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Contents and Instructions

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INSTRUCTIONS FOR COMPLETION:

1. This training packet will be completed on hire and annually for all direct care and office employees.
2. The employee will read the materials included and complete the post test.
3. An office employee will grade the test and determine that the employee has successfully comprehended the information by at least a 75% passing score on the test.
4. The training certificate will be completed and the post-test along with the certificate will be placed in the personnel file.

Cultural Awareness/Diversity

Cultural Diversity History

First introduced in 2000 by the Department of Health and Human Services' Office of Minority Health, and then updated in 2010, the National Standards for Culturally and Linguistically Appropriate Services in Health Care work to increase cultural competence in the health care industry. Among these standards is a cultural diversity training recommendation. Since then, a number of federal agencies, including the Joint Commission on Accreditation of Health Care Organizations and the Centers for Medicare and Medicaid Services, have adopted the national standards and require health care professionals to receive cultural competence training.

Workforce Diversity Training

Internal training focuses on the beliefs, attitudes, and expectations of a culturally diverse workforce. The emphasis is on teamwork, developing good interpersonal relationships and maintaining effective work performance. Cultural diversity is essential to maintaining a balanced organization. In global organizations whose operations include business dealings and affiliations in other countries, understanding cultural differences is key to successful business partnerships.

Employees should be aware of the importance of respecting the cultural differences of others, and employers can offer training to increase awareness and to better equip employees to function in a diverse workplace.

Importance of Cultural Diversity

Recognizing and respecting cultural differences in the workplace is essential to a company's organizational structure and the health of its human resources.

Companies with employees of culturally diverse backgrounds recognize the benefits of having people with different perspectives, problem-solving skills, and creativity. Many companies benefit from multilingual employees. Training is key to helping employees with different backgrounds understand and respect each other's differences, so they learn to collaborate and achieve the company's goals.

Common Diversity Issues

It is not uncommon for companies to hire employees of various nationalities and ethnic groups.

Issues such as differences in pay or differing treatment of employees because of cultural differences could be perceived as discrimination.

By emphasizing awareness of and promoting sensitivity to cultural issues, employers can show they recognize the contributions and value of all workers.

Importance of Cultural Competence

Cultural competence relates to the quality of the day-to-day interactions and relationships between health care providers and patients.

Unlike workforce diversity training, which affects patients indirectly, cultural competence affects patients directly.

For example, the quality of patient interactions, including communication, determines how well or whether a patient is able to communicate symptoms, follow instructions and participate in his care. It also affects whether a

patient feels respected or disrespected, as both an individual and a member of a cultural group.

Cultural Competence Training Importance

Working with a diverse patient population requires ongoing training that provides workers with specific knowledge, abilities, and skills. For example, health care workers must understand common cultural barriers to preventing and treating conditions or disease. When interacting with patients, an ability to ask questions tactfully and respectfully and negotiate between a patient's cultural interpretation of a condition or disease and treatment expectations and options is crucial to good patient care. Practical skills such as using a telephone or working with an interpreter are also important.

Employee Relations

The lack of cultural diversity or the perception of disrespect for other cultures can be detrimental to partnerships. Organizational leaders can benefit from understanding the differences in the way operations at other organizations are structured.

Cultural differences are not limited to ethnicity and race relations; they extend to areas of religious views, sexuality and even differences in geographical differences pertaining to the location of one's upbringing.

Consideration should be given to each of these areas when evaluating the organizational balance.

Managers should demonstrate sensitivity to employees who express concern regarding the ability to interact with others in the group.

In some cases, communication may be hindered due to cultural differences.

Moving past these barriers requires training and sensitivity to the differences of the employees and ensuring that other employees recognize this importance as well.

Prevention and Education

A complete understanding of cultural diversity is imperative for successful business operations.

Mandatory diversity training for managers should be incorporated as part of a developmental learning process to ensure managers can effectively deal with diversity issues.

By staying abreast of federal guidelines governing employment discrimination and the importance of cultural diversity and employment practices, managers become equipped on how to handle conflicts in the organization that may stem from these differences.

Managers with an understanding of the importance of cultural diversity also can key in on employee relations and retention.

Workplace Discrimination Laws

A company's leaders are charged with ensuring compliance with federal laws that govern the equal treatment of employees regardless of race, ethnicity, religious views, and many other individual traits.

When employees believe they are treated differently because of their individualism, this perception could lead to legal trouble for the company.

The U.S. Equal Employment Opportunity Commission prohibits companies from discriminating against employees for any reason.
Allegations of discrimination in the workplace, if proved, could result in financial penalties for the company.
The EEOC website provides information about employment laws and ways to avoid discrimination for both employers and employees. www.eeoc.gov.

Customer Service

Cultural diversity training and education is important to support the customer service efforts of an organization.
Providing quality customer service across many cultures requires a solid understanding of what different cultures consider appropriate behavior.
Diversity training will help businesses understand what barriers are affecting key customer relationships as well as improve communication between employees and their clients.

Tips on Culture Diversity in the Workplace

Attempts at cultural diversity in the workplace have been met with mixed reviews, according to AdminSecret.com.
To a small business owner, diversification may mean hiring only a handful of workers from different cultural backgrounds.
However, due to the highly interdependent nature of the small-business work force, it is critical that diversity is implemented successfully.

Learn to Communicate

You may need to communicate differently with workers from other cultures.
For example, some cultures do not openly praise workers in front of others, preferring that it be done in private.
You may need to read and study about the differences in your worker home culture to build trust and avoid offending them.

Train Frequently

To ensure that workers fully understand policies and procedures, you may need to spend additional time on training and orientation so that there are no ambiguities. For example, you may need to spend extra time covering areas such as sexual harassment or general behavior, so employees are clear as to how you expect them to act.
If you have a dress code, you may also need to clarify what attire is appropriate.
Cultural diversity training can help employees improve their performance by creating a workplace free of judgments and stereotypes. Although employees may have certain opinions about their co-workers, diversity training will help employees recognize the behaviors that could possibly create a hostile or uncomfortable work environment.
Educational activities about cultural variations also provide employees with a level of understanding about other cultures they may not have had before.

Orient Current Workers

You may also need to spend some time getting your current workers to accept a more diverse work force.

This may include sensitivity or diversity training that allows employees to understand the difficulties people from different cultures may have in adapting.

You should also attempt to identify any issues your current workers may have with the implementation of a multicultural work force.

Assign Mentors

Some of your workers may have an easier time and will be more receptive to adapting to a diverse work culture than others. These individuals could fill a valuable role as mentors.

Pair them with workers from different cultures to provide training and help with assimilation into the work environment.

Finding common ground in an environment rich with varying opinions and perspectives can be challenging to some employees.

Education initiatives that teach employees how to succeed and perform optimally across a multi-cultural workforce can directly support diversity efforts in the workplace.

Diversity education encourages thoughtfulness and consideration between co-workers of different nationalities and backgrounds.

Leadership Role

The business owner and managers, bear the ultimate responsibility for developing a more diverse work culture. If they show strong leadership during this adjustment period by demonstrating commitment to diversity and including everyone in the process, the chances of attaining success in diversification are likely to increase.

Supervisors are in a position where they have to manage the diverse perspectives of workers and customers. Managers are obligated to treat their people equally, but sometimes fall short of communicating effectively with individuals from diverse backgrounds or experiences.

Training that focuses on managing a diverse workforce will help supervisors connect with all team members and include every worker in the activities that support the agency's bottom line.

Examples of Cultural Differences in the Workplace

Workplace diversity trainers often mention that there are more similarities among employees than there are differences; however, despite the many common attributes employees share, there still exist cultural differences.

Culture is defined as a set of values, practices, traditions, or beliefs a group shares, whether due to age, race or ethnicity, religion, or gender.

Other factors that contribute to workplace diversity and cultural differences in the workplace are differences attributable to work styles, education, or disability.

Generations

There are cultural differences attributable to employees' generations.

A diverse workplace includes employees considered traditionalists, baby boomers, Generation X, Generation Y and Millennials.

Each generation has distinct characteristics.

For example, employees considered baby boomers tend to link their personal identity to their profession or the kind of work they do. Baby boomers are also characterized as being committed, yet unafraid of changing employers when there's an opportunity for career growth and advancement. Employees considered belonging to Generation Y, on the

other hand, also value professional development, but they are tech-savvy, accustomed to diversity and value flexibility in working conditions.

Education

Differences exist between employees who equate academic credentials with success and employees whose vocational and on-the-job training enabled their career progression.

The cultural differences between these two groups may be a source of conflict in some workplace issues when there's disagreement about theory versus practice in achieving organizational goals.

For instance, an employee who believes that a college degree prepared him for managing the processes and techniques of employees in the skilled trades may not be as effective as he thinks when compared to employees with years of practical knowledge and experience.

Personal Background

Where an employee lives or has lived can contribute to cultural differences in the workplace.

Many people would agree that there is a distinct difference between the employee from a small town and the employee from a large metropolis. New York, for example, is known for its fast pace and the hectic speed of business transactions. Conversely, an employee from a small, Southern town may not approach her job duties with the same haste as someone who is employed by the same company from a large city where there's a sense of urgency attached to every job task.

Ethnicity

Ethnicity or national origin are often examples of cultural differences in the workplace, particularly where communication, language barriers or the manner in which business is conducted are obviously different.

Affinity groups have gained popularity in large organizations or professional associations, such as the Hispanic Chamber of Commerce or in-house groups whose members are underrepresented ethnicities, such as the Chinese Culture Network at Eli Lilly. The pharmaceutical conglomerate organizes affinity groups to bridge cultural differences and establish productive working relationships within the workplace and throughout its global locations. In his article "Winning with Diversity," author Jason Forsythe explains that Eli Lilly's many affinity groups are necessary: "Because the company currently markets products in 156 countries and has affiliates in many of them, multicultural competency is a priority."

How to Resolve Cultural Communications in the Workplace

Differences in race, sex, religious beliefs, lifestyle, and sexual orientation are among many cultural differences that may affect how people communicate in the workplace.

Resolving communications problems caused by cultural differences requires patience, understanding and respect.

A major mistake is forming opinions before even engaging in communications.

Opinions reached before an opportunity to discuss the matter makes resolving conflict difficult.

Respect

Treating people as individuals regardless of culture is sometimes a key to resolving communication issues.

For example, it is improper to assume that a woman takes a certain position on a subject because she is a woman.

Such generalizations can cause conflict in communication.

Not all people who are members of the same culture will react to communication in the same way or offer the same opinion on a subject.

However, it is true that cultural backgrounds may affect how people act, behave, and communicate.

But that does not mean people of a certain culture will all communicate or react to events in the same way.

Knowledge

Learning more about other lifestyles and cultures helps people avoid conflict in communication, particularly in multicultural settings. Information on cultural awareness is widely available in books at public libraries.

Open and honest discussions about cultural differences with friends and colleagues are helpful as well.

Learning more about cultural differences helps avoid jumping to unfair or wrong assumptions about a person's statements or other communication efforts.

Blame

Conflict in communications between cultures also is avoidable when all parties resist assigning blame.

Two companies merging staffs in a business transaction may have different styles of managing and working. Putting the teams together can cause an immediate clash of cultures, with problems intensified if both sides always blames the other for problems and breakdown in communication.

Simply placing the blame on others is not constructive and can make communication problems worse.

Listening Skills

Focusing on listening well with an open mind also helps resolve cultural communications problems.

Paying close attention to words used in a conversation or other form of communication can help resolve these problems.

It's also important to pay attention to the context of the discussion and the tone of the communication.

Cultural Diversity Policy

The Agency will provide care to patients and families regardless of their cultural background and beliefs.

Cultural considerations for all patients/clients shall be respected and observed. Where such considerations impede the provision of prescribed health care or treatment, personnel shall notify the supervisor and physician in an effort to accommodate the patient/client.

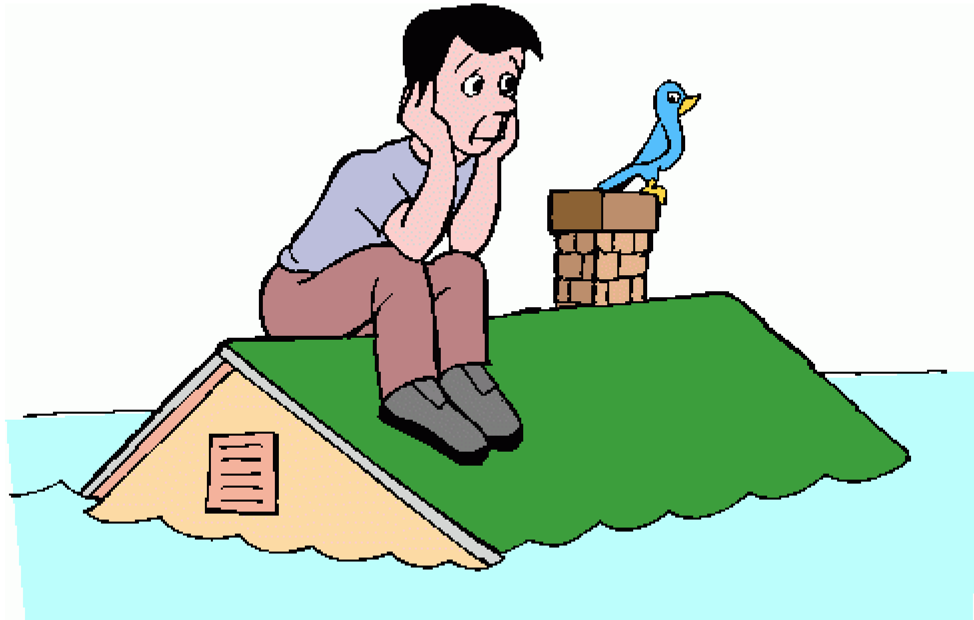
Different cultural backgrounds, beliefs and religions impact the patient's lifestyles, habits, and view of health and healing. Employees must be able to identify differences in their own beliefs and the patient's beliefs and find ways to support the patient.

Upon admission, staff will identify the patient's individual beliefs based on their cultural background and develop the plan of care accordingly.

The Agency will not assign personnel unwilling to comply with the Agency's policy, due to cultural values or religious beliefs, to situations where their actions may be in conflict with the prescribed treatment or the needs of the patient.

Cultural diversity training will be completed for all employees at time of orientation and annually thereafter.

Emergency/Disaster



The Emergency/Disaster Plan provides an orderly procedure to be implemented in an emergency to assure that the health care needs of patients continue to be met. The plan comprehensively describes its approach to a disaster. The Agency must maintain documentation of compliance with emergency preparedness. The Agency is not required to physically evacuate or transport a patient in the event of an emergency. All employees shall be oriented to the plan and their responsibilities in carrying out the plan. Possible emergency or risk factors will be identified for each patient and appropriate emergency plans discussed with the patient and/or the responsible person at the time of admission as indicated. The name and telephone number of an emergency contact will be obtained by the Agency.

The Agency has taken the following actions to develop, maintain and implement an Emergency Preparedness and Response Plan as follows:

1. The Agency must involve the Administrator, Director of Nursing, if applicable, and, based on the Agency's organizational chart, other Agency leaders designated by the Administrator.
2. The Administrator of the Agency is designated as the Agency's disaster coordinator. In his/her absence, the Alternate Administrator is designated as the alternate disaster coordinator.
3. The Agency has a continuity of operations business plan to address emergency financial needs, essential functions for the patient services, critical personnel and how to return to normal operations as quickly as possible.
4. The Agency has a risk assessment to identify the potential disasters from natural and man-made causes most likely to occur in the Agency's service area.
5. The Agency has determined the actions and responsibilities for Agency staff in each phase of emergency planning, including mitigation, preparedness, response, and recovery. The response and recovery phases include actions and responsibilities when warning of an emergency is not provided.
6. The Agency has a plan to monitor disaster-related news and information including after hours, weekends, and holidays, to receive warnings of imminent and occurring disasters.
7. The Agency has implemented the following for the response and recovery phases of the Plan:
    a. The Agency Administrator is responsible for initiating each phase of the Plan. In his/her absence the office manager is responsible.
    b. The Agency has procedures for communicating with staff, patients or responsible representative, local, state, and Federal emergency management agencies, and other entities as applicable including:
        i. Emergency medical services.
        ii. State regulatory departments.
        iii. Other healthcare providers and suppliers.
        iv. Primary and alternate modes of communication or alert systems in the event of telephone or power failure.
8. The patient is provided with the following:
    a. A copy of the Agency's policy on how to handle disaster related emergencies in the home.
    b. Patient responsibilities in the Agency's Emergency Preparedness and Response Plan.
    c. A list of community disaster resources that can assist during a disaster-related emergency.
    d. Survival tips and plans for evacuation and sheltering in place.
9. The patients are categorized into groups determined by the need for continuity of services, the acuity level of the patient, and the availability of someone to assume responsibility for the patient's Emergency Response Plan if needed by the patient.
10. The Agency has identified patients who may need evacuation assistance from local or state jurisdictions and can readily access recorded information about a patient's triage category in the event of an emergency to coordinate and communicate as required.

11. All employees including contractors are oriented about their responsibilities in the Agency's Emergency Preparedness and Response Plan on hire and the plan is reviewed at least annually with an emergency drill performed.
12. The Agency reviews its Disaster Plan as needed and after every response, but at least yearly through its Professional Advisory Committee. The Agency discusses the plan and the procedures for communicating with staff.
13. The Agency will follow the emergency requirements during a disaster and will document in the Agency's records attempts of staff to follow procedures in the event they are unable to comply with any of the requirements.
14. The Agency will present its best efforts to provide care to patients in emergency situations. However, if the Agency is unable to comply with situations beyond its control making it impossible to provide services, such as when roads are impassable or when a patient relocated to a place unknown to the Agency, the Agency is not required to continue to provide care.

Our community is vulnerable to a wide range of emergencies, including natural, technological, and man-made disasters, all of which threaten the life, health, and safety of its people; damage and destroy property; disrupt services and everyday business and recreational activities; and impede economic growth and development. This vulnerability is exacerbated by the state's growth and population, especially the growth in the elderly population, in the number of seasonal vacationers, and in the number with persons of special needs.
State policy for responding to disasters is to support local emergency response efforts

1. To reduce the vulnerability of the people and the property of this state to damage, injury, and loss of life and property.

2. To prepare for prompt and efficient rescue, care, and treatment of threatened or affected persons.

3. To provide for the rapid and orderly rehabilitations of persons, and for the restoration of services and properties.

4. To provide for the coordination of activities relating to emergency preparedness with public and private agencies in the community.

5. A comprehensive emergency plan is prepared, reviewed annually, and revised as necessary.

Emergencies:

1. Any occurrence, or threat thereof which results or may result in substantial injury or harm to the population, or substantial damage to or loss of property.
2. In the event of an emergency that disrupts the Agency's ability to provide care, needs shall be prioritized to determine those which are the greatest. Patients will continue to receive care, if possible, with minimal disruption of schedule. Patients will be instructed in emergency measures if nursing availability is limited.
3. If an emergency occurs, either within the Agency causing staffing limitation (such as labor disputes, staff illnesses) or within the environment (such as floods, hurricanes, fires, or other natural disasters), the Director of Nursing or designee will be responsible for reviewing patients and prioritizing them. When the demand for personnel exceeds available resources, the following factors should be considered in deciding priorities with the safety of the patient being the first priority:
    a. Availability of appropriate alternative coverage (family, friends, etc.) for the hours of service in question. A patient who has no other appropriate person to assist should receive a higher priority that those with appropriate alternatives.
    b. Level of priority of the patient's medical and nursing needs. Those patients whose medical and nursing needs are more acute should receive higher priority than those with less acute needs.
    c. Usual number of personnel hours that the patient routinely receives from nursing services. Those patients receiving a greater number of personnel hours should receive a higher priority than those receiving less.
    d. If an emergency occurs, either within the Agency causing staffing limitation (such as labor disputes, staff illnesses) or within the environment (such as floods, blizzards, hurricanes, fires, or other natural disasters), the DON or his/her designee will be responsible for reviewing patients and prioritizing them according to the following classifications:

Class I Emergency:

When the patient has a condition which is potentially life threatening, requires ongoing medical treatment, or requires assistance of a medical device to sustain life (i.e., there is a potential widespread power black-out and the patient is on ventilator), the home environment and support system will be reviewed. When appropriate, arrangements for evacuation to an acute care facility will be made. These patients will be seen immediately. The Agency will obtain assistance from emergency personnel as necessary. (Examples: Oxygen, Multiple Assistive Devices, Infusion)

Class II Emergency:

The patient has in-home support that may be mobilized in the event of disaster. The family is responsible for evacuation and care of patient. Patients with the greatest need for care will be seen as soon as possible by available staff. Patients requiring daily insulin injections, IV medications, sterile wound care of a wound with a large amount of drainage.

Class III Emergency:

Services could be postponed 24-48 hours without adverse effects on the patient. (Examples: a new, insulin dependent diabetic able to self-inject, patient under cardiovascular and/or respiratory assessment, and a patient that requires sterile wound care to a wound with minimal amount or no drainage.)

Class IV Emergency:

The patient has maximum in home support through the family structure. The family is totally responsible for the care and transfer. Services could be postponed 72-96 hours without adverse effect on the patient (Examples: a postoperative patient with no open wound, a patient who is anticipated to be discharged within the next 10-14 days, a patient who requires routine catheter changes.)

1. In the event evacuation of the patient is required, the local authority responsible for coordinating disaster preparedness and emergency response will be contacted. The Agency is not responsible for evacuating patients.
2. If some patient visits cannot be made and it is not a life-threatening situation, contact will be maintained by phone if possible. If office phone service is disrupted, phones will be turned over to the answering service, if possible. A staff member will be assigned to remain in contact with the answering service to receive and send messages.

Types of Emergencies

Man-Made Emergencies: Those that are caused by acts against persons or society, including but not limited to enemy attack, sabotage, terrorism, civil unrest, and bioterrorism.

Natural Emergencies: Those that are caused by natural events, including but not limited to winter storms, hurricane, flood, mudslides, severe wave action, drought, and earthquakes.

Technological Emergencies: Those caused by a technological failure or accident, including but not limited to explosions, transportation accidents, radiological accidents, chemical and/or other hazardous materials incident.

Staff Emergency Preparedness Plan

Know your Agency's Emergency Preparedness Plan: OUR CARE IN HOME SERVICES LLC Know who to report to and procedures to follow.

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

Have the automobile equipped:

1. A full tank of gas.
2. A shovel.
3. Blankets.

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

Have alternative communication devices available for use:

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

Establish a family preparedness:

1. Escape routes.
2. Evacuation plan.
3. Have a family communication plan.
4. Have a point of contact that is out-of-town.
5. A plan for pets.
6. For a laptop computer have a converter that plugs into the cigarette lighter.

Damage of Written Records

1. If written records are damaged during a disaster, the Agency must not reproduce or recreate patient records except from existing electronic records. Records reproduced from existing electric record must include:
    a. The date the record was reproduced.
    b. The Agency staff member who reproduced the record.
    c. How the original record was damaged.
2. The Agency is responsible to notify the State licensing unit, by fax or email, no later than five working days after any of the following temporary changes resulting from the effects of an emergency or disaster:
    a. Temporary relocating address including date of temporary relocation.
    b. License number, physical address, and phone number.
    c. Date the Agency plans to return to its permanent location.
3. If the Agency is temporarily expanding its service area to assist in the emergency, the state should be notified of:
    a. License number, and revised boundaries of the original service area.
    b. Date of temporary expansion.
    c. Date temporary expansion of the service area ends.

Complaints and Grievances

Definition

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

Policy

All patients will be informed of their right to voice a complaint/grievance against anyone furnishing services on behalf of the Agency.

All patients will receive verbally and in writing the Agency's process for receiving, investigating, and resolving complaints.

All patients receive the state regulatory hotline number as well as the appropriate person/department within the Agency to contact regarding a complaint/grievance regarding services furnished by the Agency and/or concerns regarding the implementation of Advance Directive requirements.

The Agency will investigate any complaint made by patient or patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the Agency. Both the existence of the complaint and the resolution of the complaint will be documented.

A summary of grievances, complaints and concerns will be reported to the Governing Body quarterly.

Patient grievances, complaints and concerns will be included in the (PI) annual report.

Agency staff will be educated on patient grievance policies at orientation and annually thereafter.

All complaints/grievances are retained for a minimum of three years.

Procedure

1. When a patient is admitted to the Agency, he/she is to be given an admission packet that includes a copy of the Agency Bill of Patient Rights and Responsibilities. This policy indicates that grievances are to be filed with the Agency Administrator. The fact that the policy was given to the patient is to be recorded in the clinical record.

2. All grievances and concerns are to be dealt with by the Administrator or his/her designee.

3. Any employee receiving a complaint/grievance will complete and submit a report to the Administrator. If the complaint is received after business hours, the supervisor on call will be notified and the complaint form will be submitted the next business day.

4. When a grievance is received, whether written or verbal, it is to be documented in the patient's clinical record by the Administrator or his/her designee. It is also to be noted in a log kept by the Administrator.

5. The resolution of the problem is also to be documented in the same manner.

6. Each written grievance received is to be responded to in writing by the Agency within ten (10) days.

7. Grievance received after hours, on weekends and holidays and whenever the office is closed are handled on the next business day.

8. Each written or verbal grievance received is to be responded to in writing by the Administrator within ten (10) days. This information is reviewed by the Administrator and a complaint form is completed by the Administrator. Each person involved is interviewed by the Administrator who then evaluates all collected information.

9. After thorough evaluation, The Administrator makes a determination and formulates a decision notifying all persons involved. All information regarding activities, investigation, analysis, resolution, and outcomes are documented in the Administrator's log and in the patient's chart.

10. The response is to explain the decision rendered by the Agency and it is to notify the patient of his/her right to appeal.

11. A copy of the outcome is to be filed in the clinical record and noted in the Administrator's log.

12. If the patient files an appeal, it is to be reviewed and responded to by a member of the Governing Body within thirty (30) days of its receipt by the Agency.

13. The response to the appeal is to be filed in the patient's clinical record and noted in the Administrator's log.

Staff Rights

All employees have rights and are entitled to fair, consistent and professional treatment including but not limited to the following:

1. Staff may request a change in assignment because of a personality conflict.

2. Staff may complain without fear of repercussion.

3. Staff has the right to special consideration to accommodate personal requests arising from cultural or religious practices provided the Agency can cover the needs of the patient/clients.

4. Staff has a right to be treated in accordance with the Agency mission and vision.

5. Staff is to receive information in a timely manner.

6. Staff is entitled to a workplace free from solicitation and distribution of unsolicited material.

Grievance Procedures

1. Any person(s) who believes that he/she or any class of individuals has been subject to discrimination may file a complaint pursuant to procedures set forth below, on behalf of him or herself another person or handicapped persons as a class. Filing of a complaint will not subject employees to any form of adverse action, reprimand, retaliation, or otherwise negative treatment by the Agency.

2. Accordingly, the Agency has adopted an internal grievance procedure providing for the prompt and equitable resolution of complaints alleging any action prohibited by the United States department of Health and Human Services regulation 45 CFR part 84, 29 USC 794. The law and regulations may be examined in the office of the Director of Nursing who has been designated to coordinate the efforts of the agency to comply with the regulation.

3. Complaint processing procedures are as follows:

    a. All complaints involving matters prohibited shall first be filed with the Director, who shall render an initial resolution within seven days of receipt of the complaint.

    b. If the complaint is not satisfied with the results achieved in step 'a,' the complainant may file an appeal with the President/CEO, who shall render a decision within five days.

    c. A complaint should be in writing, contain the name and address of the person filing it and briefly describe the action(s) alleged to be prohibited.

    d. All complaints should be filed as set forth above within three days after the complaining party becomes aware of the action(s) allegedly prohibited by the regulations.

e. All complaints should also be referred to the office of the Coordinator, who shall maintain the files and records of the Agency relating to complaints filed hereunder. The Coordinator may assist persons with the preparation and filling of complaints, participate in the investigation of complaints and advise the President/CEO concerning their resolution.

f. The President/CEO, or his designee, shall take steps to insure an appropriate investigation of each complaint to determine its validity. These rules contemplate informal but thorough investigations, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint. The right of a person to prompt and equitable resolution of the complaint filed hereunder shall not be impaired by the person's pursuit of other remedies such as the filing of a Complaint with the Office for Civil Rights of the United States Department of Health and Human services. Utilization of this grievance procedure is not a prerequisite to the pursuit of other remedies.

4. These rules shall be liberally construed to protect the substantial rights of interested persons, to meet appropriate due process standards and to assure Agency compliance with regulations.

Complaint Form

Patient Name: ___________________________ Date: _______________

Name of person filing the complaint if not the patient: ___________________________________

Relationship to the patient: _________________________

Name/title of who received the initial complaint: _______________________________________
Date: ________________________

Was the complaint logged in complaint logbook? ❑ Yes ❑ No

Description of the complaint:____

____

____

____

____

Use back or additional paper

Resolution of the compliant (action taken):____

____

____

Follow up needed:____

____

Date complainant was notified of proposed resolution (within 30 days): ____________________

Was the person making the complaint satisfied with the resolution and/or action plan?
❑ Yes ❑ No

If no what follow up was implemented?____

I have reviewed and ensured the implementation related to this complaint including any follow up needed.

Signature and title____________________________________ Date__________________

HIPAA

Purpose/Goals:

This learning module is designed to provide practicing nurses with the nuts and bolts about the requirements of the Health Insurance Portability and Accountability Act (HIPAA) particularly as it relates to patient privacy. HIPAA also contains legislation aimed at reducing health care related administrative costs, eliminating pre-existing clauses and waiting periods for individuals changing insurance coverage, and increasing access to insurance for individual purchasers. Strict guidelines for maintaining privacy, confidentiality, and security of health information are also part of HIPAA legislation. The implications HIPAA has for researchers are also discussed.

Objectives:

Upon completion of this module, the learner will be able to complete the following objectives:

1. Explain the components of the HIPAA legislation.

2. Discuss how HIPAA expands availability of health care coverage.

3. Describe who is affected by the privacy and confidentiality requirements.

4. Explain what is meant by protected health information (PHI) and individually identifiable health information (IIHI).

5. Describe processes that must be used to assure patient information is kept confidential and secure.

6. Describe how HIPAA influences informed consent and the use of patient data for research.

Introduction:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as “Kennedy-Kassebaum”, passed congress rapidly and with great bipartisan support in 1996. Many aspects of the legislation have been implemented in the ensuing years; the deadline for full implementation of the privacy and confidentiality requirements was April 14, 2003. Health care providers and organizations have strict guidelines that must be followed to remain within the law. While this module and most of our attention now is focused on the provisions of the legislation that deal with privacy, confidentiality, and security of patient records, HIPAA also contains other requirements that have an impact on employers, insurance companies, and purchasers of health insurance coverage.

HIPAA was designed to address public concerns about managed care, insurance availability, and insurance affordability. For example, HIPAA prohibits insurance companies from denying coverage because of:

1. preexisting conditions,

2. a family member’s health status, or

3. whether or not an individual has been covered under a group policy and is seeking a personal health insurance policy.

Further, HIPAA ensures immediate coverage without regard to pre-existing conditions for individuals who change jobs and insurance carriers. HIPAA also established a pilot program for medical savings accounts (MSAs) that allows individuals to create a “health insurance individual account” to purchase health services and retain unspent funds rather than paying monthly premiums. Further, to encourage the purchase of long-term care insurance, HIPAA allows employers to deduct premiums and most benefits are tax-free to the beneficiary. Additionally, to facilitate purchase of health insurance by self- employed persons, the law allows 80% of the annual premiums to be tax- deductible by 2006. While many health policy analysts agree that these provisions have little impact on reducing the number of uninsured, they do, however, think these efforts are worthwhile. At this time, however, attention to HIPAA is riveted on implementing and paying for the privacy, confidentiality, and security aspects of the legislation (DiBenedetto, 2003).

In 1996, HIPAA was viewed as a way to reduce administrative costs, provide better access to health information, reduce fraud, and guaranty privacy of health information. However, the American Hospital Association estimates that it may cost between $4 billion and $22 billion to implement the tenets of the law. A search of the literature failed to produce specifics regarding cost; however, according to Gue and Upham (2004), the majority of costs are associated with developing and implementing software that integrates providers, payers, and governmental agencies.

As part of the HIPAA rule promulgation, the Centers for Medicare and Medicaid Services CMS mandated standardization of transaction and code sets (TSC) to reduce duplication, confusion, and non-compliance. CMS standards rely on use of ICD-9 codes for disease classification, CPT codes for procedures, and national drug codes (NDC) for medications. CMS admits that problems with these coding sets exist; new ICD-10-CM and ICD-10-PCS are thought to reduce the ambiguity and facilitate full implementation of electronic processing. The industry is working toward integrating HIPAA fully, it is just taking longer than they hoped to get the electronic interfaces coordinated (Gue and Upham 2004).

HIPAA is just the beginning of the ultimate conversion of healthcare information into an electronic health record (EHR). The Bush administration projects it will cost $100 million a year for 10 years primarily to fund demonstration projects and trial programs aimed at achieving four major goals:

1. establish routine use of EHRs in clinical practice,
2. connect health care workers in information exchange for clinical decision making,
3. enhance patients' ability to choose providers based on quality, and
4. integrate public health surveillance systems into an interoperable network to support new research and better care (Scott 2004, p. 34).

The Basics

HIPAA contains provisions for both privacy and security. Privacy rules have been promulgated and compliance was required by most health plans by April 14, 2003; plans with less than $5 million in annual receipts had until April 14,

2004 to fully comply. These rules have gone through several iterations, some as recently as March 2003 and refinements continue. Security rules that detail further requirements for the health care industry and patients were issued in October 2004.

A key factor for all health care providers and organizations to keep in mind is that, while HIPAA rules are strict, if state law covering the same topic is more stringent, the state law must be followed (Herrin, 2003). Health providers are well advised not to overlook state law as they accommodate HIPAA. Providers and organizations must remain up to date with both HIPAA and state law changes.

The intent of HIPAA is to protect patients from unauthorized or inappropriate use and access to their health information. Further, the rules protect patients by giving them access to their health information, so they know what has been documented about their health status. Proposed by-products of HIPAA are to improve quality of care, restore trust in the health care system, and improve the efficiency and effectiveness of information dissemination by building on existing legal frameworks. HIPAA also contains an administrative simplification section designed to improve the efficiency of health information coding to facilitate digital transfer of information between and among health care providers, payers, and health plans.

HIPAA creates safeguards so that only those people or entities having a real need to know health information will be able to access it (Calloway and Venegas 2002). The HIPAA rules complement other standards that protect patients' rights. Compliance with privacy rules promises to be a cornerstone of future JCAHO and Medicare/Medicaid surveys. Remember, compliance is mandatory, not voluntary.

Why is HIPAA Needed

Health care professionals have long realized the need to protect patients from unauthorized use of their health information; at the same time, they want to have access to needed information when treating a patient. Widespread use of electronic data is facilitating the rapid transfer of information and the Institute of Medicine has urged the creation of standards so electronic records can be available (Follansbee, 2002).

Similarly, the public is greatly concerned about the privacy of their medical records. Prior to the electronic medical record, patient information was maintained in paper form and neatly locked away,

accessible only to those who had authorized access. With computerized records information can be accessed, changed, distributed, and copied with far less regard for appropriate authorization (Follansbee, 2002).

Serious breaches of record confidentiality have occurred. An employee of the Hillsborough county health department was able to carry home a disk with the names of 4000 HIV positive patients. People have purchased used computers that contained prescription records of patients; Eli Lilly recently sent out an email with the names of patients taking Prozac; the University of Montana inadvertently placed the medical records of some 62 people on the internet. Consequently, patients, health care providers, and other health care entities are very concerned about confidentiality, restoring the public trust, and protecting themselves from lawsuits.

Yet, the ability of multiple providers to access a patient's record can significantly improve the overall quality of care. Think about the chronically ill individual who receives care from more than one or two specialist providers. If each provider has access to the most recent treatment plan, it stands to reason that care will be more coordinated, efficient, and effective.

Understanding HIPAA and What is Included in the Law

HIPAA describes those affected by the law as "covered entities". Included under this umbrella are health care providers, health plans, health care clearinghouses, and business associates.

Health care providers are defined as anyone who is paid for health care services or bills for services provided. The list is all inclusive: physicians, licensed health care providers, hospitals, outpatient physical therapists, social workers, certified nurse midwives, technicians administering X-rays done at home, home health agencies, pharmacists, providers of home dialysis supplies and equipment, nursing homes, nurses, and nurse administrators. This list means that any hospital or health facility worker who may see confidential patient information is included.

A health plan is any individual or group that pays for health care services. Included are health maintenance organizations (HMOs), insurance companies, Medicare/Medicaid, self-insured plans, employee group plans, federal plans such as CHAMPUS, military, veteran's administration, and Indian health services.

Clearinghouses are those entities that receive health information from providers and health plans. They typically are responsible for standardizing the information to improve claims processing. Included in this group are third-party administrators, billing services, and re-pricing agencies

The **business associates** category covers a broad range of professionals and services. Included are attorneys, consultants, auditors, accountants, billing firms, data processing companies, and practice management firms. Nurses working as independent contractors, i.e., case managers, legal nurse consultants, and educators are included and subject to compliance with HIPAA law. A contract between the business associate and hiring agent must be in place before the associate can see any patient information.

What Health Information is Protected

HIPAA created two new phrases to describe information protected by the legislation. The medical record is now referred to as protected health information (PHI). This includes all information that is created by any covered entity. All forms of the information are part of protected health information, i.e., paper, electronic, video tapes, photos, audiotapes, and any information that has been duplicated, discussed, read from a computer screen, or shared over the internet.

The other new HIPAA phrase is individually identifiable health information (IIHI). Included in this category is any information that could reasonably be linked to a specific patient, such as a photo, name, address, date of birth, next of kin or responsible relative, medical record identifier, social security number, driver's license number, health beneficiary, account number, employer, finger, or voice prints.

The law specifies that some information that is not individually identifiable can remain. Age that is reported as 60+ if the patient is older than 60, zip code if the patient lives within a zip code with greater than 20,000 people in it, race, gender, ethnicity, marital status, and the year only of the health care occurrence are not considered individually identifiable information and these data may be used in the aggregate.

All facilities must limit access to information only to those who have a need to know. A nurse who seeks information about a patient not under her care is violating the HIPAA rules. Similarly, health information can only be used for health purposes. Employers cannot use the information to screen candidates for hire or promotion. Financial institutions may not use it to determine lending practice. Only the patient can explicitly authorize employers, banks, and individuals to have access to his/her medical information.

HIPAA also established the "minimum necessary rule" which stipulates that only the minimum necessary information may be shared, even with the patient authorization. A classic example would involve treatment for a case of child or domestic abuse; the provider would, rather than providing an entire medical record, furnish the pertinent data furnished in the form of an abstract outlining the information that is necessary to provide treatment and protect the victim(s). The abstracted information could be provided to legal and law enforcement entities. Health providers involved in the treatment of patients are not subject to the minimum necessary rule and can have full access to all information that is needed to provide patient care. Health

information that has implications for the public health and safety can be shared without consent. There are several situations where medical information can be shared: In Emergency 911 situations, when communicable diseases are involved, when law enforcement agencies participate, or if national defense or security is a factor.

The public health department is deemed a legitimate recipient of certain personal health information and providers may, in fact in some instances, must report some findings to the proper public health agency. Included are:

1. cause of death even when the patient dies at home
2. reportable communicable diseases
3. child abuse
4. reporting an adverse drug reaction to the Federal Drug Administration
5. occurrence of cancer in a state with a cancer registry
6. meningitis, and
7. immunizations for children.

These examples are thought to be important to the health of the public (Campos-Outcalt 2004).

Patient Consent and Authorization

HIPAA makes a distinction between informed consent and patient authorization. Patients are entitled to know exactly how an entity plans to use the information.

Informed consent is signed at the first encounter the patient has with the provider/health care facility; the consent covers treatment, payment, and other health care information. The meaning and use of the patient's consent must be carefully explained to the patient. Facilities must explicate their disclosure process in a document called Information Practices. The American Hospital Association published a sample consent and explanation document that was 10 pages long. The document explains patient rights, as well as a description of how patient information is collected and used. Facilities must decide how and when the information concerning consent is presented to patients and how patients can use their right to revoke consent. Patients must also be advised about the agency's policy that covers conditions for admission that are related to consent.

Patients may also sign authorizations. These are required when information is used by the agency for purposes outside of treatment. Agencies must assess their policies and procedures to assure that they are always using an authorization when it is needed; some agencies may not realize that information sharing policies violate the patient's right to restrict release of data (Cichon, 2002). Patients must be fully informed about the way agencies use a signed authorization and are entitled to receive a free accounting every twelve months describing how their health information has been used.

HIPAA privacy regulations also mandate specific patient rights that include the following:

1. Right to privacy notice requires disclosure and reasonable effort to assure that the patient understands the agency's policy concerning privacy of information.
2. Right to request restrictions means that patients may specify health information that cannot be released and/or, they may restrict to whom information can be released.
3. Right to access of PHI means that patients must be allowed to inspect and copy information contained in the agency's record.
4. Right to know what disclosures have been made means the agency must track all information released and be able to provide documentation to the patient.
5. Right to amend the PHI means that while patients may request amendments to the PHI and the agency must allow amendments, the agency may deny some requests.

All covered entities are required to comply with certain procedural rules. Most have had to develop new policies and procedures to address the many aspects covered under these rules. The following are some of the rules:

1. Agencies must appoint a privacy officer who will monitor and audit compliance.
2. Agencies must develop an internal compliance process that will assure no patient rights are violated, complaints are addressed and investigated, and that a process for remediation is in place.

3. Training must be provided to employees to assure that they are informed about patient rights and disclosure of information.
4. HIPAA requires that agencies document any and all violations and that sanctions parallel other disciplinary policies.
5. Agencies must have a process for mitigating any harmful effect of disclosure.
6. All forms of communication must be addressed in administrative safeguards.
7. Agencies must agree and have policies that specify no retaliation for an employee or consumer who files a complaint.

Practical Implications

Questions about the implications HIPAA rules have been numerous. Can an office or laboratory have a patient sign in sheet? Can you use a patient's name to call him into a treatment room? Can the patient's name be posted outside the hospital door? At this point, there is some agreement about some of these. As long as personal information regarding the patient's care or procedures to be done remain confidential, names can be outside hospital room doors, patients can be verbally called to treatment rooms, etc. New questions will undoubtedly arise in the future. Staying informed about the rules and regulations concerning HIPAA will be every health care worker's obligation.

Sign-in sheets, once disallowed, can now be used along with bedside charts as long as reasonable precautions are taken to safeguard patient information. Sign in sheets can only have the name and time; no information about the nature of the appointment can be included. The patient can give consent or may decline to have information given to family members; facility staff is not obligated to verify the identity of relatives.

HIPAA retains the rights of parents as the personal representative for minor children. There are exceptions, however. Parents may decide that the child and provider have a confidential relationship that excludes the parent from receiving information. A provider may choose to exclude the parent when abuse is suspected or when including the parent would endanger the child.

Patients have the right to restrict clergy visits and religious information. If the patient does want the clergy to visit, health care individuals should provide only the name and location of the patient. They should not provide any information about the patient's medical condition. Further, patients have the right to restrict informing callers or visitors that they are in the hospital. Most patients are asked on admission to the facility if they want such restrictions and, if they do, hospital workers may not acknowledge that a patient is in the hospital even including visitors, florists delivering flowers, etc.

Some information can be provided to law enforcement without patient consent. Emergency technicians can contact the police at a crime scene and convey nature and location of the crime. Information about a suspicious death may also be reported to the police. HIPAA has a one call rule that permits contacting an organ procurement agency following a death.

Repositories that store human tissue and fluids for future scientific analysis, i.e., genotyping, cell lines, other biotechnologies, express concern that HIPAA will fundamentally change how these commercial repositories function. At question is whether property rights continue to apply to human tissue after removal from the body. Prior to HIPAA, the Supreme Court in California ruled on the side of future research and determined that property rights end when tissue is removed from the body (Allen 2004). However, depending on how HIPAA rules are interpreted, informed consent may be required in order for research to be conducted on removed tissue.

HIPAA AND RESEARCH

Patients must sign an authorization to allow their information to be included in research projects. Information can only be disclosed in accordance with a research protocol approved by an institutional review board. All identifying individual information must be removed. One difficulty researchers may experience is the lack of specific guidance from HIPAA regarding construction of compliant, de-identified data sets, at this point researchers are developing strategies that they believe comply with the intent of privacy under HIPAA. Ongoing analysis of medical information is critical for developing strategies to improve patient outcomes and reduce medical errors (Clause, S.L.; Triller, D.M.; Bornhorst, C.P.; Hamilton, R.A.; Cosler, L.E. 2004). Information that can be used in compliance with HIPAA includes gender, race, ethnicity marital status, dates of treatment if reported in years, age (for individuals older than 60, one must use 60+), and zip code if more than 20,000 reside in that zip code (Erlen, J.A. 2004)

CONCLUSION

HIPAA regulations require new behavior from health care professional and health care facilities. Close coordination with other partners in health care delivery and reimbursement is mandatory to assure a continuous process of patient privacy.

Restrictions and the ability to amend IIHI give patients new control over their health information. Health care professionals may be challenged. Involving patients as active participants in their care will dispel and avoid potential problems.

Administrators are advised to be sure staff is well-trained and knowledgeable about the requirements of HIPAA. Similarly, they many want to scrutinize day- to-day practices to evaluate whether violations of patient rights are occurring.

Communication Barriers

Communication is a process beginning with a sender who encodes the message and passes it through some channel to the receiver who decodes the message. Communication is fruitful if and only if the messages sent by the sender is interpreted with same meaning by the receiver. If any kind of disturbance blocks any step of communication, the message will be destroyed. Due to such disturbances, managers in an organization face severe problems. Thus the managers must locate such barriers and take steps to get rid of them.

Effective communication requires messages to be conveyed clearly between communicators, but along the way there are many communication barriers that can create misunderstandings and misinterpretations of your message.

There are several barriers that affects the flow of communication in an organization. These barriers interrupt the flow of communication from the sender to the receiver, thus making communication ineffective. It is essential for managers to overcome these barriers. The main barriers of communication are summarized below.

Successful communication requires knowing what barriers to communication exist and how to navigate around these roadblocks.

Physical Barriers – These barriers are those that separate people from each other and mark territories. This type of barrier can often be seen in the workplace where offices and closed doors stop communication.

Language Barriers – Not using words another can understand will certainly stop your message from being conveyed. This not only applies to actual languages, but that of expressions, buzz words, and other jargon. If one is not familiar with your language, misinterpretation will occur.

Gender Barriers – Variation exists among masculine and feminine styles of communication. While women often emphasize politeness, empathy, and rapport building, male communication is often more direct. Meshing these two styles without awareness could be become a barrier.

Interpersonal Barriers – These are barriers are created to distance themselves from others. These can be done through withdrawal, meaningless rituals which keep one devoid of real contact, superficial activities through pastimes, and more.

Perceptual Barriers – Different world views can create misunderstanding. Without thinking, one might only view a message from their mindset rather than looking to see it from another viewpoint.

Cultural Barriers – Ethnic, religious, and social differences can often create misunderstandings when trying to communicate. These differences can also affect perceptual factors, as mentioned above.

Emotional Barriers – Trouble listening can occur if one is consumed with emotion. Hostility, anger, fear, and other emotions make it hard to hear outside of oneself.

Overcoming these barriers to communication is no easy task. It takes great awareness and a willingness to adapt and look at communication from new perspectives. But, if you begin to focus on how these communication barriers are affecting your everyday conversation, you will be well on your way to becoming an effective communicator.

Written Communication

Written communication has great significance in today's business world. It is an innovative activity of the mind. Effective written communication is essential for preparing worthy promotional materials for business development. Speech came before writing. But writing is more unique and formal than speech. Effective writing involves careful choice of words, their organization in correct order in sentences formation as well as cohesive composition of sentences. Also, writing is more valid and reliable than speech. But while speech is spontaneous, writing causes delay and takes time as feedback is not immediate.

Advantages of Written Communication

- ✓ Written communication helps in laying down apparent principles, policies, and rules for running of an organization.
- ✓ It is a permanent means of communication. Thus, it is useful where record maintenance is required.
- ✓ It assists in proper delegation of responsibilities. While in case of oral communication, it is impossible to fix and delegate responsibilities on the grounds of speech as it can be taken back by the speaker, or he may refuse to acknowledge.
- ✓ Written communication is more precise and explicit.
- ✓ Effective written communication develops and enhances an organization's image.
- ✓ It provides ready records and references.
- ✓ Legal defenses can depend upon written communication as it provides valid records.

Disadvantages of Written Communication

- ✓ Written communication does not save upon the costs. It costs huge in terms of stationery and the manpower employed in writing/typing and delivering letters.
- ✓ Also, if the receivers of the written message are separated by distance and if they need to clear their doubts, the response is not spontaneous.
- ✓ Written communication is time-consuming as the feedback is not immediate. The encoding and sending of message takes time.
- ✓ Effective written communication requires great skills and competencies in language and vocabulary use. Poor writing skills and quality have a negative impact on organization's reputation.
- ✓ Too much paperwork and e-mails burden is involved.

Non-Verbal Communication

Non-verbal communications are the communication of feelings, emotions, attitudes, and thoughts through body movements / gestures / eye contact, etc.

The components of non-verbal communication include:

- **Kinesics:** It is the study of facial expressions, postures & gestures. Did you know that while in Argentina to raise a fist in the air with knuckles pointing outwards expresses victory, in Lebanon, raising a closed fist is considered rude?
- **Oculesics:** It is the study of the role of eye contact in non-verbal communication. Did you know that in the first 90 secs - 4 min you decide that you are interested in someone or not. Studies reveal that 50% of this first impression comes from non-verbal communication which includes oculesics. Only 7% of comes from words - that we actually say.

- **Haptics:** It is the study of touching. Did you know that acceptable level of touching varies from one culture to another? In Thailand, touching someone's head may be considered as rude.
- **Proxemics:** It is the study of measurable distance between people as they interact. Did you know that the amount of personal space when having an informal conversation should vary between 18 inches - 4 feet while, the personal distance needed when speaking to a crowd of people should be around 10-12 feet?
- **Chronemics:** It is the study of use of time in non-verbal communication. Have you ever observed that while AN employee will not worry about running a few minutes late to meet a colleague, a manager who has a meeting with the CEO, a late arrival will be considered as a nonverbal cue that he / she does not give adequate respect to his superior?
- **Paralinguistics:** It is the study of variations in pitch, speed, volume, and pauses to convey meaning. Interestingly, when the speaker is making a presentation and is looking for a response, he will pause. However, when no response is desired, he will talk faster with minimal pause.
- **Physical Appearance:** Your physical appearance always contributes towards how people perceive you. Neatly combed hair, ironed clothes and a lively smile will always carry more weight than words.

Remember, "what we say" is less important than "how we say it" as words are only 7% of our communication. Understand and enjoy non-verbal communication as it helps forming better first impressions.

Language Barriers

Language barrier is a figurative phrase used primarily to indicate the difficulties faced when people who have no language in common attempt to communicate with each other.

More than 46 million people in the United States do not speak English as their primary language, and more than 21 million speak English less than "very well." Persons who have limited English proficiency are less likely to have a regular source of primary care and are less likely to receive preventive care. They also are less satisfied with the care that they do receive are more likely to report overall problems with care and may be at increased risk of experiencing medical errors.

Since federal laws stipulate no one can be denied or forced to wait for medical care due to language barriers, some healthcare providers resort to secondary strategies like drawings and hand signals to compensate for gaps in communication. Still, the possibility for error is simply too high. To help alleviate these issues, patients are often urged to bring a bilingual friend or familiar member to explain their medical problems. Hospitals and healthcare facilities, based on the population they serve, translate documents to ensure patients complete all required paperwork properly. Brochures and resources are provided to those who speak limited English to help facilitate their participation in American society and encourage them to take ownership of their health.

Because most health care organizations provide either inadequate interpreter services or no services at all, patients who have limited English proficiency do not receive needed health care or quality health care. Often, persons enlisted to help patients communicate with health care providers are not trained interpreters; instead, they are fellow patients or are family members, friends, untrained nonclinical employees, or non-fluent health care professionals. Reliance on such ad hoc services has been shown to have negative clinical consequences.

Many health care providers do not provide adequate interpreter services because of the financial burden such services impose. However, these providers fail to take into account both the consequences of not providing the services and the potential cost benefits of improving communication with their patients. The failure of health care providers to consider these issues is at least partially attributable to the paucity of data documenting the full costs and benefits of interpreter services. To acquire a better understanding of these costs and benefits, we assessed the impact of implementing a new interpreter service program on the cost and utilization of health care services among patients with limited English proficiency.

Tips for Communicating with Deaf and Hard-of-Hearing People

Deafness is a fact of many people's lives … more than 22 million Americans have some form of hearing loss. Like their hearing counterparts, deaf people build successful careers, have families, watch television, go to the movies, talk on the telephone, play sports, and travel throughout the world.

Most deaf people don't view their deafness as a disability or as a problem that should be fixed. For many of them, it's a natural part of a cultural experience that they share with friends, both deaf and hearing.

Deaf culture is a sense of community among deaf people. Cultural activities can include

communicating in American Sign Language (ASL), sharing information about resources that can enhance deaf people's lives, performing and attending theatrical events with no spoken language, joking about the experience of being deaf, and reflecting on role models and events important to deaf people.

All of us have our own way of doing things, and deaf people are no different.
Deaf people communicate in different ways, depending on several factors: age at which deafness began; type of deafness; language skills; amount of residual hearing. speech reading skills; speech abilities; personality; family environment; educational background; and personal preference.
Some deaf people use speech or sign language only … or a combination of sign language, Finger spelling, and speech … or writing … or body language and facial expression. You can communicate with deaf people in several ways. The key is to find out which combination of techniques works best with each deaf person. Keep in mind that it is not how you exchange ideas, but that you do.

To Communicate with a Deaf Person in a One—to-One Situation:

Get the deaf person's attention before speaking. Call out the person's name; if that is not successful, a tap on the shoulder, a wave, or another visual signal usually does the trick.

Key the deaf person into the topic of discussion. Deaf people need to know what subject matter will be discussed in order to pick up words that help them follow the conversation. This is especially important for deaf people who depend on speechreading.

Speak slowly and clearly, but do not yell, exaggerate, or over pronounce. Exaggeration and overemphasis of words distort lip movements, making speechreading more difficult. Try to enunciate each word without force or tension. Short sentences are easier to understand than long ones.

Look directly at the deaf person when speaking. Avoid turning away to write on the board, look at a computer screen, or pull something from a file while speaking.

Do not place anything in your mouth when speaking. Mustaches that obscure the lips, smoking, pencil chewing, and putting your hands in front of your face all make it difficult for deaf people to follow what is being said.

Maintain eye contact with the deaf person. Eye contact conveys the feeling of direct communication. Even if an interpreter is present, continue to speak directly to the deaf person. He/she will turn to the interpreter as needed.

Use the words —I‖ and —you‖ when communicating through an interpreter, not "Tell him…" or "Does she understand?"

Avoid standing in front of a light source, such as a window or bright light. The glare and shadows created on the face make it almost impossible for the deaf person to speech read.

First repeat, then try to rephrase a thought if you have problems being understood, rather than repeating the same words again. If the person only missed one or two words the first time, one repetition usually helps. Don't hesitate to communicate by pencil and paper, if necessary, as particular combinations of lip movements sometimes are difficult to speech read. Getting the message across is more important than the medium used.

Use pantomime, body language, and facial expression to help supplement your communication. A lively speaker always is more interesting to watch.

Be courteous to the deaf person during conversation. If the telephone rings or someone knocks at the door, excuse yourself and tell the deaf person that you are answering the phone or responding to the knock. Do not ignore the deaf person and carry on a conversation with someone else while the deaf person waits.

Use open-ended questions that must be answered by more than "yes" or "no". Do not assume that deaf people have understood your message if they nod their heads in acknowledgement. A coherent response to an open-ended question ensures that your information has been communicated.

The Americans with Disabilities Act (ADA) guarantees equal opportunities in the workplace for people with disabilities. Accommodations made will vary depending on deaf employees' job responsibilities, technical skills, and communication preferences as well as the characteristics of the organization.

It generally is not necessary to make major modifications in the work area to accommodate a deaf employee. There are some things you can do, however, to make the work area more accessible and therefore more comfortable for a deaf employee.

Consider the deaf person's sensitivity to noise. It is a myth that deaf people can work in noisy environments that hearing people cannot tolerate. Most deaf people have some residual hearing and are bothered by loud noises. A noisy environment may create a barrier to communication for someone who wears a hearing aid. Loud or background noises can interfere with and distort the sound amplification of a person's hearing aid, making speech discrimination difficult. Loud noises also may further damage whatever residual hearing the deaf person has.

Consider the buddy system for a new deaf employee. This can make the job transition much easier for the deaf person. A co-worker can be asked to check a deaf employee's awareness of emergency situations, such as fires or evacuation.

Use signaling devices if a deaf employee works alone in an area. Most of these devices are inexpensive and can be incorporated easily into existing alarm systems. Alarms to warn of fire or gas leaks by use of a flashing light and audio signal can plug into regular electrical outlets. Other devices indicate machine malfunction, doorbells, and ringing telephones.

Minimize vibration in the work area. Vibration can distort the sound being received by a hearing aid, making it difficult for the deaf person to concentrate on work or a conversation. Since it is not always possible to eliminate vibration, it is best to arrange meetings in a location where vibration can be minimized.

Use visual clues to enhance communication. Use of a round or oval table during meetings will facilitate the line of sight between people, as will semicircular seating arrangements. Open doors or panels in offices allow deaf people to see into rooms before entering. A good line of sight between the deaf employee and the secretary also will facilitate telephone communication.

Use paging devices to contact deaf employees in the field. Radio frequencies have been set aside by the Federal Communications Commission to permit the use of "tactile

pagers" vibrating paging devices that can be used to contact or warn deaf employees in the field or in remote locations. Such pagers usually can be incorporated into existing security paging systems.

Always ask deaf people if they prefer written communication. Do not assume that this is the preferred method. When using writing as a form of communication with deaf people, take into consideration English reading and writing skills. Their skills may depend on whether they were born deaf or became deaf later in life, what teaching method was used in their education, and which communication method they prefer.

Keep your message short and simple. Establish the subject area, avoid assumptions, and make your sentences concise.

It is not necessary to write out every word. Short phrases or a few words often are sufficient to transfer the information.

Do not use yes or no questions. Open-ended questions ensure a response that allows you to see if your message was received correctly.

Face the deaf person after you have written your message. If you can see each other's facial expressions, communication will be easier and more accurate.

Use visual representations if you are explaining specific or technical vocabulary to a deaf person. Drawings and diagrams can help the person comprehend the information.

COMMUNICATIONS BARRIERS AND CULTURAL CONSIDERATIONS

In order to provide optimal quality care to our patients/clients, the Agency will facilitate communication with sensory-impaired patients/clients and patients/clients with limited formal education. The Agency shall attempt to arrange for bilingual staff members or an interpreter to work with non-English speaking patients/clients.

1. When the Agency assigns a staff member who does not speak the patient/client's language, the Agency will provide the services of a qualified interpreter at no charge to the patient at any home visit. The Limited English Proficiency (LEP) person may prefer or request to use a family member, friend or significant other. Children and other patients will not be used to interpret in order to ensure confidentiality of information and accurate communication.
2. Interpreters will be used when no one is available in the home to provide interpretive services.
3. Cultural considerations for all patients/clients shall be respected and observed. Where such considerations impede the provision of prescribed health care or treatment, personnel shall notify the supervisor and physician in an effort to accommodate the patient/client.
4. Every effort will be made to obtain the services of an available interpreter when necessary for persons using sign language. The Agency will advise/refer regarding telecommunications devised for the deaf.
5. Educational materials, visual aids and/or special devices will be used as needed to facilitate communication.
6. Written and verbal communication will be at an educational level that the patient/client will understand.
7. When a significant portion of the caseload does not speak English, written materials are provided in a language understandable to patients/clients.
8. Obtaining an outside interpreter if a qualified interpreter on staff is not available. An interpreter will be obtained from one of the following:

   Accredited Language Services - 1-800-322-0284

   Verbatim Solutions 1-800-575-5702

   www.languageline.com
9. Communicating with persons who are deaf or hard of hearing the agency will use the state relay system.

Workplace/Patient Safety (OSHA)

What is OSHA?

The Occupational Safety and Health Act (OSH Act) of 1970 was passed to prevent workers from being killed or seriously harmed at work. The law requires employers to provide their employees with working conditions that are free of known dangers. The Occupational Safety and Health Administration (OSHA) was created, as a result, to set and enforce protective workplace safety and health standards. OSHA provides information, training and assistance to workers and their employers. Workers may file a complaint to have OSHA inspect their workplace if they believe that their employer is not following OSHA standards or that there are serious hazards (1-800-321-6742).

Workers are entitled to working conditions that do not pose a risk of serious harm. To help assure a safe and healthful workplace, OSHA also provides workers with the right to:

- Ask OSHA to inspect their workplace’
- Use their rights under the law without retaliation and discrimination’
- Receive information and training about hazards, methods to prevent harm and OSHA standards that apply to their workplace.
- Get copies of test results done to find hazards in the workplace.
- Review records of work-related injuries and illnesses.
- Get copies of their medical records.

The Agency is responsible for implementing a formal, comprehensive, and active safety program with written records of program activities.

1. Every safety program shall include as a minimum the following elements: (Reference the Safety Manual for appropriate management techniques and examples)
    a. New employee hiring practices, which include:
        i. Completion of an employment application.
        ii. A check of listed references.
        iii. Completion of a voluntary medical questionnaire.
    b. The assignment of responsibility and accountability for employee safety to appropriate supervisors who are responsible for:
        i. Operating procedures and job safety rules for tasks that are written within each department and will include guarding procedures and rules regarding the use of required personal protective equipment.
        ii. Training of all new and transferred employees with respect to safe job procedures and rules.
        iii. Safety training will be continually refreshed for all employees as needed.
        iv. A self-inspection program by responsible supervisors to detect and correct unsafe conditions or acts.
2. Safety management is the responsibility of each employee at all times in the workplace, and when in the patient's home. All appropriate employees and patients/caregivers shall receive instruction in safety management including but not limited to:
    a. Electrical safety
    b. Environmental
    c. Bathroom safety
    d. Hand washing
    e. Infection control
    f. Refrigeration
    g. Use of gloves
    h. Trans-filling of medical gases
    i. Transfers and ambulation safety
    j. Use of medical equipment
    k. Disposal of needles in a non-penetrable non-glass container
    l. Double boxing and bagging
    m. Hazardous waste handling and disposal
    n. Storage, handling, delivery and access to supplies, medical gases and drugs, especially chemotherapeutic agents, controlled substances, parenteral and enteral nutrition solutions, and needles.

3. Patients/caregivers shall acknowledge in writing the receipt of verbal and written instructions regarding safety management. Patient care employees shall monitor the patient/caregiver's understanding and compliance with safety management on an ongoing basis. Appropriate instructions will be provided. All patient care employees will attend in service education on safety management upon employment, annually and as the need for further instruction is identified by their supervisor.

4. Patient related safety hazards will be documented in the clinical record and brought to the attention of the supervising nurse. All accidents or injuries will be reported to the supervising nurse and documented on an incident report. If the accident involves the patient, appropriate actions will be initiated, and the physician will be notified to obtain specific follow-up orders. A report of safety related incidents will be presented to the Advisory Committee and governing body including the causal factors and actions to prevent a similar incident.

5. If an accident or incident involves equipment malfunction and serious injury, illness or death, the incident will be reported to the Food and Drug Administration (FDA) within 10 days of notification of the incident.

6. An annual report summarizing incidents occurring in the previous 12 months must be filed with the FDA. The form 3419 is located on your USB.

Employers have the responsibility to provide a safe workplace that does not have serious hazards and to follow all relevant OSHA safety and health standards. Employers must find and correct safety and health problems. OSHA further requires employers to try to eliminate or reduce hazards first by making changes in working conditions rather than relying on masks, gloves, or other types of personal protective equipment (PPE).
Employers MUST also:

- Inform employees about hazards through training, labels, alarms, color-coded systems, chemical information sheets and other methods.
- Keep accurate records of work-related injuries and illnesses.
- Perform tests in the workplace, such as air sampling required by some OSHA standards.
- Provide hearing exams or other medical tests required by OSHA standards.
- Post OSHA citations, injury and illness data, and the OSHA poster in the workplace where workers will see them.
- Notify OSHA within 8 hours of a workplace incident in which there is a death or when three or more workers go to a hospital.
- Not discriminate or retaliate against a worker for using their rights under the law.
- Recordkeeping Requirements for the Survey of Occupational Injuries and Illnesses
  As in the past, OSHA requires that all recordable work-related injuries and illnesses information be reported, utilizing Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses (SOII) recordkeeping requirements annually. These forms (OSHA 300, Log of Work-Related Injuries, and Illnesses) have changed to include an additional column on (M5) on Hearing Loss.

As of January 1, 2015, all employers must report:

a. All work-related fatalities within 8 hours.

b. All work-related inpatient hospitalizations, all amputations, and all losses of an eye within 24 hours.

OSHA Hazardous Communication Standard

OSHA has revised its Hazard Communication Standard, March 2012, 77 FR 17574, (HCS) concerning classification and labeling of chemicals. This is recognized by health care providers as Material Safety Data Sheets (MSDS) and will now be called Safety Data Sheets (SDSs). Two significant changes contained in the revised standard require the

use of new labeling elements and a standardized format for Safety Data Sheets (SDS). Effective December 1, 2013, employers must have trained their workers on the new label elements and SDS format. It is important that employees understand the new label and SDS formats. The specific requirements of the revised standard will be phased in over several years (December 1, 2013, to June 1, 2016)

The Hazard Communication Standard (HCS) is intended to inform employees of the proper recognition, use, and handling of hazardous chemicals and products in the workplace. This standard applies to all employers regardless of size if any employee has a potential exposure risk.

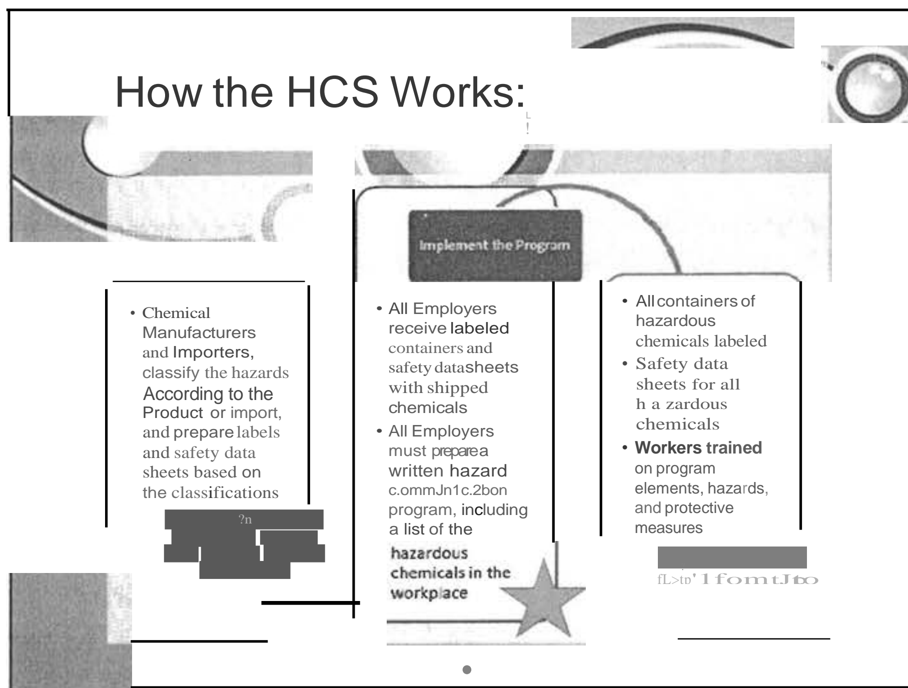
The Hazard Communication Standard also protects employees from dangerous chemicals by:

1. Eliminating hazardous chemicals if possible
2. Substitute a toxic substance with a less toxic substance
3. Redesign processes that use toxic chemicals to eliminate or reduce exposure to the chemical hazard.
4. Change work procedures to reduce the duration, frequency, and severity of exposure to the chemical hazard.
5. Ensure employees have appropriate personal protective equipment (PPE) appropriate to the chemical hazard.

The Agency is responsible to have a written communication program, have safety data sheets on each chemical, ensure all hazardous chemical containers are appropriately labeled, and train employees about the hazards of the chemicals they use.

The employee is responsible for:

1. Being familiar with the location and availability of safety data sheets (SDS's) and the written hazard communication program.
2. Use chemical products in a manner that is consistent with the information set forth on the label and SDS, including but not limited to directions for use, hazard warnings, and precautionary measures.
3. Follow appropriate work practices when working with hazardous chemical products, such as the use of PPE and ventilation.
4. Report hazardous conditions to your supervisor.



Hazard Classification

All chemicals must be classified by the manufacturer based on OSHA criteria. Hazards are either physical or health classifications. A “hazard class” may be subdivided into “hazard categories” based on the degree of severity of the hazard. Classifications indicate not only the hazard, but also the severity of the effect.

Physical Hazards: combustible liquids, compressed gases, explosives, flammables, organic peroxides, oxidizers

Health Hazards: carcinogens, toxic or highly toxic, reproductive toxins, irritants, corrosives, sensitizers, hepatotoxins, nephrotoxins, neurotoxins, hematopoietic system impact, or target organ damage.

Labels

Labels must include specific components to protect workers when working with chemicals. Companies that produce hazardous chemicals must include specific elements on the labels. There is no exemption for small packages. There are no size requirements for labels. Labels must include:

Product Identifier:
This can be the chemical name, code number or batch number. The manufacturer decides the identifier and must print the identifier on both the label and in Section 1 of SDS (Identification).

Signal Word:
This will be used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. There are only 2 signal words, “Danger” and “Warning”. Only one will appear on the label.

Danger - used for the more severe hazards
Warning - less severe hazards

Pictogram:
A symbol intended to convey specific information about the hazards of a chemical. Pictograms are intended to alert users of the chemical hazards to which they may be exposed. Each pictogram consists of a symbol on a white background framed with a red border. The pictogram on the label is determined by the chemical hazard classification. OSHA has designated 8 pictograms which can be used under this standard.

Hazard Statements(s):
This will describe the nature, and where appropriate, the degree of the hazard(s). i.e. “Causes damage to kidneys through prolonged or repeated exposure when absorbed through the skin”. The hazard statements are specific to the hazard classification categories, and chemical users should always see the same statement for the same hazards, no matter what the chemical s or who produces it.

Precautionary Statement(s):
A phrase that describes recommended measures to be taken to minimize or prevent adverse effects resulting from exposure to or improper handling/storage of a hazardous chemical. Precautionary statements address prevention, response, storage, and disposal. (Examples: do not eat, drink, or smoke when using this product or keep container tightly closed)

Name, address and phone number of the chemical manufacturer, distributor, or importer:
How the employee might use the labels in the workplace, for example,

- How information on the label can be used to ensure proper storage
- How the information might be used to quickly locate information on first aid when needed by employees or emergency personnel.

General understanding of how the elements work together. For example,

- That where a chemical has multiple hazards, different pictograms are used to identify various hazards.
- When precautionary statements are similar, the one providing the most protective information will be included on the label.

The Hazard Communication Standard (HCS) requires chemical manufacturers, distributors, or importers to provide Safety Data Sheets (SDSs, formerly known as MSDSs) to communicate the hazards of hazardous chemical products. Employers must ensure that SDSs are readily accessible to employees. By June 1, 2015, the HCS will require new SDSs to be in a uniform format and include the section numbers, the headings, and associated information under the headings below:

Hazard Communication Safety Data Sheets

Safety Data Sheets are formally known as Material Safety Data Sheets. They provide a detailed source of information about the chemical to ensure the chemical is handled safely. Required information appears in the same sections of an SDS regardless of the supplier. The most important information will be listed in the first section of the SDS. SDS's must be readily available to workers when they are in their work areas, during each shift. SDS's may be maintained electronically as long as backup hard copy is available in the event of a computer or electrical failure. SDS's must be in English and other languages may be optionally provided by the agency. A red border is not required for pictograms on SDS's.

SDS Sections

Section 1, Identification, includes product identifier; manufacturer or distributor name, address, phone number; emergency phone number; recommended use; restrictions on use.
Section 2, Hazard(s) identification includes all hazards regarding the chemical; required label elements.
Section3, Composition/information on ingredients includes information on chemical ingredients, trade secret claims.
Section 4, First-aid measures includes important symptoms/effects, acute, delayed; required treatment.
Section 5, Fire-fighting measures lists suitable extinguishing techniques, equipment, chemical hazards from fire.
Section 6, Accidental release measures lists emergency procedures; protective equipment; proper methods of containment and cleanup.
Section 7, Handling and storage lists precautions for safe handling and storage, including incompatibilities.
Section 8, Exposure controls/personal protection lists OSHA's Permissible Exposure Limits (PELs); Threshold Limit Values (TLVs); appropriate engineering controls; personal protective equipment (PPE).
Section 9, Physical and chemical properties lists the chemical's characteristics.
Section 10, stability, and reactivity lists chemical stability and possibility of hazardous reactions.
Section 11, Toxicological Information includes routes of exposure; related symptoms, acute and chronic effects; numerical measures of toxicity.
***OSHA will not be enforcing sections 12 -15 as other agencies are responsible**
Section 16, other information includes the date of preparation or last revision

HAZARD COMMUNICATION PROGRAM

The purpose of the HCP is to ensure that hazardous chemicals in the workplace are evaluated and that information concerning physical and health hazards are communicated to potentially exposed employees. The HCP must be readily accessible by all employees at all times.
The goals of the HCP are:

1. Prevent chemical-related illnesses and injuries in the workplace
2. Enhance and support the organization's overall safety program
3. Establish open lines of communication between employees and the agency to support safe work practices
4. Substitute less hazardous chemicals when possible
5. Avoid OSHA violations and citations related to unsafe work practices

Hazard Categories

Chemicals may fall into more than one category and in order to protect yourself from hazardous chemicals it is important to read the label and identify the specific hazards associated with the chemical.

1. Corrosives- can cause visible destruction of, or irreversible damage to, living tissue by chemical action at the site of contact. They are often found in the form of concentrated acids and bases. Examples include oven and grill cleaners, acid toilet bowl cleaners, alkaline drain cleaners. Corrosives often react violently if mixed with other products and can have immediate and damaging effects on the skin or mucous membranes. Examples include burns, blisters, scarring.
2. Irritants- are chemical products that cause a reversible inflammatory effect on living tissue by chemical action at the site of contact. Examples are industrial cleaners and degreasers, sanitizers, general purpose cleaners.

When using irritants or corrosives you should wear PPE, handle the product in a well-ventilated location and when mixing an acid with water, always add the acid to the water.

First aid:

Skin exposure: remove contaminated clothing, rinse skin immediately with plenty of water for 15-20 minutes

Eye contact: hold eye open and rinse slowly and gently with running water for 15-20 minutes, remove contact lenses, if present, after the first 5 minutes, then continue rinsing. Seek emergency care or contact a poison control center. Check the product's SDS and label for specific first aid information.

3. Flammable and Combustibles- are substances that can catch fire and burn. Examples are flammable liquids such as acetone, gasoline, or solvent based products; Combustible example is mineral oil. Gases under pressure such as propane, liquid nitrogen, and aerosol products. The vapors can ignite easily and burn rapidly and may explode and produce toxic vapors. Exposure to the vapors may produce adverse health effects like headaches, dizziness, nausea, and chronic effects of damage to the lungs, liver, and kidneys. Precautions include not to use these products near open flames or other sources of ignition, keep the container closed when not in use, store in a cool, dry place and store separately from oxidizers (chlorine, ammonia, hydrogen peroxide).
4. Oxidizers- are substances that enhance the burning of other materials through the release of oxygen. They are generally very reactive chemicals and contact with flammable or combustible materials is likely to result in fire. Oxidizers may react with other products to form noxious odors/fumes such as bleach. The health hazards include inflammation/destruction of tissue,

   severe irritation of the upper respiratory tract, irritation of eyes or nose, damage to the nervous
5. system, and potential fertility disorders. Oxidizers should be stored separately from flammables and combustibles. Do not mix with other products and materials such as bleach and ammonia. Keep containers closed when not in use and check the SDS for product specific information.
6. Toxins and Poisons- these are extremely poisonous and access to these should be restricted. Examples include sulfuric acid-based drain cleaners, ethylene glycol-based cleaners, hydrofluoric based aluminum cleaners/brighteners.

Signs of Chemical Exposure

There are 3 methods to detect a hazardous chemical release: sight, smell, and air monitoring (carbon dioxide monitor). If you smell a chemical, it has already entered your body. Report any odors that are different or stronger than normal.

Preventing or Reducing Exposure to Hazardous Chemicals

Hazardous materials may enter the body through four different routes of exposure: inhalation, absorption, ingestion, or injection. When exposed to hazardous material, there may be 2 kinds of health effects to the body, acute and chronic. Acute is characterized by sudden and severe exposure and rapid absorption of a material (e.g., chemical burn). Chronic is characterized by prolonged and repeated exposure over a longer period of time (e.g., exposure to lead pain may result in cancer). Wear PPE. OSHA requires that PPE provide adequate protection against the hazard, be reasonably comfortable, fit snugly without interfering with movement or vision, be durable, be capable of being disinfected (for reusable items), and be kept in good repair and clean. Assess the chemical's label for the appropriate PPE to use.

Managing an Unprotected Chemical Exposure

The steps to take after an unprotected exposure depends on the toxicity of the material, dose, and route of exposure. Read the label for directions on post-exposure follow up. Identify the closest location of running water. If in doubt call 9-1-1.

Managing Spills and Leaks

Consult the appropriate SDS for instructions on disposal. Clear the area. If spilled materials are flammable or combustible, remove sources of ignition or heat. Do not use tools or items that create sparks, heat, or flames. Stop the spill from spreading, especially into drainage or sewer systems. For liquid spill, use absorbent solid to soak and contain the spill (spill kit). Sweep up used absorbent and dispose of properly(biological waste should be disposed of in the a hazardous waste container/bag). Notify your supervisor as appropriate.

General Safety

1. Only use chemicals that have appropriate labels and SDS's.
2. Always read the label on the chemical bottle.
3. Always follow the directions and precautions listed on the label and on the safety data sheet.
4. Never use a chemical if you are unsure what it is or how to protect yourself.
5. Always use appropriate PPE when working with chemicals.
6. Always dispose of a chemical properly.
7. Maintain adequate ventilation.
8. Practice hand hygiene.
9. Never bring chemicals into the workplace that have not been logged into the SDS manual.

NOTE:

Training on the format of the SDS must include:

- Standardized 16-section format, including the type of information found in the various sections (see previous example)

For example, the employee should be instructed that with the new format, Section 8 will always contain information about exposure limits, engineering controls and ways to protect self, including personal protective equipment,

- Section 8, Exposure controls/Personal Protection will always contain information about exposure limits, engineering controls and ways to protect self, including personal protective equipment,
- Precautionary statements on label would be the same on the SDS.

OSHA requires employers to present information in a manner and language that their employees can understand. If the employee speaks/reads a language other than English, the employer will need to provide safety and health training in that language. OSHA's Hazard Communication website (http://www.oshagov/dsg/hazcom/index.html) has the following "quick cards" and OSHA briefs in English and Spanish to assist employers with training:

- Label QuickCard
- Pictogram QuickCard
- Safety Data Sheet QuickCard
- Safety Data Sheet OSHA Brief
- Label/;Pictogram OSHA Brief

Safety Committee

1. An Ad Hoc Safety committee will be organized within the agency to establish a network for communication of safety information pertaining to the work environment.

2. The Committee will be organized to distribute safety information, observe, and monitor compliance with OSHA standards, determine safety needs, review problems, and develop means to improve or resolve those problems.

3. The Committee will be composed of representatives appointed by the Professional Advisory Committee.

4. The Safety Committee will be responsible for distributing safety related information, monitoring compliance, maintaining, and updating OSHA compliance as per OSHA standards.

2. The Safety Committee will be knowledgeable in safety subject matter and conduct training in-services.

3. Safety Committee meetings will be scheduled once yearly and as needed to address special issues or situations.

4. The Administrator sets the dates and times for the meetings of the Safety Committee and plans the agendas for the meetings.

5. The minutes of the Safety Committee meetings are reported to the Professional Advisory Committee and to the Governing Body. They are filed by the Administrator along with any and all safety reports, papers, and written recommendations. They are maintained for a minimum of five (5) years and made available upon request.

6. The Administrator is responsible for informing the employees of the decisions, actions, and recommendations of the Safety Committee.

7. Each employee of the Agency may submit suggestions, complaints, or questions to his/her supervisor to submit to the Safety Committee.

8. The Safety Committee discusses all such suggestions, complaints, and questions and takes actions when necessary.

9. The Safety Committee reviews as required, all reports of work-related injuries and loss reports in order to design, develop and implement corrections as needed, to eliminate and prevent injuries at work.

10. The Safety Committee reviews every work-related injury to determine what caused the injury, what could have been done to prevent it and what has been done to prevent a recurrence.

Patient Rights and Responsibilities

Patient Rights are an integral part of healthcare today. All clients come to our Agency with different healthcare experiences and may or may not be aware of their rights. Protections are afforded by federal and state legislation and as health care providers we must educate our client about their rights and the manner in which they may exercise them. For ease of access and teaching, the patient's rights are clearly stated in one document that is called The Patient's Bill of Rights.

Accessibility and Education

The Bill of Rights must always be accessible to the client, family, public and staff. It can be found posted in the office and in the client's admission packet. If a client would like an additional copy, they are located in the office. Upon admission, the nurse will explain the Bill of Rights to the client and/or caregiver. The client/caregiver must be given the opportunity to ask questions. Receipt of the Bill of Rights is documented in the clinical record. The client must also be informed that he/she has the right to excursive the rights at any time without fear of reprisal. Any questions about the protections afforded by the Bill of Rights may be directed to the Administrator if the employee/ contractor cannot answer it.

Key Areas

Key things to remember about the Bill of Rights are:

- ✓ The rights can be exercised at any time.
- ✓ Clients are to receive the best quality care without regard to race, creed, nationality/origin, lifestyle choice and diagnosis.
- ✓ The client/caregiver ALWAYS has the right to refuse care.
- ✓ The client/caregiver must be informed of care prior to initiation.
- ✓ Privacy, including protection of PHI is paramount.
- ✓ The client/caregiver must be informed of charges prior to initiating service.
- ✓ The client has the right to be safe.
- ✓ The client has the right to be treated with respect.
- ✓ The client has the right to make concerns/ grievances known without the fear of reprisal.

Specific questions about patients' rights may be directed to the Administrator.

Interacting with Clients
Client rights not only govern what the client may do and when, but how Agency staff interacts with the client and their environment. Appropriate and professional interaction can increase client confidence and overall satisfaction.

When you are in a client's home, remember:

- ✓ Address the client using his or her name and the appropriate title. Nicknames like sweetie and honey are well meaning but it can come across as demeaning. Terms of endearment should never be used, and nicknames should only be used if and when the client gives permission.
- ✓ Treat the client's property with respect. Remember although you are working, you are in someone's home! Observe cultural considerations and do not slam doors or damage personal property.
- ✓ Clients have the right to know who you are and what you are doing.
    - Always introduce yourself when you enter into a client's environment and at the beginning of telephone conversations.
    - ALWAYS wear your ID badge.
    - Explain procedures prior to starting them.
    - Answer questions honestly.
    - Be professional and smile.

Complaints/ Grievances
The client has the right to make concerns known. The Agency has a responsibility to investigate the problem and resolve the issue to the client's satisfaction in a timely manner.
Upon admission the client is given a copy of the grievance process and rights pertaining to having problems resolved. If a client is upset, it is important to remember:

- ✓ Remain calm and objective.

- ✓ Respond to questions and problems promptly
- ✓ Do not take complaints personally
- ✓ Remain professional
  - Do not yell
  - Do not name call
  - Do not make accusations
  - Do not accept or assign blame

Responsibilities

For every right, there is a responsibility to assure that the right is exercised in a safe manner. As a healthcare provider you have the responsibility to:

- ✓ Listen to you patient when they tell you what they need. Do not assume you know what they need or want.
- ✓ Explain what you are going to do with the patient prior to starting in language that is appropriate for his/her level of development/ national origin.
- ✓ Be honest. If you do not know the answer to a question, redirect the question to the office or your supervisor.
- ✓ Remember client privacy!
- ✓

Do

- ✓ Secure documents with client information.
- ✓ Use the assigned number in place of identifying information when you can.

Don't

- ✓ Gossip about clients.
- ✓ Hold conversations with or about clients in public.
- ✓ Encourage independence.

Statement of Purpose:

It is anticipated that observance of these rights and responsibilities will contribute to more effective care and greater satisfaction for the patient as well as the staff. The rights will be respected by all personnel and integrated into all Home Care programs. A copy of these rights will be given to patients and their families or designated representative. If the patient or his/her designated representative is unable to read the Bill of Rights and Responsibilities, it will be read to them. If the patient or his/her representative does not speak English, a copy of these rights will be provided in a language that is understood. The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the patient are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law.

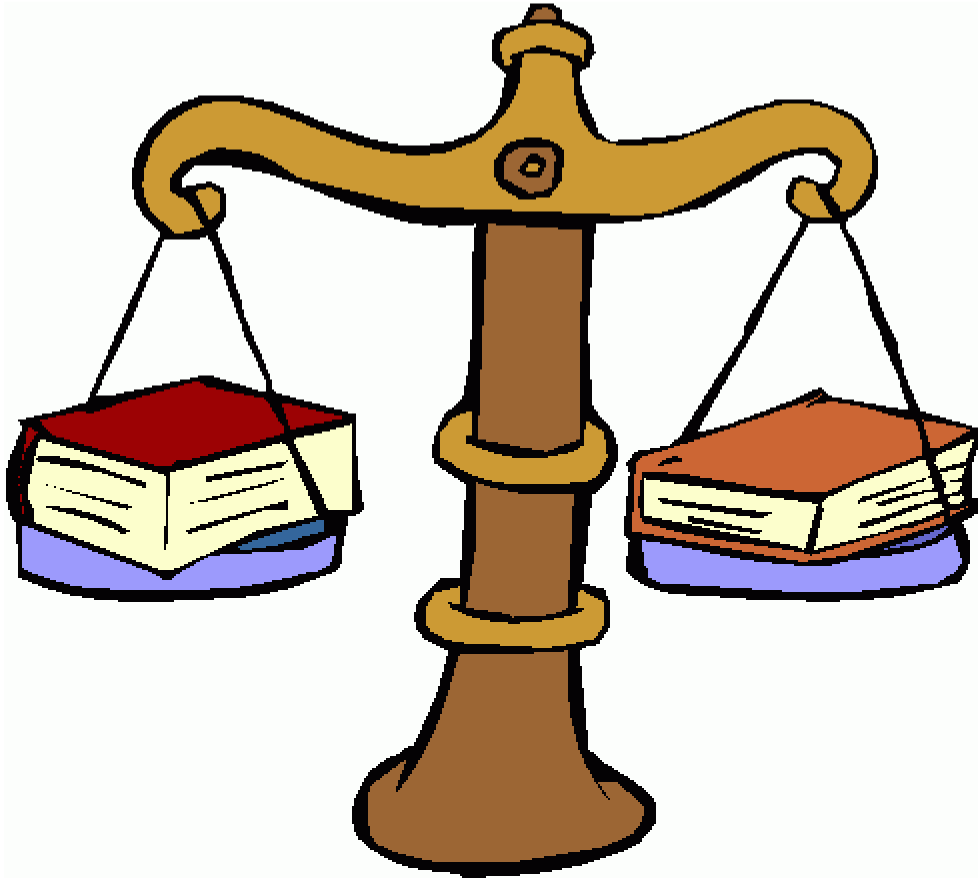
Each patient receives a copy of the Bill of Rights and Responsibilities on or before admission to the agency.

The Bill of Rights are based on payers and state specific requirements.(refer to the patient rights policy for the agency)

Included are the some of the rights below:

1. To be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care.
2. To choose a health care provider.
3. To access necessary professional services 24 hours a day, 7 days a week. This care will be appropriate and professional care relating to physician orders.
4. Be informed, both orally and in writing in advance of care being provided, of the charges, including payment for care/service expected from the third parties including Medicare, Medicaid, or any other federally funded or aided program known to the organization, Charges for services that will not be covered by the payer.
5. Receive information about the scope of services that the HHA will provide and specific limitations on those services.
6. Participate in the development and periodic revision of the plan of care.
7. Refuse care or treatment after the consequences of refusing care or treatment are fully presented.
8. To be advised that the agency complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and to know that the Agency will honor the patient's advance directives in providing care.

9. Be informed of patient rights under state law to formulate an Advance Directive.
10. Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality.
11. Have patient's family or guardian exercise the patient's rights when the patient has been judged incompetent.
12. Be able to identify visiting personnel members through proper identification.
13. Be free of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.
14. Voice grievances/complaints regarding treatment or care that is (or fails to be) furnished, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal and to know that grievances will be resolved, and the patient notified of the resolution within 30 days.
15. Have grievances/complaints investigated regarding treatment or care that is (or fails to be) furnished, or lack of respect of property.
16. Confidentiality and privacy of all information contained in the patient record and of Protected Health Information.



What is a Corporate Compliance program?

A Corporate Compliance program is a system which is designed to detect and prevent violations of law by the agents, employees, officers, and directors of a business.

Although we use the general term "corporate compliance", the need for an effective compliance program is not limited to corporations. Any form of business entity is well served by having an effective compliance program.

Why does my organization need one?

In 1991, the federal government enacted the Organizational Sentencing Guidelines (Chapter 8 of the Federal Sentencing Guidelines), in an effort to make the penalties for corporate crime both uniform and predictable, so as to encourage "good corporate citizenship".

Penalties under the guidelines include fines and imprisonment, as well as "corporate probation", which is mandatory in the case of a business which does not have an effective compliance program in place. Probation involves intrusive federal monitoring of the organization and adoption of a government authored compliance program, which can be far more expensive and invasive than a voluntary compliance program could have been.

The Guidelines take a carrot and stick approach in order to encourage businesses to police themselves. Each crime or violation is assigned a base fine, which is either increased or decreased based upon the presence of certain aggravating and mitigating factors. One such mitigating factor is the existence of an effective corporate compliance program.

Under the Guidelines, an organization which has such a program may receive a substantially reduced fine, and maybe able to avoid corporate probation and criminal prosecution altogether.

What Are the Potential Penalties Companies Face?

Among the penalties which apply to organizations are:

- prison
- fines
- restitution
- sanctions
- forfeiture
- Corporate probation

An effective corporate compliance program is designed to prevent and detect violations of law and that the organization exercised due diligence in seeking to prevent and detect criminal conduct by its employees and other agents.

Due diligence requires at a minimum that the organization has a policy that is implemented and monitored for compliance.

Employees can report fraud, waste, and abuse to the OIG in HHS programs and be protected under the Whistleblower Protection Act.

The agency must post information for the employee in the office.

OIG Office of Inspector General

U.S. Department of State • Broadcasting Board of Governors

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Corporate Compliance

Purpose:

The Agency is committed to conducting its business in full compliance with all applicable laws and regulations, be they state or Federal. Interpretation unlike many laws that effect our daily lives, the laws, and regulations by which the Agency must abide, cannot always be clearly interpreted by using the concept of right versus wrong. Misinterpretation, even it is unintentional, can subject the Agency to fines and other penalties and also impact its reputation in the marketplace. In such, the purpose of the Corporate Compliance Plan is to provide a corporate culture under which the Agency and its employees, from the President/CEO to the Home Health Aide, will not conduct themselves in a manner, be it wittingly or unwittingly, that would violate applicable laws and regulations.

At a minimum the Corporate Compliance Program will address the following areas:

1. Implementation of written policies, procedures, and standards of conduct
2. Designation of a Compliance Officer and Compliance Committee
3. Conducting effective training and education programs
4. Develop open lines of communication between the Compliance Officer or Committee and Agency personnel for receiving complaints and protecting callers from retaliation
5. Performing internal audits to monitor compliance
6. Establishing and publicizing disciplinary guidelines for failing to comply with Agency standards and policies and applicable statutes and regulations
7. Prompt response to detected offenses through corrective action.

Policy:

Clearly, the policy of this Agency is to obey all laws, regulations and guidelines and the Agency's existing Policies and Procedures manuals do set forth and address the issues include in a corporate compliance plan.

However, while these subjects are in virtually all cases already addressed in the sections of Policies listed below, the need for a distinct Corporate Compliance Plan is an obvious one and that is to assure that Corporate Compliance has its own individual focus so it can be made to work effectively.

Further, it is the Agency's goal to have its Corporate Compliance Program adhere to the "best practices" of its industry

The sections of the Policies and Manuals that address corporate compliance issues include but are not limited to:

1. ADMINISTRATIVE POLICIES
2. PATIENT CARE POLICIES
3. FINANCIAL MANAGEMENT POLICIES
4. PERSONNEL POLICIES
8. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT POLICY (QAPI) – all sections are pertinent.

Responsible Personnel

1. While it is the responsibility of all staff to implement the Agency's Corporate Compliance Plan, monitoring its compliance is the responsibility of senior staff, in particular the Administrator and the Board of Directors.

2. Further, as it has been noted above, the interpretation of laws and regulations is often complicated. While lower ranking staff will be able to make clear cut determinations, they cannot be expected to make those interpretations which are complicated or "lie in a gray area."

3. It therefore becomes important to instruct staff not only on which matters they are allowed to resolve on their own but also to report to their supervisors any instances which they come across that involve matters of law or regulation that are not entirely clear cut.

4. Such "interpretive cases" must be reported up the chain of command until they are resolved and when appropriate brought to the attention of the Board of Directors.

5. The Corporate Compliance Plan will be implanted under the direction of the Administrator, but the Board of Directors, itself has ultimate responsibility. The Administrator will be the Corporate Compliance Officer (CCO), or the position may be designated.

6. The Board of Directors/Governing Body will appoint a committee (The Corporate Compliance Committee) to oversee corporate compliance. It members will include:

   a. The Board of Directors/Governing Body or a representative
   b. The Administrator
   c. The Chief Executive Officer or a designee
   d. Regional Managers (if any) or designees
   e. The Chief Financial Officer or a consultant
   f. The Director of Human Resources if such position has been established
   g. Ad Hoc Members as necessary.

7. The Corporate Compliance Committee will meet at least annually. Ad Hoc meetings may take place with a two-week notice given to the members. Emergency Ad Hoc meetings may be called if necessary. Telephone conferencing for absent Board members is permissible.

8. The Corporate Compliance Committee agenda for its scheduled meetings:

   a. A review of the report of the Corporate Compliance Officer (CCO).
   b. Review of fraud alerts issued by the Officer of the Inspector General.
   c. Review of topical issues with respect to corporate compliance in the health care industry in general and in the Home Health Care industry in particular.
   d. Review of "Hot-line referrals" made to the CCO.
   e. It will make recommendations with respect to the improvement of compliance efforts, which will be subject to final approval by the Board of Directors.
   f. It will review the effectiveness of recommendations that were implemented as the result of previous meetings.

9. The CCO will be the Administrator or a designee. His/her duties will be discussed below under the sections devoted to principle and the section devoted to procedures in greater detail but broadly will consist of efforts to assure that individual policies established by the Agency with respect to corporate compliance topics are considered to "best practice" that they are being obeyed consistently.

Principles

The basic principle of the Agency's Corporate Compliance Plan is that it should always act as a good corporate citizen. It will do this by:

1. Maintaining honesty and integrity in all of its operations by adhering to a high standard of conduct.
2. Maintaining confidentiality of Agency and patient records.
3. Avoiding unauthorized use of Agency assets.
4. Maintaining job accountability at every level.
5. Avoiding conflicts of interest.
6. Refraining from patient abuse and reporting too appropriate authorities any abuse that does occur, regardless of who perpetrates it.
7. Maintaining appropriate communication with patients by assuring the integrity of patient satisfaction surveys and assuring that patients are aware of their rights and know who to call inside and outside the Agency if they feel their rights have been violated or if their care has been inadequate.
8. Adhering to the Patient's Plan of Care and following all regulations and guidelines concerning the administration of that care.
9. Adhering strictly to policies concerning the control of medication.
10. Refraining from misrepresentation in any manner be it with a patient, a contractor, or any government agency or third party.
11. Refraining from the engagement in illegal or unfair trade practices such as the solicitation of patients.
12. Complying with all standards regarding billing.
13. Preparing all financial reports in a manner consistent with accepted accounting practices.
14. Complying with all labor and employment laws, including those involving job discrimination and providing for Workman's Compensation and Unemployment Insurance, when required by law.
15. Complying with all payroll practices including those involved with withholding tax and avoiding improper withholding as detailed in the Fair Labor Standards Act (FLSA) and other statutes.
16. Maintaining employee privacy.
17. Maintaining a working environment that is both safe and free of abuse and harassment.
18. Investigating promptly any abuse or violation of policy or complaint and taking corrective action.
19. Preventing individuals who have been involved in illegal activities from exercising any discretionary authority by screening them at the time they submit an employment application. With respect to The Medical Director and other applicable professional staff, the Agency will check the National Practitioner Data Bank and Cumulative Sanction Report. Members who have been sanctioned or excluded by the any federal health program or who have been debarred from contracting with any other federal agency will not be hired or contracted.
20. Committing the Agency and it contractors to abide by all state and Federal laws and regulations including, but not limited to the following:
    a. The Federal False Claims Act
    b. The Stark Bill
    c. State licensure requirements
    d. Federal, state, and local Civil Rights Laws

Procedure

It is the duty of the CCO to assure adherence to all of the principles laid out in the previous paragraph. He/she will do this by:

1. Assuring that each staff member has been advised by his/her supervisor of the existence and importance of the Agency's Corporate Compliance Plan as well as their responsibilities to assure adherence to the policy.
2. Assuring that each supervisor and each and every person that the supervisors report to (together, "Senior Staff") fully understand the Corporate Compliance Plan and sign a statement (copy provided below) attesting to their understanding and agreement to obey it.
3. Reviewing all existing Agency policies which relate to corporate compliance to include those noted in the Policy section, above, paragraphs 1-4. The CCO will:
    a. Assure that the policies are adequate, up to date and are of "best standards quality".
    b. Coordinate additions or corrections to policies as needed, report such changes to the Corporate Compliance Committee and arrange for their presentation to Board of Directors for approval.
    c. The CCO will also assure that the policies are being adhered to, by noting exceptions and asking randomly questioning staff members, their supervisors, and Senior Staff.
    d. The CCO will act as a focal point for all matters concerning corporate compliance:
        i. Any violation of law, regulation or Agency policies will be reported to the CCO by the supervisor of Senior Staff person promptly once that person becomes aware of the violation.
            1. The CCO will make his view known as to the appropriate action that should be taken once a violation has been discovered. If the CCO feels that the corrections are inadequate, he/she will notify the Corporate Compliance Committee and/or the Board of Directors.
        ii. All inquiries with respect to the interpretation of specific policies made by staff to their supervisors will also be reported to the CCO. The CCO will track and record these inquires (as well as the violations) to ascertain if there is a trend among employees as it relates to the understanding of laws, rules, and policies:
            1. To the extent that trends do exist the CCO will hold discussions with appropriate Senior Staff and if necessary, coordinate the preparation of policies additions, as in 3.b above.
        iii. The Agency will encourage its Senior Staff to provide any and all input with respect to compliance to the CCO. The CCO will track all such information and any suggestions made by staff.
4. In addition to advising the CCO of violations and staff inquires with respect to corporate compliance, each department and subsidiary shall submit a well-documented status report to the Compliance Committee as part of the annual evaluation. The status report should also contain a self-assessment addressing the department or subsidiary's corporate compliance posture and experience as well as any other matters concerning corporate compliance that are relevant.
5. The CCO will prepare reports for the Corporate Compliance Committee at the time of each meeting. The report will make note of the violations that have occurred, and the staff inquires and suggestions that have been made. It will include any other observations that the CCO has made with respect to Agency procedures as they affect compliance. The CCO will also make note of experiences of other Agencies as well as industry developments.
6. CCO reports will be more frequent when necessary. Such reports can be made to be coincident with AD Hoc meetings of the Corporate Compliance Committee or they can be completely separate if dictated by urgency.
7. The CCO reports will include recommended changes to policy subjects in the Agency's manuals. It will also include any other recommendations for changes in the Agency's procedure or in the Corporate Compliance Program itself.

Training and Continuing Education

1. All employees, agents representing this Agency and independent contractors providing health care services on behalf of the Agency shall receive a copy of the Corporate Compliance Policy and have an opportunity to review the program along with specific policies contained in other manuals that relate to their job functions.
2. All new employees, agents and independent contractors will likewise be so oriented, within two weeks of hiring contract date.
3. Any of the individuals listed above who have questions regarding the program or his/her obligation under it should contact the CCO.
4. All employees, agents or independent contractor must sign and return an acknowledgment form. This acknowledgment form will become part of the personnel folder or agent/ independent contractor file.
5. Employee, agent, and independent contractor training is as follows:
    a. Initial Training: All employees, agents and independent contractors providing health care services will be required to complete an orientation of this program within one month following their employment or engagement.
    b. Certain company employees, agents or independent contractors may receive specialized training if their job activity requires it. This specialized training may focus on complex areas or on areas in which the CCO or the Corporate Compliance Committee has identified as high risk with respect to misconduct or error.
    c. As new developments or concerns arise with respect to corporate compliance issues the CCO or the Corporate Compliance Committee may require additional training for some individuals.
    d. All persons in supervisory positions are responsible for ensuring that each employee, agent, and independent contractor reporting to them has attended the orientation/training sessions applicable to that person's job duties.
    e. Medical Directors shall be strongly encouraged to attend training sessions and review all relevant compliance policies and sign an Acknowledgment form affirming their understanding of the Program policy.

Ethics

Ethical Issues in Healthcare

Healthcare ethics involves making well researched and considerate decisions about medical treatments, while taking into consideration a patient's beliefs and wishes regarding all aspects of their health.

The healthcare industry, above any other, has a high regard for the issues surrounding the welfare of their patients.

Doctors, nurses, and other professionals who have the ability to affect a patient's health are all forced to make ethical decisions on a daily basis.

This power over a patient's wellbeing creates a mandatory need for all healthcare organizations to develop an ethics committee.

Health care professionals practice in an environment that is complex, with many regulations, laws, and standards of practice.

Performing an abortion is legal but may not be considered ethical by other health care professionals or members of the public at large.

Other ethical dilemmas arise at the end of life when a decision must be made to turn off life-support machines and allow death to occur.

Other common ethical issues a health care professional might face are confidentiality, relationships with patients and matters related to consent, especially in the treatment of minors.

The agency's goal is to establish a written code of ethics that details the policies and procedures that determine proper conduct for all employees.

The Ethics committee meets and gives direction to assist the staff, patients, and their families; all working together cohesively to identify, understand, and resolve difficult ethical decisions.

There are many ethical issues that may arise in regard to a patient's healthcare.

These major issues as well as ways to manage them are as follows:

- **Confidentiality**- Confidentiality is both an ethical and a legal issue. Keeping information about a patient confidential is a way of showing respect for the person's autonomy; releasing information can damage the patient. There are also specific laws regarding the release of information under the Health Insurance Portability and Accountability Act, or HIPAA. The laws define exactly what information can be released and to whom. Insurance companies, for example, may not have the right to certain aspects of a patient's medical record. However, if there is risk to a third party, an ethical health care professional may need to break confidentiality to prevent harm. The Administrator needs to make sure that its patients' medical records are safeguarded.

- **Transmission of diseases**- The risk posed to healthcare professionals of acquiring a communicable disease from patients is a concern to those serving on ethical committees. This is especially true if a patient's health history is not made available to the providers. While healthcare providers do not want to make the patient uncomfortable by taking obvious protective measures, they still have every right to protect themselves from any pathogens that may be able to spread by direct or indirect contact.

- **Aggressive marketing practices** - Certain guidelines, ethics, and standards need to be adhered to when promoting and marketing an agency's services. It is extremely inappropriate for agencies to recommend unnecessary services to a patient just for the sake of profit. The main goal of the agency should be patient care, not marketing schemes. Ethical committees should always be involved in the agency's marketing practices in some way so that the result of any marketing campaign is tasteful and sincere.

- **Provided information**- The information that an agency provides to advertising needs to be 100% accurate and honest. It is important that the advertisements for the agency and its services are not misleading or false. Again, the patients' welfare is most important.

- **Patient welfare** - A doctor, nurse, and any other type of healthcare professional involved in the care of a patient needs to remember their main motive: safeguarding the welfare of their patients. All personal information needs to be kept private. It is also important that physicians are honest with their patients. No matter what the healthcare provider's personal beliefs are; a patient should never be discriminated against based on race, income, or sex. Reports of such discrimination should be taken very seriously.

- **Elderly patients**- Dealing with patients of advanced age may sometimes pose problems in regard to ethical decision making since they are not capable of making rational decisions on their own. As a result, their families are left with the responsibility of making difficult choices. This task can be incredibly difficult when the patient is terminally ill and wants to end their life in order to avoid unnecessary suffering. Even if the ethical committee has a difference of opinion regarding such matters, proper ethical protocol needs to be adhered to at all times. It is always best to check if the patient has a living will so that unnecessary confusion can be avoided.

- **Terminally ill patients** - As with elderly patients, terminally ill patients may have specific wishes for the manner in which they want their lives to end. Dealing with an issue such as euthanasia is very difficult and therefore requires a deep understanding of ethical processes.

- **Sexual harassment** - The ethical committee should be very strict about sexual harassment of any kind at the healthcare facility. There is a risk of occurrence not only between a patient and a doctor, but also between two medical practitioners. When such situations arise, the ethical committee should involve a branch of ethics called sexual ethics, which involves any issue regarding sexuality and sexual behavior.

- **Therapies** - There are different techniques and therapies that can be performed with a patient or victim so that any trauma or stress related to an offending incident can be alleviated. Hearings and investigations into the incident may also occur.

- **Relationships-** Relationships with patients, particularly sexual relationships, are forbidden by both the medical and nursing code of ethics. Such actions are considered serious misconduct and can result in expulsion from the profession and losing the license to practice. A sexual relationship is considered to be an abuse of power on the part of the physician or nurse, as patients are dependent and vulnerable. A sexual relationship with a patient can be very harmful, and an ethical practitioner will avoid even the appearance of sexual interest in a patient.

- **Malpractice-** Health care practitioners of all sorts face the risk of being sued for malpractice. A lawsuit may be brought from an injury related to surgery, defective equipment or medical products, care that was omitted or a deliberate act that caused harm to a patient. The risk of litigation is such that many health care professionals practice what is called defensive medicine -- for example, ordering a test or performing a procedure primarily to ensure that the patient cannot allege negligence.

- **Consent**- Patients must provide informed consent for treatment to be legal. A surgery performed without proper consent is generally considered assault, according to a 2009 article in the "Internet Journal of Surgery." When treating an adolescent, the health care professional faces potential conflict between ethics and the law in certain situations. The professional might believe that parents should be kept informed of their child's health issues. In California, however, a 12-year-old can consent to medical care and counseling related to the treatment of a drug or alcohol problem, the National Center for Youth Law reports. The treating doctor cannot disclose information to the parents without the child's consent except in very specific circumstances, such as risk to another person.

- **Discrimination-** Discrimination is also another very serious issue in medical ethics. Discrimination can be because of race, gender, color, or even religion. This may happen between a patient and a medical practitioner or between a medical practitioner and another member of the healthcare team. All members of the team must always protect the welfare of the patients and of themselves as well.

- **Honesty-** Being honest and giving out authentic pieces of information to the concerned parties are also common ethical issues in healthcare. When results of diagnostic tests are available, these pieces of information must be relayed to the patients and their families. Their diagnosis and other important data should also be discussed properly by the physician and the nurses so that there will be transparency in the treatment process. Giving false hopes and false reassurances are strictly discouraged.

- The Code of Ethics is intended to serve as a guideline to the agency in the following areas:
  A. Patient Rights and Responsibilities
  B. Relationships to Other Provider Agencies
  C. Fiscal Responsibilities
  D. Marketing and Public Relations
  E. Personnel

Patient Rights and Responsibilities

It is anticipated that observance of these rights and responsibilities will contribute to more effective patient care and greater satisfaction for the patient as well as the agency. The rights will be respected by all Agency personnel and integrated into all home care agency programs. A copy of these rights will be prominently displayed within the agency and made available to patients upon request.

- The patient is fully informed of all patient rights and responsibilities.
- The patient has the right to appropriate and professional care relating to physician orders.
- The patient has the right of choice of care providers.
- The patient has the right to receive information necessary to give informed consent prior to the start of any procedure or treatment.
- The patient has the right to refuse treatment within the confines of the law and to be informed of the consequences of his action.
- The patient has the right to privacy.
- The patient has the right to receive a timely response from the agency to his request for service.
- A patient will be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed.
- The patient has the right to reasonable continuity of care.
- The patient has the right to be informed within reasonable time of anticipated termination of service or plans for transfer to another agency.
- The patient has the right to voice grievances and suggest changes in service or staff without fear of restraint or discrimination.
- The patient has the right to be fully informed of agency policies and charges for services, including eligibility for third-party reimbursements.
- The patient denied service solely on his inability to pay shall have the right of referral.

- The patient and the public have the right to honest, accurate, and forthright information regarding the home care industry in general and his chosen agency in particular, (e.g., cost per visit, employee qualifications, etc.).

Relationship to Other Provider Agencies

- The principle objective of home care and hospice agencies is to provide the best possible service to patients. Agencies shall honestly and conscientiously cooperate in providing information about referrals and shall work together to assure comprehensive services to patients and their families.
- Staff shall engage in ethical conduct of their affairs so that maximum fair trade occurs.

Fiscal Responsibilities

- The amount of service billed is consistent with amount and type of service provided.
- The cost per visit includes only legitimate expenses.

- The medical equipment sold or rented to a patient is provided at the lowest possible cost consistent with quality, quantity, and timeliness.
- The salaries and benefits of the provider and administrative staff shall be consistent with the size, responsibility, and geographical location of the agency.
- The provider shall not engage in "kick-backs" and "pay-offs."

Marketing and Public Relations

- Oral and written statements will fairly represent service, benefits, cost, and agency capability.
- Agencies that promote their service to the public through the media shall include information descriptive of home care and hospice in general, as well as agency specific information.

Personnel

- The agency shall be an equal opportunity employer and comply with all applicable laws, rules, and regulations.
- The agency shall have written personnel policies available to all employees and uniformly applied to all employees.
- The agency shall provide an ongoing evaluation process for all employees.
- The agency shall hire qualified employees and use them at the level of their competency.
- The agency shall provide supervision to all employees.
- The agency shall provide continuing education and in-service training for all employees to update knowledge and skills needed to give competent patient care.
- The agency shall hire adequate staffing to meet the needs of the patients to whom they render care.
- The agency shall have a pay scale that is consistent with the area and pay only for those expenses for travel and business that are within a reasonable norm.

- **Ethics Policy**

1. The Agency recognizes that issues of an ethical nature related to the patient/client, Agency and the provision of services may develop. Such issues may include but are not limited to:

    a. Informed Consent

    b. Decision making

    c. High technology and medical experimentation

    d. Patient/client safety

    e. Accepting or refusing care

    f. Standards of care

    g. Advance Directives

    h. Confidentiality

    i. Care for persons with inadequate reimbursement for services

    j. Right to freedom of choice, dignity, and movement

2. It is the policy of the Agency to:

    a. Provide care within an ethical framework established by the professional disciplines provided by the Agency, established in Agency policy and procedure, and as established by law and standards of care.

b. Allow the patient/client or his/her representative the right to participate in any discussion concerning ethical issues and to document such involvement.

c. Have Agency staff and the patient/client's physician participate in the consideration and resolution of ethical issues.

d. Furnish staff with education regarding ethics and the mechanisms available to assist them with consideration and resolution of ethical issues.

3. Patient/Client Ethical Issues

a. Ethical issues for patient/clients include but are not limited to the following:

   i. The patient/client has a Do Not Resuscitate or Do Not Intubate order but there is conflict among the family members.
   ii. The patient/client and/or family is participating in and/or conducting rituals, religious healing activities or other behaviors that are disturbing to the employee and/or causing the employee to be concerned for the patient/client's well-being.
   iii. The family and physician are concealing from the patient/client true information about his condition.
   iv. The physician does not respond to requests for care that the nurse believes is necessary, i.e. an increase or decrease in pain medication, testing for TB, to be seen by the physician, etc.
   v. The patient/client refuses to accept assistance the employee feels are necessary, i.e. bathing, food stamps, companion, homemaker, ALF placement, etc.
   vi. The patient/client refuses part of the ordered care (i.e., nursing) but chooses to accept another part of the ordered care (i.e., pharmacy).
   vii. There is obvious drug use or other unusual or illegal activity in the patient/client's home which jeopardizes the employee's safety.

b. The Agency will convene an Ad Hoc Committee of the Professional Advisory Committee to discuss and attempt to resolve ethical issues that arise. This committee will meet for ethical issues arise.

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

c. The patient/client's physician (or if unavailable, the Agency's Medical Director/Advisor), and the Agency employees involved in the patient/client's care will be included in the Ethics Committee.

d. The Agency's Quality Improvement Committee or other designated individual(s) or group may serve as a resource to assist in the consideration of ethical issues.

e. The Governing Body will receive the minutes of the Ethics Committee meetings and may be called upon to take action on issues as required.

f. Anyone may initiate consideration by notifying the Administrator and/or Director of a potential or actual concern. The Administrator or Director shall present the issues at a meeting of the committee as soon as possible. Minutes shall be kept of the meeting, and as appropriate, staff, the patient/client and the patient/client's physician shall be advised of the results of the meeting in a manner appropriate to the individual situation.

4. Ethical Issues For Employees

a. The Agency recognizes that from time-to-time staff members' personal values and beliefs enter into their ability to provide care. Such issues include but are not limited to:

   i. Working or traveling on certain religious holidays

   ii. Right to life issues

iii. Administering blood transfusions

iv. Respecting an individual decision not to seek medical care because of their religious beliefs

v. Ethnic and sexual orientation issues for care

vi. Termination of life support systems and participation in certain advanced directive decisions

vii. Conflicting ethical, cultural, or religious beliefs

b. It is the Agency policy that:

i. Refusal of an individual staff member to participate in certain aspects of care based upon personal values and beliefs will not disrupt the patient/client's care.

ii. When a situation arises for care that is in conflict with individual staff values and beliefs there is an alternative method of care.

iii. Individual performance evaluations will appropriately reflect the manager's consideration of motives related to refusal to participate based upon cultural values or religious beliefs.

Fraud, Abuse, and Whistle blowing

Financial Policies (refer to your agency's policy)

Introduction:

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

Purpose:

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

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

Procedure:

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

1. **Immediately report it to a supervisor/manager.**
2. **If a client of the Agency is the potential victim of the theft, the supervisor/manager will advise the client and advise the client that they will be contacted by a another agency representative.**
3. **The supervisor/manager, preferably, together with the staff member will report the incident to the Administrator.**
4. **An incident report addressed to the Administrator will be prepared as quickly as possible, and in no evident later than 24 hours after the event. The report will include:**
    a. **In the event that the incident involved the possible compromise of PHI held by the Agency:**
        i. **The names and contact information for all individuals that may have had their Personal Information or PHI compromised or unwittingly passed to an unauthorized person**
        ii. **The reasons that led the staff member to believe that PHI and or personal Information may have been compromised**
        iii. **A detailed description of the circumstances of the event**
    b. **In the evident that the incident involved an attempt by a person to make fraudulent use of information belonging to another person:**
        i. **The name and contact information of the potential victim of theft**
        ii. **A description of the attempt to defraud and if known, the extent of any potential monetary damages**
        iii. **The information that was being used in the attempt to defraud**
        iv. **A description of the incident itself and what led to its detection**
        v. **The results of initial contact with the potential victim**
        vi. **Safeguards that had been taken (or had not been taken) to protect the potential victim's information**

5. The Administrator will keep one copy of the incident in a dedicated file and another in the client's record.
6. The Administrator will make a determination based on the evidence presented as to whether or not suspicion was warranted, and the incident could be potentially one of theft.
7. If the Administrator determines that there is the potential that identity theft exists, the appropriate law enforcement will be notified within 48 hours.
8. Whether or not the Administrator concludes that is the potential for theft, he/she will contact the potential victim within 48 hours and explain the situation and explain the potential victim's rights. If the Administrator has decided that there is no need to contact law enforcement, but the potential victim feels otherwise, then Law Enforcement will be contacted as above.
9. If the incident involves the compromise of PHI or Personal Information held by the Agency, the Administrator will, if deemed appropriate after a review of evidence presented:
    a. Contact Law Enforcement
    b. Create a task force to contact each and every client whose personal information may have been compromised
    c. Conduct an investigation as to the scope of the problem that created the incident and the duration of the problem
    d. Notify the Agency's insurance carrier

Prevention of Theft and Embezzlement

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

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

Orientation and Annual In-Service Post Test

Employee Name: ________________________________ **Date:** ____________ **Score:** _____________

1. Cultural differences are not limited to ethnicity and race relations; they extend to areas of religious views, sexuality and even differences in geographical differences pertaining to the location of one's upbringing.
   a. True
   b. False

2. Where an employee lives or has lived can contribute to cultural differences in the workplace.
   a. True
   b. False

3. What federal agency prohibits companies from discriminating against employees for any reason?
   a. OSHA
   b. CMS
   c. U.S. Equal Employment Opportunity Commission
   d. All of the above

4. The agency is not required to transport or physically evacuation a patient in the event of an emergency.
   a. True
   b. False

5. The patient is provided with the following:
   a. A copy of the Agency's policy on how to manage disaster related emergencies in the home.
   b. Patient responsibilities in the Agency's Emergency Preparedness and Response Plan.
   c. A list of community disaster resources that can assist during a disaster-related emergency.
   d. All the above.

6. The agency reviews the Emergency Disaster Plan as:
   a. Needed.
   b. At least yearly.
   c. After each response.
   d. All the above.

7. What are the types of emergencies?
   a. Man-Made.
   b. Natural.
   c. Technological.
   d. Any of the above.

8. All patients are informed of their right to voice a complaint/grievance against anyone furnishing services on behalf of the agency at:
   a. On admission.
   b. Before admission.
   c. A and B.
   d. None of the above.

9. What is the timeframe to provide the patient a response to the complaint?
   a. 10 days.
   b. 3 days.
   c. 30 days.
   d. As soon as possible.

10. How often are complaints reported to the Governing Body?
   a. Monthly
   b. Weekly
   c. Quarterly
   d. B and C

11. Who serves as the Agency's Privacy Officer?
   a. Director of Nursing
   b. Governing Body
   c. Administrator
   d. CFO

12. What does HIPAA stand for?
   a. Health Information Privacy Administrative Act
   b. Health Insurance Portability Accountability Act
   c. Health Information Protected and Accessed

13. Successful communication requires knowing what barriers to communication exist and how to navigate around those roadblocks. These may include:
   a. Physical barriers.
   b. Language barriers.
   c. Gender barriers.
   d. Any of the above.

14. Non-verbal communication components can include physical appearance.
   a. True
   b. False

15. SDS
   a. Is the new acronym for MSDS.
   b. Means "Service Date Same."
   c. Will give symptoms for diseases.
   d. Stands for Safety Data Sheets.

16. OSHA was created to:
   a. Enforce local and state regulations.
   b. To require employers to assure a safe and healthful workplace.
   c. Provide a place to buy protective equipment.
   d. As a "catch all" for employee complaints, in general.

17. Key items to remember about the Patient Bill of Rights are:
   a. The rights can be exercised at any time.
   b. The patient always has the right to refuse care.
   c. The patient has the right to be treated with respect.
   d. All the above.

18. A Corporate Compliance program is a system which is designed to detect and prevent violations of law by the agents, employees, officers, and directors of a business.
    a. True
    b. False

19. What are the potential penalties the agency may face for non-compliance?
    a. prison
    b. fines
    c. sanctions
    d. possibly all the above

20. The Code of Ethics is intended to serve as a guideline to the agency in the following areas:
    a. Patient Rights and Responsibilities
    b. Relationships to Other Provider Agencies
    c. Fiscal Responsibilities
    d. Marketing and Public Relations
    e. Personnel
    f. All the above

CERTIFICATE *of* COMPLETION

THIS ACKNOWLEDGES THAT ON THIS DATE: ___________________________________

[Recipient Name]

HAS SUCCESSFULLY COMPLETED THE ANNUAL MANDATORY IN-SERVICES

CULTURAL DIVERSITY; EMERGENCY/DISASTER; HOW TO HANDLE COMPLAINTS/GRIEVANCES; HIPAA; INFECTION CONTROL; COMMUNICATION BARRIERS; WORKPLACE/PATIENT SAFETY (OSHA); PATIENT RIGHTS/RESPONSIBILITIES; CORPORATE COMPLIANCE; ETHICS; TB/BLOODBORNE PATHOGENS; MEDICAL DEVICE ACT/REPORTING

x ___________________________________

SIGNATURE/TITLE