A comprehensive listing of the policies and procedures in numeric order can be referenced under the Crosswalk tabbed section of this manual.

**SECTION B: GOVERNING**

- **Agency Budget Planning** B-140
- **Annual Evaluation** B-240
- **Bed Bug Action Plan For Home Health** B-301
- **Cleaning and Disinfecting in the Home** B-406
- **Clinical Record Review** B-220
- **Conflict of Interest** B-110
- **Corporate Compliance Policy** B-115
- **Customer Evaluation of Service** B-280
- **Documentation for Claims Submission** B-150
- **Emergency Management Policy** B-400
- **Encoding and Reporting Oasis Data** B-250
- **Governing Body** B-100
- **Hazardous Material Management** B-305
- **Incident Reporting** B-340
- **Infection Control Plan** B-401
- **Infection Control Surveillance** B-402
- **Infection Prevention/Control** B-403
- **Infectious Disease Reporting** B-415
- **Information Management Plan** B-225
- **CLIA Waiver - Laboratory Testing** B-360
- **Medicaid and Medicare Fraud and Abuse** B-155
- **Organization Chart** B-120
- **Orientation Guidelines for Advisory Board and Governing Body Members** B-200
- **OSHA 300 Log** B-320
- **OSHA Infection Control/Exposure Control Plan** B-405
- **Performance Improvement (QAPI)** B-260
- **Policy Development** B-210
- **Professional Advisory Committee** B-160
- **Professional Advisory Committee Membership** B-180
- **Safety Management Program** B-315
GOVERNING BODY

POLICY

The Governing Body shall assume full legal authority and responsibility for the operation of Agency. New governing body members are oriented to the agency as appropriate to responsibilities.

PURPOSE

To ensure lines of authority are established.

To ensure clients are provided with appropriate, quality services.

SPECIAL INSTRUCTIONS

The duties and responsibilities of the Governing Body shall include:

1. Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the provision of home care services in accordance with state and federal regulations, accreditation standards, and Agency mission.

2. Appoint the Professional Advisory Board as required by state licensure and/or Medicare Conditions of Participation to guide the organization in the formulation and review of policies and procedures and ensure the highest quality of client care.

3. Adopt and periodically review and approve the administrative and personnel policies, client care policies and procedures, bylaws as required by state licensure regulations and the annual operating budget.

4. Oversee the management and fiscal affairs of the agency. This shall include budget preparation, and reviewing/monitoring financial information and organizational operations.

5. Define the corporate structure and clearly indicate lines of authority.

6. Implement a Conflict of Interest policy.

7. Provide for proper licenses and insurance liability coverage.
CONFLICT OF INTEREST

POLICY

No Board member or employee will place himself or herself in a position where personal interest may influence decisions between agency and other entities. All officers, directors, and management will adhere to the policy regarding avoiding conflicts of interest to ensure the agency’s mission is not harmed by their relationships.

PURPOSE

To assure the mission of Agency is not harmed by relationships of staff or governing body members.

To assist persons who serve as officers, directors, and management positions to understand and meet the standard of conduct required for such persons.

To clarify whether Board of Director members or management level employees could derive profit or gain through association with the agency.

SPECIAL INSTRUCTIONS

1. Any possible conflict of interest on the part of the governing board member, administrative staff member, management staff member or a member of his or her immediate family should be disclosed to the board and made a matter of record through an annual procedure and when the interest becomes a matter of board action.

2. No officer, director, or management person of this agency shall participate in a relationship if he/she is a party to, or has financial interest in that relationship, is employed by or negotiating prospective employment with the other party, or has financial interest in the other party.

3. All officers, directors, or management personnel shall promptly report any matters that may pose a potential conflict of interest.

4. In matters involving a conflict of interest, a Board member or employee must disclose any known significant reasons why a transaction may not be in the best interest of the agency.

5. A Board Member may not participate in discussions unless requested and may not vote on transactions where conflict may or does exist. Abstention and reason for it will be included in the minutes.
6. No officers, directors, or management personnel shall solicit or accept any gratuities, favors, or anything of significant monetary value from any person or party while representing the agency. Significant value is defined as something that cannot be consumed or used up within twenty-four (24) hours or has a face market value of more than $25.00.

7. All staff shall conduct business practice in such a manner that no conflict of interest, real or implied could be construed. Staff and families may not have financial interests in competing or supplying companies that could affect their performance or influence business decisions.

8. The presiding chair of the governing body will have final authority on what constitutes conflict of interest.

In a Medicare certified agency there must be evidence of annual disclosures that include:

1. Names, addresses of individuals or corporations having direct/indirect ownership or controlling interest of 5% or more in agency or in any subcontractor in which the agency has direct/indirect ownership interest of 5% or more.

2. Persons who are related (spouse, parent, child, sibling) that have direct or indirect ownership or controlling interest of 5% or more in agency or subcontractor.

3. Persons who have ownership/controlling interest in a Medicare certified facility.

4. Names/addresses of any officer, director, or partner who has ownership or control of such facility.

5. Conviction of any criminal offense involving Medicare or Medicaid on the part of any person or organization, agent or managing employee.

6. Names and addresses of any current managerial staff who were employed by the fiscal intermediary in the last year.

7. Changes in ownership or control.

8. Change of address for parent corporation, sub-unit or branches.

**DEFINITION**

A conflict of interest may occur when the home care agency officers, directors, or management staff enters into a relationship with another organization or person(s), which in its content or process, may result in a compromise of the agency’s obligation to act in the best interest of its clients. An actual or potential conflict of interest occurs when an person is in a position to influence a decision that may result in a personal gain for that employee or for a relative as a result of the Agency’s business dealings.
DISCLOSURE OF INTERESTS AND CONFLICTS

Pursuant to the purposes and intent of the policy adopted by the Agency, requiring the disclosure of certain interests and conflicts, I hereby state that I have received a copy of the policy and understand that my responsibilities to the agency require that I disclose any duality of interest or possible conflict of interest, for myself and any member of my immediate family, that I will not vote or use influence on any matter in which I have a conflict or duality of interest; and will not accept gifts, favors, or hospitality with a monetary value in excess of $25.00, and will make every effort to Comply with the Agency Policy.

I hereby disclose the following interests and activities of possible conflicts:

*Conflict of Interest Policy will be discussed at the 2015 Advisory Meeting

Name: ____________________________
Date: ____________________________
Position: _________________________
CORPORATE COMPLIANCE POLICY

POLICY

The Agency will have a written policy that outlines the specifics of the Agency Compliance Plan.

The Agency has developed a code of standards of conduct for all affected employees and contractors that reflect compliance with federal, state and accreditation regulations and standards.

The Agency will review the compliance plan annually and expects all employees to review and receive education about the compliance plan annually.

The agency will have focus on fraud and abuse issues and ethical areas specific to an employee/subcontractor’s duties.

PURPOSE

To establish systems that will guide agency practice and assure compliance with state and federal laws, accepted standards of practice (clinical, legal and financial).

To develop and distribute written standards of conduct as well as policies, procedures and systems that promote commitment to compliance.

To identify a vehicle to evaluate managers and employees and address areas of potential fraud.

SPECIAL INSTRUCTIONS

1. Agency will designate a compliance officer and corporate compliance committee who will be responsible for operation and monitoring of the compliance program. These individuals will report directly to the Administrator and the Governing Body.

2. Agency will develop and implement an education and training program for all affected employees.

3. Agency will create and maintain a process to receive complaints and adopt procedures to protect confidentiality of complaints and protect whistleblowers from retaliation.

4. Agency will develop and implement a system to respond to allegations of improper/illegal activities and enforce appropriate disciplinary action against those who violate internal compliance policies, regulations, or federal/state health care program requirements.

5. Agency will develop and implement evaluation tools to monitor compliance and
assist in reducing problem areas.

6. Policies will be developed to address non-employment or retention of individuals who have been identified as cause or contributing to systemic problems.

7. Agency leadership will develop and implement a client safety program throughout the organization.

8. Corporate compliance program will have ongoing evaluation and reporting as component of performance improvement.
AGENCY BUDGET PLANNING

POLICY
Agency, under the direction of the Governing Body, shall prepare an overall plan and budget. This will include an annual operating budget. This plan will be prepared, carried out, and monitored in collaboration with leaders and other appropriate staff.

PURPOSE
To provide financial, operating, and planning guidelines for the agency.
To develop an annual operating budget.
To determine whether the Agency’s financial plan is appropriate to meet the needs of the agency staff and clients.

SPECIAL INSTRUCTIONS
1. Annual Operating Budget:
   a. There shall be an annual operating budget that shall include all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items.
   b. The budget reflects the goals and objectives of the Agency and meets requirements of all applicable laws, regulations and standards for home care accounting principles.
   c. This budget is prepared before the beginning of the fiscal year.
   d. The budget is approved by the Governing body (Board of Directors) and revised as needed.
   e. The Administrator is responsible for reviewing budget expenses and revenue, and as appropriate, the capital expenditure plan.
   f. The Administrator provides quarterly budget reports to the Governing Body.
   g. The Agency Managers seek staff input in preparing the annual budget.

2. The review and updating of the budget includes any strategic plans, and impact of the budget on the ability of the staff to provide client care, treatment and services. Annual review of all policies that relate to the budget, financial management, and changes recommendations for the financial viability of the agency.
DOCUMENTATION FOR CLAIMS SUBMISSION

POLICY
Agency will establish systems and procedures to assure compliance with Medicare and Medicaid regulations, established protocols of other payers, and accepted standards of practice.

PURPOSE:
To define the responsibilities of the agency in billing for services.
To identify the procedures and processes that will assure regulatory compliance, accurate claims submission and appropriate practices.

SPECIAL INSTRUCTIONS:
1. Billing information is obtained during the intake process and prior to the initiation of service.
2. The client is notified during admission, and as changes occur, of their financial responsibility for services provided.
3. All services are provided under a physician plan of care and only services ordered by the physician may be submitted to third party payers for payment.
4. The agency routinely submits claims to third party payers for services rendered to the client. Invoices will be produced in accordance with the procedures defined by the third party payers advising the payer of its responsibility.
5. A designated clinician reviews the clinical record for compliance with coverage requirements and the appropriateness of billing prior to claims submission.
6. The agency collects funds and applies them against the appropriate account.
7. The agency recognizes payment from Medicare and other designated third-party insurers for eligible beneficiaries as payment in full unless there are co-pays or non-coverage that has been communicated to the client verbally and in writing.
8. Medicare Claims Submission Under PPS:

a. All clients admitted to the agency who are eligible for Medicare reimbursement will have an order to begin care (verbal or written) from the physician.

b. All clients receiving Medicare/Medicaid skilled services will have a comprehensive assessment, including OASIS data elements, completed and entered into Haven or alternative software program for transmission to the state and CMS.

c. When the above steps are completed, the agency will submit a RAP (request for anticipated payment) to the intermediary. This is not a claim and the physician order does not have to be signed at this time. M0110 - Will identify early or late episode. If not marked it will default to early.

d. When the RAP is received by the intermediary, the agency will be paid 60% of the anticipated episode payment based on the assessment and related HHRG (home health resource group).

e. Face to Face Documentation must be available in the client record within 30 days of start of care.

f. At the end of the episode or at discharge whichever comes first, a claim for the episode of care is submitted to the intermediary. This claim must include all services provided by discipline and exact times of visits (time in and time out). The claim must also identify non-routine supplies provided to the client during the episode of care. The agency must have signed physician orders in the file before this claim is submitted. With successful submission of this final claim the agency receives the remaining 40% of the episode payment.

g. An episode of care claim must include all supplies (routine and non-routine) and the services the client received during the course of providing care. Medical supplies must be included on 485 for payment justification. When the RAP is submitted, the agency becomes the provider of record and other providers will not be able to bill Medicare for home care related services during this time. Outpatient therapies are included in this home care episode of care.

h. If the client continues to receive services for another sixty (60) day episode, the client will have a reassessment visit within the last five (5) days of the episode. The assessment including OASIS will be entered into the Haven/alternate program. A physician order must be obtained for the new episode of care. When this is completed another RAP may be submitted. For subsequent episodes the agency is paid 50% at the beginning of the episode and the remaining 50% at the end of the episode.

i. When episodes are altered due to significant changes in condition (SCIC) or
partial episode payment circumstances, the agency submits a new OASIS assessment and the episode payments are adjusted.

j. If the client receives four or less visits per episode, the client qualifies for a LUPA (Low Utilization Payment Adjustment) and the agency will receive per visit payment for these visits.

9. Medicaid/Other Insurance Claims:

a. Agency will obtain prior authorization for services based on assessment and specific requirements of the payer.

b. Agency follows established procedures established by the payer for claims submission.

c. Clients receiving skilled services will have the comprehensive assessment, including OASIS, documented in their files and the plan of care will reflect the needs identified. Assessments and re-assessments will follow Medicare guidelines.

d. Clients are notified in writing of services authorized and any limitations in payment. Clients are informed of any co-pay amounts required by the payer, and signs an acknowledgement that they were informed of the financial responsibility.

e. Claims are submitted after the physician orders are signed and documentation of services provided is present in the client’s record.

10. Private Pay:

a. Services requested by the client/family are provided according to the service agreement. Client/responsible party are informed of the charges for the services and the billing procedures.

b. Physician orders will be obtained as needed.

c. Claims will be sent to the client/responsible party based on time records signed by the client/responsible party.

d. Any change in services will be documented on the service agreement.

e. Clients/responsible parties will be notified of any rate changes thirty (30) days prior to the change.
MEDICAID AND MEDICARE FRAUD AND ABUSE

POLICY

AGENCY is committed to providing care and service in compliance with all applicable rules and regulations. The agency will comply with the requirements of the Deficit Reduction Act of 2005 and its obligations related to Fraud and Abuse under state and federal laws. As part of the commitment, Agency has established and will maintain a Corporate Compliance Program that includes a Fraud and Abuse program.

Employees and contractors are expected to immediately report any potential false, inaccurate or questionable claims to their supervisors, the Fraud and Abuse Coordinator or the Compliance Officer according to this policy.

Agency is prohibited by law from retaliating in any way against any employee or contractor who reports a perceived problem, concern or fraud and abuse issue in good faith.

Examples of potential false claims may include the following; when they are done intentionally and knowingly:

1. Claiming reimbursement for services that have not been rendered
2. Characterizing the service differently than the service actually provided
3. Billing for services that are not medically necessary
4. Failing to provide medically necessary services/items
5. Forging or altering prescriptions and improperly obtaining prescriptions for controlled substances

PURPOSE

- To identify the steps the agency will take to comply with the requirements of the Deficit Reduction Act and its obligations related to fraud and abuse
- To provide guidance regarding the agency’s responsibilities under the DRA, the State False Claims acts, and any contracts with payers
- To inform employees about the protections under the laws and contracts, and the roles of these laws to prevent and detect fraud, waste, and abuse in Federal and State Programs.
PROCEDURE

Agency shall develop a comprehensive internal Fraud and Abuse Program, as part of its Compliance Program to prevent and detect program violations.

Employees and contractors must immediately report any false, inaccurate or questionable claims or actions as well as questions, concerns or potential Fraud or Abuse to:

- Immediate supervisor
- Agency Fraud and Abuse Officer (Administrator and/or Director of Nursing / Clinical Services).

All activity reported related to this policy will be investigated in accordance with the agency fraud and abuse program.

Agency will not discriminate or retaliate against any employee or contractor for reporting a potential fraudulent activity or for cooperating in any government or law enforcement authority’s investigation or prosecution.

If it is determined that the Agency submitted claims in error, Agency will make every effort to recover improper payments or funds misspent due to fraudulent or abusive actions by the agency or its contractors.

RESPONSIBILITY AND ACCOUNTABILITY

**Employees and Contractors:** All agency employees and contractors are responsible for reporting any potential false, inaccurate or questionable claims or actions as well as questions, concerns of potential fraud or abuse.

**Internal Fraud and Abuse team:** Group of individuals representing billing, clinical, quality improvement, medical records is responsible for ensuring that all reported suspected Fraud or Abuse are fully investigated and if appropriate, are reported to proper authorities.

**Compliance Officer:** The Compliance Officer has oversight for the Fraud and Abuse Program, including but not limited to policies/procedures and communications. The Compliance Officer will communicate with the Management Team, Governing Body, and Professional Advisory Committee as needed but at least annually as part of the annual agency evaluation.

References:
False Claims Act 31 USC sect. 3279-3733
Agency Non-Retaliation Policy
The following is a summary of the Federal False Claims laws and whistleblower protections.

**The Federal False Claims Act**

The Federal False Claims Act (FCA) helps the Federal government combat fraud and recovers losses resulting from fraud in Federal programs. A person or entity may violate the FCA by *knowingly*

- Submitting a false claim for payment
- Making or using a false record or statement to obtain payment for a false claim
- Conspiring to make a false claim or get one paid
- Making or using a false record to avoid payments owed to the Government

*Knowingly* means that a person

- Has actual knowledge of the information
- Acts in deliberate ignorance of the truth or falsity of the information
- Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required

**Medicaid and Medicare Violations**

Violations of Medicare laws and the Medicare Fraud and Abuse Statute also constitute violations of the False Claims Act. Home Health Care agencies that seek and receive reimbursement for Medicare and Medicaid funds are Government contractors subject to the False Claims Act. **Billing for services not rendered or misrepresenting the type of services rendered, can trigger liability under the False Claims Act.**

**False Statements of Contract Compliance**

Violations of contract terms or of statutes and regulations that are often required by Government contracts and set forth in what might otherwise be termed "boilerplate" sections of contracts, may be sufficient to violate the False Claims Act. Knowing presentation of claim for payment can be deemed equivalent to a false certification of compliance with such laws, rules, and regulations. If federal funding is conditioned on compliance with these contract provisions, such misconduct gives rise to a viable False Claims Act case. **It should be remembered that claims may be false and the law violated, even though goods or services provided fulfill other contract specifications.**

The FCA imposes penalties of $5,500 to $11,000 per claim plus three times the amount of damages to the Government for FCA violations. Lawsuits must be filed by the later of either (1) three years after the violation was discovered by the federal
official responsible for investigating violations (but no more than ten years after the violation was committed, or (2) six years after the violation was committed.

**False Claims Act Whistleblower Employee Protections**

In 1986, Congress added anti-retaliation protections to the False Claims Act. These provisions, which did not exist previously, are contained in 31 U.S.C. Sec. 3730(h):

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of his employer or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

The protection against retaliation extends to whistleblowers whose allegations could legitimately support a False Claims Act case even if the case is never filed. The statute of limitations for Sec. 3730(h) claims is 6 years in most jurisdictions.

The whistleblower plaintiff is entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys fees and costs. There is federal jurisdiction for these whistleblower claims. To establish a Sec. 3730(h) retaliatory discharge claim, the whistleblower must engage in conduct protected by the False Claims Act. Second, the courts require a showing that the defendant have some notice of the protected conduct that the whistleblower was either taking action in furtherance of a qui tam action or assisting in an investigation or actions brought by the Government. Finally, the whistleblower must show that the termination was in retaliation for the protected activities. A False Claims Act qui tam case can include whistleblower claims and other legal claims based upon other state and federal laws.

**Federal Whistleblower Protection Laws**

Unlike the False Claims Act, which allows a whistleblower to file a lawsuit in federal court, many of the federal whistleblower laws do not permit a whistleblower to go directly to court, but instead are to be pursued "administratively." Congress designed many of these laws so that an individual, with or without an attorney, may make a simple complaint or "charge" of retaliatory discrimination to a federal government agency. If not resolved administratively, an administrative law judge may preside over the only evidentiary hearing that will take place. Some retaliation and whistleblower statutes are relatively "hollow," that is, they prohibit illegal employer retaliation, but do not allow the individual to pursue an administrative charge or file a lawsuit. In legalese, such laws are described as providing no "private cause of action."
RAC (RECOVERY AUDIT CONTRACTOR) LEGISLATION

Medicare Modernization Act required the 3 year RAC demonstration
Requires a permanent and nationwide RAC program by January 1, 2010

RAC reviews claims on a post payment basis to detect and correct past improper payments so that CMS and carriers, FIs can implement actions that will prevent future improper payments

Each RAC will employ:
- Certified coders
- Nurses and/or therapists
- A physician (contracted)

This will affect all providers who bill Medicare fee for service programs

Providers must prepare for audits by:
Knowing where previous improper payments have been found
Know if agency is submitting claims with improper payments
Prepare to respond to RAC medical record requests
Conduct an internal assessment to identify compliance with Medicare rules
Identify corrective actions to implement for compliance

Agency can appeal using the same process for Carrier/FI/MAC denials
Related Policies
Annual Evaluation
Clinical Documentation
Conflict of Interest
Documentation for Claims Submission
Performance Improvement
Professional Advisory Board
Code of Ethics
Documentation of changes to Medical Records
Physician Orders
Plan of Care
Service Agreement/Service Plan
Supervision of Staff
In service Education/Staff Development

Other Resources
Agency Compliance Plan
Employee Handbook
PROFESSIONAL ADVISORY COMMITTEE

POLICY
A group of professional personnel shall be established to function as an advisory group to the agency management team. This group shall meet frequently, at least annually.

Committee membership is voluntary but shall be for a term of at least two (2) years and may be renewed upon mutual agreement between the Agency and the member.

PURPOSE
To review and advise agency on professional clinical policies, client safety issues and performance improvement activities.

To advise the agency on professional issues.

To participate in the annual program evaluation.

To assist the agency in maintaining relationships with other health care providers in the community and in developing the agency’s community information program.

SPECIAL INSTRUCTIONS
1. The governing body or administrator appoints a committee that must include at least one physician, one registered nurse and appropriate representative from other disciplines, community groups and consumers. The objectives of the Advisory Committee include:

   a. Provide supervision of the clinical aspects of the program.

   b. Provide medical consultation to professional staff.

   c. Promote home health in the community.

   d. Review and approve admission, discharge, clinical record policies and personnel qualifications.

   e. Participate in an annual review of the agency’s home care program which includes administrative, governing, clinical and personnel areas.
2. An annual roster of the committee membership shall be maintained. The roster shall include each member’s full legal name, professional designation and/or community business affiliation.

3. The Professional Advisory Committee shall participate in reviewing initial policies and approve the agency policy manual.

4. The Advisory Committee shall annually review selected additions or changes to agency policies.

5. The Professional Advisory Board shall review the findings of the quarterly clinical record review and other Performance improvement activities.

6. The Professional Advisory Board shall meet, as needed, but minimally on an annual basis.

7. The Professional Advisory Board meeting minutes will be maintained in writing and signed by the Administrator.

8. Subcommittees of the Professional Advisory Board may be formed for utilization review and clinical record review.

9. Written agenda and minutes of previous meetings shall be sent prior to the scheduled meeting.
PROFESSIONAL ADVISORY COMMITTEE MEMBERSHIP

Name/Title/Business:

Pam Brede, RN, Administrator, Divine Home Care
Debra Shriver, CFO, Divine Home Care
Dr. Larry Okerlund, MD, Consultant, Divine Hospice Care
Cheryl Dyberik, Pharmacist, TruCare Pharmacy
Stephanie Swanson, RN, Divine Hospice Care
Angie Rudningen, MSW, LSW, Divine Hospice Care
Karen Carlson, Operations Director, Divine Home Care
Sue Nathe, Community Member
ORIENTATION GUIDELINES
FOR ADVISORY BOARD AND
GOVERNING BODY MEMBERS

POLICY

Agency shall provide effective orientation to members of its Advisory Board and Governing Body. This orientation shall minimally include:

1. Agency Philosophy and Objectives.

2. Roles and Responsibilities:
   b. Calendar for meetings.

3. Orientation to the Agency:
   a. Historic background of Agency and the services provided.
   b. Organizational chart.
   c. Agency purpose.
   d. Agency philosophy.
   e. Agency objectives.
   g. Operating and capital budget/Funding sources.
   h. Policies and procedures; review of manuals.
   i. Quality improvement plan and activities.

4. Planning Function:
   a. Plan for annual agency evaluation.
   b. Demographic data compilation.
   c. Quality improvement measures.
   d. Home Visits With Field Staff (Optional) (with client consent).
POLICY DEVELOPMENT

POLICY

Policies and procedures will be written in a standardized format and address significant operational areas of the agency. The policies will conform to state and federal regulations and accreditation standards for home health.

All policies will be incorporated into the agency policy manual. Selected policies and procedures will be reviewed and revised at least annually by the professional advisory committee. Other policies and procedures will be reviewed as defined by the organization and as needed based on review by clinical managers and quality improvement committee. The governing body makes final approval.

PURPOSE

To assure a consistent methodology for the development, review, revision, approval, and distribution of administrative and clinical policies and procedures.

To identify responsibility of policy development revision and compliance.

SPECIAL INSTRUCTIONS

1. All departments/divisions that will be impacted by a policy or procedure must be identified.

2. All levels of approval required will be identified. New or revised policies will be approved.

3. When the clinical expertise necessary for developing policies or procedures is not available, outside consultants will be utilized.

4. Input on new or revised policies will be solicited from appropriate agency staff.

5. Policy reviews will be documented on the policy crosswalk.
CLINICAL RECORD REVIEW

POLICY
A clinical record review will be conducted to determine the extent to which agency staff complies with accepted professional standards and principles, federal and state regulations, FWA and accreditation standards. This review will be completed by representatives of appropriate health care disciplines.

PURPOSE
To evaluate appropriate admission and discharge.
To evaluate services provided for consistency with professional practice standards, agency policies, and the Plan of Care.
To evaluate the appropriateness, adequacy and effectiveness of services.
To identify over- or under-utilization of services.
To identify gaps in agency service, and need for in-service education, staffing consultation services, and agency policies.
To ensure records reflect care and/or service provided, the client’s current condition, and the client’s progress towards goals and condition at the time of discharge.
To ensure documentation is complete, accurate, and timely.
To ensure compliance with the OASIS data collection and utilization of assessment data in ongoing plans of care.
To evaluate adverse outcome reports and identify documentation limitations or the need for focused plan to improve client outcomes through targeted interventions.

SPECIAL INSTRUCTIONS
1. Appropriate Health professionals representing at least the scope of the program will review a sample of both active and closed charts at least quarterly.
2. The responsibility for the review program is primarily assigned to the Director of Clinical Services and Nursing Director.
3. Record reviews will focus on whether established policies are followed and whether services delivered are in compliance with the Plan of Care and established standards.
4. Services provided under contract will be reviewed to assure compliance with agency policies, and reflect progress toward goals and expected outcomes.

5. The agency shall review a random sample of at least 10% of the agency client base, but not less than 10 records each quarter. The agency shall review a sampling of each service offered. A client receiving multiple services may be included in the sample of each service. Selection of cases shall include active and discharged cases by:
   a. Random sampling to give a picture of total service.
   b. Specific evaluation studies to focus on identified problem areas, diagnosis, discipline, utilization of services, number of visits, cost effectiveness and outcomes.
   c. Cases questioned or limited by the intermediary.
   d. Cases presenting management problems.
   e. Adverse outcome reports.

6. The agency reviews and evaluates client care as reflected in the clinical record to identify and analyze the use of staff and services necessary to render care in compliance with the agency’s policies. This will include evaluation of prevailing professional standards, including their necessity, appropriateness, adequacy, and effectiveness.

7. The agency shall routinely examine the findings of previous reviews to determine focus and assure quality of client care.

8. Specific studies may be requested by the Professional Advisory Committee, Administrator, or Performance/Quality Improvement managers.

9. Identified concerns in the areas of quality of care or client safety shall be referred to the appropriate person for action.

10. Summaries of quarterly reports will be maintained. This would include any specific focus or targeted areas. This shall include cases reviewed, random or targeted, findings, recommendations, and action taken. The summaries and copies of the audit tool will be retained and used to compile reports for the professional advisory committee, and annual agency evaluation.

11. Record reviews may be done by individuals at separate times. The reviews will be reviewed to determine patterns and identify areas for focused improvement activities.

12. The Director of Clinical Services or Nursing Director shall report findings and results of the quarterly review to the Professional Advisory Committee annually.
There shall be an ongoing review of client status every sixty (60)-day period using the OASIS follow-up assessment and other pertinent documentation that support changes in client condition and/or plan of care. This data will be included in the clinical records and reviewed as part of the agency’s ongoing review of appropriate care delivery.
INFORMATION MANAGEMENT PLAN

POLICY
The Agency has information management needs including availability, accuracy, and timeliness of information. Systems will be in place to ensure safe and effective management of information. The Agency management Team is responsible for ensuring that the required information is available in an accessible and secure system. The information management system is designed around the agency’s mission, goals, service needs, delivery settings, and resources available.

PURPOSE
To define information management processes and systems.

To identify agency plan to protect and provide information as needed to serve the clients and staff of the agency.

SPECIAL INSTRUCTIONS
1. Internal communication requirements for the Agency are:
   a. Performance improvement activities.
   b. Infection control.
   c. Incident report system.
   d. Inventory.
   e. Billing.
   f. Clinical information.
   g. Internal reporting (admissions by diagnosis, productivity reports, visits by disciplines, financial reports, etc.).

2. External communication requirements for the Agency are:
   a. CMS and intermediary.
   b. Community agencies.
c. Relevant allied health providers.
d. Physicians.
e. Contracted services.
f. Third party payers.
g. State licensure and regulatory agencies (federal and state.)

3. Data collection/information management is necessary for the following reasons:
   a. Client care/treatment management.
   b. Performance improvement.
   c. Reimbursement.
   d. Liability.
   e. Care coordination/communication.
   f. Direction, staffing and material resource allocation.
   g. Assessing, selecting and integrating information.

4. Standardized data collection nomenclatures pertinent to the Agency include:
   b. ICD-9/ICD-10 CM coding requirements.
   c. Taber’s Cyclopedic Medical Dictionary.
   d. Unacceptable abbreviations, acronyms and symbols list.

5. Sources for external database comparison include:
   a. CMS intermediary.
   b. OBQI and OBQM reports.

6. Federal and state licensure/regulators and surveyors, including accrediting organizations, can access any Agency information at the appropriate levels of security.

7. Client records are kept in a locked location with limited access. Information stored or transferred via computers is accessed by individual passwords. Original clinical notes are stored in a file cabinet. Computerized information is “backed-up” daily preventing inadvertent loss of vital information.
8. Information is only transferred/released from the Agency with written authorization of the client/family.

9. Information is shared between individuals/groups involved in the current plan of care without additional consent. Only those with a “need to know” have access to protected information.

10. Copies of certain medical information will be utilized in the client’s record for continuity of care until signed originals are available. Any copies of documents containing client information will be destroyed (by shredding or defacing) before disposal.

11. Data confidentiality:
   a. All client information and personnel information is strictly confidential.
   b. Confidential data may be used in an aggregate manner as long as the confidentiality of the client is maintained, e.g., performance improvement purposes.
   c. Staff is oriented to the Agency’s policy on confidentiality.

12. Groups served by information management function include:
   a. Governing body.
   b. Professional Advisory Committee.
   c. Agency leaders/managers/supervisors.
   d. Agency staff.
   e. Clients/families/caregivers.
   f. Payer/purchaser.
   g. Regulatory bodies, e.g., CMS, state and federal licensure, OSHA, CDC, etc.
   h. Physicians and relevant allied health providers.

13. Support needed for planning purposes includes:
   a. Allocation of staff time.
   b. Allocation of resources.
   c. Computer technology.
14. Support needed for education and/or research activity includes:
   a. Data retrieval.
   b. Allocation of staff time.
   c. Allocation of resources.
   d. Expertise for specific activity.

15. National/state guidelines requiring access of information systems and sending equivalent data and information from one location to another include:
   a. CMS.
   b. State licensure.
   c. Third party payer.

16. Long-term data and information for reporting purposes include:
   a. Home care records/retention after discharge.
   b. Performance improvement results.
   c. Cost reports.
   d. Personnel records.
   e. Employee health records.
   f. Financial reports.
   g. Joint Annual Reports.
   h. Federal/state/survey results.

17. Requirements for internally and externally generated data and information to support continuous improvement in performance include:
   a. Allocation of staff time.
   b. Allocation of resources.
   c. Data retrieval.
   d. Data comparison and interpretation.
   e. Computer systems.
18. Enhancement of work flow activities includes:
   a. Through PI Committee and staff input, all management of information processes are continually reviewed to enhance work flow activities, e.g., through revision of documentation forms and ongoing upgrade of computer systems.

19. Support needed for information management systems and processes includes:
   a. Human and financial resources.
   b. Computer technology.
   c. Manual systems to support lacking computer technology.
   d. Staff involvement and commitment.

20. Data encryption occurs as required by law and regulation, e.g., for OASIS transmissions.

21. Original home care records and administrative information are maintained on-site at the Agency. If the Agency is a branch or subunit, original home care records and administrative information may be transported to the parent organization for billing, utilization review, risk management and performance improvement. If such transport is necessary, records will be transported in a secure box by a delegated employee in the employee’s locked trunk of his/her car or by carrier (e.g., Fed Ex) with return receipt requested. Such transport will be coordinated with the parent organization. Communication, exchange and retrieval of such information will occur according to established process.
ANNUAL EVALUATION

POLICY
The annual agency evaluation is a systematic collection and analysis of information necessary to guide the agency in future planning for services. The evaluation is completed at the end of the agency’s fiscal year.

PURPOSE
To assess the total program for ability to meet the needs of the community, compliance with regulations and standards of practice, customer satisfaction, and administration and management of the agency.

To maintain accountability for all programs and services, and enhance the agency performance improvement plan.

To evaluate and make recommendations based on the needs of the community and satisfaction surveys.

SPECIAL INSTRUCTIONS
1. The components of the evaluation include:
   a. Organizational structure and systems review.
   b. Policy and procedure review.
   c. Clinical record review.
   d. Program review for appropriateness, adequacy, effectiveness, efficiency of client care.

2. Agency representatives will evaluate the different aspects of the program. Those participating in the evaluation will include: representatives from the financial, clinical, and administrative departments. Reports from Quality Improvement, Record reviews and satisfaction surveys are reviewed in the data collection process. This will include OBQI/OBQM reports from OASIS data collection and Home Health Compare as well as satisfaction reports from CAHPS.

3. The management team will review the findings of each department and prepare a plan for the year based on needs, financial resources, and available staff.

4. Annually the annual evaluation will be presented to the Professional Advisory Committee. The Advisory Committee reviews the findings and plans and offers suggestions/advice. The group approves the final evaluation report. After
approval the report is submitted to the Governing Body for review and approval.

5. The report is kept on file and becomes part of the Agency Administrative records. Recommendations are incorporated into the Agency plan of action for the coming year.

6. The plan is available for surveyor review if requested.
ENCODING AND REPORTING OASIS DATA

POLICY

The agency will electronically report all OASIS data collected in accordance with federal regulations. The agency and agents acting on behalf of the agency will ensure confidentiality of all client specific information in the clinical record.

PURPOSE

To demonstrate compliance with the Medicare Conditions of Participation.

To transmit assessment data on all skilled (Medicare and Medicaid) clients receiving services from Agency (except: pediatric and pre/post partum clients).

To provide aggregate data to be used in evaluating client outcomes.

To assure confidentiality of client identifiable information.

SPECIAL INSTRUCTIONS

1. Agency will encode individual client assessment data within thirty (30) days of completing the comprehensive assessment. When the data is locked, it is transmitted to the State Oasis System. This is to be done within 30 days of the day the OASIS was completed. Validation reports will be obtained and reviewed to determine if corrections are needed.

2. Data will reflect client status at time of assessment.

3. Encoding of all OASIS data must be completed (locked) to accurately complete the information necessary to send Medicare claims under the prospective payment system.

4. Agency will use CMS Software Program (HAVEN) or software that conforms to standard layout, edit specifications, data dictionary, and includes the required OASIS data set.

   Client identifiable information will not be released to the public unless required.
PERFORMANCE IMPROVEMENT (QAPI)

POLICY

Agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes. This plan will be based on the organization’s mission and goals and designed to improve client outcomes and the perceptions of clients/families about the quality and value of services. The agency will adopt a performance improvement model to guide the process.

Agency’s Performance Improvement Plan is reviewed quarterly and revised as necessary.

PURPOSE

To design processes, which through collaboration of all services and disciplines, will meet the needs of clients, staff and the community.

To identify areas for improvement in the quality of care, treatment and services.

To improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational performance.

To evaluate all areas of concern and implement plans to resolve the issues.

The agency’ performance improvement program consists of, but is not limited to the following:

- Outcome based OBQI and OBQM data from OASIS submission documents
- OASIS review and evaluation of accuracy and content
- Staff performance assessment activities
- Staff recruitment, orientation and continuing education programs
- Case Conferences
- Clinical record and utilization review findings
- Clinical staff competency evaluation programs
- Satisfaction surveys of clients, referral sources, physicians and staff
- Risk management program
- Adverse events
- Incident reports, accidents and worker compensation claims
• Infection control activities and systems that support them
• Annual program evaluation

OBJECTIVES OF THE PROGRAM

• To assess and evaluate the quality of client care services provided, appropriateness of services, and satisfaction of clients and families.

• To improve quality of client care by strengthening communication systems between caregiver, clients and families, management and staff, and agency and the community it serves.

• To identify deviations from agency and professional standards and pursue improvement opportunities by assessment, planning and evaluation.

• To identify, address, track and resolve problems in client care services and satisfaction to insure resolution and/or improvement.

• To increase the awareness of each staff member of their role within the organization and foster involvement and participation in agency’s performance improvement program.

• To meet state and federal regulatory requirements

• To support the organization’s process improvement through data collection and outcome measurement in compliance OASIS Data Collection required by CMS.

• To reduce factors that contribute to unanticipated adverse events and/or outcomes.

SPECIAL INSTRUCTIONS

1. The development of a performance improvement plan will be guided by the mission, vision and strategic goals of the organization. Additional activities for performance improvement will be prioritized by the agency’s management team. Program will reflect participation by all services and levels of staff; and will subscribe to compliance with internal and external standards including the Medicare Conditions of Participation.

2. Data will be collected to allow the agency to monitor its performance. Data will be collected, measured, and analyzed. The goal is to decide the statistical control methods, agree on how data will be collected and determine how it will be measured. The agency will assess for improved efficient processes. Data collection will be prioritized based on the organization’s mission, care services provided, and populations served. Data that may be used for data collection include the following:
a. Staff perception of risks to individuals and suggestions for improving safety for clients.
b. Staff willingness to report unanticipated adverse events.
c. Utilization of services.
d. Staff opinion and needs.
e. Adverse events/outcomes identified from OASIS reports.
f. Infection control surveillance and reporting.
g. The needs, expectations and satisfaction of individuals and organizations served. CAPHS reports.
h. Perceptions of care, treatment and services including:
   • How well the agency meets these needs and expectations.
   • How the organization can enhance client safety and improve outcomes.
   • Effectiveness of programs in responding to specific concerns such as pain management and medication management.
i. Client diagnosis and demographics.
j. Environmental conditions of the organization or clients.

3. The activities will meet the needs of clients, staff and others, and will unite new and existing improvement activities into a system wide approach.

4. Data will be systematically collected to measure process and outcome.

5. Data will be assessed to:
   a. Identify current level of performance.
   b. Evaluate the stability of the processes.
   c. Identify effectiveness of communication systems.
   d. Identify areas to be improved.
   e. Identify strategies to stabilize or improve processes.
   f. Evaluate whether outcomes were achieved.
   g. Compare results with self, others standards, and best practices, using statistical techniques.

6. This process will encourage the following behaviors/activities:
a. Recognizing and acknowledging the risks and anticipated adverse events/outcomes.

b. Initiating actions to reduce risks and outcome.

c. Reporting internally on risk reduction initiatives and their effectiveness.

d. Minimizing blame or retribution for involvement in an unanticipated adverse event/outcome.

e. Investigating factors that contribute to unanticipated adverse events.

f. Sharing knowledge within the organization and with other organizations.

7. Intensive assessment will be completed when undesirable patterns or trends in performance is detected.

8. The plan will target the performance of existing processes and outcomes and identify/design new processes based on priorities, standards and resources.

9. An ongoing program will be in place to identify and reduce unanticipated adverse events and safety risks to clients.

10. The Board of Directors will receive information about findings and activities that is needed to fulfill their responsibility for the quality of client care and safety and security of clients, staff and others.

11. Information is communicated to all departments when they are impacted by Performance Improvement activities or findings that impact the agency and its goal of providing quality care in an efficient and effective manner.

12. Performance improvement activities, minutes, reports, correspondence are considered to be confidential and privileged. Some information may be disseminated on a “need to know” basis as required to meet regulatory requirements and other review organization. This would be approved by the agency administrator/Board of Directors.

13. The Performance Improvement Plan is evaluated at least annually and is incorporated into the annual agency evaluation required by CMS.
CUSTOMER EVALUATION OF SERVICE

POLICY
Agency will have a system for collecting information from client/families to assess satisfaction with services provided and determine whether their expectations were met. The process will identify specific time points when data will be collected and methods for data collection. Data may be collected by using a telephone survey or evaluation form mailed to the client’s home. A summary report of the findings will be submitted quarterly to the Performance Improvement Committee. The Administrator or designee will evaluate physician satisfaction and referral source satisfaction data at designated intervals.

Agency will participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Care Survey is designed to measure the experiences of people receiving home health care from Medicare certified home health care agencies.

The survey is designed to meet three goals

(1) Produce comparable data on the client’s perspective that will allow objective and meaningful comparisons between agencies on domains that are important to consumers,

(2) Public reporting of survey results is designed to create incentives for agencies to improve quality of care, and

(3) public reporting serves to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment.

Data is collected on Medicare and Medicaid clients receiving skilled services.

PURPOSE
To provide a mechanism for customer evaluation of the agency’s ability to provide satisfactory services to clients, physicians, referral sources, and agency staff.

To obtain client’s/family members, referral sources and other customers perception of care and services provided.

To identify areas that could be improved to enhance the quality and safety of services provided.
SPECIAL INSTRUCTIONS

1. An agency representative will contact the specific clients or a sampling of all clients at the designated time points either by phone or through written survey to evaluate initial services. A client satisfaction survey will be sent to the client’s home at the time of discharge from agency services.

2. The Director of Clinical Services/designee will prepare a summary report to be reviewed by the Professional Advisory Board.

3. Based on the results of the client evaluation survey, the organization will evaluate the need to refocus its service and/or redesign the existing process of providing service, as appropriate.

4. Input will be obtained from internal and external customers on an ongoing basis. This information will be reviewed to determine whether needs and expectations are being met. Data may be collected through one or more of the following methods:
   a. Verbal or written satisfaction surveys.
   b. Exit interviews with employees leaving the agency.
   c. Performance appraisals.
   d. Staff meetings.
   e. Focus groups.

5. Results of data collected through the CAHPS process will be reviewed and presented to agency staff. Improvement processes will be identified based on information from the surveys.

6. Agency will collect data from representation of clients not included in the CAHPS survey. This data will be analyzed quarterly and presented to staff and management. Data collected will be aggregated and reviewed by leadership with other performance measurement information to identify patterns or trends in customer satisfaction. Based on this information, opportunities for improvement will be identified and improvement plans defined. As appropriate, it will be incorporated into the agency’s Performance Improvement Plan, and the annual agency evaluation.
ENVIRONMENTAL SAFETY

POLICY
It is the policy of Agency to maintain an environment free of hazards and risks. Every effort is made to prevent accidents and injuries to both Agency staff and clients. All staff will receive safety education during orientation programs, annual safety in-services, and thorough ongoing education as need arises.

Clients will receive written information addressing identified risks in the home setting. An annual inspection will be completed to identify environmental hazards in the workplace and unsafe practices in the office. An action plan will be developed to address problem areas.

Each year the Agency will participate in one community practice drill relevant to emergency preparedness in the community. These drills will evaluate the communication, coordination and attention to “chain of command” structures in the agency and in the community.

PURPOSE
To reduce the risk of injuries or threats to life and health in the client’s environment by identifying and implementing activities to reduce safety risks and mobility risks.

To identify and implement infection prevention and control systems that allow the agency to respond to infection risk to the agency and community.

To identify and implement activities to reduce the risk of staff injuries.

To identify and manage agency security risks.

To create an environment that focuses on client safety at all times.

SPECIAL INSTRUCTIONS
1. Home safety assessments are performed on all clients at time of admission and include fire safety, electrical safety, bathroom safety, medication safety, equipment usage and adequate storage and handling of medical gases, drugs, and hazardous wastes. The client will be provided written information related to risks identified and how they may be corrected.

2. An office safety program is established that includes:
   a. Emergency preparedness plan.
   b. Fire safety, evacuation plan, and maintenance of fire detection systems,
including an annual fire exit drill.

c. Office disaster plan including, but not limited to, a severe weather watch.

d. Equipment safety with specific attention to the maintenance of equipment and testing of alarm systems.

e. Infusion Pump Safety that includes free flow protection on all pumps used in the home care setting.

f. Infection control plan for responding to influx or risk of an influx, of infectious clients.

g. Body mechanics.

h. Safe storage of office supplies and equipment and hazardous products.

3. A security plan is established which includes protocol regarding personal safety and handling of unsafe situations.

4. All client care employees will attend in-service on safety management and infection control upon employment, annually, and as the need for further instruction is identified by their supervisor.

5. Systems are in place to communicate with staff and, as appropriate, clients and families, about infection prevention and control issues including their responsibilities in preventing the spread of infection within the organization.

6. Client related safety hazards will be documented in the clinical record and brought to the attention of the Supervising Nurse.

7. All accidents, injuries, errors or acquired infections will be reported to the Supervising Nurse and documented on an Incident Report. This would include medication errors, adverse drug reactions, transfusion reactions.

8. If the accident/incident involved the client, appropriate actions will be initiated. The physician will be notified to obtain specific follow-up orders.

9. If an accident or incident involves equipment malfunction and serious injury, illness, or death, the incident will be reported in writing to the vendor and/or manufacturer. (See safe medical device policy.)

10. The agency implements systems for investigating all accidents, errors, injuries and their outcomes. This includes documentation of all reported incidents and the investigations and corrective actions taken.

11. Documentation of incidents with trends and patterns will be incorporated into an Agency Performance Improvement Plan.
BED BUG ACTION PLAN FOR HOME HEALTH

POLICY
Agency will provide education/training to home care staff to prepare them for working in environment with bed bugs.
Agency staff will follow guidelines for identifying and managing bed bug infestations.

PURPOSE
To identify presence of bed bugs and actions to take to prevent infestation.
To assist clients to contact authorities to remove bedbugs from the home or apartment building.

SPECIAL INSTRUCTIONS
1. First remember that bedbugs are not known to cause disease. They are a nuisance and actions can be taken to remove them.
2. Contact your local extension agent and ask them who can provide an excellent bed bug training program. The agent may recommend a bed bug experienced pest management company, or some other local authority.
3. Once you have located a bed bug expert, schedule a training program for all employees. The training should include the identification of live bed bugs (all life stages), and bed bug evidence (including fecal stains and molted skins).
4. Seeing bed bug evidence in place will help employees to recognize the signs of bed bug infestation in someone’s home, even if they do not see live bugs.

PREPARING FOR HOME VISITS
1. Always wear simple clothing when visiting a client’s home.
2. Avoid shirts with buttons and pockets (professional looking, long-sleeved, light colored tee-shirts are advisable).
3. Avoid cargo pants or pants with cuffs.
4. Simple shoes that can be thrown in a hot dryer, and that have minimal tread are also recommended.

5. Do not accessorize with anything, particularly scarves, jewelry or handbags

AFTER YOU ARRIVE:

1. Wear protective booties at all times or at least when you are uncertain about the presence of an infestation in the client’s home. If asked about the booties, let the client know that you are trying to protect them from insects that you may have encountered at other residences.

2. Coveralls or a Tyvec® suit can be worn if you are entering a home where you know there is a severe infestation. Coveralls should also be considered if you know that you will be moving or carrying items, like a wheelchair from an infested home. Coveralls should also be worn if you are physically moving people or animals from an infested home

3. Do not sit on upholstered furniture or the bed. Take a quick look in the cracks of hard chairs before sitting down

4. Carry only those items with you that are essential to the home visit. Leave everything else in the car.

5. A plastic clipboard can be used to hold your paperwork. A fanny pack can be used to hold your wallet, personal items, spare gloves and booties.

6. Avoid placing anything on upholstered furniture, bedding, or on carpeted floors.

IF BED BUGS ARE DISCOVERED IN THE HOME DURING THE VISIT, REMAIN CALM!

1. Record the infestation in notes and notify the office so you will be prepared for the next visit.

2. When you return to your vehicle, remove your booties immediately and seal them in a plastic bag. Dispose of the bag before you get in the car.

3. If you were wearing coveralls or a Tyvec® suit remove it by turning it inside out to trap any bed bugs inside.

4. Place the suit in a sealed plastic bag and dispose of it before you get in the vehicle.

5. Check your clothing (the back of your pants, tread of your shoes, shoe laces, socks, cuffs and collar).

6. If you find an insect on yourself (bed bug or cockroach), don’t freak out. Use a “wet wipe” to capture the insect (for later identification). Use another to wipe down the surrounding area, paying attention to seams, buttons and other bed bug
hiding places. Wipe downs are not necessary if you do not find any bugs during your self-inspection.

**IF YOU ARE REPEATEDLY VISITING INFESTED HOMES:**

1. Protect yourself and other clients by always wearing booties and protective coveralls and using a bed bug containment kit. The kit is illustrated below:
   a. A portable, hard surface chair or stool.
   b. A fanny pack for holding personal items like your identification, cell phone, additional booties or gloves.
   c. A change of clothes and shoes (kept in your vehicle).
   d. A plastic storage container with a sealed lid that is large enough to contain the items listed below or items that you might suspect to be infested.
      i. Protective booties and Tyvek® type coveralls
      ii. Disposable gloves
      iii. A roll of duct tape (light colored)
      iv. Small plastic garbage bags
      v. A roll of clear plastic drum liners (50 gallon garbage bags)
      vi. Flashlight
      vii. Narrow banded spatula (for crushing bed bugs)
     viii. A fresh container of wet wipes (i.e. Wet Ones antibacterial)

**WHEN RETURNING HOME:**

1. **HEAT IS EXCELLENT BED BUG KILLER,** and nothing is more effective for killing all bed bug life stages than a hot clothes dryer.

2. Remove your work clothes as soon as you return home. Your clothes, including shoes, can be tumbled in the dryer on high for 30 minutes and emerge bed bug free. A dryer with a removable shelf is excellent for heating items that cannot be tumbled, like backpacks or other supplies. Avoid shirts with buttons and pockets (professional looking, long-sleeved, light colored tee-shirts are advisable).

**IF STAFF MEMBER CONTACTS BED BUGS:**

1. Notify nursing supervisor of the source, and return to your home.
2. Remove all clothing before entering the home if possible (or in the bathroom if not).
3. Immediately place your clothing in sealed plastic bags. Get into the shower.
4. After showering, collect your sealed items and place them in the washer with hot soapy water. Place shoes in a hot dryer for 30 minutes. Dry your clothes on high heat.
HAZARDOUS MATERIALS MANAGEMENT

POLICY

Agency will identify materials used by staff that need special handling and develop processes to minimize the risk of their unsafe use and improper disposal. The agency will create an inventory that identifies hazardous materials and waste used, stored or generated which is consistent with applicable law and regulation.

All employees who work with or may be exposed to hazardous materials under normal working conditions or foreseeable emergencies have the need and “right to know” what health and physical hazards exist from chemicals found in the workplace.

The agency establishes and implements processes for handling, transporting and disposing of hazardous materials and waste including chemicals, chemotherapeutic agents, infectious or regulated medical waste and sharps containers.

Agency will properly and safely dispose of, or arrange for the disposal of, all hazardous waste. The agency will be responsible for implementing a waste management plan, educating employees and clients, and assuring that all required records are completed and maintained.

PURPOSE

To protect all employees, clients, and caregivers/family members from unnecessary exposure to hazardous substances.

To provide information about the chemicals in the workplace and their hazards to all employees. This will include employee training, material safety data sheets (MSDS), container labeling and lists of hazardous materials present in the workplace.

To assure the agency meets federal, state, and local regulations as recommended by OSHA, the CDC, and the EPA.

DEFINITIONS:

Hazardous Material: any material or chemical that is a physical or health hazard. This includes infectious material, radiation, ethylene oxide, or chemotherapy agents.
Health Hazard: any chemical that is toxic or highly toxic, cancer causing, irritant, corrosives, sensitizes, hepatotoxins, nephrotoxins, agents that act on the blood system or that damage the lungs, skin, eyes or mucous membranes.

SPECIAL INSTRUCTIONS

1. The agency is responsible for implementing a waste management plan, maintaining records, and training staff members.

2. The waste management plan shall be composed of three areas:
   a. Identifying the seven classes of medical waste.
   b. Establishing procedures for the safe handling and storage of waste prior to disposal.
   c. Disposing of waste materials properly and documenting of their disposal.

3. Records documenting the disposal of waste will be maintained in a separate waste management file. Records will be made available to authorized federal and state agencies upon request or as required by law.

There are seven (7) classes of medical waste as identified by the EPA:
Classes 3, 4, 6, and 7 may be generated by a home health care provider.

a. Class 3: Liquid waste, human blood, blood products, items contaminated with blood, serum, plasma, and other blood products.

b. Class 4: Sharps, such as any discarded article contaminated with blood or other potentially infectious materials and/or specimens, including, but not limited to:
   - Needles.
   - Vacutainer tubes.
   - Microhematocrit tubes.
   - Microscope slides and cover slips.
   - Injection ampules.
   - Vials and other glassware items that may be contaminated.

c. Class 6: Discarded articles contaminated with body fluids from humans who are known to be infected with a highly communicable disease.

d. Class 7: Unused, discarded sharps including hypodermic needles, suture needles, syringes, and scalpel blades.
HANDLING AND STORAGE OF WASTE

Waste generated by the agency will fall into three categories: general waste, medical waste, and sharps.

1. General Waste

   General waste consists of normal office or household waste such as paper, packing materials, and client products such as diapers, dressings, drapes, etc. that are not visibly soiled with blood or other potentially infectious materials. This waste may be disposed of in normal trash bags and stored in regular, unmarked trash containers.

2. Medical Waste

   Medical waste includes items that have been contaminated with blood or other potentially infectious materials. This includes client paper products that are visibly soiled. These items are handled with employees wearing gloves as protective equipment for infection control.

   If there is not an approved sanitary sewer connection available, liquid medical waste (blood, urine, irrigating solutions, drainage) will be stored in a sealable, leak proof container and labeled. These items may be disposed of by pouring directly into a waste drain/toilet if sewer hook-up is present.

   Chemotherapy waste (tubing syringes, gloves, etc.) must be placed in a container specifically labeled for chemotherapy waste.

3. Sharps

   Sharps include items that are capable of causing a cut or puncture that have been in contact with blood or other potentially infectious material.

   a. All used sharps will be placed into a puncture-resistant, leak proof impervious container immediately after use.

   b. Sharps are to be disposed of in an approved puncture-resistant container with an international biohazard symbol labeled as “biohazardous” or “infectious medical waste.”

   c. The containers should remain upright. They should have a closable lid and be leak proof when sealed.

   d. Containers should not be filled above the identified “fill line.” Once the container is filled, the lid should be tightly closed. The container should be returned to the office for disposal according to agency policy.

   e. Used sharps should not be recapped, bent, removed from disposable syringes, or manipulated by hand unless the specific procedure requires that recapping be performed.
WASTE STORAGE

1. Medical waste shall be separated from other waste and stored in a red or orange bag labeled as biohazardous. The bags must be strong enough to resist tearing or bursting under normal conditions of handling. When containers are three-fourths full, they will be closed tightly and returned to the office for disposal.

2. Biohazard bags must be kept in a waste receiver labeled with the international biohazard symbol and stored in a low traffic area. Medical waste containers must have closable lids.

3. Waste will be stored for a period not to exceed 30 days, or as defined by state laws.

HAZARDOUS MATERIAL LABELING:

- All hazardous containers will be labeled with the identity of the material and appropriate hazard warnings.
- Labels must be legible and prominently displayed.
- Unlabeled containers will not be used and their presence will be reported to the Director or designee.

Safety Data Sheets (SDS)

The chemical name stated on the warning label must be identifiable to the chemicals described on the SDS.

The S will provide detailed information on each hazardous chemical including its potential hazard effects, its physical and chemical characteristics and recommendations for protective measures. Information about products can be accessed at www.msdsonline.com.

A master list of all hazardous chemicals/products will be available from the Director of Clinical Services at any time.

TRANSPORTING WASTE

1. Waste will be transported from the client’s home in the locked trunk of a vehicle and kept segregated from clean supplies and equipment. The waste will be placed in a designated storage area prior to pickup by the licensed biomedical waste disposal company.

2. Chemotherapy waste will be segregated from other waste.

3. Medical waste and sharps containers are placed into a containment device provided by the biomedical waste company.
WASTE TREATMENT AND DISPOSAL

1. The agency will contract with a commercial, licensed biomedical waste company to transport waste for treatment and final disposal. All final disposal methods will be in compliance with federal, state, and local regulations.

2. Each client with hazardous waste potential shall receive a puncture proof container on the first visit. Filled containers are to be placed in a large sealable polyethylene or polypropylene bag that is labeled with a distinctive warning to the waste disposal company.

3. Unused portions of drugs and equipment used to administer the drugs are to be disposed of according to the established agency policies and procedures. Employees shall be advised not to dispose of unused drugs or contaminated solutions in drains or toilets but to use the original vial, IV bag/cassette, or other closed container, which is to be placed in a labeled double plastic bag. Contaminated materials such as gloves, gowns, masks, vials, tubings and pads shall be double bagged in leak proof sealable bags or containers that should include a prominent and distinctive warning label. An example of a warning label is: CAUTION: chemotherapy waste.

4. When waste containers are picked up, the company representative will obtain a signed copy of the manifest (the listing of what has been picked up) to keep on file in the office.

HAZARDOUS WASTE AND SPILL EXPOSURE

1. If there is employee exposure to general waste materials, hands should be washed with soap and water as soon as possible. No other precautions are necessary. If there is exposure to hazardous waste with potential for exposure to blood borne pathogens, the employee will immediately cleanse the site with soap and water and report the occurrence to the Director of Nursing or designee.

2. The client and family should be instructed what to do if accidental exposure occurs. All available information shall be given to the family concerning possible toxicity so they make decisions regarding place for treatment in the home. The client family shall be instructed to call the nurse immediately to report the occurrence of a spill.

3. Gloves should always be worn when cleaning spills of body fluids or waste. Disposable towels should be used to wipe up the spill. The surface should then be cleaned with an appropriate solution, such as 1:10 bleach solution or 70% isopropyl alcohol (rubbing alcohol).

4. Federal disposal regulations depend upon the category of hazardous waste. Many Antineoplastic agents are currently classified as toxic waste and must be disposed of in
accordance with federal regulations. Some of the more commonly used drugs in this category are: Daunomycin, Cyclophosphamide/Cytotoxan, Daunomycin, Mitomycin, and Streptozotocin.
SAFETY MANAGEMENT PROGRAM

POLICY

The agency will develop a program for identifying and reducing unanticipated adverse events and safety risks to clients and employees. The safety program will have one or more qualified individuals assigned to manage the organization wide program.

All clients will receive a home safety assessment and instruction in safety management, as appropriate.

All employees, clients and caregivers, as indicated, will receive instruction in applicable safety management including but not limited to: home safety, fire response, electrical safety, environmental safety, infection control and hazardous waste handling and disposal.

PURPOSE

To foster a safe environment throughout the agency by integrating safety priorities into relevant processes, functions and services. Improve client safety by reducing risk of system or process failures.

Inform the client and his/her family of their responsibilities in reducing unanticipated adverse events.

To increase employee awareness of potential risks and appropriate actions to take for personal and client safety.

SPECIAL INSTRUCTIONS

1. All appropriate employees and clients/caregivers, as indicated, shall receive instruction in safety management including, but not limited to:
   a. Basic home safety.
   b. Fire response.
   c. Electrical safety.
   d. Bathroom safety.
   e. Transfers and ambulation.
   f. Use of medical equipment.
g. Storage, handling, delivery, and access to supplies, medical gases and drugs, especially chemotherapeutic agents, controlled substances, parenteral and enteral nutrition solutions, and needles.

h. Standard Precautions.

i. Refrigeration.

j. Disposal of needles in a non-penetrable, non-glass container.

k. Double boxing and bagging.

l. Infection control.

m. Hand washing.

n. Hazardous waste handling and disposal.

2. Clients and families will be informed of the risks identified in the home safety assessment, and encouraged to participate in managing the risks.

3. Direct care employees shall monitor the client/caregiver’s understanding and compliance with safety management on an ongoing basis. Appropriate instructions will be provided.

4. All direct care employees will attend education programs as part of agency orientation, annually, and as needed to assure safety for employees and clients.

a. Employee responsibilities will include:

   - Reporting all work related injuries, illness, symptoms, etc.

   - Reporting any unsafe working condition or unsafe work practice.

   - Wear all required personal protective equipment and observe safety policies.

   - Use safe lifting techniques.

   - Maintain good housekeeping to prevent slip, trip and fall hazards.

5. Client-related safety hazards will be documented in the clinical record and brought to the attention of the Supervising Nurse.

6. All accidents or injuries will be reported to the Supervising Nurse and documented on an Incident Report.

   - All injuries, illnesses and first aid incidents will be investigated.
• Investigation is focused on looking for causal factors or hazards.

7. If the accident involves the client, appropriate actions will be initiated. The physician will be notified to obtain specific follow-up orders.

8. If an accident or incident involves equipment malfunction and serious injury, illness, or death, the incident will be reported in writing to the vendor and/or manufacturer (See Medical Device Policy).

9. Information identified about risks and events will be evaluated by the safety program managers and recommendations made to reduce or eliminate practices leading to safety issues.

10. Documentation of incidents, including follow-up documentation with trends and patterns will be incorporated into the agency performance improvement plan.

11. The Agency will conduct an annual environmental site inspection to identify hazards, unsafe practices, environmental deficiencies and opportunities for improvement.
OSHA 300 LOG

POLICY
The Agency will maintain a record of occupational injuries and illnesses. The information will be documented on the OSHA 300 Log and maintained as a confidential administrative file. A summary of this information will be incorporated into Performance Improvement Plan, and reported to the Governing Body at least annually.

PURPOSE
To meet OSHA requirements for recording and maintaining records of occupational injuries and illnesses.

To identify areas for performance improvement and to strive to provide a safe work environment for employees.

SPECIAL INSTRUCTIONS

1. The Human Resource Manager is responsible for completing, maintaining and posting the OSHA 300 Log in accordance with OSHA record keeping requirements.
   a. All work-related illnesses are recorded. Injuries requiring medical treatment (other than first aid) or involving loss of consciousness, restriction of work, or motion or transfer to another job are recorded.
   b. Medical treatment does not include: one-time treatment and/or subsequent observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care even though provided by a physician or registered professional personnel.
   c. Exposures to and/or contraction of reportable communicable diseases in the course of work performance are considered reportable on the log.
   d. Employee needlesticks with contaminated needles must also be recorded on the log. Each injury or illness is recorded within five (5) days after learning of the occurrence and maintained for each calendar year.
2. The OSHA 300 Log is retained for a five (5)-year period and available for inspection by employees, former employees and authorized federal and state officials.

3. The “Annual Summary” half of the OSHA 300 Log for the preceding year is posted with employee notices each February 1 - March 1. The log is posted even if there are no recorded injuries or illnesses.

4. The OSHA 300 Log may be obtained from the local regional OSHA office.
INCIDENT REPORTING

POLICY

The Incident Report Form is to be completed whenever there is an incident involving a staff member or a client. An incident is defined as any occurrence that involves an employee, client or family member that is not consistent with regular routine. This is the definition regardless of whether there was apparent injury or other damage.

Staff is expected to follow agency policies to prevent incidents and seek assistance immediately in the event of an incident.

The reporting of incidents and the investigation are part of the agency’s Performance Improvement Program. Trends or problem areas will be brought to the attention of the appropriate committee.

PURPOSE

To ensure a mechanism is in place for reporting and documenting all accidents, occupational illness, property damage, injuries, and safety hazards related to staff or clients.

To document the agency’s investigation and response to each incident.

To identify processes and/or systems that require change to reduce risk to agency, staff and clients.

SPECIAL INSTRUCTIONS

1. Agency will document and report all incidents that deviate from routine agency operations and will or could result in injury or potential harm to a client/caregiver or employee.

2. Incidents to be reported include, but are not limited, to:
   a. Missing or damaged property.
   b. Client endangerment.
      • Alleged/suspected client abuse or neglect.
      • Unexpected death within twenty-four (24) hours of admission.
      • Witnessed client falls or other injury.
- Untoward outcomes—drug reaction or toxic effect, IV complications.
- Medication and treatment error.

c. Equipment/medical device failure or malfunction.

d. Staff endangerment.

  - Motor vehicle accidents involving agency vehicle or employee’s vehicle while on agency business.
  - Any staff incidents that require treatment, lost work days, hospitalization or that identify new safety hazards previously unrecognized.

e. Refusal of treatment.

f. Solution or supply contamination.

g. Treatment/procedures resulting in client injury.

h. Noncompliance of client/family resulting in injury.

i. Staff member fails to report significant findings.

j. Witnessed cardiac arrest when no DNR order is present.

3. Staff members will immediately report the incident to their supervisor. An Incident Report form shall be completed in its entirety by the person involved or the first person to become aware of the incident. The incident report should not include opinions or conclusions, but facts, direct observations and witness statements.

4. Client outcomes shall be documented in the progress report if necessary. When indicated the appropriate staff or supervisor will notify the client’s physician to determine the need for follow-up treatment.

5. If the injury has occurred to staff, they will be advised to receive medical evaluation. Within twenty-four (24) hours the staff person will file a report with the Worker’s Compensation Insurance Provider.

6. Following an exposure to blood or body fluids, a confidential medical evaluation will be offered to staff at no cost to the employee (See Post exposure Policy).

7. Incident reports are reviewed by appropriate supervisors and a determination of whether further action is needed is made. After the report is reviewed by the administrator, the leadership team determines opportunities for performance improvement or whether to continue monitoring.
8. Aggregated results are part of the annual Performance Improvement Program evaluation.

9. The administrator shall be notified immediately of serious client/employee injury that may be a potential liability issue. An investigation will be conducted to determine causal factors, and recommendations for actions to correct or prevent a similar occurrence. A corrective action plan shall be developed, reviewed and approved by the Administrator prior to implementation.

10. Incident reports will be treated as privileged communication among agency staff, quality council, and legal counsel.

11. If the incident involves a client, documentation will address the objective facts in the client record. Do not chart that an “error” or “mistake” was made, or that an incident report has been completed.

12. Incident reports will be filed in a locked administrative file, not in the clinical record. The administrative file will contain the original report, follow-up report, and specific interventions taken to prevent reoccurrence. Records will be retained for a minimum of five (5) years for adults and two (2) years beyond the state’s legal age of majority for minors.
CLIA WAIVER - LABORATORY TESTING

POLICY

The agency will obtain a CLIA Waiver for the laboratory tests that will be done in the home setting and communicated to the physician. Testing done will be according to physician orders.

Laboratory specimens obtained by Agency staff will be referred to a certified facility for those services. A certificate of waiver will be maintained by Agency for laboratory specimen collection and analysis done in the home setting with equipment owned by the agency, client, or a staff member. Note: if the client performs the blood glucose collection and analysis and staff is not involved, the CLIA requirement would not be applicable to client owned glucometers or INR machines.

Agency staff will perform only waived testing procedures that meet Clinical Laboratory Improvement Amendment of 1988 (CLIA88) Requirements. Tests performed in the home include, but are not limited to: blood glucose levels and PT/INR obtained via fingerstick and read by the nurse.

The agency will identify those tests staff must demonstrate competency in and establish a process to assure continued competency.

PURPOSE

To ensure compliance with federal and state regulations concerning laboratory testing outside the context of assisting an individual in self-administering a test.

To ensure agency staff who performed waived testing demonstrate current competence.

To ensure that waived tests are performed accurately and appropriately.

SPECIAL INSTRUCTIONS

1. Waived tests are simple, stable and require a minimal degree of judgment and interpretation.

2. Agency will identify when waived tests are to be completed by agency personnel and which personnel may provide each test.

3. Agency will provide training to agency personnel performing waived tests and
determine clinical competencies for those tests.

4. CLIA requirements apply to Agency owned, staff owned or client owned glucometers or other instruments used for testing. (If the client performs the blood testing and agency staff is not involved the CLIA requirement would not be applicable.

5. The results will be used for diagnosis and/or treatment. Follow up confirmation testing is required per physician order and/or potential or suspected equipment malfunction. If follow up confirmation testing is required, such testing will be performed by an outside laboratory.

Only tests on waived list may be performed by agency personnel. These tests include those listed here. (A complete list is maintained by CDC and changes rapidly. This complete list can be found on the Internet at /www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf.

6. Some common CLIA-Waived tests:
   a. Dipstick/Tablet Urinalysis.
   b. Some automated Urine Dipstick Readers.
   c. Fecal Occult Blood/Gastric Occult Blood Tests.
   d. Glucose Tests (whole blood systems).
   e. Cholesterol Tests (whole blood systems).
   f. Prothrombin Time Instruments (whole blood meters).

7. Manufacturers’ instructions must be followed in performing the test.

8. Licensed staff will receive training and orientation prior to performing the tests. Competency will be assessed prior to performing the testing and at designated time period afterwards.

9. The training and orientation will be specific to the laboratory tests the staff member will perform. The orientation may be obtained through reviewing the manufacturers’ written material, viewing videotapes, or through arrangement with a certified laboratory.

10. All testing results must be documented in the client record.

11. The agency will maintain a log of laboratory testing performed in the home and will establish a system that allows for retrieval of results and quality control values for a minimum of two years.
12. Records must be made available and reports submitted as required by the Department of Health and Human Services.

13. All laboratory tests performed on waiver list will be per physician orders.

14. A record is maintained of all equipment used by agency personnel, (agency owned) including serial numbers and a record of preventive maintenance.

15. Staff competence will be assured through random observation of qualified staff performing specific lab tests.

16. As applicable to tests agency staff perform, the agency will maintain written procedures, and these will be reviewed at least annually. Written policy procedure includes:
   
   a. Specimen collection.
   
   b. Specimen preservation.
   
   c. Instrument calibration per manufacturer guidelines.
   
   d. Quality control checks per manufacturers guidelines and remedial actions taken as necessary.
   
   e. Equipment performance evaluation (on equipment owned/leased by agency).
   
   f. Test performance.

17. Quality control documentation will be kept on a log that tracks equipment by serial number of owned equipment.

18. Agency will maintain a copy of the current CLIA certificate for each outside laboratory (CHAP requirement).
EMERGENCY PREPAREDNESS

POLICY

An emergency will be described as any unforeseen happening which causes much damage or disruption; examples of emergencies will include:

1. Tornadoes.
2. Floods.
3. Snowstorms.
4. Chemical spills.
5. Industrial accidents.
6. Automobile accidents involving multiple injuries.
7. Earthquakes.
8. Bio hazardous Weapons
9. Pandemic

Home Health and Hospice staff members will implement this Emergency Preparedness Policy as soon as the Agency becomes aware of the existence of an emergency.

PURPOSE

- To readily identify the patients who are affected in the case of an emergency.
- To provide those patients with the care and assistance that they need in the event of an emergency.
- To be readily available to assist emergency responder personnel in first aid care for those in the community.
- To assess patient’s home environment for safety and assist them to a safe environment if needed.
- To coordinate Agency staff members in patient care and evaluation, as well as any Agency personnel assistance with care of those in the community who are affected by the emergency.
EMERGENCY PREPAREDNESS PLAN

Calling Order (refer to Calling List)
Administrator will notify Operations Director, then goes to the Director of Nursing and Director of Clinical Operations to develop assignments. Operations Director will go to the corporate office in Willmar. (Administrator and Operations Director will be referred to as the Emergency Supervisors).

Office Managers and Staffing Coordinators will notify persons listed below them on the calling list. If they are unable to reach an employee on the telephone, they will proceed to the next listed person on the list. The Office Manager and Staffing Coordinator will call the corporate office and list the employees available for assistance then come to their local office. Upon arrival Office manager and Staffing Coordinator or will try those employees not found with the first call attempt and notify the Emergency Supervisors of any other employees found to available to be on standby. They will also manage calls upon arrival at the office. If Office Manager is not able to reach Staffing Coordinator, Office Manager will notify persons under staffing coordinator on the calling list.

After Receiving Notification of an Emergency - Patient Care Staff
- Do not leave your home until you receive your assignment.
- Do not ask questions when you are called. This will only slow down the rate of calling and response time to the emergency.
- When you receive a call with your assignment, you will receive all of the necessary information about the emergency and those affected.
- Please wear your nametag and Agency shirt if you have one so you can be easily recognized by other cooperating agencies.
- Stay off of the phone so your second call can come through uninterrupted.

If You Are Away From Home When a Emergency Happens - Patient Care Staff
- Call the Agency office to let the Emergency Supervisors know that you are available to help. You will receive an assignment at that time.
- If there are no working telephones, either come to the triage site or Agency office (whichever is closest) for assignment. In the event that the telephones are not working, the Emergency Supervisors will be at the triage site or office and all assignments will be made from there.

If an Emergency Occurs During Working Hours - Patient Care Staff
- When you report for assignment of emergency patients, give a list of those patients you have yet to see to the Emergency Supervisor. A decision will be made by one of the Emergency Supervisors as to whether you will be pulled to help with the emergency assessments, or be assigned to continue with your regular assignments or to assume some patients left from those who are assigned to work on the emergency assessments. Those staff
members who have had first aid training will be high priority to be assigned to emergency assessments.

Assignments
- Administrator will be in full charge of assignment of staff to specific tasks. Operations Director, Office Manager and/or Staffing Coordinator will assist in pinpointing patients affected by the emergency and assigning staff members to check on those patients by utilizing the pre-arranged coding system. On admission, each patient will be assigned a code, dictating that patient’s emergency rating.
- After Office Manager and Staffing Coordinator have called and put a staff member on alert, that staff member will wait for a call back with their assignment and where to meet their partner, if a partner is assigned.

Emergency Assessments
- Each nurse making home visits to patients needs to call the Agency office with an update on the patient’s situation. If there are no working phones, each nurse will go to the triage site or office to get an update on the patient’s situation. New assignments will be made at that time. When the nurse has completed the list of patients assigned to them, they will be assigned to a community assistance first aid site to help with triage if needed, or will be assigned to specific patients from the regular case load to complete that day’s schedule. If a patient needs to be moved to another site, the following procedure will be followed:

1. If the patient is unharmed but the home is damaged or unsafe and the telephone system is working, contact family or friends that the patient may request and help make arrangements to move them. Keep track of where the patient is going and all the necessary telephone numbers. Contact Emergency Supervisor who will make arrangements with local county emergency planners for transportation to an alternate care facility if other arrangements cannot be made.
2. If the patient/client is injured and needs transport, contact local ambulance personnel.

- Remember- the official personnel who are at the site (police, ambulance personnel, etc.) have had training in handling emergencies, as well as potentially hazardous situations. If they tell you not to go to a certain area, don’t go. In the event of blocked or impassable roads, staff members will take alternate routes or notify county emergency management of inability to reach an area.

Unsafe Home Situation
Before entering a patient’s home, determine if there is safety issue such as possible gas leak, exposed electrical wire, etc. Assess the situation and report to the emergency supervisor or local county emergency personnel to secure the site.
Emergency Supervisor Tasks

When Administrator gets a call asking for assistance with an emergency, she will call the Operation Director and Office Manager or Staffing Coordinator. Both will then go to the Agency office immediately. Immediate tasks for the Emergency Supervisors will be:

- Determine the area struck and that patient of the Agency’s affected by the emergency.
- The emergency code for each of these patients.
- An assignment list

While this is being determined, calls will be made to nursing homes and Assisted Living Facilities to determine the number of volunteer rooms which will be available for temporary placement of displaced patients. The Emergency Supervisors will also maintain a list of employees who have been notified and are available to assist in the emergency assessments. The patients who need assessments will be reassigned among the staff available and an Emergency Supervisor will then call each employee with assignments for who their team member is as well as the patient assignment.

Service Provision in a Pandemic

In the event of a pandemic every possible effort to continue service and minimize the exposure to our patients will be made. Patient and employee infections will be tracked and recorded. Emergency supervisors will use the same guidelines they use for disasters in evaluating patient’s need to be seen. Those with a high risk rating will be seen first. Possible staffing solutions include:

1. Utilization of existing staff and lengthening staff shifts.
2. Training of non-facility staff brought in from other locations to provide client care when the facility reaches a staffing crisis.

- All staff are encouraged to receive the flu vaccine. Staff have three options for receiving the vaccine and should contact their office for instructions.
- Staff should use additional personal protective equipment such as a mask and gown as appropriate during a pandemic. Universal precautions, such as gloves, hand washing and disinfecting wipes and cleaners, will always be used and reinforced.
INFECTION CONTROL PLAN

PURPOSE
The infection control plan defines the structure and activities for surveillance, prevention and control of infections among clients, employees and all others who come into contact with clients, and establishes responsibility for oversight of these activities. The Agency has developed an Infection Control Plan that conforms to OSHA regulations, CDC guidelines, JCAHO, CHAP, and ACHC requirements, state and local regulations and commonly accepted Standards of Practice.

AUTHORITY
The home care management team including the Director of Clinical Services, Director of Nursing and others as designated have the authority for routine identification and analysis of the incidence and cause of all infections and shall develop and implement a plan for surveillance, prevention and control of infection hazards.

SURVEILLANCE
The activities related to the Infection Control Surveillance Plan shall be based on an assessment of the population served by the agency, JCAHO, CHAP, and ACHC indicators, high risk and high volume indicators, CDC definition of infections, and assessed agency needs based on data collection.

ORIENTATION AND CONTINUING EDUCATION OF PERSONNEL
All new employees of the agency shall complete an education session that covers Blood Borne Pathogen Exposure Control Plan, Tuberculosis Plan, CDC’s Hand Hygiene Guidelines and basic infection control. Ongoing education will also be provided to employees, clients, and visitors, utilizing a variety of formats and modalities, and based on the most current CDC, and OSHA guidelines, state regulations and requirements of accrediting bodies.

REPORTS TO PUBLIC HEALTH OFFICIALS
Data obtained through surveillance activities shall be appropriately organized and reported to Public Health officials in a timely manner for their review and action.

EMPLOYEE HEALTH
The agency shall develop policies and procedures related to surveillance, prevention and control of employee infection, including pre-employment assessments, immunizations, exposures to Blood Borne Pathogens and other infectious agents. The agency will promote employee vaccination for vaccine preventable diseases, i.e.
Influenza. The agency will work with employees to create new programs, resolve problems, and promote knowledge of their responsibilities in personal health and Infection Control.

**AGENCY INFECTION CONTROL PLAN**

Policies and procedures shall describe activities of prevention and control of infections in all client care activities. Infection control policies and procedures shall be reviewed annually or as indicated. The Infection Control Committee and/or the Professional Advisory Committee will approve the policies and procedures.

**PERFORMANCE IMPROVEMENT PLAN**

Infection Control surveillance indicators will be included in the activities reviewed and the data collected as part of the agency performance improvement plan. Data collected and reports or other information relating to the condition and treatment of any person that is used for improving agency performance and enhancing client care is declared to be privileged information.

**TUBERCULOSIS CONTROL PLAN**

This plan is written to ensure compliance with the Guidelines for preventing transmission of Mycobacterium Tuberculosis in health care settings. The plan is based on a TB risk assessment of the agency’s client population, identifying the number of suspected or confirmed infectious TB cases treated in the previous year. The plan establishes guidelines for isolation as needed, respiratory protection education and training for all staff, TB exposure follow-up, and pre-employment and annual employee testing.

**EXPOSURE CONTROL PLAN**

The Exposure Control Plan shall be written to ensure compliance with the requirements for Occupational Exposure to Blood Borne Pathogens and shall include guidelines for employee risk assessment by job classification and task, employee education and training, engineering controls, Personal protective equipment (PPE), exposure follow up and related treatment and record keeping, and shall be approved by the Infection Control Committee or other designated group.

**DISASTER/EMERGENCY PLAN**

The agency will develop a plan to coordinate a response to disasters and potential client surge conditions, including bio-terrorist attacks. The agency will work with community organizations to clarify roles in disaster situations.

**PREVENTION**

Education for staff, clients and visitors will continue with signs and other methods regarding hand hygiene and cough hygiene importance for staff and clients.
INFECTION CONTROL SURVEILLANCE

POLICY
Agency will establish a continuous data monitoring and collecting system to detect infections or identify changes in infection trends. The three types of surveillance that may be used are:

- Total surveillance – all infections identified in clients and employees.
- Targeted surveillance – specific infections, populations, or procedures.
- Outbreak surveillance – specific infections or infection clusters within multiple individuals at the same time.

The Agency will implement a process of identifying all infections in the client and/or employee population and evaluate effectiveness of current control measures or identify an action plan to improve incidence of infections.

SPECIAL INSTRUCTIONS
- The Agency will perform targeted infection control surveillance as follows: Client infections that will be reported at the time of admission include Hepatitis B and C, MRSA, VRE, TB or any reportable communicable disease (as defined by the health department).
- Client infections to be reported while the client is receiving services from the agency: wound infections that develop thirty (30) days or greater after admission that require antibiotic treatment or are identified by lab test.
- IV site infections that develop ten (10) days after admission or at any time if the IV cannula was inserted by Agency staff; and all infections identified are to be reported upon admission.
- Employee infections are to be reported if an employee develops or has a known exposure to: conjunctivitis, MRSA, VRE, and any reportable communicable disease as defined by local health department.

1. The agency staff will attempt to identify the source of infection to determine if it was acquired while the client was receiving home care (agency-acquired), from the community (community-acquired), or during a recent inpatient facility stay (nosocomial).

2. The most common nosocomial infections in adults are urinary tract infections, surgical site infections, lower respiratory infections such as pneumonia, and bloodstream infections.
3. A community-acquired infection would be monitored through outbreak surveillance. This would include infections such as salmonella or Hepatitis A.

4. A home-acquired infection (agency acquired) results from contact between a client and a staff member during the time the agency is providing home care services. This may include transmission from either the staff member to the client or the client to the staff member.
   a. Currently, there is no nationally accepted criteria that defines an organization-acquired infection or acceptable infection rates. Therefore, they will be defined by the agency.
   b. When a pattern or trend in infections is identified, the agency will investigate where clients and/or staff may have acquired the infections and what the source of contamination was.
   c. Data regarding infections may be obtained from a number of sources including home visits, verbal orders for antibiotics or culture and sensitivity orders, laboratory reports, and interviews with staff.
   d. If infections are identified as, “agency-acquired,” an investigation will be done to determine if the cause is one of the following:
      - Employees not following agency policies and procedures.
      - Employees transmitting infections among clients they see on home visits.
      - Employees and/or clients using contaminated equipment or supplies.

5. The agency will closely monitor and investigate employee’s occupational exposure to determine the cause. Any illness or injury resulting from the health care professional’s client care activities will be closely monitored.

6. An infection control log will be maintained. The agency will identify follow-up actions taken as a result of identified infections. Information will be integrated into orientation in-services and quality improvement activities.

7. Targeted surveillance activities will be identified and implemented based on the results of the total surveillance program.

8. Data related to identified infections will be reviewed and analyzed. Policies and procedures will be reviewed in light of infection surveillance reports and updated as needed to address areas of concern. All changes and/or modifications to agency policies and procedures will be communicated to employees and clients appropriately. All infection control policies will be reviewed at least annually.
INFECTION PREVENTION/CONTROL

POLICY
Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those clients with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission.

The agency will have an infection prevention and control component to the Infection program. This program will evaluate those client populations to be at risk and implement processes as needed.

PURPOSE
To ensure employee and client safety.

To reduce the risk of transmission of microbes from both recognized and unrecognized sources of infection.

SPECIAL INSTRUCTIONS
1. The Occupational Safety and Health Administration (OSHA) Bloodborne pathogens standard, incorporating the Needlestick Safety and Prevention Act of 2000, is designed to protect at risk employees from exposure to blood and other potentially infectious materials. Employees and healthcare workers covered by this standard include those who:
   a. Have direct client contact
   b. Draw blood
   c. Work with blood and other bodily fluid specimens
   d. Handle contaminated equipment

2. Standard precautions contain two tiers of approach. The first tier uses major features of standard precautions and the principles of body substance isolation.

STANDARD PRECAUTIONS - TIER ONE
1. Standard precautions apply to blood, all body fluids, secretions, excretions, non-intact skin, and mucous membranes. All are to be treated as a potential source of infection regardless of whether the client has a communicable disease.
2. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganisms between other clients or the environment.

3. Gloves are worn when touching blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items.

4. Masks, eye protection, or face shields are worn if client-care activities may generate splashes or sprays of blood or body fluid.

5. Gowns are worn if clothing is likely to be soiled from blood or body fluid. Wash hands after removing gown.

6. Equipment used for client care is properly cleaned and reprocessed. Single-use items are discarded.

7. Contaminated linen is placed in a leak proof bag and carefully handled to prevent skin and mucous membrane exposure.

8. All sharp instruments and needles are discarded in a puncture-resistant container. The CDC recommends needles be disposed of without capping or that a mechanical device be used for recapping.

9. When possible devices, which offer an alternative to needles, will be used. Examples of such devices include stopcocks (on-off switch) needle-protected systems or needleless systems that can be used in place of open needles to connect intravenous lines. Other devices that are integral to the syringe, such as self-sheathing needles, allow both hands to remain behind the needles.

**DISEASE-SPECIFIC STANDARD PRECAUTIONS - TIER TWO**

This approach provides isolation guidelines with new transmission categories based on airborne, droplet, and contact transmission of infectious disease.

1. Airborne Precautions: Use mask or respiratory protection *(see CDC TB Guidelines)*.

2. Droplet Precautions: Use mask. Isolate clients from those at risk of infection.

3. Contact Precautions: Use gowns, gloves, and masks as appropriate.
SPECIAL INSTRUCTIONS

The agency will have a process in place to identify the need for infection prevention control activities by evaluating the following:

- Client populations to be served.
- Clients at high risk for infection.
- Common diagnosis of clients served.
- Types of care provided by the agency.
- Risks of infectious transmission.
- Types of medical devices, equipment or supplies used in client care and provided by the agency.
- Types and amount of medical waste generated.
- Risks of occupational exposure.
- Clients who are identified as high-risk groups include those experiencing immunosuppression. This group includes those with HIV-related illnesses, bone marrow transplantation, hematologic malignancy, cancer, drug-induced suppression, radiation therapy, and the very young or very old. Other groups designated at risk are individuals with trauma, burns, surgical wounds or malnutrition.

Types of care that may place clients at risk for infection:

- Airway suctioning.
- Blood specimen collection (arterial or venous puncture).
- Blood product administration.
- Burn care.
- Cardiopulmonary resuscitation (CPR).
- Dialysis (hemodialysis or peritoneal).
- Enteral tube feedings and tube replacements.
- Epidural catheter care and management.
- Implantable port access.
- IV medication or solution administration.
- Oxygen administration.
- Urethral or suprapubic catheterization.
- Venous access device insertion and site care.
- Wound and ostomy care.

Medical devices, equipment, and supplies that clients may use or that agencies may provide fall into three categories – noncritical, semicritical, or critical:

- Noncritical items come into contact with intact skin, but not mucus membranes or skin that is non-intact.
- Semicritical items come into contact with the mucus membranes or skin that is non-intact.
- Critical items enter directly into the bloodstream or into other normally sterile areas of the body.

These three categories were developed based on the potential risk of infection identified in their use as well as the methods required for cleaning, disinfection, and sterilization.

**METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)**

Care of client with identified infection:

- MRSA is a strain of Staphylococcus Aureus that is resistant to most antibiotics. Vancomycin is the most reliable antibiotic for treatment.
- Clients who are colonized with MRSA can act as reservoirs for transmission to family, employees and other health care personnel.
- Can be transmitted via unwashed hands, contaminated equipment, or clothing.
- Home care staff who touch their nose with unwashed hands are at risk for colonization of MRSA.
- MRSA can live up to fourteen (14) days in the environment.

Policy:

- Standard precautions will be used with all clients.
- Handwashing must be done before and after all client contact.
- Personal protective equipment including gloves, mask or gown will be used when appropriate for care.
- No special treatment is needed for linens, clothing, or waste.
- ALL involved staff will be informed of the diagnosis and the care plan will be tailored accordingly.
OSHA INFECTION CONTROL/EXPOSURE CONTROL PLAN

POLICY
Agency shall maintain policies and procedures for the care of clients with infectious and/or contagious diseases and for infection control practices by employees; these policies and procedures shall conform with OSHA regulations, Accreditation standards, local and state laws, and currently accepted standards of practice.

PURPOSE
If a client is suspected or known to have an infectious or contagious process, agency personnel shall be advised. Agency shall implement the procedures specific to the suspected disease. In addition, employees shall implement infection control procedures with regard to clients, employees, and the employees' environment. Agency shall provide all client care employees with appropriate protective equipment.

SPECIAL INSTRUCTIONS
1. Client infection control procedures shall include, but not be limited to:
   a. Wearing and changing gloves as necessary during the delivery of client care.
   b. Appropriate wound and skin care and dressing techniques following sterile or aseptic dressing procedures.
   c. Appropriate handling and disposal of waste products.
   d. Proper packaging of laboratory specimens of blood and other infectious materials.
   e. Provision by the agency and use by employees of impervious containers for disposal of needles.
   f. Frequent hand washing by home health care employees:
      • Before and after the provision of direct client care.
      • Before working in the kitchen.
      • After handling soiled or contaminated materials.
      • After going to the bathroom.
      • After removing gloves.
g. Covering nose and mouth when coughing or sneezing.

h. Covering open sores or cuts on fingers or hands with clean bandages or gloves.

i. Use of appropriate protective equipment including gloves, gowns, and masks when indicated.

2. Environmental infection control procedures include, but are not limited to:
   a. Maintaining a clean work environment e.g., clean counters, tables, and shelves where food is stored.
   b. Refrigerating food promptly and covering food by closing cartons and replacing covers.
   c. Rinsing cans and bottles before disposing of them in the garbage.
   d. Using assistive means to pick up broken glass.
   e. Washing garbage cans, dirty pails, and trashcans with hot, soapy water.
   f. Disposing of garbage properly by:
      • Draining off liquid before putting garbage in paper or plastic-lined pails.
      • Wrapping garbage in paper and placing it in covered trash cans.
   g. Keeping clean and dirty items separate.
   h. Keeping the client's environment, especially the bathroom, clean, neat, and orderly. This includes keeping supplies off the floor and out of the reach of children.
   i. Regularly cleaning client equipment such as commodes, bedpans, urinals, suction machines, and measuring containers.
   j. Decontaminating equipment prior to servicing or shipping. Properly labeling equipment as clean or contaminated.
   k. Using protective coverings, such as aluminum foil and plastic. Replacing coverings if contamination is thought to have occurred.

3. Home health care employees shall provide information to clients regarding infection control principles and procedures as appropriate. To comply with OSHA requirements, the agency shall ensure the infection control plan is appropriate to the work environment and the agency's responsibilities and that the plan is fully implemented.
The agency will:

a. Select safer needle devices as they become available.

b. Involve employees in identifying and choosing the devices.

c. Periodically evaluate all job responsibilities for potential risk.

d. Review the program’s effectiveness at least annually, revising as necessary.

e. Evaluate incidence of exposure and revise operating policies and procedures as indicated.

f. Educate employees in the infection control program upon employment, when changes occur, and at least annually.

g. Monitor compliance with the program through on-site supervisory visits, performance evaluations, periodic review of personnel files, and training records.

h. Monitor and evaluate the performance of any individual or provider contracted to perform any portion of the program, such as waste disposal, transportation of lab specimens, and cleaning companies.

4. All materials related to OSHA regulations and all agency infection control activities shall be incorporated into an infection control plan which includes:

a. An outline for employee education.

b. Records of employee training.

c. Standard precautions procedures.

d. Isolation procedures, when and if appropriate in home care setting.

e. Clinical procedures for obtaining, handling, and transporting laboratory specimens.

f. Decontamination and labeling procedures.

g. Documentation of investigation of exposure incidents and infection occurrences.

(Note: Client and employee confidentiality will be considered and, as appropriate, information may be maintained in the clinical record or the employee's personnel file or separate confidential files which must be maintained for 30 years.)

h. Contracts for infection control-related services, such as waste disposal.

i. Copies of applicable state and local regulations.
5. The agency shall maintain procedures for the care of clients with infectious and/or contagious diseases, as well as those clients with compromised immunity.

6. If a client is suspected or known to have an infectious or contagious disease, personnel providing care shall implement the procedures specific to the suspected disease.

7. Employees providing client care shall comply with the agency's health requirement for periodic examination and disease screening. Employees with a known or suspected infectious and/or contagious disease shall be restricted from providing client care until a statement is received from the employee’s physician stating that the employee is free from contagious diseases and is able to return to work.

8. The company shall be aware of, and comply with, all state requirements for the reporting of communicable diseases.

9. Employees will be informed of risk factors and performance/compliance requirements during, but not limited to, the following times:
   a. New employee orientation.
   b. In-service/continuing education programs.
   c. Employee supervision.
   d. Employee counseling/discipline.

10. Agency will review and analyze infection data in an effort to identify trends or patterns.

**EMPLOYEE PROTECTIVE EQUIPMENT**

1. The Agency shall provide to all employees, at no cost, appropriate protective equipment, which may include but not be limited to, gloves, gowns or aprons, masks, eye protection, and face shields. Employees may be classified in one of three categories.

a. **Category I Employees:**
   - Perform tasks that involve exposure to blood, body fluids, or tissues. Category I includes all procedures or job-related tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids, or tissues or a potential for spills or splashes. For airborne infections such as tuberculosis, **all employees who will have direct contact with the person are at risk and should wear appropriate mask.** The use of personal protective equipment is required for every employee. This includes skilled nurses (RN, LPN) and home health aides.
b. **Category II Employees:**
   - Perform tasks that involve no exposure to blood, body fluids, or tissues but their employment may require performing unplanned Category I tasks. Appropriate protective measures should be readily available. This group includes: Physical Therapists, Physical Therapy Assistants, Occupational Therapists, Occupational Therapy Assistants, Speech Therapists, and Medical Social Workers.

c. **Category III Employees:**
   - Perform tasks that involve no exposure to blood, body fluid or tissues; and Category I tasks are not a condition of employment. Persons who perform these duties are not called upon to assist in emergency medical care and first aid. This category includes administrative and office staff.

2. The agency shall provide to all employees, at no cost, appropriate protective equipment. This may include, but not be limited to gloves, gowns or aprons, masks, eye protection, and face shields.

3. All direct caregivers will receive the following personal protective equipment. They shall be accountable for proper usage in compliance with OSHA standards.

4. RN/LPN's: goggles, gloves, one-way resuscitation mask, NIOSH approved N95 respiratory protective device (TB mask) and when appropriate, gowns, and masks.

5. Home Health Aides: gloves, gowns, masks, NIOSH approved N95 respiratory protective device (TB mask) (TB Mask, where indicated) and when appropriate, goggles and one-way resuscitation mask.

6. Therapists, Social Workers, and all other home care personnel: gloves, one-way resuscitation mask, and, when appropriate, goggles, gowns, and mask.

7. The employee shall use protective equipment when there is exposure or the possibility of exposure to blood; body fluids including amniotic, pericardial, peritoneal, pleural, synovial, cerebrospinal fluids, semen, and vaginal secretions; or any body fluid visibly contaminated with blood. The employee will wear the particulate respirator mask when there is any possibility of exposure to active tuberculosis.

8. The agency shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible and issued to employees.

9. If a garment is contaminated, it should be removed as soon as possible and disposed of in accordance with the agency’s policy on hazardous waste.

10. Hypoallergenic supplies shall be made available to employees with allergies.

11. Gloves, gowns, aprons, and other protective equipment shall be worn any time an employee is at risk of occupational exposure.
EXPOSURE DETERMINATION FOR TUBERCULOSIS

All employees who will have contact with clients must be aware of the possibility of exposure to an individual with known or suspected tuberculosis.

All employees, including employees working under contract, will receive infection control orientation and training during their agency orientation.

Infection control practices including those related to tuberculosis exposure will be reviewed at least annually and as deemed necessary.

All employees, including employees working under contract, who are at risk for exposure to individuals with known or suspected tuberculosis, will have personal protective equipment issued to them. This specifically includes a NIOSH approved N95 respiratory protective device (TB mask) for tuberculosis prevention.

All employees who may have contact with individuals suspected of having tuberculosis will be informed prior to accepting assignment with the client.

The agency will establish a mechanism to prevent exposure, identify exposures and implement treatment to prevent disease:

- TB skin tests (Mantoux) will be given at the time of employment, using the two-step method. The tests will be repeated annually and/or at the time of suspected or known exposure (See health screening policy).
- Employees with known or suspected exposure will be monitored on a regular schedule.
- Employees who have a positive Mantoux test prior to employment must show evidence that they have been evaluated by a physician and have no evidence of active disease.
- If an employee’s skin test converts to positive, they would be referred for a chest x-ray and physical examination (See Health Screening Policy).
- If an employee exhibits symptoms of tuberculosis, they would not be allowed to provide direct care until they had received a release from the physician.
- If a client exhibits symptoms of tuberculosis, employees will observe infection control precautions including wearing the particulate respirator until they are informed the client does not have the disease. Clinical supervisors will notify the client’s physician and request that the client be evaluated for the disease.

NOTE: Some states have state specific guidelines for TB based on risk and these will be incorporated into agency policy.
### OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION

#### EMPLOYEES WITH OCCUPATIONAL EXPOSURE

<table>
<thead>
<tr>
<th>Job Classification</th>
<th>Potential for Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>Some</td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Director of Clinical Services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Warehouse Delivery Rep.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nursing Supervisor</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>LPN</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Speech Therapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Homemaker Companion Live-In Homemaker</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Staffing Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretary/Receptionist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION

**Job Classification:** Registered Nurse

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood</strong></td>
<td><strong>OPIM</strong></td>
<td><strong>None</strong></td>
</tr>
<tr>
<td>1. Insertion, use, maintenance, discontinuation of any of the following needles or catheters: subcutaneous, intradermal, intramuscular, intravenous, intrathecal, epidural procedures.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Intention, use, maintenance discontinuation of any type of urinary*, fecal* or transmucous membrane catheter.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Performing CPR.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5. Tracheal/esopharyngeal care and suctioning.*</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. Insertion, use, maintenance, discontinuation of nasogastric, gastrostomy or related catheters.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. Performing personal care where contact with blood or potentially infectious materials is possible.*</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>8. Cleaning/handling any equipment that has had contact with blood or OPIM.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

OPIM = Other Potentially Infectious Materials
**OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION**

**Job Classification: Registered Nurse (continued)**

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood</td>
<td>OPIM</td>
</tr>
<tr>
<td>10. Administration of blood or blood products.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>11. Performance of any special procedures where contact with blood or OPIM is possible.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>12. Handling/obtaining laboratory specimens or tissues.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**OPIM = Other Potentially Infectious Materials**
# OSHA Bloodborne Pathogens Exposure Determination

**Job Classification:** LPN/LVN

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insertion, use, maintenance or discontinuation of any type of urinary*, fecal* or transmucous membrane catheter.</td>
<td>X X</td>
<td>* That contains visible blood.</td>
</tr>
<tr>
<td>2. Wound/stoma care.*</td>
<td>X X</td>
<td>* That contains visible blood.</td>
</tr>
<tr>
<td>3. Performing CPR.</td>
<td>X X</td>
<td></td>
</tr>
<tr>
<td>4. Tracheal esopharyngeal care and suctioning.*</td>
<td>X</td>
<td>* That contains visible blood.</td>
</tr>
<tr>
<td>5. Insertion, use, maintenance, discontinuation of nasogastric, gastrostomy or related catheters.*</td>
<td>X</td>
<td>* That contains visible blood.</td>
</tr>
<tr>
<td>6. Performing personal care where contact with blood or potentially infectious materials is possible.*</td>
<td>X X</td>
<td>* That contains visible blood.</td>
</tr>
<tr>
<td>7. Cleaning/handling any equipment that has had contact with blood or OPIM.</td>
<td>X X</td>
<td>IV equipment, ventilators, suction equipment.</td>
</tr>
<tr>
<td>9. Performance of any special procedure where contact with blood or OPIM is possible.*</td>
<td>X X</td>
<td>* Ex. Removing sutures/staples, post-surgical care.</td>
</tr>
<tr>
<td>10. Handling/obtaining laboratory specimens or tissues.</td>
<td>X X</td>
<td></td>
</tr>
</tbody>
</table>

OPIM = Other Potentially Infectious Materials

* That contains visible blood.
### OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION

**Job Classification: Physical Therapist**

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bronchial drainage and pummeling treatments.</td>
<td>Blood X, OPIM X</td>
<td>All activities involve direct hands-on care - therapist may need to assist client with personal care, e.g. bathroom assistance.</td>
</tr>
<tr>
<td>2. CPR</td>
<td>Blood X, OPIM X</td>
<td>All activities involve direct hands-on care.</td>
</tr>
<tr>
<td>3. Transfer training.</td>
<td>Blood X, OPIM X</td>
<td>All activities involve direct hands-on care - therapist may need to assist client with personal care, e.g. bathroom assistance.</td>
</tr>
<tr>
<td>4. Prosthetic training.</td>
<td>Blood X, OPIM X</td>
<td>All activities involve direct hands-on care - therapist may need to assist client with personal care, e.g. bathroom assistance.</td>
</tr>
<tr>
<td>5. Therapeutic Exercise Programs.</td>
<td>Blood X, OPIM X</td>
<td>Clients needing therapy may have complex medical diagnoses involving wounds/drainage, etc. which could create risk for exposure.</td>
</tr>
<tr>
<td>6. Therapeutic Massage.</td>
<td>Blood X, OPIM X</td>
<td>Clients needing therapy may have complex medical diagnoses involving wounds/drainage, etc. which could create risk for exposure.</td>
</tr>
<tr>
<td>7. Ultrasound</td>
<td>Blood X, OPIM X</td>
<td>Clients needing therapy may have complex medical diagnoses involving wounds/drainage, etc. which could create risk for exposure.</td>
</tr>
<tr>
<td>8. Electrotherapy</td>
<td>Blood X, OPIM X</td>
<td>Clients needing therapy may have complex medical diagnoses involving wounds/drainage, etc. which could create risk for exposure.</td>
</tr>
</tbody>
</table>

OPIM = Other Potentially Infectious Materials
### OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION

**Job Classification: Occupational Therapist**

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Teaching Compensatory Techniques:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use of prosthesis</td>
<td>X</td>
<td>Risk of exposure varies with client. Occupational therapists work with all ages and are directly involved with hands-on care, specifically with children.</td>
</tr>
<tr>
<td>• Function without ambulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assistance with ADLs such as dressing, feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Teaching safety techniques to clients with paraplegia or hemiplegia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>2. Orthotics/Splinting</strong></td>
<td>X</td>
<td>Prostheses and splints may cause skin breakdown.</td>
</tr>
<tr>
<td>• Designing and fitting of splints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Application of splints</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Restorative Therapy</strong></td>
<td>X</td>
<td>Involves personal contact with client.</td>
</tr>
<tr>
<td>• Activity/exercise program</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>4. Therapeutic Tasks</strong></td>
<td>X</td>
<td>Clients may be in wheelchair or have need for assistance while therapist is present.</td>
</tr>
<tr>
<td>• Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sensory perceptual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Psychiatric (confusion - hands-on activities may restore reality)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>5. Vocational Assessment and Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6. CPR</strong></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

OPIM = Other Potentially Infectious Materials
## OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION

**Job Classification: Speech Therapist**

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood</td>
<td>OPIM</td>
</tr>
<tr>
<td>1. Assessments</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Restorative Therapies</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• Treating swallowing disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assist aphasic clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assist to develop control of vocal/respiratory efforts (e.g., laryngectomy clients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Assist clients with communication disorders due to impaired hearing.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Teaching and training.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

OPIM = Other Potentially Infectious Materials
**OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION**

**Job Classification: Respiratory Therapist**

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aerosol treatments including Pentamidine for AIDS clients.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Bronchial drainage, pummeling and suctioning.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. CPR</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Care and maintenance of equipment (respirators, oxygen tubing, suction machines, etc.).</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5. Draw arterial blood gases.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
| 6. Handle specimens 
  Delivery to laboratory.                                      | X                  | X        |
| 7. Change tracheostomy tubes.                                                    | X                  | X        |
| 8. Clean inner cannulas of trach tubes.                                         |                    |          |

OPIM = Other Potentially Infectious Materials
## OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION

**Job Classification:** Home Health Aide

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care including bathing, shaving, mouth care, skin care.</td>
<td>Blood: X, OPIM: X</td>
<td></td>
</tr>
<tr>
<td>Bowel programs.</td>
<td>Blood: X, OPIM: X</td>
<td></td>
</tr>
<tr>
<td>Enemas</td>
<td>Blood: X, OPIM: X</td>
<td></td>
</tr>
<tr>
<td>Housekeeping including laundry and emptying trash.</td>
<td>Blood: X, OPIM: X</td>
<td></td>
</tr>
<tr>
<td>Assistance with transfers, ambulation, range of motion exercises.</td>
<td>Blood: X, OPIM: X</td>
<td></td>
</tr>
<tr>
<td>CPR</td>
<td>Blood: X, OPIM: X</td>
<td></td>
</tr>
</tbody>
</table>

**OPIM = Other Potentially Infectious Materials**
### OSHA BLOODBORNE PATHOGENS EXPOSURE DETERMINATION

**Job Classification:** Homemaker/Companion

<table>
<thead>
<tr>
<th>Tasks/Procedures</th>
<th>Potential Exposure</th>
<th>Comments</th>
</tr>
</thead>
</table>

**OPIM = Other Potentially Infectious Materials**
Cleansing and Disinfecting in the Home

Policy
Agency shall enforce good housekeeping practices involved in the provision of home health care services.

Purpose
To ensure that the worksite is maintained in a clean and sanitary condition.

Special Instructions
General Housekeeping

1. Client Homes:
   a. Nurse Case Manager/designee shall determine the specific cleaning/decontamination practices needed in the home, based on client needs and medical diagnosis.
   b. A written schedule and method of decontamination will be placed in the Care Plan with a copy left in the client’s home.
   c. Cleaning and disinfecting/decontamination procedures will be determined by the type of surfaces to be cleaned, type of soil present, and types of procedures being performed.

2. Equipment/Environmental and Working Surfaces:
   a. All equipment and environmental and working surfaces will be cleaned and disinfected after contact with blood or other potentially infectious materials.
   b. All work surfaces will be decontaminated with an appropriate disinfectant:
      • After completion of all procedures.
      • Immediately, or as soon as possible, when surfaces are contaminated with blood or potentially infectious materials.
      • At the end of each work shift if the surface has become contaminated
since the last cleaning.

c. Protective coverings such as plastic wrap, aluminum foil, or imperviously backed absorbent paper used to cover equipment and environmental surfaces will be removed and replaced as soon as possible after:
   - They become contaminated.
   - At the end of the work shift.

d. All bins, pails, cans, and similar receptacles intended for reuse, which have a likelihood of becoming contaminated with blood or other potentially infectious materials, shall be inspected and disinfected:
   - On a regularly scheduled basis.
   - Immediately upon visible contamination.

3. Regulated Waste
   a. Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:
      - Closable.
      - Puncture-resistant.
      - Leak proof on sides and bottom.
      - Labeled and color-coded.

4. During use, sharps containers shall be:
   a. Easily accessible to personnel and located as close as feasible to the area where sharps are used or can be found.
   b. Maintained upright throughout use.
   c. Replaced routinely and not allowed to overfill.

5. When moving containers of contaminated sharps from use area, the containers will be:
   a. Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.
   b. Placed in a secondary container if leakage is possible. The second container must be:
      - Closable.
      - Constructed to hold all contents, prevent leakage/spillage.
      - Labeled and color-coded.
6. Other Regulated Waste Containment
   a. Waste will be placed in containers that are:
      • Closable.
      • Constructed to contain all contents and prevent leakage of fluids.
      • Labeled and color-coded.
      • Closed prior to removal to prevent leakage/spillage.
   b. If outside contamination of regulated waste containers occurs, place the container in a second container which is:
      • Closable.
      • Constructed to contain all contents and prevent leakage of fluids.
      • Labeled and color-coded.
      • Closed prior to removal to prevent spillage or protrusion of contents.

7. Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, states, and political subdivisions of states.

**SPILLS OF BLOOD OR OTHER BODY FLUIDS IN CLIENT CARE/WORKSITE AREA:**

1. Health care personnel shall don the appropriate personal protective equipment.

2. Visible materials shall be removed and placed in an appropriate hazardous waste container.

3. The area shall be decontaminated using diluted bleach solutions (1:10 or 1:100 dilution) or chemical germicides that are approved as “hospital disinfectants.”

4. A 1:10 bleach solution is 1 part bleach and 9 parts water. This kills most infectious agents. It is important to note that some infectious agents are not killed by bleach. For example Cryptosporidium species are killed only by ammonia or hydrogen peroxide.

5. Bleach solutions must be mixed fresh every 24 hours

6. All equipment and sharps (reusable or nonreusable) will be handled as stated above.
INFECTIOUS DISEASE REPORTING

POLICY
Agency will identify and report incidences of infectious diseases identified in clients and employees, as appropriate.

PURPOSE
To establish a system for reporting of infectious disease and to assure compliance in implementing and following the system.

SPECIAL INSTRUCTIONS
1. The Director of Clinical Services designee will be responsible for assuring compliance with the infectious disease reporting rules.

2. Infections identified in clients after admission that will be reported include:
   a. Urinary tract infections requiring physician intervention.
   b. Upper and/or lower respiratory tract infections requiring physician intervention.
   c. Wound infections.
   d. Peripheral or central venous access device exit site infections.
   e. Fever of unknown origin.
   f. Positive culture reports.
   g. Signs and symptoms of two or more of the following:
      • Fever greater than 100.4°F Fahrenheit.
      • Elevated pulse rate.
      • Chills.
      • Sore throat.
      • Cough.
      • Malaise.
• Nausea or vomiting.
• Acute diarrhea (liquid stools over a twelve (12)-hour period of time).
• Headache.
• Dyspnea.
• Rash.
• Ulcer.
• Pustule.
• Drowsiness.
• Confusion coma.
• Localized tenderness, redness, erythema, or heat.
• Urinary urgency, frequency, or dysuria.
• Change in odor, color, or consistency of drainage from wounds.
• Any of the diseases from the list of reportable diseases.

3. Infections will be defined as nosocomial if they develop within the first seventy-two (72) hours after admission to the agency following hospitalization or within one year of surgical implantation of a device.

4. Infections will be defined as community or home acquired if they develop more than seventy-two (72) hours after admission to the agency.

5. Employees with signs and symptoms of a communicable disease will be directed not to work during that time unless approved by a physician. All staff members directly exposed to any pathogens during client care activities will be directed to a physician for evaluation and follow-up.

6. When community-acquired or nosocomial infections are identified by the agency staff, they will be reported to the Director of Clinical Services and recorded on the Infection Control Log form. Nosocomial infections will also be reported to the health care facility's infection control compliance person.

7. When infections are identified and reported on the Infection Control Log, an investigation is conducted to determine possible causes.

8. Immediate actions are taken to prevent the transmission of infection, such as isolation procedures, family/client education, etc.
9. The appropriate authorities are notified through verbal and/or written notification, per state guidelines.

10. Information from the Infection Control Log is reviewed on a quarterly basis to identify trends or patterns. This data is included in the monitoring and evaluation activities of the quality improvement committee or teams to identify opportunities to improve client care and agency performance.

11. At least annually, the agency will review the results of this surveillance, monitoring, and evaluation and provide a report to the quality council, advisory board, and governing body of knowledge obtained, policy changes, or new procedures instituted.

**REPORTING OF INFECTIONS**

The agency will establish internal and external reporting mechanisms for those infections identified during the surveillance activities.

1. Infections to be reported externally include:
   a. Infections on the state’s list of reportable diseases: It is generally the physician diagnosing the case who is required to report the disease to the state health department. However, infections developed among home care staff may require reporting by the home care provider.
   b. Nosocomial infections: If nosocomial infections are identified by the home care staff, reports should be made to the hospital infection control program manager.
   c. Suspected intrinsic drug manufacturing contamination: This should be reported to the FDA and the drug manufacturer.
   d. Suspected blood product contamination: This should be reported to the blood center that performed the cross-match procedure.

2. Infections to be reported internally include:
   a. Externally reported infections.
   b. Organization-acquired infections.
   c. Infections diagnosed in staff members acquired while providing care.
   d. Infections identified by the agency for surveillance as part of their targeted surveillance activities.

The agency will maintain records of all identified and reported infections. The report will be used to compile reports identifying risks, trends, and rates. This information will be used to improve the infection prevention program and reduce risk to clients and staff.