AGENCY PHILOSOPHY

MISSION STATEMENT:

Nannies for Grannies, Inc. is dedicated to providing quality, compassionate and supportive services in an ethical manner to home care clients. These services, performed with dignity and respect, will be available to individuals of all ages regardless of race, creed, disability or national origin. Nannies for Grannies, Inc. also supports caregiver staff by providing continuing education opportunities for continuing professional growth.

Nanny's For Granny's

Employee Code of Ethics and Conduct Agreement

Agency Copy

***All employees are expected to be professional at all times in dealing with the clients, family and other employees. Remembering at all times that they are the representatives and employees of Nanny's for Granny's

Companions-HHA-PCA's and LPN's

- Are expected to follow the care plan as prescribed.
- Always are expected to function within the scope of your job description.
- Abide by all HIPPA policies and procedures set forth by the agency
- If any changes in the home or client you are to notify the office immediately. **Initial______**

Dress Code

- All employees are expected to dress according to agency/facility dress code at caregivers own expense.
- If any client/facility requests a change in dress code, aide must inform agency of change request.
- Purchase of uniforms and/or cleaning is the sole expense of caregiver.
- **NO** jewelry, heavy makeup, big hair styles, no heavy perfume
- **NO** chemical hair processing: Which includes but not limited to hair dressing of client or caregiver whatsoever is expressly prohibited.
- **NO** provocative or inappropriate clothing ex: pajama pants sweat pants, ripped clothing, low cut blouses or shorts. Please dress professional! **Initial______**

Agency ID Badge

- You are always expected to wear your agency ID badge at all times while on duty
- ID badge must be returned to agency upon termination of employment. **Initial______**

Inappropriate Behavior

- **ABSOLOUTELY NO drinking, smoking, use of drugs or controlled substances while on duty at any time**
- **ABSOLOUTELY NO use of slang or foul language while on duty at clients home**
- **ABSOLUTELY NO family, friends, acquaintances or pets of caregiver are ever allowed on premise while on duty.** **Initial______**

Being On Time

- All aides are expected to arrive to all scheduled assignments in timely fashion. Please take travel time into consideration during foul weather and/or holiday schedules.
  Remember if you're not on time, you're late!!
- If there is an emergency that should cause you to be late, please notify/call the office immediately
- If you cannot make it to a job/case due to an emergency, foul weather or if you expect to be late for a scheduled appointment, you are to notify the office immediately at **631-730-8500.** If it is after regular business hours, leave a message on the answering machine at the number above.
- You may call Nanny's For Granny's 24 hours a day if you need to cancel your assignment or appointment at **631-730-8500** if it is not during business hours please leave a message
- **PLEASE DO NOT EVER CALL THE CLIENT OR FAMILY DIRECT- CALL THE OFFICE IMMEDIATELY.**

Initial______

Time Off and Overtime

- If for some reason an aide does not show up for scheduled shift relief, the on call caregiver must allow the agency ample time to find a replacement, failure to do so will result in immediate termination and a possible charge of abandonment.
- Live in aides are required to devote no less than 13 hours of care to the client per 24 hour period, and are expected to have no less than 8 hours of sleep, (5 uninterrupted) and 3 hours personal calm time (downtime). If any of these requirements are not met it is the responsibility of caregiver to notify the agency immediately to rectify the situation and/or recommend changes to the care plan.
- It is accepted that in the event there is any deviation to the guidelines outlined in this agreement and or care plan, it is the caregivers sole responsibility to notify the office of any changes immediately in writing and allow a reasonable amount of time for agency to react and rectify the situation with family, physician or agency or forego any claims or liabilities against agency, nurses, employees (past or present), administrators, family members and or any coordinators, case managers, representatives or principles of Nannys For Grannys for an indefinite period of time.
- "Live Out" or "hourly" caregivers as per DOL, mandates overtime at 1 1/2 times the regular rate of pay for all hours worked over 40.
- "Live In" caregivers as per DOL, mandates overtime at 1 1/2 times the regular rate of pay for all hours worked over 40.

Initial_______

Being Relieved

- If you have any problem, incident or accident on the job, do not discuss with the client, call Nanny's for Granny's immediately.
- If you are to be relieved by someone else, it is understood that you are not to leave client alone until the relief aid has arrived. Additional compensation will be provided.
- **CLIENTS ARE NEVER TO BE LEFT UNATTENDED FOR ANY REASON**! Leaving a clients home or unattended is considered "Abandonment" and grounds for immediate termination.
- When a shift replacement arrives for relief, it is the caregiver that is presently on call to review care plan with relief aide upon arrival immediately to discuss client's present condition related to, but not limited to, well being, changes in clients general behavior and or physical condition, duties performed and relay any modifications or changes that need to be addressed for the well being and safety of client and caregiver to agency if needed.

Initial_______

Change of hours

- If the client/family asks you to stay longer than outlined in your assignment, or the need arises to leave earlier, it must be completely understood that you must notify Nanny's For Granny's of the change and or approval.

Initial_______

Outline of Services

- Outline of services to be performed by caregiver are outlined as follows and are to be provided for the client exclusively unless otherwise noted. Companionship, conversation, prepare grocery lists, clip coupons, plan, prepare, cook and clean up after meals, plan outings, trips, visit neighbors and friends within walking distance, monitor diet and eating, check food expirations, assist with morning wake up and preparation if needed, assist with evening tuck in preparation if needed.

Initial_______

- Arrange appointments and provide reminders, provide medication reminders, double check amounts but "NOT" administer medications, assist with walking, assist with getting in and out of shower or bathroom, answer the door, telephone, assist with clothing selection, care for houseplants, participate in craft projects, play games, cards etc, over see home deliveries, escorting to appointments, accompany to luncheons, dinners, escort for shopping, religious services. Provide light housekeeping ex: dusting, washing dishes, light vacuuming, taking out the garbage, making beds, changing sheets, laundry, and ironing. (Not to exceed 20% of the caregivers daily hours worked)

Initial_______

Medications

- You as an aide herby acknowledge that you **WILL NOT UNDER ANY CIRCUMSTANCE DISPENSE OR ADMINISTER ANY MEDICATION AT ANY TIME,** you are only approved for medication reminders

Initial_______

Accepting Money or Gifts

- **UNDER NO CIRCUMSTANCE** are you to ask for, or accept any money from your client or take home property that belongs to the client, even if the clients family say it's a gift. **Initial_______**

Confidentiality

- **UNDER NO CIRCUMSTANCE** is there to be any involvement with the client's financial affairs
- (i.e., check writing, banking, signing credit cards, etc)
- You are expected to honor the confidentiality of any client's information which is obtained during the regular course of your employment **Initial_______**

Cell Phones-Personal Computers

- **NO** cell phone use or texting upon entering clients home. All cell phones must be turned off when entering client's home or facility while on duty.
- Always use or provide the agency's telephone number for your family to contact you if in the event of an emergency. **Initial_______**

Pay and Benefits

- There should be no discussion what so ever regarding pay and or benefits with client/guardian or any relief aids while employed by the agency.
- It is expressly understood, that there is to be absolutely "NO" contact for any reason, with any client, (past or present) guardian or family member, or after termination or in the event case has ended to avoid suspension, termination and or penalty or court costs incurred by Nannys for Grannys in the event of such breach in this agreement.
- Any questions with regard to pay and or benefits are to be addressed "off time" (not in the clients home if possible) with the proper personal employed by Nannys For Grannys.
- Any violation of these terms outlined may result in a penalty charge of $5000. Plus any court fees related to any such breach of this agreement. **Initial_______**

Direct Pay and Employment

- As an employee of Nanny's For Granny's, you are prohibited to accept any direct employment, compensation or solicit on behalf of yourself or any other persons, direct employment, compensation from the client or clients family without the express consent from an authorized representative in writing from Nannys For Grannys. **Initial_______**

- If you are requested to do so, please notify us immediately or have the client or family contact us.
- Any violation of this will result in a penalty charge of $5000. Plus any court fees to Nanny's For Granny's.

Initial______

Privacy

- Knock on doors before entering home, bedrooms and or bathrooms. Drape client during personal care. Take into consideration, and respect your client's right to privacy and dignity while under your care or supervision.

Initial______

Unannounced Office Visits

- Employees are to never come to office unless they have an appointment
- Any employee that shows up to the office uninvited or without an appointment will be turned away.
- The only time an employee should come to this office, would be for updating paperwork or in service education, but in either event an appointment is required.

Initial______

Time Slips

- Every week it is Mandatory a time sheet must be submitted to the office without fail in a timely manner to alleviate any interruption of pay cycle. Failure to notify the office of hours worked or beyond the billing cycle will result in your paycheck being delayed for one week.
- Approved methods of relaying hours and days worked to the office are "telephony" for those not familiar with this method, directions will be provided and or the "website electronic time sheet"
- Without a time sheet you will not be able to get your pay for that week.
- If neither option is available to you, a time/duty sheet can be supplied where client, guardian or family member will have to sign and attest to the days and hours worked and duties performed.

Initial______

Holiday Pay

- For **PRIVATE CASES ONLY**. The following holidays are paid one and a half time your regular hourly pay as long as you are expected to work on that day.
- For **All INSURANCE CASES**: including, but not limited to, (MLTC's) managed Long Term Care Insurance, Medicare, Medicaid, etc. Holiday pay is **NOT** included.
- Christmas Day, New Years Day, Memorial Day, Thanksgiving Day, Fourth of July, Dr. Martin Luther King Day, Labor Day, or substitution of caregivers own personal holiday.
- After providing "1 year" of continuous employment without interruption (52 weeks) you are entitled to three paid days of rest which can be in taken in the form of monetary compensation at the regular rate of pay outlined in your DOL rate form or paid time off whichever is desired.
- If your work schedule is intermittent or irregular and not performed on a regular basis, you are considered employed on a "casual basis" and therefore the 3 days of rest do **Not** apply.
- Live In Holiday Pay pertains to working hours **ONLY** and **NOT** sleeping hours. Start of shift needs to be on the working holiday day in order to earn holiday pay. If shift starts day prior and sleeping falls onto holiday, you do not earn holiday pay for sleeping hours.
- If shift is hourly, the above rule does not apply and holiday pay will be paid for all working hours

Initial______

Situations to Avoid

- Discussing religion, politics, personal issues with the client and/or others while in the care setting.
- Engaging the consumer in sexual conduct or in a conduct that a reasonable person may interpret as sexual in nature, even if the conduct is consensual. **Initial______**
- Consuming the consumer's food or drink, or using the consumers personal property without his or hers consent is forbidden
- **NO CALL, NO SHOW, NO MESSAGE, IS GROUNDS FOR IMMEDITATE TERMINATION!**

Initial______

Vaccinations

- In order to work for the agency all necessary vaccinations requirements must be met as per Dept of Health (DOH). PPD, Rubella, Rubeola, Hepatitis B and as of 11-1-13 an Influenza shot (Flu Shot) is required. If the influenza vaccination is not an acceptable option, a surgical mask must be worn at all times while on duty. **Initial______**

If by chance I happen to have not mentioned something, please use your best judgment. You are being hired to take care of a senior because in most cases they cannot take care of themselves. Do it to the best of your ability, you are representing us as well as being judged by your client. We don't like negative comments about our caregivers.

Consider the client interests. Many seniors have had extremely interesting pasts. Ask questions and get to know them. Ex: how many children? Grandchildren? Did they serve in the military? Where have they lived? What was their career? Are they sports fans? Did they have a hobby? Be alert to topics that they like to talk about and you will have a happy client.

Last but not least, Show up with a smile! Many seniors are not able to see their loved ones often or in many cases have outlived their closest friends. Be happy to see them and they will be happy to see you.

LATENESS or **NO SHOW** **to a case or interview without properly notifying the office at least 3hrs in advance will result in suspension, termination or having your name permanently removed from our roster. If after hours leave message on the emergency line**
631-730-8500.
Excessive absence or call outs from any case will result in immediate termination.

*****Any violation of the agency policies and procedures will result in immediate dismissal and penalty charge of $5000 plus any court fees related too and incurred by Nanny's For Granny's. As an employee of Nannies For Grannies Inc, A Home Health Care Agency, I accept and will explicitly follow these policies, procedures, guidelines and standards of work conduct carefully. I understand that failure to comply with agency policies may jeopardize my employment, present and future, and in many instances, may be grounds for immediate suspension or termination.**

Employee Signature ____

RT12/9/16

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Excessive absence or call outs from any case will result in immediate termination.

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Employee Signature ____

RT12/9/16

Nannys For Grannys

Reference Request Form

Name of Applicant:______________________________

Position Applied For:______________________________

Name: ________________ Company: ________________ Title:____________

Phone Number: ________________ Fax Number: ________________

Address: ______________________________

Release of information: I hearby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

Signature of Applicant: ____________________ Date: __________

The person identifed above has applied for a positon at Nannys for Grannys, Inc. Would you kindly complete the reference information below and return the reference information. This information will be kept confidential. Thank you.

Position held at your organization: ______________________________

References relationship to applicant: ______________________________

Dates employed from: ________________-________ To: ________________

Reason for Leaving: ______________________________

Would you re-employ?__________ If No, then why? ____________________

Applicants Work Record	**Satisfactory**	**Unsatisfactory**	**Unable to Evaluate**
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Critisim			
Appearance			

Any Additional Comments: ______________________________

References Signature: ____________________ Date: __________

Reference Validation: ________________ Title: __________ Date:__________

Nannys For Grannys
Reference Request Form

Name of Applicant:______________________________

Position Applied For:______________________________

Name: ____________________ Company: ____________________ Title:____________________

Phone Number: ____________________ Fax Number: ____________________

Address: ______________________________

Release of information: I hearby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.

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Reason for Leaving: ______________________________

Would you re-employ?____________ If No, then why? ______________________________

Applicants Work Record	Satisfactory	Unsatisfactory	Unable to Evaluate
Quality of Work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Critisim			
Appearance			

Any Additional Comments: ______________________________

References Signature: ______________________________ Date: ____________

Reference Validation: ____________________ Title: ____________ Date:____________

13R

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   a. Foreign passport; and
   b. Form I-94 or Form I-94A that has the following:
   (1) The same name as the passport; and
   (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B
Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C
Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   (1) NOT VALID FOR EMPLOYMENT
   (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: ______________ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . **A** ______

B Enter "1" if:
- You're single and have only one job; or
- You're married, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . . **B** ______

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . **C** ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . **D** ______

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ______

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ______
(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child. **G** ______

H Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ______

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- ***Separate here and give Form W-4 to your employer. Keep the top part for your records.*** -----

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	**2** **Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $ ______

7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ **7** ______

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date ▶**

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2017)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

NYS Department of Health
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION
THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.
chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.
6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
   ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**
   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
   ____
8. My current mailing or home address is indicated in Section 1 of this form.
9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: ______________________________ Date: ______________

Signature of Parent or Legal Guardian ______________________________ Date: ______________
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

NANNIES FOR GRANNIES, INC.

Employee Name: ______________________________
Print Name

DRUG TESTING POLICY

DRUG FREE WORKPLACE

Purpose:

To provide guidelines for the maintenance of a drug-free workplace to support and ensure the safety of clients and employees.

Policy:

In order to provide for the health and safety of clients, **NANNIES FOR GRANNIES, INC.**, supports and maintains a drug-free working environment. Employees may not be at work under the influence of alcohol or while unlawfully using controlled substance. The unlawful manufacture, distribution, dispensation, possession or use of controlled substances or the use of alcohol, including use in vehicles is prohibited.

(Exception: An employee who possesses or uses a drug authorized by a physician/primary health care provider for the employee's use while on the job, and whose performance is not noticeably impaired will not be considered in violation of this policy. Employees are responsible for asking the prescribing practitioner about any side effects that may influence performance. In the event that the medication may affect performance, the employee is responsible to notify his/her immediate supervisor prior to reporting to work.)

Definition: Controlled substances/drugs: include but are not limited to narcotics, depressants, stimulants, hallucinogens, cannabis, and any chemical compound added to federal or state regulations and noted as a controlled substance.

Drug Testing:

- All federal, state and local regulations regarding drug testing and monitoring will be followed.

There are two types of drug tests:

Pre-employment testing

• Applicants for employment at **NANNIES FOR GRANNIES, INC.** are drug-tested after receiving a final offer of employment and prior to beginning work. Applicants are notified at the time of application that testing for drugs is a requirement for employment process. Offers of employment are contingent upon successfully passing a drug test.

Testing for Reasonable Suspicion:

• A drug screen may be ordered by the Director of Clinical Services, in consultation with the

Administrator, when a reasonable suspicion of working under influence exists. Refusal to submit to the testing may result in disciplinary action, up to and including termination.

• A positive drug screen means the verified presence of alcohol or other controlled substances. All positive test results are maintained in a separate, confidential, need-to-know access file.

• Every employee, as a condition of continued employment, is required to immediately notify the Administrator, if they are convicted under federal or state criminal statue whether the act causing the conviction occurred on or off work time.

• The company will report information concerning possession distribution or use of any illegal drug to law enforcement officials.

*** I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.**

_______________________________ Employee Signature

_______________ Date

NANNIES FOR GRANNIES, INC.

EMPLOYEE PHYSICAL EXAMINATION REPORT

☐Pre-Employment Physical Assessment ☐Annual Assessment ☐Return to work/LOA ☐Other:

Name:	Marital Status: ☐M ☐S ☐W ☐D	Sex: ☐M ☐F
Address	SS #:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:

EYES:

NECK:

BREASTS:

LUNGS:

CARDIOVASCULAR:

MUSCULOSKELETAL:

ABDOMEN:

GENITOURINARY:

CENTRAL NERVOUS SYSTEM:

COMMENTS:

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	DATE	RESULTS	
RUBELLA TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
MEASLES TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY (+PPD)	Date:	Results:	

IMMUNIZATIONS:	**DATE**	**DATE**	**DATE**
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
OTHER:			

☐This individual is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his/her behavior.

☐**This individual is able to work with the following limitations:**

☐**This individual is not physically/mentally able to work.** ***(specify reason):***

Physician Signature: **Lic. No.** **Date:**

22R

The following individual has a positive PPD and has had an initial negative chest x-ray for tuberculosis. This assessment form must be completed annually for continued employment with Nannys for Grannys.. This self assessment is in place of additional x-rays that it may be harmful to the employee's health.

Name: ______________________________ Date: ______________

Please complete:

<u>Do you have any signs or symptoms of the following:</u>

Cough lasting longer than 3 weeks	☐yes	☐ no
Fever lasting longer than 3 weeks	☐yes	☐ no
Night sweats	☐yes	☐ no
Unintentional weight loss	☐yes	☐ no
Malaise/fatigue	☐yes	☐ no

If I have answered yes to two or more of the above symptoms I will check with my physician regarding my condition. To the best of my knowledge as a health care professional, I certify that I do not have any symptoms or conditions which indicate I may have tuberculosis as of this time.

Signature: ______________________________ Date: ______________

NANNIES FOR GRANNIES, INC.

HEPATITIS B VACCINE PROGRAM

☐ I do not wish to be given the Hepatitis B Vaccine at this time. I am aware that I may request to be provided the vaccine at a later date during my employment with the agency.

☐ I have already received the Hepatitis B Vaccine series.

Signature: ______________________________ Date: ________________

☐ I am requesting to receive the Hepatitis B Vaccine. (complete consent below)

HEPATITIS B VACCINATION CONSENT

I, ______________________________, have been provided with information on the Hepatitis B vaccine and have been evaluated by an agency health professional.

I have had the opportunity to ask questions about the benefits and risks of Hepatitis B Vaccination.

I also understand that there is no guarantee that I will become immune and that there is a possibility that I will experience an adverse side effect from the vaccine.

I am **NOT allergic** to yeast or yeast products.

I am **NOT currently immunosuppressed**, neither by disease or medication.

For women: I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the Hepatitis B vaccine relating to the developing fetus is currently unknown.

Employee Signature: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

POLICY FOR THE ADMINISTRATION OF INFLUENZA VACCINE FOR EMPLOYEES IN HEALTH CARE SETTINGS

PURPOSE: The purpose of this policy is to minimize transmissions of the influenza virus in the workplace by providing occupational protection to employees and thus preventing transmission to members of the community, which we serve.

Annual influenza vaccination has been found to be both safe and effective in reducing the risk of influenza and health-care related transmission. The CDC recommends vaccination of all workers in health care settings. Research, however, has shown that vaccination programs restricted to those who actively seek the vaccine have limited penetration and, thus effectiveness in protecting patients and employees. This policy is intended to maximize the protection offered to our employees and clients.

POLICY: All employees of Nannys For Grannys shall be expected to receive the flu vaccine during the annual influenza vaccination campaign. Employees will be required to obtain vaccination by December 1 of each calendar year or sign a de3clination. Records will be maintained documenting vaccinations and declinations.

DEFINITIONS:

EMPLOYEE: - any person that received financial compensation for work performed at Nannys For Grannys, whether merit, contractual, or consultants.

INFLUENZA (flu) – a mild to severe contagious illness caused by viruses that infect the respiratory tract.

INFLUENZA VACCINE – A preparation of influenza antigens (live or killed virus), which stimulates the production of specific antibodies when introduced to the body. These antibodies provide protection against influenza virus infections.

TIV – Also known as the Trivalent Inactivated Influenza Vaccine, is made with killed virus and is administered through the muscle.

LAIV – also known at the Live Attenuated Influenza Vaccine – is made with live, weekend viruses that do not cause the flu and is administered through a nasal spray.

PROCEDURES:

GENERAL REQUIREMENTS – All employees will be required to obtain the flu vaccine or sign the declination on the Influenza Vaccination Employee Statement(attachment 1) each year.

IMPLEMENTATION :

Local businesses , clinics, and doctor offices can provide the influenza vaccination annually.

The LAIV or TIV will be administered to employees based on vaccine availability and published CDC guidelines

RESPONSIBILITIES

Employee shall be responsible for:

Familiarizing themselves with the Administrative Policy and Procedure and signing and returning the Acknowledgement of Receipt form to HR

Annually, completing and signing the Influenza Vaccination Employee Statement, whether consenting or declining vaccination by the established deadline.

Taking one of the above actions by Dec 1st, if hired during the annual flu vaccine campaign, within one month of employment.

Annually, submitting the signed form to Nannys For Grannys (if consenting) or to Nannys For Grannys(if declining) by the established deadline.

SUPERVISORS SHALL BE RESPONSIBLE FOR:

Allowing employees time to obtain vaccine

Assuring that employees comply with the Administrative Policy and Procedure

HUMAN RESOURCES

Providing copies of this Administrative Policy and Procedure to employees and maintaining copies of the Acknowledgement of Receipt form in employees' personnel files

Providing each employee annually with a reminder of this policy and a copy of the Influenza Vaccination Employee Statement for the year's influenza vaccine campaign.

Providing new employees with information about the annual influenza vaccine policy during orientation and where to obtain the vaccine if employment begins during the influenza campaign.

Notifying supervisors regarding those employees who are not in compliance with this policy and taking appropriate personnel action.

EFFECTIVE DATE

The effective date of this Administrative Policy and Procedure is September 3, 2013

9/3/13

DATE

Pat Phelan

NAME

Patricia Phelan

SIGNATURE

President of Nannys For Grannys

Declination of Influenza Vaccination
For Health Care Personnel

Employee's Name:________________________________

Employee's ID#:________________________________

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

• Influenza is a serious respiratory disease that kills thousands in the United States each year.

• Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.

• If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.

• If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.

• I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.

• I understand that I cannot get influenza from the influenza vaccine.

• The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

• Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature:________________________________

Date:________________________________

Witness:________________________________

Date:________________________________

Employee Influenza Vaccination Policy
Acknowledgement of Receipt

Please print your name and title and then sign and date the form to indicate that you have received a copy of Nannys For Grannys Policy for the Administration of Influenza Vaccine dated September 3, 2013. You are responsible for reading and adhering to the policy.

______________________________ ______________________________

Print Name **Signature**

______________________________ ______________________________

Job Title **Date**

NANNYS FOR GRANNYS CONTINOUS QUALITY IMPROVEMENT

NEW EMPLOYEE ORIENTATION NANNYS FOR GRANNYS

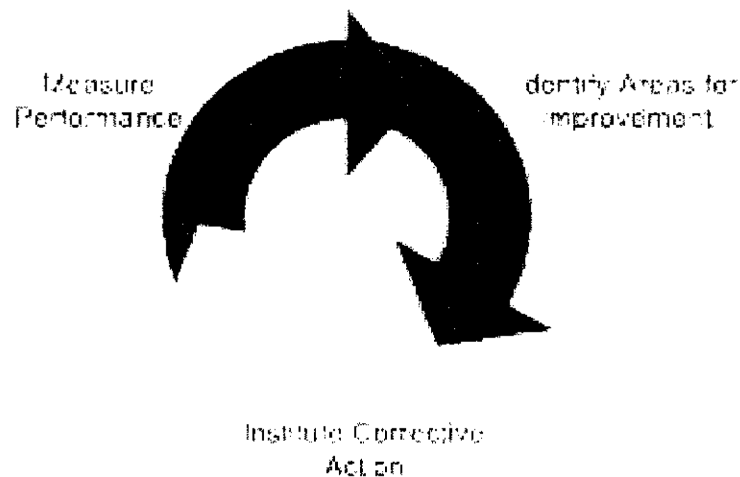
- WHAT IS QUALITY IMPROVEMENT

  -A WAY OF LOOKING AT NANNYS FOR GRANNYS SERVICES

  -DECIDING IF OUR SERVICES ARE MEETING THE NEEDS OF OUR CLIENTS

  -WHAT WE ARE DOING GREAT

  -WHAT CAN WE DO TO IMPROVE OR DO BETTER



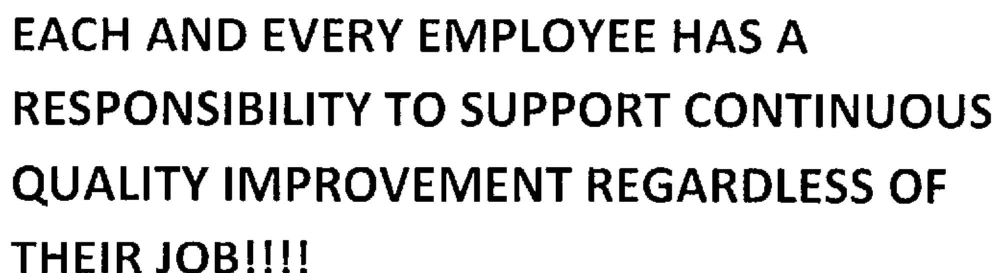
-IN ORDER FOR A QUALITY IMPROVEMENT PLAN TO BE SUCCESSFUL EACH EMPLOYEE HAS TO TAKE OWNERSHIP OF THEIR WORK AND FOLLOW THE VALUES AND MISSION OF NANNYS FOR GRANNYS

- NANNYS FOR GRANNYS MISSION IS TO PROVIDE QUALITY, COMPASSIONATE AND SUPPORTIVE SERVICES IN AN ETHICAL MANNER TO HOME CARE CLIENTS.

- IN ORDER TO EVALUATE NANNYS FOR GRANNYS SERVICES, WE COLLECT INFORMATION BY OBSERVATION, SURVEYS, REVIEWING RECORDS AND GAREGIVER SKILLS

- THIS INFORMATION WE COLLECT HELPS US TO CONTINUE TO PROVIDE EXCELLENT SERVICE AND BETTER MEET OUR CLIENTS NEEDS

- NANNYS FOR GRANNYS IS CONTINUALLY LOOKING FOR WAYS TO IMPROVE OUR CLIENT SERVICES, SATISFACTION AND PROGRAMS.



EACH AND EVERY EMPLOYEE HAS A RESPONSIBILITY TO SUPPORT CONTINUOUS QUALITY IMPROVEMENT REGARDLESS OF THEIR JOB!!!!

NANNYS FOR GRANNYS POLICIES AND PROCEDURES REVIEW

- Overview of the Agency's Policy and Procedure Manual including: Service delivery and administration
- Communication (including the ability to read and write)
- Clients' rights and responsibilities
- Ethical behavior
- Confidentiality
- Client rights
- Privacy and confidentiality of client information, including finances and health
  - Interpersonal relationships
- Infectious/communicable diseases
- Blood-borne diseases
- Infection control and related policies
- Universal Precautions
  - Immunizations

Recognizing and reporting suspected abuse, neglect or exploitation

- The roles of, and coordination with, other community service providers; including emergency medical services
- Environmental emergencies/disasters
- Working with the elderly
- Dementias and confusion in the elderly
- Rights and privileges of the client and worker

- Money management – time management
- Personnel issues: – smoking; – dress-code, grooming and personal hygiene
- Discipline, theft, absenteeism
- Complaints and grievances
- Medical and other appointments scheduled during working hours
- Abuse of clients and/or co-workers
- Cultural diversity – sexual harassment
- Agency expectations: – need for background checks
- Performance standards; – competency evaluations
- Probationary period training and development
- Workloads
- Staff meetings
- Assignment and supervision of services
- documentation of client needs and services provided
- safety in the workplace
- personal and home safety
- Medical and non-medical emergency responses
- Environmental emergencies and disasters
- reporting accidents
- adverse/threatening clients
- Obligation to notify Supervisor of any known exposure to Tuberculosis, Hepatitis or other infectious/communicable diseases.

WHAT IS PATIENT CONFIDENTIALITY?

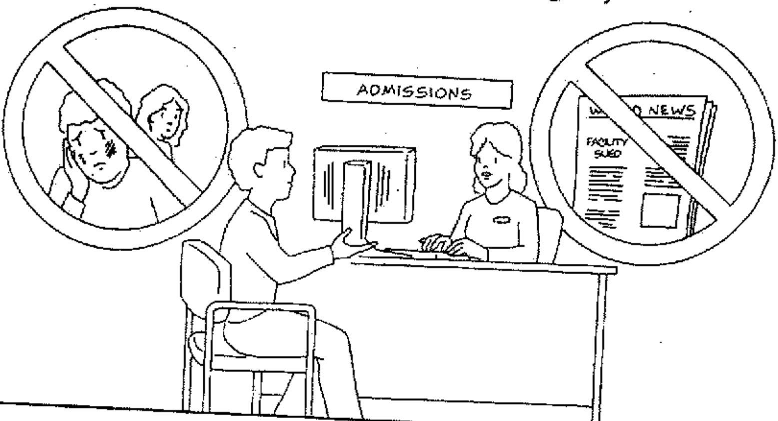
It's keeping information about patients' health care private. Patient confidentiality:

PROTECTS PATIENTS
If made public, patients' health records can cause:

- embarrassment
- discrimination at work or in housing.

Patients may not share important health information if they're afraid it won't be kept private.

PROTECTS YOU AND YOUR FACILITY
Both the law and job standards require confidentiality. Failure to comply may lead to disciplinary or legal action against you and your facility or agency.



Please read:
Talk to a professional! This booklet is not a substitute for the advice of a qualified expert. • The information in this booklet does not replace state or federal laws, including the Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule), as required by the Health Insurance Portability and Accountability Act (HIPAA) and the American Recovery and Reinvestment Act of 2009.

Every patient has a right to privacy—and confidentiality.

2010 Edition

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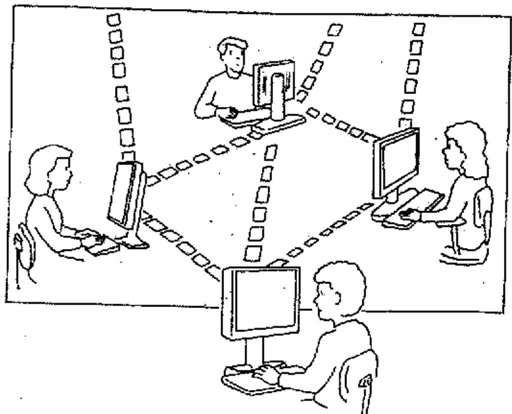
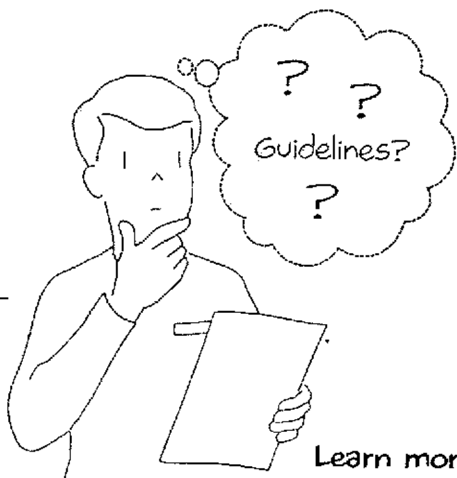
WHY SHOULD I LEARN ABOUT PATIENT CONFIDENTIALITY?

Because protecting it is part of your job. It's also a complicated issue, because:



HEALTH CARE IS CHANGING
Computer networks, larger health-care teams and other issues mean there are new ways of protecting confidentiality.

ANSWERS AREN'T ALWAYS CLEAR
Guidelines may not always tell you what to do in every situation. Protecting patient confidentiality requires an understanding of the issues—and sound judgment.



Learn more . . .

Answers to quiz on page 15:

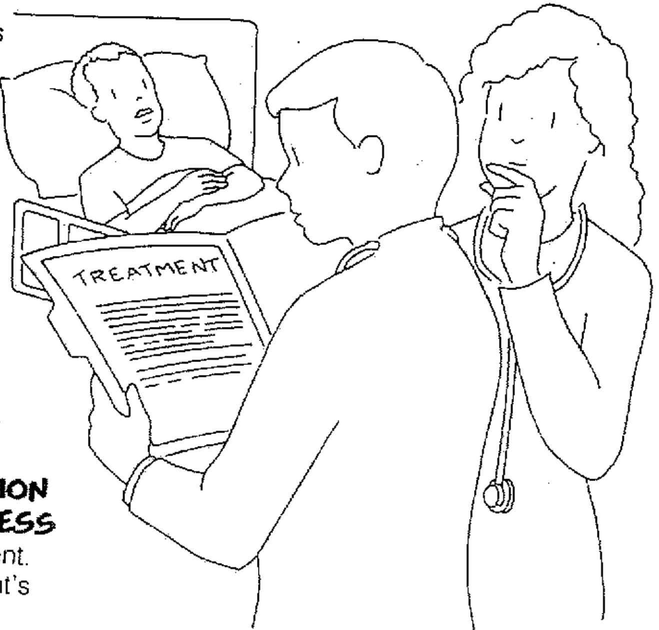
WHAT IS CONFIDENTIAL INFORMATION?

It includes a wide variety of information about a patient's health care.

EXAMPLES OF CONFIDENTIAL INFORMATION

may include:

- details about illnesses or conditions
- information about treatments
- photographs or videos of a patient
- a health-care provider's notes about a patient
- conversations between a patient and health-care provider.



PATIENT INFORMATION MAY SEEM HARMLESS

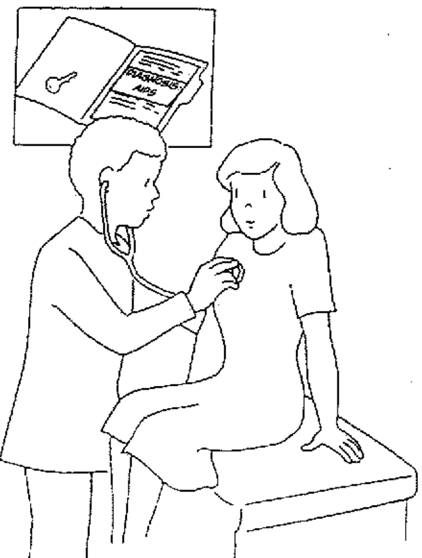
to you, but not to the patient. In any case, it is the patient's right to have certain information kept private.

> **IF INFORMATION IS DISCLOSED INAPPROPRIATELY**
> the patient must be notified. He or she may be able to get compensation. Also, those responsible may be fined.

SOME INFORMATION CAN BE RELEASED,

such as the patient's location. This may be included in the hospital directory to make it easier for friends and family to visit. (A patient can request NOT to be listed.)

A patient's condition should only be given if the person asking provides the patient's name and the patient has not requested that the information be withheld. Only one-word descriptions of the condition should be provided, such as "good," "serious" or "critical."



KNOW THE EXCEPTIONS,

such as when information about the patient would reveal that he or she is being treated for AIDS, psychiatric problems or abuse of alcohol or other drugs.

Remember: ANY patient may request that general information not be released.

Know your facility's policies for the release of all patient information!

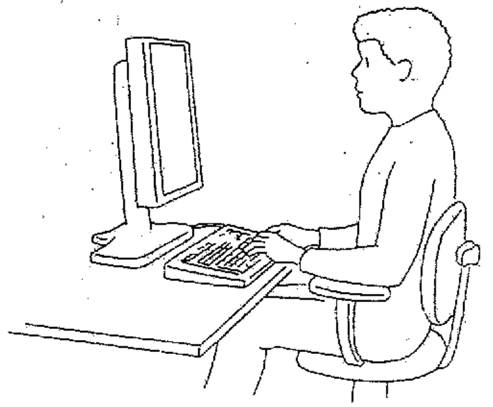
WHO IS AUTHORIZED TO SEE CONFIDENTIAL INFORMATION?

Generally, patient information is available to:

CERTAIN EMPLOYEES

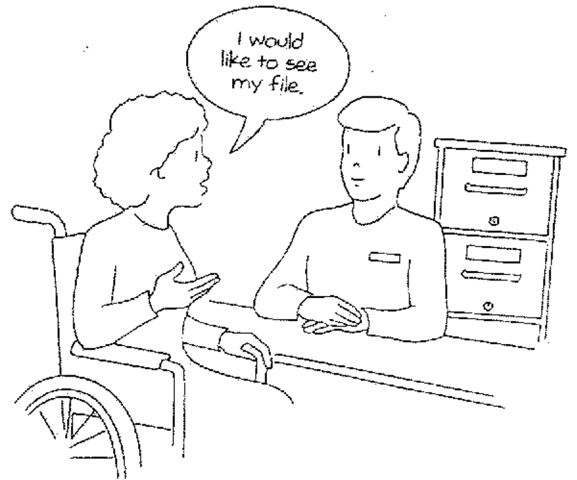
No patient consent is required to share information with people who need it for:

- the patient's care.
- quality assessment
- billing
- maintaining and distributing records.



THE PATIENT

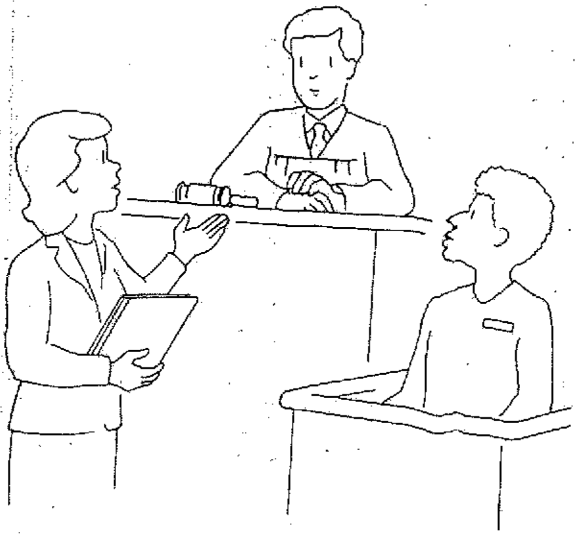
In general, patients have the right to see and request changes (amendments) to their records. In very limited cases, a patient may be denied access to his or her record—for example, if releasing the record would endanger the life of the patient.



COURTS AND LAW-ENFORCEMENT OFFICIALS

For example:

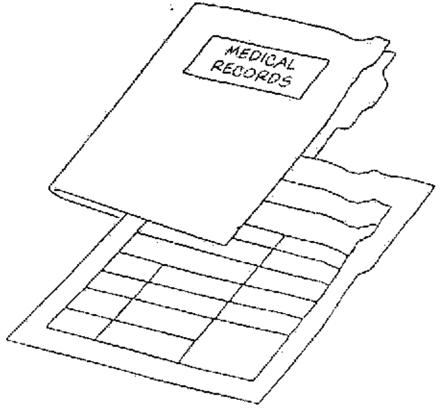
- A court can order the release of confidential patient information for use in a trial.
- Mandatory reporting laws can force health-care providers to report gunshot wounds and certain other injuries to local officials.



OTHER GOVERNMENT AGENCIES

For example:

- Public health officials may require the reporting of certain communicable diseases and other conditions or events.
- Child welfare and other agencies may require reporting of abuse.



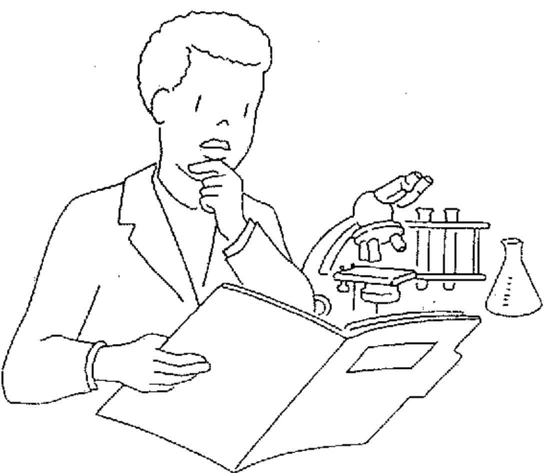
OTHERS WITH A RIGHT TO PATIENT INFORMATION

may include:

INSURANCE PROVIDERS

If a patient wants an insurer to pay for treatment, he or she must authorize the release of information to the insurer.

(NOTE: If a patient does not want insurance coverage, an insurer has no right to information.)



RESEARCHERS

Scientists may need medical information for their research. Facilities may sometimes provide information without patient authorization when the research is important to the welfare of the patient or society in general. (In most cases, information provided to researchers does not identify patients by name.)

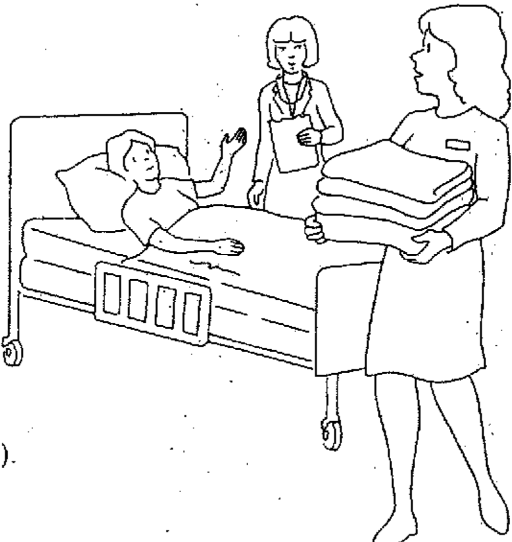
CONFIDENTIAL INFORMATION SHOULD NOT BE REVEALED

to any unauthorized person, including:

EMPLOYEES WHO HAVE NO "NEED TO KNOW"

Employees don't automatically have a right to see or hear confidential patient information. To see a patient's information, an employee must need it to:

- provide care
- perform his or her job (billing, record-keeping, etc.).



UNAUTHORIZED FRIENDS AND FAMILY

No matter what their intentions, friends and family do not have an automatic right to an adult patient's confidential information. Be sure you have the approval of the patient before you give information to anyone, even loved ones.

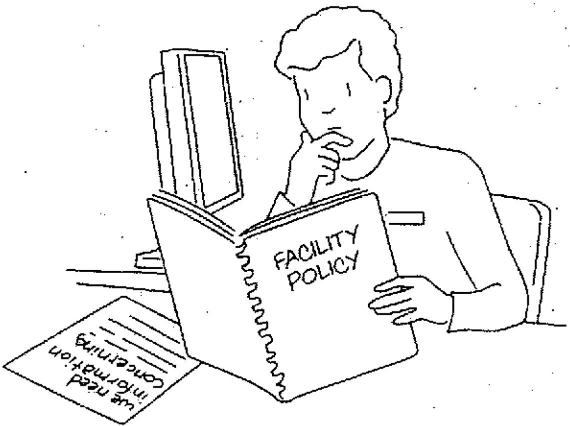
If you are in doubt about someone's right to know, ask your supervisor for help.

TIPS FOR PROTECTING PATIENT CONFIDENTIALITY

FOLLOW PROPER PROCEDURES

They can vary widely from facility to facility and from state to state. When you're faced with a tough question:

- Find out about laws or facility policies that address the issue.
- Get help! Ask your supervisor, or your facility's ethics committee or privacy officer for guidance.

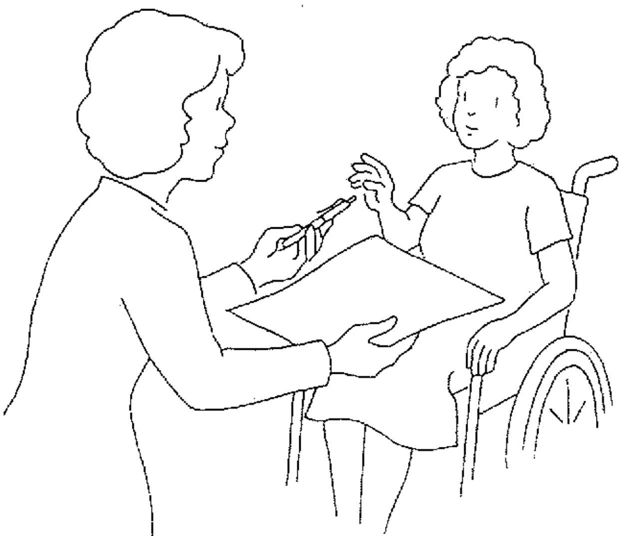


GET PROPER AUTHORIZATION

In general, you need a patient's permission to share confidential information with any unauthorized person or agency. You should:

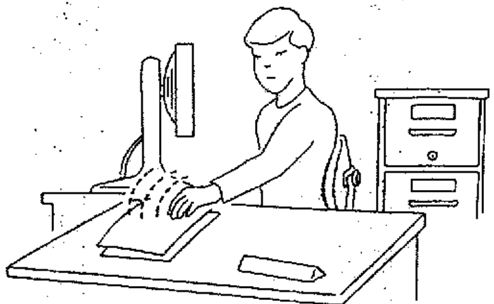
- Make clear to the patient what information is being requested and who is requesting it.
- Get the patient's authorization in writing.
- Get a new authorization for each new request for confidential information.

Remember, you also need authorization to take or use photos or videos.



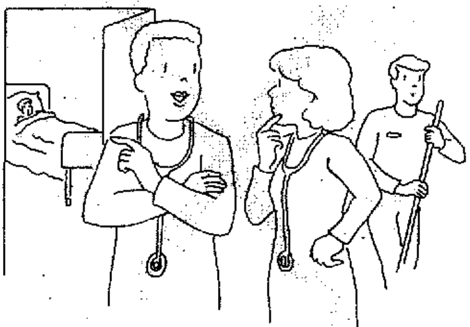
PROTECT ALL RECORDS

Keep all patient information secure. For example, keep computer screens and paper records out of view of unauthorized people. Also remember to password protect your computer and safeguard paper records—even if you step away for just a moment.



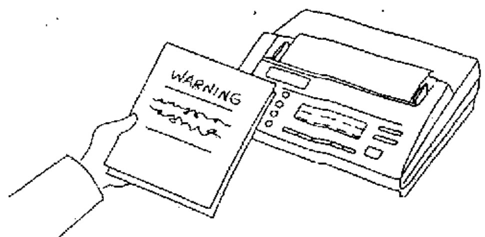
DON'T TALK ABOUT PATIENTS IN PUBLIC

Be careful not to discuss confidential information where others—including patients, visitors or other employees—might overhear.



USE CARE WITH PHONES, FAX MACHINES AND COMPUTERS

- Be sure to confirm that the other party has a need to know before responding to requests.
- Double-check all numbers before dialing—or all e-mail addresses before sending—to be certain you're reaching the right party.
- For faxes, use a cover sheet with a warning about misuse of confidential information.
- Follow your facility's policies and procedures for keeping electronic patient information secure.



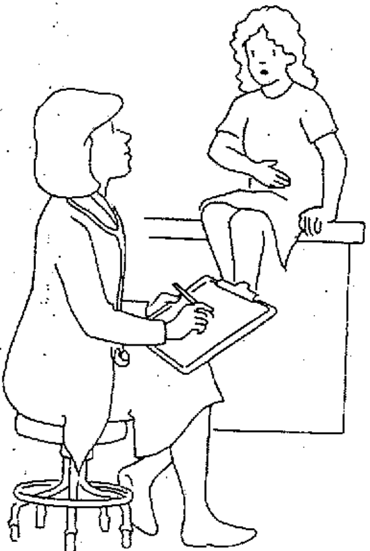
SOME COMMON BUT COMPLICATED SITUATIONS

MINORS

State laws vary. In general, you must give information to a minor's legal guardian. But, keep in mind that:

- A parent or guardian may agree to a confidential relationship between the minor and the health-care provider.
- A health-care provider may choose not to treat the parent or guardian as the personal representative of the child if he or she reasonably believes (in his or her professional judgment) that the child has been abused or neglected.
- A parent or guardian may be denied access to information related to certain protected conditions (as outlined by state law).

Know the status of minor patients and their parents or guardians!



A PATIENT WHO THREATENS OTHERS

Courts have ruled that a health-care provider may be responsible for disclosing information about dangerous patients to possible victims.

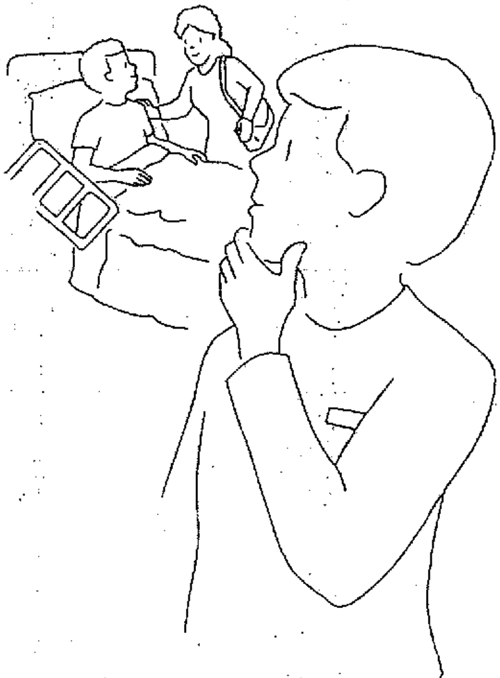
If you encounter such a situation, discuss the matter with your supervisor.

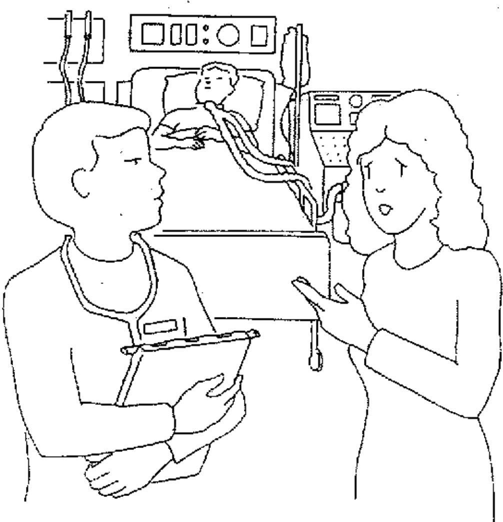
PATIENTS WITH HIV AND AIDS

Patients with HIV deserve confidentiality, but employees often feel a need to inform others at risk of infection.

Laws and policies about HIV disclosure vary—by state, facility and even job classification. If a patient is knowingly placing partners or others at risk:

- Talk with your supervisor.
- Don't give the patient's name until you know which rules and laws apply.





INCOMPETENT, INCAPACITATED OR DECEASED PATIENTS

Generally, an incompetent or incapacitated patient's next-of-kin can receive confidential information. However, many patients have advance directives, such as living wills or powers of attorney. If such documents exist, only persons named in them can receive information.

For a deceased patient, only the personal representative, such as the authorized executor, can receive confidential information in most cases. However, in some cases, a relative may be able to receive confidential information if the information could affect the relative's health.

SOME QUESTIONS AND ANSWERS

What if I see an unauthorized use of confidential information?

It's your responsibility to report it. Remember, confidentiality is the patient's right—and the legal and professional responsibility of your facility and co-workers.

Doesn't my facility own its patient health records?

The facility owns the records. But patients should be able to see their medical records and request changes to correct any errors.

Must I really keep information from a parent or an HIV patient's partner?

It depends on the situation, state laws and your facility's rules, but in many cases, yes. Confidentiality is not always easy. Try to encourage the patient to share the information him- or herself. Offer your support if the patient is nervous.

No matter what happens, always follow proper procedures. See your supervisor if you have questions.

TEST YOUR KNOWLEDGE

about patient confidentiality by checking "true" or "false."

1. Patients may be more likely to share information with health-care providers if they know it will be kept private. . . . . True ☐ False ☐
2. Failure to protect patient confidentiality can lead to legal and disciplinary action. . . . . True ☐ False ☐
3. Most health-care staff are not responsible for safeguarding confidentiality. . . . . True ☐ False ☐
4. Conversations between patients and health-care providers are confidential. . . . . True ☐ False ☐
5. In general, a facility should never release a patient's location without that patient's consent. . . . . True ☐ False ☐
6. A court has the power to force disclosure of confidential patient information. . . . . True ☐ False ☐
7. In general, close friends and family have a right to a patient's information. . . . . True ☐ False ☐
8. Policies and laws regarding patient confidentiality can vary. . . . . True ☐ False ☐
9. It isn't always necessary to share patient information with a minor's parent. . . . . True ☐ False ☐
10. Patients with AIDS and HIV have no right to patient confidentiality. . . . . True ☐ False ☐

I have read the booklet, "About Patient Confidentiality."

______________________________ ______________

Employee's signature Date

Answers are on page 3.

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CLIENT BILL OF RIGHTS

As a Client you have the right to:

1. Competent, concerned, individualized care without regard to race, creed, color, age, sex. national origins, or handicap.
2. Be treated with dignity, consideration, and respect.
3. Expect the Agency to maintain a written care plan and to participate in all decisions affecting your care, treatment, and discharge.
4. Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third-party payment.
5. Know the names and functions of those people responsible for coordinating, rendering and supervising your health care, including the identity of health care providers with which the Agency may have contractual relationship; to know when and how services will be provided by these persons.
6. Be fully informed of your diagnosis, prognosis and treatment, including alternatives to care and risks involved.
7. Refuse treatment after being fully informed of and understanding the consequences of such action.
8. Be informed of continuing health care needs following discharge and be involved in the plan for the provision of such care.
9. To indicate an Advance Directive and/or a Heath Care Surrogate.
10. Voice grievances and recommend changes in policies and services to the Agency staff and to the governing authority free from interference, coercion, reprisal or discrimination. In the event Clients are not satisfied with the Agency's resolution

Clients have the right to contact the New York State Department of Health Home Health Hotline at 212-417-5888 or (1-800-628-5972) which can be called 24 hours per day, seven days per week. The hotline is manned by Division of Home and Community Based Care staff from 10 a.m. to 4 p.m. Monday through Friday. Complaints/incidents may also be submitted by fax (518-408-5309) or by mail to: NYS DOH-Metropolitan Regional Office-90 Church Street-NY, NY 10007 Alternatively, you may send an e-mail to homecare@health.state.ny.us with the nature of the complaint. We also would appreciate if you would optionally provide us with your e-mail address, contact number, and name, so that we may contact you promptly regarding the complaint **to file grievance, call or contact the Administrator at 631-730-8500**

11. View your Clinical Record in the Agency office and have copy of the record forwarded to your physician. The Agency will release the record to other parties as authorized by law and at their discretion.

12. Examine, question, and receive a full explanation of any bill regardless of source of payment.

13. Be informed of your rights in writing.

CLIENT RESPONSIBILITIES

The Agency expects that as a Client you will:

1. Be seen by your doctor if a change in your health status occurs.

2. Share complete and accurate health information with Agency staff.

3. Inform staff of any change in your health status and make it known if you do not understand or cannot follow instructions.

4. Be responsible for following the treatment plan recommended by the Agency.

5. Cooperate with and be respectful to staff and not discriminate against staff because of race, creed, color, sex, age, national origin or handicap.

6. Notify the Agency in advance whenever you find you will not be home at the time of your next scheduled Agency visit.

7. Make arrangements for a family member or substitute to participate in care when necessary.

8. Make arrangements in the home to ensure safe care.

9. Notify the Agency if you receive services from any other Agency or facility.

10. Be responsible for your actions if you refuse treatment or do not follow the Agency's instructions.

11. Be responsible for assuring that the financial obligations of your health care are fulfilled as promptly as possible.

12. Keep valuables in a secure location.

Please feel free to contact the Administrator Or Director of Nursing should you have any questions or comments regarding your rights and responsibilities.

In the case of a Client adjudicated to be incompetent in accordance with state law, all rights and responsibilities specified above devolve to the person(s) appointed responsible by the court.

A Client may authorize another to make medical decisions if they become incompetent through utilization of a Health Care Proxy (Surrogate Decision Maker) or Advance Directive.

In addition to the above rights and responsibilities, the agency complies The Health Insurance Portability a Accountability Act (HIPAA) effective April 14, 2003. This federal law ensures that in addition to confidenti about your treatment, other personal identifying information is also treated as confidential and can not b released without authorization. Protected information includes but is not limited to: name, social securi number, phone number, address, and next of kin. If you have any questions about how your confiden information is treated by the agency please call the Administrator for clarification.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Nannys for Grannys is providing this Notice of Privacy Practices ("Notice") because the privacy of your Protected Health Information ("PHI") is very important to you and to us, and in compliance with Federal and State regulations.

By "your PHI"S we mean the information that we maintain that specifically identifies you and your health status or services.

This Notice describes how we use your PHI within the Company and disclose it outside the Company, and why. This Notice covers:

I. Uses or disclosures which do not require your written authorization:

A) Treatment, Payment, and Healthcare Operations:
To carry out your treatment, to obtain payment and to conduct health care operations. For example:

1. For treatment, we use your PHI to plan, coordinate, and provide your care. We disclose your PHI for treatment purposes to physicians and other health care professionals outside our agency who are involved in your continued care.
2. For payment, we use your PHI to prepare documentation required by your third-party payor (your insurance company).
3. For healthcare operations, we use or disclose your PHI, for example, to improve the quality of our services, to plan better ways of treating patients, to evaluate staff performance and oversee the Company's operation by an accredited agency.

B) Uses or Disclosures of Your PHI to Which You May Object:
We may use or disclose your PHI for the following purposes, unless you ask us not to:

1. Disclosure of your PHI to family, friends, or others identified by you who are involved in your care.
2. Assistance in disaster relief efforts.
3. Confirming our visits to your home or other appointments.
4. Informing you about treatment alternatives or other health-related benefits and services that may be of interest to you. If you object to our use or disclose of your PHI for any of these purposes please do so in writing.

C) Uses or Disclosures Required or Permitted:
Where we are required or permitted to do so, we may use or disclose your PHI in the following circumstances without your written authorization.

1. Federal, State or Local law requirements.
2. Federal government investigation when required by the Secretary of Health and Human Services to investigate or determine our compliance with federal and State regulation.

3. Public health activities, for example to report communicable diseases or death; or for matters involving the Food and Drug Administration.
4. Reporting of abuse, neglect or domestic violence.
5. Health oversight activities by a health oversight agency. (A health oversight agency is an organization authorized by the government to oversee eligibility and compliance and to enforce civil rights laws.)
6. Judicial or administrative proceedings, for example responding to a court order or subpoena.
7. Law enforcement purposes, for example to report certain types of wounds or other physical injuries or to identify or locate a suspect, fugitive, material witness, or missing person.
8. Use by coroners, medical examiners, or funeral directors.
9. Facilitating organ or tissue donation.
10. Research, provided that very strict controls are enforced.
11. Averting a serious threat to your health or safety or that of the public.
12. Workers' compensation.

II. Uses or disclosures which require your written authorization:
Your written authorization, which you may revoke (in writing), is required if we use or disclose your health information for **Non** Treatment, Payment, or Healthcare Operations.

A) Our use of psychotherapy notes beyond treatment, payment, and healthcare operations.

B) Marketing of goods or services to you.

C) To other parties and/or organizations beyond treatment, payment, and healthcare operations.

III. Your Rights As A Patient to Privacy Of Your PHI:

A) You have the right to request restriction(s) on our uses and disclosures of your PHI; we may however refuse to accept the restriction(s), if the restriction(s) are deemed unreasonable.

B) You have the right to request that we communicate PHI with you confidentially or with an individual you identify. For example to speak with you or an individual you identify only in private, to send mail to an address you designate or to telephone you at a number you designate.

C) You have the right to request access to your PHI in order to inspect or copy it.

D) You have the right to request in writing an amendment of your PHI providing a justifiable reason for the amendment. If we deny your request, you may submit a statement of disagreement.

E) You have the right to request an accounting of our disclosures of your PHI for purposes **other than** treatment, payment, and healthcare operations. We are not required to provide an accounting for disclosures before April 14, 2003 or for more than six years prior to the date of your request.

F) If you have received this Notice electronically, you then have the right to receive a paper copy. Your request for any of the above must be in writing. We may deny your request and, if so, you may request a review of the denial. We will however make every attempt to honor your request. A nominal fee for copying and supplies would be applied if there were more than one request per year.

IV. Our Duties in Protecting Your PHI:

A) We are required by law to maintain the privacy of your PHI.

B) We must inform patients or their legal representatives of our legal duties and privacy practices with respect to PHI. This Notice discharges that duty.

C) We must abide by the terms of the Notice currently in effect.

D) We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. You may obtain a copy of the current Notice form at any time.

V. Complaints, Contact Person, Effective Date, and Acknowledgement:

A) You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated.

B) You will not be retaliated against for filing a complaint.

C) You may file your request or complaint with our Company by writing to us at:

Compliance Officer
Nannys For Grannys
34 Sunset Lane
Patchogue, NY 11772

D) You may file a complaint with the Secretary of Health and Human Services by writing to: **Secretary of Health and Human Services, Office of Civil Rights**
Web page: www.hhs.gov **U.S. Department of Health and Human Services 200 independence Avenue S.W., Washington, DC 20201**

Nannys For Grannys
Client Information Booklet

As a patient of Nannies for Grannies, Inc., you have the right to:

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.

2. Receive competent, individualized care and service from Nannies for Grannies, Inc. staff regardless of age, race, color, national origin, religion, sex, disease, disability or any other category protected by law or decisions regarding advance directives.

3. Be treated with dignity, courtesy, consideration, respect and have your property treated with respect.

4. Be informed verbally and in writing of the services available and related charges, as they apply to the primary insurance, other payers, and self-pay coverage before care is initiated. To be informed of any changes in the sources of payment and your financial responsibility as soon as possible no later than thirty (30) calendar days after Nannies for Grannies, Inc., becomes aware of the change.

5. Be informed both orally and in writing, in advance of the Plan of Care, of any changes in the Plan of Care, and to be included in the planning of care before treatment begins; be informed of all treatment prescribed, when and how services will be provided, and the names and functions of any person and affiliated program providing care and services, including photo identification of Nannies for Grannies, Inc. staff and participate in the development of the discharge plan.

6. Be provided with a copy of the Agency's Notice of Privacy Practices.

7. Participate in the planning of your care and be advised in advance of any changes to the plan of care.

8. Refuse care and treatment after being fully informed of and understanding the consequences of such actions and to initiate an Advance Directive, "Living Will", durable power of attorney and other directives about your care consistent with applicable law and regulations. Refuse to participate in research or experimental treatment.

9. Receive information regarding community resources and to be informed of any financial relationships between Nannies for Grannies, Inc. and other providers to which you may be referred to by the agency.

10. Express complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services on behalf of Nannies for Grannies, Inc. and to expect the agency to investigate such complaints within 15 days of receipt of complaint. Also, if dissatisfied with the outcome, may submit an appeal to the agency's governing authority, which will be reviewed within 30 days of receipt of appeal request.

11. Be informed of the procedures for submitting patient complaints, voice complaints and recommend changes in the policies and services to Director of Patient Services by calling the following telephone number: 631-730-8500. If dissatisfied with the outcome, you may also submit a complaint to the New York State Department of Health or any outside representative of the patient's choice.

NYS Department of Health
Metropolitan Regional Office
90 Church Street
New York, New York 10007
1-800-628-5972

12. The expression of such complaints by the patient or patient designee shall be free from interference, coercion, discrimination or reprisal.
13. Receive timely notice of impending discharge or transfer to another agency or to a different level of care and to be advised of the consequences and alternatives to such transfers.
14. Privacy, including confidential treatment of records and access to your records on request. Information will not be released without your written consent except for those instances required by law, regulation or third party reimbursement.
15. In the situation when the patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the patient.

As a Home Care Patient, you have the responsibility to:

1. Be seen by a doctor on a regular and ongoing basis.
2. Share complete and accurate health information.
3. Be responsible for following the recommended treatment plan.
4. Make it known if you do not understand or cannot follow the treatment plan.
5. Cooperate with Agency staff and not discriminate against staff.
6. Notify Nannies for Grannies, Inc. in advance when you cannot keep a scheduled appointment.
7. Notify Nannies for Grannies, Inc. if you receive services from another agency.
8. Notify Nannies for Grannies, Inc. in the event of change in your health status.
9. Be responsible for your actions if you refuse treatment or do not follow the Agency's recommendations/directions.
10. Take responsibility for financial obligations of your care.
11. Maintain a home environment that facilitates effective home care.
12. Keep Valuables in a safe place

Please feel free to contact the Administrator or Director of Nursing should you have any questions or comments regarding your rights and or responsibilities

In the case of a Client adjudicated to be incompetent in accordance with state law, all rights and responsibilities specified above devolve to the person(s) appointed responsible by the court.

A client may authorize another to make medical decisions if they become incompetent through utilization of a Health Care Proxy (Surrogate Decision Maker) or Advance Directive.

SUMMARY OF THE HIV CONFIDENTIALITY LAW

On February 1, 1989, New York State Public Health Law Article 27-F regarding the confidentiality of HIV related information became effective. This law regulates the conditions under with HIV testing can be carried out and the circumstances under which HIV related information can be released. Both the statute and the applicable Department of Health regulations are subject to change and further interpretation. The following summary is based on the statute and the regulations as presently worded and interpreted. If you have any questions regarding the law, please call the Director of Patient Services.

I. Definitions:
As used in the HIV Confidentiality Law, the following terms have the following meanings:

"Protected individual" means a person who is the subject of an HIV-related test or who has been diagnosed as having HIV infection, AIDS or HIV-related illness.

"Confidentiality HIV-related information" means any information concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.

"Capacity to consent" means an individual's ability, determined without regard to such individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment and procedure.

"Contact" means an identified spouse or sex partner of the protected individual or a person identified as having shared hypodermic needles or syringes with the protected individual.

II. HIV-related testing

A. Written informed consent: The law requires that written consent be obtained before an HIV test can be performed. The consent must be obtained from either the subject of the test or if that individual lacks capacity to consent, from a person authorized by law to consent to health care for the individual.

A State-approved form must be used. The person ordering the test must certify in the laboratory requisition form that informed consent has been obtained.

B. Pre-test and post-test counseling: Both pre-test and post-test counseling on certain subjects must be provided.

C. Exceptions:

1. for testing related to use of a human body or human body part (including organs, tissues, eyes, bones, arteries, blood, semen or other body fluids) in medical research or therapy, or for transplantation to persons, provided that if the test results are communicated to the tested person, post-test counseling is required.

2. for research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher.

3. for testing of a deceased person to determine cause of death or for epidemiological purposes.

4. for court-ordered testing pursuant to Civil Practice law and Rules Section 3121 (i.e., in a malpractice lawsuit, under certain conditions).

5. if otherwise authorized or required by State or Federal law.

III. Confidentiality and Disclosure of HIV-Related Information

A. General Confidentiality Rule: No person who obtains confidential HIV-related information in the course of providing any health or social service, or pursuant to a release of confidential HIV-related information, may disclose or be compelled to disclose such information except in response to a special release form (see Section "B" below) or to certain persons or entities and under the circumstances described in section "C" and "D" below.

B. Use of Special Releases: A general authorization for the release of medical information is not sufficient to authorize release of confidential HIV-related information. Disclosure of such information is permitted pursuant to a special release form#2557, which has been developed by the Department of Health. The release must be signed by the protected individual, or if the protected individual lacks capacity to consent, by a person authorized pursuant to law to consent to health care for the individual. The release must be dated and specify to whom the release is to be effective.

C. Disclosure to Authorized Persons and Entities: Confidential HIV-related information may be disclosed without a special release form to the following persons and entities, under the circumstances described:

1. To the protected individual or, if the protected individual lacks capacity to consent, to a person authorized by law to consent to health care for the individual.

2. To a health care provider employee, agent or attending physician if the person (I) provides health care to the protected individual; or (II) handles medical records for billing and reimbursement purposes; or (III) reasonably needs the information to supervise, monitor, administer or provide health services, provided the person is authorized to access HIV information as reflected on the health care providers' list of authorized employees (by job title).

3. to another health care provider or health facility when knowledge of the HIV-related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual.

4. to a health care provider or health facility when organ procurement research or transplantation is involved.

5. to hospital committees or accreditation or oversight review organizations responsible for monitoring or evaluating health facilities.

6. to a federal, state, county, or local health officer when disclosure as required by federal or state law has been obtained.

7. to an employee or agent of a governmental agency, when the agency needs the information to supervise, monitor, administer, or provide a health or social service.

8. to an authorized agency in connection with foster care or adoption of a child.

9. to child protective services when necessary to comply with child abuse reporting requirements.

10. to third party payers to the extent necessary to reimburse for health services, provided a general release has been obtained.

11. to an insurance institution, for other than the purpose set forth in paragraph (10) above, provided the insurance institution secures a dated and written authorization that indicates that health care providers, health facilities, insurance institutions, and persons are authorized to disclose information about the protected individual, the nature of the information to be disclosed, the purpose for which information is to be disclosed and which is signed by: (I) the protected individuals; (II) if the protected individual lacks the capacity to consent, such other person authorized pursuant to law to consent for such individual; or (III) if the protected individual is deceased, the beneficiary or claimant for benefits under the policy or plan.

12. to any person to whom disclosure is ordered by a court, under limited circumstances set forth by law (confidential HIV-related information may **not** be released pursuant to a subpoena).

13. to an employee or agent of the Division of Parole, the Division of Probation, the Commission of Correction or a medical director of a local correctional facility, as permitted by HIV confidentiality regulations or such organizations.

D. Disclosures Permitted to be Made by Physicians: A physician may disclose confidential HIV-related information in the following circumstances:

SUMMARY OF THE HIV CONFIDENTIALITY LAW

1. To Determine Fitness to Attend School: A physician may, upon the consent of a parent or guardian, disclose HIV-related information to a state, county, or local health officer for the purpose of reviewing the medical history of a child to attend school.

2. To Provide Timely Treatment: A physician may also disclose HIV-related information to a person (known to the physician) authorized pursuant to law to consent to health care for the protected individual when the physician reasonably believes that disclosure is medically necessary to provide timely care and treatment to the protected individual, unless the physician believes such disclosure would not be in the protected individual's best interest, or if the protected individual is authorized by law to consent to health care. Before such disclosure takes place, however, the protected individual must first have been counseled as to the need to disclose information to a person authorized by law to consent to health care, and despite counseling, must have refused to do so. Any decision or action by a physician under this provision and the basis for the decision is to be recorded in the protected individual's medical record.

3. To Warn Contacts:

Criteria for disclosure. A physician may - but is not required - to disclose HIV-related information without the protected person's consent to a contact or a public health officer when: (I) the physician reasonably believes disclosure is medically appropriate and a significant risk of infection exists, and (II) the protected individual has been counseled to notify his/her contacts and the physician reasonably believes the individual will not inform the contacts.

b. Who should disclose? The physician must inform the protected individual of the physician's intent to disclose, and the physician must comply with the protected person's choice of whether the physician or a public health officer will attempt to notify the contact.

c. Disclosure requirements. Contact must be notified in person except where circumstances reasonably prevent doing so. The identity of the protected individual may **not** be disclosed to the contact. Finally, the person notifying the contact shall provide counseling or make referrals for counseling as appropriate. Such counseling must address coping emotionally with potential exposure to HIV, an explanation regarding the nature of HIV infection and HIV-related illness, availability of anonymous and confidential testing, information on preventing exposure or transmission of HIV infection, information regarding problems that might occur as the result of disclosure of HIV-related information, and legal protection against such disclosures.

d. When the protected individual is deceased. If a protected person is now deceased and the physician reasonably believes the protected person had not informed his/her contacts and reasonably believes disclosure is medically appropriate and that a significant risk of infection exists, the physician may notify the contact or request the public health officer to notify the contact. All such notifications must be in person, except where circumstances reasonably prevent doing so, and the identity of the deceased must not be disclosed.

SUMMARY OF THE HIV CONFIDENTIALITY LAW

e. No obligation to locate. A physician has no obligation to identify or locate any contact.

E. Statement Prohibiting Redisclosure

A written statement prohibiting redisclosure must accompany or follow all disclosures of confidential HIV-related information, except disclosures (I) to the protected individual or, when the protected individual lacks capacity to consent, to a person authorized pursuant to law to consent to health care for the individual, (II) to a contact, as permitted by section III, D, 3 or (III) to provide timely treatment, as permitted by section III, D, 2.

Written disclosures must be accompanied by the statement. Oral disclosures must be accompanied by the statement within ten days.

The Statement must include the following language or substantially similar language:

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 authorization for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for release of medical or other information will be in violation of the state law and may result in a fine or a jail sentence or both.

F. Notations of Disclosures: All disclosures of confidential HIV-related information must be noted in the medical record of the protected individual, except:

1. only initial disclosures for insurance companies need be noted;
2. notation is not required for disclosure to health care provider personnel authorized to access HIV-related information; and
3. notation is not required for disclosure to persons engaged in quality improvement, program monitoring or evaluation, or for governmental payment agents pursuant to contract or law (i.e., Medicare and Medicaid agents). The protected individual must be informed of all disclosures upon request.

G. Recording the HIV-Related Information: Confidential HIV-related information must be recorded in the medical record such that is readily accessible to provide proper care. The HIV Confidentiality Law does not prohibit the listing of AIDS or HIV-related illness or infection on a death certificate, autopsy report or related documents.

SUMMARY OF THE HIV CONFIDENTIALITY LAW

H. The following in-house job titles have medical record access and therefore, access to HIV+ confidential information :
   1. Administrator;
   2. Agency Management Staff;
   3. Director of Patient Services;
   4. Supervising Nurses;
   5. Nurses;
   6. Physical Therapists;
   7. Occupational Therapists;
   8. Medical Social Workers;
   9. Nutrition Counselors;
   10. Coordinators;
   11. Bookkeepers;
   12. Office Assistants; and
   13. Patient's Insurance Company.

**Please note, that this list does not include the caregivers. In the event other staff need to have access to confidential information, the patient must give us permission to do so. Nannies for Grannies, Inc. manager shall then list the staff to have access on the "Authorization for Release of Confidential HIV Information" form, and send it to the Patient for signature. Upon receipt in the office, this completed form enables the office staff to share Patient information.*

CONFIDENTIALITY AND RELEASE OF HIV INFORMATION

POLICY:

1. Employee Education
   - Each employee shall receive initial orientation and annual inservice regarding the legal prohibition against unauthorized disclosure of confidential HIV information.
   - Initial education shall be documented on orientation records with date and employee's signature and filed in the employee's personnel record.
   - Only employee's who have documentation of such training shall have access to confidential HIV information while performing authorized job functions.
   - All employees shall respect the patient's right to confidentiality, fear of disclosure, and discrimination as it related to HIV information.
   - The Director of Patient Services/designee shall monitor and evaluate the implementation of its policies regarding confidentiality in order to attain maximum compliance in the proper handling of confidential HIV related patient information.
2. Patient Records
   - Records containing any confidential HIV related information should remain in the office at all times. The record shall be kept in the file except when being actively used by authorized employees.
   - Confidential HIV related information should be recorded in the medical record so that it is readily accessible for planning proper care and treatment.
3. Release of HIV Related Information
   - Confidential HIV information shall not be disclosed to a health care provider, or health care facility if the sole purpose of disclosure is infection control. This means that Nannies for Grannies, Inc. will not release HIV confidential information to the aides or nurses since our regular infection control procedures are adequate for Patient care situations.
   - All requests for release of HIV related information should be directed to the Director of Patient Services/designee.
   - Prior to release of information a signed Authorization for Release shall be on file in the patient record. Only New York State Department of Health Form shall be used to release HIV related information. No other release form shall be acceptable. Confidential HIV information shall not be released pursuant to a subpoena. A court order pursuant to Public Health Law Section 2785 is required.
   - The protected individual shall sign the release, or a person authorized pursuant to law to consent to health care for the individual.

- All disclosures of HIV related information should be recorded in the patient record except disclosure made to those individuals granted statutory access to such information.

- All disclosures of HIV related information should be accompanied by a statement prohibiting redisclosure of such information and the penalties inherent in unauthorized redisclosure. Nannies for Grannies, Inc. form entitled Redisclosure of Confidential HIV information shall be used for this purpose.

- Oral disclosures of HIV related information should be accompanied by an oral statement prohibiting redisclosure. Nannies for Grannies, Inc. personnel shall read the agency form entitled Redisclosure of Confidential HIV information and then mail the form prohibiting redisclosure to the party to whom disclosure occurred. Documentation of these activities shall appear in the patient record.

- Confidential HIV related information shall not be disclosed pursuant to Public Officers Law, Article 6 (the Freedom of Information Law), a routine medical information release or a subpoena.

- The protected person shall be informed of disclosures of HIV related information upon request.

PROCEDURE:

1. Employee Education

   - Provide each employee with HIV confidentiality education during the initial orientation period and annually thereafter.

   - Include personnel responsibilities in protecting the patient's right to confidentiality, fear of disclosure, and discrimination based on HIV related information. Discuss legal charges and monetary penalties for unauthorized disclosures.

   - Include an explanation of the following definition:

     "CONFIDENTIAL HIV related information means any information concerning whether an individual has been the subject of an HIV related test, or has HIV infection, HIV related illness or AIDs, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts."

     Explain that HIV related information may only be disclosed to agents/employees of Nannies for Grannies, Inc. who require this information to fulfill the functions of their position and as listed in Access to Confidential HIV Related Information by Job Title. Provide this list to employees during education sessions.

CONFIDENTIALITY AND RELEASE OF HIV INFORMATION

- Document the initial education on the appropriate orientation records and file in the employee's personnel file. Document subsequent annual education on the inservice education log.
- Store all patient files in areas of limited access.
- File HIV related information immediately.
- Strictly limit access of HIV related information to those who reasonably need such information to supervise, monitor or administer health services.
- In circumstances of verbal disclosures, include a written notation of disclosure in the patient record, read and send the Redisclosure of Confidential HIV information to the party to whom information is being released.
- The statement prohibiting redisclosure is not required to release HIV information to:
  - The patient
  - The patient's legal representative
  - Release made by physician or public health officer to a contact
  - Other persons with statutory access to such information
- Insurance institutions and third party payers have statutory access to confidential HIV related information.
- Any release of HIV related information to other than those persons designated by NY law and regulation, requires the completion and receipt of an authorized release form designated by New York State Public Health Law.
- All written disclosures of HIV related information must be accompanied by the Statement Prohibiting Redisclosure.
- Inform the patient of disclosures of HIV related information upon patient request.

2. Patient Records
   - Review Access to HIV Related Information by Job Title, for those persons authorized access to the patient's record containing HIV related information.
   - Maintain confidential HIV related information in the patient record readily accessible to those planning the care of the patient.
   - Maintain patient records containing confidential HIV related information in Nannies for Grannies, Inc. office at all times.
   - Do not leave records open on desktops. File records promptly after use.
   - HIV related information may be noted on the certificate of death, the autopsy report or related documents prepared to document the cause of death.

CONFIDENTIALITY AND RELEASE OF HIV INFORMATION

3. Release of HIV Related Information
   - Contact the Director of Patient Services/designee to review and approve al request for HIV related information.
   - Determine whether the person or party requesting confidential information has statutory access to such information or requires and Authorization of Release of HIV information.
   - When a release is required, authorization for release of HIV information must be obtained on New York State Department of Health form.
   - Provide the requested information with a statement prohibiting redisclosure of the protected information.
   - When protected information is disclosed verbally, read Nannies for Grannies, Inc. redisclosure statement to the party to whom protected information was released. Mail the form to the party to whom information was released.
   - Document in the patient record the request for information, the release of information and the recitation and or mailing of form.
   - Provide the patient with information regarding disclosure of HIV related information upon request.

Who Can Receive HIV* Related Information: Under New York State Public Health Law HIV related information is confidential and may be only given:

a. To you (or a person authorized by law who consented to the test for you).

b. To anyone whom you have specifically authorized to receive such information by signing a written release.

c. To a health care facility (such as a hospital, blood bank, or clinical laboratory) or a health care provider (such as a physician, nurse, or mental health counselor) providing care to you or your child, and anyone working for such a facility or provider who reasonable needs the information to supervise, monitor or administer a health service.

d. To a person who your doctor believes is at significant risk of HIV infection, if you do not notify that person after being counseled to do so.

e. To a committee or organization responsible for reviewing or monitoring a health facility.

f. To a federal state, county or local health officer when state or federal law requires disclosure.

g. To a government agency, when the agency needs the information to supervise, monitor or administer a health or social service.

h. To an authorized foster care or adoption agency.

i. To insurance companies and other third party payers such as Medicaid if necessary for the payment of services to you.

j. To any person to whom a court orders disclosure under limited circumstances set forth by law. Except in an emergency situation, advance notice and an opportunity to oppose the release of such information would be given to you.

k. To the Division of Parole, the Division of Probation, the Commission of Correction, or a medical director of a local correctional facility, as permitted by HIV confidentiality regulations of such organizations.

l. By a physician to the person who consents for your health care (parent, guardian, etc.) If disclosure is necessary to provide timely care for you, and you have been counseled regarding the need for disclosure. A physician may not disclose such information if it is against your best interest to do so.

You can ask your doctor if HIV* related information about you had been released to anyone listed above.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection. HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (800) 523-2437. This Agency is responsible for protecting your rights.

**Name of Person Whose HIV Related Information Will Be Released

____

Name and address of person signing this form (if other than above).

____

Relationship to person whose HIV information will be released.

____

Name and address of person who will be given HIV related information.

____

Reason for release of HIV related information.

____

Time during which release is authorized From: To:

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

* Date ______ Signature ______ Witness ______

New York State Form 2557
*Human Immunodeficiency Virus That Causes AIDS

HIV CONFIDENTIALITY STATEMENT AND ACKNOWLEDGEMENT

" CONFIDENTIAL HIV RELATED INFORMATION MEANS ANY INFORMATION CONCERNNG WHETHER AN INDIVIDUAL HAS BEEN THE SUBJECT OF AN HIV RELATED TEST, OR HAS HIV INFECTION, HIV RELATED ILLNESSES OR AIDS, OR INFORMATION WHICH IDENTIFIES OR REASONABLY COULD IDENTIFY AN INDIVIDUAL AS HAVING ONE OR MORE OF SUCH CONDITIONS, INCLUDING INFORMATION PERTAINING TO SUCH INDIVIDUAL'S CONTACTS"

I HAVE BEEN GIVEN AND UNDERSTAND NANNYS FOR GRANNYS POLICY AND PROCEDURE REGARDING HIV CONFIDENTIALITY LAW AND RELEASE OF HIV INFORMATION

PRINT NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

Advance Directives: Definitions

ADVANCE DIRECTIVE

An advance directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

There are two main types of advance directive – the "Living Will" and the "Durable Power of Attorney for Health Care." There are also hybrid documents which combine elements of the Living Will with those of the Durable Power of Attorney.

LIVING WILL

A Living Will is the oldest type of health care advance directive.

It is a signed, witnessed (or notarized) document called a "declaration" or "directive." Most declarations instruct an attending physician to withhold or withdraw medical interventions from its signer if he/she is in a terminal condition and is unable to make decisions about medical treatment.

Since an attending physician who may be unfamiliar with the signer's wishes and values has the power and authority to carry out the signer's directive, certain terms contained in the document may be interpreted by the physician in a manner that was not intended by the signer.

Family members and others who are familiar with the signer's values and wishes have no legal standing to interpret the meaning of the directive.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A Durable Power of Attorney for Health Care is a signed, witnessed (or notarized) document in which the signer designates an agent to make health care decisions if the signer is temporarily or permanently unable to make such decisions.

Unlike most Living Wills, the Durable Power of Attorney for Health Care does not require that the signer have a terminal condition.

An agent must be chosen with great care since the agent will have great power and authority to make decisions about whether health care will be provided, withheld or withdrawn from the signer.

It is extremely important that the signer carefully discuss his/her values, wishes and instructions with the agent before and at the time the document is signed. Such discussions may also continue after the document is signed.

It is also important that the agent be willing to exercise his/her power and authority to make certain that the signer's values, wishes and instructions are respected.

COMBINATION ADVANCE DIRECTIVE

A combination advance directive is a signed, witnessed (or notarized) document which contains specific written directions that are to be followed by a named agent.

Since it is not possible to predict all circumstances that may be faced in the future or to cover all possible interventions, specific directions may severely limit the discretion and flexibility that the agent needs and may restrict the agent's authority in a way the signer did not intend.

In addition, the specific written directions may not be altered through discussions between the signer and the agent. Any changes necessitate a new document to reflect nuances or changed directions.

It is important that all adults consider who will make medical decisions for them if they are temporarily or permanently unable to make them for themselves.

Unless a person has an advance directive, many health care providers and institutions will make critical decisions for him/her or a court may appoint a guardian who is unfamiliar with the person's values and wishes.

State of New York
Department of Health

Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name______________________________

Date of Birth __ / __ / __

Do not resuscitate the person named above.

Physician's Signature_______________

Print Name ________________________

License Number _________________

Date __ / __ / __

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

DOH-3474 (04/09)

Infection Control and OSHA

Objectives

By the end of this course, the nurse will be able to:

1. Recognize importance of infection control regulations in the workplace
2. Identify OSHA Regulations regarding bloodborne pathogens
3. Identify regulations regarding sharps safety and handling

Introduction

The purpose of this educational activity is to give the nurse a working knowledge of Occupational Safety and Health Administration Standards (OSHA) and to educate and reinforce knowledge regarding bloodborne pathogen and sharps safety as well as other important OSHA standards relative to infection control for healthcare workers.

OSHA was established by an act of Congress in 1970 with the mission to "assure the safety and health of America's workers by setting and enforcing standards; providing training, outreach, and education; establishing partnerships; and encouraging continual improvement in workplace safety and health" (Shenold, 2008).

OSHA regulations in healthcare are enforced by a joint effort between OSHA, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and Medicare. All regulatory agencies work together by ensuring compliance with OSHA standards during surveys.

In 2005, there were 4.2 million job related accidents and illnesses that were non fatal in nature that amount to 117 billion dollars in costs. In 2006, there were a total of 5, 703 employee deaths, although these figures do not account for deaths that were from occupationally acquired illnesses.

Three federal agencies comprise OSHA as a whole: OSHA, within the Department of Labor; the Occupational Safety and Health Review Commission; and the National Institute for Occupational Safety and Health (NIOSH), within the Department of Health and Human Services (Shenold, 2008).

The duties of OSHA include writing the standards or regulations for workplace safety, conducting reviews to assure compliance, and prosecuting violations of standards. The Review Commission is responsible for the mediation of disputes between OSHA and the employers, and NIOSH is responsible for research into best practices for workplace safety and making recommendations regarding proper procedures and equipment.

The need for OSHA in the healthcare environment came to the forefront with the emergence of the HIV virus and concern for the possibility of health workers acquiring the virus through patient contact. In 1989, OSHA made recommendations regarding bloodborne pathogens and after review and comments by experts in multiple sectors of healthcare the final rule was published in 1991.

Bloodborne Pathogens

The bloodborne pathogens act of 1991 is to limit the exposure of the healthcare worker to blood and body fluids that could potentially cause occupational disease. The standards cover all employees who could reasonably be expected to come into contact with blood or other body fluids during the course of their job activities.

Employers are required to implement an Exposure Control Plan than makes Universal Precautions mandatory and treats all blood and body fluids as infectious with the exception of sweat. This plan centralizes hand hygiene and the use of Personal Protective Equipment (PPE) as protection against blood and body fluid infection. PPE includes gowns, gloves, masks, goggles and resuscitation bags. These materials must be available to the employee at no charge.

Also part of the standard are measures to prevent needle sticks and blood splashing, and to ensure the appropriate packaging and handling of body fluid specimens and to lable the specimens and waste with biohazardous labeling before shipping or waste removal. The standard also requires methods for the disposal of contaminated sharps and the container used for such disposal.

Another rule of the standard allows for the vaccination, within 10 days of employment, of all healthcare workers at no charge, against Hepatitis B if they have occupational exposure to blood. For employees that have an exposure, post-exposure evaluation and followup such as laboratory evaluation, counseling, and prophalaxis are made available to the employee

Common pathogens transmitted by bloodborne exposure include Hepatitis B, Hepatitis C, and HIV.

Hepatitis C Virus (HCV)

Hepatitis C can be transmitted to healthcare workers by accidental needle sticks, cuts, or blood splashed onto the conjunctiva. Following percutaneous injury the infection rate is only 1.8%. One thousand health care workers are infected on an annual basis and Hepatitis C is the number one cause of liver transplantation in the United States.

Hepatitis C is considered more lethal than Hepatitis B because there is no preventative vaccine for the illness. Hepatitis C can lead to liver failure and liver transplant. Often patients with Hepatitis C have HIV as well and both viruses can be acquired with one exposure of the health care worker. HCV is usually treated with interferon injections, but the medication is expensive, side effects are many, and the disease often returns when the treatment is stopped. It is not recommended that healthcare workers who have an exposure to HCV be treated by prophylaxis with interferon preparations.

HIV

The likelihood of HIV infection after percutaneous injury is 0.3%. However, if the patient has severe advanced disease, the needle was used in an artery or vein prior to exposure and the needle is visibly contaminated with blood, then the risk is increased.

For healthcare workers who are exposed to HIV, then post-exposure prophylaxis is recommended with HIV specific medications to prevent seroconversion. A two-drug regimen must be used and continued for at least 4 weeks of therapy. The medications can cause side effects and are often discontinued by the worker due to the side effects, before the 4-week time interval is up (CDC, 2003).

Hepatitis B Virus (HBV)

Hepatitis B virus is a highly infectious and transmissible virus. Between 6 and 62% of all needle stick exposures result in transmission of the hepatitis B virus. Vaccination of healthcare workers has dramatically reduced the incidence to occupational transmission of hepatitis B, however, not all workers who have the potential for blood exposure have been vaccinated against the virus.

If you receive a blood exposure, wash cuts and needle sticks with soap and water. There is no scientific evidence that squeezing the wound or using antiseptics or bleach on the wound will prevent inoculation with bacteria or a virus. If the exposure is to the mouth, nose, or skin flush those areas

immediately with water. For splashes to the eye, irrigate the eyes with clean water, saline, or sterile irrigation solution. You should report the exposure to the department that handles occupational events such as employee health, infection control, or occupational health. Prompt reporting is essential, as some measures may need to be taken to prevent infection within the first 24 hours if deemed appropriated to the situation.

The CDC reports that 385,000 hospital workers receive sharps injuries each year. These statistics prompted the requirement that all healthcare facilities have in place a plan to prevent needle stick injuries and that the plan is updated at least annually. This plan must be made accessible to employees, and education regarding the standards must be done as each employee is hired and at yearly intervals thereafter.

Employers are required to implement improved engineering controls to prevent the occurrence of needle sticks when feasible, such as needless systems, or needle shield devices. Employees should avoid the use of needles where safer controls have been instituted. Avoid recapping needles, if needles must be recapped, use the one-handed scoop technique. Never bend or break needles under any circumstance.

Dispose of sharps appropriately in designated sharps containers, which display the red sticker with the biohazard symbol. Never pick up broken glass with your hands, always use a dust pan and brush or other approved method as designated by your facility and dispose of it in a puncture proof container.

Sharps containers are required to be rigid, leak proof and puncture resistant at the bottom and around the sides. The containers must be placed in areas close to where the devices are to be used, maintained in an upright position and not allowed to become overly full. A sharps container is considered full when it is filled to ¾ of its capacity, and should be closed and placed in the appropriate area for disposal.

When the containers are removed from the area, they must be closed immediately prior to moving, and placed in a secondary container if leaking. The secondary container must be closeable and able to contain the entire contents during shipping, handling, and transport. The secondary container must also be labeled or color-coded correctly.

Eating, drinking, applying cosmetics, or lip balm is prohibited in areas where contamination with blood or body fluids is likely to occur. In addition, no food or drink is to be kept in refrigerators or at workstations where contamination with body substances is likely.

All procedures involving blood or other body substances shall be performed in a manner to reduce the likelihood of splashing or spattering of droplets.

PPE

Personal protective equipment shall be provided to the employee at no cost in the appropriate sizes. PPE is considered appropriate if it does not allow the passage of potentially infectious substances too the employees works clothes, street clothes, undergarments or skin, eyes, mouth, or mucous membranes under normal circumstances and for normal durations of use. Hypoallergenic gloves, glove liners, powderless gloves or alternatives shall be provided for employees who are allergic to the gloves normally provided. The employer shall also clean, launder, or dispose of personal protective equipment at no cost to the employee.

If garments become soiled with blood or body fluids, the garments should be removed as soon as reasonably feasible to do so. All PPE should be removed before the employee leaves the immediate work area. When PPE is removed is shall be placed in the proper designated area for disposal, cleaning, storage, or decontamination.

When gloves become contaminated, they should be replaced as soon as it is feasible. They should also be promptly replaced if they become torn, punctured, or their ability to effectively act as a barrier is lost. When using gloves, remember to use the correct size. Gloves that are loose, floppy, and too big pose a hazard to the patient and the employee as they obscure the nurse's view during procedures and can be potentially caught in equipment posing an injury risk to the hands.

OSHA standards state that the employer shall provide handwashing stations for employees. If hand-washing facilities are not feasible then the employer is required to provide waterless antiseptic hand gel and clean towels. When using hand gel, hands should be washed with soap and water as soon as is reasonably possible. Hand washing should occur as soon as possible after the removal of gloves or other PPE.

When it is anticipated that blood or body fluid spattering or splashing is likely and it is reasonable to assume that contact with the eyes, face, or mucous membranes could occur, the employee shall wear a chin length face shield or a combination of mask and eye protection. The eye protection must have wraparound shields to protect the eyes from the sides.

Gowns, aprons, clinical jackets or other suitable protection shall be worn over the clothing when it can reasonable be expected that blood or body substance contact is likely to occur. Surgical hoods or caps and shoe covers should also be worn when it is likely that gross contamination could feasibly occur.

The employee health department is most frequently responsible for the training and documentation of training on the proper use of Personal Protective Equipment (PPE). Since the employer is required to have documentation that the employee received and understood the training given, the employee health department should define clear objectives for the training and ensure that the content and testing of the training revolves around the objectives. Elements for PPE training should include:

When to wear PPE
How to properly put on, apply, wear, and dispose of PPE
When the use of PPE is necessary
Limitations of PPE
Care and Maintenance of PPE

Environmental

All equipment shall be cleaned after use with an approved disinfectant per hospital policy after contact with blood or body fluids. Contaminated work surfaces shall be cleaned as soon as possible after the procedure is completed or as soon as is feasible if it is contaminated with blood or body substances. Work surfaces shall be cleaned at the end of every shift if there is possibility of contamination since the last cleaning.

Protective coverings of plastic or other materials shall be replaced as soon a possible when they become contaminated by potentially infectious material or at the end of the shift if they become contaminated during the shift.

Any pails, bins, or storage receptacles that are not designed to be disposable will be routinely inspected and removed for cleaning and decontamination when visible contamination is detected.

Laundry must not be sorted or rinsed in patient care areas. Contaminated laundry must be placed in red bags or in bags labeled with the biohazard symbol unless the facility uses Universal precautions in the handling of all soiled linens.

Tuberculosis (TB)

According to the Centers for Disease Control (CDC), one third of the world's population was infected with TB in 2005. TB kills an estimated 2 million persons annually, and has become the second most common cause of death on the worldwide level after (HIV).

OSHA allows for the use of N95 disposable respirator for employee protection against Tuberculosis in the health care setting. The N95 disposable respirator

must be fit tested. The N95must be retested for fit on an annual basis and the employee must receive training in its use. The devices must be stored in a clean, sanitary, and convenient location. The employee must undergo a medical evaluation and be declared physically capable of performing regular duties while wearing the respirator without causing physical distress to the employee. The respirator must be one of the types that is approved for use by NIOSH.

Workplace Violence

Homicide is the fourth leading cause of workplace death. In 2005, 792 workers were killed in workplace assaults in the United States. Each week 18,000 workers are the victims of non-fatal workplace assaults. Most of these assaults occur in hospitals, nursing homes and social service settings. Most of the assaults are inflicted by a patient or client.

Hazard Communication/ MSDS

The Hazard Communication Standard was first made law in 1983. This OSHA standard is also called the right to know law, and its basis is the right of every employee to know about and have access to information concerning all potentially hazardous materials found in the workplace.

The employer must evaluate the workplace for potentially harmful chemicals, assure that they are properly and completely labeled, have available Material Safety Data Sheets (MSDS) on every potentially hazardous substance, train and document the training of employees, and maintain a written Hazard Communication Program. Training must also be conducted whenever a new hazardous chemical is introduced into the workplace. In addition to the above requirements, the employer is required to maintain protection for employees, eye wash stations, and must monitor the levels of exposure from hazardous chemicals to employees.

Radiation

The employer is responsible to monitor levels of radiation exposure of employees whenever there is potential for contact with radiation. In the healthcare setting, common sources of radiation include radiation that occurs during the exposure of exposure of x-ray film or the presence of radioactive isotopes such as used in nuclear medicine. The employer is responsible for having appropriate monitoring equipment available and areas of potential radiation exposure must be posted with a radiation symbol.

OSHA has set standards for radiation levels and a radiation-monitoring program is a requirement of OSHA standards. Employers are required to provide radiation-monitoring badges to employees likely to receive a radiation dose in excess of 25% of the quarterly allowable radiation limit and to employees who work in high radiation levels. When a healthcare facility can document that routine exposure levels are below 25% of the allowed quarterly limit, or the employee does not work in a high-level radiation area, then routine monitoring can be discontinued.

Chemical and Blood Spills

The employer is responsible for maintaining a safe working environment for all employees. Blood or chemical spills can represent a hazard and have the potential for employee injury.

When a spill occurs certain factors must be evaluated:

- The location of the spill
- The size of the spill
- The characteristics of the substance involved
- The type of equipment needed to contain the spill

Supplies that may be needed to contain a spill may include:

- Neutralizers
- Absorbents such as sand or commercial solidifying agents
- Scoops, pans, or shovels
- Covered containers for disposal of clean-up waste

In the event of a spill the following priorities assessed and appropriate action(s) taken:

- Contamination of any employees or persons
- Notification of persons in immediate spill area.
- In the event of flammable spill, electrical devices should be turned off
- Containment of spill

Absorbent material should be poured around the area of the spill. The additional absorbent is placed in the center of the spill. The spill is then cleaned from the outer area, moving the contents toward the center. Proper protective equipment should be used during cleanup of the spill. The area of the spill should be ventilated if necessary. Cleanup of chemical spills should only be undertaken by personnel having the knowledge to safely contain and cleanup the spill. Some chemicals can present a greater hazard if improper clean up is attempted.

Spill kits for blood and chemicals should be placed in convenient areas within the facility. All personnel must be trained in the use of spill kits and that training must be documented. Written policies must also be in place for dealing with spills and the storage of chemicals.

Fire Safety

OSHA regulations mandate that any facility that houses patients have a fire safety program. Smoke alarms, sprinklers, and fire extinguishers must be present. Fire safety is a part of the employer's Hazards Communication program and training in fire safety must be documented. All employees must know the fire risks associated with chemicals, gases, or equipment. The employee must be trained in rescuing patients, and the location and correct use of fire extinguishers. The acronym RACE (Rescue, Alert, Confine, Extinguish) is used by many hospitals to assist employees in remembering how to manage fire.

Indoor Environmental Air Quality

During the 1970's, changes in the way that buildings were made resulted in virtually airtight structures. This decrease in natural ventilation can allow for the buildup of emissions from office products, mechanical equipment, biological contaminants such as fungi, and air pollution.

The NIOSH office is responsible for the oversight of air quality in the workplace. NIOSH has found that most problems of physical complaints that the employee believes to be poor air quality are really due to a variety of factors in addition to the quality of the air such as lighting, temperature, building comfort and ergonomics, and physical and job related stressors.

With regard to hospitals, one area of concern is the operating room where ergonomic concerns exist along with potential problems due to latex allergy and anesthetic gases such as nitrous oxide.

NIOSH has identified these measures to help with air quality in operating rooms:

- A properly functioning air scavenging system must be in place
- Monitoring of anesthetic equipment with leak test monitors
- Monitor room air
- Replace improperly fitting hoses, gaskets, seals and other parts of the anesthesia administration equipment which would allow the escape of anesthetic gases
- Make sure that waste nitrous oxide emissions into the room are controlled by scavenging systems and vented vacuum pumps

Ergonomics

Back injuries are the most common injury of the workplace. However, back injuries are not the only threats to employee disability. Approximately 75% of all jobs now require the use of video display terminals or computers. These changes in the workplace have led to increased employee problems with occupational related neck pain and carpal tunnel syndrome.

OSHA attempted to pass universal Ergonomic standards in 2001, but the standards were struck down by lawmakers. As of this time, OSHA has no standard that is specific to ergonomics, but this does not mean that they will no issue citations. At the present OSHA can utilize the General Duty Clause to issue citations for ergonomics related hazards. "The General Duty Clause (CFR Par 1977.1) states:

(a) Each Employer--

> (1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.
>
> (2) shall comply with occupational safety and health standards promulgated under this Act.

(b) Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders pursuant to this Act which are applicable to his own actions and conduct.

Latex Glove and Allergy Management

An increasingly important problem for both employees and patients is the problem of Latex allergy in the healthcare setting. Latex allergy has been increasingly seen since Universal Precautions requiring the use of gloves for all contact with body substances was implemented. Most latex allergies are not serious, however, in some instances they can be life threatening. Persons at highest risk for latex allergy include medical personnel, persons with previous history of allergies, and persons with repeated exposure to latex.

There are three main categories of latex allergy:

- Irritant contact dermatitis- A non-allergenic inflammatory response to latex gloves. A combination of sweat and glove powder irritates the dermatitis. Irritant contact dermatitis is manifested by rash of the hands with cracks, sores, dryness, and flaking. Irritant contact dermatitis can be controlled or eliminated by wearing cotton glove liners, using vinyl or nitrile gloves, or avoiding glove use altogether whenever possible.

- Allergic Contact Dermatitis- The symptoms of allergic contact dermatitis are almost identical to Irritant Contact Dermatitis. However, in this case it is caused by the activation of a cellular response due to repeated exposure to latex.
- Hypersensitivity immune system response is an actual allergic manifestation of latex allergy. The patient may experience systemic symptoms such as itching, hives, shortness of breath, and anaphylaxis in response to latex. This can be a life-threatening emergency.

The changing of gloves to a non-latex product may not solve the problem. Some non-latex gloves still contain chemical sensitizers. Latex proteins can become airborne in the powder from gloves being used by other healthcare workers and glove powder can be deposited on environmental surfaces. Latex is also found in a multitude of sources in the healthcare setting such as urinary catheters, elastic, and foam rubber.

Conclusion

A full examination of all OSHA regulations and issues applicable to the healthcare setting is beyond the scope of this educational encounter. What has been aimed to accomplish is to give the clinician a working knowledge of OSHA standards and an understanding of how those standards apply to workplace health and safety.

OSHA regulations are under constant scrutiny and revisement as the equipment, procedures, and technology of the workplace continually changes. Employers are required to provide the employee with annual retraining on applicable standards and when major changes occur. Knowledge of current OSHA standards will make the healthcare environment a safer place for all employees.

Information derived from OSHA Quick Start Website unless other wise indicated.

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Infection Control and OSHA - 2.0 Contact Hours

1. The acronym OSHA stands for:
   - A. Occupational Standards Healthcare Association.
   - B. Occupational Services Health Association.
   - C. Occupational Safety and Health Administration.
   - D. None of these.

2. What agency is responsible for enforcing Occupational Safety and Health Administration regulations?
   - A. OSHA
   - B. Medicare
   - C. JCAHO
   - D. All of the above.

3. How many federal agencies make up OSHA as a whole?
   - A. three
   - B. four
   - C. two
   - D. one

4. Which federal OSHA agency is responsible for researching best practices in safety?
   - A. OSHA
   - B. JCAHO
   - C. The review commission.
   - D. NIOSH

5. Which disease spurned the Bloodborne Pathogens act?
   - A. TB
   - B. Hepatitis C
   - C. HIV
   - D. Hepatitis B

6. Which of the following is not considered an infectious body fluid under universal precautions?

A. tears

B. saliva

C. sweat

D. urine

7. Which of the following is not considered a bloodborne pathogen?

A. TB

B. HIV

C. Hepatitis B

D. Hepatitis C

8. Which of the following are modes of transmission for Hepatitis C?

A. Needlestick

B. Cuts

C. Blood splashes to the eye.

D. All of the above.

9. Which of the following is considered the most lethal?

A. Hepatitis B

B. Hepatitis C

C. TB

D. HIV

10. A sharps container should be replaced when?

A. It is filled to overflowing.

B. When it is half full.

C. When it is 3/4 full.

D. When it is 2/3 full.

11. What is the best method for picking up broken glass?

A. Use your hands.

B. Use a dustpan or scoop.

C. Use a vacuum cleaner.

D. Call housekeeping to clean it up.

12. Which of the following is not an example of PPE?

A. Gown

B. The employee's uniform.

C. Goggles or face shield.

D. Gloves

13. Which of the following is approved protection against TB?

A. Gloves

B. Mask

C. N95 disposable respirator.

D. Gown

14. Which of the following is the fourth leading cause of workplace death?

A. Falls

B. Workplace acquired infection.

C. Stress

D. Homicide

15. The standard that covers the employees right to know about chemicals in the workplace is?

A. Hazard Communications Standard.

B. General Duty Clause.

C. Indoor Air Quality Act.

D. OSHA Fire Act.

16. The proper method for cleaning up a spill after applying absorbent material is:

A. Scoop up the material using a side to side motion.

B. Start at the edges and work inward.

C. Start at the center and work outward.

D. It doesn't matter.

17. The acronym RACE is used to help employees remember how to manage:

A. Chemical spills

B. Blood spills

C. Fire

D. Indoor air quality

18. The General Duty Clause states:

A. The employee is considered a general duty employee unless otherwise specified.

B. The employee has a right to know about hazardous materials in the workplace.

C. The employer must provide the employee with free medical care.

D. The employer must provide a place of employment free of recognized hazards that are likely to cause death or physical harm.

19. Which of the following does not involve an allergic response?

A. Hypersensitivity Immune System Response.

B. Allergic contact dermatitis.

C. Irritant contact dermatitis.

D. None of the above.

20. Persons at highest risk for latex allergy include:

A. Medical personnel.

B. Persons with previous history of allergies.

C. Persons with repeated exposure to latex.

D. All of the above.

Tuberculosis Awareness

This employee handbook is one of a series of fully-illustrated employee handbooks, informative posters, broadcast-quality video training programs, interactive CD-ROM and Web-based courses produced by Coastal Training Technologies Corporation. Each product is the result of painstaking analysis, design, development and production by the instructional designers and technical specialists on our staff.

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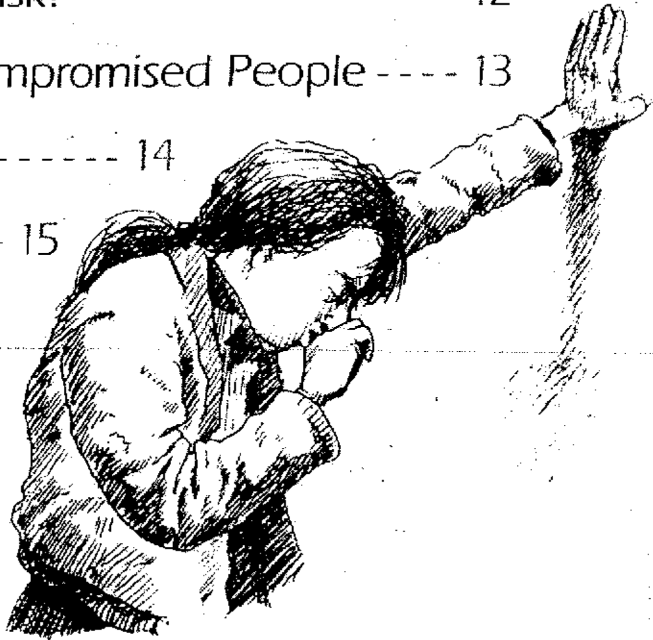
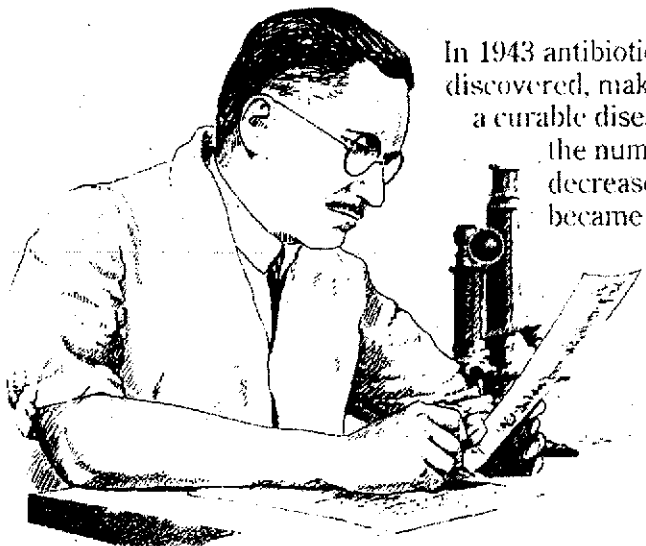


Introduction

In the early 1900s the best treatment doctors could prescribe for tuberculosis (TB) was plenty of nutritious food, bed rest, sunshine and fresh air.

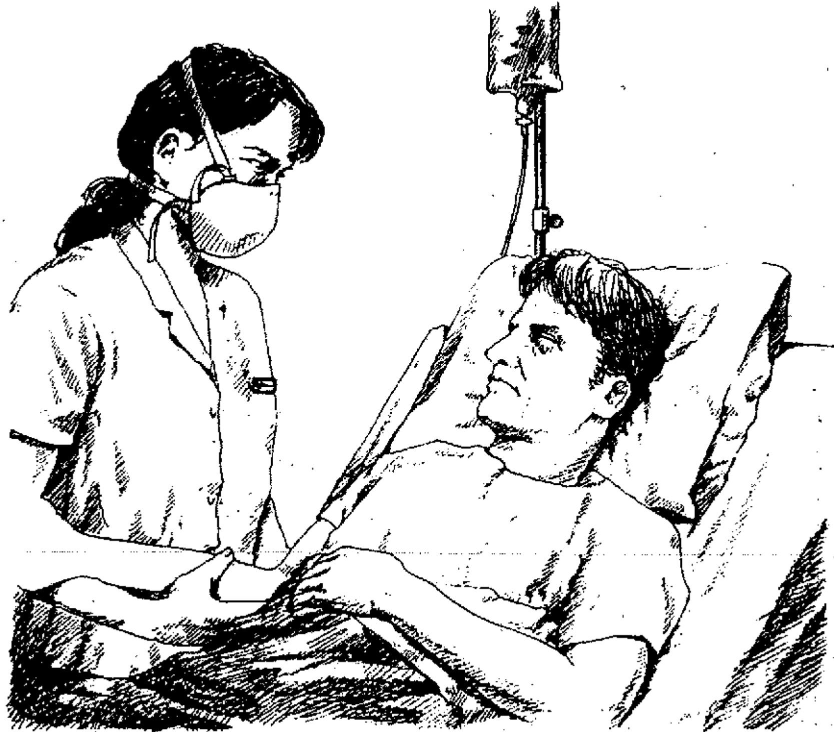


In 1943 antibiotics were discovered, making tuberculosis a curable disease. For years the number of TB cases decreased and people became complacent, sure that TB was under control.

Introduction

However, tuberculosis is making a comeback! Among microbes (disease germs), tubercle bacilli are the leading killers. According to the World Health Organization, they cause eight million new cases and three million deaths each year.

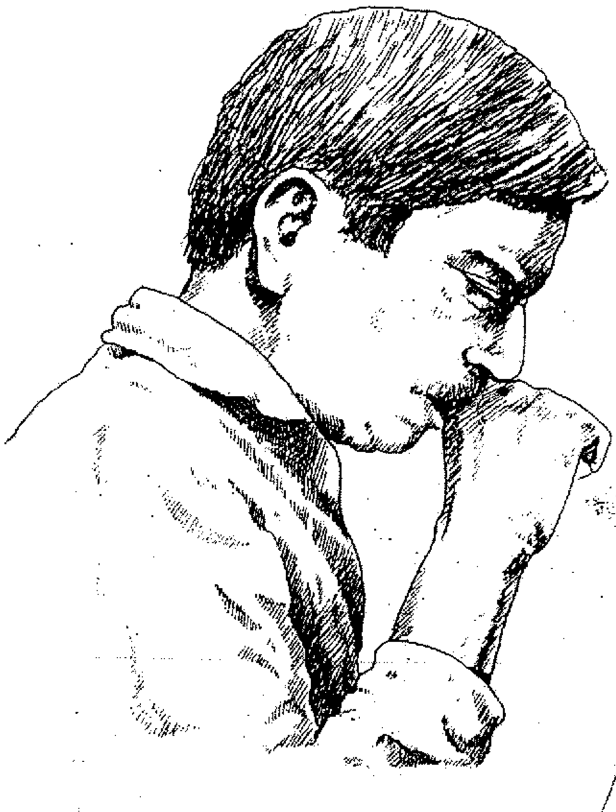
Since 1985 there has been a resurgence of TB, as well as an emergence of new strains of TB. The number of TB infections is also up significantly since 1985 among children under 15 — a result of the increase in adult TB diseases.



What is Tuberculosis?

TB is an infectious disease which spreads through the air from person to person when droplet nuclei become airborne. These droplets are expelled from the lungs of those with active TB through coughing, speaking, singing, sneezing or spitting and are then breathed into the lungs of those around them.

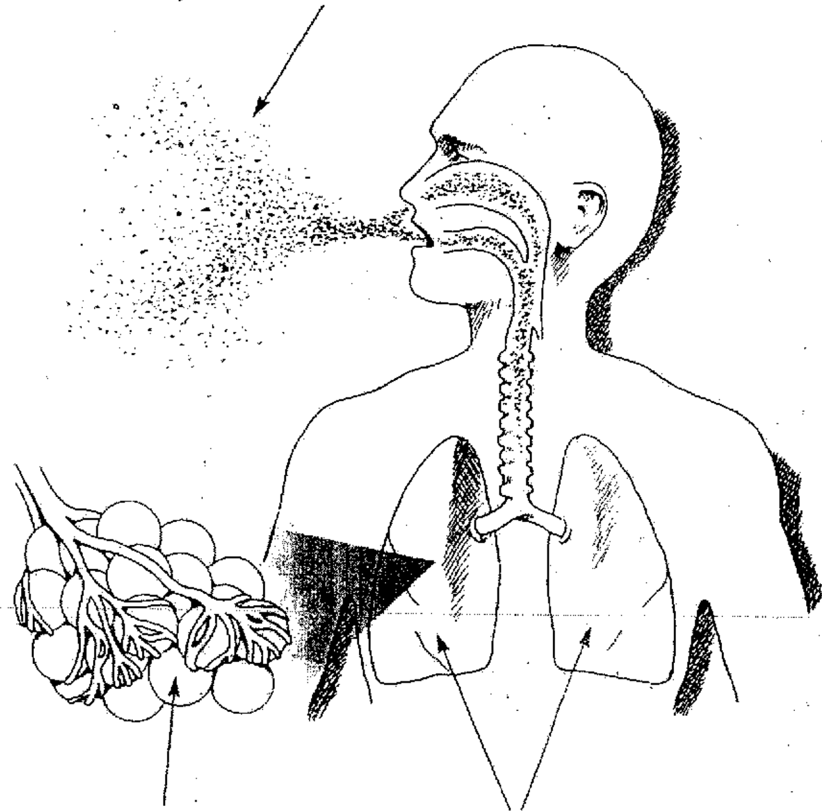
Covering the mouth and nose when coughing or sneezing is an important method of preventing the spread of TB because this helps keep droplets from becoming airborne.



What is Tuberculosis?

Once the tuberculosis bacteria are inhaled, they reach the alveoli (air sacs) of the lungs. If the infection is not treated, it can become active and affect the liver, skin and other organs of the body.

Between two and ten weeks after exposure to TB, the immune system will usually limit the spread of bacteria and keep the infection from becoming active. However, if the immune system has been weakened for any reason, the bacilli can multiply and spread from the lungs to other parts of the body.

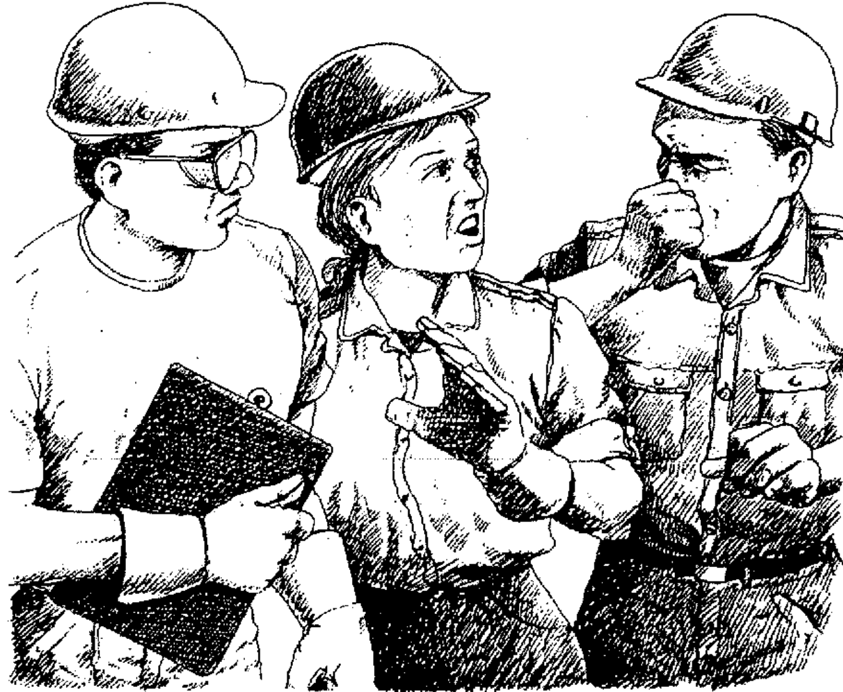


How Do You Get TB?

Tuberculosis spreads through the air when a person infected with active TB coughs, speaks, sings, sneezes or spits. Generally, it takes more than one exposure to someone with active TB for infection to occur. Most often a person must have repeated and prolonged indoor exposure to tuberculosis.

People who are frequently in comparatively crowded, poorly ventilated places are more at risk of contracting TB because these are ideal environments for the spread of TB bacilli. Some examples of such places are:

- Homeless shelters
- Correctional facilities
- Substance abuse centers
- Hospitals
- Nursing homes
- Factories
- Schools.



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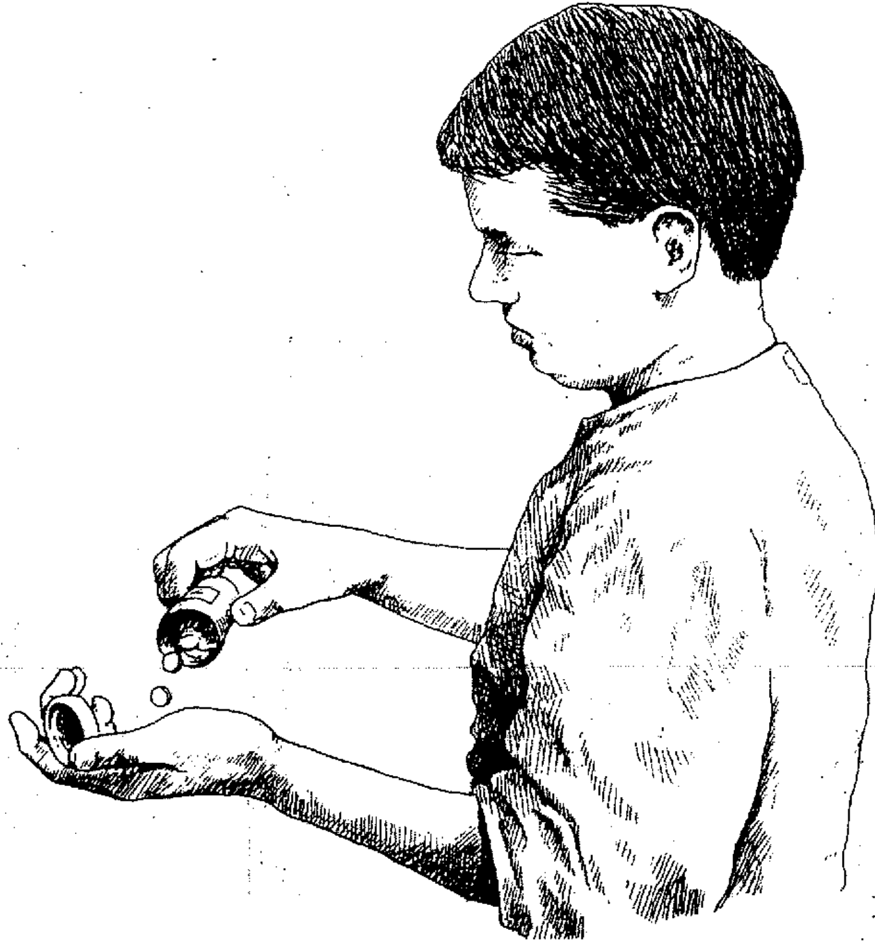
Latent TB Infection vs. Active TB

A tuberculosis infection can be either latent (inactive) or active. If it is latent, the bacilli are present in the body, but the individual will not be contagious and will have no symptoms. Taking a series of preventive drugs can aid the immune system in curing the latent infection once it has been identified.

Persons with a latent TB infection have about a 10 percent chance of developing active TB in their lifetime. The risk is highest in the first two years after contracting the infection, but some risks may remain for decades.



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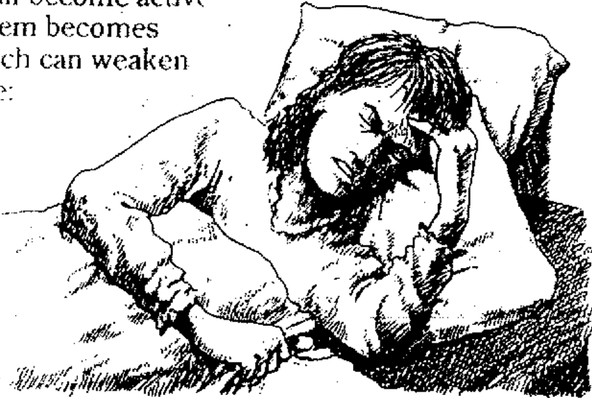
Latent TB Infection vs. Active TB

Without treatment, a latent TB infection can become active, which means individuals could become contagious and may show symptoms of TB. These symptoms include:

- Coughing
- Fever
- Fatigue
- Night sweats
- Weight loss.



An active TB infection can seem like a regular cold, the flu or pneumonia. Because TB affects the lungs, anyone who exhibits a cough for more than three weeks, or coughs up bloody sputum, should be evaluated.

Latent TB infections can become active when the immune system becomes weakened. Factors which can weaken the immune system are:

- Stress
- Poor nutrition
- Substance abuse
- Sickness
- HIV (AIDS).

Remember that tuberculosis has a long incubation period — it can take months or years to show up.

Do You Have a TB Infection?

The only way to know for certain if you have been infected with TB is to be tested by a medical professional. One test commonly used to detect TB is the PPD skin test.

The area of the arm where the test was administered should be checked within 48 to 72 hours by a healthcare professional. The test results help to determine the presence of the TB bacteria in the body.

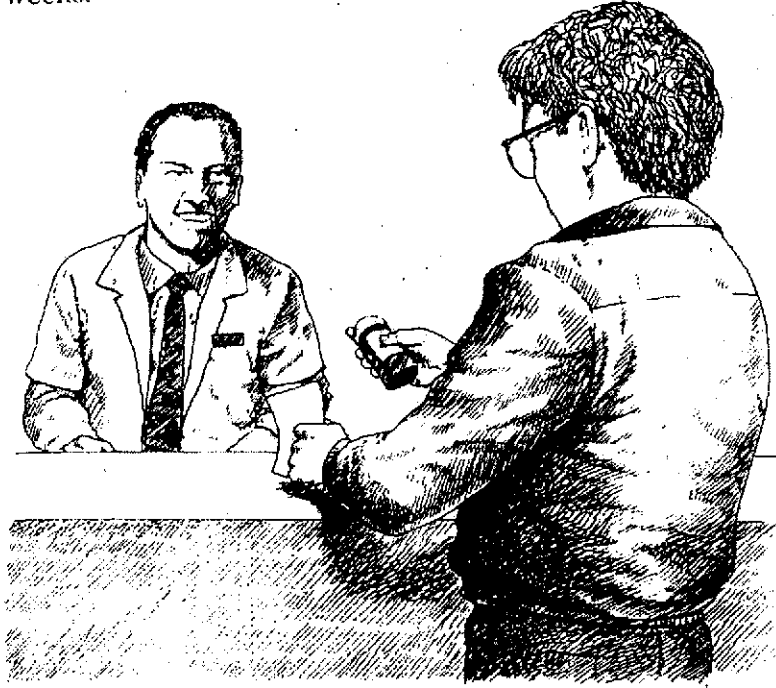
Someone who has the symptoms of TB or who has been exposed to active TB should have a skin test done *immediately*. If the skin test is positive, further testing will be necessary.

Otherwise, a thorough assessment should be conducted to evaluate the risk of TB exposure to someone in your facility and your position. Please refer to your facility's guidelines to determine appropriate testing intervals.

Diagnosis: Active TB

If the doctor diagnoses active TB, the individual will be placed on antitubercular drugs — usually some form of antibiotics. These medications will relieve the symptoms and make the patient noninfectious to others.

While infectious, the individual must be separated from other people to ensure that he or she will not expose others to TB. If properly treated, TB patients may become noncontagious in approximately four weeks.



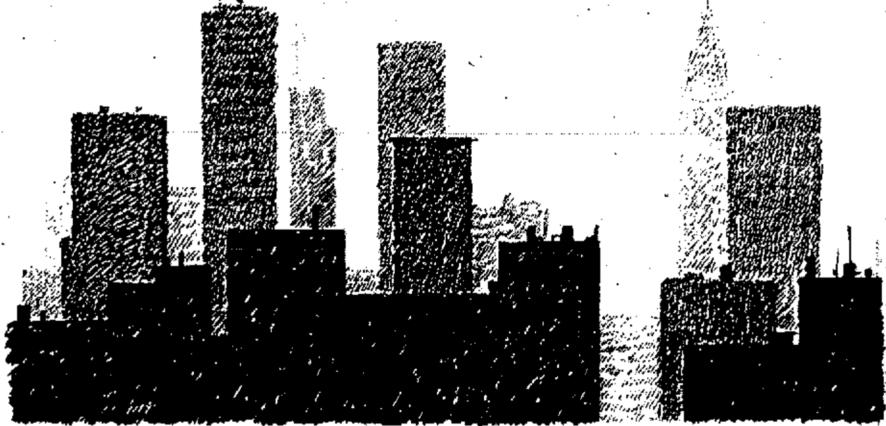
Antitubercular drugs relieve the symptoms very quickly, but it is extremely important to continue the medication until the doctor pronounces the patient cured.

What is Drug-Resistant TB?

If medications are not properly prescribed or are not taken regularly, the TB organisms can build up a resistance to the medication. Not only can tuberculosis then recur, but these resistant organisms can be transferred to others, giving them a TB infection which is harder to cure.

These drug-resistant TB organisms are multiplying at an alarming rate because so many people stop taking their medication too soon. Some strains of TB only resist one or two drugs, but others develop resistance to several.

Strains which resist two or more drugs are called multi-drug resistant TB (MDR-TB). MDR-TB has a 50 to 80 percent mortality rate. Today it is estimated that up to 5.5 percent of new TB cases are MDR-TB. Multi-drug resistant TB cases are mostly concentrated in, though not limited to, large urban areas.



Who is at Risk?

Anyone who is exposed can contract tuberculosis, but there are five groups of people who are more likely to be susceptible:

- Immunocompromised individuals — people with HIV, diabetes, silicosis, malnutrition and people undergoing chemotherapy
- Individuals in depressed socio-economic circumstances — the homeless, current or past prisoners, drug-users and alcoholics
- Foreign-born people from countries where TB rates are still high — places like Mexico, the Philippines, Vietnam, Haiti, South Korea, China and the former Soviet Union
- Anyone living with someone who has active TB
- Anyone who regularly comes in contact with a member of these high-risk groups, especially in crowded, poorly ventilated conditions.

People who work in a setting where they regularly come into contact with high-risk groups should get Mantoux skin tests every six months.

Immunocompromised People

People who are immunocompromised for any reason are the most vulnerable to TB infection. Their weakened immune systems cannot fight the TB organisms as a healthy person's system can, so an infected person has a greater risk of progressing to active TB. Immunocompromised individuals are therefore encouraged to get tested at least every six months.

Drug-resistant TB is especially dangerous to immunocompromised individuals. Because they succumb more quickly to the disease, their chances for recovery are jeopardized by the time spent finding an effective medication. HIV-positive patients with MDR-TB have a very high mortality rate.

Tuberculosis Quiz

1. True or False: Tuberculosis is passed through the air when a person with active TB coughs, speaks, sings, sneezes or spits.

2. True or False: TB is on the rise mostly in adults.

3. True or False: TB enters the body in the form of bacilli which eventually reach the alveoli of the lungs.

4. True or False: Wearing a face mask is the only way to prevent the spread of TB.

5. True or False: It usually only takes one exposure to someone with active TB to become infected with tuberculosis.

6. True or False: Persons with latent TB infections show symptoms of tuberculosis and are contagious.

7. True or False: The symptoms of TB can include coughing, fatigue, night sweats, fever, and weight loss.

8. True or False: TB is often mistaken for a cold, the flu, or pneumonia.

9. True or False: One of the warning signs of TB infection is a cough which persists or more than three weeks.

10. True or False: TB has a very short incubation period, so symptoms show up very quickly after infection.

11. True or False: When a person's immune system becomes weakened through stress, illness, poor nutrition or substance abuse, latent TB can turn active.

12. True or False: The skin test area should be checked by a healthcare professional within 24 hours.

13. True or False: TB can be detected through a skin test.

14. True or False: People taking antitubercular drugs can stop taking them once they feel better because the drugs are very hard on a person's system.

15. True or False: Patients can become noninfectious only after they have been on antitubercular medication for approximately four weeks.

16. True or False: If medication is not prescribed properly or taken regularly, the TB organism may develop a resistance to the drugs being used to treat it.

17. True or False: Multi-drug resistant TB is no more dangerous than regular TB.

18. True or False: Only people who are immune compromised or are in depressed socio-economic conditions are susceptible to TB.

19. True or False: Anyone who regularly interacts with individuals from high risk groups should be tested for TB at least every six months.

20. True or False: Immune compromised people should be tested for TB every year.

Employee Signature____ Date____________________

Hepatitis B and the Vaccine (Shot) to Prevent It

The best way to protect against hepatitis B is by getting the hepatitis B vaccine. Doctors recommend that all children get the vaccine.

Why should my child get the hepatitis B shot?

The hepatitis B shot:

- Protects your child against hepatitis B, a potentially serious disease
- Protects other people from the disease because children with hepatitis B usually don't have symptoms, but they often pass the disease to others without anyone knowing they were infected
- Prevents your child from developing liver disease and cancer from hepatitis B
- Keeps your child from missing school or childcare (and keeps you from missing work to care for your sick child)

Is the hepatitis B shot safe?

The hepatitis B vaccine is very safe, and it is effective at preventing hepatitis B. Vaccines, like any medicine, can have side effects. No serious side effects are known to be caused by the hepatitis B vaccine.

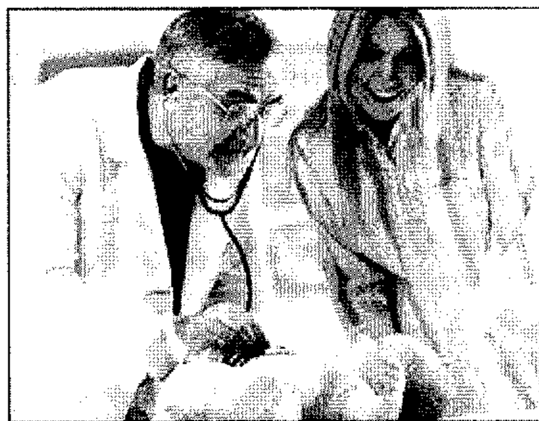
What are the side effects?

Most people who get the hepatitis B vaccine will have no side effects at all. When side effects do occur, they are very mild, such as a low fever (less than 101 degrees) or a sore arm from the shot.

What is hepatitis B?

Hepatitis B is a contagious liver disease caused by the hepatitis B virus. When a person is first infected with the virus, he or she can develop an "acute" (short-term) infection. Acute hepatitis B refers to the first 6 months after someone is infected with the hepatitis B virus. This infection can range from a very mild illness with few or no symptoms to a serious condition requiring hospitalization. Some people are able to fight the infection and clear the virus.

For others, the infection remains and is "chronic," or lifelong. Chronic hepatitis B refers to the infection when it remains active instead of getting better after 6 months. Over time, the infection can cause serious health problems, and even liver cancer.



Doctors recommend that your child get 3 doses of the hepatitis B shot for best protection. Ask your doctor when your child should get the next shot. Typically, children get one dose at each of the following ages:

- Birth
- 1 to 2 months
- 6 months

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

American Academy of Pediatrics

What are the symptoms of hepatitis B?

Infants and young children usually show no symptoms. But, in about 7 out of 10 older children and adults, recent hepatitis B infection causes the following:

- Loss of appetite (not wanting to eat)
- Fever
- Tiredness
- Pain in muscles, joints, and stomach
- Nausea, diarrhea, and vomiting
- Dark urine
- Yellow skin and eyes

These symptoms usually appear 3 or 4 months after being exposed to the virus.

Is it serious?

Hepatitis B can be very serious. Most people with recent hepatitis B may feel sick for a few weeks to several months. In some people, the infection goes away on its own (i.e., resolves without treatment). For other people, the virus infection remains active in their bodies for the rest of their life.

Although people with lifelong hepatitis B usually don't have symptoms, the virus causes liver damage over time and could lead to liver cancer. For these people, there is no cure, but treatment can help prevent serious problems.

How does hepatitis B spread?

Hepatitis B virus spreads through blood or other body fluids that contain small amounts of blood from an infected person. People can spread the virus even when they have no symptoms.

Babies and children can get hepatitis B in the following ways:

- At birth from their infected mother
- Being bitten by an infected person
- By touching open cuts or sores of an infected person
- Through sharing toothbrushes or other personal items used by an infected person
- From food that was chewed (for a baby) by an infected person

The virus can live on objects for 7 days or more. Even if you don't see any blood, there could be virus on an object.

Where can I learn more about the hepatitis B vaccine and my child?

To learn more about the hepatitis B vaccine, talk to your child's doctor, call 1-800-CDC-INFO or visit www.cdc.gov/vaccines/parents.

The Hepatitis B Vaccine Dose at Birth

It's hard to imagine putting your newborn through the pain of a shot. But a little stick early in life is an important first step to protecting your baby against a deadly disease.

All babies should get the first shot of hepatitis B vaccine before they leave the hospital. This shot acts as a safety net, reducing the risk of getting the disease from moms or family members who may not know they are infected with hepatitis B.

When a mom has hepatitis B, there's an additional medicine that can help protect the baby against hepatitis B, called the hepatitis B immune globulin (HBIG). HBIG gives a baby's body a "boost" or extra help to fight the virus as soon as he is born. This shot works best when the baby gets it within the first 12 hours of his life. The baby will also need to complete the full hepatitis B vaccination series for best protection.

The Centers for Disease Control and Prevention, American Academy of Family Physicians, and the American Academy of Pediatrics strongly recommend all children receive their vaccines according to the recommended schedule.

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Home Care Community Forum

Workbook #13

Standard Precautions, Bloodborne Pathogens & Needlesticks in Home Care

community health care services foundation, inc.

3. PORTAL OF EXIT

Mechanism or way by which the infectious organism leaves the body

Coughing, Sneezing
Oral / Respiratory Secretions
Blood, Bodily Fluids / Substances
Stool, Urine, Vomitus
Non-intact Skin (cuts, sores, lesions)

Most home care patients are elderly and infirm. Their skin is often fragile and can be easily damaged. It is important to be observant of small cuts and sores. The nurse clinician of a home care agency should be advised of such changes in the skin.

4. MODE OF TRANSMISSION

Method by which a pathogen is transmitted to a person

Direct / Indirect Contact
Droplet (from coughing or sneezing)
Airborne (carried in the air)
Vectors (insects such as mosquitoes, fleas and ticks)

5. PORTAL OF ENTRY

Place and way by which organisms are introduced into the body

Mucous membranes (nose, mouth)
Non-intact skin (cuts, tears / open areas)
Gastrointestinal tract (eating, drinking)
Respiratory tract (breathing)
Genitourinary tract (urinary catheter)
Reproductive system (sexual contact)

6. SUSCEPTIBLE HOST

Person or animal lacking effective resistance to a particular infectious agent

UNIVERSAL PRECAUTIONS vs. STANDARD PRECAUTIONS

Universal Precautions are designed to reduce the risk of transmission of microorganisms from bloodborne pathogens; required by OSHA; applies to Bloodborne Pathogens only.

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources.

STANDARD PRECAUTIONS

- The use of gloves, gowns and other personal protective equipment to prevent any exposure to blood or other potentially infectious body fluids.
- Standard Precautions apply to blood; all body fluids, secretions, and excretions, except sweat, regardless of whether or not they contain visible blood; non-intact skin; and mucous membranes.

Additional precautions include:

PRECAUTION	METHOD	REASON
Contact Precautions	The use of gloves when coming in contact with certain microorganisms. Gowns may be used in addition to the gloves if excessive soiling is anticipated.	*Contact Precautions* are designed to reduce the transmission of pathogens by direct or indirect contact.
Droplet Precautions	The use of a surgical mask (with or without shield) when the transmission of pathogens involves contact of the conjunctivae or the mucous membranes of the nose or mouth.	*Droplet Precautions* are designed to reduce the risk of droplet transmission of infectious agents.
Airborne Precautions	The use of a N-95 respirator mask to prevent the inhalation of airborne droplet nuclei/centers (or evaporated droplets that may remain suspended in the air for long periods of time) or dust particles containing the infectious agent.	Special air handling and ventilation are required to prevent *Airborne Transmission.*

WORK PRACTICE CONTROLS

These are controls that reduce or eliminate the likelihood of exposure by altering the manner in which a task is performed.

Handwashing

1st line of defense against any infectious organisms (germs)

- Wash before and after patient care or contact.
- Wash before handling any equipment or supplies.
- Wash before meal preparation.
- Wash before and after applying gloves.
- Use soap (liquid) and paper towels (Personal Protective Equipment – PPE).
- Follow specific manufacturer's instructions when using waterless hand cleanser solutions.

> Handwashing should be done with a rubbing action (not just rinsing) with running water and soap for *at least* 15 seconds.

Bag Technique

- Placement on hard, clean surface.
- Contents clean—wash hands prior to entering bag.
- Clean equipment prior to placement back in the bag.
- Bag is clean, NEVER place bag on the floor.

Personal Protective Equipment

Specialized clothing or equipment worn by a health care worker (HCW) for protection against a hazard.

- Gloves
  - Sterile and Non-sterile.
  - Latex.
  - Nitrile/Rubber.
- Cover Garb
  - Aprons (use when changing linen is advisable).
  - Gowns.

- Masks
  - Fluid Shield.
  - Surgical.
  - Particulate Respirator (PR); N-95 PR mask.
- Face Shields
- Eye Protection
  - Goggles.
  - Safety Glasses.

USE of PPE – Guidance on Proper Application of PPE/Barriers for Protection

- Proper fit
- Integrity of barrier
- Disposable vs. reusable barriers (PPE)
- Potential for cross-contamination
- Implications of over and under-utilization

Standard Precautions in Home Care

Learning Objectives:

By the end of this program, participants will:

1. Understand and be able to follow accepted scientific principles and practices of infection control to reduce the spread of disease causing organisms and to protect themselves, their patients and their families.
2. Understand how to lower the risk of transmission of disease-causing organisms.
3. Understand the chain of infection.
4. Know the role of OSHA in employee safety.
5. Be familiar with the Needlestick Safety and Prevention Act.
6. Understand the various precautions regarding the transmission of disease.

Glossary

Barrier	A material object that separates a person from a hazard.
Bloodborne	Pathogen carried in the blood.
Cleaning	The removal of all foreign materials (soil, organic debris) from objects.
Communicable Disease	An illness due to a specific infectious agent, which arises through the transmission of that agent from an infected person, animal or object to a susceptible host.
Contamination	The presence of organisms on objects (clothing, surgical instruments) or in substances (water, food, milk).
Decontamination	The process of removing disease-producing microorganisms and rendering an object safe for handling.
Disinfection	A process that results in the elimination of many or all pathogenic microorganisms on inanimate objects with the exception of bacterial endospores.
Infectious Disease	A disease caused by the entrance, growth, and multiplication of bacteria or other organisms into the body that may or may not be contagious.
Microorganism	A living thing that can only be seen with the aid of a microscope.
Needlestick	Puncture of the skin caused by any sharp object usually a needle.
Pathogen	Any disease-causing organism.
Personal Protective Equipment (PPE)	Specialized clothing or equipment worn by a health care worker for protection against a hazard (medical, physical).
Transmission	Spread of pathogen.

It is the responsibility of every health care worker to follow accepted scientific principles and practices of infection control.

What does this mean in our patients' homes?

- Infection control practices (tasks/things that we do) to lower the risk of transmission of disease-causing organisms.
- Reduce the spread of disease-causing organisms.
- Protect ourselves, our patients, our families and our community.
- What *we do* and what *we don't do* are important in infection control.
- Break the Chain of Infection.

For home care workers, understanding the path by which individuals can be exposed to infection is necessary to effectively follow the steps of disease prevention. This path is known as the "Chain of Infection." The individual steps in this chain is as follows:

The Chain of Infection

1. PATHOGEN

An infectious agent (germ) capable of causing disease

Bacteria **Virus** **Fungus** **Parasite**

Some pathogens (bacteria) can be treated with the use of antibiotics, others such as viruses cannot. Using antibiotics to treat the common cold is ineffective and can result in resistant strains of bacteria, making future use unpredictable at best.

If a patient has been prescribed antibiotics and ceases their use after three days, the nurse clinician should be notified.

2. RESERVOIR

Any person, animal, plant, soil or substance (or a combination of these) in which an infectious organism normally lives and multiplies. Some bacteria such as anthrax can produce spores (hard cases) in which they remain dormant for extended periods of time until favorable conditions for their growth occur.

QUIZ

True or False

1. ______A term used for any disease-causing organism is *pathogen*.

2. ______Diseases can only be transmitted from person to person by direct contact.

3. ______Droplet infections can be transmitted by coughing or sneezing.

4. ______Special care in the use of needles is important because of the possibility of transmitting bloodborne pathogens.

5. ______Standard precautions include the use of gloves, gowns, etc.

6. ______The risk of droplet infections is reduced by the use of a mask.

7. ______Dust is sometimes a source of airborne infectious agents.

8. ______The use of gloves makes hand-washing unnecessary.

9. ______Proper bag technique requires that a bag never be put on the floor.

10. ______A small cut in a sterile glove doesn't present a risk of infection.

Choose the best answer

11. A term used for diseases that can be transmitted from person to person is
    a. communicable
    b. allergy
    c. viral
    d. all of the above.

12. Which of the following is a disease causing agent?
    a. bacteria
    b. fungus
    c. virus
    d. all of the above

13. A way in which an infectious organism can leave the body is
    a. blood
    b. urine
    c. coughing
    d. all of the above

14. A way in which an infectious organism can enter the body is
    a. mucous membrane
    b. eating
    c. sexual contact
    d. all of the above

15. A health care worker's responsibilities include
    a. infection control practices
    b. protecting ourselves
    c. breaking the chain of infection
    d. all of the above

16. A person is susceptible to a disease if they
    a. are of foreign descent
    b. live near a hospital
    c. lack resistance
    d. all of the above

17. Good work practice controls include
    a. handwashing
    b. proper bag technique
    c. use of personal protective equipment
    d. all of the above

18. The first line of defense against germs is
    a. use of a mask
    b. a good diet
    c. handwashing
    d. latex gloves

19. Personal protective equipment includes
    a. goggles
    b. gloves
    c. gowns
    d. all of the above

20. Standard Precautions include
    a. contact precautions
    b. airborne precautions
    c. droplet precautions
    d. all of the above

Home Care Community Forum

Workbook #10

Emergency

Disaster Preparedness

community health care services foundation, inc.
www.chcforum.org

Community Health Care Services Foundation, Inc.
90 State Street, Suite 200
Albany, New York 12207
(518) 463-1167 Fax (518) 463-1606

Welcome!

The Home Care Community Forum is an educational program for home care workers developed by Community Health Care Services Foundation, Inc. (CHC) and funded by the New York State Department of Labor. In recognition of all their hard work in difficult circumstances, the Forum is designed to provide education and support to home care workers.

This workbook is one of ten in-service training programs for home care workers. Each workbook has been developed to accompany an hour-long audio conference on the same topic.

The last pages of the workbook include a quiz to test your knowledge of the materials covered in the audio conference and workbook; a program evaluation for you to complete and give to your training coordinator.

Website

www.chcforum.org is a website dedicated to the home care worker. The workbooks and the audio conferences will be made available on the CHC website shortly after they are first presented. Additional materials of interest for home care workers are also available. We invite you to visit often!

Funded through a grant from the New York State Department of Labor

Emergency Disaster Preparedness

Learning Objectives:

By the end of this program, participants will be able to:

1. Appreciate the types of disasters for which home care paraprofessionals must be prepared.
2. Understand the local, state, and national structure for disaster preparedness.
3. Identify the key components and strategies of an Emergency Disaster Preparedness plan.
4. Identify the specific challenges associated with each type of disaster.
5. Know how to respond to each type of disaster.
6. Understand the immediate, short term and long term requirements of a disaster preparedness plan that meets the needs of a variety of clients.

Glossary

EDP	Emergency Disaster Preparedness—the ability to respond to a sudden need for immediate action.
Catastrophic Event	Disaster of such magnitude that human and medical resources are quickly overwhelmed.
Surge Capacity	Maximum capacity/capability to provide care and services with available resources (human, medical, physical)
"Dirty Bomb"	Conventional explosive device combined with radioactive materials designed to disperse harmful radiation
Mass trauma	Mass admissions to home care
Bioterrorism	Use of a biological agent, microbe or toxin, to harm a person, an animal, a food supply, or a water system
Microbe	Any disease causing agent
Toxin	Poison
OEM	Office of Emergency Management (New York State)
FEMA	Federal Emergency Management Agency (Federal)
CDC	Centers for Disease Control and Prevention (Federal)

What is Emergency Disaster Preparedness for the home care worker?

- Emergency Disaster Preparedness (EDP) is the ability to respond to a sudden need for immediate action. EDP assures that health care and safety needs of the patient and staff continue to be met during emergencies that interfere with the delivery of care and services.
- The Home Health Aide (HHA) or Personal Care Aide (PCA) is on the front line of disaster preparedness planning.

- Home care agencies must have a plan that includes communication, safety, and transportation for personnel and patients.

Structure of Emergency Disaster Preparedness

- Local communities are required to have a plan for emergency management. Local emergency management offices, public health departments, fire departments, and law enforcement are key components of any plan.
- The New York State Office of Emergency Management and the New York State Department of Health coordinate many aspects of disaster preparedness at the State level.
- The United States Department of Homeland Security, the Federal Emergency Management Agency, the Federal Bureau of Investigation, the Central Intelligence Agency, the United States Department of Health and Human Services, and the Centers for Disease Control and Prevention are responsible for disaster management at the Federal level.

Why the need for Emergency Disaster Preparedness?

Historically, the United States has had to deal with certain natural disasters such as floods, fires, tornadoes, and hurricanes as well as an occasional toxic spill, rail or air catastrophe. Our ability to respond to those problems as a nation, State, and individual home care providers has been compounded by world events including 9/11 and the increasing use of terrorism to gain political goals. Recent events have revealed a number of shortcomings in our ability to respond to disaster.

- Emergency disaster plans have only been used for snow days, hurricanes, electrical outages and strikes and may not meet the public needs during other catastrophic events.
- Backup communication systems are inadequate.
- There is a need for backup transportation plans.
- There must be a comprehensive plan in anticipation of events that have been relatively ignored in current plans.
- There is an overall lack of preparedness for dealing with any mass trauma event.

Should home care workers be aware of agency's EDP plans? YES!

- Home care workers are on the "front lines" and are a direct line of care, comfort and information to patients.
- In order to ensure the care and safety of patients, home care workers need to be informed and prepared of steps to take in the event of a disaster.
- Emergency planning and preparation protects both home care workers and patients in the event of a disaster.
- Informed caregivers make better caregivers.

What type of events must be considered?

In order to help effectively plan for potential dangers, agencies must now approach EDP planning as "All-Hazards" planning. This means that in addition to the disaster plans that have historically been developed, such as responses to natural weather hazards or utility or transportation shut-downs, the home care industry must now plan for other disasters such as the NBC disasters. In this case, NBC stands not for a television network but for Nuclear, Biological, and Chemical.

NUCLEAR (RADIOLOGICAL) EVENTS

Radiation is the spontaneous emission of particles and rays from certain elements such as uranium, plutonium, and radium. The short-term effects of exposure to radiation include nausea, fatigue, and non-healing burns. The sources of radiation can be:

Accidents at nuclear facilities—Harmful radiation is a natural byproduct in the production of energy at nuclear power plants. It is rare, but radiation leaks can and do occur.

Nuclear Bombs—These are unconventional tools of warfare that use nuclear energy to cause massive destruction and death. A byproduct of their use is the release of harmful radiation.

"Dirty Bomb" —A dirty bomb is a radiological dispersal device (RDD). It uses conventional explosives to spread radioactive materials usually in the form of powder or pellets. It is a weapon of mass destruction (WMD) with a primary function to frighten people and make buildings or land unusable for a long period of time.

Protection from exposure to radiation include the following:

TIME—decrease the amount of time spent near the source of radiation.
DISTANCE—increase your distance from the source of radiation.
SHIELDING—increase the shielding between you and the source of radiation—shielding consists of anything that creates a barrier—certain materials such as lead and concrete are much more effective as shields than other materials.

BIOLOGICAL EVENTS

Biological events can result from the normal transmission of disease (SARS, Influenza, West Nile Virus) or as the result of accidental or intentional release of biological agents.

Bioterrorism—The intentional use of a biological agent, microbe or toxin, to harm a person, an animal, a food supply, or a water system so as to achieve a personal or political goal or objective. Bioterrorism is especially dangerous because there are no warnings, no alarms or sirens and no specific crime scene. There are often signs that help signal when a biological event is underway:

First Sign—sick people scattered throughout an area, often identified days after an event.

Secondary Sign—rapid appearance of large numbers of severe or fatal illness.

Biological Events are unique because we are dealing with the consequences before there is a crisis. Home care aides are more likely to be the first responders as individuals become sick and need support. A narrow window exists in which identification can lead to appropriate prevention and care.

INFECTION CONTROL

Infection control is an important part of any Emergency Disaster Preparedness Plan, and plays an extremely important role in the delivery of home care services. There are certain steps that should be taken to ensure the safety of persons dealing with infection control. These steps include:

1. ***Surveillance***—closely watching for signs and symptoms of infection.
2. ***Monitoring Infections***—keeping track of infections in our patients, their families, agency staff, and in the community.
3. ***Recognition***—noting any changes in "normal" infections.
   a. severity and the number of individuals affected.
   b. any unusual symptoms of illness.
4. ***Reporting***—notification of RN supervisor immediately.
5. ***Prevention of Transmission and Spread of Infection***
   a. Hand washing
   b. Isolation Precautions
   c. Proper use of Personal Protective Equipment (PPE) including gloves, gowns, etc.

Standard Infection Control Precautions

These apply to blood, all body fluids, secretions, and excretions, *except sweat*, regardless of whether or not they contain visible blood; non-intact skin; and mucous membranes.

CONTACT PRECAUTIONS—reduce risk of transmission (spread) of infectious organisms (germs) by *direct* or *indirect* contact.

Use **GLOVES** when coming in contact with organisms spread through bodily fluids.
Use **APRON/GOWN** if excessive soiling is anticipated

DROPLET PRECAUTIONS—reduce risk of transmission of organisms by *droplet spread* (coughing, sneezing, close contact with 3 to 6 feet)

Use **GLOVES**
Use a **SURGICAL MASK** when spread of the organisms involves contact of the *conjunctivae (eye) or mucous membranes of the nose or mouth*

AIRBORNE PRECAUTIONS—reduce the risk of transmission of infectious organisms spread by inhalation (breathing) of airborne droplet nuclei (evaporated droplets that may remain suspended in the air for long periods of time, or dust particles containing the germs).

Use an **N-95 RESPIRATIOR MASK**

CHEMICAL EVENTS

Accidental spills of certain chemicals used on a daily basis can present serious consequences upon exposure. Most of us have seen chemical spills on the news and the HAZMAT (hazardous materials) crews in their protective gear, clean up the spill. Chemical agents can also be used to intentionally harm, kill, or immobilize exposed individuals or populations. Common symptoms of exposure to chemicals are pinpoint pupils, vomiting, choking, salivating, redness of skin and blisters.

Nerve Agents that impede the normal functioning of the nervous include:

Sarin—One of the world's most dangerous chemical warfare agents, sarin is an extremely toxic substance that disrupts the nervous system, overstimulating muscles and vital organs. It can be inhaled as a gas or absorbed through the skin. In high doses, sarin suffocates its victims by paralyzing the muscles around their lungs. One hundred milligrams of sarin—about one drop—can kill the average person in a few minutes if he or she is not given an antidote. Experts say sarin is more than 500 times as toxic as cyanide.

VX—VX Gas disrupts the passage of messages between neurons, and from nerves to muscles. VX Gas is easily absorbed into the body, and inhalation at concentrations as low as 30mg per cubic meter kills within fifteen minutes.

Blister Agents that cause irritation and burns to the skin and membranes of the body include:

Nitrogen Mustard—Nitrogen mustards are powerful irritants that damage the skin, eyes, and respiratory (breathing) tract. Nitrogen mustards can enter the cells of the body very quickly and cause damage to the immune system and bone marrow.

Sulfur Mustard—A potentially deadly chemical agent that attacks the skin and eye, it is one of the best-known and most potent chemical weapons. Mustard gas causes severe blisters and, if inhaled, can also damage the lungs and other organs. It is usually disabling—sometimes gruesomely so—but not fatal. Unlike the symptoms of exposure to other chemical agents, which usually appear immediately, the symptoms of exposure to mustard gas appear one to six hours later. This makes mustard gas especially insidious, since victims can suffer tissue damage before they even realize they need treatment. Mustard gas also attacks a cell's DNA, so it can cause cancer and birth defects.

Cyanide—Cyanide is a rapidly acting, potentially deadly chemical that can exist in various forms. Breathing cyanide gas causes the most harm, but ingesting cyanide can be toxic as well. Cyanide prevents the cells of the body from getting oxygen. When this happens, the cells die. Cyanide is more harmful to the heart and brain than to other organs because the heart and brain use a lot of oxygen.

Emergency Disaster Preparedness in the Patient's Home

Follow your agency's specific protocols.

Example: **Fire/Explosion**

1 Be familiar with fire escape route appropriate to patient's abilities.
2 At the first sign of fire/smoke, go immediately to safest exit with the patient
3 Once away from danger, call the Fire Department
4 If the patient cannot be moved, close the door of the patient's room and go to the nearest safe telephone

Be prepared with Six Basic Emergency Home Stock Items
1 Water
2 Food
3 First Aid Supplies
4 Clothing and Bedding
5 Tools and Emergency Supplies
6 Special Items – glasses, medications, etc.

The structure of your agency's Emergency Disaster Preparedness Plan

COMMUNICATION

Communication

- Call Down System/Telephone Tree
- Current phone numbers; contact info

Communication Systems

- Backup systems (radio station, check-in)
- Ongoing communication plans
- Office re-location site(s)

Lines of Authority /Reporting Mechanisms

- To whom do you report?

Activation of Plan

- What is your role?
- Patient Priority Classification Levels
- Readjustment of cases/staff schedule

Transportation

- Identification (ID badge)
- Backup plans (alternate transportation)
- Street/road closures
- Map of service area nearest your home
- Safety/security

Support/Counseling Needs

- Staff personnel may be casualties of the disaster
- Family members of staff may be casualties
- Provisions for care of children or elders of staff
- Provisions for relief due to exhaustion
- Provisions for exposure of staff to hazards
- Provisions for illness of staff

SUPPLIES/EQUIPMENT

Emergency Preparedness Kits – Location for immediate use is important

Office	Car	Patient's Home	Your Home

Emergency Preparedness Kit Checklist

Source : American Red Cross

General Requirements

- ☐ Copies of Emergency Disaster Plan
- ☐ Emergency telephone numbers
- ☐ Map of service area
- ☐ Flashlights
- ☐ Matches; Candles
- ☐ Batteries
- ☐ Blankets
- ☐ Personal Protective Equipment—i.e. masks, gloves, aprons, barriers

Water and Food

- ☐ Water—three day supply (one gallon/person/day).
  Minimum needs for a normally active person is two quarts per day. Heat, intense physical activity, age, pregnancy and illness increase need. Supply includes need for drinking, food preparation and sanitation.
- ☐ Food—three day supply.
  Select foods that do not require refrigeration, preparation or cooking and that are light weight and compact

First Aid Supplies

- ☐ Sterile adhesive bandages is assorted sizes
- ☐ Assorted sizes of safety pins
- ☐ Cleansing soap/agent
- ☐ Latex gloves (2 pair)
- ☐ Sunscreen
- ☐ 2-inch and 4-inch sterile gauze pads (4-6 each)
- ☐ Triangular bandages (3)
- ☐ Non-prescription drugs
- ☐ 2-inch sterile roller bandages (3 rolls)
- ☐ 3-inch sterile roller bandages (3 rolls
- ☐ Scissors
- ☐ Tweezers
- ☐ Needle
- ☐ Moistened towelettes
- ☐ Antiseptic
- ☐ Thermometer
- ☐ Tongue blades (2)
- ☐ Tube of petroleum jelly or other lubricant

Emergency Preparedness Kit Checklist (cont.)

Source : American Red Cross

Clothing and Bedding – Include at least one complete change of clothing and footwear per person plus

- ☐ Sturdy shoes or work boots
- ☐ Rain gear
- ☐ Blankets or sleeping bags
- ☐ Hat and gloves
- ☐ Thermal underwear
- ☐ Sunglasses

Tools/EDP Supplies

- ☐ Mess kits or paper cups, plates and plastic utensils
- ☐ EDP Manual
- ☐ Battery operated radio and extra batteries
- ☐ Flashlight and extra batteries
- ☐ Cash or traveler's checks, change
- ☐ Non-electric can opener, utility knife
- ☐ Fire extinguisher, small canister ABC type
- ☐ Tube tent
- ☐ Pliers
- ☐ Tape
- ☐ Compass
- ☐ Matches in waterproof container
- ☐ Aluminum foil
- ☐ Plastic storage containers
- ☐ Signal flare
- ☐ Paper, pencil
- ☐ Needles, thread
- ☐ Medicine dropper
- ☐ Shut-off wrench – to turn off household gas and water
- ☐ Whistle
- ☐ Plastic sheeting
- ☐ Map of area (for locating shelters)

Emergency Preparedness Kit Checklist (cont.)

Source : American Red Cross

Special Items for Families with Infants

- ☐ Formula
- ☐ Diapers
- ☐ Bottles
- ☐ Powdered milk
- ☐ Medications

Special Items for Families with Elderly or Disabled

- ☐ Heart and high blood pressure medication
- ☐ Insulin
- ☐ Prescription drugs
- ☐ Denture needs
- ☐ Contact lenses and supplies
- ☐ Extra eye glasses

Special Items for Families - Entertainment

- ☐ Games and books

Special Items for Families – Documents – Keep these in a waterproof, portable container

- ☐ Will, insurance policies, contracts, deeds, stocks and bonds
- ☐ Passports, social security cards, immunization records
- ☐ Bank account numbers and companies
- ☐ Inventory of valuable household goods
- ☐ Important telephone numbers
- ☐ Family records – birth, marriage, death certificates

HOMELAND SECURITY ADVISORY SYSTEM

In the wake of the 9/11 disaster the Federal government established numerous procedures to safeguard the American people. Among those is the Homeland Security Advisory System that provides a simple code for identifying the level of readiness we as citizens should maintain. The system is as follows:

Low condition (green) —Low risk of terrorist attacks. Government and private sector entities should reduce vulnerabilities in facilities.

Guarded condition (blue— General risk of terrorist attack. Government and critical locations; coordinate emergency plans with nearby jurisdictions; and activate, as appropriate, contingency and emergency response plans.

Elevated condition (yellow) —Significant risk of terrorist attacks. Government and private sector entities should increase surveillance of critical locations; coordinate emergency plans with nearby jurisdictions; and activate, as appropriate, contingency and emergency response plans.

High condition (orange) —High risk of terrorist attacks. Government and private sector entities should coordinate necessary security efforts with armed forces or law enforcement agencies; take additional precautions at public events; prepare to work at an alternate site or with a dispersed workforce; and restrict access to essential personnel only.

Severe condition (red) —Severe risk of terrorist attacks. In these cases, government and private sector entities should assign emergency response personnel and pre-position specially trained teams; monitor, redirect, or constrain transportation systems; close public and government facilities; and increase or redirect personnel to address critical emergency needs.

EMERGENCY DISASTER PREPAREDNESS - What's Next?

PRACTICE

EVALUATE

REVISE & PRACTICE AGAIN

Preparation is incomplete and inadequate without PRACTICE

WEBSITE RESOURCES

www.bt.cdc.gov
www.hopkins-biodefense.org
www.usamriid.army.mil
www.nbc-med.org/others
www.hhs.gov
www.apic.org
www.fbi.gov/programs

Name: ____________________

QUIZ

1. Essential components of a communication system are:

   a. Up-to-date contact information
   b. A telephone tree
   c. Back-up systems such as radios or check-in locations
   d. All of the above.

2. When the Country is at an Elevated Condition alert status, which color is used to communicate the alert level:

   a. Yellow
   b. Blue
   c. Green
   d. Purple

3. Common symptoms of exposure to chemical agents include:

   a. Redness of skin and blisters
   b. A cold
   c. Pinpoint pupils
   d. A and C

4. Three approaches to standard infection control precautions include:

   a. Contact Precautions, Droplet Precautions, and Airborne Precautions
   b. Heavy Lifting Precautions, Droplet Precautions, and Surveillance Precautions
   c. Contact Precautions, Glove Precautions, and Prevention Precautions
   d. Airborne Precautions, Emergency Planning Precautions, and Respirator Precautions

5. You can protect against exposure to radiation if you:

   a. Increase your distance from the source of radiation
   b. Shield yourself from the source of radiation
   c. Decrease the amount of time spent near the radiation
   d. All of the above

6. Home care workers should be aware of agency's EDP plans because:

   a. They may be asked to help the National Guard
   b. They are on the "front lines" of direct care, comfort and information for their patients
   c. Informed caregivers make better caregivers
   d. B and C

True or False

7. Emerg ency Disaster Preparedness was in place before 9/11.

8. There are local, State, and Federal structures in place to address emergency situations.

9. The Centers for Disease Control and Prevention is a State level organization.

10. In EDP the acronym NBC stands for a television network.

11. The secondary sign that a biological event is occurring is the rapid appearance of large numbers of severe or fatal illness.

12. Infection control surveillance means closely watching for signs and symptoms of infection.

13. Nitrogen mustard is a nerve agent.

14. Biological events are especially dangerous because there are no warnings, alarms or a specific crime scene.

15. "Dirty bombs" spread West Nile Virus.

EMERGENCY MANAGEMENT AND DISASTER
PREPAREDNESS PLAN

PART II: IMPLEMENTATION OF THE EMERGENCY AND DISASTER PREPAREDNESS PLAN

A. At the first home visit, the agency's "Welcome" packet will contain materials/directions regarding emergency and disaster preparedness. The purpose of providing this information is to begin preparing each patient/family for emergency and disaster preparedness i.e. supplies, maintaining sufficient medication by renewing prescriptions timely, etc. Each patient will need to be reviewed individually with respect to information and supplies specific to their condition and circumstance.

B. The patient is asked to provide the name, address and telephone number of a designated family/friend to be the emergency contact person. It is important that this individual be available and willing to participate in case of and emergency and disaster that may interfere with the

C. Patient's care needs or in case of an evacuation. The contact person should be geographically available i.e. not living out of state etc.

D. At admission the Emergency Kardex is completed that provides information as to the patient's physician, medications and care needs. As appropriate, any patients dependent on electric/power for life-sustaining equipment are registered with the local fire department/emergency management office.

E. At the time of admission to the Agency, the patient's Priority Category is established by the admitting health care professional. Priority Categories will be consistent with the NYS and Local Governmental Designations. This information is documented on the initial assessment form. The identified patient Priority Code is entered into the agency's Patient Profile and is documented in the agency's On-Call book.

PRIORITY CLASSICIFICATION

At the time of Admission to the agency and upon recertification of Medical Orders (no less frequently than every 6 months) or significant change in health or environmental status each patient is evaluated and categorized using the agency's Patient Priority Classification System.

The Patient Priority Classification System is a method of grouping or categorizing patients based on their individual home care service needs and available support systems.

The patient condition and medical needs are among the first factors to consider but not the only ones. Key factors are:

1. Patient needs
2. Patient supports
3. Agency Staff Resources
4. Local Emergency Management Coordination

Patient support systems are those people in the patients' life who are available, willing and have the ability to provide assistance, and at times, care as needed. These systems may include family members, friends, neighbors or members of the community. The presence of a patient support

EMERGENCY MANAGEMENT AND DISASTER PREPAREDNESS PLAN

system carries significant weight when determining the need for uninterrupted home care services or if a patient visit can be skipped and staff is sent to help with an emergency.

When conducting the initial assessment for admission determination, the nurse will ask each patient about support systems and any emergency plans already in place. The nurse will also Assess a patient support systems ability to provide necessary care or treatment in an emergency situation. Agency staff can be resources in the areas of education, coordination and referrals for patients with adequate supports.

Counties/regions have coding systems in place to identify persons with special care needs who require relocation should normal services be interrupted. (The definition of special care needs varies locally, focusing on those needing assistance with medical or personal care because of physical or mental impairments or reliance on medical equipment.)

This coding usually relates to evacuation and shelter planning. One example is a color-code system matching a persons care needs with the appropriate type of shelter.

1. Green: Public Shelter
2. Yellow: Special Care Facility
3. Red: Skilled Nursing Facility/Hospital

This classification consists of three basic levels. Each level identifies and ranks the necessity of uninterrupted home care service.

LEVEL I High Priority. (RED) Patients in this priority level need uninterrupted services. The patient must have care. In case of a disaster or emergency, every possible effort must be made to see this patient. The patients' 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 II Moderate Priority. (YELLOW) 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 III Low Priority. (GREEN) 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.

DECLARING AN AGENCY EMERGENCY

The Administrator/designee activates the plan and initiates the identification and recall of other employees (Field Nurse Supervisors, Professional Staff) who could assist in the emergency response effort. Patient contact staff include, but are not limited to: Nurses and Schedulers/Coordinators.

If a potential disaster is known, each primary nurse/scheduling coordinator will contact their patients and check on their supplies if needed. In addition the nurse will question

EMERGENCY MANAGEMENT AND DISASTER PREPAREDNESS PLAN

the patient regarding food, water, flashlights, etc. depending on the nature of the disaster.

1. All patients will be notified if the nurse/paraprofessional is unable to make a home visit due to a known or potential disaster. The nurse will also evaluate the patient's condition to ascertain if hospitalization needs to be considered. The patient's emergency contact is notified, as appropriate.

2. The Administrator and/or DPS will call in additional agency personnel to assist in an emergency as deemed necessary. In extreme emergencies the HR department may be requested to contact former employees to determine their availability. If applicable, contracted agencies are notified to determine the disposition of specific at risk patients.

3. The Administrator and/or DPS will determine when the disaster is over and will notify all staff and patients as appropriate.

4. The Administrator and/or DPS notifies the Governing Authority if applicable, of the type of disaster, the status and eventual resolution; this information is also presented at the next quality improvement committee meeting for review and evaluation.

PART II: OCCURRENCE SPECIFIC EMERGENCIES

I. WEATHER EMERGENCIES:

1. The Administrator/DPS is alerted to a potential weather disaster via weather reports/news bulletins.
2. The Administrator/DPS notifies professional staff assigned to the office of potential problem and activates general disaster plan.
3. Nurses are informed to make home visits, as necessary, prior to the weather emergency and to focus on getting to the patient's home rather than to the office. The nurses will address medication supplies, food and water storage with each patient/family.
4. As appropriate, paraprofessional schedules will be altered to meet the needs of the patients as per priority designation i.e. 24 hour assignments may require change in staff assigned earlier than expected, cluster care, assignment by zip codes etc.
5. Nurses will maintain telephone communications with the patients, physicians, and the DPS as indicated. If telephone communication is disrupted during the weather emergency, staff will follow the agency's procedures regarding communications.
6. All office staff who can report to the office must do so.
7. A list of phone numbers for the following will be kept at each office, with the On-call staff and the DPS
   - Individuals or service groups with 4-wheel drive vehicles;
   - Community service agencies which assist with transportation, food, clothing and shoveling; and
   - State and local police;
8. All patients will be contacted to check on their status in severe weather conditions. Persons to be notified in case of emergency will be contacted for high-risk patients. Appropriate arrangements for supervision and/or care of these patients will be made;
9. The DPS will monitor the extent and status of the weather disaster via weather reports, news bulletins, community resources, and will evaluate and communicate this information.

II. UTILITY EMERGENCIES:

A. DISRUPTION OF TELEPHONE SERVICE

1. The agency is a designated health care provider listed with the telephone company, this designation assures priority attention in situations when disruption of telephone service occurs. The first person identifying a problem with telephone services immediately notifies the telephone company to alert them of the need for priority service repair, and then the Administrator/DPS.

2. Alternate telephones will be used (payphones, cellular phones) as necessary. The Agency maintains cellular phones for each office/on-call; the agency also utilizes other forms of communication i.e. email.
3. The office's answering service will be used to triage important messages.
4. If the office telephone service is not working, operations will be maintained out the answering service or as appropriate, the alternate emergency "command" center, or if necessary a home.
5. All high risk/priority patients will be contacted to make sure service is being provided.
6. Nurses are directed to keep in contact with their patients and the DPS using alternate phones.
7. The DPS monitors the situation, keeping contact with the Telephone Company and notifies the appropriate personnel when the problem is resolved.

B. DISRUPTION OF ELECTRIC/POWER SERVICES

1. The DPS/Designee will alert the local gas/electric company to determine the extent of the problem and will incorporate that information into his/her decision making process. The DPS/Designee notifies professional staff assigned to this office of a potential problem and initiates the general disaster plan.
2. Any patient's dependent on equipment powered by electricity for life sustaining operation will be identified at admission and this information processed to the local emergency services unit. Communication with the vendor providing the equipment will occur to establish an appropriate power back up source, batteries, generators etc.
3. Nurses using the Patient Priority Codes identify those patients whose health and well being depends upon the use of equipment that requires electrical power so that emergency services can be mobilized to arrange for emergency transportation to an appropriate facility.
4. Nurses will maintain telephone contact with their patients to provide support and conduct home visits, as needed.
5. All office staff is to report to their assigned branch office or an office closest to his/her home, must do so.

C. DISRUPTION OF WATER SUPPLIES/EMERGENCIES

1. The DPS/Designee will alert the local water department to determine the extent of the problem and will incorporate that information into his/her decision making process. The DPS/Designee notifies professional staff assigned to this office of a potential problem and initiates the general disaster plan.

EMERGENCY MANAGEMENT AND DISASTER PREPAREDNESS PLAN

2. The agency staff will communicate with any patients living in the involved areas to determine if they require bottled water, notifying the local government emergency management company of the need.

3. If authorities determine that there is a concern about drinking water quality, the residents will advised of what actions to take. In some cases, the residents will told not to use water for cooking for drinking purposes unless it is boiled, treated with bleach or disinfected by other means. In an extreme case, you may be told not to use the water for cooking, drinking, hand-washing or bathing purposes. The Agency staff will reinforce these directives, as appropriate.

C. **DISRUPTION IN TRANSPORTATION SERVICES**

1. The Administrator/DPS is alerted to a potential transportation problem.

2. The DPS notifies professional staff assigned to the agency office of the potential problem and initiates the General Disaster Plan.

3. The DPS evaluates the transportation needs of the nurses and makes necessary arrangements to assure that patients are seen utilizing the patient's emergency priority code and any other information known regarding the patient's needs. The nurses evaluate their visit schedules and rearrange to allow carpooling, drop offs/pick ups to high-risk patients.

4. As necessary patients are assisted with transportation plans using available resources to ensure continuing care.

III. WORK STOP ACTION

1. High risk patients will be called or visited first by nurses, appropriate arrangements will be made for service when necessary, at local hospitals or with family/friends in conjunction with the contracted agencies.

2. All patients and contract agencies will be notified and appropriate arrangements will be made;

3. Patients will be referred to other healthcare agencies/facilities as necessary;

4. Recruitment and training activities will be stepped up to meet needs;

5. Negotiations will take place to try to resolve the situations as quickly as possible; and

6. Contractual arrangements with other agencies will be implemented in order to provide care and services as necessary.

STRIKE AT LOCAL HOSPITAL, OR OTHER REASON TO CAUSE HIGH RATE OF PATIENTS DISCHARGED FROM AREA HOSPITAL

1. Recruitment and training efforts will be stepped up. The director will be contacted regarding coordination of staff to be assigned to the appropriate geographic location.

2. Existing staff will be asked to adjust their availability schedule and to work additional hours, as necessary.

3. The Administrative staff will maintain close communication regarding the situation i.e. negotiations and settlement issues to be able to anticipate and act in accordance with a evolving emergency situation.

4. Communications and collaboration with other community agencies, LHCSA's to distribute workload to meet agency/patient needs.

IV. FIRE

A. OFFICE SETTING

KNOW THE LOCATION OF FIRE EXTINGUISHERS, FIRE EXITS, AND PULL ALARM SYSTEMS IN YOUR AREA AND HOW TO USE THEM.

In the event of a fire, follow these steps:

1. If an emergency exists, activate the manual pull station building alarm system.

   A. If a minor fire appears controllable, promptly direct the charge of the fire extinguisher toward the base of the flame.

   B. If large fires appear uncontrollable, activate the manual pull station building alarm system, then DIAL 911. Proceed to evacuate all rooms, closing all doors to confine the fire and reduce oxygen – DO NOT LOCK DOORS!

2. When the building alarm is sounded, an emergency exists. Walk quickly to the nearest marked exit and alert others to do the same.

3. ASSIST THE DISABLED IN EXITING THE BUILDING! USE THE STAIRS, DO NOT USE THE ELEVATORS DURING THE FIRE.

4. Once outside, move to a clear area up wind, if possible, at least 300 feet away from the affected building. Keep streets, fire lanes, hydrants, and walkways clear for emergency vehicles and crews.

DO NOT RETURN TO AN EVACUATED BUILDING unless told to do so by a police officer.

EMERGENCY MANAGEMENT AND DISASTER PREPAREDNESS PLAN

NOTE: Should you become trapped inside a building during a fire and a window is available, place an article of clothing (shirt, a coat, etc.) outside the window as a marker for rescue crews. If there is no window, stay near the floor where the air will be less toxic. Shout at regular intervals to alert emergency crews of your location, DO NOT PANIC!

WHEN TO TRANSMIT AN ALARM

It is imperative the alarm be transmitted immediately when a fire is seen or suspected. Neither permission nor approval is ever necessary.

In the event of fire you must realize that, psychologically, people will look to the employees to guide them to safety. Orderly evacuation of an area depends primarily on you and your efficiency in implementing the fire response and evacuation protocol. Staff are encouraged to walk and keep moving quietly toward safety, this will often overcome the tendency to panic.

- Persons closest to the source of the fire should be moved first. Fire marshal(s) is assigned to the office to direct staff in evacuation in an orderly fashion. The fire marshal will calmly guide other employees and visitors, as appropriate, out of the building and be sure that no
- one is left in the office areas, halls, bathrooms, and that all doors are closed as soon as the last person has left.
- The senior staff person on duty automatically assumes responsibility at the time of the emergency.

Practice drills will be held so that staff becomes familiar with procedures. These drills will be held at least annually. Once the fire department is on-site, they are in command of the office.

In the event of cessation or interruption of service for any period of time, the agency will assure the appropriate coordination of patient services from other buildings/branches of the organization's facility or other home care agencies, as appropriate. The LHCSA will provide pertinent patient information from their records to caregivers assigned to provide services. The agency will secure storage of clinical records and related information at a place.

IN THE EVENT OF A FIRE:

- If your clothes catch on fire, **Stop** where you are, **Drop** to the ground, and **Roll** over and over to smother the flames.
- If you are in a high-rise multiple dwelling, and the fire is not in your office suite/apartment, stay in your office suite/apartment rather than entering smoke-filled hallways.
- In high-rise office buildings, only evacuate if the fire is on your floor or the one above it, and descend to the second floor below the fire floor. Other occupants should stay on their floor and monitor the PA system for further instructions.
- If a fire breaks out in your house or non-fireproof apartment building, get out as soon as possible.

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- Feel doors with the back of your hand before you open them. If they are hot, find another way out. When exiting, stay as close to the floor as possible – smoke and heat rise and the air is clearer and cooler near the floor. **Close doors behind you.**
- If you are unable to get out of the home for any reason, stay near a window and close to the floor. Close the door and stuff the bottom with a towel to avoid smoke. If possible, signal for help by waving a cloth outside the window.
- **Call 911** from a safe place such as a neighbor's house.
- **Do not stop to get anything.**
- **Do not use the elevator.**
- To prevent fires, keep an ABC fire extinguisher and working smoke detectors in the house. Check batteries twice a year at daylight-saving times.

FOLLOW THESE TIPS TO HELP SAVE YOUR LIFE & PROPERTY FROM FIRE:

1. For minimum protection, **install a smoke detector outside of each bedroom** or sleeping area in your home.
2. Keep your bedroom doors closed while you are asleep. Better, **install detectors on every level of your home.**
3. Keep your smoke detectors properly maintained. **Test them once a week** to ensure that the detectors are working properly.
4. Every Spring and Fall **when you change your clocks, remember to change your smoke alarm batteries.** Use only the type of batteries recommended on the detector
5. Develop an escape plan and review the plan with all members of the family frequently. Be aware that children and elderly people may need special assistance should a fire occur. Establish a meeting place outside the house for all members of the family to ensure that everyone gets out safely. **When fire occurs, get out of the house** and use a neighbor's telephone to notify the Fire Department.

The attack on the World Trade Center created a catastrophic collapse of both towers. While this tragedy will be reviewed and evaluated for a long time to come, it is still recommend you follow the safety guidelines presented below.

- A fire in a high-rise residential building usually can be confined to the apartment where it starts. However, smoke and heat can travel throughout the building, especially upward.
- High-rise residential buildings are constructed to be fireproof. Most of what is inside the buildings, including your furnishings and belongings, can burn and produce a tremendous amount of heat and smoke.

V. NUCLEAR EMERGENCY

County and State officials are required to develop detailed response plans for areas within a ten-(10) mile radius of a nuclear energy plant. This area is called the Emergency Planning Zone (EPZ).

Each planning area has evacuation routes and reception centers, as well as plans for schools and other special facilities such as hospitals, nursing homes and group homes.

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EMERGENCY CLASSIFICATIONS

An **UNUSUAL EVENT** indicates a potential problem with operation of the plant. Emergency officials are notified, but no public action is required.

An **ALERT** indicates an event that could reduce the plant's level of safety but would not require public action. Any release of radioactivity would be a small fraction of federal protective action guidelines.

A **SITE AREA EMERGENCY** indicates a problem that substantially reduces the plant's level of safety. Releases of radioactivity outside the plant site would not be expected to exceed federal protective action guidelines.

A **GENERAL EMERGENCY** indicates a problem affecting the plant safety systems that could lead to a release of radioactivity that would exceed federal protective action guidelines outside the plant site.

SPECIAL FACILITIES

Hospitals, Nursing homes, Day care centers, Home Care agencies and group homes are considered special facilities. Special facilities in the emergency-planning zone have single-station alert radios, which will notify the person in charge if there is an emergency situation. The person in charge will be advised by county officials and/or over the Emergency Alert System (EAS) what protective actions are recommended.

If advised that staying indoors is safer, the person in charge will see that people in these facilities remain inside and await further instructions.

If advised to evacuate the person in charge will use normal evacuation procedures, such as that use during fire drills, to empty the building. Residents will go to reception centers or health care facilities outside the emergency-planning zone.

If additional or special transportation is needed, it will be provided through the county Emergency Management Office.

PEOPLE WITH DISABILITIES

Special provisions have been made for people who may not be able to leave their homes on their own because of physical disabilities, Confinement or advanced age. All individuals with disability are to be encouraged to fill out an advanced registration card available at the local Office of Emergency Management.

SIRENS

Special sirens are installed around a nuclear plant to alert people in the area to an emergency that could require them to take action. The sirens are only a signal to turn on an Emergency Alert System (EAS) station for more information.

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In some areas where sirens may not be heard, police care public address systems or special single-station alert radios will be used to notify residents of an emergency. People in these areas have been told how to get these radios.

If a steady, three to five minute siren sound or if alerted by the police, turn on the radio to an EAS station. These stations will provide information about the nature of the emergency and the protective actions that should be taken. Stay tuned to an EAS station and follow official instructions carefully until the emergency ends.

- A three to five minute siren: Turn to an Emergency Alert System (EAS) station for official information concerning the emergency.

  AM Stations: WFAN-AM 660; WABC-AM 770; WCBS-AM 880; WQEW 1560
  FM Stations: WQXR-FM 96.3;
  TELEVISION: WCBS-TV Ch 2; WNBC-TV Ch4; WABC-TV Ch7

- If told to stay indoors, remain in the home or office.
- If told by an EAS message to leave the area :
  If it is necessary to evacuate an area, this will be announced on the EAS station. The message will include any special instructions for a particular situation. If an advisement to evacuate occurs, follow instructions promptly and carefully.
- Remain Calm
  Ignore all rumors, stay tuned to an EAS station for official instructions.
- Don't use the telephone, so lines will not be overloaded.
  Gather the items needed for a three-day visit, including, clothing, Blankets or sleeping bags, Prescription medications, Personal items (shaving kits, soap and cosmetics, Formula for infants, Checkbook, credit cards and important papers, Portable radio, flashlight and batteries
- Close windows and air vents of your car, and do not operate the air conditioner until out of the emergency area
- Follow the recommended evacuation routes
- If a car is not available, walk to the nearest emergency bus pickup point
  Individuals will be directed to the Reception Center and as necessary, assignment to a Congregate Care Center will be arranged.
  - Congregate Care Centers will be professionally staffed by the American Red Cross and will offer food, medical care, communications, and sleeping and sanitation facilities.
  - Do not overload the phone lines; use the phone for emergencies only.

EMERGENCY MANAGEMENT AND DISASTER PREPAREDNESS PLAN

VI. TERRORISM

A. BIOTERRORISM

RECOGNIZING CHEMICAL TERRORISM-RELATED ILLNESSES

Home care exists in the community at large, not within a single facility. This affords home care agencies a comprehensive view of the community and its population as well as the potential for exposure. Disease processes have an incubation period (delay between exposure and onset of illness). There is only a small window of opportunity for reporting and intervention after the first cases are identified and before the outbreak of more widespread illnesses occur. Your agency may be first to identify a potential outbreak.

In order for home care to be prepared for its role in active surveillance and reporting, agencies must first be aware of the infection/ disease norms and trends within the agency and community. Home care agencies have a responsibility to identify potential blips on the radar, unusual symptoms, groups of symptoms or clusters of illness, in order to rapidly notify local public health officials.

IC programs must include a procedure for getting information about possible communicable disease to the IC designated person within the agency so the local county health department can be notified immediately. Local health officials will coordinate response activities.

NANNIES FOR GRANNIES, INC. has a responsibility to follow infection control strategies to prevent transmission and spread.

Adequate planning and regular training are the key to preparedness for terrorism-related events. Healthcare providers should be alert to illness patterns and reports of chemical exposure that might signal an act of terrorism. The following clinical, epidemiological and circumstantial clues may suggest a possible chemical terrorist event:

- An unusual increase in the number of people seeking care, especially with respiratory, neurological, dermatological or gastrointestinal symptoms
- Any clustering of symptoms or unusual age distribution (e.g., chemical exposure in children)
- Location of release not consistent with a chemical's use
- Simultaneous impacts to human, animal and plant populations
- Any unusual clustering of patients in time or location (e.g., persons who attended the same public event)

Any unusual symptoms, illnesses or clusters of these should be reported immediately. EMS personnel should call their medical control facility and dispatching agency. The county health department and local Poison Control Center should also be notified.

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Infection Control Plan

The Infection Control (IC) Plan is a system to monitor and track infectious processes, recognize and report changes or abnormalities, and take action to prevent transmission and spread. There are two key reasons to integrate your infection control plan into the EDP Plan.

1. First, a **bio-terrorism event** would make enhanced infection control surveillance processes necessary in all areas of health care.
2. Additionally, **the management of an infectious disease outbreak**, whether intentional or naturally occurring, has the potential to overwhelm human, medical and financial resources.

The infection control plan contains four components:

1. Active Surveillance and Identification
2. Rapid Reporting
3. Response and Prevention of Transmission
4. Evaluation

Surveillance is the close observation of infectious processes in patients, their families and staff.

Identification is the recognition of any changes in the trends of infections being monitored or any unusual symptoms or patterns in diseases. This is also the place where early identification of specific diseases (e.g. Smallpox) should be recognized.

Reporting is the notification of local public health officials of potential infectious process concerns or threats.

Response is adherence to specific infection control strategies for care and prevention of identified infectious conditions and transmission.

Evaluation is a review of the efficacy of the IC Plan.

*** **The Director of Patient Services is the assigned** Infection Control Point Person within the agency. Any surveillance issues or concerns should be immediately reported to that person.

IMPORTANT PHONE NUMBERS

Poison Control Centers **1-800-222-1222**

County Health Department

New York State Department of Health (NYSDOH)

Bureau of Toxic Substance Assessment **518-402-7800**

Wadsworth Center Laboratories **518-474-7161**

After hours: NYSDOH Duty Officer **1-866-881-2809**

After hours: SEMO State Warning Point
(SEMO - State Emergency Management Office) **518-457-2200**

New York City Department of Health

Poison Control Center **212-764-7667**

TABLE 1
RECOGNIZING AND DIAGNOSING HEALTH EFFECTS OF CHEMICAL TERRORISM

Agent Type	Agent Names	Any Unique Characteristics	Signs and Symptoms
Nerve	- Cyclohexyl sarin (GF) - Sarin (GB) - Soman (GD) - Tabun (GA) - VX - Some insecticides (cholinesterase inhibitors) - Novichok agents/ Soviet V	- Miosis (pinpoint pupils) - Copious secretions/ sweating - Muscle twitching/ fasciculations	- Miosis (pinpoint pupils) - Blurred/dim vision - Headache - Nausea, vomiting, diarrhea - Copious secretions/ sweating - Muscle twitching/ fasciculations - Breathing difficulty - Seizures - Loss of consciousness
Asphyxiant/Blood	- Arsine - Cyanogen chloride - Hydrogen cyanide	- Possible cherry red skin - Possible cyanosis - Possible frostbite*	- Confusion - Nausea - Patients may gasp for air, similar to asphyxiation but more abrupt onset - Seizures prior to death
Choking/ Pulmonary-damaging	- Chlorine - Hydrogen chloride - Nitrogen oxides - Phosgene	- Chlorine is a greenish-yellow gas with pungent odor - Phosgene gas smells like newly-mown hay or grass - Possible frostbite*	- Eye and skin irritation - Airway irritation - Dyspnea, cough - Sore throat - Chest tightness
Blistering/ Vesicant	- Mustard/Sulfur mustard (HD, H) - Nitrogen mustard (HN-1,HN-2,HN-3) - Lewisite (L) - Phosgene oxime (CX)	- Mustard (HD) has an odor like mustard, garlic or horseradish - Lewisite (L) has an odor like geranium - Phosgene oxime (CX) has a pepperish or pungent odor	- Redness and blisters of the skin - Tearing, conjunctivitis, corneal damage - Mild respiratory distress to marked airway damage
Incapacitating/ Behavior-altering	- Agent 15/BZ	- May appear as mass drug intoxication with erratic behaviors, shared realistic and distinct hallucinations, disrobing and confusion - Hyperthermia - Mydriasis (dilated pupils)	- Dry mouth and skin - Initial tachycardia - Altered consciousness, delusions, denial of illness, belligerence - Hyperthermia - Ataxia (lack of coordination) - Hallucinations - Mydriasis (dilated pupils)

*Frostbite may occur from skin contact with liquid arsine, cyanogen chloride or phosgene.

Table 2: DECONTAMINATION AND TREATMENT

Agent Type	Decontamination	Treatment	Other Patient Considerations
		Assess ABCs	
Nerve	- Remove clothing immediately - Gently wash skin with soap and water - Do not abrade skin - For eyes, flush with plenty of water or normal saline	- Atropine before other measures - Pralidoxime (2-PAM) chloride - See nerve agent antidote Table 3	- Onset of symptoms from dermal contact with liquid forms may be delayed - Repeated antidote administration may be necessary
Asphyxiant/ Blood	- Remove clothing immediately if no frostbite* - Gently wash skin with soap and water - Do not abrade skin - For eyes, flush with plenty of water or normal saline	- Rapid treatment with oxygen - For cyanide, use antidotes (sodium nitrite or amyl nitrite, if available, and then sodium thiosulfate) - See cyanide antidote Table 4	- Arsine and cyanogen chloride may cause delayed pulmonary edema
Choking/ Pulmonary-damaging	- Remove clothing immediately if no frostbite* - Gently wash skin with soap and water - Do not abrade skin - For eyes, flush with plenty of water or normal saline	- Fresh air, forced rest - Semi-upright position - If signs of respiratory distress are present, oxygen with or without positive airway pressure may be needed	- May cause delayed pulmonary edema, even following a symptom-free period that varies in duration with the amount inhaled
Blistering/ Vesicant	- Immediate decontamination is essential to minimize damage - Remove clothing immediately - Gently wash skin with soap and water - Do not abrade skin - For eyes, flush with plenty of water or normal saline	- Immediately decontaminate skin - Flush eyes with water or normal saline for 10-15 minutes - If breathing difficulty, give oxygen	- Possible pulmonary edema - Mustard has an asymptomatic latent period - Phosgene oxime causes immediate pain - Lewisite has immediate burning pain, blisters later - Specific antidote British Anti-Lewisite (BAL) may decrease systemic effects of Lewisite
Incapacitating/ Behavior-altering	- Remove clothing immediately - Gently wash skin with water or soap and water - Do not abrade skin	- Evaluate mental status - Use restraints as needed - Monitor core temperature carefully	- Hyperthermia and self-injury are greatest risks - Hard to detect because it is an odorless andnon-irritating substance - Possible serious arrhythmias - Specific antidote (physostigmine) may be available

*For frostbite areas, do NOT remove any adhering clothing. Wash area with plenty of warm water to release clothing.

References for Preparedness and Response Card:

1. Agency for Toxic Substances and Disease Registry (ATSDR). 2001. Managing Hazardous Materials Incidents Vol. I, II, III. Division of Toxicology, U. S. Department of Health and Human Services. Public Health Service: Atlanta, GA. **http://www.atsdr.cdc.gov/mhmi.html**

2. Chemical Casualty Care Division USAMRICD. 2000. Medical Management of Chemical Casualties Handbook, Third edition. U.S. Army Medical Research Institute of Chemical Defense (USAMRICD). Aberdeen Proving Ground: Aberdeen, MD. **http://ccc.apgea.army.mil/products/handbooks/books.htm**

3. U.S. Army Edgewood Research, Development and Engineering Center. 1999. Technician EMS Course. Domestic Preparedness Training Program, Version 8.0. U.S. Army SBCCOM. Aberdeen Proving Ground: Aberdeen, MD.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

First responders face the greatest exposure potential, often to unidentified agents. To protect yourself:

- Be alert
- Keep an appropriate distance
- Stay upwind
- Wait for assessment by a HAZMAT team before entering

Ideally, responders in an unknown situation should wear Level A PPE. Exposure can occur from inhalation of vapors, dermal contact or eye contact. The following is a general discussion to help responders/healthcare providers determine appropriate PPE.

PPE to Prevent Inhalation Exposure:

Protection from both vapors and particulates may be required when the chemical agent is being released. After release, protection from vapors is most important. Half-face and full-face respirators, with the appropriate canister, can provide good protection from vapors. These operate by negative pressure and must be fit tested for optimal protection. Powered, air-purifying respirators (PAPR) and self-contained breathing apparatus (SCBA) provide even greater protection and operate under positive pressure so that fit characteristics are less important. Surgical and N-95 masks will not protect against inhalation of vapors.

PPE to Prevent Dermal Exposure:

Latex examination gloves provide very little protection from most chemical agents and can cause allergies. Gloves made of Viton, nitrile, butyl or neoprene provide more protection and, in some styles, allow adequate dexterity. However, the resistance of these materials to different chemicals varies and it is best to have a variety of gloves available. Double gloving may provide additional protection. Chemical-resistant aprons or suits can also prevent dermal exposure.

PPE to Prevent Eye Exposure:

Full-face respirators, PAPR and SCBA will provide protection from both splashes and vapors. Protective eyewear, such as goggles or a face shield, will not provide protection from chemical vapors. Protective eyewear is required during decontamination to prevent splashing into eyes.

B. RADIOLOGICAL TERRORISM

RADIOLOGICAL TERRORISM

This guide provides health care providers with basic information to manage radiologically contaminated patients, or patients who received a large dose of radiation from an external radiation source. This guidance is applicable in all radiological incidents, including terrorism. The format is designed to be a quick reference guide for use during emergencies, but it is important to become familiar with the information in advance. While this rapid response card is directed at those who would provide medical management, the concepts discussed will be of practical use by all first responders.

PHONE NUMBERS

New York State Department of Health (NYSDOH)

Bureau of Environmental Radiation Protection	**518-402-7550**
Wadsworth Center Laboratories	**518-473-4854**
After hours: NYSDOH Duty Officer	**518-465-9720**
After hours: SEMO State Warning Point (SEMO - State Emergency Management Office)	**518-457-2200**

New York City Department of Health

Bureau of Radiological Health	**212-676-1572**
After hours	**212-764-7667**

County Health Department

Poison Control Centers **1-800-222-1222**

EXPOSURE VS. CONTAMINATION

External Radiation Exposure: Radiation exposure occurs when a person is near a radiation source. Persons exposed to a radiation source do not become radioactive. For example, an x-ray machine is a source of radiation exposure. However, you do not become radioactive when you have an x-ray taken.

Contamination: Radioactive contamination results when loose particles of radioactive material settle on surfaces, skin, or clothing. Internal contamination may result if these loose particles are inhaled, ingested, or lodged in an open wound. Contaminated people are radioactive and should be decontaminated as quickly as possible. However, the level of radioactive contamination is unlikely to cause a health risk to another individual.

RADIATION EXPOSURE AND CONTAMINATION EVENTS

There are four types of radiation accident victims:

1. **A person who has received a significant dose from an external source(s).** This includes an exposure to a large radiation source over a short period of time or exposure to a smaller radioactive source over a longer time frame. Such exposure will cause symptoms that depend on the amount of exposure. This includes nausea, reddening of the skin and fatigue. An extremely high exposure may result in death of the victim. These symptoms may not appear immediately; it may take several days or weeks before symptoms are observed. (See Recognizing Radiation-Related Illnesses) ***Externally exposed patients do not become radioactive and therefore they do not pose a risk to EMS or other first responders. Do not delay medical attention.***

2. **Internal contamination from inhalation and/or ingestion of radioactive material.** Patients are not likely to exhibit any symptoms related to radiological contamination. Internal contamination needs to be assessed and treated in a clinical setting (emergency department). It is extremely unlikely that the level of internal contamination would be sufficient to cause an external exposure hazard from the patient to EMS and other first responders. A person who has inhaled and/or ingested radioactive material is very likely to also have external contamination (see the next item).

3. **External contamination of the body surface and/or clothing by liquids or particles.** Patients are not likely to exhibit any symptoms related to radiological contamination. A person who is externally contaminated is likely to also have internal contamination from breathing contaminated dust/dirt/air. (Internal contamination needs to be assessed and treated in a clinical setting). The amount of radioactive material expected to be on the surface of the victim is not likely to cause a radiation hazard to EMS or any first responder. In most cases, external skin contamination is not life threatening and can be removed with soap and water.

   Use of Standard Precautions will help prevent the spread of contamination to emergency responders. ***Emergency responders should not delay treatment of victims due to fear of becoming contaminated with radioactive materials.*** The victim should be handled in a manner that will reduce the potential spread of contamination to other individuals and medical equipment (e.g., stretcher, ambulance).

External contamination is likely in the situation with a radiological dispersal device – a so-called "dirty bomb." In a dirty bomb event, the major hazard to health and safety is the explosion itself and/or injury from shrapnel. An exception would be when a fragment of a high activity radiation source pierces the victim. In that situation, an external exposure hazard may exist.

4. **A combination of the above.** In this situation, using the guidance for external contamination is warranted.

PRECAUTIONS

Contamination: STANDARD PRECAUTIONS should be used in any situation where the presence of radioactive materials is suspected. Persons entering a radiological area, sometimes referred to as a "Hot Zone", may be directed to wear overshoes and a dust mask. Rescuers (i.e., fire department) should move victims out of the hazard area (for example a fire, compromised structure or vehicle) to a location where EMS can attend to the victim's medical needs.

External Radiation Exposure: The three cardinal rules of radiation protection for external radiation exposure (not contamination) from a radiation source are time, distance and shielding.

- **TIME** – The less time you spend near the radiation source, the lower your exposure will be.
- **DISTANCE** – The greater your distance from the source, the less your exposure will be. Radiation exposure decreases with distance according to the inverse-square law. That is, if you triple your distance from the radiation source, your exposure will decrease by a factor of 9 (three squared).
- **SHIELDING** – External exposure to radiation can be partially blocked by the use of shielding. Traditionally, shielding is made of lead or concrete. However, staying behind vehicles, buildings, or other objects will also decrease exposure.

HEALTH AND SAFETY RISK

It is important to understand that a person who has been exposed to radiation is unlikely to pose a radiological health risk to any other person. However, if a relatively high activity gamma source (external exposure) is present at the emergency site, it is possible for an individual to receive a radiation dose that could pose a health risk. It is anticipated that hazardous materials (HAZMAT) personnel will have made an initial radiological assessment, and specific safety precautions will be given.

RADIOLOGICAL ASSESSMENT

First responders, fire fighters, or HAZMAT, may have performed an initial assessment or screening for the involvement of radioactive materials. Ask the incident commander (IC), or fire/HAZMAT Chief, if radioactive materials have been identified or are suspected. If contamination is identified or suspected, assume that the victim has external contamination.

The IC will likely have set up a "Hot Zone" to limit access to a contaminated area. Responders working in the hot zone should limit their time in this zone to what is necessary to assist victims. The incident commander should position EMS outside of the hot zone so that patient triage/treatment can be done safely. Patients should be decontaminated prior to delivery to EMS, if possible.

RECOGNIZING RADIATION-RELATED ILLNESSES

Determining that someone has been exposed to radiation can be difficult in situations other than catastrophic events (nuclear detonations and severe nuclear power plant accidents). Effects of exposure and/or contamination will not appear immediately following exposure. It can take days or weeks to see symptoms. Some symptoms can be similar to those for chemical exposure.

In most cases, there will be no immediate symptoms of radiation exposure or contamination. The following clinical clues suggest a possible radiological terrorist event:

- The acute radiation syndrome follows a predictable pattern that unfolds over several days or weeks after substantial exposure or catastrophic events. See below for specific symptom clusters.
- Victims may present individually over a longer period of time after exposure to unknown radiation sources.
- Specific symptoms of concern, especially following a 2-3 week period with nausea and vomiting, are:
  - thermal burn-like skin lesions without documented heat exposure;
  - a tendency to bleed (nosebleeds, gingival (gum) bleeding, bruising);
  - hair loss.
- Symptom clusters as delayed effects after radiation exposure:
  - Headache, fatigue, weakness
  - Partial and full thickness skin damage, epilation (hair loss), ulceration
  - Anorexia, nausea, vomiting, diarrhea
  - Reduced levels of white blood cells, bruising, infections

C. MASS TRAUMA

Mass trauma is the term used to describe the injuries, death, disability, and emotional stress caused by a catastrophic event, such as a large-scale natural disaster or a terrorist attack. When mass trauma occurs, CDC helps state and local health departments in responding.

D. BURNS

Mass trauma and disasters such as explosions and fires can cause a variety of serious injuries, including burns. These can include thermal burns, which are caused by contact with flames, hot liquids, hot surfaces, and other sources of high heat as well as chemical burns and electrical burns. It is vital that people understand how to behave safely in mass trauma and fire situations, as well as comprehend basic principles of first aid for burn victims. For burns, immediate care can be lifesaving.

Note: Most victims of fires die from smoke or toxic gases, not from burns (Hall 2001). This guideline covers burn injuries.

E. EXPLOSIONS AND BLAST INJURIES

As the risk of terrorist attacks increases in the US, disaster response personnel must understand the unique path physiology of injuries associated with explosions and must be prepared to assess and treat the people injured by them.

Key Concepts

- Bombs and explosions can cause unique patterns of injury seldom seen outside combat.
- The predominant post explosion injuries among survivors involve standard penetrating and blunt trauma. Blast lung is the most common fatal injury among initial survivors.
- Explosions in confined spaces (mines, buildings, or large vehicles) and/or structural collapse are associated with greater morbidity and mortality.
- Half of all initial casualties will seek medical care over a one-hour period. This can be useful to predict demand for care and resource needs.
- Expect an "upside-down" triage - the most severely injured arrive after the less injured, who bypass EMS triage and go directly to the closest hospitals.

Background

Explosions can produce unique patterns of injury seldom seen outside combat. When they do occur, they have the potential to inflict multi-system life-threatening injuries on many persons simultaneously. The injury patterns following such events are a product of the composition and amount of the materials involved, the surrounding environment, delivery method (if a bomb), the distance between the victim and the blast, and any intervening protective barriers or environmental hazards. Because explosions are relatively infrequent, blast-related injuries can present unique triage, diagnostic, and management challenges to providers of emergency care.

Few U.S. health professionals have experience with explosive-related injuries. Vietnam era physicians are retiring, other armed conflicts have been short-lived, and until this past decade, the U.S. was largely spared of the scourge of mega-terrorist attacks. This primer introduces information relevant to the care of casualties from explosives and blast injuries.

Classification of Explosives

Explosives are categorized as high-order explosives (HE) or low-order explosives (LE). HE produce a defining supersonic over-pressurization shock wave. Examples of HE include TNT, C-4, Semtex, nitroglycerin, dynamite, and ammonium nitrate fuel oil (ANFO). LE create a subsonic explosion and lack HE's over-pressurization wave. Examples of LE include pipe bombs, gunpowder, and most pure petroleum-based bombs such as Molotov cocktails or aircraft improvised as guided missiles. HE and LE cause different injury patterns.

Explosive and incendiary (fire) bombs are further characterized based on their source. "Manufactured"

implies standard military-issued, mass produced, and quality-tested weapons. "Improvised" describes weapons produced in small quantities, or use of a device outside its intended purpose, such as converting a commercial aircraft into a guided missile. Manufactured (military) explosive weapons are exclusively HE-based. Terrorists will use whatever is available – illegally obtained manufactured weapons or improvised explosive devices (also known as "IEDs") that may be composed of HE, LE, or both. Manufactured and improvised bombs cause markedly different injuries.

Blast Injuries

The four basic mechanisms of blast injury are termed as primary, secondary, tertiary, and quaternary (Table 1). "Blast Wave" (primary) refers to the intense over-pressurization impulse created by a detonated HE. Blast injuries are characterized by anatomical and physiological changes from the direct or reflective over-pressurization force impacting the body's surface. The HE "blast wave" (over-pressure component) should be distinguished from "blast wind" (forced super-heated air flow). The latter may be encountered with both HE and LE.

PART III: EVACUATION AND SHELTERING IN PLACE

How You May Be Notified Of A Possible Emergency

- NOAA weather radio.

  These special radios provide the earliest warning with an alarm that will alert you in case of anticipated bad weather. To learn more, call your local National Weather Service office.

- Commercial radio and television stations.

  Know your designed Emergency Alert System stations (EAS).
  My EAS Radio Station is:____________________
  My EAS Television Station:____________________

- Door to door warning from local emergency officials.

A. EVACUATION

First Stop: Reception Center

The emergency management units recommend evacuees stay with friends or family outside evacuation zones when possible. However, for those who have no alternative shelter, the Local Officials will identify Evacuation Shelters.

To ensure the most efficient use of resources and to make necessary parking available, the Officials will ask all evacuees seeking public shelter to report to a Reception Center. These centers are easily reached via public transportation and many provide parking facilities.

Each Reception Center is associated with several evacuation shelters in what is known as its "solar system." i.e. there are currently 23 such systems in NYC, each of which can accommodate between 3,000 and 12,000 people.

Reception Centers help ensure the number of people in each is roughly the same, eliminating potential overcrowding or underutilization of particular facilities. At the Reception Center, evacuees will be assigned to a particular evacuation shelter and be transported by bus or van.

Destination: Evacuation Shelter

Shelters provide for basic needs for those with no other place to go. They are often located in school buildings. Shelters are carefully selected and managed by American Red Cross staff, in conjunction with many other partners assisting with facilities, food services, security, communications, health services and staff support.

Shelters are selected based upon the safety of their location (outside of category-four inundation areas), proximity to Reception Centers. If you have a mobility disability, make sure you notify Red Cross staff to ensure you are transported to an accessible shelter.

No pets are allowed in shelters. The only exception to this rule is for people who rely on trained service animals. If you must take refuge in an Evacuation Shelter, you will have to make alternative arrangements for your family pets.

Officials will notify evacuees when and if it is safe to return to their homes

Evacuation Instructions

Evacuation Order: Instructs residents of specified zones or communities to leave their homes for the protection of their health and welfare.

Evacuation Recommendation: Suggests that certain residents take steps to evacuate voluntarily. A recommendation might be issued to cover residents of certain zones, communities or building types. An evacuation recommendation could also be issued for the benefit of people with mobility challenges who need extra time to take precautionary measures in a coastal storm.

In such an instance, residents affected by the instructions would be asked to complete their evacuation tasks well before weather conditions begin to deteriorate.

How to Evacuate

It is critical that evacuees leave their specified evacuation zones as soon as possible after evacuation instructions are issued. Evacuees are encouraged to seek shelter with friends or family or outside evacuation zones when possible.

To avoid being trapped by flooded roads, washed-out bridges or disruptions to mass transportation, evacuees should plan their mode of transportation with special care.

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- In a coastal storm, **plan to use mass transit as much as possible**, as it offers the fastest way to reach your destination. Using mass transit reduces the volume of evacuees on the roadways, reducing the risk of dangerous and time-consuming traffic delays.

- **Listen carefully to your local news media**, which will broadcast reports about weather and transportation conditions.

- **Evacuations from at-risk zones will be "phased,"** encouraging coastal residents to leave their homes before inland residents do.

- **Leave early**. Evacuations will need to be completed before winds and flooding become a threat, because wind and heavy rain could force the early closure of key transportation routes, like bridges and tunnels.

If you must go to a Reception Center, it is important to carefully select what you take with you. Do not bring more than you can carry, but be sure to bring your Go Bag with you in the event of an evacuation. This should include a small supply of food, water and blankets, if possible

B. SHELTER IN PLACE

In a chemical emergency, you may be told to shelter in place. This means staying where you are and making yourself as safe as possible until the emergency passes or you are told to evacuate.

In this situation it is safer to remain indoors than to go outside where the air is unsafe to breathe.

Keep enough supplies in your home to survive on your own for at least three days. If possible, keep these materials in an easily accessible, separate container or special cupboard. You should indicate to your household members that these supplies are for emergencies only.

- One gallon of drinking water per person per day
- Non-perishable, ready-to-eat canned foods and manual can opener
- First-aid kit, medications and prescriptions
- Flashlight, battery-operated AM/FM radio and extra batteries
- Whistle
- One quart of unscented bleach or iodine tablets (for disinfecting water ONLY if directed to do so by health officials) and eyedropper (for adding bleach to water)
- Personal hygiene items: soap, feminine hygiene products, toothbrush and toothpaste, etc.
- Sturdy shoes, heavy gloves, warm clothes, a mylar blanket and lightweight raingear
- Extra fire extinguisher, smoke detectors, carbon monoxide detectors
- Child care supplies or other special care items
- Other supplies and tools

If Told To Shelter In Place

- Close all windows.
- Turn off all fans, heating, and air conditioning systems.
- Close the fireplace damper.

- Go to an above-ground room (not the basement) with the fewest windows and doors.
- Take your Disaster Supplies Kit with you.
- Wet some towels and jam them in the crack under the doors. Tape around doors, windows, exhaust fans or vents. Use plastic garbage bags to cover windows, outlets and heat registers.
- If told there is danger of explosion, close the window shades, blinds or curtains. To avoid injury, stay away from the windows.
- Stay in the room and listen to your radio until told all is safe or told to evacuate.

PART IV: STAFF ORIENTATION AND EDUCATION

All agency staff are oriented to the Agency's Emergency Preparedness Plans with the following to be addressed with each employee:

1. Specific roles and responsibilities during emergencies:
2. The information and skills required to perform duties during emergencies;
3. Infection Control Plan
4. The backup communication system used during disasters and emergencies and
5. How supplies and equipment are obtained during disasters or emergencies.

As part of orientation, the DPS or designee educates all caregivers regarding the agency's disaster response process, their own obligations to the agency and its patients during a disaster, and are instructed regarding agency specific processes.

- To call the agency immediately to report circumstances affecting safety and well being of the patient and employee.
- To call the agency immediately after hearing sirens or radio notification of weather or civil emergency.
- To participate in telephone triage, as assigned.
- To stay away from disaster areas, i.e., to make no visits to patients in a disaster area and await communication from the supervisor/coordinator.
- On an on-going basis, caregivers are informed as to the disaster plans made by DPS or designee and on behalf of their dependent patients.

EXPECTATIONS FOR DEPARTMENTS AND STAFF

Expectations of staff are:

1. Be familiar with and follows the Emergency Preparedness Plan.
2. Participate in drills and training sessions as required. Walk over your primary and secondary evacuation routes at least once to familiarize yourself with emergency exits and shelter areas.

3. Know where hazardous conditions or situations in your area may exist. Knows the location of flammable, radioactive, biological, and other hazardous materials.

4. Know where the fire alarm pull stations are located and knows HOW to turn them on.

5. Know where fire extinguishers are located in your building and how to use them.

6. Know the different alarm sounds and how to respond accordingly.

7. Know where the first aid kits are located in your building.

TERRORISM: RISK ASSESSMENT

Annually the agency's CQI/PI Committee/Safety Committee will assess the Agency's risk/treat level with regard to terrorist attacks. The following questions will be addressed:

1. Is the agency /organization the target of a particular group or do you receive specific threats? Is your agency a landmark or located in a "signature" tourist attraction?
2. Is your organization synonymous with American or New York culture/government or religious affiliations?
3. Are any of your employees or managers high profile individuals i.e. clergy, politician?
4. Does your agency, or the building in which your agency is located, house any important data, valuable art, valuable products, sensitive information, or raw material that is urgently wanted by an individual or group?
5. Does your agency have a high traffic volume? Is that traffic volume primarily comprised of non-employees, visitors, delivery people?
6. Is there a agency, organization, individual, or agency within your building or in close proximity to your agency that would answer yes to any of the before-mentioned questions?
7. Does your building have a commercial parking garage?
8. Where in the building is the parking garage located?
9. What level security is there at the parking garage?
10. Does your building have a loading dock?
11. Where is the dock located and is there adequate security at the dock?
12. Does your building have a central entrance or multiple entrances?
13. Who has access to the building and under what level of security?
14. What are the physical attributes of your building?
15. Is it old or new?
16. Out of which materials is it built?
17. How much glass is in the building?
18. How tall is the building?
19. How wide is the entrance?
20. What type of doors/windows does the first level of your building have?
21. Is it close to other buildings?
22. What is the proximity of your building to the roads?
23. What are the traffic patterns and traffic regulations around your building?

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24. Are there parking spaces outside your building and when can they be accessed and by what types of vehicles?
25. Are there any secure barriers, Jersey barriers or steel/concrete bollards, along the perimeter of your building to prevent a vehicle from driving into or closer to your building?
26. Does a subway line run under or adjacent to your building?
27. Are there any other tunnels or major utility lines that run under or close to your building's foundation?
28. Are there mailboxes, trashcans, and newspaper boxes outside your building?
29. Are the areas around your building well lit at night?
30. Do you have closed circuit television cameras monitoring inside and outside your building?
31. Does someone monitor this coverage?
32. Are there street vendors outside your building?
33. If so, do the street vendors have permits and if so, are they stationed where they are relegated to be stationed?
34. Do the street vendors have trucks with them or large mobile carts or boxes of goods?
35. Does your building have roof access?
36. Who has access to the roof?
37. How reinforced is the access?
38. Is the roof patrolled on a regular basis?
39. Who works the security in your building if any?
40. Have security personnel undergone background checks?
41. Have other employees and maintenance personnel undergone background checks?
42. Do all visitors to your building have to check in, and show ID?
43. Are they positively matched with a person and destination?
44. What is the access control at the entrance of your building?
45. Do you have a metal detector?
46. Do you scan your visitor's and employee's bags?
47. Who has access to the infrastructure of your building, i.e. the boiler room, the ventilation system, the electrical system, the water supply, elevator bays and freight elevator.
48. How often is your emergency/security notification system checked and who maintains them?
49. Is everyone working in your building required to wear identification (badges or uniform) at all times?
50. Who makes your identification badges?
51. What security features if any are incorporated into the badges?
52. What is the international climate?
53. What terrorist campaigns are currently being waged at home and abroad?

If you are a commercial landlord, in addition to the previous questions:

1. Are you familiar with all of your tenants?
2. If the space in question is commercial, are you familiar with all of your tenants and their business?
3. It is essential to evaluate the potential type of attack your business, agency, and employees may face. It is also critical to assess what your business or agency can do to decrease the likelihood of an attack and reduce the injury and destruction a possible attack could have on your staff and agency.

4. After reviewing what threats your organization, agency, and staff may face, it is important to take measures to improve security and reduce the threats to your property and people. It is also essential that you establish an emergency plan, make sure your staff is familiar with this plan, and practice the plan.
5. First, not all agencies will require the same approach to security. The needs of a small home care agency will be very different from the needs of a large organization's head quarters. Steps that can be taken to improve security at your agency thus making it more difficult to attack and rendering attacks less injurious and destructive are as follows, but are not limited to:

Outside the agency

i) **Traffic**

Be aware of the traffic patterns and restrictions on the streets surrounding your building. Be aware of taxi, bus, limo, etc. drop-off and pick-up points.

ii) **Lighting**

Review existing interior and exterior lighting systems. Ensure that exterior doors, ground floor windows, and garages/loading docks are all well lit. Ensure that you have a backup lighting system and your system's wiring is protected.

iii) **Sidewalks**

If appropriate, research the cost, feasibility, and benefit of installing jersey barriers, bollards, or removable bollards to prevent vehicles from driving up onto the sidewalk around your agency.

Research the options and alternatives for different types of trash cans, mail boxes, and newspaper/newsletter distribution boxes for the sidewalks outside your agency. Contact your local or city authorities about the possibility of replacing existing structures with the newer, explosive resistant variety? Also, review street furniture and street art and its locations.

Review the existing system of Closed Circuit Television Cameras (CCTV) or consider installing a CCTV system. Conduct a review of what is monitored, by whom, when, etc. to establish if their are security lapses in the existing system.

Be aware of the vendors who operate on your street, ensure that vendors have permits to set up outside your agency. Inform law enforcement personnel about vendors who 'set up shop' illegally.

Enforce good housekeeping - important both outside and inside your agency. Ensure that your agency is free from trash and other un-permitted items. For example, do not allow trash bags to wait on your curb on days other than those designated for trash pickup. Lock cabinets and store rooms when not in use. Only provide access to appropriate personnel when needed.

Assess landscaping around your agency. Are there any plantings that diminish the security of your agency? For example, is there a tree close to the building that someone could climb to gain access to the roof or upper windows?

Inside the agency

i) **Entrances**

Examine the quality and strength of your doors and entrances. Frame construction, hinges, locks, etc should all be inspected.

Examine other openings to the agency; gates, skylights, manholes, roof hatches, ventilators or shafts, sidewalk gates, etc.

Make sure locks are master-keyed, have interchangeable cores, are maintained, and changed when appropriate.

ii) **Windows**

All windows should have appropriate security devices, such as locks and bars, especially on the lower floors of the building or the floor reached by other means.

Glaze your agency's windows - the majority of casualties caused by terrorist attacks have resulted from flying glass caused by bombings. Windows can be replaced with specially designed windows or for a smaller cost, anti-shatter film or net curtains can be added to existing widows to reduce the effects of an explosion on glass.

iii) **Entrances**

Streamline entrance to your agency through a couple of well monitored entrances. Place your security apparatus at the greatest perimeter possible, if that be outside or right when you come into the lobby.

Implement increased security at your facilities entrances. Strengthen identification systems for employees and visitors. Use picture identification or facial imaging systems. Do not allow personnel without proper identification into the building.

Match visitors to those they are visiting. Do not allow visitors into the building without identification, confirmation of their destination within your agency, and escort by the individual who they are visiting.

Distinguish between public and private areas within your agency and provide appropriate levels of security controls respectively.

iv) **Elevators/Stairs**

Implement controls and/or surveillance over elevators and stairwells especially in off hours.

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v) **Alarms**

If appropriate, consider installing radiation and/or chemical agent detection machines. Consider placing monitors in your ventilation and water intake systems. If feasible, consider having these detection devices hooked up directly to your security apparatus and perhaps to your local health and law enforcement departments.

Ensure that your other alarm systems are functioning on a regular basis. Create specific alerts for specific attack scenarios.

vi) **Communication Systems**

Ensure that only cleared personnel have access to your agency's communications systems and make sure these systems are well protected.

vii) **Security Personnel**

Security personnel should be posted at all entrances.

Make sure all security personnel are well informed about security policies. Review security personnel performance to ensure that all personnel are strictly enforcing security policies. Run background checks on security personnel as well as maintenance, cleaning, and other service personnel.

Make sure security personnel keep accurate logs.

viii) **Delivery Depots**

Consider accepting truck parcel drop offs only from established carriers with good security records. Consider requiring badge identification from delivery personnel prior to allowing their truck into your depot.

Make sure that the Delivery depot, private and public parking facilities are not adjacent to critical building systems.

Inspect parcels to ensure that they have not been tampered with.

ix) **Garages**

Private and Public garages should have attendants at the entrances at all times. Private garages should require identification and proof of access to the agency by each vehicle. Public garages should have attendants who check each vehicle prior at the entrance. Under the car, the trunk, and the other areas of the vehicle should be checked thoroughly. Suspicious behavior should be reported and suspicious individuals should be reported to law enforcement and not allowed to park at the agency.

x) **Personnel**

Create a system of clearances that ensures that only approved individuals have access to secure areas.

If you observe something suspicious, notify your local police!

New York City Areas at Risk

Communities most at risk of coastal flooding include:

Bronx: Edgewater Park, Silver Beach, Locust Point, Classon Point and Throggs Neck

Brooklyn: Coney Island, Brighton Beach, Manhattan Beach and Sheepshead Bay

Manhattan:

- Lower Manhattan — Battery Park City and South Street Seaport area
- Lower West Side — Battery Park to Midtown
- East Side — Entire FDR Drive
- Lower East Side — East of Avenue C, East 14th Street to Houston Street

Queens: Rockaway Peninsula, Broad Channel, Howard Beach and West Hamilton Beach

Staten Island: New Dorp Beach, Oakwood Beach, Foxwood Beach, Great Kills and Tottenville

Resources

Links

The American Red Cross National Headquarters
www.redcross.org
Americares Foundation
www.americares.org
The American Veterinary Medical Association (AVMA) Veterinary Medical Assistance Team (VMAT) Program: Animal disaster preparedness and response
www.avma.org/disaster/vmat/
Centers for Disease Control and Prevention
www.cdc.gov
National Immunization Hotline: 800-232-2522
www.cdc.gov/nip
Public Health Emergency Preparedness and Response
www.bt.cdc.gov
Center for the Study of Bio-terrorism and Emerging Infections, St. Louis University
www.bioterrorism.slu.edu
The Disaster Center
www.disastercenter.com
Disaster Relief
www.disasterrelief.org
Environmental Protection Agency (EPA)
www.epa.gov/swercepp
Federal Bureau of Investigation (FBI)
www.fbi.gov
Federal Disaster Medical Assistance Teams (DMATs)
www.ndms.dhhs.gov/dmat.html
Federal Emergency Management Agency (FEMA)
www.fema.gov
Food Safety and Inspection Service (FSIS)
www.fsis.usda.gov
Greater New York Hospital Association
www.gnyha.org
www.gnyha.org/eprc/ (Resource Center)
Hospital Association of New York State
www.hanys.org
Metropolitan Medical Response System (MMRS)
www.mmrs.fema.gov
National Disaster Medical System (NDMS)
www.ndms.dhhs.gov
National Institute of Health (Research Facility Only)
www.nih.gov
National Pharmaceutical Stockpile (NPS) Part of the CDC
www.bt.cdc.gov/stockpile
New York City Office of Emergency Management
www.nyc.gov/html/oem

New York State Office of Public Security
www.state.ny.us/security
The Salvation Army
www.salvationarmy.org
The Survival Guide: What to Do in a Biological, Chemical, or Nuclear Emergency
www.911guide.com
U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID)
www.usamriid.army.mil
U.S. Department of Health and Human Services
www.hhs.gov
U.S. Department of Homeland Security
www.dhs.gov
U.S. Department of State
www.state.gov
U.S. Department of Transportation
www.dot.gov
U.S. Food and Drug Administration (FDA)
www.fda.gov
www.fda.gov/oc/opacom/hottopics/bioterrorism.html
U.S. Nuclear Regulatory Commission, List of NYS Nuclear Power Plants
www.nrc.gov/info-finder/region-state/newyork.html
The White House, Office National Security
www.whitehouse.gov/response
www.whitehouse.gov/homeland
The World Health Organization
www.who.int

XI. Regional Resource Centers
Regional Resource Center (RRC) information is current as of August 2003. Contact with an agencys RRC should be made as possible. The home health care agency should ask to be kept updated if a RRC contact person changes.

Buffalo
Erie County Medical Center
Jerry Olszewski - (716) 898-4295

Rochester
Strong Memorial Hospital
Kathy Parrinello - (585) 275-4605

Syracuse
SUNY Upstate Medical Center
Kathy Same - (315) 464-4180

Albany
Albany Medical Center
Mary J. LaPosta at (518) 262-3760

Plattsburgh
Champlain Valley Physicians Medical Center
Ed Lydon - (518) 562-7449
Westchester
Westchester Medical Center
Ted Tully - (914) 493-8250
Northshore University Hospital
Mark Solazzo â?? (516) 465-8021
Stonybrook University Hospital
Dr.Susan Donelan / Simminate Ennever - (631) 689-8333

EMERGENCY AND DISASTER RESOURCES: NYC OFFICE OF EMERGENCY MANAGEMENT-NYC.GOV

OEM Briefing Document (in PDF)
This document provides an overview of the Office of Emergency Management (OEM). It contains sections on the agency's history, its mission, its organization, key activities and partnerships.

NYC Hazard Overview (in PDF)
The Hazard Overview provides general information on the hazards that may affect the City and their potential impacts.

Ready New York Household Preparedness Guide (in PDF)
Learn more about how you can better prepare for emergencies. Our guide is built on three guiding principles — what to have in your hand (a Go Bag), what to have in your home (an Emergency Supply Kit), what to have in your head (a Household Disaster Plan).

- English (in PDF)
- Arabic (in PDF)
- Chinese Traditional (in PDF)
- Chinese Simplified (in PDF)
- Haitian Creole (in PDF)
- Korean (in PDF)
- Polish (in PDF)
- Russian (in PDF)
- Spanish (in PDF)

Ready New York: Hurricanes and New York City (in PDF)
Download the 2004 Ready New York: Hurricanes and New York City brochure and review the companion Hurricane Evacuation Zones map today to learn more about how Hurricanes and New York City is available in five languages:

English	Español	Kreyòl Ayisyen	中文(繁體)	Русский
brochure	brochure	brochure	brochure	brochure
map	map	map	map	map

Ready New York: Beat the Heat
Learn how to prepare for hot weather in New York City.
Beat the Heat is available in six languages (in PDF):

English 中文(繁體) Kreyòl Ayisyen 한국어 Русский Español

Ready New York for Seniors & People with Disabilities
Learn how to address the added challenges emergencies can present for seniors and people with disabilities living in New York City.
Ready New York for Seniors & People with Disabilities is available in four languages (in PDF):

English Español 中文(繁體) Русский

Pet Preparedness (in PDF)
Learn how to ensure your pet's safety during an emergency.

Emergency Online Locator System (EMOLS)
A tool developed by OEM to allow NYC residents to determine whether they are in an evacuation zone, or to find the nearest cooling center at times of emergency.

Nannies for Grannies, Inc.
POLICY AND PROCEDURE MANUAL

EMERGENCY MANAGEMENT AND DISASTER PREPAREDNESS PLAN

POLICY VII-18

INTRODUCTION

NANNIES FOR GRANNIES, INC. has developed and maintains an agency-wide emergency and disaster preparedness plan (EDPP) that incorporates patient/support systems, agency, community resources and local, state and federal government agencies that will enhance the agency's ability to continue to meet our patients' health care needs in emergency situations.

- The Agency is a member of the NYS Department of Health's "HPN" (Health Provider Network) and maintains a minimum of 2 staff members as HPN Coordinators.

- The EDPP includes the identification of a 24/7 emergency contact telephone number and email address of the agency's emergency contact person and alternate on the agency's Call-Down List as well as on the Communications Directory of the HPN. The EDPP can also be activated after business hours, on holidays and weekends through the agency's On-Call Process.

- A list of community resources, (Community Partners) are maintained with which the agency collaborates and participates in planning efforts, as appropriate.

- Maintains a current HPN Policy (See Policy VII-18.5)

- A current roster of active patient's is maintained and updated daily and contains or facilitates rapid identification of patient's at risk:
    - Patient name, address and telephone number
    - Patient Classification Level
    - Identification of patients dependent on electricity to sustain life
    - Emergency contact telephone numbers of family/caregivers (Emergency Kardex)
    - Other specific information identified as critical to first responders (Emergency Kardex)

- The EDPP addresses procedures to requests for information by local emergency and health responders. A release of information consent for EDPP is obtained from each patient at the time of admission. An emergency Kardex is also completed for each patient with a copy left in the home and the original filed in the patient record.

- At least annually, the agency conducts an Internal Readiness Assessment in order to determine if any revisions are necessary for the Emergency and Disaster Policy. This Assessment is conducted by the CQI Committee under the direction of the Administrator.

- All staff are oriented to the agency's EDPP at the time of orientation for new hires and annually. Any changes in the policy are communicated to staff via staff meetings and memo's. Included in the inservice is infection control information regarding surveillance and identification of infections/bioterrorism and proper use of PPE and Infection Control.

- The agency conducts a minimum of 2 agency specific EDP Drills and whenever possible with community-wide disaster drills and exercises. Following each drill, a review of the agency's performance is conducted with revisions in the policy/procedure, as necessary.

EMERGENCY MANAGEMENT AND DISASTER
PREPAREDNESS PLAN

POLICY VII-18

PART I THE PLAN

This Plan and associated materials constitute the Emergency Management and Disaster Preparedness Plan (hereinafter referred to as the "Plan") of NANNIES FOR GRANNIES, INC..

This Plan is to be implemented in the event of a major emergency or disaster and/or as declared by the Agency's Administrator/Director of Patient Services.

Definition.

This Emergency/Disaster Plan shall be activated under the following circumstances:

1. When civil authorities declare a State of Emergency that affects the geographic areas covered by the home care agency, either local, citywide, regional, statewide or national.

2. When the Administrator or designee as per succession guidelines declares an agency Emergency.

3. When an occurrence, potential or actual, seriously disrupts the overall operation of the Agency or threatens the health or safety of employees and clients.

Note: Unless otherwise directed by the Administrator, operational management of minor emergencies, i.e., incidents, potential or actual, which do not seriously affect the overall functioning of the Agency, depending upon the nature of the incident, rests with either the DPS and the various Department within the agency in accordance with established protocols.

The purposes of this plan are:

- To protect the lives of staff and clients as well as property of the home care agency during emergencies.
- To preserve the orderly functioning of the Agency's services during emergencies.
- To establish clear lines of authority and communication among Agency Departments and with external constituencies during an emergency.
- To coordinate decision making and effective use of available manpower and resources in the event of an emergency.
- To identify the Agency's role in coordinating emergency operations with outside agencies.

B. EMERGENCY AND DISASTER PREPAREDNESS

1. Have materials/directions available for your patients at admission. Begin preparing and providing education to each patient/family for emergency and disaster preparedness at the time of admission and provide ongoing education i.e. supplies, maintaining sufficient medication by renewing prescriptions timely, etc. Each patient will need to be reviewed individually with respect to information and supplies specific to their condition and circumstance.

2. Participation in the NYS DOH HPN System. (See Policy VII-18.5)

C. EMERGENCY PLAN ACTIVATION

Unless otherwise directed by the Administrator, operational management of minor emergencies, i.e., incidents, potential or actual, which do not seriously affect the overall functioning of the Agency, depending upon the nature of the incident, rests with either the Director of Patient Services/Managerial Staff in consultation with related department heads and in accordance with established protocols.

Types of emergencies and disasters covered by the Emergency/Disaster Plan include but are not limited to:

I. Natural Causes:

- Tornados
- Earthquakes
- Ice Storm
- Severe Winter Storm
- Hurricanes
- Floods
- Communicable diseases

II. Accidental Causes:

- Fires (chemical, natural gas, electrical or ordinary structural)
- Hazardous chemical accidents or spills (vapor or liquid)
- Transportation accidents (airplane, railroad car, automobile/truck)
- Explosions (compressed gas, containerized liquid or man made)
- Prolonged utility outages (gas, electricity, cooling system, water)
- Building Emergency (Structural damage caused by any emergency)

III. Societal Causes/Terrorism:

- Civil disturbance
- Hostage situation
- Bomb-threats or explosions

- Labor disruptions/strikes
- Violent Crime
- Contamination of air, water or food
- Bioterrorism
- Dirty Bomb/Nuclear

Activation of the Plan

In the case of a perceived Agency emergency and/or disaster occurrence, the Administrator or the DPS or designee will declare if a state of emergency exists and activation of the Plan is in order. If the Agency declares a state of emergency, the first designee reached activates the Communication Tree/Phone Tree. The first designee reached is responsible for maintaining a log of who (on the Emergency Management Committee) has been reached and who has not been reached. All members of the Emergency Management Committee, if reached, must report back to the designee within one half hour of activation of the tree.

Emergency Management Team Contact List –Attachment A (1)

In the case of a State of Emergency declared by civil authorities, all designated emergency personnel should attempt to report for duty and assume their defined roles if permitted by civil authorities, whether or not they have received official notification from the Agency.

Note: The Agency has the right to expect employees to make themselves available for work in the event of an emergency, to report promptly, and to remain as long as is deemed necessary.

Successive Designees for Determination of an Agency Emergency:

1. Administrator
2. Director of Patient Services
3. Department Directors/Supervisors

EMERGENCY MANAGEMENT TEAM

Members of the response team should each be assigned specific roles to avoid duplication of some steps and neglect of others. All team members should be very familiar with the disaster plan and with the recovery techniques; outlined in it. They can in turn train other staff members or volunteers as the need arises.

The chief administrator can play a variety of roles during a disaster but is not generally the head of the team. The administrator should be somewhat detached from the actual provision of services so that he/she can continue to function as the chief administrator of the institution. The administrator will authorize procedures and expenditures and provide cash or a credit card for necessary purchases. He or she will contact insurance companies to find out exactly how the agency is covered in specific cases. If the institution has a legal department, the administrator will stay in touch with it as needed and will also deal with fire and police officials. In the planning stage, the administrator is sometimes the best person to deal with the emergency management

officials. The administrator may also be the one to contact authorities and may contribute information to public relations announcements.

- In each County, there is a county wide disaster preparedness agency which provide emergency planning information. The administrator/designee will participate in county planning for emergencies, as appropriate.
- The American Red Cross also provide assistance in the event of emergencies and disasters such as the designation of emergency shelter and food for temporarily displaced people, the Red Cross can sometimes help with volunteer workers, transportation and other matters.

This plan includes a summary of emergency procedures and will list the proper response to various situations: fire, flooding, medical emergency, bomb threat, vandalism, etc. Police, fire department will be shown in large type. Evacuation directions; are best accompanied by clear floor plans.

Copies of the Emergency plan is posted in various areas of the Agency's office. Diagrams posted point out the location of fire extinguishers, pull boxes, emergency exits and the best routes to them. They are oriented so the person looking at the diagram can tell immediately in what direction to move. The Agency's administration will review the Emergency Plan, related diagrams and instructions at least annually. All staff are provided with emergency and disaster preparedness education at Orientation and at least annually. Staff will be inserviced as soon as any changes or revisions to the Emergency and Disaster Preparedness plan are made.

In the event that an emergency is declared, the Administrator/designee will initiate the notification of the Emergency Management Team. At the earliest possible time, all available members of the Emergency Management Team are to assemble at the Emergency Command Center or, if not accessible, at the Secondary Emergency Command Center. Once assembled, the Director of Patient Services, if present, or a person designated by the Administrator will assume the responsibility of keeping an accurate log of all actions taken by the Team.

The Emergency Management Team consists of:

Administrator
Director of Patient Services
Agency Operator
Nurse Supervisors
On-Call Staff
Field Nurses
Office Manager
Supervisor of Coordinators/Schedulers
Coordinators/Schedulers
Representatives of the other agency department, as appropriate, i.e. HR, finance etc.

In addition, the Administrator's Administrative Assistant will be contacted along with the Emergency Management Team, and will provide administrative assistance to the Committee.

COMMUNICATION PLAN

Communicating effective alerts/warnings as well as conveying what is happening throughout an emergency results in a more effective protection of staff and clients, can reduce damage and risk and improves response and recovery following the emergency.

Various methods of communication will be utilized based on the specific circumstances presented by the Emergency/Disaster situation. Communication resources will include:

A. NYS DOE HPN
B. E-mail /Web site communications
C. Voice Mail
D. Designated contacts/runners in geographic locations
E. Cell Phones
F. Staff verbal relay in situations where face to face contact can occur, i.e. field supervision, cluster care situations.

1. Alternate telephones will be used (payphones, cellular phones) as necessary. Alliance Home Services, Inc. maintains cellular phones for each office/on-call;
2. The office's answering service will be used to triage important messages;
3. If the office telephone service is not working, operations will be maintained out the answering service or as appropriate of the DPS's home or if available a branch office.
4. All high risk patient will be contacted to make sure service is being provided;
5. Nurses are directed to keep in contact with their patients and the DPS using alternate phones.
6. The DPS monitors the situation, keeping contact with the Telephone Company and notifies the appropriate personnel when the problem is resolved.

The agency maintains a "Phone Tree" that will be implemented in extreme circumstances to convey information that cannot be communicated in normal business communication methods. The determination to implement the phone tree will be made by the Agency's Administrator and in the Administrator's absence, by the Director of Patient Services.

1. If the Phone Tree is implemented during regular business hours between 8AM and 6 PM, the Administrator/DPS will direct the management staff/coordinators to initiate the appropriate, pre-planned communication procedure.
2. If the Phone Tree needs to be implemented after normal business hours, the On-Call staff will contact the Administrator/DPS to discuss the contents of the message that needs to be communicated.

IMPLEMENTATION OF THE EMERGENCY RESPONSE PLAN

The Administrator/designee has the responsibility to decide if the emergency response plan is to be activated, including the establishment of the Emergency Command Center, the recall of office

employees (Office Manager, Coordinator) to the Agency during non-work hours, and the identification and recall of other employees (Field Nurse Supervisors, Professional Staff) who could assist in the emergency response effort.

If the emergency occurs during non-office hours, the individual(s) assuming the most responsibility will be in the following descending order.

1. Administrator
2. Director of Patient Services
3. Nurse On-Call
4. Coordinator/Scheduler On-Call

The first member of the Emergency Management Team to arrive at the Agency assumes responsibility for directing activities until the Administrator/designee or a supervisor arrives. Alternates or staff will report to the Team member and/or senior supervisor on the scene. Once notification of the Administrator/ designee has occurred, full responsibility for directing Agency efforts rests with the Administrator/ designee.

EMERGENCY COMMAND CENTERS

The primary Emergency Command Center is located:

34 Sunset Lane, Patchogue, New York 11772

In the event that the primary site is inaccessible, a secondary Emergency Command Center is located:

To Be Determined

Emergency Command Centers may include the agency's office, a branch office, a private home, rental space etc. and will be determined based on the actual type of emergency, the geographic areas involved and activities of the local county/city emergency management personnel.

In the event that the Agency's offices are not accessible, Emergency Management Team members will be directed to a designated location.

EMERGENCY MANAGEMENT AND DISASTER
PREPAREDNESS PLAN

Both Primary and Secondary Emergency Command Centers will include:

Copies of the Emergency Management Plan
Access to phones
Access to a computer (w/email and internet access)
Access to radio and television
Fax Machine
Lights and/or Emergency Generator

EMERGENCY EQUIPMENT

Stored at the primary and secondary site (stored in a carry all bag by the on-call/designated individual) are the following materials:

Battery Operated Lighting
Emergency Medical Equipment Bag
First Aid Kit
Sign-Making Material
Tape/Tacks/Rope
PPE (gloves, mask, gowns/aprons)

OPERATIONS PLAN PRIORITIES

1. ***General***. The Emergency Management Team will, upon assembly:

   a. Assess the situation
   b. Determine resources needed to address the emergency
   c. Determine resources available to address the emergency
   d. Issue staff assignments
   e. Establish necessary communication with outside agencies and civil authorities
   f. Monitor progress and continue assessment
   g. When appropriate, declare end of emergency status
   h. Designate one of its members as keeper of a Log of Events/Actions. This person will normally be the Office Manager/Designee.

2. ***Priority Goals***. The essential goals of the Emergency Management Team will be, in order:

   1. Preservation of human life and welfare
      a. Establish emergency communications.
      b. Assess damage, injuries, and location of major problems.
      c. Evacuate affected locations pending additional assessment.
      d. Isolate dangerous areas until judged safe for reentry.
      e. Establish medical triage and first aid areas and transport seriously injured to medical facilities if necessary.
      f. Repair utilities and lifelines to prevent further life/safety hazards.
      g. Identify and Rescue persons trapped in damaged facilities.
      h. Control secondary hazards.

2. Preservation of human health and safety
    a. Communicate critical information and instructions to staff, clients and families.
    b. Communicate with Emergency Management Personnel re: Shelters/Services.
    c. Monitor appropriate sources for information and updates (health departments, CDC, faxes, emails)
    d. Stress wearing of ID badges.
    e. Track status of all injured and missing personnel.
    f. Restore telecommunications systems as soon as possible.
    g. Assess local transportation conditions and advise staff regarding viable routes.
    h. Secure closed facilities.
    i. Begin documentation of damages.

3. Protection of Agency property and, where possible, personal property
    a. Initiate Data Recovery Plans.
    b. Identify and secure valuable Agency Records, Reports, materials.
    c. Normalize flow of staff assignments, supplies and equipment.
    d. Provide psychological and personal assistance to staff, clients/families and others impacted by the event.
    e. Re-allocate administrative operating space, if necessary.
    f. Provide space to external agencies, if necessary and possible.

4. Maintain the ability to provide agency care and services to clients in their homes. These activities are to be maintained on a regular basis as the agency should be able to respond to an emergency within minutes.
    a. Maintain current, up-to-date patient roster with each patient's level of acuity/priority code.
    b. Review staffing patterns (vacations, holiday time)
    c. Keep all cell phones and pagers fully charged at all times.
    d. Staff are encouraged to keep vehicle gas tanks at ½ to full at all times.
    e. Stress use of PPE.
    f. Stress proper infection control procedures and how to identify a biological event in the community.
    g. Identify any uncovered cases, notify emergency personnel re: patient issues i.e. equipment, oxygen, medications etc.
    h. Provide supervision to all client care staff via home visit, if possible, telephone, assigned team leaders.

5. Respond to external community needs.

    a. Assist Emergency Management Personnel as requested i.e. staffing shelters, providing services to uncovered cases of other agencies, etc.

RESPONSIBILITIES

Under a declared emergency, the Emergency Management Team will assign responsibilities to operating staff. Staff may be directed to suspend day-to-day operations that do not contribute directly patient care or to emergency management. Individuals not in specified emergency areas, may be temporarily reassigned to assist in emergency operations.

EMERGENCY MANAGEMENT AND DISASTER
PREPAREDNESS PLAN

Job assignments , this defines the specific responsibilities expected to be assumed by assigned personnel:

(1) Maintain communication with;

- Local public safety agencies.
- Utility providers to coordinate continuation of services.
- Fire protection services to assist in their operations

(2) Request initial fire protection services, rescue operations and emergency medical services and provide assistance to them in obtaining access to emergency sites.
(3) Provide and/or coordinate protection for life and property at emergency and related sites.
(4) Provide emergency access to the office for administrative staff.
(5) Provide or coordinate transportation service, Direct services restorations, cleanup operations.
(6) Compile and submit reports required by federal or state law, regarding hazardous materials.
(7) Provide health and safety assessments to the Emergency Management Team.
(8) Identify, evaluate and monitor the presence of hazardous materials and other public health hazards.
(9) Act as site liaison with regulatory agencies as necessary.
(10)Assure the integrity of the telecommunications infrastructure and data systems and implement data disaster recovery plan.
(11)Provide Emergency Management Team with evaluation and assessment of communications and data retrieval capabilities.
(12)Manage all client services.
(13)Provide information and communication to staff, clients/families If necessary, establish and maintain, with the assistance of authorities, if necessary, appropriate, restricted "press areas" to provide regular information updates to the media.
(14)In consultation with the Emergency Management Team, coordinate and provide information to the media.

NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

POSITION DESCRIPTION

POSITION: Home Health Aide

REPORTS TO: Nurse

POSITION SUMMARY:

A Home Health Aide is an individual who provides personal care, home management and other related home health supportive services in order to assist the individual to continue living in their home environment when there are disruptions due to illness, disability, social disadvantage or other problems in the home. The Home Health Aide is under the direct supervision of the licensed nurse. The HHA provides care in accordance with the DOH Matrix: Permissible and Non-Permissible Activities: HHA Services.

QUALIFICATIONS:

Successful completion of a New York State Department of Health approved Home Health Aide training program as demonstrated by a valid Home Health Aide Certificate.

- Ability to speak, read and write in English sufficiently to understand and interpret the HHA Plan of Care, document care provided on the HHA Time and Activity report and able to call agency to report change and/or issues related to the patient and/or 911 in case of an emergency.
- Ability to add and subtract two digit numbers and to multiply and divide with 10's and 100's. Ability to perform these operations using units of American money and weight measurement, volume and distance.
- Holds a valid Home Health Aide Certificate.
- Ability to apply common sense understanding to carry out simple one or two step instructions. Ability to deal with standardized situations with only occasional or no variables.

CONTACT:

Most frequent contact:	Nature or Purpose:
Patients/Patient families;	Provide care and service
agency staff (coordinator, nurse)	Receive supervision, development of POC

EQUIPMENT OPERATION:

Walker, Cane, Crutches, Wheelchair, Commode, Hospital Bed, Hoyer Lift, Household appliances (i.e. vacuum, refrigerator, stove, blender, toaster, etc.)

SPECIFIC DUTIES AND RESPONSIBILITIES: In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if: (1) the position exists to perform that duty; (2) it requires specialized skills and/or expertise; (3) it can only be performed by a limited number of available employees.

ADA	DUTIES / RESPONSIBILITIES
X	Preparing and serving normal/therapeutic diets. Assisting patient with eating, monitors intake.
X	Assisting with bathing of patient - in bed, tub and shower
X	Assisting with grooming, care of hair, including shampoo, shaving with electric razor only, and ordinary care of nails - this means soaking and filing nails.
X	Assisting with care of teeth and mouth.
X	Assisting patient on and off bedpan, commode and toilet.
X	Assisting patient in transferring from bed to chair, to wheelchair and in walking with or without devices.
X	Assisting patient with dressing
X	Assisting patient with self-administered, oral medications that have been ordered by the medical practitioner.
X	Taking temperature, pulse and respiration as directed
X	Use of special equipment i.e. hoyer lift.
X	Assisting, as instructed with a home exercise program including passive range of motion, turning and positioning.
X	Reporting any change in patient's mental and physical condition or home situation to the nurse.
X	Making and changing bed/linens
X	Dusting and vacuuming the rooms the patient uses.
X	Tidying kitchen, dishwashing
X	Tidying bedroom
X	Tidying bathroom
X	Patient's personal laundry; this may include necessary ironing and mending.
X	Provides a supportive environment and ongoing reality orientation to confused patients using appropriate interpersonal behavioral techniques.
X	Assists with self-administered medications.
X	Take and record temperature, pulse, respiration.
X	Measure and record Intake and Output
X	Reinforce sterile dressing.
X	Empty urinary or ostomy bag
X	Cleanse catheter insertion site.
X	Administer special skin care as directed
X	Collect stool, sputum and urine specimens using appropriate techniques
X	**FUNCTIONS PERMISSIBLE FOR HOME HEALTH AIDES UNDER SPECIAL CIRCUMSTANCES:** If no family member is present or capable of providing care for a specific patient, the nurse may with the approval of the physician, teach and closely supervise the Aide in the following procedures:
	FUNCTIONS PERMISSIBLE UNDER SPECIAL CIRCUMSTANCES: (continued)
X	Assist with changes of colostomy bag
X	Reinforce dressing and change simple non-sterile dressing.
X	Assist with the use of devices geared to disability to aid in daily living
X	Assist patient with prescribed exercises which the Home Health Aide has been taught by appropriate professional personnel.
X	Apply prescribed ice cap or ice collar.
X	Perform simple urine test for sugar, acetone or albumen and record results
X	Perform functions allowable as per : NYS DOH Approved Scope of Practice

THE HOME HEALTH AIDE WILL NOT PERFORM THESE FUNCTIONS UNDER ANY CIRCUMSTANCES:

1. Foley catheter irrigation.
2. Apply a sterile dressing.
3. Give enemas or remove impactions.
4. Perform gastric lavage or gavage.
5. Applications of heat in any form.

CUSTOMER SERVICE/INTERPERSONAL SKILL

1. Assists other employees where needed;
2. Is responsible and cooperative with patients/families, supervisors, fellow employees;
3. Maintains friendly working atmosphere;
4. Maintains appropriate attitude;
5. Maintains appropriate appearance;
6. Accepts constructive criticism as evidenced by appropriate changes in behavior.
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals;
9. Recognizes limitations and seeks assistance appropriately.

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Ability to apply prostetic devices;
2. Ability to take and record TPR and measure I&O;
3. Ability to reinforce sterile dressing and change non-sterile dressing;
4. Ability to follow the instructions related to exercise and positioning;'
5. Ability to safely use the hoyer lift;
6. Ability to care for urinary, ostomy and foley catheters;
7. Ability to apply warm or cold compress, ace bandage and elastic stockings.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. Check one physical requirement which applies to this position:

MEDIUM WORK: Exerting up to 50 pounds of force occasionally and/or up to 20 pounds of force frequently and/or up to 10 pounds of force constantly to move objects.

WORK ENVIRONMENT: Patient's home

Confidentiality Statement:

Agency records are maintained in a safe and secure area with specific access availability to ensure confidentiality. Agency records, files, documents and reports are the exclusive

property of the Agency. Only authorized personnel will have access to clinical/financial/personnel records.

All agency records, files, documents and Access to confidential employee/patient information files will be limited to agency personnel involved in the care and service of the patient.

Agency staff with access to computer files holds all information in strictest confidence in the processing, storage and discarding of all data. Only authorized personnel will have access to written and computer data information; Authorized personnel will be assigned passwords/access codes to computer files necessary to conduct their responsibilities;

Responsibilities of this job position has clearance for access to the following confidential information:

Patient plans of care and identifying data

I have been oriented to the agency's confidentiality policy. I understand that any Agency employees who do not honor the <u>Confidentiality Policy</u> are subject to termination and possible legal action. I agree to abide by the agency's confidentiality policy.

Employee Signature: ______________________ Date: __________

Effective:	Signature :	Review:	Signature:

POSITION DESCRIPTION

POSITION: Personal Care Aide

REPORTS TO: Nurse

POSITION SUMMARY:

A Personal Care Aide is a person who provides nutritional support, assistance with personal hygiene and the environmental maintenance necessary for an individual to remain in his/her own home. The Personal Care Aide is under direct supervision of the licensed nurse. The PCA provides services in accordance with Level I and Level II Personal Care Aide Functions and Tasks Scope of Practice.

QUALIFICATIONS:
Successful completion of a New York State Department of Health/Department of Social Services approved Personal Care Aide training program as demonstrated by a valid Personal Care Aide Certificate.

- Ability to speak, read and write in English sufficiently to understand and interpret the HHA Plan of Care, document care provided on the HHA Time and Activity report and able to call agency to report change and/or issues related to the patient and/or 911 in case of an emergency.

- Ability to add and subtract two digit numbers and to multiply and divide with 10's and 100's. Ability to perform these operations using units of American money and weight measurement, volume and distance.

- Holds a valid Personal Care Aide Certificate.

- Ability to apply common sense understanding to carry out simple one or two step instructions. Ability to deal with standardized situations with only occasional or no variables.

CONTACT:

Most frequent contact:	Nature or Purpose:
Patients/Patient families;	Provide care and service
agency staff (coordinator, nurse)	Receive supervision, development of POC.

EQUIPMENT OPERATION:

Walker, Cane, Crutches, Wheelchair, Commode, Hospital Bed, Hoyer Lift, Household appliances (i.e. vacuum, refrigerator, stove, blender, toaster, etc.)

SPECIFIC DUTIES AND RESPONSIBILITIES: In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if: (1) the position exists to perform that duty; (2) it requires specialized skills and/or expertise; (3) it can only be performed by a limited number of available employees.

ADA	DUTIES / RESPONSIBILITIES
X	Preparing and serving normal diets. Assisting patient with eating, monitors intake.
X	Assisting with bathing of patient - in bed, tub and shower
X	Assisting with grooming, care of hair, including shampoo, shaving with electric razor only, and ordinary care of nails - this means soaking and filing nails.
X	Assisting with care of teeth and mouth.
X	Assisting patient on and off bedpan, commode and toilet.
X	Assisting patient in transferring from bed to chair, to wheelchair and in walking with or without devices.
X	Assisting patient with dressing
X	Assisting patient with self-administered, oral medications that have been ordered by the medical practitioner.
X	Use of special equipment i.e. hoyer lift.
X	Passive range of motion, turning and positioning.
X	Reporting any change in patient's mental and physical condition or home situation to the nurse.
X	Making and changing bed/linens
X	Dusting and vacuuming the rooms the patient uses.
X	Tidying kitchen, Dishwashing.
X	Tidying bedroom
X	Tidying bathroom
X	Patient's personal laundry; this may include necessary ironing and mending.
X	Provides a supportive environment and ongoing reality orientation to confused patients using appropriate interpersonal behavioral techniques.
X	Assists with self-administered medications.
X	Administer special skin care as directed
X	Collect stool, sputum and urine specimens using appropriate techniques

THE PERSONAL CARE AIDE WILL NOT PERFORM THESE FUNCTIONS UNDER ANY CIRCUMSTANCES:

1. Foley catheter irrigation.
2. Apply a sterile dressing.
3. Give enemas or remove impactions.
4. Perform gastric lavage gavage.
5. Applications of heat in any form.

CUSTOMER SERVICE/INTERPERSONAL SKILL

1. Assists other employees where needed;
2. Is responsible and cooperative with patients/families, supervisors, fellow employees;
3. Maintains friendly working atmosphere;
4. Maintains appropriate attitude;
5. Maintains appropriate appearance;
6. Accepts constructive criticism as evidenced by appropriate changes in behavior.
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals;
9. Recognizes limitations and seeks assistance appropriately.

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Knowledge of safe and appropriate method of provid ng personal care.
2. Knowledge of meal preparation and basic nutrition.
3. Knowledge of environmental management and safety.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. Check one physical requirement which applies to this position:

MEDIUM WORK: Exerting up to 50 pounds of force occasionally and/or up to 20 pounds of force frequently and/or up to 10 pounds of force constantly to move objects.

WORK ENVIRONMENT: Patient's home, facilities

Confidentiality Statement:
Agency records are maintained in a safe and secure area with specific access availability to ensure confidentiality. Agency records, files, documents and reports are the exclusive property of the Agency. Only authorized personnel will have access to clinical/financial/personnel records.

All agency records, files, documents and Access to confidential employee/patient information files will be limited to agency personnel involved in the care and service of the patient.

Agency staff with access to computer files holds all information in strictest confidence in the processing, storage and discarding of all data. Only authorized personnel will have access to written and computer data information; Authorized personnel will be assigned passwords/access codes to computer files necessary to conduct their responsibilities;

Responsibilities of this job position has clearance for access to the following confidential information:

Patient plans of care, identifying patient data.

I have been oriented to the agency's confidentiality policy. I understand that any Agency employees who do not honor the Confidentiality Policy are subject to termination and possible legal action. I agree to abide by the agency's confidentiality policy.

Employee Signature: ______________________________ Date: ________________

POSITION: Homemaker

REPORTS TO: Nurse

POSITION SUMMARY:
The Homemaker is accountable for performing household activities to maintain an environment which is safe, clean, and promotes the physical and emotional well-being of the patient. The HM provides services in accordance with Level Personal Care Aide Functions and Tasks Scope of Practice.

QUALIFICATIONS:
Successful completion of New York State Department of Health/Department of Social Services approved Personal Care Aide training and/or Home Health Aide training program as demonstrated by a valid Person Care Aide/Home Health Aide Certificate.

Ability to speak, read and write in English sufficiently to understand and interpret the HHA Plan of Care, document care provided on the HHA Time and Activity report and able to call agency to report change and/or issues related to the patient and/or 911 in case of an emergency.

Ability to perform these operations using units of American money and weight measurement, volume and distance.

EQUIPMENT OPERATION:
Household appliances (i.e. vacuum, refrigerator, stove, blender, toaster, etc.)

SPECIFIC DUTIES AND RESPONSIBILITIES: In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if: (1) the position exists to perform that duty; (2) it requires specialized skills and/or expertise; (3) it can only be performed by a limited number of available employees.

ADA	RESPONSIBILITIES
X	Follows care/service plan developed by the Registered Nurse
X	Maintains patient privacy and treats patients with dignity and respect
X	Performs duties, as assigned, in accordance with Agency policies
X	Maintains confidentiality of all patient related information
X	Maintains a safe and clean environment
X	Assures patient safety
X	Assists with personal laundry
X	Prepares, serves meals
X	Cleans kitchen/bathroom
X	Grocery Shopping
X	Escorts patient to appointments
X	Household management
X	Care of children as supervised and directed by patient
X	Documents services provided on activity records in a timely manner
X	Reports pertinent observations to supervisor
X	Participates in inservice program and meetings as requested by the DCS
X	Utilizes Standard Precautions and infection control techniques as necessary
X	Refusal to participate in aspects of care are appropriately justified, based on cultural or religious beliefs

CUSTOMER SERVICE/INTERPERSONAL SKILL

1. Assists other employees where needed;
2. Is responsible and cooperative with patients/families, supervisors, fellow employees;
3. Maintains friendly working atmosphere;
4. Maintains appropriate attitude;
5. Maintains appropriate appearance;
6. Accepts constructive criticism as evidenced by appropriate changes in behavior.
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals;
9. Recognizes limitations and seeks assistance appropriately.

SPECIALIZED SKILLS AND TECHNICAL COMPETENCIES:

1. Knowledge of safe and appropriate household management skills
2. Knowledge of meal preparation.

PHYSICAL DEMANDS: The physical demands described here are representatives of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions. Check one physical requirement, which applies to this position:

Moderate physical effort required. Exerting up to 50 pounds of force occasionally and/or up to 20 pounds of force frequently and/or up to 10 pounds of force constantly to move objects.

WORK ENVIRONMENT:

Client homes/families involves moderate exposure to physical risks, such as automobile/public transportation or personnel safety.

Confidentiality Statement:

Agency records are maintained in a safe and secure area with specific access availability to ensure confidentiality. Agency records, files, documents and reports are the exclusive property of the Agency. Only authorized personnel will have access to clinical/financial/personnel records.

All agency records, files, documents and Access to confidential employee/patient information files will be limited to agency personnel involved in the care and service of the patient.

Agency staff with access to computer files holds all information in strictest confidence in the processing, storage and discarding of all data. Only authorized personnel will have access to written and computer data information; Authorized personnel will be assigned passwords/access codes to computer files necessary to conduct their responsibilities;

Responsibilities of this job position has clearance for access to the following confidential information:

Patient Plan of Care/Patient identifying data..

I have been oriented to the agency's confidentiality policy. I understand that any Agency employees who do not honor the Confidentiality Policy are subject to termination and possible legal action. I agree to abide by the agency's confidentiality policy.

Employee Signature: ______________________________ Date: ________________

Effective:	Signature :	Review:	Signature:

If you have a problem:

1. Re-read this instruction manual and attempt to re-enter your Clock In or Out
2. If that does not work, do not give up. *YOU WILL NOT BE CLOCKED IN/OUT.*
3. Contact your manager at the agency. Write their contact information below for reference.

Manager Name:

Manager Phone Number:

HHA eXchange

Clock In and Out Instructions

NANNY'S for GRANNY'S INC.

Dial:

English: 646-979-2517

TO CALL IN

1. From the patient's home phone, dial the number on the cover of this guide.
2. Press 1 to Call In.
3. Enter your Assignment ID.
4. Confirm the entry.

*- If you enter your number **INCORRECTLY**, you will be asked to retype your Assignment ID again. If you fail to enter a valid Assignment ID after multiple attempts you not be able to Call In. Contact your agency.*

*- If you enter your Assignment ID **CORRECTLY** you will hear:*

5. Your call has been successfully registered.

Write your Assignment ID below for reference.

TO CALL OUT

1. From the patient's home phone, dial the number on the cover of this guide.
2. Press 2 to Call Out.
3. Enter your Assignment ID.
4. Confirm the entry.

*- If you enter your number **INCORRECTLY**, you will be asked to retype your Assignment ID again. If you fail to enter a valid Assignment ID after multiple attempts you not be able to Call In. Contact your agency.*

*- If you enter your Assignment ID **CORRECTLY** you will hear:*

5. Enter the 3-digit ID # for the first duty performed for the first patient.

*- If you enter an **INVALID DUTY ID**, you will be told so and asked to enter the next Duty ID.*

*- If you enter a **VALID DUTY ID**, you will be asked to enter the next Duty ID.*

6. Enter each Duty ID. When finished, type 000.

The system will say:

Your Call-Out has been registered successfully. Goodbye.

SPECIAL SCENARIOS

If you are calling for a shared (Mutual) case (two Patients at once):

1. Follow the calling instructions on the left.
2. You will clock **IN** *ONCE* at the beginning of the visit, and clock out ONCE at the end of the visit.
3. When you clock **OUT**, first enter the duties for the primary patient and then enter 000.
4. Enter the duties for the secondary patient and again enter 000.
5. The system will then complete the clock-out

If you are calling for a Live-In:

1. Follow the calling instructions on the left.
2. You will clock **IN** *ONCE* when you first arrive with the Patient.
3. Each day after, you will only clock **OUT**.
4. The system will ask for duties and clock you **OUT** for yesterday, and automatically clock you **IN** for today

	Task #	Duty
Personal Care		
	100	Bath-Tub
	101	Bath-Shower
	102	Bath-Bed
	103	Patient requires total care
	104	
	105	
	106	mouth care/denture care
	107	hair care-comb
	108	hair care-shampoo
	109	grooming-shve
	110	grooming-nails
	111	dressing
	112	skin care
	113	foot care
	114	toileting-diaper
	115	toileting-commode
	116	toileting-bedpan/urinal
	117	toileting-toilet
Nutrition		
	201	patient is on a prescribed diet
	202	prepare-breakfast
	203	prepare-lunch
	204	prepare-dinner
	205	prepare-snack
	206	assist with feeding
	207	record intake-food
	208	record intake-fluid
Activity		
	300	Transferring
	301	Assist with walking
	302	Patient walks with assistive devices
	303	
	304	
	305	Assist with home exercise program
	306	Range of motion exercises
	307	
	308	

	309
	310
	311 Turing and positioning (at least Q2)
Treatment/	
Special Needs	
	400 Take temperature
	401
	402
	403 Take pulse
	404 Take respirations
	405 Take blood pressure
	406 Weigh patient
	407 Record output(urine/BM)
	408 Assist with catheter care
	409 Empty foley bag
	410 Assist with ostomy care
	411 remind to take medication
	412 Assist with treatment
Patient Support	
Activity	
	500 Change bed linen
	501 Patient laundry
	502 Light housekeeping
	503
	504
	505 Clean patient care equiptment
	506 Do patient shopping and errands
	507
	508 Accompany patient to medical appointment
	509 Diversional Activities-Speak/Read
	510
	511 Monitor Patient Safety

Nannys For Grannys

Home Health Aide Service Report **Week Ending** ____________

Clients Name Print: Last, First	
Employee Name Print: Last, First	

Day	Date	Start Time	End Time	Total Hours	Visits/Live In	Mileage	Clients Signature
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Weeks Total							

Check All Tasks Where Assistance Was Completed or Provided

Date							
Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Service Provided							
Personal Care							
Bath Shower							
Shampoo							
Skin Care							
Comb Brush							
Shave							
Dressing							
Med Remind							
Transfer Ambulation							
Feeding							
Toileting							

I verify that the following services were performed and the dates and times are correct

Employee Signature____ Date ______________________________

Clients Signature____Date______________________________

NANNIES FOR GRANNIES, INC.
POLICY AND PROCEDURE MANUAL

CLINICAL DOCUMENTATION

PURPOSE:

To provide a complete and accurate record of patient care in the clinical record.

POLICY:

All Agency patients will have an individual, comprehensive clinical record. The clinical record is maintained in accordance with the Agency's confidentiality policy and information protected in accordance with HIPAA regulations. All clinical documentation will be recorded on Nannies for Grannies, Inc. approved forms. All documentation will follow the Clinical Documentation Procedure and the Clinical Record Forms Policy.

PROCEDURE:

1. All interactions between Nannies for Grannies, Inc., nurses/prescribing practitioner/clinicians/caregivers and other professionals/non-professionals will be documented in the clinical record. This will include:
   - Identifying patient data;
   - Admission Consents, Acknowledgement of receipt of Bill of Rights, Advance Directive literature, Statement of services and cost of services/responsibility;
   - Advance Directive and/or proxy information for executed directives, as appropriate;
   - Patient nursing assessments and reassessments;
   - Individualized Plans of Care;
   - Medication Profile, if applicable;
   - Medical orders, if applicable;
   - Visit reports;
   - Progress notes, signed and dated following each patient visit or phone contact by all professional personnel providing care. Progress notes include a summary of the patient status and response to plan of care and any contacts with family, informal supports and other community resources that are relevant to the patient's condition and treatment;
   - Supervisory reports of the paraprofessional caregiver;
   - Observations and reports made to the nurse by the aide, including aide time and activity sheets;
   - Teaching;
   - Discharge planning;
   - Conferencing activities;
   - Documentation of incidents and accidents;
   - Coordinating activities;

Nannys for Grannys
34 Sunset Lane
Patchogue, NY 11772
Phone # 631-730-8500

Home Health Aides in New York State remain certified as long as they work for a Home Health Agency, which is certified or licensed by the New York State Department of Health. The Home Health Agency where the Home Health Aide is employed must provide nursing supervision and 12 hours of in-service training per year. If the aide leaves the employment of an agency to work privately in New York State or to work out-of-state, the home health aide certification lapses two years from the date that the person last worked at a home health agency in New York State.

Personal Care Aides in New York State remain certified in New York State as long as they work for a Home Health Agency, which is certified or licensed by the New York State Department of Health. Personal Care Aides must attend at least 6 hours of in-service annually. Additional in-services are given in the patient's home by the Nurse as necessary to follow the plan of care and meet the needs of the patient.

HHA & PCA SKILLS ASSESMENT TEST

Name ______________________________ Date ______________

Score ______________

Multiple Choice: Circle the correct answer. There is one answer for each question. Be sure to answer every question.

1. You are assisting your patient with a tub bath. She says she is beginning to feel faint. What should you do?

A. Add some cold water to the water in the tub; tell the patient she'll be all right in a moment or so.

B. Leave the patient, but only long enough to find some help.

C. Start draining the water out of the tub. Then give the patient a drink of water.

D. Add some hot water to the water in the tub. Then give the patient a drink of water.

2. If you are going to be later for work in the morning you should:

A. Call the patient's physician.

B. Ask another aide to substitute.

C. Notify the agency as early as possible.

D. Say nothing, but get to work as soon as possible.

3. The home health aide works under the direct supervision of a:

A. registered nurse

B. physician

C. patient

D. patient's family

4. If a patient has been acting increasingly hostile and rebellious, which response should a home health aide make?

A. Ask the patient's family for advice on how to handle the situation

B. Discuss the patient's behavior with the supervising nurse

C. Tell the patient that such actions will not be allowed.

D. Resign from the case immediately.

5. Small grease fires in a frying pan can be put out by:

A. Turning off the heat

B. Blowing out the flame

C. Sprinkling water on the flame

D. Putting baking soda on the flame

6. Which is the best method for lifting a heavy object from the floor?

A. Keep the back straight, feet apart, and flex knees.

B. Keep feet apart and bend from the waist.

C. Keep both feet together and bend the knees.

D. Put one foot in front of the other and arch the back.

7. Under which conditions do germs grow most rapidly?

A. Cold and dry

B. Cold and moist

C. Warm and moist

D. Warm and dry

8. The chief reason for cooking vegetables in a small amount of water and boiling them as a short a time as necessary is to:

A. Preserve the vitamins

B. Retain the color of the vegetables

C. Keep the vegetables firms

D. Improve the flavor

9. What furnishings should be removed from the home of a patient with partial paralysis who is beginning to walk?

A. Easy chairs

B. Dining table and chairs

C. Sofa and floor lamps

D. Scatter rugs

10. The position of a bed patient should be changed frequently to:

A. relax the patient

B. increase the blood circulation

C. provide a chance to wash the patient

D. increase the patient's appetite

11. To prevent infections, it is important to keep the skin:

A. warm

B. covered

C. moist

D. Clean

12. When you are uncertain about the details of an assignment, which action should you take?

A. Ask another aide about the assignment.

B. Do as much as possible and then ask the supervising nurse for help with the rest of the assignment.

C. Question the supervising nurse before starting the assignment.

D. Ask the patient how the assignment was done the last time.

13. Which of the following should be done for a patient with a Foley catheter:

A. Empty the bag at the end of your shift and measure amount.

B. Record output.

C. Keep bag lower than the bladder

D. All of the above.

E. None of the above, as the aide is never involved in Foley care.

14. Before transferring a patient to the wheelchair, the Home Health Aide should:

A. Make sure the patient is wearing a bathrobe.

B. Lock the wheels of the wheelchair.

C. Offer the patient the bedpan.

D. Bathe the patient.

15. Which of the following are low in salt?

A. Ketchup and barbeque sauce.

B. Cheddar cheese and Colby cheese.

C. Carrots and apples.

D. Potato chips and instant soups.

16. A diabetic patient must:

A. Eat at regular intervals.

B. Stay on a prescribed diet.

C. Use a sugar substitute instead of sugar.

D. All of the above.

17. Which are NOT allowed on a low salt diet?

A. Garlic salt and Accent (monosodium glutemante)

B. Garlic powder and onion powder

C. Oregano and basil

D. Pepper and chili pepper

18. A patient is receiving oxygen through a nasal tube. What safety precautions should the home health aide take?

A. Keep the television set at least 5feet from the oxygen tank

B. Do not permit the patient to drink soda.

C. Allow no smoking in the patient's room.

D. Do not use any lotions that contain oil in the patient's care.

19. An elderly male patient occasionally wets his trousers. What should the home health aide do?

A. Give him fluids with his meals only.

B. Avoid giving him coffee and tea.

C. Tell him that if he urinates on himself he will have to be put in diapers.

D. Encourage him to go to the bathroom at least every two hours.

20. Diabetics are prone to infection and are very slow in healing, therefore:

A. Never cut their nails.

B. Keep feet clean and dry.

C. Observe for infection.

D. All of the above.

E. None of the above.

21. What is the chief reason for covering your mouth or nose when coughing or sneezing?

A. To prevent the escape of bad odors.

B. To prevent the spread of germs.

C. To avoid injury to the lining of the nose and mouth.

D. To avoid getting clothing dirty.

22. Which of these fluids is highest in protein?

A. Vegetable broth.

B. Lemonade.

C. Tomato juice.

D. Eggnog.

23. Milk is a good source of calcium. Which of these foods is also high in calcium?

A. Cheese

B. Bananas

C. Orange juice

D. Raisins

24. When patients do not have enough fluids, they may develop which of these problems?

A. Diarrhea

B. Swelling

C. Constipation

D. Dandruff

25. Hands should be washed when soiled but especially:

A. Before preparing food.

B. After using the toilet.

C. Before and after giving personal care.

D. After touching nose or mouth.

E. All of the above.

26. Gloves should be worn when:

A. Touching blood-soiled items.

B. Touching body fluids and secretions.

C. Touching contaminated surfaces.

D. All of the above.

27. In general, when you are involved in assisting families and patients in their home, you must:

A. Accept their ethnic and cultural background.

B. Be sensitive to the individuals needs.

C. Respect their privacy.

D. Be careful with their personal belongings and property.

E. All of the above.

28. Of the following, which might the Home Health Aide be expected to do:

A. give injections

B. give pills and other medication

C. give a bed bath

D. give oxygen

29. In order to maintain safety when caring for an elderly patient, you should:

A. assist the patient slowly and allow them to move at his/her own pace

B. never leave a patient alone in the bathtub

C. put side rails in upright position when leaving patient unattended

D. all of the above.

30. List 4 measures you should take in an effort to prevent skin breakdown in a bedridden patient.

A.

B.

C.

D.

31. The objectives of the HHA are:

A. keeping the whole house clean

B. providing good patient care, while keeping the patient safe and comfortable

C. make the family happy

32. Communicable diseases are:

A. diseases discussed in class so that we know more about them

B. diseases which can be transmitted from one person to another

C. diseases which no longer pose a health hazard

33. Mrs. Jones fell and broke her hip. In caring for her you should:

A. consider what she can do, not can't do

B. tell her she doesn't have to worry, you will do everything for her

C. encourage her to cry it out

D. discourage her family from visiting

34. To cut down on the amount of salt in a diet, you would purchase:

A. fresh vegetables

B. canned vegetables

C. TV dinners

D. ready-prepared food

35. Mr. Desmond is 79 years old. He lives alone and is on a low fat diet. Select the best menu from the ones below.

A. Fried chicken, baked potato with butter, green beans, apple pie, whole milk

B. Baked ham, potato salad, green peas, bread and butter, chocolate ice cream, tea

C. Baked chicken, boiled potatoes with parsley, steamed car rots, fresh peaches, skim milk

D. Meat loaf, French fried potatoes, mixed vegetables, jello with whipped cream, tea

36. The safest way to shape the fingernails of a client is to use:

A. a pair of nail clippers

B. a pair of nail scissors

C. any scissors you can find

D. an emery board/nail file

37. When transferring a client from a bed to a wheelchair, you should place the wheelchair:

A. facing the bed

B. at the foot of the bed

C. alongside the bed facing the client

D. alongside the bed away from the client

38. In using proper hand washing technique, you should:

A. wash your hands up to the palms

B. rinse hands so water and soap can drain the elbow

C. repeat the washing process once

D. wash the tap before turning off the water

39. If an elderly person seems to be anxious or upset the Home Health Aide should:

A. encourage the client to tell you what is bothering him

B. tell him he has nothing to worry about

C. discourage his family from visiting

D. ignore him

40. Of the following observations, which would be important to tell your supervisor?

A. the menu for dinner

B. the activities of the client's family

C. the new clothing the client received

D. the refusal of the client to take her medication

41. When the client cannot control bladder and bowel movements, it is called:

A. diarrhea

B. constipation

C. urination

D. incontinence

TRUE OR FALSE: Read the following statements. Circle T if the statement is true, and circle F if the statement is false.

42. A Home Health Aide worker may work with a physically disabled client.	T	or	F
43. Problems on the job should be reported to your supervisor.	T	or	F
44. The patient is always encouraged to help in his/her own care.	T	or	F
45. As people get older they need to eat more food.	T	or	F
46. If elderly people have trouble getting around, they should be encouraged to sit all day.	T	or	F
47. Elderly people are not able to learn anything new.	T	or	F
48. Elderly people may want to talk more about their past than the present.	T	or	F
49. A stroke can change the personality of a person.	T	or	F
50. Elderly people who are not able to take care of their own needs should be treated like children.	T	or	F

HHA & PCA SKILLS ASSESSMENT ANSWERS

Name: ____________________ Date: __________

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NANNIES FOR GRANNIES, INC.

PARAPROFESSIONAL COMPETENCY/PERFORMANCE REVIEW

☐ Initial/Orientation ☐ Annual ☐ Remediation ☐ Other:

Employee Name: **Title:**

Period From: **To:** **SS#**

Key: Score: S=Satisfactory U=Unsatisfactory **N/A**=Not Applicable **Method: O**=Observation **I**=Inservice **T**=Testing/written or oral

	TASKS	METHOD	SCORE	DATE	RN	COMMENTS
☐	Handwashing					
☐	Pulse & Respiration and Recording (HHA ONLY)					
☐	Temperature and Recording (HHA ONLY)					
☐	Bed Bath					
☐	Tub Bath					
☐	Shower					
☐	Shampoo (Sink, Bed)					
☐	Nail Care					
☐	Oral Hygiene/Denture Care					
☐	Toilet/Commode/Bedpan					
☐	Assist Ambulation with Device					
☐	Assist Ambulation without Device					
☐	Normal Range of Motion (HHA ONLY)					
☐	Transfer (Chair/Bed) and Positioning					
☐	Other:					

RN Signature:	NYS RN License No.	Date:

NANNIES FOR GRANNIES, INC.

ACKNOWLEDGMENT OF ORIENTATION

Name: ______________________ Social Security # : ______________

Title: ______________________ Date of Employment: ______________

I acknowledge that I have received orientation to the following:

Agency's Mission, Philosophy and Goals

Agency's Personnel Policies and Procedures

Continuous Quality Improvement

Agency's Administrative Policy and Procedure Manual

Patient Bill of Rights, Patient Confidentiality, Right to Respect/Privacy/Property/Complaint Process

HIV Confidentiality/HIPAA

Advance Directives/DNR

OSHA Standards:
- Occupational Exposure to Bloodborne/Tuberculosis Program
- Epidemiology and Symptoms
- Modes of Transmission
- Engineering Controls, Work practices and use of Protective equipment
- Hepatitis B Vaccine Program
- Responsibilities and Reporting Mechanism for Exposure incident
- Universal Precautions/Standard Precautions
- Infection Control Practices

Job Description

Time and Activity Reports

Clinical Documentation Requirements

Disaster and Emergency Preparedness / Safety Policy and Procedure/Fire Safety

Policies and Procedures specific to my job responsibilities

Inservice and Continuing Education Requirements

I understand that this information is readily accessible as a resource to me. I have been given the opportunity to ask for clarification as necessary and will seek additional clarification from my supervisor, as necessary.

I have read the above statements and agree to comply with the agency's policies and procedures.

Employee Signature: ______________________

Date: ______________