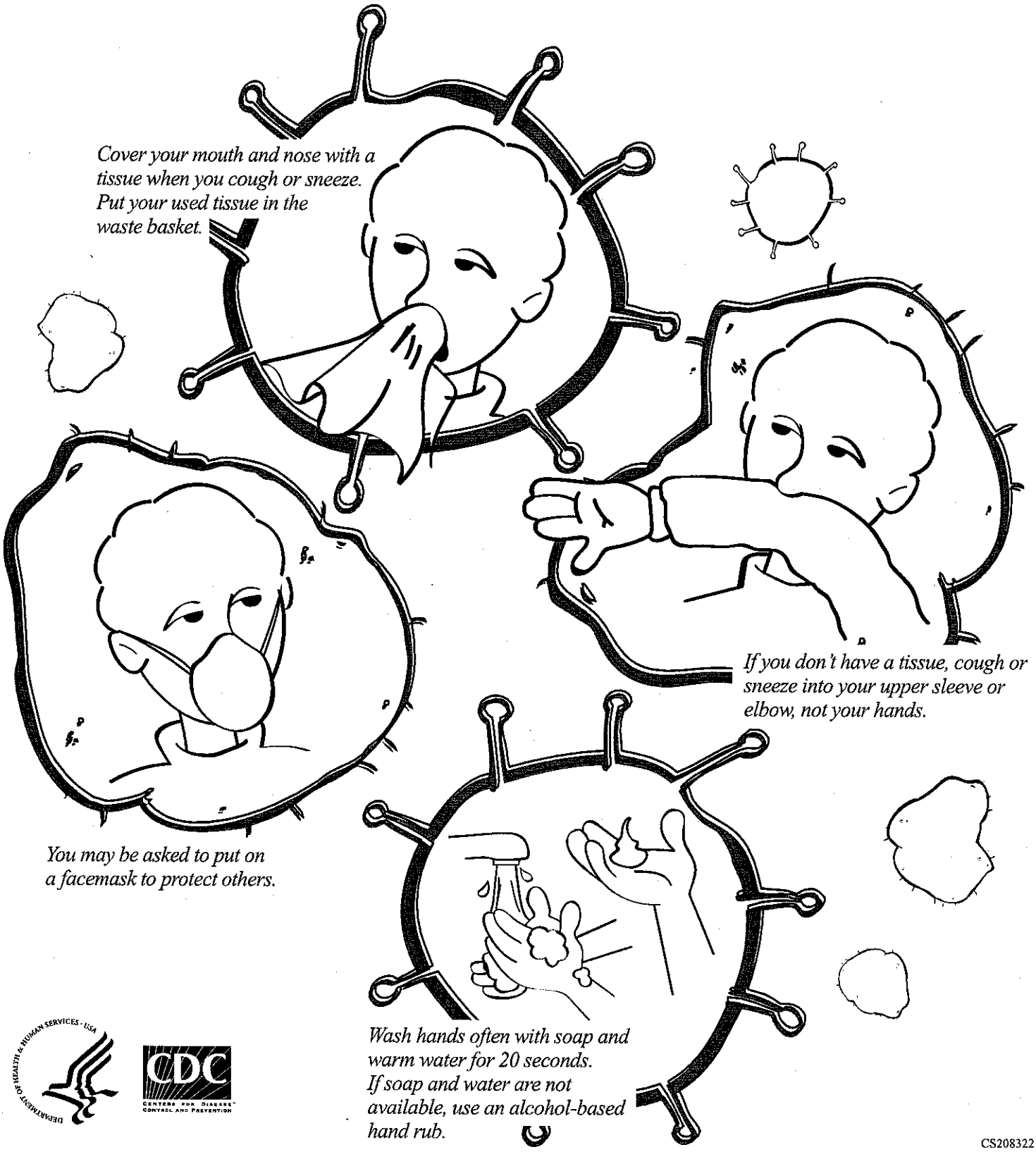
- Patient / caregiver education regarding infection control methods will be assessed and reinforced continuously, with additional instruction provided as needed.
- Pertinent infection prevention and control information shall be accessed regularly via Joint Commission, Department of Health, Health Commerce System, and CDC websites. Additionally, related healthcare information is received via trade publications, newsletters, newspapers and TV stations. As appropriate, information shall be considered for inclusion in the Agency's Infection Control Plan and shall be communicated to patients, caregivers and field staff.
- All patient and staff infections are documented and tracked by the Clinical Department for purposes of identifying trends and patterns, and determining the need for process changes and/or reprioritization [if required] based upon new findings.
- In accordance with applicable laws, regulations, local public health authorities and accrediting bodies, this Agency shall adhere to systems for reporting infection surveillance, prevention and control information.
- Should this Agency become aware of a patient's active infection following the referral or transfer of said patient, this Agency shall communicate the omission to the referring and/or receiving organization.
- Surveillance activities including data collection and analysis are used to identify infection prevention and control of risks pertaining to patients and staff.
- At least four times annually and whenever risks significantly change, leadership shall evaluate the organization's Infection Control Plan in order to measure its performance, strategy effectiveness and outcomes. This evaluative process shall address changes in the results of the Infection Control Program, and shall facilitate redesign, restructure and / or re-prioritization of risks and goals for the organization's Infection Control and Patient Safety Programs as needed.

Should this Agency encounter an influx of infection to our current patient population, the following actions would be taken:

- Temporary halting of all services in order to prevent spread of infection to Agency field staff.
- Prohibited contact between exposed staff and all other patients and/or staff.
- Recommendations to exposed patients, caregivers and staff to strictly limit visitors and community outings.
- Through association with various local departments of health and other health facilities, should this Agency be asked to accept new, infected patients for service, the Agency would decline doing so, and no new patients would be accepted.
- Throughout such an "infection" crisis, the Agency shall maintain current information regarding the status of the particular infectious outbreak via communication with the Department of Health, CDC, Joint Commission, Health Commerce System and any other available, reliable news source. Upon receipt of new information, the Agency shall communicate this information to patients, caregivers and field staff via telephone, email, fax or any other efficient means of relaying information.
- The designated individual[s] responsible for managing the Infection Control Program shall coordinate all infection prevention and control activities within the organization and facilitate ongoing monitoring of the effectiveness of all activities and interventions. The designated individual[s] and organization leadership shall collaboratively participate in the development of strategies for the Infection Control Program, assessment of the adequacy of resources allocated to support infection prevention and control activities, assessment of the overall success or failure of key processes for preventing and controlling infection, and the review and revision of the IC Program as warranted to improve outcomes.

Cover your Cough

Stop the spread of germs that can make you and others sick!



Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.

If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.

You may be asked to put on a facemask to protect others.

Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CS208322

POLICY AND PROCEDURE

Hand Hygiene – IC-15

EFFECTIVE DATE: 03/15/07

REQUIREMENT

To reduce the risk of health care-associated infections this agency will comply with the CDC guidelines hand hygiene guidelines. Health care-associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. To ensure compliance with the CDC guidelines and the National Patient Safety Goals (The Joint Commission) this agency will establish a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.

IMPLEMENTATION

Upon hire and/or acceptance to this Agency for service, employees, patients and their caregivers will be informed of the importance of strict adherence to proper hand hygiene and will be informed of the appropriate guidelines. Improved compliance with hand hygiene guidelines based on annual goals set for this agency.

See Attached CDC Hand Hygiene Fact Sheet.

Healthcare Providers

Protect yourself and your patients from potentially deadly germs by cleaning your hands. Be sure you clean your hands the right way at the right times.

What is Hand Hygiene?
Hand Hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis

Why Practice Hand Hygiene?
Cleaning your hands reduces:

- The spread of potentially deadly germs to patients
- The risk of healthcare provider colonization or infection caused by germs acquired from the patient

Two Methods for Hand Hygiene: Alcohol-Based Hand Sanitizer vs. Washing with Soap and Water

- Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers.
- Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations.
- Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.

During Routine Patient Care:

Use an Alcohol-Based Hand Sanitizer

- Immediately before touching a patient
- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
- Before moving from work on a soiled body site to a clean body site on the same patient
- After touching a patient or the patient's immediate environment
- After contact with blood, body fluids or contaminated surfaces
- Immediately after glove removal

Wash with Soap and Water

- When hands are visibly soiled
- After caring for a person with known or suspected infectious diarrhea
- After known or suspected exposure to spores (e.g. *B. anthracis, C difficile* outbreaks)

Healthcare Providers

When to Perform Hand Hygiene?

Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene:

Use an Alcohol-Based Hand Sanitizer

- Immediately before touching a patient
- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
- Before moving from work on a soiled body site to a clean body site on the same patient
- After touching a patient or the patient's immediate environment
- After contact with blood, body fluids or contaminated surfaces
- Immediately after glove removal

Wash with Soap and Water

- When hands are visibly soiled
- After caring for a person with known or suspected infectious diarrhea
- After known or suspected exposure to spores (e.g. *B. anthracis, C difficile* outbreaks)

Techniques for Using Alcohol-Based Hand Sanitizer
When using alcohol-based hand sanitizer:

- Put product on hands and rub hands together
- Cover all surfaces until hands feel dry
- This should take around 20 seconds

Techniques for Washing Hands with Soap and Water

- The CDC Guideline for Hand Hygiene in Healthcare Settings pdf icon[PDF – 1.3 MB] recommends:
  - When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.
  - Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet.
  - Avoid using hot water, to prevent drying of skin.
- Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. (Either time is acceptable. The focus should be on cleaning your hands at the right times)

Healthcare Providers

When and How to Wear Gloves

- Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur.
- Gloves are not a substitute for hand hygiene.
    - If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment.
    - Perform hand hygiene immediately after removing gloves.
- Change gloves and perform hand hygiene during patient care, if
    - gloves become damaged,
    - gloves become visibly soiled with blood or body fluids following a task,
    - moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs.
- Never wear the same pair of gloves in the care of more than one patient.
- Carefully remove gloves to prevent hand contamination.

Skin and Nail Care

Methods to Maintain Hand Skin Health

- Lotions and creams can prevent and decrease skin dryness that happens from cleaning your hands
- Use only hand lotions approved by your healthcare facility because they won't interfere with hand sanitizing products

Fingernail Care and Jewelry

- Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing
- It is recommended that healthcare providers do not wear artificial fingernails or extensions when having direct contact with patients at high risk (e.g., those in intensive-care units or operating rooms)
- Keep natural nail tips less than ¼ inch long
- Some studies have shown that skin underneath rings contains more germs than comparable areas of skin on fingers without rings
- Further studies are needed to determine if wearing rings results in an increased spread of potentially deadly germs

HOW TO ENGAGE YOUR PATIENTS:

Make hand hygiene a topic of conversation with your patients.

ADDRESS HAND HYGIENE BEFORE YOU BEGIN CARE

Explain how and why you clean your hands before, after, and sometimes during patient care.

DISCUSS AND ACT

Let your patients know it's OK to ask you about hand hygiene. They might request that you clean your hands. Put them at ease and clean your hands for them!

Discuss how and why patients should also clean their hands.

THANK THEM FOR BEING ENGAGED IN THEIR CARE

Hand hygiene works better when patients and healthcare providers work together.

Contact CDC:

www.cdc.gov/info
800-CDC-INFO
(800-232-4636)
TTY 888-232-6348

CLEAN HANDS COUNT

CDC

Learn more at:

www.cdc.gov/HandHygiene

This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and GOJO.

CLEAN HANDS COUNT

FOR HEALTHCARE PROVIDERS

Protect yourself and your patients from potentially deadly germs.

CLEAN HANDS COUNT

No matter where you treat patients, clean hands count.

Your hand hygiene affects patients wherever they go...

Did you know...?

- Studies show that some healthcare providers practice hand hygiene **less than half of the times they should.**
- Healthcare providers might need to clean their hands as many as **100 times per 12-hour shift,** depending on the number of patients and intensity of care. Know what it could take to keep your patients safe.

When using alcohol-based hand sanitizer:

Wearing gloves is not a substitute for hand hygiene.

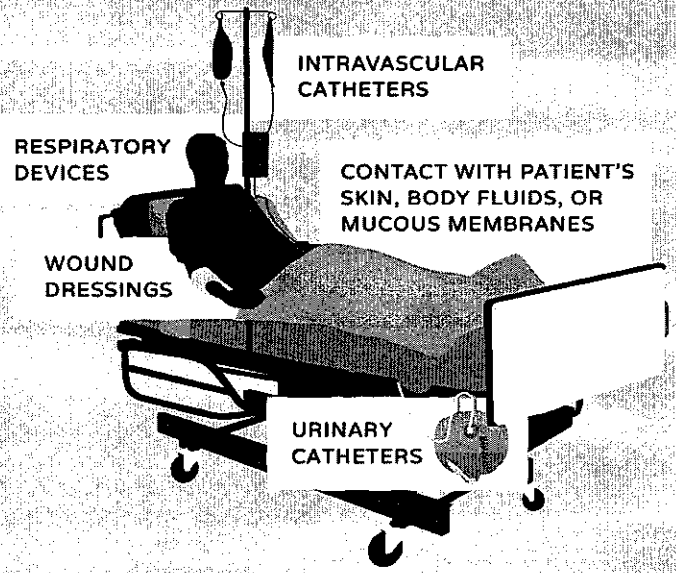
Dirty gloves can soil your hands. **Always clean your hands** after removing gloves.

It's also important to **remove or change your gloves if:**

- Gloves are damaged
- Moving from a contaminated body site to a clean body site
- Gloves look dirty, or have blood or bodily fluids on them after completing a task

Practice hand hygiene before and after every patient contact.

Clean hands count in the **Patient Zone:**

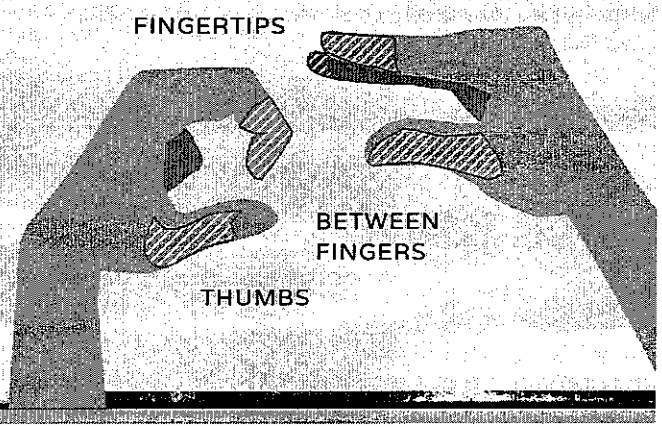


Did you know...?

- **Always use gloves when caring for patients with *C. difficile*.** In addition, when there is an outbreak of *C. difficile* in your facility, wash your hands with soap and water after removing your gloves.
- **For alcohol-based hand sanitizer,** your hands should stay wet for around 20 seconds if you used the right amount.
- When washing your hands with **soap and water,** avoid hot water, to prevent drying of skin, and use disposable towels to dry.

Areas you might miss:

These areas are most often missed by healthcare providers when using alcohol-based hand sanitizer.



YOU HAVE A VOICE

PROTECT YOURSELF BY
ASKING QUESTIONS

Clean your own hands and ask everyone to do the same.

It's important to ask your healthcare providers questions about your healthcare, such as:

"I didn't see you clean your hands when you came in, would you mind cleaning them again before you examine me?"

"I'm worried about germs spreading in the hospital. Will you please clean your hands once more before you start my treatment?"

Ask your visitors to clean their hands too:

"You cleaned your hands a while ago when you got here, but could you please clean them again? It would help put me at ease."

Learn more at:
www.cdc.gov/HandHygiene

Contact CDC:

www.cdc.gov/info
800-CDC-INFO
(800-232-4636)
TTY 888-232-6348

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PATIENTS AND VISITORS

CLEAN HANDS COUNT

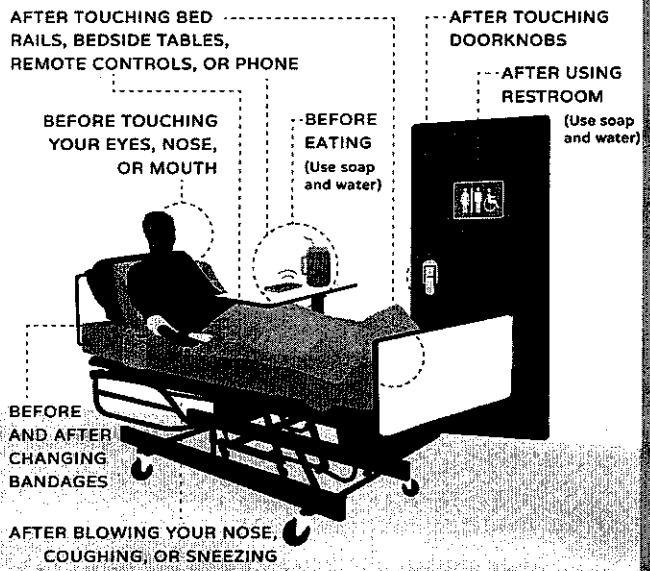
PROTECT YOURSELF FROM SERIOUS INFECTIONS

CLEAN HANDS COUNT FOR YOUR PROTECTION

Did you know...?

- Cleaning your hands is a great way to protect yourself from serious infections.
- Every patient is at risk of getting an infection while they are being treated for something else.
- Preventing the spread of germs is especially important in hospitals and other facilities such as dialysis centers and nursing homes.

PATIENTS AND VISITORS: When to clean your hands



What is alcohol-based hand sanitizer?

- A product that kills germs on the hands.
- It should contain 60% to 95% alcohol.

Use alcohol-based hand sanitizer:

When hands do not look dirty.

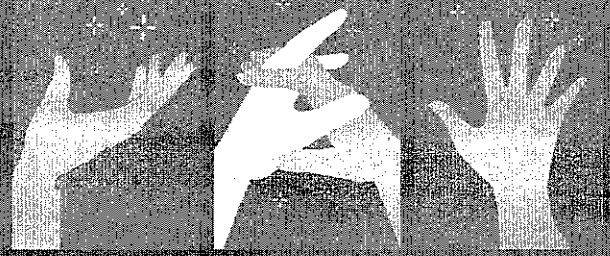
Use soap and water:

When hands look dirty.

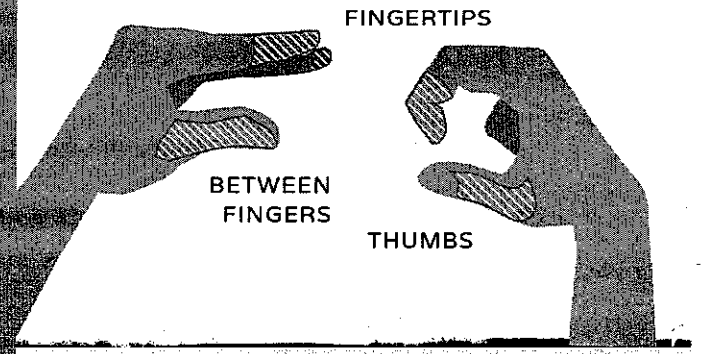
If you have a *C. difficile* infection.

Before eating and after using the restroom.

When using alcohol-based hand sanitizer:



People often miss certain areas when cleaning their hands using alcohol-based hand sanitizer:



What if I have a *C. difficile* infection?

- *C. difficile*, or *C. diff*, causes severe diarrhea.
- If you have a *C. diff* infection, you should wash your hands with soap and water.
- Your healthcare providers should wear gloves while caring for you.

Healthcare providers need to clean their hands:

- Every time they enter your room and when they remove gloves.
- Wearing gloves alone is not enough to prevent the spread of infection.

Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

POLICY AND PROCEDURE

HIV Confidentiality - Related Information – D2A

REQUIREMENT

In accordance with New York State Department of Health and The Joint Commission guidelines, this Agency will adhere to all requirements for ensuring patient privacy and confidentiality.

Implementation:

During the initial orientation of new staff and annually thereafter, all employees shall be oriented to the Agency's HIV Confidentiality Policy and their individual responsibilities in carrying out the Plan. The Policy shall be reviewed at least annually by the Agency's Management Team and Staff. All Agency staff shall be notified when there are changes to the Plan.

Confidentiality and disclosure:

No person who obtains confidential HIV-related information in the course of providing any health service or pursuant to a release of confidential HIV-related information may disclose or be compelled to disclose such information.

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient for further disclosure.

Generally, HIV-related information may only be disclosed if the person signs an approved HIV release form. The Department of Health form, HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information (DOH 2557), is used for this purpose. This form allows the release of both non-HIV- and HIV-related information.

Confidential HIV-related information shall be recorded in the medical record such that it is readily accessible to provide proper care and treatment.
Under certain circumstances HIV-related information may be disclosed without and approved HIV release form:

For medical treatment:

- Medical professionals working on the treatment team with the person's existing provider may discuss a patient's HIV-related information with each other or with their supervisors, but only to give necessary care. The general release is needed to disclose medical information to a provider who is not affiliated with the person's current medical provider.

- With a general consent, a hospital or health care provider may share HIV-related information with a patient's insurance company if the information is needed to pay for medical care;
- Disclosure may occur without consent in certain cases of on-the-job exposure to HIV when all criteria for exposure have been met;
- Parents or guardians of a minor or individuals who are legally authorized to provide consent can be given HIV-related information about a person if it is necessary to provide timely care, unless it would not be in the person's best interest to disclose the information;
- Additionally, health care facility staff and committees, oversight review organizations, or government agencies that are authorized to have access to medical records may be given HIV-related information when it is needed to supervise, monitor, or administer health services.

Prevention Strategies

To prevent transmission of HIV to health care workers in the workplace, health care workers must assume that blood and other body fluids from all patients are potentially infectious. They should therefore follow these infection control precautions at all times:

- Routinely use barriers (such as gloves and/or goggles) when anticipating contact with blood or body fluids.
- Immediately wash hands and other skin surfaces after contact with blood or body fluids.
- Carefully handle and dispose of sharp instruments during and after use.

Safety devices have been developed to help prevent needle stick injuries. If used properly, these types of devices may reduce the risk of exposure to HIV. Many percutaneous injuries, such as needle sticks and cuts, are related to the disposal of sharp-ended medical devices. All used syringes or other sharp instruments should be routinely placed in "sharps" containers for proper disposal to prevent accidental injuries and risk of HIV transmission.

Although the most important strategy for reducing the risk of occupational HIV transmission is to prevent occupational exposures, plans for post exposure management of health care personnel are in place.

This agency follows CDC protocol for the management of health care worker exposures to HIV and recommendations for post exposure prophylaxis (PEP)

Occupational exposure is considered an urgent medical concern and should be managed immediately after possible exposure - the sooner the better; every hour counts. The CDC guidelines outline considerations in determining whether health care workers should receive PEP (antiretroviral medication taken after possible exposure to reduce the chance of infection with HIV) and in choosing the type of PEP regimen. For most HIV exposures that warrant PEP, a basic 4-week, two-drug regimen is recommended, starting as soon as possible after exposure (within 72 hours). For HIV exposures that pose an increased risk of transmission (based on the infection status of the source and the type of exposure), a three-drug regimen may be recommended. Special circumstances, such as a delayed exposure report, unknown source person, pregnancy in the exposed person, resistance of the source virus to antiretroviral agents, and toxicity of PEP regimens, are also discussed in the guidelines.

Rev: 12/31/2015 /dm
Rev: 08.2018 /dm

UNIVERSAL PRECAUTIONS

Universal Precautions for all Health Care Workers include the following:

- Assume that all blood / body fluids, with or without visible blood, are potentially infectious.
- Hands must be washed before and after patient contact. Should any other body surface become contaminated with blood / body fluids, body surface[s] should be washed immediately with soap and water.
- Non-sterile latex-free gloves must be worn when providing direct patient care, handling items soiled with blood / body fluids, and when handling equipment contaminated with blood / body fluids. Gloves should be changed after each patient contact. When gloves are removed, thorough hand washing is required. Gloves **do not** replace the need for hand washing.
- Goggles or protective glasses should be worn when there is a potential for a splash with blood / body fluids.
- Gowns or aprons should be worn when there is a potential for blood / body fluid splatters or sprays.
- Masks should be worn if there is potential for splash or splatters, or when the patient is on respiratory precautions.
- Although saliva has not been implicated in HIV transmission, a one-way airway mouthpiece, resuscitation bag or other ventilation device should be in the home for use during resuscitation, when resuscitation is predictable.
- To prevent needle stick injuries, needles should never be recapped, bent, broken or manipulated by hand. All sharps should be considered potentially infectious and handled with extraordinary care. Used, intact needles should be placed in puncture resistant containers. Full containers should be disposed properly per community requirements for biohazardous waste. If an infusion company has provided the sharps container, the company is responsible for its disposal.
- All laboratory specimens should be treated as if contaminated. All specimens should be clearly marked as such and transported in a well-constructed container with a secure lid.
- Double bagging technique should be used for the disposal of all contaminated supplies other than needles.
- Areas and equipment contaminated with blood / body fluids should be cleaned as soon as possible with 1:10 bleach solution. Equipment can also be cleaned thoroughly and soaked in 70% isopropyl alcohol for ten minutes to inactivate HIV. A fresh solution must be used daily.
- Soiled linens should be handled as little as possible, with minimum agitation to prevent gross microbial contamination of the air and persons handling the linen. Linens soiled with blood / body fluids should be placed in leak-proof bags until they can be properly washed. Such linens should be washed separate from regular household laundry.

Influenza Policy and Procedure

IC-16

POLICY

Vaccination Status

All J&D Ultracare employees shall be offered the influenza vaccine during the Agency's annual influenza vaccination program.

On or before November 1st of each year, employees will be required to either receive vaccination or complete a vaccination declination. The Agency will maintain documentation of each employee's vaccination status.

Should a vaccine shortage occur, or CDC recommendations are altered, the Agency reserves the right to suspend or revoke all or part of this policy. In the event of a vaccination shortage, the Agency will offer vaccinations based upon availability.

Masking Requirements

In accordance with NYS DOH guidelines, all unvaccinated personnel are required to wear a surgical mask while providing direct patient care during periods that the Commissioner of Health has determined influenza to be prevalent in the Agency's service area.

PROCEDURES

General Requirements

All Agency employees will be required to receive the influenza vaccine or complete the declination each year on or before **December 1, 2023.**

The Clinical Operations Manager and/or his/her designee shall continually monitor the State's HPN website for declarations that flu is prevalent and/or no longer prevalent in the Agency's service area.

The Clinical Operations Manager and/or his/her designee shall monitor and report Agency employee vaccination status as required by the Department of Health.

Influenza Policy and Procedure

IC-16

IMPLEMENTATION

- J&D Ultracare shall offer the influenza vaccination annually to Agency employees.
- The Influenza Vaccination will be administered to employees in accordance with published CDC guidelines, based upon vaccine availability.
- The Agency shall provide written notification to all Agency staff and patients / families explaining the State's masking requirements.
- The Agency shall monitor receipt of documentation regarding employee vaccination status, and submit the Healthcare Personnel Influenza Vaccination Report as required by the NYS Department of Health.
- AS an employee of this agency you consent to information sharing as it relates to your influenza status which may be shared with our patients and families.
- The Agency encourages families to request proof of vaccination from their nurses or to request they be masked while providing care.

RESPONSIBILITIES

Employees shall be responsible for:

- Reviewing this policy and submitting signature as confirmation of receipt, review and understanding upon hire and annually thereafter.
- Submitting evidence of vaccination or declination of vaccination to the Agency on or before **December 1st** of each year.
- If hired during the annual influenza vaccination program, employees shall submit required documentation within **1 month** of date of hire.
- Follow NYS DOH masking requirements, if not vaccinated.
- Nurses should either be vaccinated or masking to comply with Department of Health regulations.
- Non-compliance to requirements, the nurse will be placed in the discipline process ranging from verbal consultation to termination, the Agency's Management Team reserves the rights to make disciplinary decision as related to employee's status within the agency.

Clinical Operations Manager / Clinical Department shall be responsible for:

- Obtaining and ensuring an adequate supply of vaccination for administration to employees.
- Following DOH and CDC guidelines for storage and administration of the vaccination.

- Training clinical staff in the appropriate administration of the influenza vaccine, in accordance with DOH and CDC guidelines.
- Providing employees [wishing to receive the vaccine] with the CDC's current Vaccine Information Statement.
- Obtaining a signed *Influenza Vaccination Consent* from all employees wishing to obtain the vaccination from the Agency, prior to administration of the vaccination.
- Administering the influenza vaccination in accordance with CDC and DOH guidelines, and documenting the activity as required.
- Providing written notification to all Agency staff and patients / families explaining the State's masking requirements.
- Ensuring that Agency staff are appropriately equipped with personal protective gear including masks and gloves.
- Ensuring Agency and employee compliance with this policy
- Evidence of employees following appropriate guidelines when it has been deemed prevalent in our geographic area. Compliance completed monthly or as needed.

  Methods:
  Telephonic communication documented by care coordinator with on-site family, patient and or caregiver within the home setting. (Form: Telephonic Flu Masking Supervision) and/ or
  On-site supervision by field supervisor and / or care coordinator. (Form: Flu Masking Supervision)

The Human Resources shall be responsible for:

- Reviewing this policy with new Agency employees during orientation, and providing employees with annual reminders of the Agency's flu vaccine policy, and obtaining required documentation of employee vaccination status.
- If an employee has obtained vaccination from another facility, documentation must include: Date, Dose, Type, Lot #, Expiration date of vaccine and Signature of person who administered the vaccination.
- *In lieu of the above, employees who are employed by a healthcare employer other than this Agency may submit a written or emailed attestation by his/her employer indicating that the employee named in the attestation has been vaccinated against influenza for the current influenza season, and that the healthcare employer maintains documentation of vaccination of those employees.*
- Providing vaccination cards to employees upon receipt of appropriate vaccination documentation.

Utilization Review / Performance Improvement

- Distribute flu vaccination information and required forms for completion to Agency staff and patients / families on or before September 1st of each year.

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A Professional Home Care Nursing Agency

Influenza Policy and Procedure

IC-16

- Review annual employee influenza vaccination rates as per the Healthcare Personnel Influenza Vaccination Report [as required by the NYS Department of Health].
- Review will consist of the following:
- Determine the number of employees who worked for the Agency from
    - October 1 – May 31
- Determine the number of employees with direct patient contact from
    - October 1 – May 31
- Determine the numbers of employees who have submitted:
    - proof of vaccination administered by the Agency
    - proof of vaccination administered by an entity other than this Agency
    - vaccination declinations [including reason for declination]
- Determine the number of employees with an unknown vaccination status

- Report Agency findings to the NYS Department of Health and the Agency's Professional Advisory Committee at least annually.

- Develop strategies for improving influenza vaccination rates Agency-wide with a goal to improve vaccination rates by 2% annually to meet the established national influenza initiatives by 2020.

The Joint Commission

2024 Home Care National Patient Safety Goals

(Easy-To-Read)

Identify patients correctly

NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Use medicines safely

NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Prevent infection

NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Prevent patients from falling

NPSG.09.02.01	Find out which patients are most likely to fall. For example, is the patient taking any medicines that might make them weak, dizzy or sleepy? Take action to prevent falls for these patients.

Identify patient safety risks

NPSG.15.02.01	Find out if there are any risks for patients who are getting oxygen. For example, fires in the patient's home.

POLICY AND PROCEDURE
Medication Management – N5A
Effective 04.20.2009

REQUIREMENT
In accordance with New York State Department of Health and The Joint Commission guidelines, this Agency will maintain ongoing processes to facilitate safe, appropriate and effective medication management for all patients.

IMPLEMENTATION
To safely and accurately coordinate Medication Management across the continuum of care, the following information is to be available to all individuals involved in medication management at all times

AGE
SEX
DIAGNOSES
ALLERGIES
SENSITIVITIES
CURRENT MEDICATIONS
HEIGHT AND WEIGHT IF NEEDED
PREGNANCY AND LACTATION
INFORMATION, IF NEEDED
LABORATORY VALUES IF NEEDED

The Agency will maintain a High Alert Medication List for the purpose of comparing each medication in use prior to administration. High Alert Medications include, but are not limited to, medications that:

HAVE BEEN INVOLVED IN A HIGH PERCENTAGE OF ERRORS / SENTINEL EVENTS
CARRY HIGH RISK FOR ABUSE OR OTHER ADVERSE OUTCOMES
ARE INVESTIGATIONAL IN NATURE
ARE CONTROLLED SUBSTANCES
ARE NOT APPROVED BY FDA
HAVE A NARROW THERAPEUTIC RANGE
ARE PSYCHOTHERAPEUTIC
ARE INDICATED ON THE AGENCY'S LOOK A LIKE AND SOUND A LIKE DRUG LIST

This Agency will provide guidance to agency staff and families for the safe handling and administration of medications designated as High Alert Medications.

ISMP (Institute of Safe Medication Practice)
http://www.ismp.org/tools/confuseddrugnames.pdf

List of High Alert Medications in Community/Ambulatory Healthcare Attachment page 9
High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. These medications require special safeguards to reduce the risk of errors and minimize harm
The following medications are appropriate for inclusion as High Alert Medications for this agency.
All Pediatric liquid medications requiring measurement, Opioids, all formulations, Midazolam liquid, for sedation of children.

LASA (look-alike sound-alike) Drug List: Anticonvulsants
Confusing drug names is a common system failure. Unfortunately, many drug names can look or sound like other drug names, often leading to potentially harmful medications errors. The following is a list of frequently administered drugs by our staff.

Topamax (topiramate)
Don't confuse Topamax with Toprol-XL, Tegretrol, or Tegretrol-XR

Tegretrol (carbamazepine)
Don't confuse Tegretrol or Tegretrol-XR with Topamax, Toprol-XL, or Toradol. Don't confuse Carbatrol with carvedilol

Lamictal (lamotrigine)
Don't confuse lamotrigine with lamivudine or Lamictal with Lamisil, Ludiomil, labetalol, or Lomotil

Keppra (levetiracetam)
Don't confuse Keppra with Kaletra

Phenobarbital (phenobarbitone) Phenobarbital sodium (Luminal Sodium)Safety Alert: Controlled substance schedule IV
Don't confuse Phenobarbital with pentobarbital
Diastat (diazepam)
Safety Alert: Controlled substance schedule IV
Don't confuse diazepam and diazoxide
Depakene (valproic acid); Depacon, Depaken (valproate sodium); Depakote, Depakote ER, Depakote Sprinkle, Epival (divalproex sodium)
Don't confuse Depakote with Depakote ER

MEDICATION ORDERS

PowerPoint review on "How to Enter a "Change Order."

- A physician's / authorized practitioner 's order shall be required prior to any medication administration.
- Orders may be handwritten, faxed or electronically generated.
- Orders taken by field nurse are documented using "**Change Order"** within the E-Chart
- Client information will be pre-populated. Confirm correct episode period.
- Complete order must contain the following elements: Diagnosis, Name of Drug (Form/ Concentration/ Dose / Route / Frequency) calculate dose if applicable.
- Purpose Field: You must enter the purpose of the medication as the Change Order prepopulates the primary diagnosis only. Example: Penicillin-Step Throat:
- A medication order shall be held if there is a suspicion of, or a known reaction to, the medication prescribed. The physician / authorized practitioner shall be notified immediately; the nurse will document his/her findings and actions in the patient record; the patient / caregiver will be informed of the reason for the nurse's actions; and the Agency will be notified by the nurse.
- If the order is not clear, legible, complete or contains an unacceptable abbreviation, the nurse should not initiate therapy until obtaining clarification from the physician / authorized practitioner and, if necessary, requesting a signed duplicate, legible copy of the order.

THE FOLLOWING ARE DEEMED ACCEPTABLE BY THIS AGENCY:

PRN Medications: All PRN medication orders must include all *standard elements* of an order and a written *indication and specific frequency* for the specific medication. PRN orders for any controlled drug shall be valid for a maximum of six months.

Example: Tylenol (325mg tabs); give 325 mg/ 1 tab po every 4Hours PRN for temp > 100.5
Xopenex (0.63mg /vial) give 0.63 mg/ 1 vial every 3Hours PRN via nebulizer for wheezing

Standing Orders: Standing orders are not applicable for our patient population but are accepted by this Agency for the **administration of particular medications / vaccinations to Agency employees.** All Standing Orders must include all *standard elements* of a complete medication order, and:

- The Standing Order must be available for review at all times.
- A *signed consent* must be obtained from the employee receiving the immunization / vaccine when the drug is administered.

Example: Administer Influenza Vaccine 0.5ml IM to all employees of J&D Ultracare who have requested the vaccine during the influenza season.

THIS AGENCY ALLOWS THE USE OF BENEDRYL AND EPI PENS AS EMERGENCY MEDICATIONS.

- Emergency Medication[s] should be stocked in the most ready-to-administer form available.

In the event an emergency medication is used, restocked as soon as possible.

Automatic Stop Orders: Automatic Stop Orders are acceptable when the *duration* of the intended stoppage is clearly written with *timed end date.*

Example: Keflex (250 mg/ 5 ml) give 250 mg (5ml) PO every 12 Hrs x 10 days

Titrating Orders: Titrating Orders are acceptable when:

- The order includes all of the *standard elements* of a physician's order.
- The order indicates a clearly written *range for the progressive increase or decrease of the medication* in response to the patient's status.
- The order indicates *specific start and end doses.*
- The order indicates a *specific length of time by which the physician wishes to be contacted* should the patient not experience the desired clinical effect of the maximum dose allowable [within the range documented].

Taper Orders: Taper Orders are acceptable when they include all of the *standards elements* of an order, the *duration for each order and the start date of the first order.*

Example: Prednisone (15 mg/ tab) give 30 mg / 2 Tabs PO BID x 5 days. To start on 9/1/07. THEN

Prednisone (15 mg / 1 tab) give 1 tab PO BID x 3 days THEN
Prednisone (15 mg / 1 tab) give 1 tab PO Daily x 3 days THEN
Prednisone (15 mg / 1 tab) give 1 tab PO every other day x 2 days and then discontinue.

Range Orders: Range Orders are acceptable when all *standards elements* are present and indication for medication is written.

A "range order" is "Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or individual's status". **Depending on the situation or a patient's status the nurse** will administer the medication initially using the lowest dose and longest time frame ordered by the physician based on best practice.

Example: Oxycodone 5mg / Acetaminophen 325mg –
Give 1-2 Tabs Q 4-6 hrs PRN for pain

Initially the patient would receive 1 tablet. Prior to the administration of the next dose the nurse would make adjustments within the dose range based on patient's status, prior dose administered and effectiveness of prior dose depending on the situation or patient's status

Ranges in dosage: The nurse will use the 10-point pain scale to assess the patient's pain level. Unless otherwise specified in the physician's order, the nurse will use the following guidelines to administer the pain medication: Pain score 0-2 (mild pain): Administer lowest dosage in the range. Pain score 3-5 (moderate pain): Administer middle dosage in range or the lowest dosage that has been previously effective. Increase dosage upward as needed for pain control. Pain score 6-10 (severe pain): Administer highest dosage in the range.

Other Range orders:

Example: Miralax (17grams /capful) range via gtube daily mix in feeding:
Miralax range of 4.25 grams (1/4 cap) to 17 grams (1 capful) to be given based on stools frequency and consistency. May hold Miralax for extremely loose or watery stools or frequent stools.

Compounded Drug Orders: Compounded Drug Orders are acceptable when they contain all *standards elements* of an order AND *the generic name and dosage of each active ingredient* is specified.

Example: Nystatin 1% cream with hydrocortisone cream 2.5%.
Apply to affected area TID x 1 week. Call physician if rash has not resolved.

Orders for Medication-Related Devices: Orders for Medication-Related Devices are acceptable when the order contains all of *standard elements* of an order, AND *the specific delivery system is indicated.*

Example: Xopenex 1.25mg / vial give 1.25 mg via nebulizer QID

Orders for Investigational Medications: Orders for Investigational Medications are acceptable when they contain all *standard elements* of an order, and the patient [for whom the medication is intended] has *signed an informed consent* clearly indicating the purpose of the medication, the drug's potential risks, side effects and complications of treatment. In the case of a minor patient, the parent or legal guardian shall sign the consent.

Investigational Drugs: Prescribing Physician Must submit to agency:

- The approval, essential information concerning the use and action of the drug, as well as the arrangements for its administration and control must be reviewed.
- Nurses asked to administer investigational drugs will be informed of all basic information concerning such drugs including dosage forms, strengths available, actions and uses, symptoms of toxicity, etc.

Orders for Herbal Products: Orders for Herbal Products are acceptable when all the *standard elements* of an order are clearly indicated on the order.

Example: Cranberry extract 3 capsules via GB BID (475 mg per capsule) give 1425 mg

Orders for Medications at Discharge / Transfer: Orders for Medications at Discharge/Transfer are acceptable when all the *standard elements* of an order are clearly indicated on the discharge or transfer summary and reconciled with medications prior to admission.

Sliding Scale Orders shall be acceptable for Insulin, as determined by the ordering physician / authorized practitioner.

Orders for Tube Feedings shall be managed in the same manner as those for medications. Additionally, flush protocol as per enteral policy and / or as prescribed by the physician clearly indicated on plan of treatment.

ALL PATIENTS' MEDICATIONS MUST BE STORED PROPERLY AT ALL TIMES.

- Medications must be stored as per the manufacturer's and/or pharmacy's instructions.
- Medications must be labeled with contents, expiration date, and applicable warnings.
- Medications must be stored separately from other family members' medications.
- All medications shall be dispensed through a licensed pharmaceutical company and shall be labeled with proper identification: patient's full name, name of drug, dosage, route, and concentration, frequency of administration and special instructions or precautions.

Prior to administration of any medication:

Prior to the administration of any medication, particularly of drugs with look-alike or sound-alike names, the administering nurse shall adhere to the following protocol:

- Check prescribed medication against the Agency's High Alert Medication List and Client Medication List and check for potential side effects / adverse reactions or contraindications with existing medications or allergies.
- Medication Reconciliation is a process to be followed by nurse prior to any administration of medication.
- Verify that the selected medication matches the medication order received from the ordering physician. Read each medication order in its entirety, carefully noting the name of the drug, dosage, concentration / form, route of administration, frequency and any special instructions.
- Verify that the label on the selected medication matches the order received from the ordering physician. Compare the written medication order to the label on the prescription bottle / container.
- If a discrepancy is noted, or any element of the order is unclear to the administering nurse, s/he must contact the ordering physician immediately for clarification.
- Visually inspect the selected medication for particulate, discoloration, or any other loss of integrity.
- Verify that the selected medication is not expired, and if so, discarded immediately.

The Agency may refuse service to a patient if the following circumstances exist:

- Medication is contraindicated for patients due to diagnosis.
- Medication ordered is beyond the recommended dosage, without specific, valid physician / authorized practitioner clarification / documentation as to why the dosage has been ordered.
- Medication is contraindicated due to possible interaction with existing medication(s).
- Administration route for prescribed medication is contraindicated by current literature.

Administration:

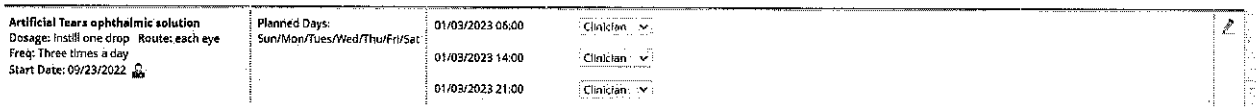
- Identify the patient using two patient identifiers.
- First Encounter: **Caregiver present**: patients name, address, and DOB
- Second Encounter: Facial Recognition, patients name
- Select the right drug to be administered to the right patient, in the right dose, by the right route and at the right time, for the right indication.
- Remain with the patient until all medications are given and ingested.
- Monitor for signs of adverse reaction: Occasionally, undesired side effects or toxicity caused by drug administration may develop. The onset of such reactions may be sudden or may take days to develop.
    - Observe / assess the patient for any sign[s] / symptom[s] of an adverse drug reaction. Immediately inform the responsible party, prescribing physician / authorized practitioner, pharmacist and Agency of the drug reaction.
    - Document the patient's specific signs and symptoms of the adverse drug reaction and subsequent treatment.
    - Instruct the patient / caregiver in follow up care / treatment.
- Monitoring medication's therapeutic effect.
- Obtain lab work for monitoring therapeutic / toxic levels as needed.
- Notify the physician / authorized practitioner and pharmacist of any adverse reactions.

Medication Administration Documentation:

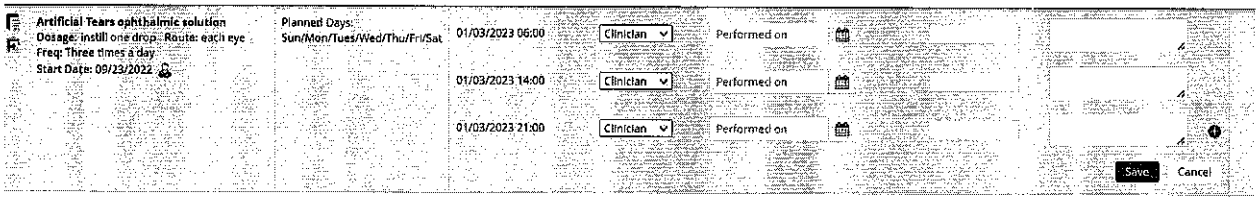
All medications due during the check in and check out time must be performed during your shift. Those items will show in red under planned time.

TAP **Administer Medication(s)** button to add your documentation.

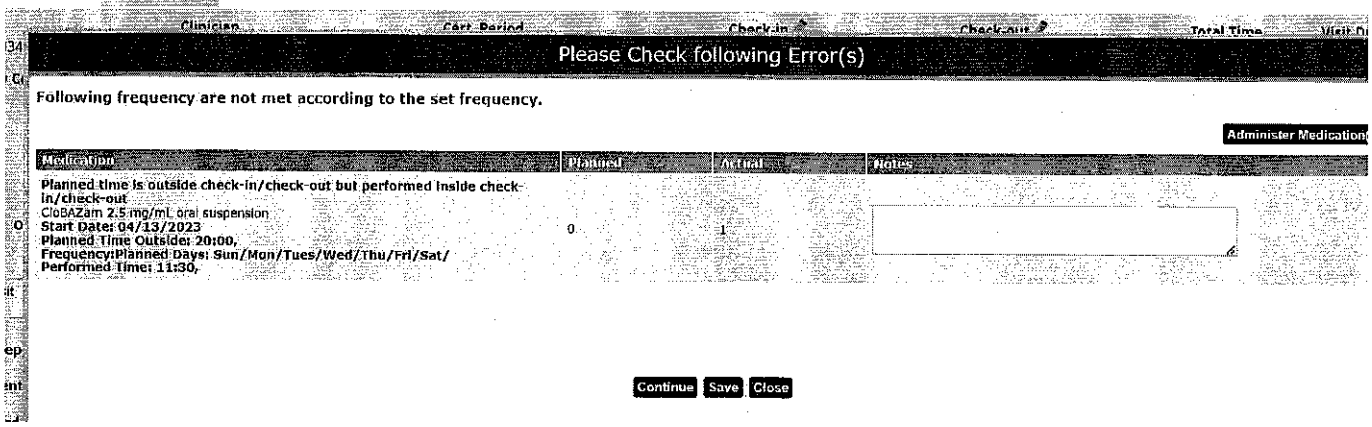
Once in this screen, tap the pencil to add your entry.



Once in this screen



- Select the clinician if you gave the med, parent if you observed the parent give or it was reported to you the parents gave, or self if the client self-administers the medication.
- Tap the calendar to get the date and time of administration- first click on time is the hour, then once you click the hour the second option will be minutes in 5-minute increments.
- You must document the medication that have planned times due within your shift time and ensure the performed time entered is within your check and check out times.
- The medications requiring documentation are listed in red until they are marked performed, then they will turn green. If a medication is grayed out, it is not required this shift.
- **When documenting your medication administration- enter the actual time of the medication which is to be given.**
- **If unable to administer during the specific time indicated, sign off on the time administered then in comment box indicate actual time given either earlier or later due to: please give reason in comment box.**
  If you document time outside of Planned times and submit your visit to QA, you will see a validation screen (see below) that following frequency are not met according to the set frequency- explain why in this comment box and hit continue.



- If you are not administering a medication within your check in and check out time, leave it blank. Once you submit to QA, a validation Alert will be displayed as above. You must document in the comment section that it was not administered and the reason.

- The reason for Use for PRN medications:

Under the medication administration record MAR

Given By	Performed On	Site	Effectiveness/ Reaction	Reassessment Time	Indication

Comments/ Warnings	Teaching Info

Please indicate: Time/ date performed.

- Site: Not applicable if within order. Except if there is more than one route listed (For example PO or G tube) then you must list the route given in the site box. If the medication is topical or injection the site should also be indicated.

Effectiveness/Reaction ie: responded to prn medication/ positive outcome.

Reassessment Time: ie: fever decreased after 1 hour.

Indication: Must be provided ie: fever, no bowel movement, increase in respiratory congestion.

Comments: ie: dissolved in water or mixed with feeding or other medication.

Teaching Info: Reinforce with family reason for medication use.

If medication is not given for any reason, do not sign off if within your clock in / clock time.
You will receive an alert once you submit your visit documentation to QA.
You will need to enter into the Comment box reason why not medication not administered: ie: out of stock, loose stools, or held based on the physician parameters for administration, hold for Apical below 60, Blood Pressure below 100.
In the event that a patient / caregiver refuses to allow the patient to receive a prescribed medication, the nurse will attempt to clarify the importance of compliance with the treatment and will encourage compliance. If however, refusal ensues, the nurse is to notify the physician / authorized practitioner in a timely fashion and amend the plan of treatment as directed. The nurse will document the refusal and any untoward side effects from this refusal in the patient's clinical record.

Post Hospitalization Orders for Medication.
In the event of a hospital admission, all medications are to be reconciled upon returning home. If there is a question with any medication, the nurse must clarify the orders prior to any medication administration. Change Order will need to be generated based on the Episode Period for new and change in medications ie: dosage, frequency.

Agency staff shall communicate a complete list of the patient's medications (Plan of Care/ MAR) to the next provider of care when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the Agency.

The complete list of medications (Plan of Care) shall be provided to the patient / caregiver upon discharge from the Agency.

MEDICATION RECONCILIATION

- RNs and LPNs can administer medication and will also provide education to patients and/or their caregivers regarding both the medication itself, and the proper administration thereof.
- Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered, existing orders are rewritten and / or transitions in care which include changes in setting, service, staff or level of care.
- Quality Assurance and Performance Improvement is monitored and reported quarterly to the Professional Advisory Committee.
- The best medication reconciliation requires a complete understanding of what the patient was prescribed and what medications the patient is actually taking. At times it can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the Joint Commission Requirement. The National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are to reduce negative patient outcomes associated with medication discrepancies.

Potential Types of Medication Errors

- Taking an unauthorized drug
- Taking the wrong dose
- Missing a dose/not completing a regimen
- Taking a dose at the wrong time
- Taking an extra dose
- Continuing a drug after it is discontinued
- Inappropriate use of a medication
- Giving a drug to the wrong patient
- Giving a drug via the wrong route
- Incorrect dilution of a drug
- Inappropriate administration of a drug

Potential Causes of Medication Errors

- Polypharmacy
- Knowledge deficits (patient and/or caregiver)
- Transcription errors/errors in communication
- Confusion over hospital discharge instructions (Patient and/or clinician)
- Confusion over brand name versus generic name
- Medications that look alike or sound alike
- Incorrect use of medication boxes
- Skipped doses due to cost, fear of side effects, lack of transportation to pharmacy
- Cognitive and visual problems

Ways to Minimize Medication Errors

- Patient and/or caregiver education
- Increased communication, collaboration, and coordination between healthcare professionals
- Reduction in polypharmacy
- Referral to social worker
- Collaboration with pharmacist
- Utilization of lists for patient use
- Creation of diagrams or charts for patient use
- Institution of medication boxes
- Evaluation of the cause of skipped doses

Reporting Medication Error

- Upon discovery of a medication error, the responsible party or Agency staff should promptly report the error to the Agency.
- Agency field staff should promptly assess the patient for any adverse reaction[s] arising as the result of the error.
- Assessment(s) must be documented in the electronic record under Incident Report. .

ISMP List of *High-Alert Medications* in Community/Ambulatory Healthcare

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors and minimize harm.

This may include strategies like providing mandatory patient education; improving access to information about these drugs; using auxiliary labels and automated alerts; employing automated or independent double checks when necessary; and standardizing the prescribing, storage, dispensing, and administration of these products.

Classes/Categories of Medications
antiretroviral agents (e.g., efavirenz, lamiVUDine, raltegravir, ritonavir, combination antiretroviral products)
chemotherapeutic agents, oral (excluding liquid forms) (e.g., cyclophosphamide, mercaptopurine, temozolomide)
hypoglycemic agents, oral
immunosuppressant agents (e.g., azaTHIOprine, cycloSPORINE, tacrolimus)
insulin, all formulations
opioids, all formulations
pediatric liquid medications that require measurement
pregnancy category X drugs (e.g., bosentan, ISOtretinoin)

Specific Medications
carBAMazepine
chloral hydrate liquid, for sedation of children
heparin, including unfractionated and low molecular weight heparin
metFORMIN
methotrexate, non-oncologic use
midazolam liquid, for sedation of children
propylthiouracil
warfarin

Background

Based on error reports submitted to the ISMP Medication Errors Reporting Program (ISMP MERP), reports of harmful errors in the literature, and input from practitioners and safety experts, ISMP created a list of potential high-alert medications. During June-August 2006, 463 practitioners responded to an ISMP survey designed to identify which medications were most frequently considered high-alert drugs by individuals and organizations. In 2008, the preliminary list and survey data as well as data about preventable adverse drug events from the ISMP MERP, the Pennsylvania Patient Safety Reporting System, the FDA MedWatch database, databases from participating pharmacies, public litigation data, literature review, and a small focus group of ambulatory care pharmacists and medication safety experts were evaluated as part of a research study funded by an Agency for Healthcare Research and Quality (AHRQ) grant. This list of drugs and drug categories reflects the collective thinking of all who provided input. This list was created as part of the AHRQ funded project "Using risk models to identify and prioritize outpatient high-alert medications" (Grant # 1P20HS017107-01).

ISMP
www.ismp.org

Timely Medication Administration Guidelines

CMS has added to its guidance on timely medication administration:

This agency will follow best practice in timely administration of medication and has established total windows of time that *do not exceed* the following:

Time-Critical Scheduled Medications, where delayed or early administration of more than the 30 minutes may cause harm or sub-therapeutic effect.
1 hour for time-critical scheduled medications (30 minutes before/after);
Examples may include antibiotics, anticoagulants, insulin, anticonvulsants, immunosuppressive agents, pain medication, medications prescribed for administration within a specified period of time, medications that must be administered apart from other medications for optimal therapeutic effect.

Non-Time-Critical Scheduled Medications which are Daily, weekly, monthly medications within 2 hours (1 hour before/ 1 hour after) the scheduled time.

Nurses play an essential role in medical reconciliation; preparing, administering, monitoring, evaluating, teaching patients; and documenting responses to medications.
Medication administration requires good decision-making skills and clinical judgment, and the nurse is responsible for ensuring full understanding of medication administration and its implications for patient safety.

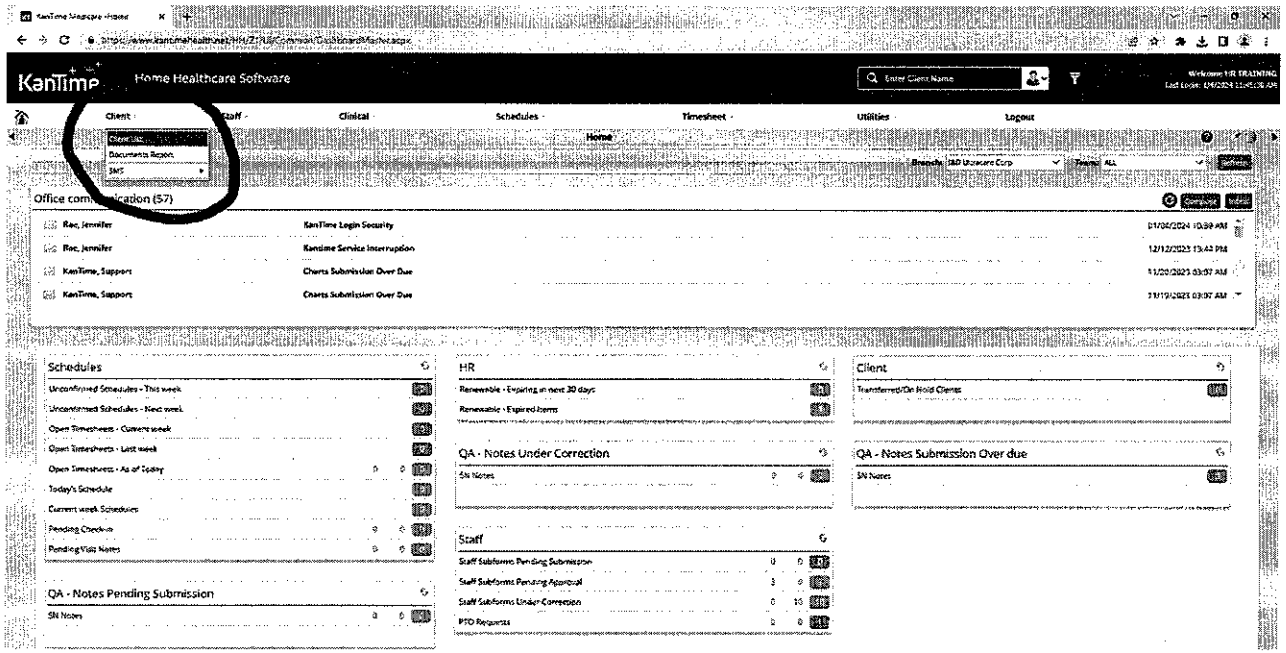
Clear concise documentation is required in the comment box if medication is administered at a different time indicated.

How To Enter Medication Change Orders

KanTime
How better happens.

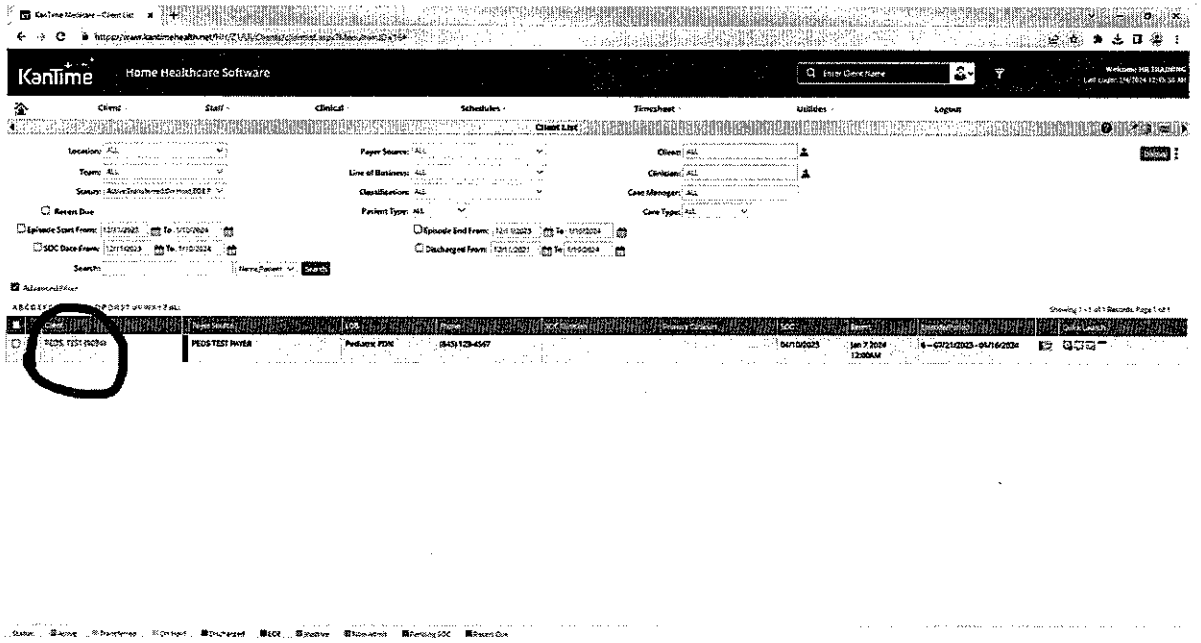
Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

Entering a Medication Change Order



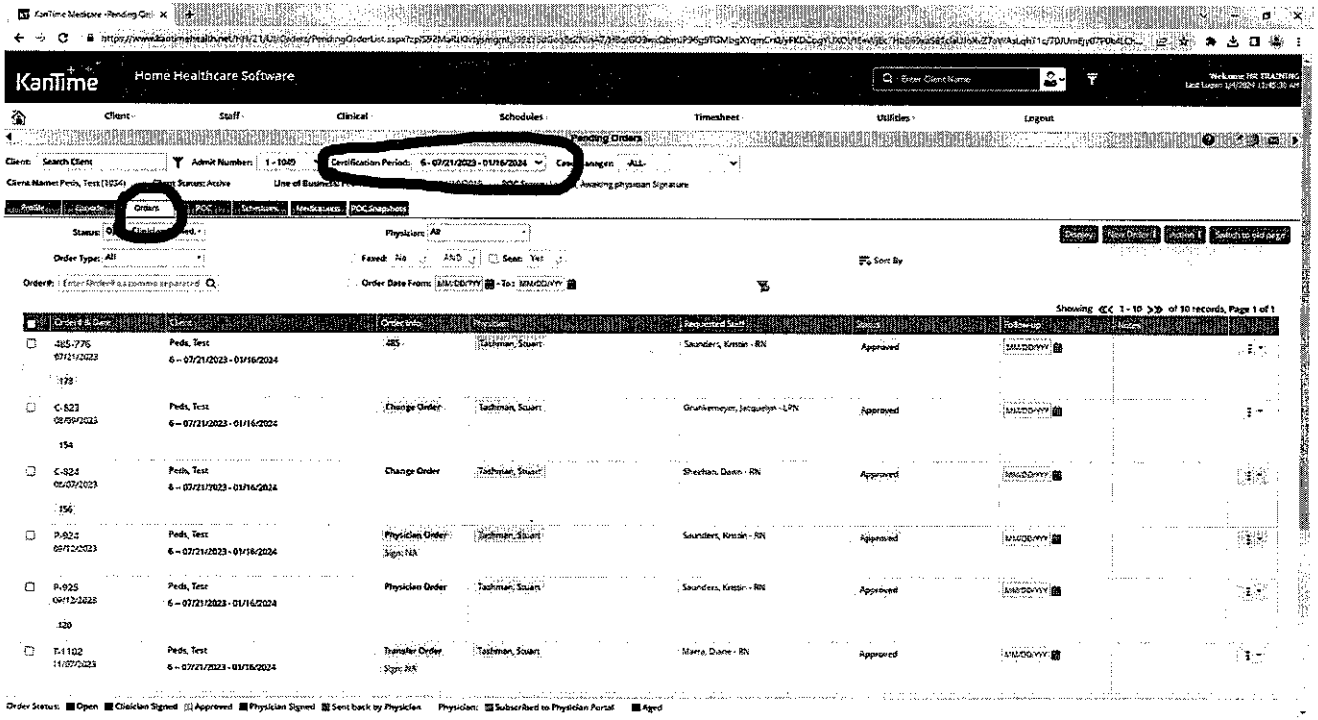
Go to the home screen dashboard and hover over the word "Client" on the top ribbon and then a dropdown will appear. Click on "Client List"

Entering a Medication Change Order



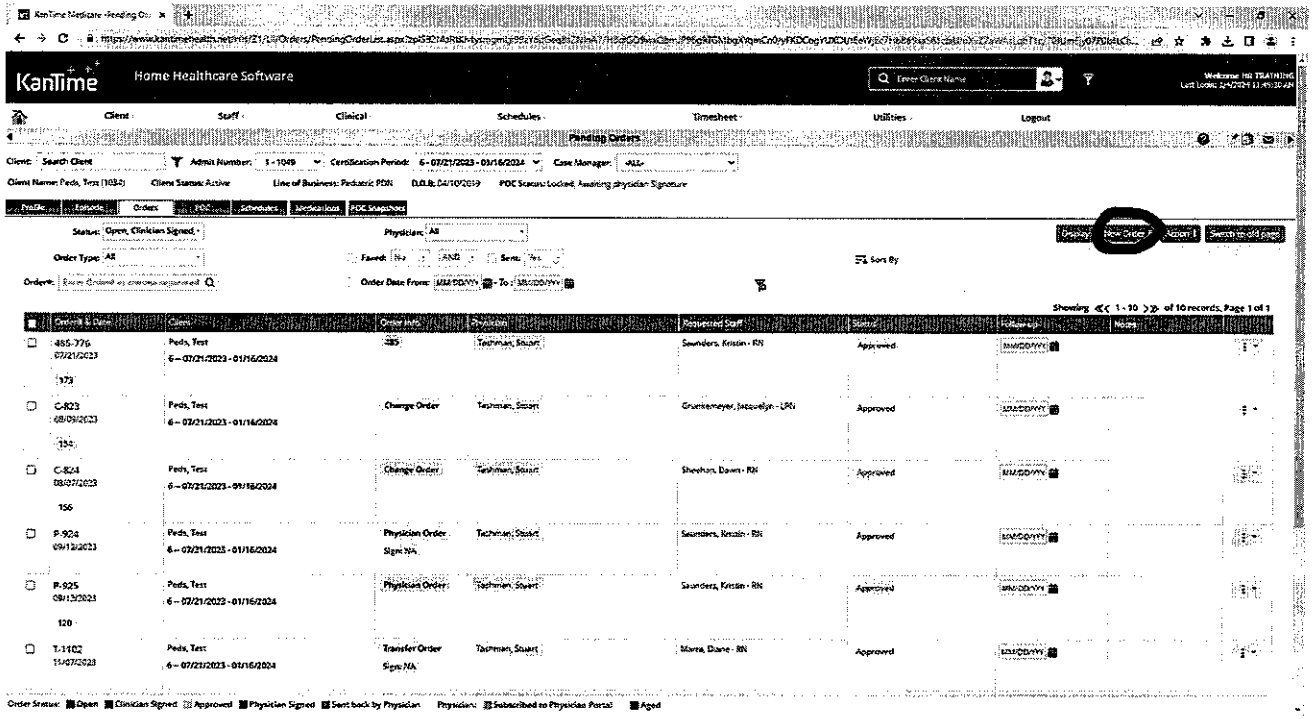
When in the client list, click on the client name in the list. This will then bring you to the client profile.

Entering a Medication Change Order



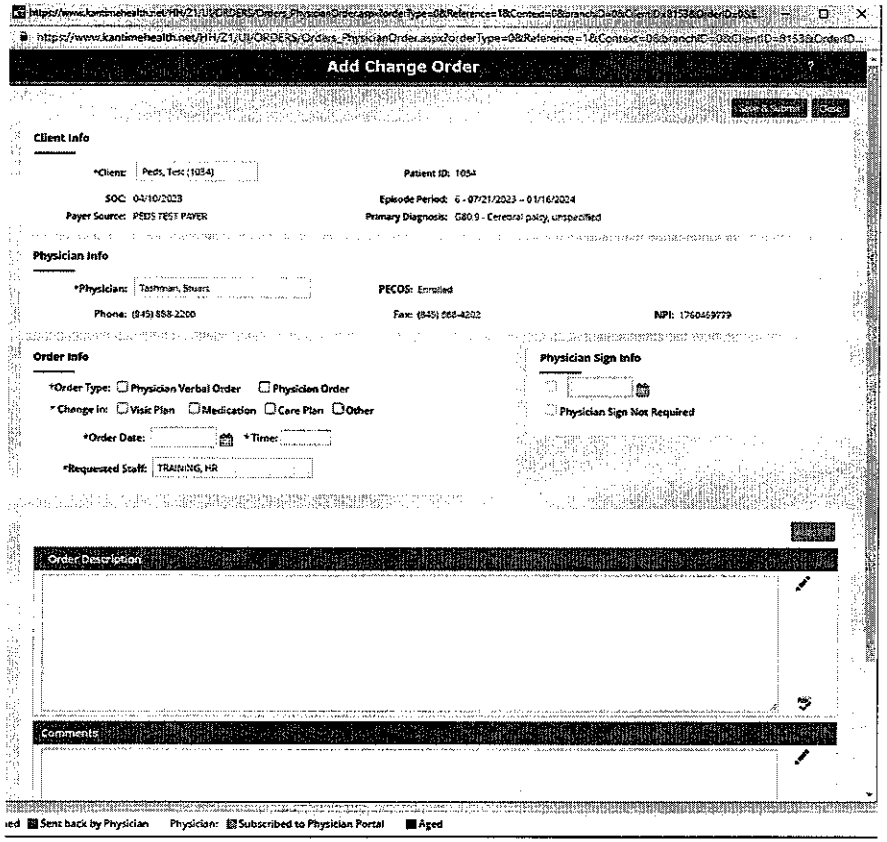
- Click on the blue tab "Orders." This will bring you to the order screen.
- Confirm that you are in the correct certification period. In order to do that, you will look at the top of the page and confirm the current episode (see circled in red below). Once you have confirmed you are in the correct certification period, then you are ready to start the change order.

Entering a Medication Change Order



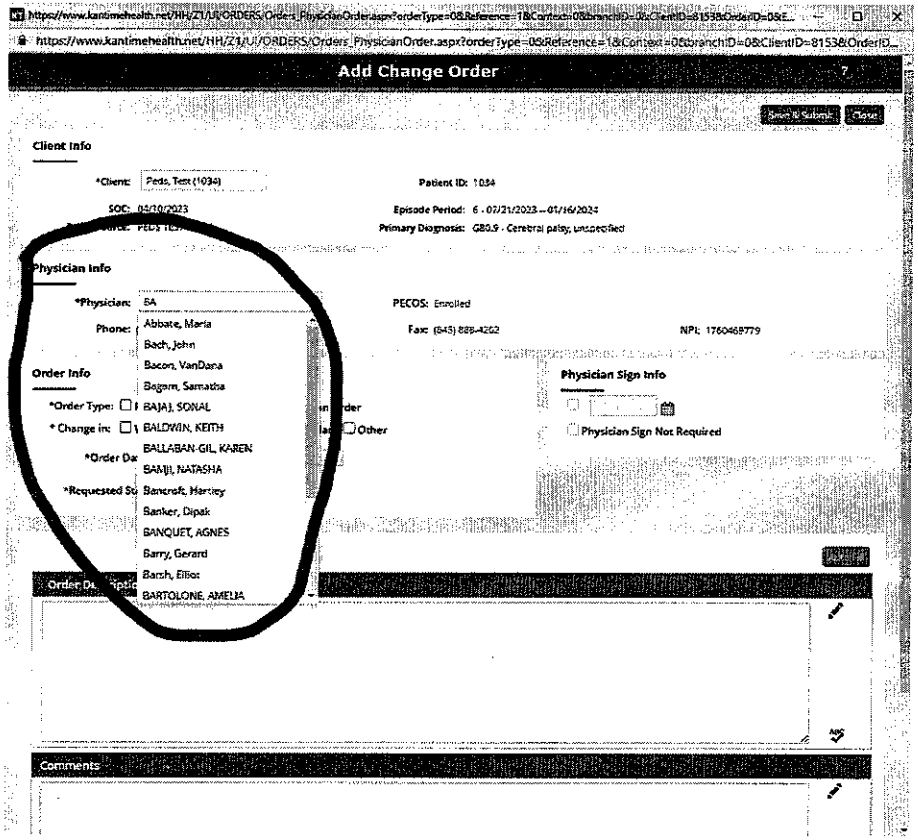
- Off to the right of the page, click the blue button "New Order" and then a drop down will appear that reads "Change Order."
- Click on the words "Change Order" and that will open another window as seen on the next slide.

Entering a Medication Change Order



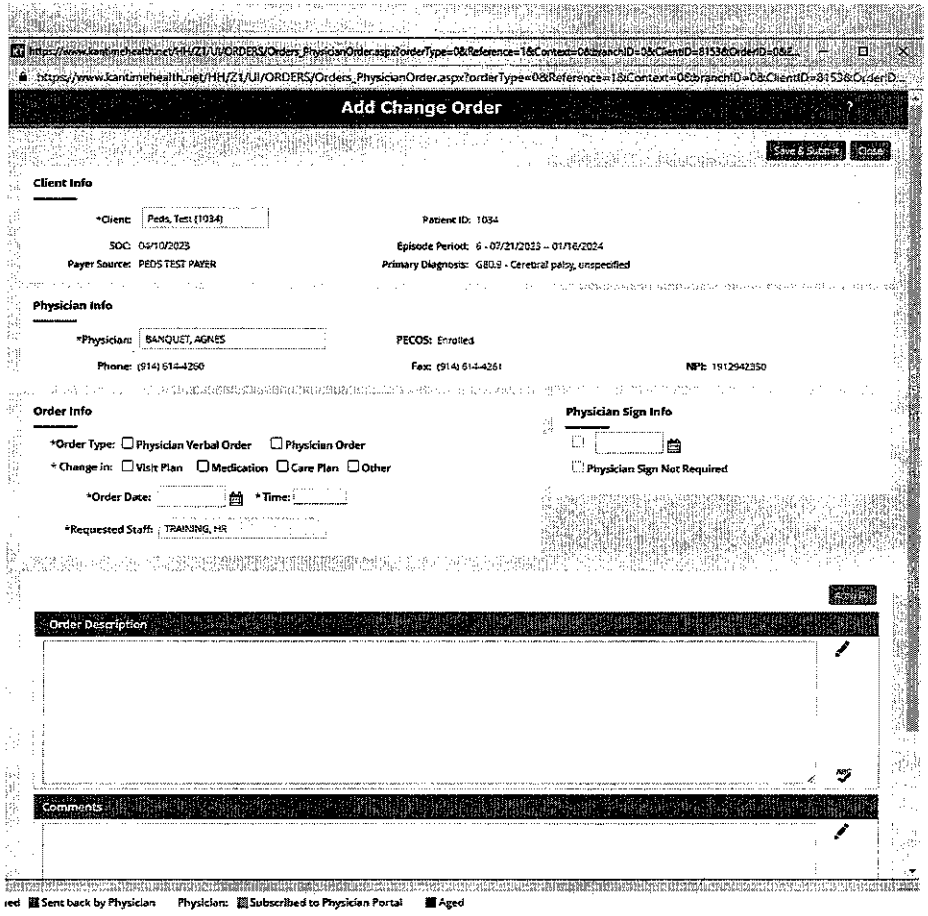
Your client information will be pre-populated. Ensure you have the correct Client.

Entering a Medication Change Order



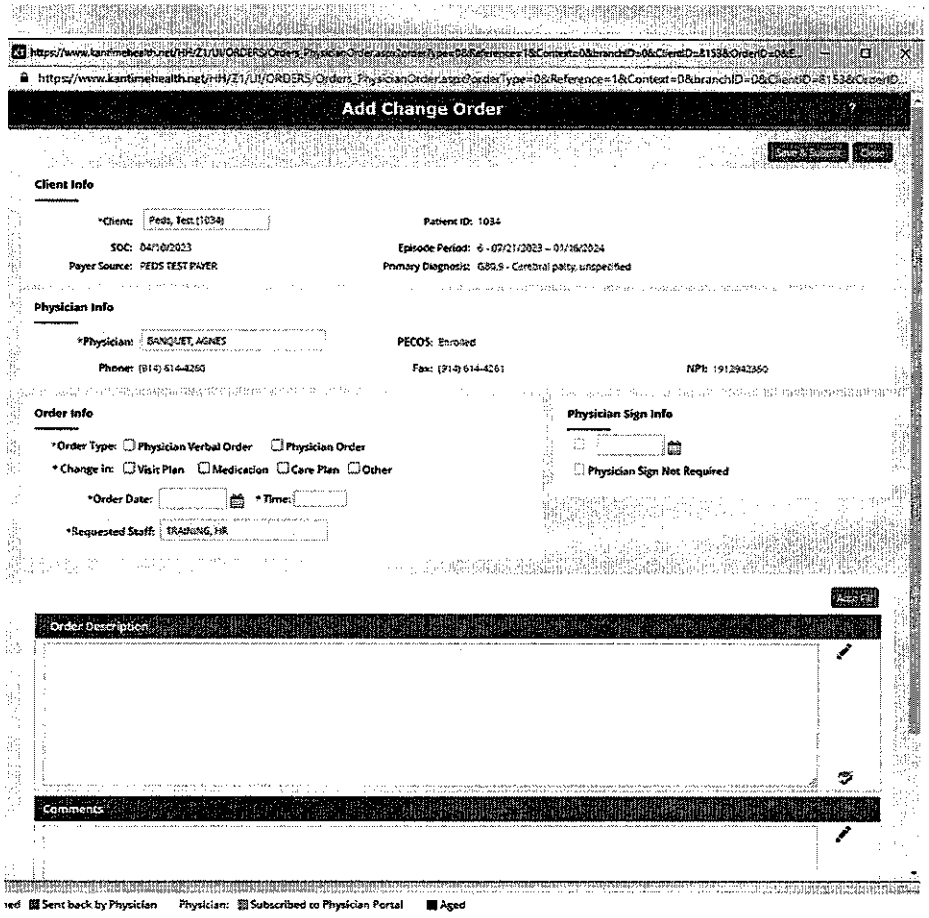
- The Physician Info will always default to the Primary Care Physician.
- If it is another prescriber ordering, then click on the text box and delete the Physician name. When you begin typing, a drop down box will appear and once you see the Prescriber, you can just click on the name.
- If the Prescriber does not come up, please contact the office as the Prescriber will need to be added into the system.

Entering a Medication Change Order



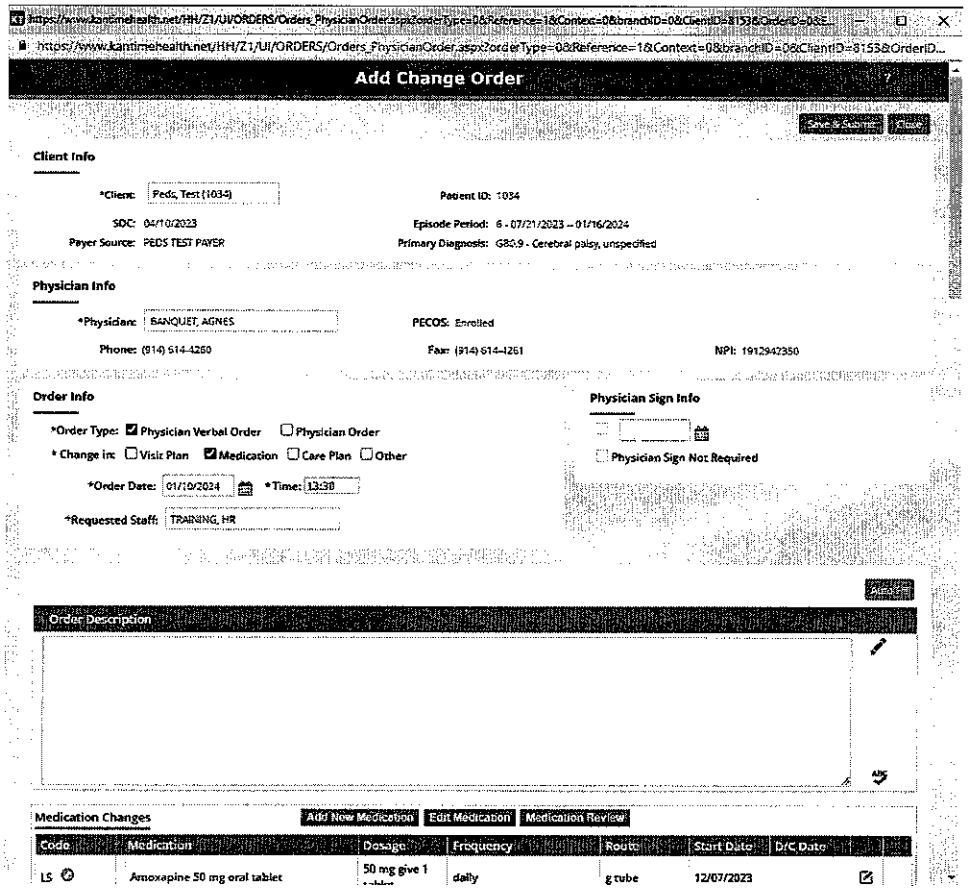
Once you have selected the correct Prescriber, the information will auto populate

Entering a Medication Change Order



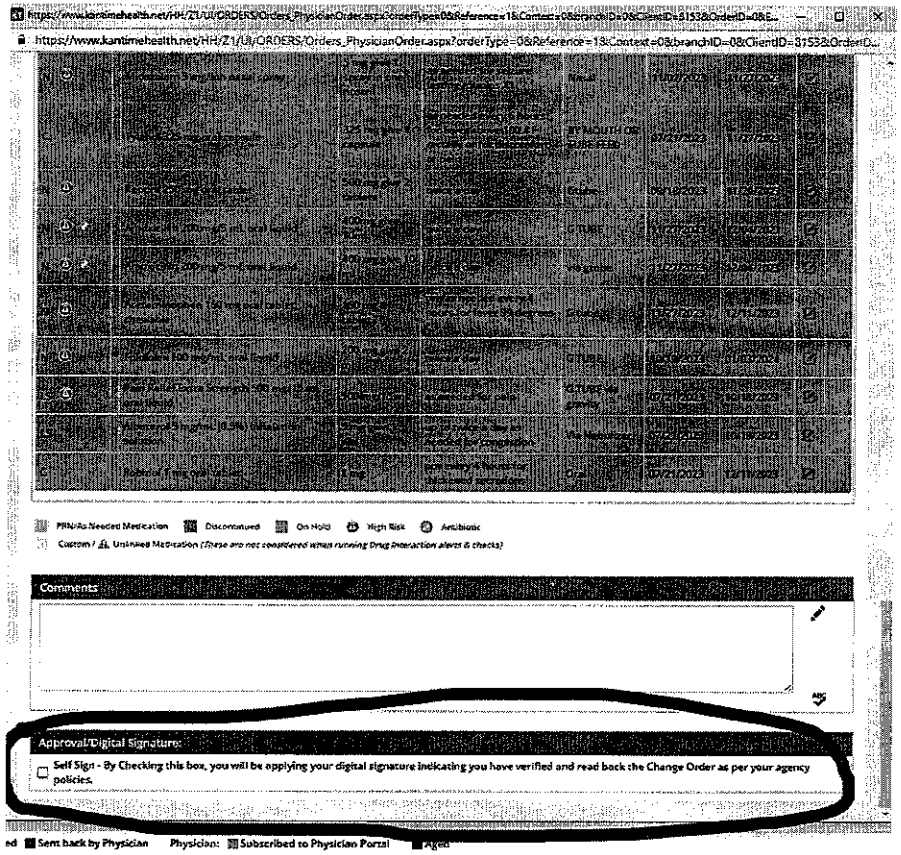
- Order Info:
  - Select either "Physician Verbal Order" if this is a verbalized change in medication that you are receiving upon oncoming shift report **OR** select "Physician Order" if there is a paper order from the Prescriber.
- Under "Change In" - click "Medication."
- Under "Order Date" - click on the calendar icon and select the date the change occurred.
- Under "Time" - enter the actual time the change occurred or the time of entry for the change order.
  - For any change in medication that you will be administering during shift, enter the time a half hour prior. For ex. Keppra to be administered at 10a, enter the change for 9:30am.
- Under "Requested Staff" your name should be auto-populated there. If not for some reason, click in the text box and type your name in.

Entering a Medication Change Order



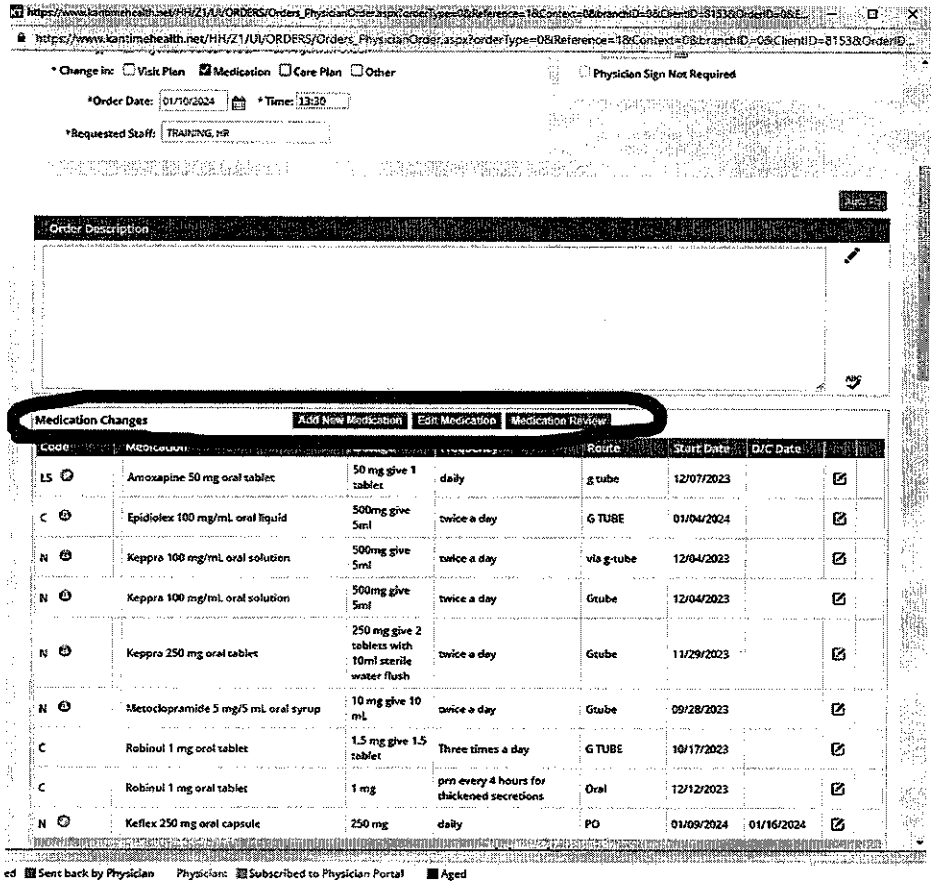
Once all this is completed, your screen will look like this

Entering a Medication Change Order



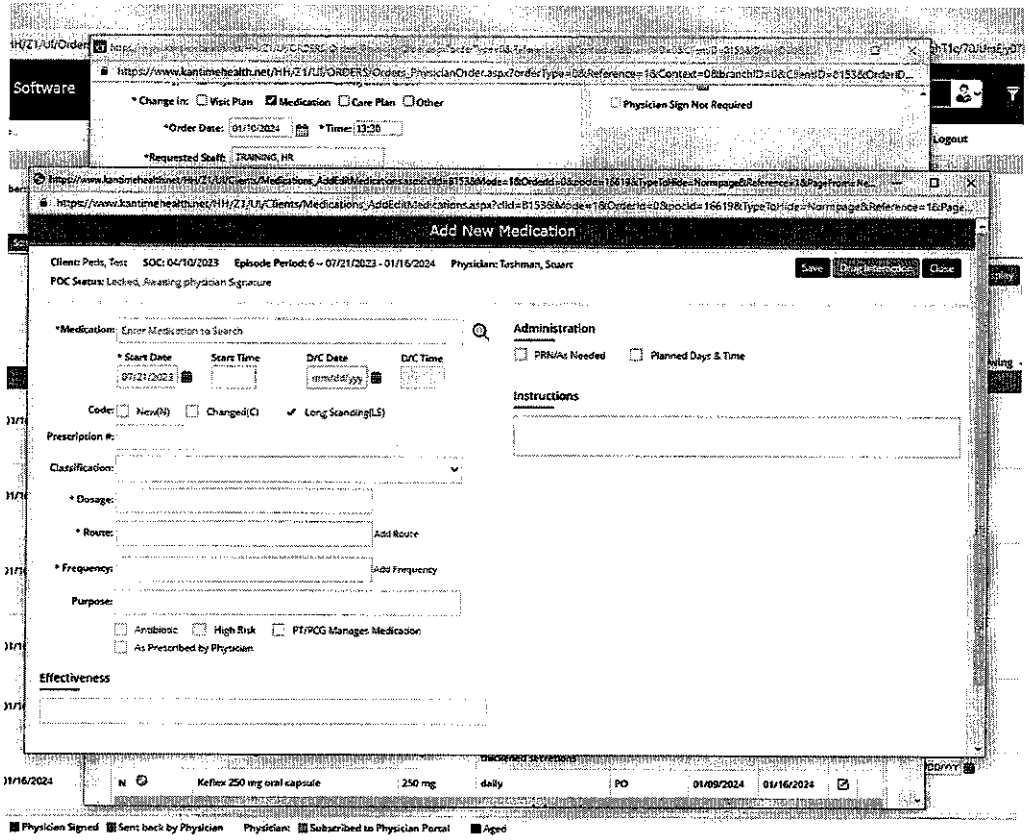
You will need to then scroll down to the bottom of the change order, and click the "Self-Sign" under "Approval/Digital Signature:"

Entering a Medication Change Order



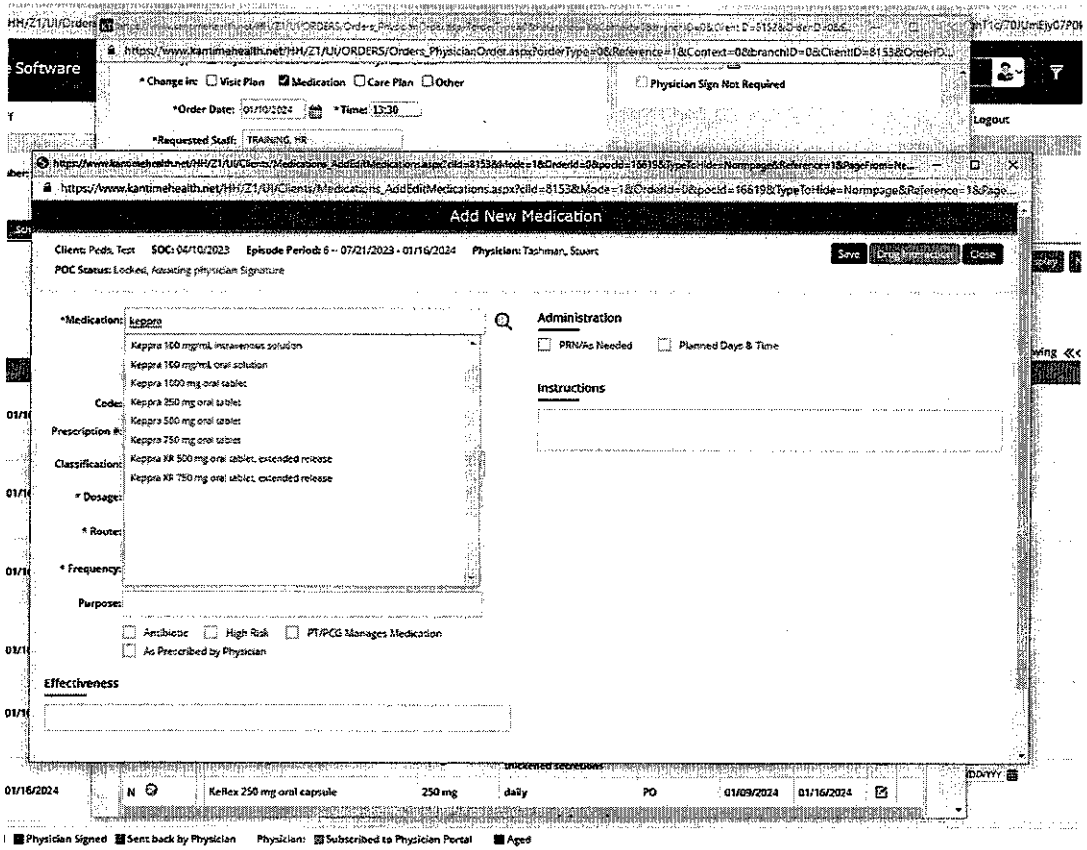
- Scroll back up to the area under the "Order Description" box which is the heading titled "Medication Changes."
- You will see three blue buttons located here. Click "Add New Medication."

Entering a New Medication



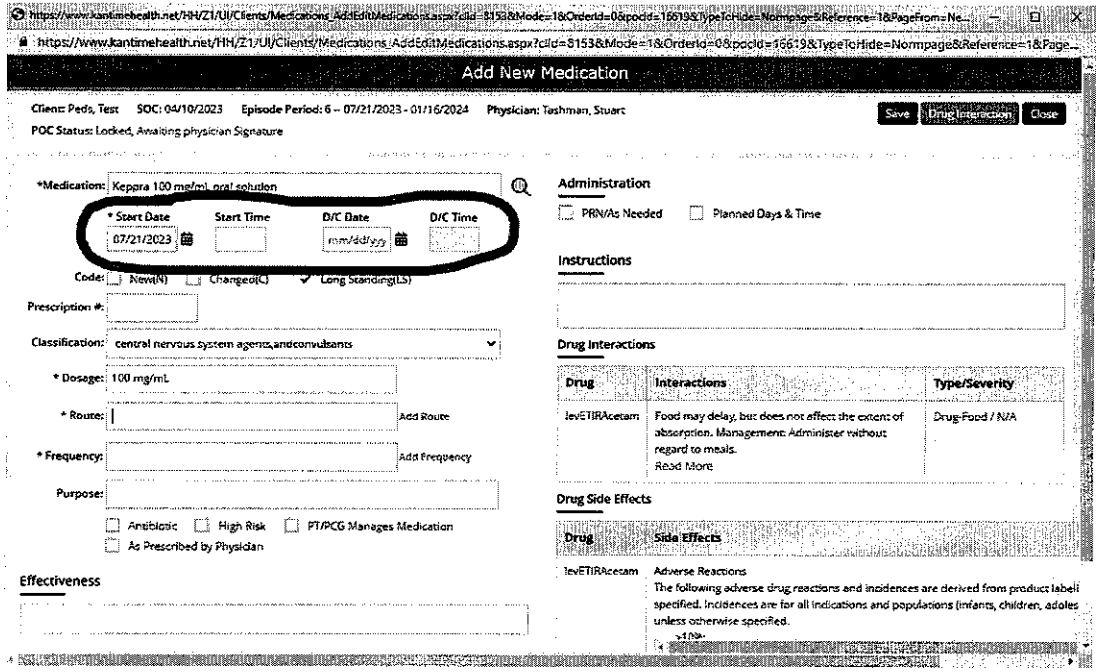
A new window titled "Add New Medication" will pop up

Entering a New Medication



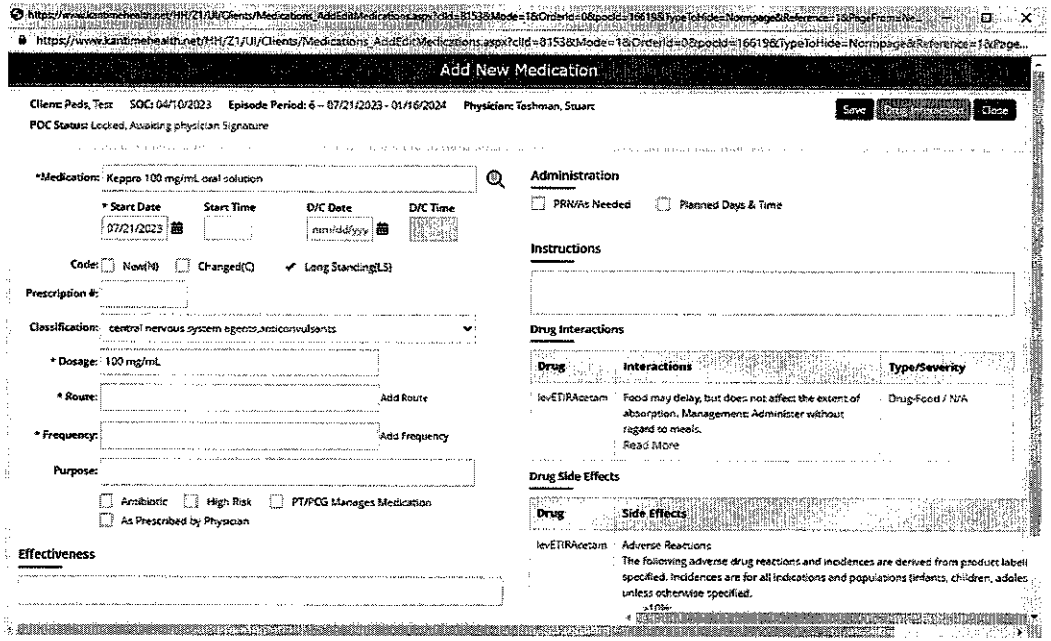
- Begin typing the name of the medication in the required medication text box.
- As you do this, you will see a drop down menu with different options for that medication that are pre-loaded in the system.
- If you see the correct name, concentration, and formulation of the medication you have, click on it and then it will pre-fill some information.
- If your selection is not there, then please enter the medication name along with concentration and formulation.

Entering a New Medication



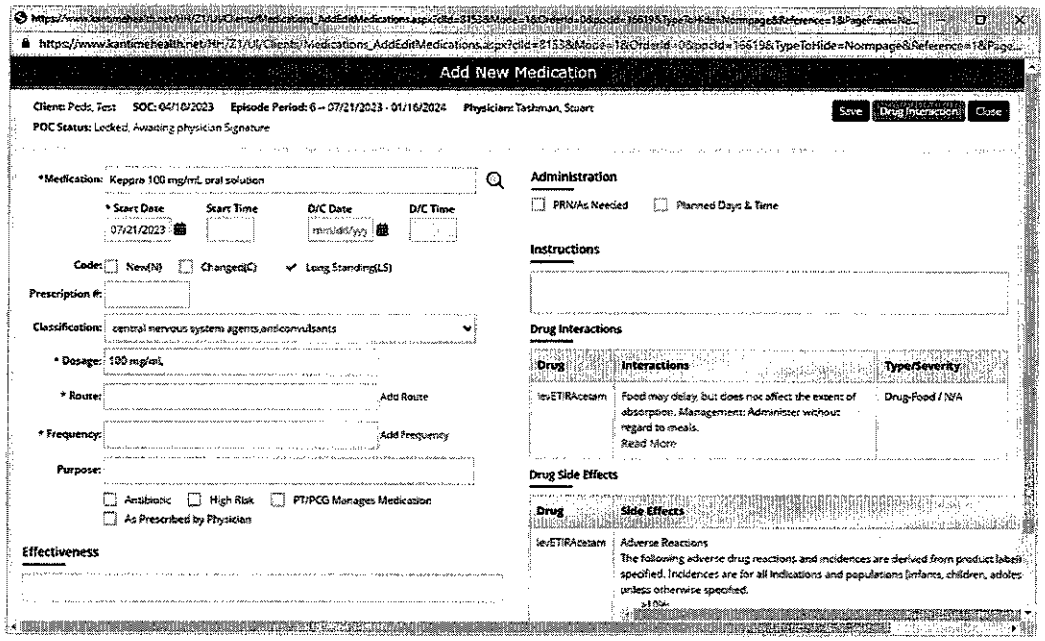
- Confirm the start date of the medication. The start date will always default to the beginning of the current certification period. Please ensure that you change the start date to the correct date.
- You do not need to enter the start time but you can provide the start time of the first dosage for that day.
- Enter a D/C date and time if this medication will only be taken for a certain amount of days. If you enter a D/C date, then please provide the time as a hour after the last scheduled dose for that day.

Entering a New Medication



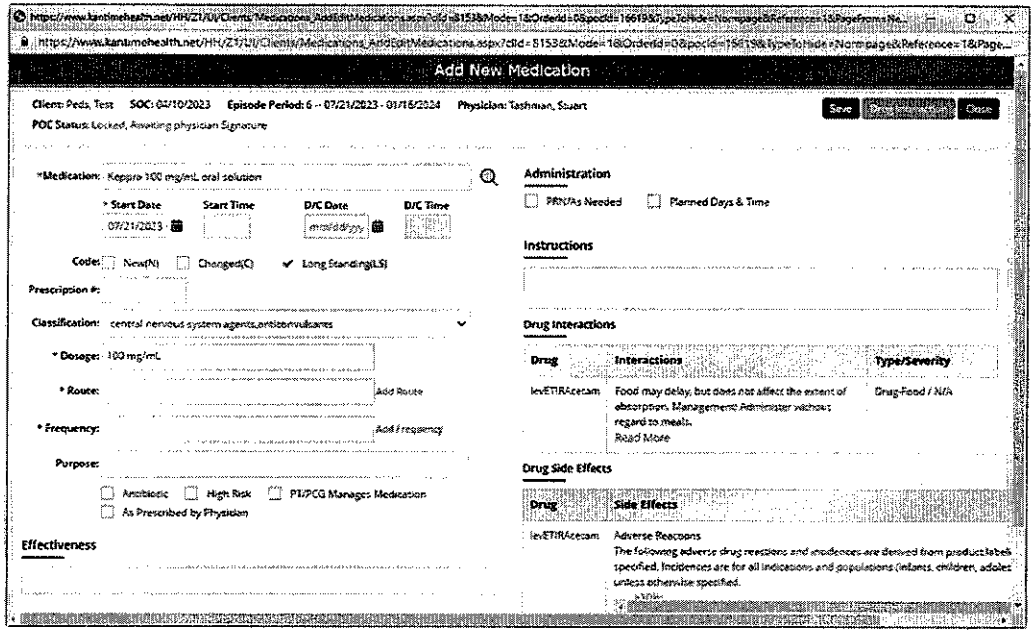
- Under code, select the box "New."
- Under Prescription #: do not enter anything in this box. It is not a required box.
- Under classification: this should be auto-populated if the medication came up in the drop down box when typing the name in the medication box.
  - If the medication was not auto-populated, you will not be able to enter anything in this box. This is NOT a required box.

Entering a New Medication



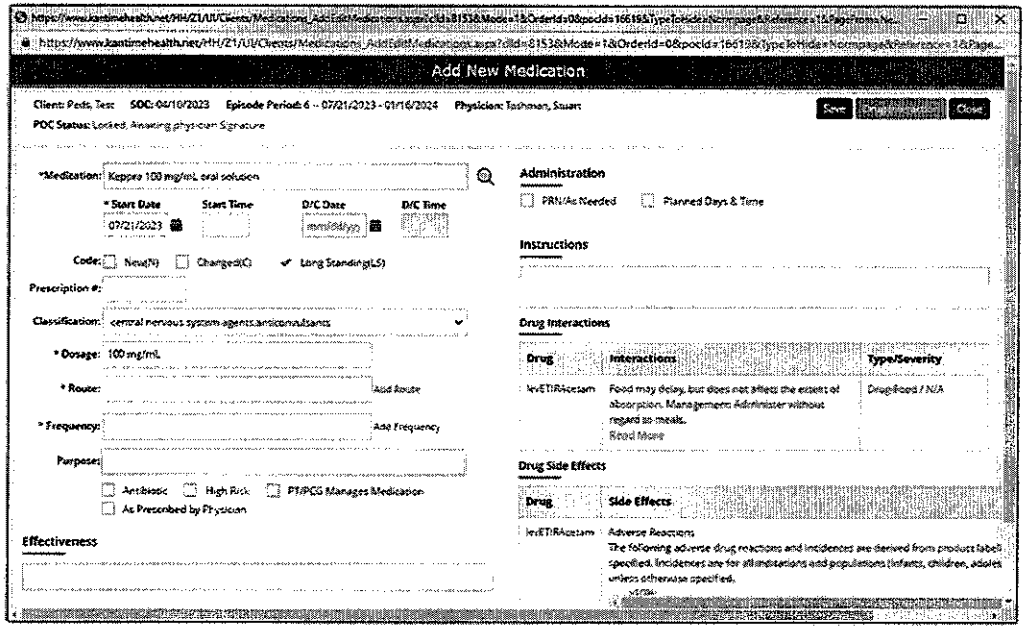
- Dosage: If the medication was auto-populated, this box will also be auto populated with the concentration of the medication. You will need to edit this and enter the ordered dosage. For ex: Keppra 100 mg/mL oral solution – Give 3 mL. You will need to calculate the mg dosage. Then, type in: 300 mg give 3 mL.
- Route: begin to type in the route of medication. Ex. G-Tube – as you type in this box, there will be a drop down box and you can select your route.

Entering a New Medication



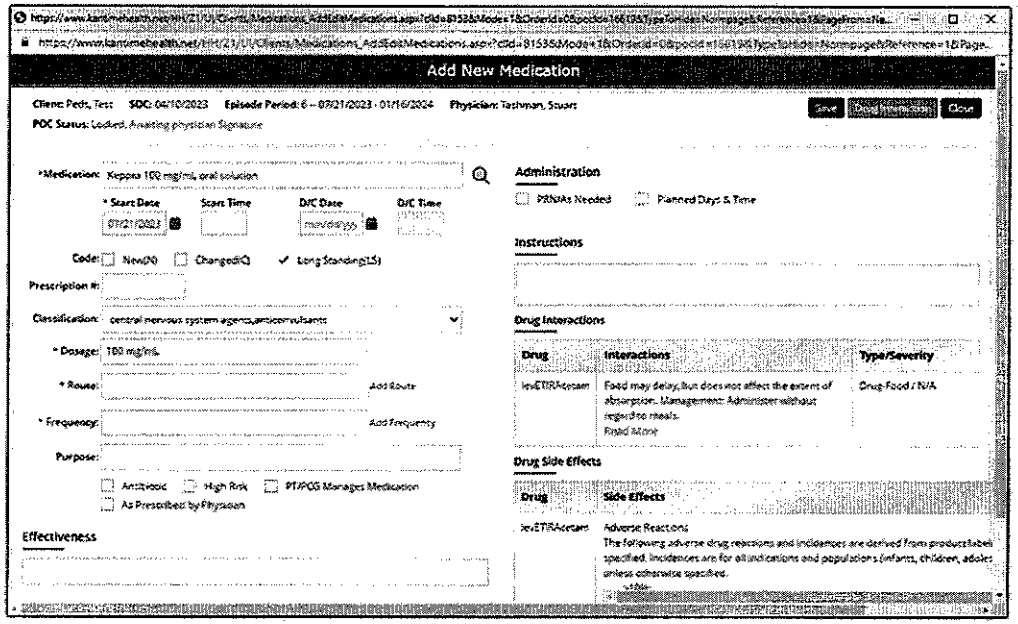
- Frequency: enter the frequency of the medication using no abbreviations. Ex.: Daily, Twice a Day, Daily at bedtime, etc. If this is an as needed medication, please enter as needed and then the details of the order.
  - For Ex. As needed every 6 hours for discomfort, pain or fever of 100.5 F and above.
- Purpose: You **MUST** enter the purpose of the medication as the change order pre-populates the Primary Diagnosis only. For ex: Penicillin – Strep Throat

Entering a New Medication



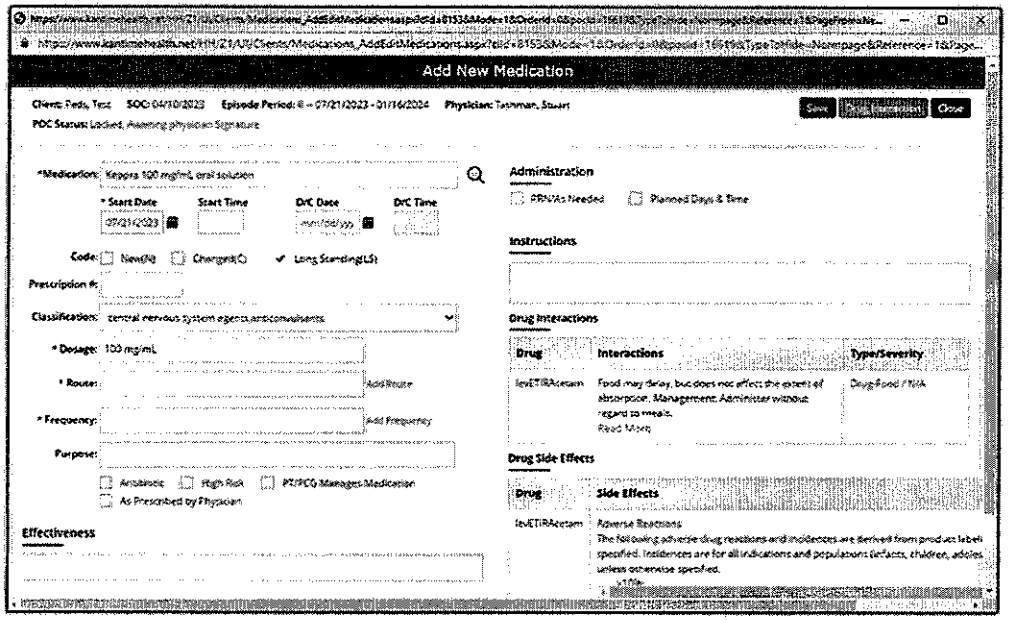
- Under purpose, there are 4 check boxes:
  - Antibiotic: ensure this is selected if this is an antibiotic
  - High Risk: Please refer to the medication management policy for a list of high risk medications.
  - PT/PCG Manages Medication: Only select this if the parent or patient caregiver gives this medication and we will never give it.
  - As Prescribed by Physician: this should ALWAYS be selected
- Under effectiveness – you do **NOT** need to complete anything here

Entering a New Medication



- Administration:
  - PRN/As needed: select this if this is an as needed medication
  - Planned Days & Times: select this if this medication is standing order. When you do this, an additional area will appear: Pattern. You will then need to select, Every Day. Once you do that, then you can enter in the Time box the times for administration. Enter the times separated with a comma. For ex. 9a, 9p. Once you click off that box, the times will be auto-formatted to Military time.
- Under Instructions: you can enter any addition instructions regarding the preparation or administration of the medication. Ex. Mix with feeding, as needed instructions such as "as needed every 6 hours for discomfort, pain, or fever above 100.5 F."

Entering a New Medication

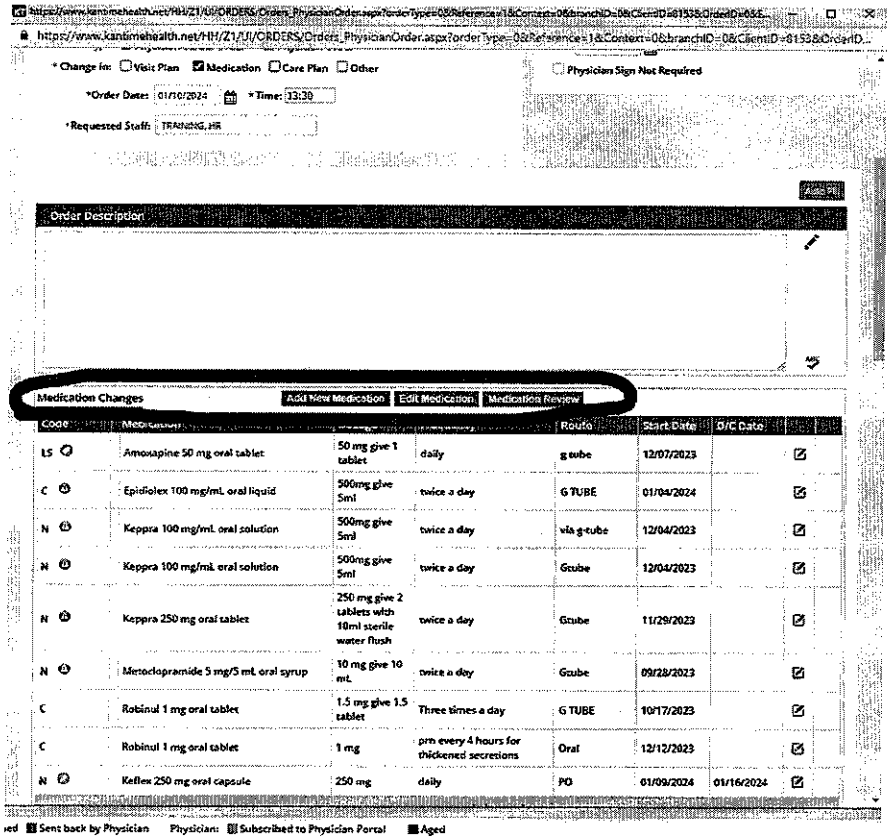


- Once all is complete, review the order for accuracy and completeness via 5 rights and per Agency Policies. Once all is confirmed, click the blue button on the top right "Save." You will see "Medication Added Successfully" and then a blank "Add New Medication" window will populate. You can click the blue button "Close" to exit from that screen.
- You will then return back to the "Add Change Order" screen. You will see in the "Order Description" box, the details of the order that you just entered.

Entering a New Medication

- If all is correct, then scroll to the top of the screen and click the blue button in the right upper corner, "Save & Submit." Once you do that, the following screen will appear.
- Click the blue "OK" button and then your order is submitted to the office. Someone from, the Clinical Department will contact you and the Primary Caregiver to review the order prior to it being sent to the Prescribers office for review and signature.
- You will be able to view your order in the "Order tab." Once the order is submitted, the changes made are immediately live in the system. In the eChart under the Medications tab, you will see changes made via the Change Order.

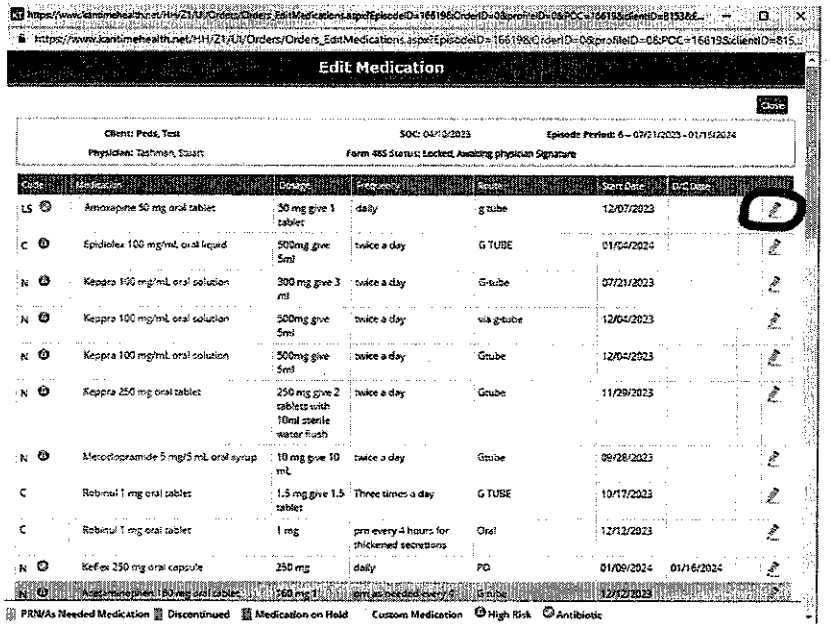
Editing a Medication

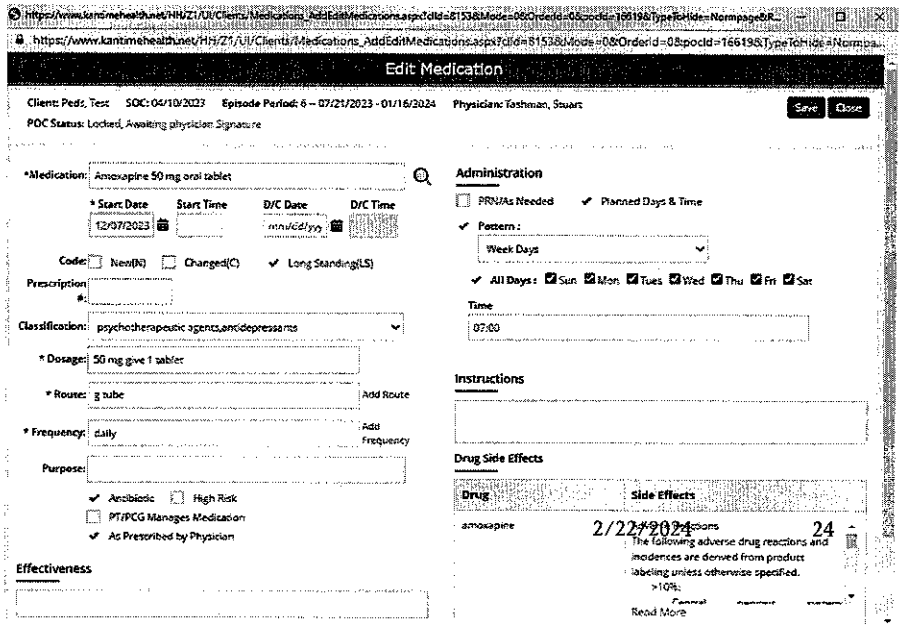


- **NOTE:** We are **NO** longer using hold orders or resume orders. **DO NOT** place any medications on hold. You will need to discontinue the medication and if it is re-started again, you will need to add a new order adding a new medication.
- Follow the prior process and then click the blue button "Edit Medication" and a window will pop up "Edit Medication."

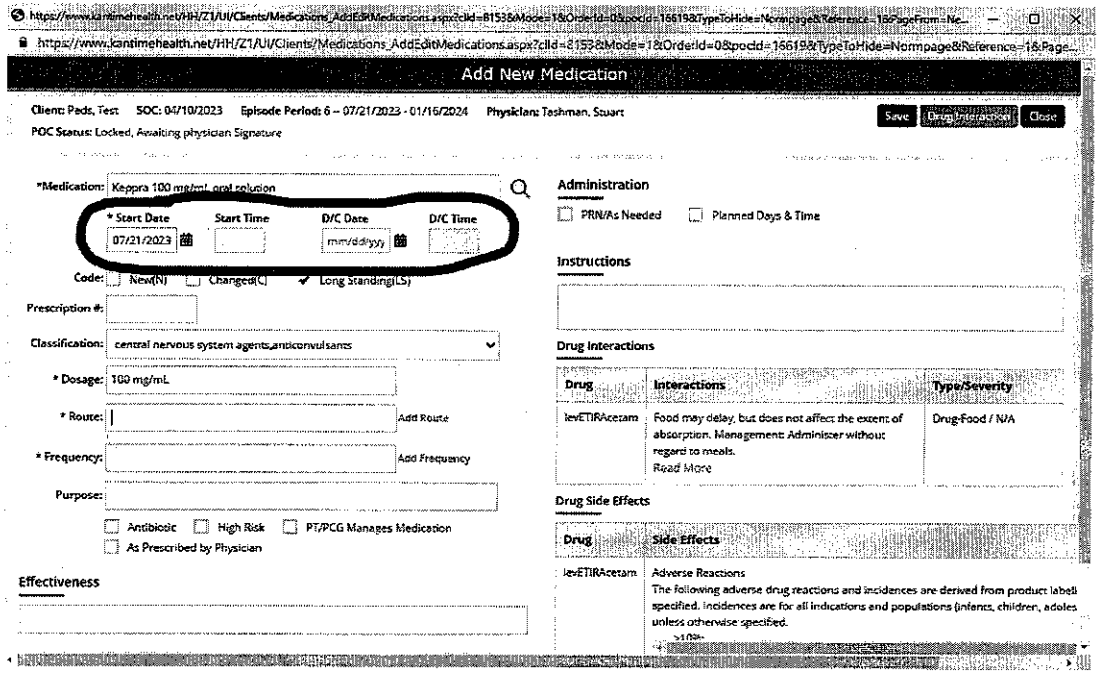
Editing a Medication

- Then, find the medication that you need to edit in the list. Once you find it, click the pencil icon to the right. It will bring up that medication in another window.



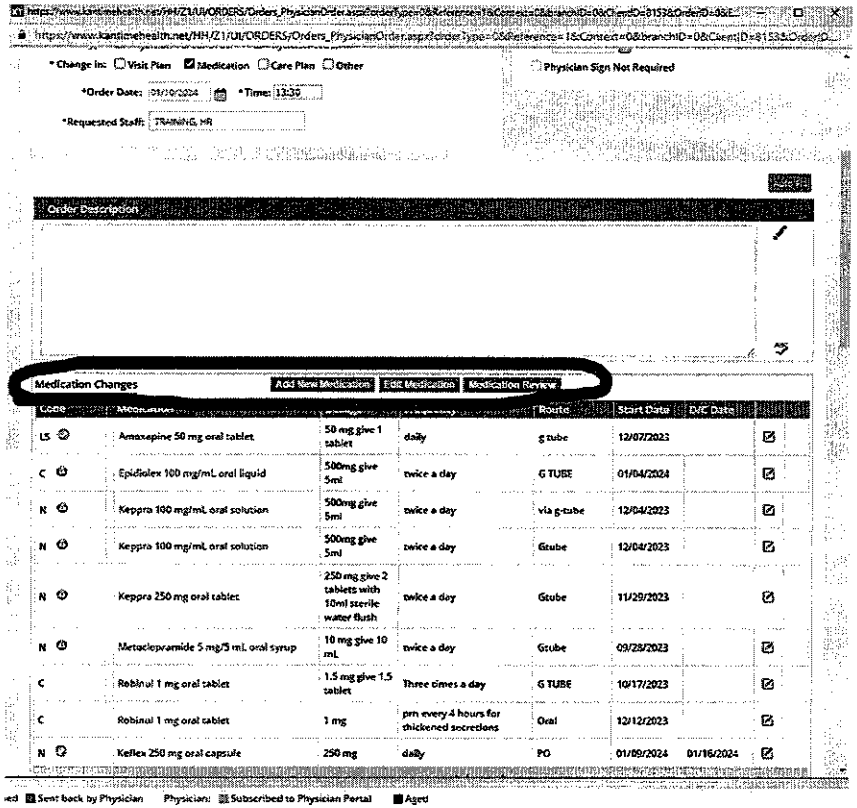


Editing a Medication



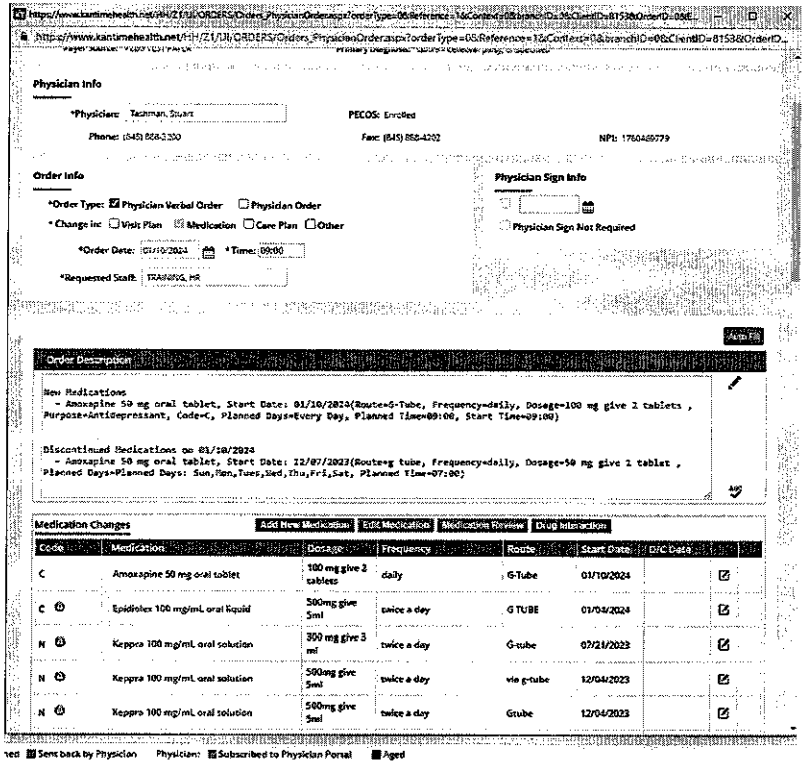
- You will then need to discontinue the medication.
  - Enter in the D/C date by clicking the calendar icon. Click the blue button "Save."
  - A message "Medication Updated Successfully" will appear on the screen.

Editing a Medication



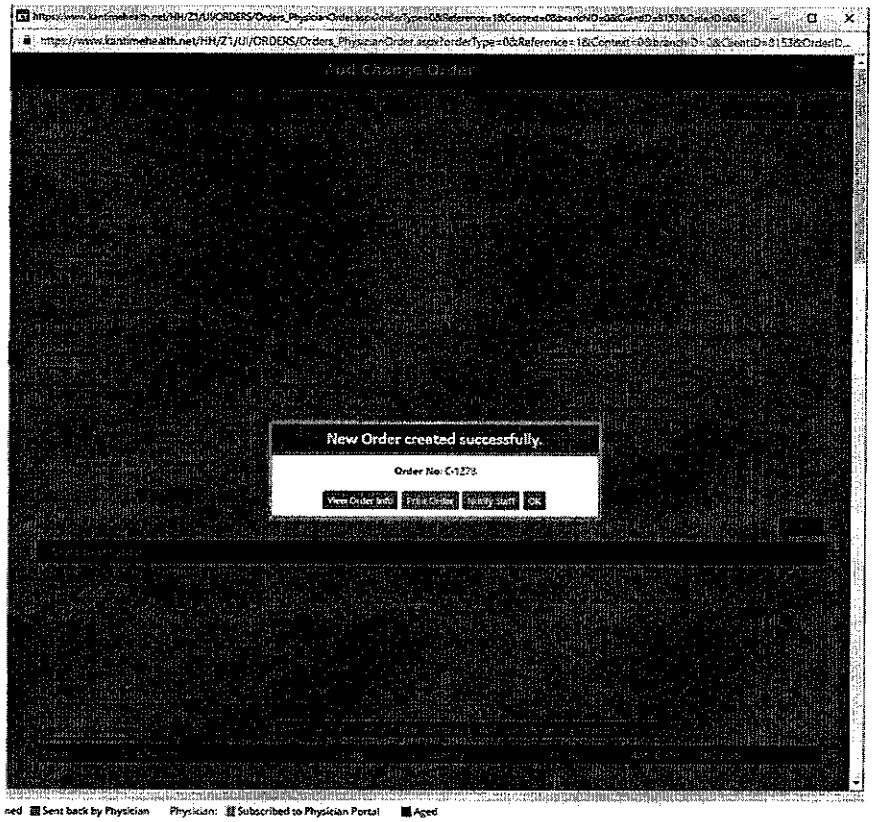
- Close the "Edit Medication" window which will then return you to the "Add Change Order" window.
- Click "Add New Medication" and follow the previous procedure.
- Ensure that under "Code" that "Changed" is selected. Then, click "Save." A message will appear on the screen: "Medication Updated Successfully."
- A blank "Add New Medication" window will populate. Click the blue button "Close" to close that window

Editing a Medication



- This will then bring you back to the "Add Change Order" screen.
- You will see in the order description box, the changes that were made to the medication.
- Review all the changes in the order and when all is accurate and complete, scroll to the top and then click the blue button "Save & Submit."

Editing a Medication



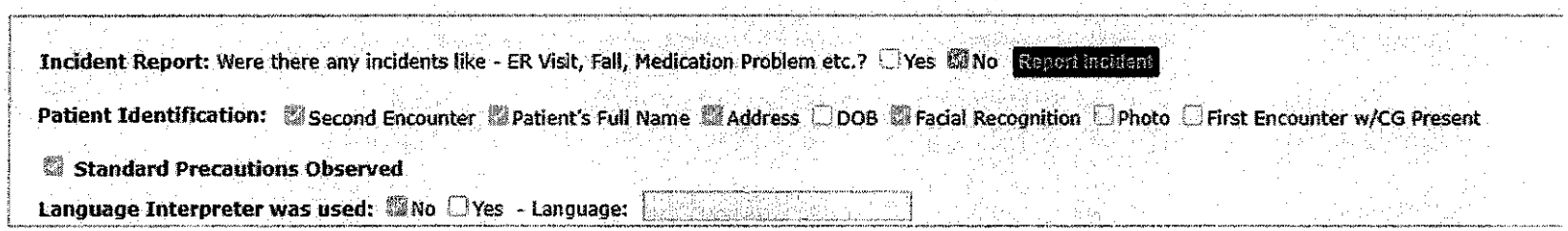
- "New Order Created Successfully" message box will appear.
- Click the blue "OK" button and then the order is submitted into the system. Someone from the Clinical Department will contact you and the Primary Caregiver to review the order prior to it being sent to the Prescriber's office for review and signature.
- You will be able to view your order in the "Order tab." Once the order is submitted, the changes made are immediately live in the system. In the eChart under the Medications tab, you will see changes made via the Change Order.

How to Complete the Visit Note

KanTime
How better happens.

Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

Nursing Clinical Note

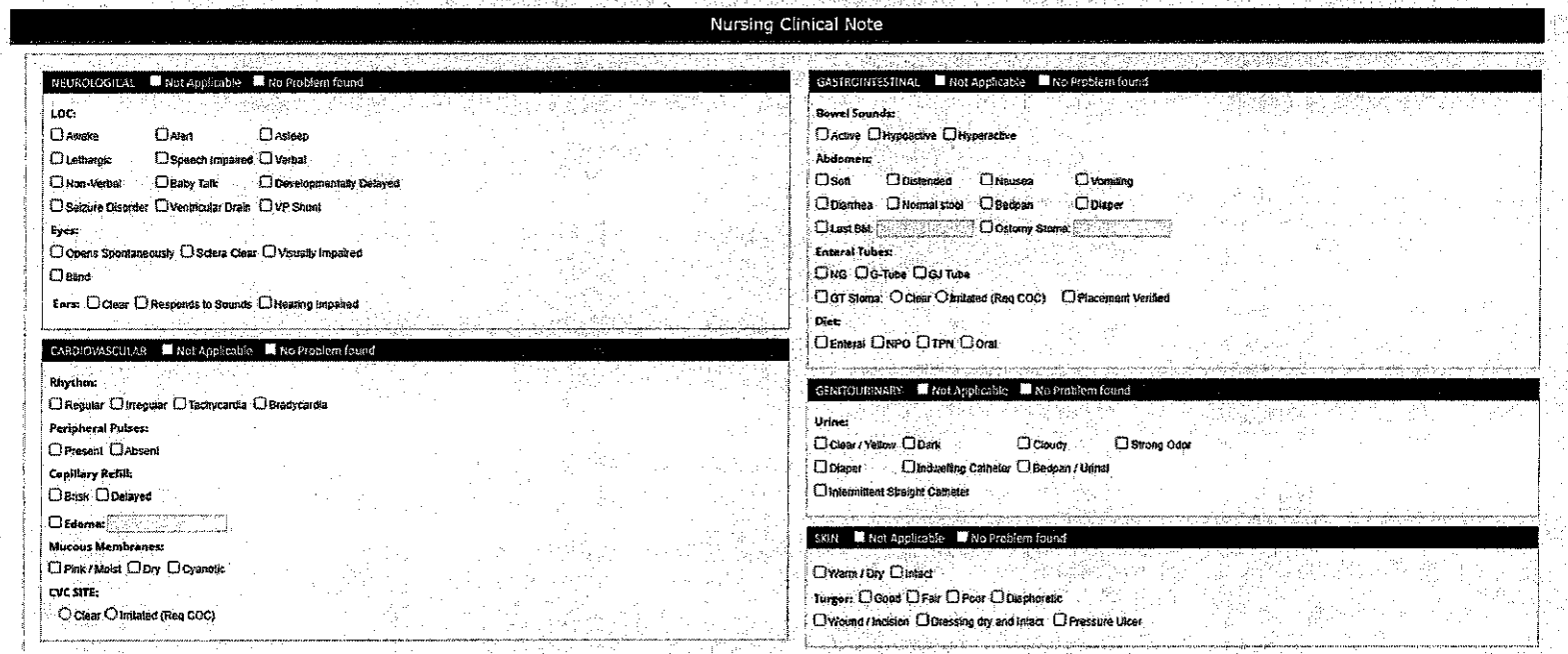


If there is an incident during your shift: please select "Yes." Then, click the blue "Report Incident" button and complete the incident report. You **MUST** notify the office immediately. Submission of this form does **NOT** automatically notify the office.

As per agency policy, the patient identification should be marked as follows:

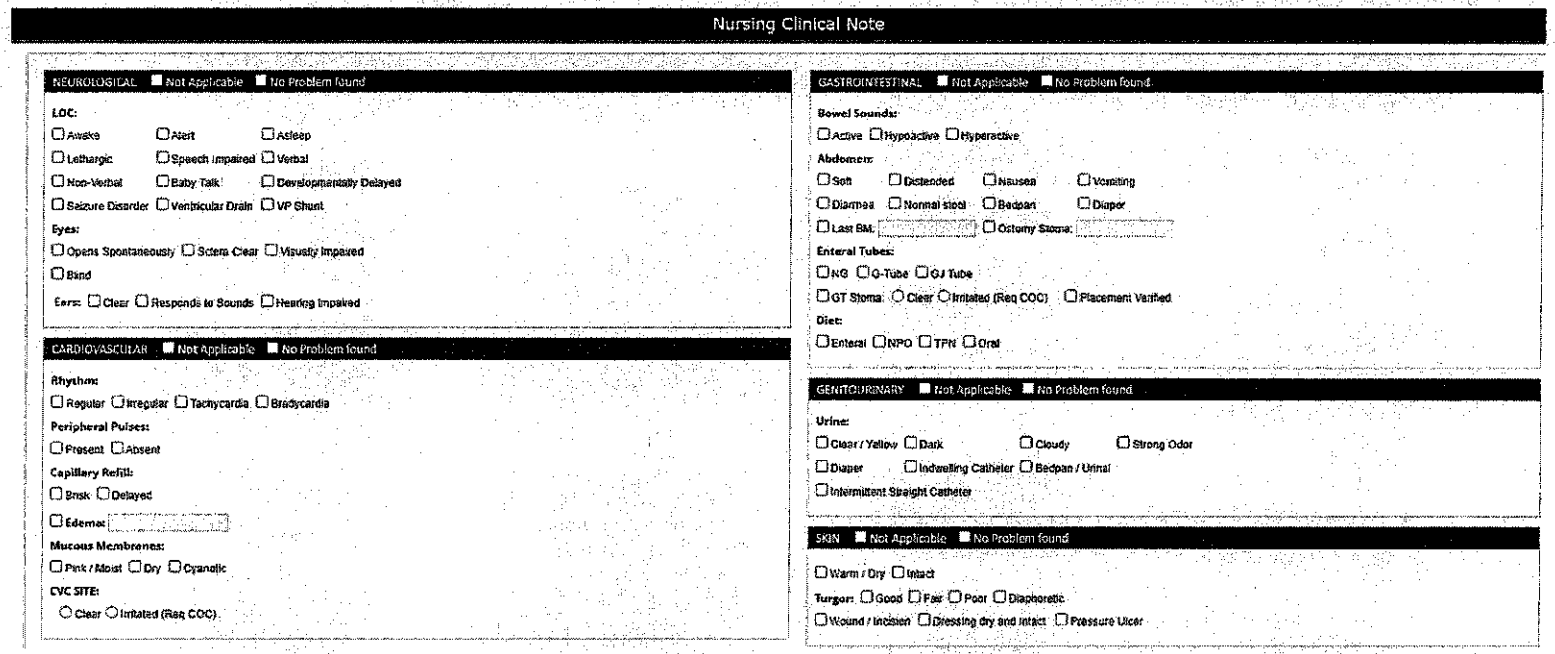
- **For first encounter:** First Encounter with CG present, patient's full name, address, and DOB
- **Second Encounter and any encounter after:** Second Encounter, Facial Recognition, patient's full name

Standard Precautions and Language Interpreter must be addressed each shift.

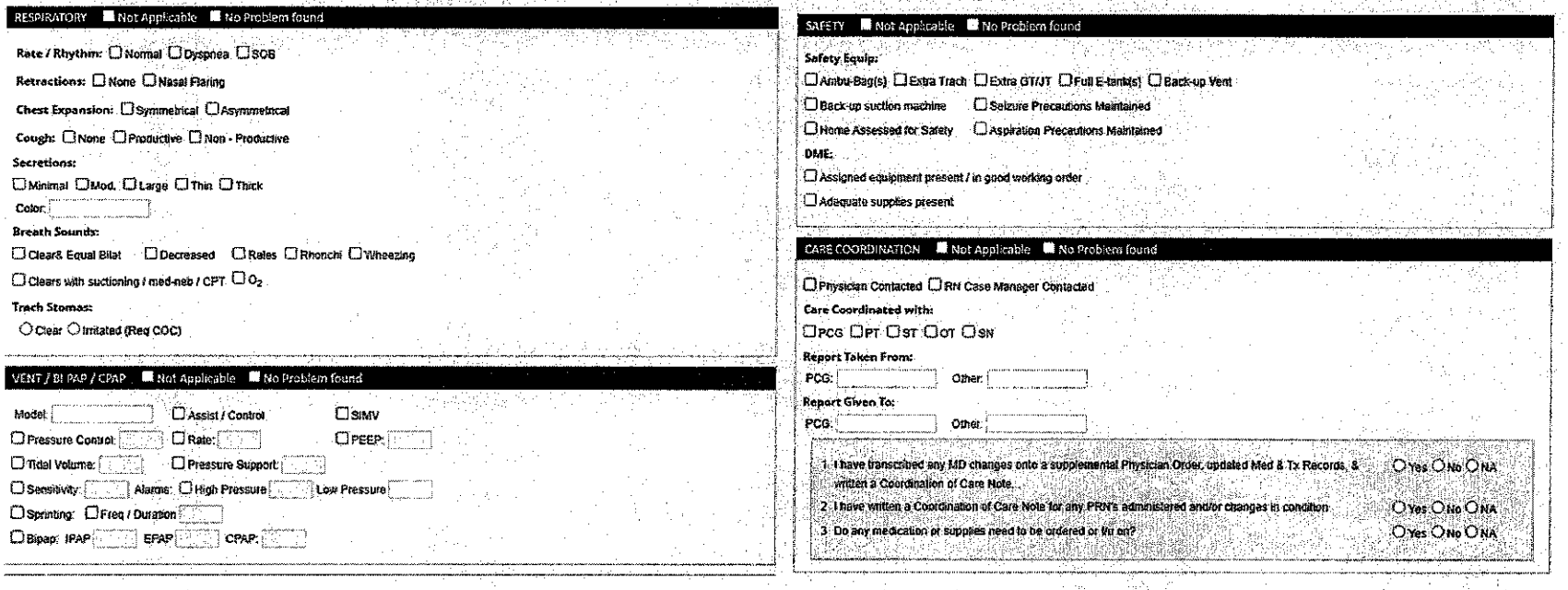


When Completing Each System Evaluation in the Visit Note:

- Under each systems heading, select what all items that are applicable to your client and what is found upon initial assessment/evaluation at beginning of shift ONLY



<u>Under Gastrointestinal:</u> Last BM: enter the date and time (time only if available) of the last reported BM during oncoming shift report



RESPIRATORY ☐ Not Applicable ☐ No Problem found

Rate / Rhythm: ☐ Normal ☐ Dyspnea ☐ SOB

Retractions: ☐ None ☐ Nasal Flaring

Chest Expansion: ☐ Symmetrical ☐ Asymmetrical

Cough: ☐ None ☐ Productive ☐ Non - Productive

Secretions:

☐ Minimal ☐ Mod. ☐ Large ☐ Thin ☐ Thick

Color:

Breath Sounds:

☐ Clear& Equal Bilat ☐ Decreased ☐ Rales ☐ Rhonchi ☐ Wheezing

☐ Clears with suctioning / med-neb / CPT ☐ O_2

Trach Stomas:

○ Clear ○ Irritated (Req COC)

VENT / BI PAP / CPAP ☐ Not Applicable ☐ No Problem found

Model: ☐ Assist / Control ☐ SIMV

☐ Pressure Control: ☐ Rate: ☐ PEEP:

☐ Tidal Volume: ☐ Pressure Support:

☐ Sensitivity: Alarms: ☐ High Pressure Low Pressure

☐ Sprinting: ☐ Freq / Duration

☐ Bipap: IPAP: EPAP: CPAP:

SAFETY ☐ Not Applicable ☐ No Problem found

Safety Equip:

☐ Ambu-Bag(s) ☐ Extra Trach ☐ Extra GT/JT ☐ Full E-tank(s) ☐ Back-up Vent

☐ Back-up suction machine ☐ Seizure Precautions Maintained

☐ Home Assessed for Safety ☐ Aspiration Precautions Maintained

DME:

☐ Assigned equipment present / in good working order

☐ Adequate supplies present

CARE COORDINATION ☐ Not Applicable ☐ No Problem found

☐ Physician Contacted ☐ RN Case Manager Contacted

Care Coordinated with:

☐ PCG ☐ PT ☐ ST ☐ OT ☐ SN

Report Taken From:

PCG: Other:

Report Given To:

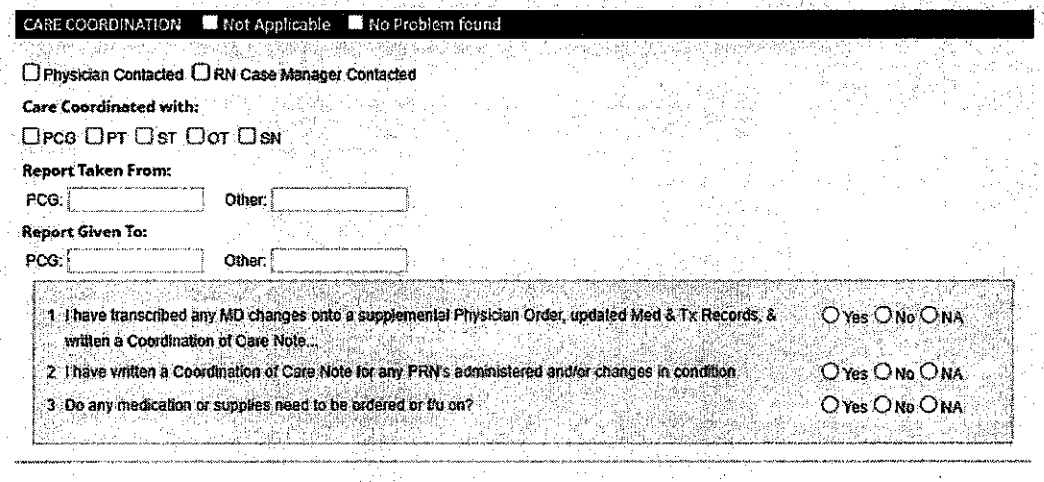
PCG: Other:

1. I have transcribed any MD changes onto a supplemental Physician Order, updated Med & Tx Records, & written a Coordination of Care Note. ○ Yes ○ No ○ NA

2. I have written a Coordination of Care Note for any PRN's administered and/or changes in condition ○ Yes ○ No ○ NA

3. Do any medication or supplies need to be ordered or fill on? ○ Yes ○ No ○ NA

- If your client does **NOT** have **Vent/BiPAP/CPAP:** check the "Not Applicable" box
- **Safety:** check off all items as they apply to your patient and what equipment is on-hand in the home/school
  - If you do not check off the boxes under DME, please include why and further explanation in the care coordination free text section of the note and notify the office and caregiver(s).


CARE COORDINATION ■ Not Applicable ■ No Problem found

☐ Physician Contacted ☐ RN Case Manager Contacted

Care Coordinated with:

☐ PCG ☐ PT ☐ ST ☐ OT ☐ SN

Report Taken From:

PCG: Other:

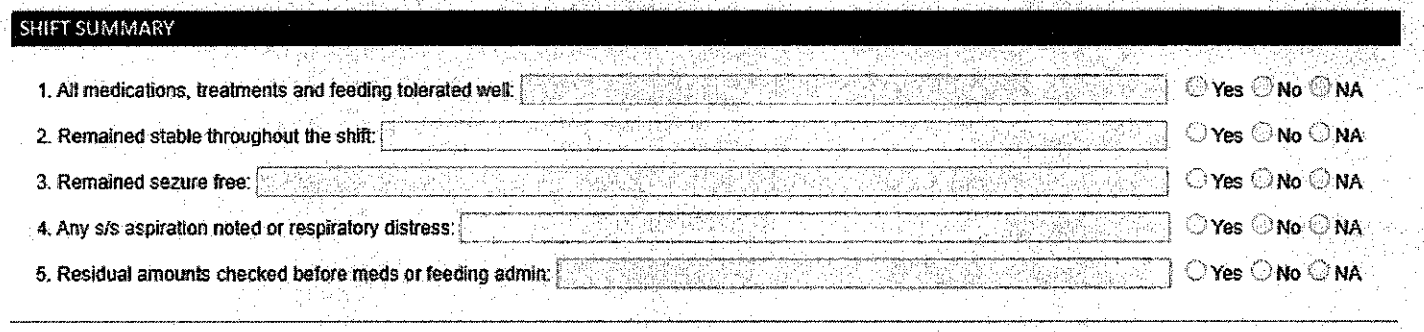
Report Given To:

PCG: Other:

1 I have transcribed any MD changes onto a supplemental Physician Order, updated Med & Tx Records, & written a Coordination of Care Note...	○ Yes ○ No ○ NA
2 I have written a Coordination of Care Note for any PRN's administered and/or changes in condition	○ Yes ○ No ○ NA
3 Do any medication or supplies need to be ordered or f/u on?	○ Yes ○ No ○ NA

Care Coordination:

- If you spoke with a Physician or RN Case Manager (J&D Clinical Department) during shift, click off the box and then include the details in the care Coordination free text section.
- **Care Coordinated with:** please select PCG (Primary Care Giver) and SN (Skilled Nursing) ONLY
- **Report Taken From/Given To**: Provide the name and relationship of the person you are receiving report from and giving it to. **This person must be signed off on the Patient Caregiver Teaching Checklist from KanTime or Patient Certificate of Education from AlayaCare. For the "Other" section, complete if it is a J&D nurse or other agency nurse. Provide the name of the nurse and nursing agency.
- You **DO NOT** need to answer the 3 questions in the blue box



When Completing the Shift Summary Section of the Visit note:

- All 5 items must be marked "Yes"/ "No"/ "NA" each shift.
- The comment section in this area is a limited text field. Please comment on the location of supporting documentation for unexpected outcomes. (Ex: See Intervention, See log, etc.)

FLOWSHEET	
	Time
VITAL SIGNS - Taken at beginning and end of Shift / PRN	Temperature
	Heart Rate
	Respiration
	Blood Pressure
	LOC
	Seizures
CARE / ACTIVITIES	Pain
	Position
	Hygiene
	Braces / Splints
RESPIRATORY	SA O_2
	Apnea Monitor
	Ventilator Check Vent / BiPAP / CPAP
	O_2 Liter
	Lavage
INTAKE/OUTPUT	PO Fluids
	Stool
	Urine
	Emesis

Flow Sheet: ***Max readings are 10 entries***

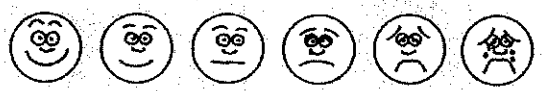
- Add a new reading each time a vital assessed or type of care is provided, using the codes below as they apply, or as respiratory changes occur. Only document what applies at that time. You do **NOT** need to complete each area

- **Intake/Output:** Under "PO Fluids": Enter one reading at end of shift with the total intake amount for the shift regardless of PO or enteral status. Ex. 1,500 mL.

- Enter output readings as they occur throughout the shift.

A	=Ambulating	AW	=Awake	AS	=Asleep
B	=Bath	BA	=Back	BD	=Bed
C	=Chair	CRL	=Crawl	H	=HOB ↑ 30 °
HLD	=Held	LS	=Left Side	O	=Oral Care
P	=Peri Care	PB	=Partial Bath	PS	=Position Self
RS	=Right Side	S	=Skin Care	SC	=Splints Checked
SF	=Splints Off	SH	=Shower	SO	=Splints On
ST	=Stander	WK	=Walker	WC	=Wheelchair

PAIN SCALE



CARE COORDINATION:

Care Coordination Free Text Note Box:

- Include details of oncoming shift report from caregiver or nurse
- Document any reported changes in status and/or medication and/or intervention changes. ****Enter change order(s) if not already entered****
- PRN medications/treatments reported currently in use.
- The status of medication administration prior to your arrival
- Last reported void
- Details of any conversations or visits with MD, Pharmacy, DME, or Clinical Dept. at J&D Ultracare. **Any order changes MUST be entered by the field nurse via change order**
- Document any abnormal occurrences
- Do **NOT** document all cares provided here or provide an hour by hour narrative. All specifics of the care you provide along with times MUST be documented in the intervention comment boxes. This section of the note will populate to the notes section of each visit for others to view without viewing your entire shift note.
- Please use the "ABC" button in the lower right hand corner in order to spell check your documentation

Interventions Tab

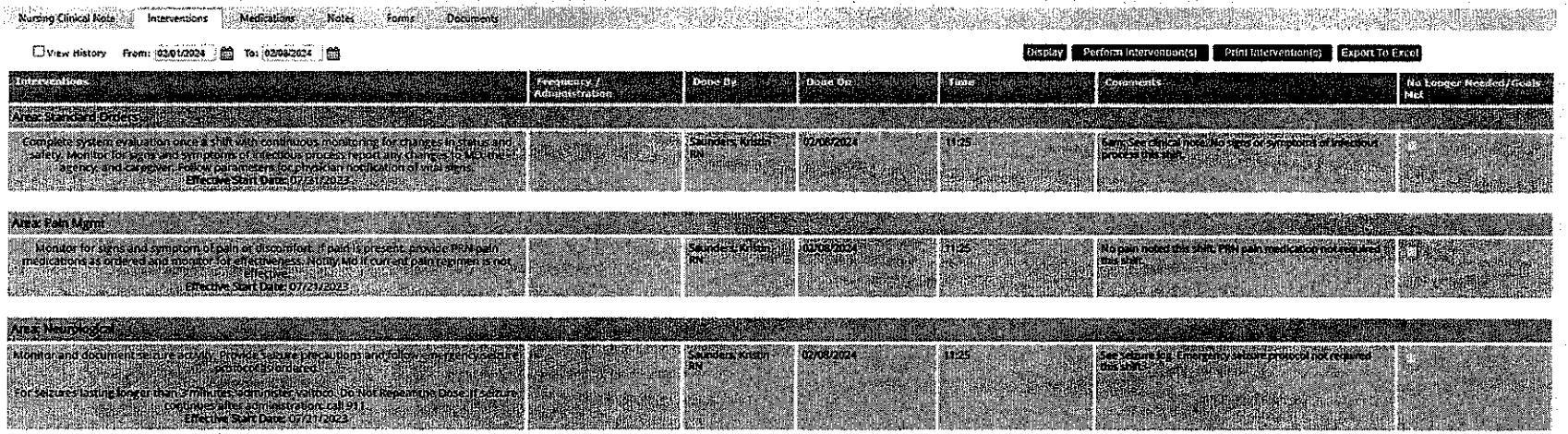

Area: Standard Orders

	Intervention	Frequency / Administration	Time	Comments	No Longer Needed/Goals Met
☑	Complete system evaluation once a shift with continuous monitoring for changes in status and safety. Monitor for signs and symptoms of infectious process report any changes to MD, the agency, and caregiver. Follow parameters for physician notification of vital signs. **Effective Start Date:** 07/21/2023		1128	see clinical note. No signs or symptoms of infectious process this shift.	☐

- You must document on **ALL** the interventions or you will not be able to submit to QA.
- To perform the intervention, check the box to the left of the intervention.
- **In the comment column of each intervention, you will document the actual time the intervention is performed and include the documentation of cares or if the intervention was not required this shift.**

  ****PLEASE NOTE – The time column is now disabled in the system. You will no longer enter times in that column****
- Please be sure to address **ALL** items within the intervention at least once per shift as some interventions contain multiple items. If you perform an intervention multiple times, provide the times and correlating documentation.
- Interventions that were reported completed by caregiver prior to arrival should be timed as start of shift and state reported completed by caregiver prior to arrival.

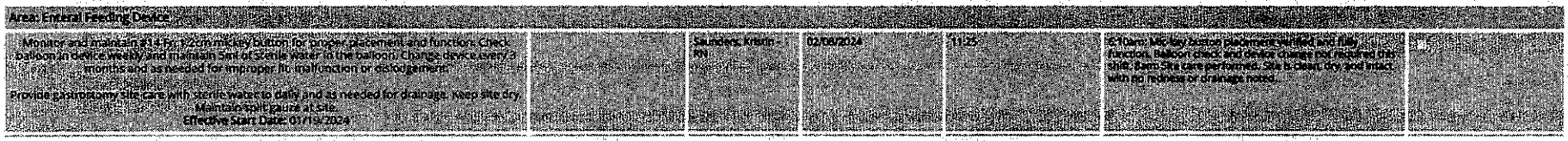
Interventions Tab



- If you document an item on a form such as the clinical nursing note or flowsheet or a log such as suction, seizure, or blood glucose log, you can time that intervention for the end of shift and state, "see log/form" in the comment box.
- **<u>DO NOT</u>** check the column "No Longer Needed/Goals Met"

Interventions Tab

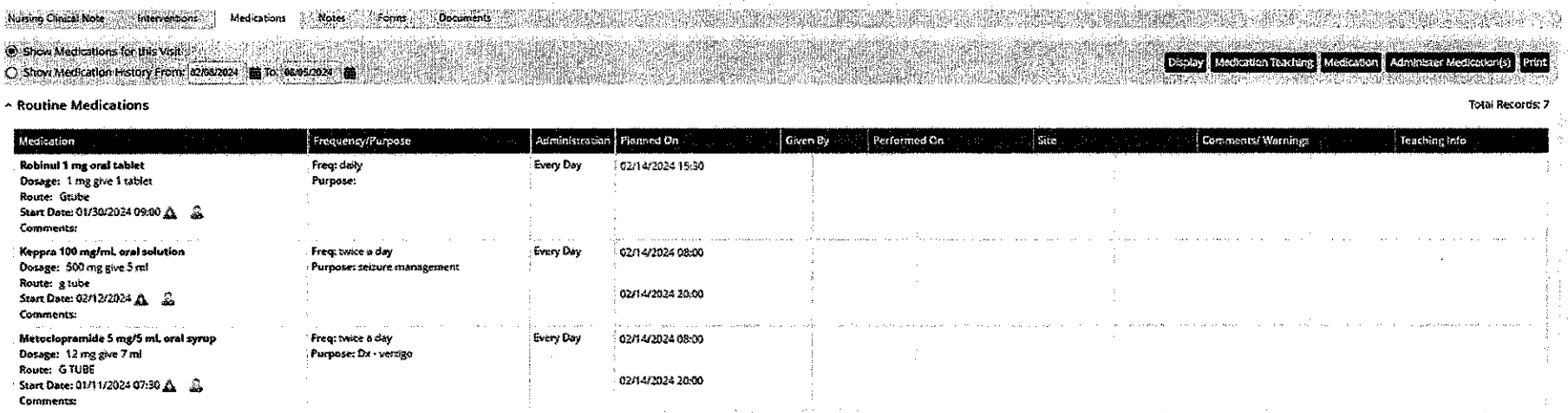
Please address all areas of the intervention. Many interventions have multiple orders listed in one intervention. For example: Enteral Feeding Device. See below:



For school cases: Do **NOT** include the time of arrival or departure from school itself.
See example below:

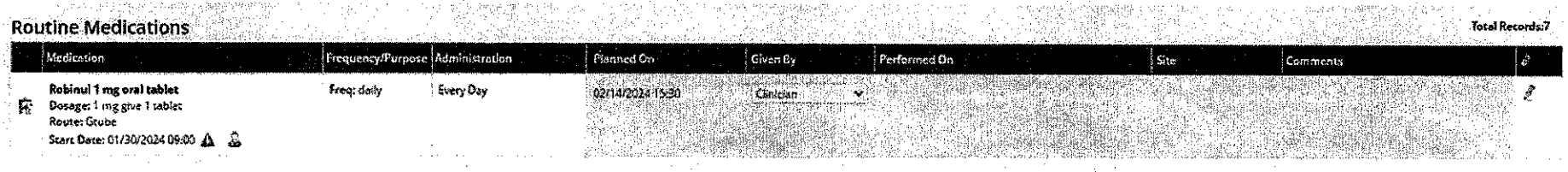
Medications Tab

All medications due during the check in and check out time must be performed during your shift. Those items will show in red under planned time.

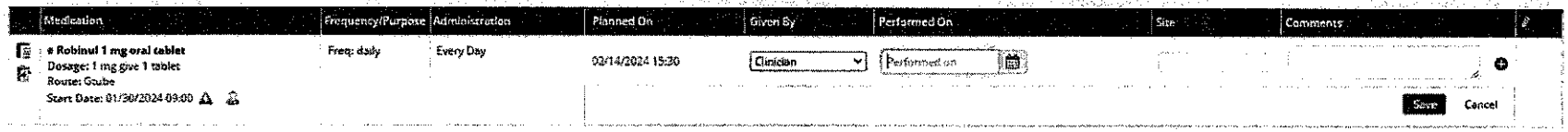


Medications Tab

Once in this tab, click the blue "Administer Medication(s)" button. Then, the screen will look like this below. Click on the pencil icon all the way to the right to document the medication administration.



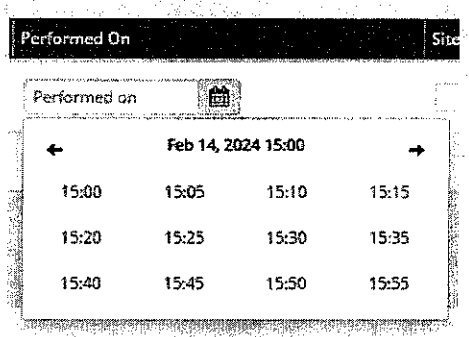
After you click on the pencil icon, the entry will then look like this:



Medications Tab – Review of all Columns

- **Given By:**
  - Select "Clinician" if you administered
  - Select "Parent" if you observed the parent give or parent reported they administered
  - Select "Self" if the client self-administered the medication.

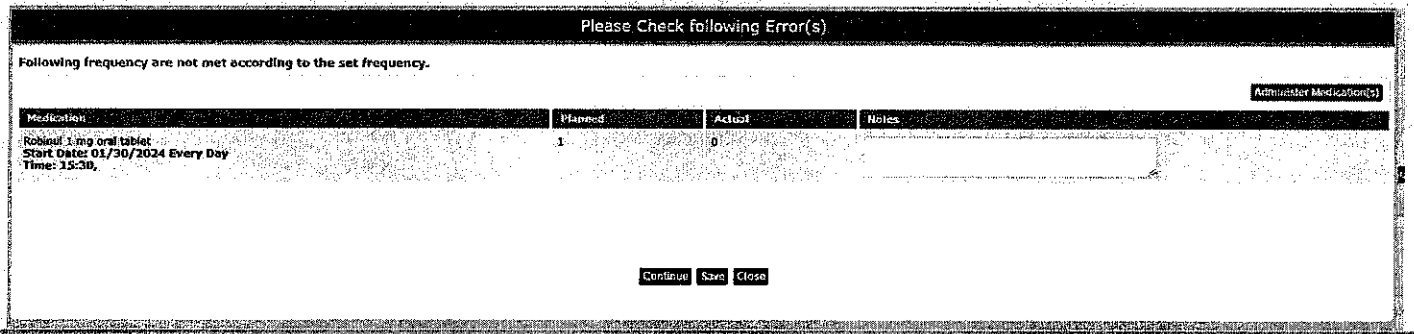
- **Performed On:** Click the calendar icon. first click on time is the hour, then once you click the hour the second option will be minutes in 5-minute increments.



Medications Tab – Review of all Columns

Performed On (Continued):

- Ensure that all documented times are within your check in and check out times
- Document the time actual time of the medication administration. Then click, "Save." The date and time in the "Planned On" column will now turn green.
- If the time is not within the half hour before or after the planed time or planned check in-check out time, you will receive a warning: "Medication is given outside the Planned Time. Do you want to Proceed?" Click the continue button. When you submit your eChart to QA, you will see a validation screen (see below) that following frequency are not met according to the set frequency- explain why in this comment box and hit continue. In the event you did not document a medication you administered, tap administer medication and document the actual time of the administration.



Medications Tab – Review of all Columns

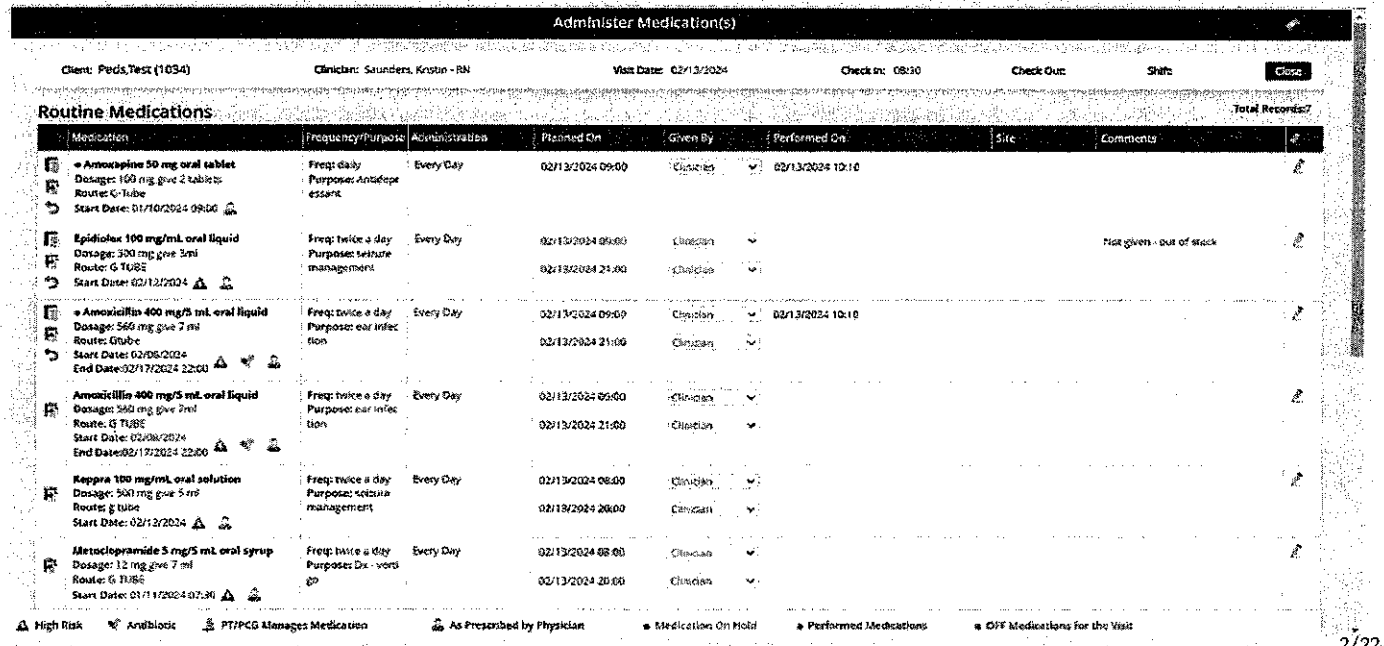
Site: you do not have to document the site if the route that is listed in the medication order is used. If there is more than one route listed (For example PO or G tube) then you must list the route given in the site box. If the medication is topical or injection the site should also be indicated.

Comment Box:

- Details of medication prep if required (crushed and dissolved in 10mls of water, added to formula, etc.)
- Details of medication administered at times other than planned times.
- If a medication was held due to client request, out of stock, or other clinically warranted rationale.

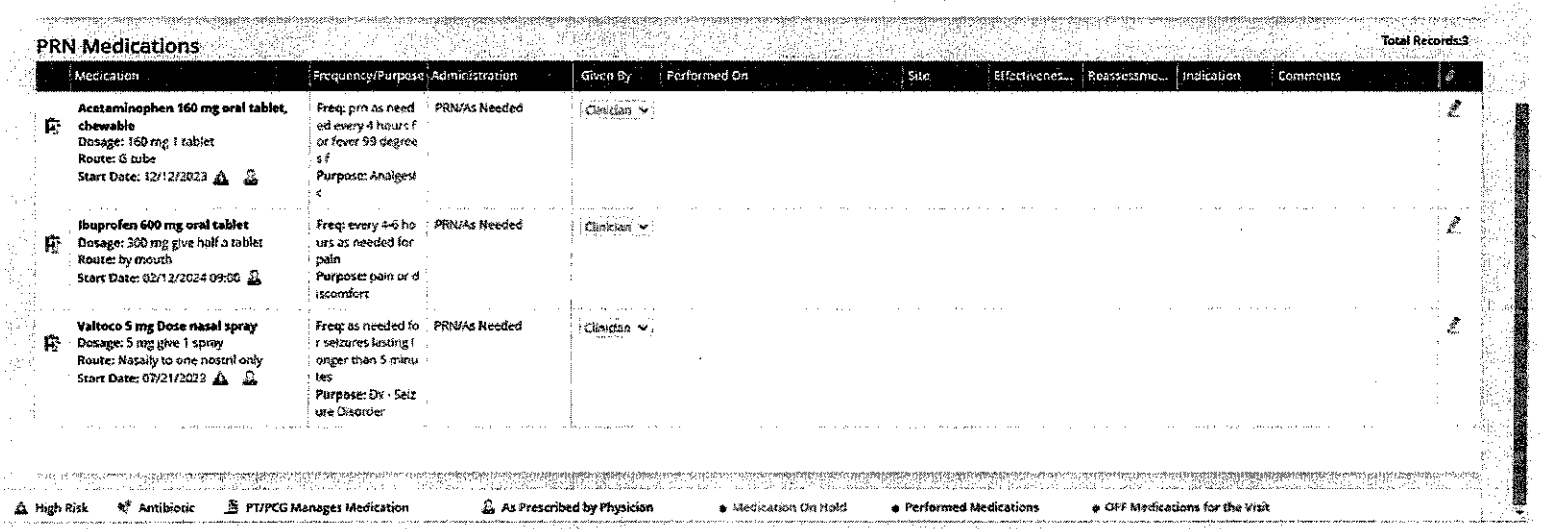
Medications Tab – PRN Medications

As your client's Plan of Care (POC/485) is updated with a new certification period, your MAR screen with change in appearance



Medications Tab – PRN Medications

PRN/As Needed Medications will be listed that the bottom of the MAR and with the new update, the screen will look like this:



Medications Tab – PRN Medications

With this new update, there are additional columns within the documentation entry: Effectiveness/Reaction, Reassessment Time, and Indication. When documenting a PRN medication, please follow the following format for all PRN administrations:

- Given By
- Performed On
- Site
- Effectiveness/Reaction
- Reassessment Time
- Indication
- Comments

Medications Tab – PRN Medications

- **Given by:** select the person administering the medication. Options are Clinician (Nurse), Parent or Caregiver (this depends on Pediatric or Adult patients), or Self (meaning the patient).
- **Performed on:** Select the actual time of administration of the medication.
- **Site:** This does not need to be documented if the site of actual administration matches the route listed in the actual order. For patients that have doctor's orders stating they can receive medications via G-tube, PO, topical, or injection then you will need to comment on the route of the medication under this area.
- **Effectiveness/Reaction:** If you administered PRN Tylenol for a fever of 100.5 F, you will come back to this entry to reassess/reevaluate your client's response. Document if the PRN medication was effective/client's reaction.
- **Reassessment Time:** You will document the time that you reassessed/evaluated your patient for the effectiveness of the medication. For example, "10am" for the above scenario is that is when you re-took the patient's temperature.

Medications Tab – PRN Medications

- **Indication:** Document the reason for PRN medication administration. This area MUST be completed for any PRN medication administration. This **MUST** match the PRN frequency order. If it does not match, you must enter a change order in to reflect this change in the Doctor's orders for the medication as it is considered a frequency change.

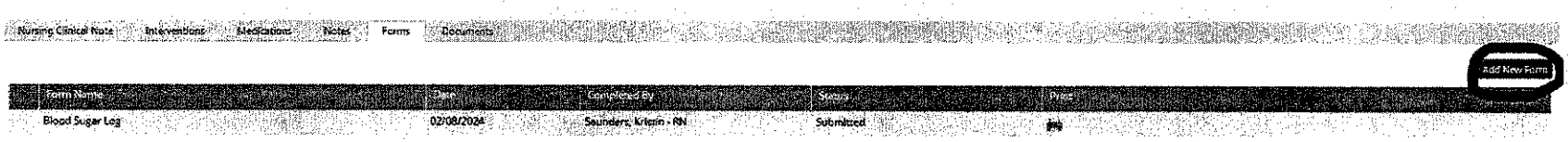
- **Comments:** document any other additional information here such as added to an enteral feeding, medication prep information such as mixed with 100ml of water, etc.

Notes Tab

- The drop down will allow you to choose which item notes you would like to view.
- By default, the note type selected is the visit note, which will show the narrative and care coordination sections of visit notes submitted from prior shifts.
- The drop down will allow you to choose which item notes you would like to view.
- You can select the date range you would like to view as well by tapping the calendars, setting the date, and then hitting display

Forms Tab

- This tab will give you access to review all forms submitted for the client and allow you to review them as well as add new forms.
- **Seizure and Suction Logs**: may have already been created with a date different than the current date by a different user. These are running logs for the current episode (certification period). Click on the actual Form name to access the log.
- If you need to add a new form - Tap add a new form (see below).



Forms Tab

Forms that are used by Field Nursing Staff are as follows:

- Seizure Log
- Suction Log
- Blood Sugar Log *(Must be added for each visit and have a maximum of 25 entries per form)*
- Incident Report
- Caregiver Teaching Checklist
- Orientation & Competency Form *(See Orientation Process located in each client's chart under Profile-→ Documents tab)*

Forms Tab

****Please note:** We are no longer using the FLACC Behavioral Scale or the Wong-Baker Pain Scale form. These will **ONLY** be used as a reference guide for pain management. Please see Pain Management Polices as they relate to your patient. ****

Please document pain relief within the PRN medications within the MAR. Also, please document any pain related cares within the pain intervention. You must record pain levels within the intervention.

Pain Management Policy (Pediatric Care)

C-7 A
Revision: 1.2020

PURPOSE

To optimize the prevention, assessment and management of pain in children.
To make pain management a collaborative effort consisting of all members of the healthcare team, the patient and the patient's family.
To educate health professionals, patients and families as a crucial aspect of pain assessment, prevention and management.
To provide the best pain management include pharmacological, psychological and physical methods.
To provide pain management evidence based guidelines and maintain individuality for each patient.
To prevent pain when possible. Pain is better prevented than treated.
Requirements for analgesics are lower if children are pretreated before painful experiences.
To identify types of pain that children may experience:

- Procedural pain such as injections, blood draws, heel pokes, IV starts, splinting, dressing changes, catheterization, sutures, NG insertion.
- Pain related to acute/chronic disease such as cancer pain, cerebral palsy, meningitis.
- Pre and post-operative pain.
- Recurrent and chronic pain such as abdominal, headache and musculoskeletal.

POLICY

Pain Assessment

Regular pain assessment is a standard of care and will be incorporated into all healthcare interactions and interventions using an evidence informed, developmentally – appropriate process and documented in the patient record.

Child's pain can be influenced by cultural beliefs, past experiences and caregiver's coping strategies/responses to pain.

Every patient will have a pain assessment:

- at time of health care interaction and/or time of admission
- with vital signs
- when the patient is at risk for pain and/or receiving pain management interventions

Pain will be reassessed within one hour of a pain management intervention and reassessment will continue q4h or more often until the pain relief goal is achieved.

Unrelieved pain should be brought to the attention of the interdisciplinary team.

Pain Classification

Acute pain is of sudden onset, is felt immediately following injury, is severe in intensity, but is usually short – lasting. It arises as a result of tissue injury stimulating nociceptors and generally disappears when the injury heals.

Chronic pain is continuous or recurrent pain that persists beyond the normal time of healing. Chronic pain may begin as acute pain and persists for long periods or may recur due to a persistence of noxious stimuli or repeated exacerbation of an injury. Chronic pain may also arise and persist in the absence of medical illness. Chronic pain can negatively affect all aspects of daily life.

PROCEDURE

Methods of Pain Assessment

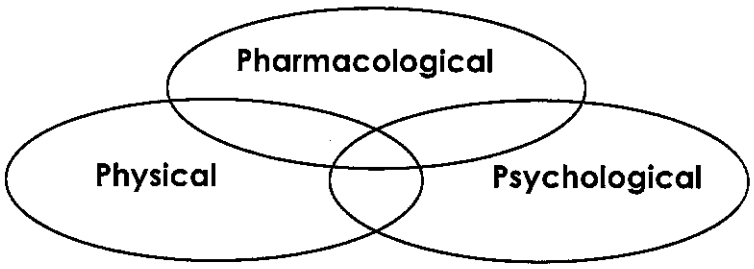
Pain assessment must be multidimensional using self-report when possible, family perceptions and health care provider observations of behavioral and physiologic signs of pain depending on the age/cognitive state of the child and/or communication capabilities (see Appendix A).

Pain Rating Scale Tool

Use developmentally appropriate scoring tool (Appendix B: Pain Measurement Tool)
Consistent use of a pain measurement tool promotes better continuity of care and allows for more accurate tracking of pain over time.
Same pain scale should be used consistently by all healthcare providers caring for that child.
Type of pain rating scale used must be documented.

Develop pain management plan with interdisciplinary health care team, patient and family incorporating:

- Pain assessment findings and identified pain goals
- Etiology of pain
- Maximum pain treatment for first procedure to reduce anxiety and pain
- Treatment strategies – 3 P's approach (pharmacological, psychological and physical)



Nursing Guidelines for Prescribing Medications:

Commonly used analgesics – Nurses are expected to have a good understanding of analgesics commonly used in pediatrics. The nurse is required to know which medications are most appropriate and the frequency with which they should be administered:

- **Acetaminophen**
  - Most commonly used medication for treatment of mild pain
  - Common side-effects are minimal and rare in the normal prescribed dose
  - These drugs have a "ceiling effect" which means that escalating the dose above the recommended dosage does not provide additional analgesia
- **NSAIDS** (non-steroidal anti-inflammatories)
  - For treatment of mild to moderate pain. They act on the peripheral nervous system to provide pain relief
  - Can be used as co-analgesics
  - Common side effects include GI irritation/upset and antiplatelet effects contributing to some bleeding tendencies
  - These drugs have a "ceiling effect" which means that escalating the dose above the recommended dosage does not provide additional analgesia
- **Opioids**
  - For treatment of moderate to severe pain. They act on the central nervous system to provide pain relief
  - Treatment of opioid side effects such as nausea, vomiting and pruritus is imperative so that adequate pain management is not compromised
  - Constipation is another common side-effect. Patients receiving opioids for 2-3 days or greater should be closely monitored for constipation and will require stool softeners
- **Adjuvants – medication which has a primary indication other than pain, but is analgesic in some painful conditions**
  - Anticonvulsants (gabapentin) tricyclic antidepressants (amitriptyline), clonidine are important in the treatment of neuropathic pain
  - Benzodiazepines may be helpful for the treatment of painful muscle spasms
  - Anticholinergics may be used for bladder and smooth muscle spasms (buscopan, oxybutynin)

Pain Management – Psychological Strategies

Use developmentally appropriate psychological comfort measures

Use of psychological strategies in conjunction with pharmacological and physical strategies can promote lower levels of anxiety, distress and pain (Appendix A)

Appendix "A" Developmental Differences of Children According to Age

Developmental Group	Expression of Pain	Working with Children
Infants	May: • Exhibit body rigidity or thrashing, may include arching • Exhibit facial expression of pain (brows lowered and drawn together, eyes tightly closed, mouth open and squarish) • Cry intensely, loudly • Be inconsolable • Draw knees to chest • Exhibit hypersensitivity or irritability • Have poor oral intake • Be unable to sleep	• Allow a pacifier • Use a quiet soothing voice • Touch, rock, cuddle • Keep infant warm • Positions of comfort during procedures • Remember that infants experience pain
Toddlers	May: • Be verbally aggressive, cry intensely • Exhibit regressive behavior or withdraw • Exhibit physical resistance by pushing painful stimulus away after it is applied • Guard painful area of body • Be unable to sleep	• Positions of comfort during procedures • Keep frightening objects out of line of vision • Provide concrete feedback -"good job" • Allow child to have their doll, blanket, toy
Preschoolers/ Young Children	May: • Verbalize intensity of pain • See pain as punishment • Exhibit thrashing of arms and legs • Attempt to push stimulus away before it is applied • Be uncooperative • Need physical restraint • Cling to parent, nurse or significant other • Request emotional support (e.g. hugs, kisses) • Understand that there can be secondary gains associated with pain • Be unable to sleep	• Positions of comfort during procedures • Explain procedure just beforehand • Talk throughout procedure • Distract with noise ie. counting • Use positive terms
School-Age Children	May: • Verbalize pain • Use an objective measurement of pain • Experience nightmares related to pain • Exhibit stalling behaviors (e.g. "Wait a minute") • Have muscular rigidity such as clenched fists, gritted teeth, contracted limbs, body stiffness, closed eyes or wrinkled forehead • Be unable to sleep	• Offer simple choices to help child feel more in control • Positions of comfort during procedures • Allow questions • Address child's fears • Give rewards, i.e. sticker
Adolescents	May: • Localize and verbalize pain • Deny pain in presence of peers • Have changes in sleep patterns or appetite • Be influenced by cultural beliefs • Exhibit muscle tension and body control • Display regressive behavior in presence of family • Be unable to sleep	• Positions of comfort during procedures • Preserve modesty • Provide opportunity for questions • Listen to concern • Explain procedure carefully and allow choices

Appendix "B" Pain Measurement Tool

PAIN INTENSITY SCORES

- Age **8+**: Start with (A). If it doesn't work use (B). If that doesn't work use (C).
- Age **4+**: Start with (B). If it doesn't work use (C).
- If the child is term birth to 3 years, or unable to give self-report, use (C).

P rovokes – What makes it worse? What makes it better?
Q uality – What does it feel like? Describe the pain.
R adiates – Where is the pain? Does it go anywhere else?
S everity – Use a scale below to give a 0-10 score.
T ime – When did it start? How long has it lasted?
micunursing.com/pain.htm

(A) Self-report for verbal patients 8 years and up: Verbal Numerical Scale (VNS)

www.usask.ca/childpain/NRS

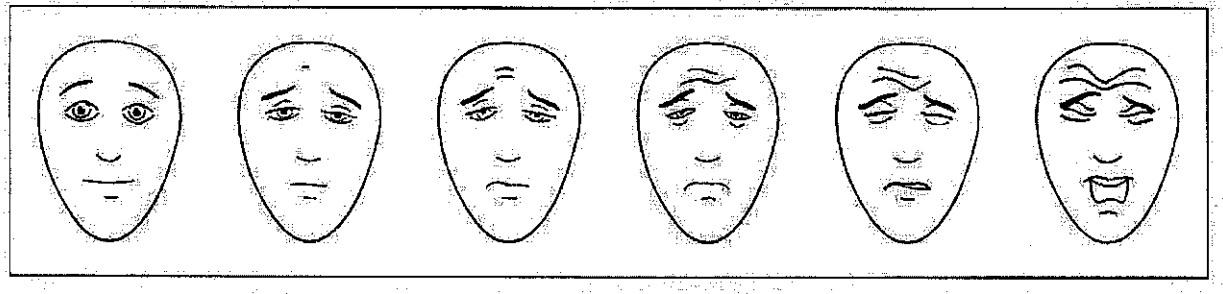
I'd like you to tell me a number from 0 to 10 to show how much it hurts right now (how much hurt or pain you have). 0 would be no pain or no hurt at all. 10 would be the most hurt or the worst hurt you could have.

(For patients who need a simpler verbal self-report scale: "no pain"=0 "mild"= 1-3 "moderate"= 4-7 "severe"= 8-10)

(B) Self-report for age 4 years and up: Faces Pain Scale – Revised (FPS-R)

www.painsourcebook.ca

These faces show how much something can hurt. This face [point to left-most face] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to right-most face] – it shows very much pain. Point to the face that shows how much you hurt [right now].



0 2 4 6 8 10

(C) Observation for infants up to adolescents: FLACC

www.childcancerpain.org/content.cfm?content=assess08

Sum the five scores to produce a score from 0 to 10

Criteria	Score 0	Score 1	Score 2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, uninterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

CL von Baeyer 20 Apr 2011 C:\Users\Carl\Documents\pediatrics\2010-simplays\pain-scales-all-ages-1-page-for-ward-color.doc

J&D Ultracare Corp
15 Suffern Pl, Ste A Suffern NY 10901-5566
Phone: (845) 357-4500, Fax: (845) 357-5039

FLACC Behavioral Pain Assessment Scale

Patient Information

Client:	**MR#:**	**SOC:**	**Episode:**
Insurance:	**Insurance ID:**	**DOB:**	**Location:**
Date:	**Gender:**	**Age:**	**Completed By:**
Address:			

Scoring

CATEGORIES	*SCORING*		
	0	*1*	*2*
Face	No particular expression or smile	Occasional grimace or frown; withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs; frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractable	Difficult to console or comfort

How to Use the FLACC

In patients who are awake: observe for 1 to 5 minutes or longer. Observe legs and body uncovered. Reposition patient or observe activity. Assess body for tenseness and tone. Initiate consoling interventions if needed.

In patients who are asleep: observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

Interpreting the Behavioral Score

Each category is scored on the 0–2 scale, which results in a total score of 0–10.

0 = Relaxed and comfortable

1 – 3 = Mild discomfort

4 – 6 = Moderate pain

7 – 10 =Severe discomfort or pain or both

Assessment

CATEGORIES		SCORE
Face	☐ **0** if the patient has a relaxed face, makes eye contact, shows interest in surroundings.	
	☐ **1** if the patient has a worried facial expression, with eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed.	
	☐ **2** if the patient has deep furrows in the forehead, closed eyes, an open mouth, deep lines around nose and lips.	
Legs	☐ **0** if the muscle tone and motion in the limbs are normal.	
	☐ **1** if patient has increased tone, rigidity, or tension; if there is intermittent flexion or extension of the limbs.	
	☐ **2** if patient has hypertonicity, the legs are pulled tight, there is exaggerated flexion or extension of the limbs, tremors.	
Activity	☐ **0** if the patient moves easily and freely, normal activity or restrictions.	

	☐ **1** if the patient shifts positions, appears hesitant to move, demonstrates guarding, a tense torso, pressure on a body part. ☐ **2** if the patient is in a fixed position, rocking; demonstrates side-to-side head movement or rubbing of a body part.	
Cry	☐ **0** if the patient has no cry or moan, awake or asleep. ☐ **1** if the patient has occasional moans, cries, whimpers, sighs. ☐ **2** if the patient has frequent or continuous moans, cries, grunts.	
Consolability	☐ **0** if the patient is calm and does not require consoling. ☐ **1** if the patient responds to comfort by touching or talking in 30 seconds to 1 minute. ☐ **2** if the patient requires constant comforting or is inconsolable.	
		Total Score:

Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. When self-report is not possible, interpretation of pain behaviors and decisions regarding treatment of pain require careful consideration of the context in which the pain behaviors are observed.

Since 1985
J&D ULTRACARE
A Professional Home Care Nursing Agency

Pain Management Policy (Adult Care) C-7B

Revision: 1.2020

Pain Management Policy:

PURPOSE: Effective pain assessment and management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the patient experiencing pain enhances healing and promotes both physical and psychological wellness. Patients need to be involved in all aspects of their care including pain management whenever possible.

DEFINITIONS:

Unrelieved pain – A pain score that remains above the patient's identified pain goal for an extended period of time.

Acute pain – Pain that subsides as tissue healing takes place and has a predictable end, is transient, and is often highly localized.

Persistent pain – Pain that persists three months beyond the usual course of an acute disease or three months beyond a reasonable time for tissue damage to heal, or pain that is associated with a persistent pathological process that causes continuous or recurrent pain.

Addiction – A primary, persistent, neuro biologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical dependence – A state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance – A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

Comfort Function Goal – A goal which is based upon the pain rating the patient requires to be able to perform necessary activities.

POLICY: Healthcare professionals respect the patient's right to pain management and to be informed of available and appropriate methods of pain relief along with possible positive and negative consequences.

Staff work with the patient/family & physician to set, develop, and implement a plan to reach a goal for pain relief. The patient's preferences for methods used to manage pain are considered.

Pain control planning includes both pharmacologic and nonpharmacological interventions.

Pain should be actively evaluated and monitored.

Methods to evaluate pain are consistent with the patient's age, condition, and ability to understand.

Patients with pain are reevaluated as necessary based on the plan of care, changes in condition, or upon patient's request.

Based upon the patient's condition and assessed needs, the education and training provided to the patient include any of the following:

- discussion of pain
- the risk for pain
- the importance of effective pain management
- the pain evaluation process
- methods for pain management

Pain control approaches are to be collaborated and interdisciplinary in nature and utilize input from all members of the health care team, particularly the patient and significant others.

Staff is oriented to the evaluation and management of pain.

The following treatment modalities as per physician orders to assist patients with treatment of pain:

- Oral, injectable, rectal, subcutaneous, sub-lingual, topical, trans-dermal, & Patient Controlled Analgesics.
- Non pharmacologic modalities, for example: distraction techniques, re-positioning, relaxation techniques, hot and cold therapy.

In home health, the presence of pain is assessed by an RN on admission to services. The RN or physician shall perform an initial assessment for acute pain and, if relevant, for persistent pain, on all patients as applicable.

Pain intensity will be quantified using one of the following pain scales:

(Policy C-7 A: Appendix "B") Modified Wong-Baker Pain Intensity Scale which is a subjective, graduated scale with color, numerical values from 0-10, facial expressions from happy to crying, and words used to describe pain from none to severe, where the patient communicates their level of pain by either stating the level or pointing to the section of the scale that most accurately describes their current level of pain.

Non-Verbal Pain Scale is an objective measure that can be used for the patient who is unable to communicate. When using this scale it is important to obtain a history when possible, from the patient's caregiver or past medical records to obtain a baseline of usual behavior. It is essential to differentiate behavioral expressions of pain from otherwise normal behavior for the patient in a similar situation.

For pediatric patients the Children's pain scale, the FLACC Pain Scale or the infant pain scale may be used.

A patient's report of pain will be accepted and respected as the key indicator of the pain he/she is experiencing. "Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does" (McCaffery, 1989)

A significant other may be asked to assign a pain scale rating when the patient is unable to respond.

Nursing staff may assign a pain scale rating based on the Non-Verbal Pain Scale only if the patient is unable to report their pain.

If the patient reports an adverse change in pain, a more detailed evaluation of the acute and/or persistent pain will be performed and may include the following data:

- Location of pain. If more than one location they are evaluated separately.
- Duration
- Type, quality/description, and patterns of radiation (if applicable)
- Alleviating and aggravating factors
- Intensity Rating
- Patient's acceptable rating of pain, Comfort Function Goal (CFG) and pain management history
- Current medications for pain and what works best
- Alternative methods of pain control used
- Vital signs and level of consciousness
- Patient's physical, emotional and behavioral expressions of pain
- Level of influence of pain on necessary activities.
- Re-evaluation. Pain is monitored throughout each shift.

Pain is evaluated at the onset, and throughout each shift and addressed accordingly.

A numerical intensity rating of pain is determined with every set of vital signs, within one hour of an intervention for pain, and if the patient spontaneously reports pain.

If no pain is present, the licensed healthcare provider will monitor for pain as warranted by patient condition, throughout the shift with the pain scale, when the patient complains of pain.

Interventions must be documented when the intensity rating is greater than the patient's stated acceptable level of pain.

The physician is notified of the patient's pain when pharmacologic and nonpharmacological treatment modalities have been exhausted in reducing the pain to a level acceptable to the patient.

In home health, pain is reevaluated at each visit (Skilled Nursing Visit) and/or shift by field nurse and documented.

In addition, telephone follow-up may also occur in between visits when appropriate.

Patients are instructed in interventions to use prior to therapy or other painful intervention/activities and to notify home health if those interventions are not working.

The physician is notified when interventions are not effective at reducing the pain to an acceptable level. With collaboration the treatment plan is modified and reevaluated for effectiveness.

Documentation of pain should include the following

- Type, description, location, timing of pain
- Intensity scale
- Level of consciousness
- Respiratory rate
- Activity
- Interventions: Pharmacologic & Nonpharmacological
- Patient and family education

Pharmacologic management of pain is dictated by physician orders and the intensity of the patient's pain, along with assessment of pain, and the effectiveness of previous pain relief strategies to meet the objective of preventing:

- Mild pain a. Scheduled and/or prn non- opioid analgesics are recommended b. Consider adjuvant options.
- Moderate to severe pain: pharmacological treatment a. When continuous pain is anticipated, a long acting or fixed-dose schedule (around the clock) is recommended. b. A PRN order of a rapid onset analgesic may be necessary to control activity related or breakthrough pain. c. To ensure opioids are safely administered, begin with a low dose (consider the patients history of opioid use) and titrate to comfort as ordered. Modification in analgesic administration is based upon effectiveness of the previous dose, including change in pain intensity, relief, and side effects experienced. d. Patients respond differently to various opioid and non-opioid analgesics; therefore if one drug is not providing adequate pain relief, another in the same class may result in better pain control. e. Consider adjuvant options.
- Safe use of opioids: Because opioid induced respiratory depression is preceded by an increasing level of sedation, sedation levels are monitored at regular intervals in patients receiving opioids. A history of sleep apnea and/or obesity increases the risk of enhanced sedative effects and those patients should be monitored more closely with pulse oximetry. Sedation should be monitored for all opioid naive patients with moderate to severe pain when opioid dosing is initiated. Sedation monitoring: Sleeping and easy to arouse: acceptable no action necessary; supplemental opioid may be given if necessary. Awake and alert: acceptable no action necessary; supplemental opioid may be given if necessary. Slightly drowsy, easily aroused: acceptable no action necessary; supplemental opioid may be given if necessary. Frequently drowsy, arousable, drifts off to sleep during conversation: unacceptable. Discuss with physician. Consider past sleep history and pain management, then consider as applicable decreasing opioid dose. Consider administration of acetaminophen or an NSAID, if ordered and not contraindicated, to control pain. Monitor sedation and respiratory status closely. Somnolent, minimal or no response to physical stimulation: unacceptable. Stop opioid. Notify physician.
- Nonpharmacological Pain Management 1. Utilization of non-drug strategies is encouraged to alleviate pain. These techniques have minimal adverse events and pose little safety threats to patients.

Patient education: Patient teaching should include as applicable such topics as:

- The patient's right to controlled pain his/her responsibility to give an accurate, subjective assessment and report pain on an appropriate scale as soon as it starts, before it becomes too severe, as it is much easier to control.
- Probable physiological causes of pain that may be specific to the patient.
- Barriers to good pain control.
- Address patient fears.
- Alternative methods of pain management.
- How to take the prescribed medication to get the optimal effect.
- Potential limitations and side effects of pain treatments.

Patient teaching: Individual teaching between the patient/family. Printed and/or online patient education resources.

Specific Considerations: Pediatrics: Ages 0 - 17 See Policy C-7 A. The nurse must consider the age of the pediatric patient and the current stressors of the situation they are under when making the decision of which pain scale to utilize. i. If the pediatric patient is able to clearly communicate, the adult scale may be utilized.

Patient education must include the parents or guardians. They need to be educated about child's pain and what interventions will be implemented to prevent or minimize the child's pain.

Geriatrics: Many elderly individuals consider pain to be a normal part of aging. Many are reluctant to report pain due to ageist attitudes (i.e., old people complain about pain a lot). Many fear being perceived as bothersome, a hypochondriac or an addict. Pain is often under treated and under reported in this population.

Cultural Considerations: Consider the cultural aspects of pain and pain management. Consider language barriers and identify what cultural differences and potential barriers exist. Identify decision makers and family members with healthcare backgrounds to be used as resources. Use translation services as needed. Consider the patient and family social organization, or that family structure, head of household, gender roles, status/roles of elderly, roles of children, adolescents, husbands/wives, significant others, parents, extended family, influences on decision making process, importance of social organization and network. Identify ways to achieve treatment and care outcomes for the patient while at the same time supporting and appreciating the culture. Plan for care with sensitivity to the differences that may present advantages and disadvantages.

Consider the patient's health beliefs, practices, and practitioners. These provide meaning/cause of illness/health and living with a life threatening illness. They may influence expectations about treatment and the health care team. They may require consideration of religious/spiritual beliefs and practices, use of traditional healers/practitioners, expectations of practitioners. Consider spiritual care referral.

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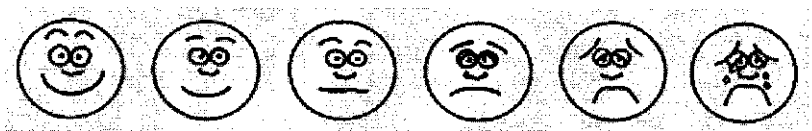
Wong Baker Pain Assessment

Patient Information

Client:	**MR#:**	**SOC:**	**Episode:**
Insurance:	**Insurance ID:**	**DOB:**	**Location:**
Date:	**Gender:**	**Age:**	**Completed By:**
Address:			

Pain Assessment Tool: This assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate their intensity.

Disclaimer: From Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Used with Permission. Copyright, Mosby.



☐ **No Pain**

Nonverbal demonstrated

☐ Diaphoresis ☐ Guarding ☐ Tense ☐ Grimacing
☐ Irritability ☐ Restless ☐ Moaning/Crying ☐ Anger
☐ Change in vital signs ☐ Other(specify):

What makes pain worse?

☐ Movement ☐ Ambulation ☐ Immobility
☐ Other(specify):

Is there a pattern to the pain?(explain)

What makes pain better?

☐ Heat ☐ Massage ☐ Rest/Relax ☐ Medication
☐ Ice ☐ Repositioning ☐ Diversion
☐ Other(specify):

Frequency: ☐ Occasionally ☐ Continuous ☐ Intermittent

Patient is satisfied with pain relief? ☐ Yes ☐ No
If No, was the physician notified? ☐ Yes ☐ No
Notes:

Current Pain Control Medication Adequate? ☐ Yes ☐ No

What was the outcome?

How often is breakthrough medication needed?

☐ Never ☐ Less than daily ☐ 2-3 times/day ☐ More than 3 times/day
☐ Other(specify):

Wong Baker Pain Assessment

Does the pain radiate? ☐ Yes ☐ No

If Yes? ☐ Occasionally ☐ Continuous ☐ Intermittent

Change in Care Plan Necessary? ☐ Yes ☐ No

If Yes, describe:

How does the pain interfere/impact their functional/activity level?(explain)

Pain Map

Pain Assessment	Location	Onset	Present Level (0-10)	Worst Pain Gets (0-10)	Best Pain Gets (0-10)	Pain Description (Aching, Radiating, Throbbing, etc)