ALLIANCE HEALTH SERVICES
2260 Cliff Road
Eagan, MN 55122
P: 651.895.8030 F: 651.895.8070

HOME HEALTH AIDE ANNUAL TRAINING

Employee Name: ______________________________ **Date of Hire:** ____________________

Position & Office Location: ____

All HHA Annual Training as listed below is in compliance with Minnesota Statutes, Chapter 144A, "Orientation Training Requirements" along with all relevant Alliance Health Care internal policies and procedures, state and federal laws and regulations. These trainings are taught by delegates of our training program, which is under the guidance and direction of Alliance's Director of Nursing. These trainings are documented below in accordance with MN Statute 144A.4796 Subd. 7

Training:	Hours:	Date:	Trainer:
Alliance Policies & Procedures *Statute 144A.4796, Subd. 6 (45)*	0.50		
Emergency Preparedness *Statute 144A.4796, Subd. 2 (3)*	1.50		
VA and Maltreatment of Minors *Statute 144A.4796, Subd. 6 (1)*	1.00		
Home Care Bill of Rights *Statute 144A.4796, Subd. 6 (2) & 144A.44*	1.00		
Grievance Policy *Statute 144A.4796, Subd. 2 (6)*	0.50		
Ombudsman & Advocacy Services *Statute 144A.4796, Subd. 2 (7)*	0.50		
Alzheimer's & Dementia *Statute 144A.4796, Subd. 5*	1.50		
Infection Control Techniques, Standards & Reporting of Communicable Diseases *Statute 144A.4796 Subd. 6 (3)*	1.50		
Skin Integrity *Statute 144A.4796*	1.00		
Working With the Deaf & Hard of Hearing *Statute 144A.4796*	1.00		
Basic First Aid Responding *Alliance annual standards*	1.00		
Boundaries & Rapport Building *Alliance annual standards*	1.00		
Fraud, Waste & Abuse *Alliance annual standards*	1.00		
Communication *Alliance annual standards*	1.00		
TOTAL HOURS:	14.00		

Training Director Signature: ____

ALLIANCE POLICY AND PROCEDURES

WELCOME TO ALLIANCE

Welcome to Alliance Health Care/Services/Medical Supplies (herein after Alliance). Alliance recognizes that the most valuable asset of any business is the employee. These personnel policies are intended to explain the working relationship between Alliance and its employees. This manual is not a contract for employment and any verbal agreement to change these policies is not valid unless placed in writing and approved by a member of the Board of Directors. The employment relationship is considered at will; both employees and management are able to end the employment relationship at any time, for any reason. Alliance reserves the right to make changes in this manual at its sole discretion and to interpret and administer these policies in light of changing circumstances and events. Any additions, revisions, or deletions to this manual are a result of Alliance's ongoing commitment to growth as well as changes in the health care community and changes in the law. It is the responsibility of each employee to carefully review the employee handbook and become familiar with the policies, rules, and regulations of their employment at Alliance. Furthermore, each employee is responsible for obtaining any and all additional documents detailing other policies, rules, and regulations that may not be addressed here.

COMPANY PHILOSOPHY

Alliance believes that health care is a basic human right. It must be available, coordinated, and provided in a comprehensive manner, combined with other human services when appropriate.

We strive to meet the goals of our consumers, specific to their individual needs. *Our* goal is to maintain a progressive, nurturing environment with a team dedicated to fulfilling the highest standard of services to help ensure the highest quality of life for our consumers.

EQUAL OPPORTUNITY EMPLOYER

Alliance is an equal opportunity employer. It is our policy to employ persons without regard to race, gender, national origin, color, creed, religion, marital status, disability, sexual orientation, age, status in receiving any form of public assistance, or any other characteristic protected by State and Federal laws.

To assure the quality of our staff, Alliance will check employment references and investigate the criminal background of all applicants being considered for employment.

WORKING AT ALLIANCE

PROBATION

All employees participate in a probation period of 90 days when starting employment. During this time, employees become oriented to the expectations of the company while management determines the compatibility of the new employee. During the probation period, if management concludes that the employee is not, or is no longer, compatible, the employee may be terminated.

OFFICE HOURS OF OPERATION/ANSWERING SERVICE

Office hours of operation are Monday through Friday, 8am-4:30pm, excluding holidays. Discuss specific work hours with your supervisor and/or client(s). Calls to the office after business hours and on weekends are answered by a contracted answering service. This service is instructed to call the appropriate on-call person for consumer/staffing emergencies only, as applicable. Please hold all non-emergency calls for business hours. *See job specific handbook for details.*

ATTENDANCE AND TIMELINESS
Employees should notify their Staffing Coordinator or the Responsible Party at **least four (4) hours before their shift** or as soon as possible to report an absence or tardiness. If the Family Coordinator or Responsible Party is not available, an available director should be notified. Failure to report absences and tardiness and/or excessive tardiness and absences may result in disciplinary action, up to and including termination of employment.

WEATHER POLICY
Alliance considers closing its offices when the State Department of Human Services office closes due to inclement weather and by reviewing MNDOT weather warnings. Please contact the Eagan office with questions.

PROFESSIONAL CONDUCT
The way employees conduct themselves while at work reflects Alliance's standards and is indicative of their interest and pride in their job. Employees should refrain from discussing personal information in the presence of staff or consumers. A professional appearance, polite tone of voice, positive attitude, and a friendly manner can mean a great deal to our staff and/or clients. Please maintain a customer service oriented demeanor at all times. Inappropriate conduct at work may lead to disciplinary action, up to and including termination.

CARE PLAN
A Client's Care Plan directs all of the services detailed in the HHA job duties and responsibilities. A Care Plan describes the level of care needed in each activity of daily living for a Client. A copy of the Care Plan is in each Client's home. All HHAs must review the Care Plan for his or her Client prior to providing services. The Care Plan is reviewed at least annually and revised when Client needs change (e.g. post-hospital care).

TRAVEL POLICY
A HHA may accompany a Client who can direct their own care outside of their home in order to perform the services outlined in the Client care plan if without these services the Client's health or safety would be jeopardized. However, HHA's **ARE NOT** permitted to drive the Client in a vehicle. HHAs may accompany a Client in a vehicle with a driver, such as a bus or taxi. HHAs may also walk with their Clients to a destination. Travel with a Client must be pre-approved by the supervising RN Case Manager prior to travel occurring, and included as part of the Client care plan.

RESPECT FOR CLIENT PROPERTY
HHAs are required to report any damage to or loss of Client property to the responsible party and the RN Case Manager as soon as possible. (See Employee Safety, Adverse Event Report Form. An Unusual Occurrence Report Form can be obtained from the RN Case Manager. An Adverse Event Report Form must be completed by the HHA and forwarded to the Alliance office.) If damage is caused by a HHA's negligence, he or she will be held responsible for repairs or replacements.

HHAs working in a Client's home may only use the Client's phone to provide assistance to the Client. HHAs may not use the Client's phone for personal use. HHAs may not disclose the phone number or address of the Client to anyone. HHAs may inform family members to call the AHC office in case of emergency. Emergency messages will be forwarded to the HHA from the AHC office.

HHAs may not smoke in the Client's home at any time. *See Alliance Smoking Policy*

HHAs must provide their own food and drink while in the Client's home. HHAs may not bring children, friends, or others to the Client's home during his or her work hours.

CLIENT BOUNDARIES
HHAs are expected to maintain a professional business-like attitude when building relationships with Clients. Violation of this policy will result in disciplinary action up to and including termination. Below are some examples of boundaries that should be carefully observed.

- DO NOT accept gifts or borrow anything such as material items or cash from the Client or the Client's family.
- DO NOT take, borrow, or accept money from Client's for any reason.
- DO NOT use personal cell phone while in the Client's home.
- DO NOT use the Client's phone(s) except to aid in caring for the Client.
- DO NOT accept or request house keys from Clients. If access to the home is difficult, HHAs should discuss that with the RN Case Manager.
- DO NOT exchange phone numbers or addresses with the Clients unless deemed necessary by RN Case Manager.
- DO NOT perform duties outside of assigned duties listed in the HHA job description and Client care plan such as picking up groceries or prescriptions, household projects, running errands, etc.
- DO NOT work off the clock for the Client (ex. home repair, picking up groceries, picking up prescriptions, lawn care, etc.).
- DO NOT ride in a vehicle driven by the Client to accompany them on their errands or appointments. This includes going to get meals, picking up prescriptions, picking up groceries, visiting the doctor, shopping, etc.
- DO NOT administer medications to the Client.
- DO NOT read, do homework, or watch TV while working with the Client.
- DO NOT discuss personal affairs with the Client.
- DO NOT make any changes to the schedule without consent from the staffing coordinator.
- DO NOT care for individuals besides the Client. This includes client siblings, children, friends, neighbors, etc.
- DO NOT bring children, friends, family, or other Clients to a Client's home.
- DO NOT lend or borrow property. (ex. vehicle, clothing, electronics, etc.)

These are examples of what goes beyond Client boundaries. If there are questions or concerns about other actions, please discuss with the RN Case Manager.

HHA- SAFETY AT ALLIANCE
Alliance is committed to providing a healthy and safe work environment for all of its employees. Regard for the safety of employees, Clients, their families, and the general public is of the utmost concern at all levels of this organization. Alliance's goal is to have ZERO accidents and injuries. Safety does not occur by chance. It is the result of employees paying careful attention to all company operations. Employees must accept responsibility in executing policies for maintaining safety and occupational health.

REPORTING INCIDENTS/ACCIDENTS
An Adverse Event Report Form is used to document any accident or incident that occurs when the HHA is working with a Client. An incident could be an injury, property that is damaged or missing, and any unusual circumstance. Employees may contact the Director of Nursing to obtain an Adverse Event Report Form.

To report an incident/accident involving Client:

1. Notify AHC (Staffing Coordinator and Director of Nursing) and Responsible Party immediately
2. Complete all blanks on the Adverse Event Report Form
3. Place HHA's signature and title on Adverse Event Report Form
4. Send Adverse Event Report Form to AHC as soon as possible (within 24 hours of occurrence)

Reporting incident/accident involving employee:
In the event of any injury at work, the HHA must contact AHC's Human Resources Department immediately. A First Report of Injury Form will be completed and further instructions for treatment of the injury will be given. If the injury is life threatening, seek immediate medical attention and then contact AHC. An injury must be reported as soon as possible (within 24 hours of occurrence).

Precautions to prevent transmission of disease (Universal Precautions):
Since medical history or examination cannot reliably identify all patients infected with blood-borne pathogens, blood and body fluid precautions should be consistently used for all Clients. This approach is referred to as *Universal Blood and Body Fluid Precautions or Universal Precautions.*

All AHC employees should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids could be expected. Gloves should be worn when touching blood, body fluids, mucous membranes, non-intact skin, or handling surfaces soiled with blood or body fluids.

Hand washing:
Hand washing is an effective way to help prevent illness. By washing hands often, disease-causing germs that may have been picked up from other people, animals or contaminated surfaces are washed away. In addition, jewelry, including rings, should not be worn where the potential for risk of exposure exists.
Follow the below steps to ensure proper hand washing:

1. Wet hands with warm water.
2. Apply liquid soap to hands.
3. Rub hands vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Use soap and warm running water. Scrub nails by rubbing them against the palms.
4. Rinse hands with water.
5. Dry hands thoroughly with a paper towel.

Alcohol-based hand sanitizers and lotions cleanse hands when soap and water are not readily available. In addition to washing hands frequently, keep fingernails less than one-quarter of an inch long and avoid wearing artificial nails. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed. Health care workers who have skin cuts, open skin areas, or weeping skin rashes should refrain from all direct patient care and from handling patient care equipment until the condition resolves.

Pregnant health care workers are not known be at greater risk of contracting HIV infection than health care workers who are not pregnant. However, if a worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from prenatal transmission. Because of this risk, pregnant health care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

VULNERABILITY
All HHA Clients are vulnerable children or adults. **All** Alliance Health Care employees are considered **mandatory reporters** of vulnerable child and adult protection issues. A report may prevent harm to a vulnerable child or adult, disrupt or terminate the harm cycle, and assist families in obtaining needed services. Minnesota law requires reports of maltreatment are made if there is reason to believe that a vulnerable adult or child is being or has been maltreated, or there is knowledge of a sustained physical injury, which is not reasonably explained.

Maltreatment consists of **abuse** (physical, emotional, sexual), **neglect** (food, clothing, shelter, health care and supervision), **financial exploitation**, unexplained injuries and threatened injuries. For a child, maltreatment also includes: Mental Injury (harm to the child’s psychological capacity or emotional stability), Neglect: failure of the caregiver to provide mental health care, education, appropriate supervision or protecting the child from conditions or actions that endanger the child or exposing a child to certain drugs or causing emotional harm to a child may also be considered neglect.

A **verbal report** shall be made **immediately**, (immediately is defined “as soon as possible, but **no longer than 24 hours** from the time initial knowledge that the incident occurred has occurred has been received”), **to the Minnesota Adult Abuse Reporting Center** (MAARC). MAARC takes reports of suspected maltreatment of vulnerable adults and is available 24 hours a day. The number is 1(844)880-1574. For children, contact the local police department or county social

services. <u>Failure of a mandated reporter to report maltreatment of a vulnerable adult or child constitutes a criminal offense-gross misdemeanor.</u>

Minnesota Statute 626.556 defines abuse of minors and Minnesota Statute 626.5572 defines abuse of vulnerable adults.

CONDITIONS FOR REFERRAL/REPORT

First, a HHA must protect the Client. Making a referral/report is the second duty of a HHA. This protection may involve medical assistance, intervention, or additional supervision. HHAs must act to protect the Client as soon as possible. Once the Client is protected, it is appropriate to make the report. The following is a list of conditions appropriate for report:

1. Child/Vulnerable Adult (VA) has suffered an injury, which appears to be non-accidental in nature
2. Substantial likelihood that the Child/VA will suffer a physical injury due to conditions within the family
3. Child/VA has suffered a physical injury as a result of hazardous conditions not corrected by his/her family
4. Child/VA is suffering emotional damage and parent or guardian is unwilling/unable to provide or permit necessary treatment
5. Parent, guardian, or custodian desires to be relieved of Child's or VA's care and custody for good cause: (a) Parent/guardian is deceased (b) Child/VA's guardian is not in the state
6. Child/VA is in need of special care and treatment required by his/her physical or mental condition and whose parent or guardian is unable to provide (such as eating disorders, suicidal, or chemical dependency, etc.)
7. Delinquent child due to responsible party neglect
8. Truancy due to responsible party neglect
9. When in doubt, REPORT IT

REPORTING PROCEDURE

A. All Alliance employees are required to report any maltreatment, which he or she knows or has reason to believe, has occurred within the past 3 years in the home (this includes the Client as well as others in the home who are children or VA's). **<u>Employees must make a verbal report</u>** to the Director of Nursing or the Client's RN Case Manager **<u>within 24 hours.</u>** During evenings, weekends, or holidays, call AHC office, Eagan, 651-895-8030 and ask the answering service to page the on-call nurse. The verbal report must be followed by a written Unusual Occurrence Report Form within seven-two (72 hours exclusive of weekends and holidays). The report (verbal and written) should identify the individual/Client, date(s) and time(s) of incidence(s), any person believed to be responsible for the suspected maltreatment abuse or neglect or financial exploitation, nature and extent of suspected maltreatment, reporter's name and phone number. <u>Be as specific as possible</u> about the concerns. It is <u>not</u> the employee's duty to have the incident investigated.
B. The Director of Nursing or appropriate designee will file the report with MAARC. These phone numbers are kept at all AHC offices.
C. Following the report, AHC will complete and send the reporter a statement indicating how the report was handled. This is called a "Confidential Notice of Status of Report of Suspected Maltreatment" and will explain whether the report was or was not forwarded to the authorities through the appropriate MAARC.
D. Employees maintain the right to report the suspected maltreatment directly to the MAARC. AHC requires that employees also make a report to the agency. AHC maintains a 'no retaliation' policy for reports made by employees.

REPORTING SUSPECTED FRAUD POLICY

As is required by section 6032 of the <u>Deficit Reduction Act of 2005</u>, any Alliance employees who suspect fraud, misuse, abuse or waste of consumer funds are required to report suspicions to the HR director and/or department immediately. Examples of fraud include but are not limited to falsifying time cards and/or records, reporting inaccurate time or turning in time before work is completed. Once a suspicion of fraud is reported, an investigation will be conducted and all findings will be documented and turned over to the proper authorities. Employees cannot be penalized, retaliated against or disciplined for their report of fraud or aiding in investigation of fraud. *Please see the Human Resources*

Director for detailed information on your responsibility to report fraud, definition of terms, and relevant state and law citations and statues.

FRAUDULENT ACTIONS

Employees are not permitted to participate in any fraudulent activity including but not limited to items listed below:

- Falsifying timesheets or records
- Signing documents for the Client/Responsible Party
- Reporting the same time worked for two separate Clients (with AHC or not)
- Reporting time worked while the Client is hospitalized or incarcerated
- Reporting time worked in the Client's home when the Client is not present
- Reporting time worked in school or day programs unless prior authorization has been obtained from the RN Case Manager and the HHA is part of the in-school IEP
- Reporting time for the care of other family members or anyone else present in the Client's home
- Reporting time worked while driving a client in an automobile (see Travel Policy)
- Turning in timesheets before work is completed
- Pre-filling timesheets prior to hours worked including timesheets that are photocopied with Client's signature

Fraudulent activities such as these are criminal offenses and cause for immediate dismissal and prosecution.

DRESS CODE

As a representative of AHC, HHAs are expected to wear appropriate attire. Appropriate attire includes:

- Clean, well maintained clothing without tears or holes
- Shorts are acceptable if worn no shorter than three inches above the knee
- Comfortable, clean shoes with socks or stockings must **always** be worn in the Client's home. It is suggested that HHAs have an extra pair of clean, dry shoes available during wet and snowy weather so as not to damage the Client's floor.
- Long, dangling earrings and excessive jewelry are a safety concern and may not be worn working with Clients
- Tight fitting clothing and clothing with obscene or offensive language/pictures are **never** acceptable.

HYGIENE

As a representative of AHC, HHAs are expected to maintain a high level of cleanliness and hygiene. Appropriate hygiene includes:

- HHAs must be clean and well-groomed while in a Client's home
- Fingernails must be clean and trimmed
- Shoulder length or longer hair must be pulled back from the employee's face
- HHAs must adhere to AHC's fragrance-free policy while in the Client's home. This includes perfume, cologne, or scented lotion, etc.

EMPLOYEE GRIEVANCES

Employees who feel they have not received fair treatment may file a grievance. All grievances must be written and are to be filed directly with the Director of Nursing. If the employee feels uncomfortable discussing the incident with the Director of Nursing, or the incident relates to or involves the Director of Nursing, or if you feel as though your grievance hasn't been adequately resolved, the grievance must go to the Board of Directors. The grievance and statement of relief requested must be submitted within ten (10) working days of the claimed unfair treatment. The appropriate department head will respond to the grievance within fourteen (14) working days of receipt.

DRUG & ALCOHOL-FREE WORKPLACE

Alliance firmly believes the use of illegal drugs and misuse of legal drugs, including alcohol and prescription medications, is a source of danger in the workplace and a threat to Alliance's goal of maintaining a productive and safe work environment.

Possession, distribution, sale or use of, or being impaired by or under the influence of alcohol or any unauthorized or illegal drug on Alliance's premises, or while on duty, is prohibited. The consumption of alcohol at mealtime, during work hours is also prohibited. Impairment by use of prescription medications is also prohibited while on duty. Off-the-job illegal drug or alcohol use, which adversely affects your job performance of which could jeopardize the safety of or harm other employees, clients, customers, the public, or company equipment will result in disciplinary action, up to, and including termination of employment. Violation of this policy could result in termination of employment. Employees are encouraged to inform their manager of their use of prescription drugs which may interfere with their work duties. *Please contact the Human Resources Department for further clarification on this policy.*

SMOKE FREE ENVIROMENT

To protect and enhance the indoor and outdoor air quality and to contribute to the health and well-being of all employees, Alliance Health Care/Services is entirely smoke free. Specifically, the use of all tobacco or similar products, including but not limited to cigarettes, pipes, cigars, snuff, or chewing tobacco, is banned from all Alliance Health Care/Services work sites.

Smoking is prohibited in all areas within Alliance Health Care/Services worksites, without exception. This includes common work areas, group homes, Client homes, assisted living facilities, classrooms, conference and meeting rooms, private offices, hallways, warehouse, lunchroom, stairs, restrooms, employer owned or leased vehicles, and all other facilities. There are no designated smoking areas inside or on company premises.

Additionally, employees may not smoke in their personal vehicles on Alliance Health Care/Services premises or worksites. Employees who wish to smoke must be off Alliance Health Care/Services property. Employees who choose to leave Alliance Health Care/Services premises to smoke may do so at their own risk. No additional breaks are allowed to any employee who smokes. If returning from a meal break during which you have used tobacco or similar products, do not leave cigarette butts or other traces of litter or tobacco use on the ground or anywhere else.

Employees may not have the smell of tobacco smoke about their persons during work hours or while on company business. In general, employees should not use or consume any substance, the effects or traces of which could interfere with the employee's presentation of a clean and professional appearance to Clients and the public in general.

Employees who wish to leave the premises to smoke must punch out and be at least 50 feet away from the end of from Alliance owned and leased property. Time away from the work site counts towards the individual employees allowed break time. For more information on how much time is allowed for break, please speak with your supervisor. Excessive time away for breaks will be addressed with employees on an individual basis.

FRAGRANCE FREE ENVIRONMENT

Alliance adheres to a fragrance-free work environment. All employees must refrain from using perfume, cologne, scented lotions, office/room sprays or plug-ins, or other scents while working either in the office or in client homes. Please also be conscientious of certain plants and flowers that can trigger allergic reactions with co-workers and clients.

PERSONAL PHONE CALLS

We understand that employees may need to be reached during work hours. We ask that personal calls that come through the Alliance phone line be kept brief. When making personal phone calls, please limit them to break times only.

CELL PHONE USE

Cell phones should be silenced during the workday and are to be used only during breaks or in case of emergency. In the event of an emergency that requires the use of a cell phone, please leave the work area so as not to disturb others. This includes checking email, checking voicemail, text messaging, instant messaging, and any other cell phone functions.

CONTINUED EDUCATION/TRAINING

Home Health Aides are required to complete at least 12 hours of in-service training per calendar year (or one (1) hour per month). This is a government regulation and; therefore, if these are not completed, the Home Health Aide will not be able to continue working until the requirement is met. AHC provides in-services throughout the year, including First Aid and CPR, to help the Home Health Aide meet this requirement. These are offered at no cost to you. You may also receive credit for in-services obtained elsewhere, provided you contact the Training Department and submit any necessary documentation. In addition, some of the on-site training which you may receive can contribute toward these 12 hours. If you are having difficulty in completing the required in-services please contact the Training Department so this can be addressed.

WEAPON POLICY

Alliance employees are strictly prohibited from carrying or possessing weapons, firearms, explosives, or other hazardous substances, whether or not by permit, on the premises of Alliance, in the workplace, or while acting within the course and scope of employment off of company premises. Employees are further responsible for ensuring that their personal firearms or weapons are never accessible to the client or consumer at any time.

Alliance reserves the right to search and inspect property and persons while on the company premises, while operating company equipment or vehicles for work-related purposes, or while engaged in company business off premises.

Violations of this policy will result in immediate termination of employment.

OFFENSIVE BEHAVIOR & SEXUAL HARASSMENT

Alliance will not tolerate conduct by any individual who harasses, disrupts, or interferes with another's work or creates an offensive or hostile work environment. Offensive behavior includes, but is not limited to fighting, hitting, pushing (or any aggressive physical contact), swearing, name calling, making threats, yelling, negative behavior/attitudes etc.

While all forms of harassment are prohibited, Alliance emphasizes that sexual harassment is specifically prohibited. Sexually harassing behavior may include, but is not limited to:

1. Making unwelcome or unwanted sexual advances, including patting, pinching, brushing up against, hugging, cornering, kissing, fondling, or any other similar physical contact considered unacceptable by another individual.
2. Use of offensive and/or threatening language, which has sexual connotation, including comments about an individual's body or appearance (where such comments go beyond giving a mere compliment), inappropriate jokes that are clearly unwanted or considered offensive by others, any other tasteless, sexually-oriented comments, innuendoes, or offensive actions.
3. Any suggestion, whether direct or indirect, that an employee's job security, job assignment, conditions of employment, or opportunities for advancement are in any way dependent upon an employee's submission to sexual advancements by any other employee, supervisor, or manager.
4. Degrading remarks, posters, graffiti, or other objects in the workplace that contribute to an intimidating work environment.

Any employee that believes he/she has been harassed should, when possible, confront the harassing individual privately and tell him/her to stop, and should then report the harassment details to the Director of Human Resources as soon as possible. If the employee feels uncomfortable discussing the incident with the Director of HR, or the incident relates to or involves the Director of HR, another Director should be notified.

Upon reporting an allegation of harassment, a prompt investigation will be conducted. Confidentiality will be maintained to the extent possible. If the investigation of a complaint of harassment indicates that harassment has occurred, the offending employee will be subject to disciplinary action, depending on the severity and type of violating behavior, including possible termination.

Retaliation is prohibited against any employee because he or she notified Alliance of an incident of alleged harassment. To report retaliation, employees should notify the Director of Human Resources. If the feels uncomfortable discussing the incident with the Director of Human Resources, it involves or relates to this person, another Director should be notified. Any form of retaliation against an individual who files a complaint will lead to disciplinary action, up to and including termination of employment.

Alliance accepts no liability for harassment of one employee by another employee. The individual who makes unwelcome advances, threatens, or in any way harasses another employee is personally liable for such actions and their consequences. Alliance will not provide legal, financial or any other assistance to an individual accused of harassment if a legal complaint is filed.

DISCIPLINE AT ALLIANCE

DISCIPLINARY PROGRAM

Alliance will typically use the following steps in disciplinary situations:

1. Verbal notice of deficiency with written documentation of this notice and expected level of performance
2. Written notice of deficiency with future expectations
3. Probation
4. Termination of employment

Any of these steps may be skipped or eliminated at Alliance's sole discretion depending on the nature of the offense.

PROBATION

An employee may be placed on probationary status at any time during his/her employment as a result of inadequate or poor job performance. The employee's work will be reviewed during this time to determine eligibility of continued employment. At any time during the probationary period, Alliance may terminate the employee if management concludes that the employee is no longer suited for the position.

WORKING WITH CLIENTS AT ALLIANCE

CLIENT CONFIDENTIALITY

By accepting employment with Alliance, employees are obligated to carefully refrain from discussing any client's condition and/or personal affairs with anyone outside the agency unless expressly authorized to do so as is required by HIPPA and other privacy rules and regulations. Employees may not share medical information with clients and visitors unless they have written permission from the client whose information could be discussed. In addition, all information seen or heard regarding clients, directly or indirectly, is completely confidential and not to be discussed with even the employee's family members. Alliance employees are required to govern themselves by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of agency ethics, but can also involve an employee in legal proceedings. Information about clients or Alliance is not to be given to the media. This is essential for protection of both the client and Alliance. Agencies such as ours must abide by very strict laws regarding the release of information concerning clients.

Please see **Alliance Notice of Privacy Practice** at the end of this handbook for details on the regulations related to protecting the Personal Health Information of our clients and employees.

NONDISCRIMINATION POLICY

All services are available without distinction to all program participants regardless of race, gender, national origin, color, creed, religion, marital status, disability, sexual orientation, age, status in receiving any form of public assistance, nor upon the basis of any other characteristic protected under federal, state, or local laws and regulations.

CHILD LABOR LAWS
Any minor between the ages of 14 and 15 years of age may not work:

- Before 7:00 a.m. or after 9:00 p.m. During the school year, Federal Law restricts hours to no later than 7:00p.m., no more than three hours a day, and not more than 18 hours a week.
- For more than 40 hours a week or more than eight hours per 24-hour period
- On school days during school hours, without an employment certificate issued by the school district superintendent (if an individual is home schooled, "school hours" are determined by the district's school day)
- State law dictates 16 and 17-year-old high school students may not work:
    - After 11:00 p.m. on evenings before school days
    - Before 5:00 a.m. on school days
    - With written permission from a parent or guardian, these hours may be expanded to 11:30 p.m. and 4:30 a.m.

COMPENSATION AND BENEFITS AT ALLIANCE

TIMESHEETS

The workweek is Sunday through Saturday. Payroll is processed every two weeks and payday is every other Thursday. A separate timesheet must be completed for <u>each</u> Client every week.

Timesheets must be completed and received every Monday at 10 a.m. following the week worked. Every timesheet must be completed in its entirety including HHA signature, Client or Responsible Party signature, date, HHA provider number, and Client MA number or birthday. Timesheets must indicate services provided for each day worked. Each timesheet must be an ACCURATE report of time worked. HHAs may not pre-fill the timesheet before hours have been worked. HHAs may not use timesheets with photocopies of the Client's signature. HHAs may drop off their timesheets in person (AHC provides a drop box at the door for after-hours drop off at the Eagan office only), US mail, or fax to AHC (651-895-8070).

Be aware that late or incomplete timesheets are a burden on employees, Clients and AHC. It delays the billing process, interrupts the calculation of Client allotted hours and delays employee paychecks.

If a HHA's timesheet is not turned in, is late, incomplete, incorrect, or illegible, resulting in the delay of normal processing, the timesheet will be considered an adjustment to be processed the next pay period-**no exceptions**. Employees who have questions about filling out timesheets should contact AHC. Adjustment checks will be included in the next paycheck-**no exceptions**.

Late timesheets will not be accepted after sixty (60) days from the hours worked. After sixty (60) days, timesheets will be considered invalid and <u>cannot be processed</u>.

90 DAYS WITHOUT WORK POLICY

An employee will be considered to have voluntarily separated from employment if they haven't worked in 90 days or more <u>and</u> haven't notified Alliance of a leave of absence status. Individuals who have not notified Alliance of their leave of absence status and want to return to work after 90 days of inactivity will be required to complete new employee paperwork including a new background study **BEFORE** they begin working again. Individuals who begin working after 90 days of inactivity without notifying Alliance will NOT be paid for hours worked. Employees, who are on a leave of absence status and want to return to work, must notify the Human Resources Department BEFORE they begin working again.

OVERTIME

Overtime is not allowed in this program without prior approval from the Director of Nursing. Overtime is calculated for time worked in one week in excess of 40 hours, not total hours. All HHAs must obtain approval from the Director of

Nursing **before** working any overtime. HHAs working overtime hours without prior authorization will be subject to disciplinary action up to and including loss of employment.

OVER UTILIZATION OF HOURS

Clients who receive HHA hours must stay within the authorized number of hours they receive each month. HHAs who work more than the number of approved hours without prior approval from the RN Case Manager, will **not** be paid the over hours. HHA's, who would like to know how many hours they have left for each month, may call the Eagan office and ask to speak with the Billing department.

LIMIT HOURS

HHAs are **NOT** permitted to work more than 16 hours in one day. This daily total includes ALL hours worked with ALL Clients between ALL agencies combined. HHAs are **NOT** permitted to work more than 275 hours per month. The monthly total includes ALL hours worked with ALL Clients between ALL agencies combined. Hours worked outside of this limit will not be processed or paid. Hours already paid to HHAs that exceed the 275-hour limit will be deducted from future paycheck(s).

HOLIDAYS

Most Clients do not request holiday coverage and it is not required that HHAs work on holidays. **However, if a HHA is asked to work a holiday and cannot, it is required that he or she give the Staffing Coordinator two (2) weeks advance notice.** The recognized holidays are as follows:

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

Time and one half of the HHA's regular rate of pay is provided for any time worked on the above listed holidays.

VACATIONS

HHAs may take vacation time unpaid. A 30-day notice is required to allow time to fill shifts. **Written notice must be given to the RN Case Manager or the Staffing Coordinator 30-days prior to vacation begin date.**

PROVIDING PCA WORK

If an HHA is interested in performing PCA work then the HHA must go through the proper process for becoming a PCA. Please contact Human Resources for information on the requirements for that. HHA's that are performing PCA work and have not gone through the proper process could have payment for those services delayed. This is because AHC cannot bill for those services until all requirements are met. **You must get notification from Human Resources before you are able to perform PCA services.**

BENEFITS

Employees who believe they are eligible for benefits but have not received notification after 90 days of employment should contact Human Resources.

EMPLOYEE INFORMATION CHANGES

All changes to employee personnel information (name, address, phone number, marital status, dependents, etc.) must be reported to the Human Resources Department immediately to ensure proper mailings and to maintain accurate record in case of an emergency. Personnel change of information forms can be picked up in the HR office. At the time of hire, staff is asked to fill out federal and state withholding forms and certain benefit forms. Staff should contact the Human Resources Department to make corrections or change their deductions.

REFERRAL BONUSES

Any current employee who refers a new employee to Alliance will receive a $50 referral bonus if the following conditions are met. The new employee must **1**) mention the referring employee's name during the initial interview, or indicate the name on the application, **2**) be hired and successfully remain employed for 90 days and, **3**) receive 6 paychecks. If these three criteria are met and the referring employee is still employed, the referring employee must

contact the Human Resources Department and ask for payment of the bonus. There is no limit to the number of bonuses an employee may collect.

EXTENDED LEAVES

Employees planning to take any extended leave must give proper notice to their supervisor and the Human Resources Department to ensure proper maintenance of his or her employment status.

Family Medical Leave

Alliance will provide up to twelve (12) weeks unpaid leave to eligible employees for a variety of reasons related to family and medical care in accordance with state and federal law requirements. Eligible employees are those who have worked for the company at least twelve (12) months and worked 1,250 hours during the twelve (12) months immediately preceding the start of the leave. When the leave is foreseeable, the employee must give notice prior to the start of the leave. When the leave is not foreseeable, the employee must give as much notice as possible. Notification and completion of all necessary paperwork must be completed within 15 days of the start of the leave. Upon notification, Alliance may request medical certification to support the necessity of the leave. Employees granted this leave will be given a Notice of Rights and will be granted the same or an equivalent position upon return to work. The employee must pay for health care coverage in order to maintain it. Please see the Human Resources Department for important specific details.

Funeral Leave

Employees are allowed up to three (3) consecutive days unpaid leave for bereavement and funeral arrangements for immediate family (spouse, children, siblings, parents, grandchildren, and grandparents). Employees have the option of using any available personal or vacation time. Please notify the Human Resources Department immediately to request funeral leave.

Jury Duty

Serving for jury duty is considered an unpaid excused absence. Employees have the option of using any available personal or vacation time. Employees should notify their direct supervisor as soon as possible and present their jury summons to the Human Resources Department.

Terminating Employment

Employees are asked to give notice before terminating employment at Alliance. Field and office employees should give a two-week notice. Managers should give a four-week notice. In the event of other situations that require time away from work, employees must notify their supervisor and the Human Resources Department as soon as possible to discuss their options.

EMPLOYEE RETURN TO WORK

In the event of illness or injury resulting in three or more consecutive days of absence from work, the employee may be required to present a physician's statement to his/ her supervisor at the time of return. This statement should verify that the employee may resume normal duties and is not contagious to others.

In the event of a medical procedure, injury or illness resulting in restrictions of the employee's ability to perform job duties, the employee must inform their supervisor of such restrictions before the day of return to work. Upon returning to work, the employee will present a written physician's statement detailing these restrictions and the expected duration. Be advised that any restrictions that disallow staff to complete the essential functions of his/her job will be enforced. If the restrictions are such that the staff should be placed in a temporary alternate placement or responsibilities, Alliance will attempt to do so if such a position is available that is compatible with the employee's abilities and qualifications.

ALLIANCE NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Alliance Health Care, Alliance Health Services and Alliance Medical Supply (hereinafter referred to as "Alliance") are providing this Notice of Privacy Practices effective April 14th, 2003 for current clients. Notice will be given when beginning services for new clients. Alliance has the responsibility to make reasonable attempts to retain the privacy of each client's personal health information. The HIPAA Rule is designed to ensure that protection for client privacy is implemented in a manner that maximizes privacy without compromising the availability or quality of medical care. In some cases, when state laws provide greater protection of your privacy, those provisions will be followed.

Covered Entities

Alliance has always been committed to maintaining the confidentiality of client and employee information. With the mandatory implementation of the HIPAA Privacy Rule effective April 14th, 2003, all healthcare providers, health plans, and healthcare clearinghouses (considered covered entities under HIPAA) will be governed by the same regulations. All covered entities will also have contracts with their business associates, which are designed to protect personal health information of clients.

Individually Identifiable Health Information

Privacy regulations protect any individually identifiable health information, including demographic information collected from an individual, that (a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and identifies the individual or to which there is a reasonable basis to believe that the information can be used to identify the individual.

Health Information

Certain health information is allowed to be shared between covered entities under the HIPPA Privacy Rule, whether verbal or recorded in any form or medium and is:

- created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- related to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

Individual Rights

Individuals/clients are given certain rights with respect to their health care information. Certain health information is allowed to be shared between covered entities when providing treatment and/or services, payment (including determining eligibility, processing claims, utilization & management of insurance benefits, medical necessity of your treatment and/or services, coordination of your care, benefits, & services, and response to complaints, appeals, & external review processes), and other health care operations (including qualification review, compliance programs, quality assessment, performance measurement & outcome assessments, case & disease management and care coordination services). Policies to maintain PHI and still retain the flow of information required to provide services include the following individual rights:

- Notice of Privacy Practices with content and distribution determined by HIPAA,
- Individual Right to Access allowing clients to access, inspect & obtain a copy of their "designated record set" (medical & billing records) of PHI,

- <u>Amendments</u> can be made by the client, when appropriate, to the PHI designated record set. The intent is to ensure accurate & complete information, without altering existing records and to retain the integrity of the original medical record,
- <u>Tracking Disclosures</u> (after 4/14/03) made for reasons other than determining insurance eligibility/coverage payment, treatment and/or services to other health care operation functions (HIPAA permits disclosure of PHI, without authorization, to continue to protect public health and safety, as it is today),
- <u>Restrictions</u> may be requested by the client regarding disclosures of PHI,
- <u>Specific authorization</u> by client to release PHI in non-routine circumstances will be requested when appropriate,
- <u>Complaints</u> may be filed by the client with the service provider/covered entity, Minnesota DHS Privacy Official, or Office of Civil Rights, Medical Privacy, Complaint Division, and
- <u>Requests</u> for access, amendments, tracking, restriction & specific authorization should be made in writing to Alliance HIPAA Privacy Officer.

The Office of Civil Rights/OCR is charged with enforcing the HIPAA statute.

- Noncompliance may result in a civil penalty of $100 per violation and a maximum of $25,000 per person for all identical violations in a calendar year.
- Knowingly obtaining or disclosing individually identifiable health information is a criminal penalty of a fine up to $100,000 and/or imprisonment for up to five years, with a greater penalty when the offense is committed with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm.

***NO TEST FOR THIS SECTION, SIGN AND RETURN SIGNATURE PAGE LABELED "POLICIES AND PROCEDURES" IN TEST PACKET B**

EMERGENCY PREPAREDNESS

INTRODUCTION
How we choose to respond to emergencies can make the difference between escalating a crisis situation or managing to solve a problem and achieve safety. It is of the utmost importance that you, as a Home Health Aide, are capable of confidently managing emergency situations if they should occur.

You never need permission to call 9-1-1! If you ever believe that anyone is in danger of physical harm, it is important that you call 9-1-1 immediately and get outside help into the situation to assist as quickly as possible. Never leave a client in an unsafe position or situation in order to make this call, make sure the client is in safe position (not mid-transfer) and in a safe location prior to contacting 9-1-1. Any time that 9-1-1 is called; you must notify your supervisor and fill out an Adverse Event Report.

ADVERSE EVENT REPORTS
The Adverse Event Report Form is also to be completed whenever a client files a complaint or when an incident occurs that is not consistent with the routine operation of the agency and the care of the client. This form will be used to report any occurrences which may involve maltreatment of a vulnerable adult or child. It will also be used to report any other incident involving the client.

Some examples might be: a client fall, a client misses a dose of scheduled medication, unusual bruises on the client, or client complaints about the agency. This form will not be used for employee injuries or incidents, and this form does not replace mandated reporting guidelines – you still must make a vulnerable adult or maltreatment of minors report either internally or externally in addition to this report.

Report incidents immediately by contacting your direct supervisor. Contact the RN On-Call if the incident occurs when the office is closed at (651) 895-8030. You will be required to complete a written Adverse Event Report as well.

The purpose of this report is:
1. To provide the client with any appropriate follow-up medical care necessary.
2. To assist Alliance to identify problems or potential problems that may be corrected to facilitate client safety.
3. To reduce the risk of financial liability.
4. To identify and document occurrences of potential maltreatment to be reported to the authorities.

Prompt reporting of the incident helps you give a clear picture of the incident while it is fresh in your mind. This will protect you and the client. In addition, the RN Case Manager can handle client or family complaints better if s/he is aware of the problem. The RN will also assist you in determining the need for the client to receive medical attention.

Some examples of the incidents to be reported are:
- Missing or damaged property
- Medical or treatment errors
- Equipment related incidents
- Client falls at home
- Suspicious occurrences which may be issues of maltreatment of a vulnerable adult or child
- Other medical mishaps

EXPECTATIONS
When you complete the Adverse Event Report, be clear and specific as to what occurred. Fill in all blanks on the form to the best of your knowledge of the event. Tell what happened, the date and time, and the mental and physical condition of the client. You should state how the client tolerated the incident (what the effects were). State the facts related to the incident, do not give your opinions. For example, you enter the client's home and find the client on the floor. You should report, "The client was found lying on the floor". Do not state that the client probably fell.

After receiving the Adverse Event Report, the Director of Nursing will follow up, including appropriate physician notification. If necessary, further employee counseling or training will be initiated. Adverse Event Reports are not a permanent part of the client medical record; they are kept in a separate file at Alliance Health Services.

EMERGENCY PROCEDURES MANUAL

INTRODUCTION AND PURPOSE
Recent disastrous fires, bomb threats, and other emergencies have intensified concern for the safe and rapid evacuation of personnel from either the area involved or an entire building. An emergency can pose additional and unique problems, particularly in high-rise buildings. Experience dictates that a safe and successful evacuation during an emergency is dependent on thorough preplanning, organization, education, training, and the rehearsal of emergency procedures. Following the procedures contained in this manual will provide safe evacuation of the Alliance Health Care/Alliance Health Services/Alliance Medical Supply (hereinafter ALLIANCE) facilities and work areas from the ALLIANCE buildings in the event of fire, bomb threat, or another emergency. Procedures contained herein shall not replace those required by police or fire department officials.

Wardens shall be responsible for executing the procedures contained in this manual. Ideally, you should appoint at least one warden per floor. Wardens shall brief the employees residing on their floor once every six months regarding the contents of this manual, fire alarms, fire protection equipment, and exits. Employees shall follow the wardens' instructions in the event of an emergency.

It is the purpose of this manual to equip ALLIANCE with established procedures pertaining to emergency conditions that may arise, in order to prevent injury or loss of life or damage or loss to property of ALLIANCE, based in the buildings.

REMEMBER

SAFETY OF LIFE IS PARAMOUNT OVER EQUIPMENT OR OTHER CONCERNS

ORGANIZATION
To effectively and efficiently implement the provisions of the emergency plan, an emergency organization has been established and staffed as shown below:

A. Floor Wardens
B. Alternate Floor Wardens

During an emergency, staff members are responsible for the positive exercise of leadership in providing for the safety and security of employees. This responsibility is inherent at every level of supervision and management. The responsibility continues even after evacuation until the emergency is terminated.

FLOOR WARDEN AND ALTERNATE FLOOR WARDEN
Each floor or zones within a floor shall be under the direction of a Floor Warden who is responsible for the evacuation of occupants in the event of an emergency.

In preparation for a fire or other emergency, the Floor Warden shall:

A: Supervise and direct the activities of the occupants during emergencies and drills.
B: Be familiar with the various layouts of assigned floors, emergency plans, and the location and operation of

any available fire alarm system, fire protection equipment, and coded door locks.

C. Know the normal number of personnel on each assigned floor.
   1. Keep an emergency contact list of all personnel in their area.
   2. Keep a copy of a list of occupants of the floor for roll call purposes at evacuation areas.

D. Know the location of and routes to exits and refuge areas.

E. Notify the ALLIANCE Human Resources Director of any changes in emergency organization personnel under their jurisdiction, including changes in their position.

F. Be assigned to cover the base floor.

G. Study the floor plan, the number of occupants and the number of exits for dividing the population into groups in order to adopt a traffic pattern to primary and secondary exits for each group.

H. Perform frequent inspections to determine that all fire exit doors to stairs on the floor are maintained in the closed position and that they are not obstructed, inoperable, or locked.

I. Have available a current listing of all personnel with physical limitations whom cannot use stairs unaided.

In the event of a fire or other emergency, the Floor Warden shall:

A. Verify that ALLIANCE, Police, and Fire Department have been notified.

B. Determine the location of the fire, if known, and report data to the Fire Command Station. Do not search for the fire.

C. Inform all persons on the floor of the fire and prepare to evacuate.
   1. Direct the occupants of the building to proceed to their designated refuge area.
   2. Select the safest stairway or other exit to use for evacuation based on the location of the fire and information received from the Fire Command Station.
   3. Check the environment near the designated fire exits before entry by occupants and if affected by smoke, select an alternate exit and notify the Fire Command Station.
   4. Inform the Fire Command Center of the emergency and the evacuation in process.
   5. Take a head count, if possible (using the roll call list of occupants), to determine if all known occupants have been evacuated.
   6. Inform the Fire Command Center when the evacuation is complete. If communications are impaired, direct a subordinate to convey this report, in person, to the Fire Command Center.
   7. Inform the Fire Command Center of missing, injured, or deceased (if known) individuals.

NOTE: Refer to later in this Emergency Procedures Manual for specific procedures in other types of emergencies.

PERSONNEL WITH PHYSICAL LIMITATIONS

The Floor Warden shall maintain a list of personnel with physical limitations. The list shall contain the following:

A. Person's Name
B. Floor
C. Normal Location
D. Department
E. Responsible Floor Warden
F. Description of physical limitation.

The Floor Warden shall assign a "helper" to assist personnel with physical limitations during emergencies.

ACCIDENT OR ILLNESS

In the event of an accident or illness of an employee or visitor on ALLIANCE premises, follow these procedures.
Call **911** immediately and request assistance.

Give the following information:

- Street address (2260 Cliff Road, Eagan, MN 55122)
- Name of Building (Alliance Health Care)
- Floor level (main or upper)

- Room location (North, South, East, or West side)
- Other pertinent information about the fire or emergency.

HAVE SOMEONE MEET THEM OUTSIDE THE BUILDING

Call the ALLIANCE Human Resources Department to report the incident at 651-895-8030. **DO NOT** move the injured or ill person. Try to make them comfortable. If possible, have someone meet the emergency unit at the front door of the building.

EMERGENCY HELP AND 911 PROCEDURES

WHEN TO CALL 9-1-1	**WHAT TO SAY**
Use the following symptom/situations and common sense to determine what is a true emergency then call 9-1-1	Dial 9-1-1 and give the following information
***Severe traumatic injuries**	***Nature of emergency**
***Traffic accident casualties**	*** Exact address and cross street**
***Injuries from falling**	***Telephone number from which you are calling**
***Severe head injuries**	***Your name**
***Heat related symptoms**	***Floor number**
If you are unsure as to the seriousness of the injuries or the situation do not hesitate to call 9-1-1	***Room number or area of location**
	Do not hang-up as additional information may be needed

EMERGENCY NUMBERS	
Building Maintenance	ALLAN FINK Eagan 651-895-8030
Alliance Policy	SHALON NOVAK Eagan 651-895-8030
Floor Warden	SHALON NOVAK Eagan 651-895-8030
Asst. Warden	JENNA NITSCHKE Eagan 651-895-8030
Human Resources Office	CORPORATE Eagan 651-895-8030
*Ambulance	911
Fire Department	911
Police Department – Emergency	911
Police Department – Non-emergency	

FLOOR OR BUILDING EVACUATION

- Remain calm.
- Close all doors as you leave.
- Proceed to the nearest practical fire exit.
- Follow the instructions of the Floor Warden and proceed out the fire exit.
- Request help for those requiring assistance from emergency personnel.
- Do not return to the evacuated building until the Fire Department or authorized ALLIANCE officials instruct you to do so.

EVACUATION PROCEDURES

The order for total evacuation will be given only in extreme cases, and then only by the Floor Warden, in coordination with the Fire or Police Departments or ALLIANCE officials. When leaving the building, move quickly; stay calm and keep clear of emergency vehicles, equipment, and personnel. Go to the designated refuge area and stay there until directed

by the Floor Warden, the Fire or Police Department or ALLIANCE officials. When or if an order to evacuate is issued, walk in an orderly manner to the nearest available exit.

A. Use only stairs.
B. Do not prop exit doors open. They shall remain closed except for exiting.
C. Proceed immediately to the predetermined outside Refuge Area.

1. Remain at the designated Refuge Area until requested to return to your workstations by the Floor Warden, a member of the Fire Department or ALLIANCE official.
2. The Floor Warden shall provide evacuation of employees with physical limitations.
3. The designated Floor Warden will insure, through an authorized designate, that:

i. The entire area is cleared, i.e.: restrooms, storerooms, conference rooms, etc.
ii. All money, safes, records, etc., in each office is secured.
iii. All operating machines are turned off.
iv. Make sure all doors, particularly fire doors, are closed upon exiting.

4. Predetermined evacuation procedures may be modified depending on the situation. Strict compliance to orders issued by the Floor Warden, the Fire Department, or ALLIANCE officials is mandatory. Violators will be subject to disciplinary action.
5. Once in the Refuge Area, reentering the building for any reason is prohibited until an all-clear announcement is made.
6. Once every six months, the Floor Warden will direct a complete stand-up fire drill of all employees in the building.

EVACUATION "FLOOR" PLAN

A "YOU ARE HERE" type of floor plan is posted at both ends of the building's main corridor (hallway). All occupants shall review this regularly to familiarize themselves with its contents and directions. The Evacuation Floor Plan sketches shall include the following information:

A. Evacuation routes from the building
B. Designated fire extinguisher and fire hose cabinet locations

IT IS IMPORTANT THAT EVERYONE FAMILIARIZE THEMSELVES WITH THE EVACUATION FLOOR PLAN FOR THE BUILDING AND THEIR PARTICULAR AREA. The closest emergency exits for the specific rooms occupied as lab or office areas are as follows. Based on the specific situation, alternative building exits from the central hallway may have to be used. Please review the exits as they're posted in each room.

FIRE PROCEDURES

REMAIN CALM

- Leave your area immediately, closing all the doors behind you.
- If no audible alarm automatically activates, call the Fire Department immediately from another location and follow local procedures. Report the following information:
  - Street address (2260 Cliff Road, Eagan, MN 55122)
  - Nearest cross street (Southwest corner of Slater and Cliff)
  - Floor level (main or upper)
  - Room location (North, South, East, or West side)
  - Other pertinent information about the fire emergency
- Notify the ALLIANCE Human Resources office as soon as possible.

NOTE: Unless you observe eminent danger of fire or smoke, remain calm and wait for further instructions from the Floor Warden, Fire Department, or ALLIANCE officials.

BE PREPARED
Your own common sense is the best safety device ever developed. Above all, use your head! Determine in advance the nearest exit to your work location and the route you will follow to reach that exit in the event of an emergency. Establish an alternate route in the event your first route is blocked or is unsafe to use. Check the evacuation drawing in the hallway. This tip will be very helpful in the event you encounter heavy smoke.

Remember, if you encounter heavy smoke, this often camouflages the exit signs above the door. If you know in advance how many doors you will have to pass through, you can crawl or crouch low with your head below the smoke (watching the base of the wall) and count the doors you pass through so that you will know when you reach the exit door.

If your clothing catches fire ... STOP...DROP...ROLL **Any attempt to fight a fire should be limited to the discharge of one appropriate hand-held fire extinguisher <u>and</u> <u>only</u> if you are properly trained.**

Fire extinguishers are located in each building. Go to your designated Refuge Area and stay there until released by the Floor Warden, the Fire or Police Department, or ALLIANCE officials. Keep all talking to a minimum to reduce noise and confusion, and to ensure that everyone can hear instructions and roll calls by the Floor Warden.

FIRE DISCOVERY
If you smell smoke:

Notify ALLIANCE Human Resources immediately.
Notify the Floor Warden.

If you see smoke (more than from a toaster or C.R.T. Terminal), filling the air or room:
If practical or possible, keep people away from the affected area while evacuating until relieved by the Floor Warden. If not, **leave**, using the fire exits.

If you see fire (more than from a candle), where it should not be:

If the fire is of wastebasket size or type and you know how to do so, get the nearest fire extinguisher and put it out. Call 9-1-1 if not easily extinguished.

Never trace the source of smoke or fire that is not obvious.

FIRE DRILLS
Fire drills shall occur at least once every six months for each working tour or shift, in the building. All occupants of the building shall participate in the fire drills; however, they are not required to leave their floors or use exterior exits unless instructed to do so by the emergency staff. Assembling outside their assigned stairwell or exterior exit fulfills the intent of the fire drill.

Since it is vital that this plan function under emergency conditions, ALLIANCE shall attempt to conduct fire drills at unexpected times to prove their effectiveness and condition employees to emergency operations. Alternate routes should be used to condition the emergency organization and building occupants to situations that might occur during an actual emergency. The plan shall be designed to familiarize the occupants with the alternate means of exit that are available.

The Floor Warden shall keep a written record of all drills for three years. This record shall be readily available for inspection. Observers from the Fire and Police departments, Safety Committee, or other agencies, may attend to observe and comment on fire drills.

Shortly after the fire drills, the Floor Warden shall hold meetings with the staff to determine the effectiveness of the fire drills, and to assure that everyone followed procedures in accordance with this emergency plan. They shall note deficiencies and review these with the Safety Committee for immediate correction. Fire drills shall include the

instruction and practice regarding fire protection equipment. This may be assigned to designated individuals or to all building occupants

MAJOR NATURAL DISASTERS

TAKE TIME TO THINK

- Your State Office of Emergency Preparedness will activate warning signals in the affected areas.
- Whenever a major storm or other peacetime disaster threatens, keep your radio or television set tuned to hear weather reports and forecasts (issued by the National Weather Service) as well as other information and advice that may be broadcast by local government.
- Use your telephone only to report important disaster events to authorities and the Building Management Office. If you tie up the telephone lines simply to get info, you may prevent emergency calls from being completed.
- Stay away from disaster areas.
- Follow the advice and instructions broadcast over the radio Emergency Warning System. The Floor Warden in your area will direct you, if you are required to evacuate your work area.
- If evacuation is required, proceed to the area of assembly designated by your Floor Warden and remain there until further instructions are given.

COLLAPSE

Collapse is a sudden falling of a natural or artificial structure in response to the force of gravity.

Pre-loss actions include:

- Maintain adequate clearances between storages and mobile equipment to support members and use barriers as required around the bases and corners of upright columns.
- Treat surfaces of structural elements with rust/corrosion/rot inhibitors (paint, plasticizers, and similar coatings).
- Adhere to recommended roof and floor loads.
- Keep roof drain clear.
- Promptly remove accumulations of ice and snow.

Post-loss actions include:

- Clear areas of unnecessary personnel and equipment, including storage materials.
- Provide temporary bracing with wood or steel elements to relieve stress on damaged components.
- Have a contractor or licensed structural engineer inspect the damage and begin repairs immediately.

FLOOD

Inland and coastal areas are subject to flooding from heavy rainfall and melting snow, as well as to tidal surges. Inland flooding occurs when soil and vegetation are saturated by rain or melting snow and when run-off water overwhelms the natural drainage systems of lakes and rivers and the man-made drainage such as dams, levees and bayous. Coastal areas subject to inland flooding conditions are also prone to tidal flooding from storms and seismic activity.

Pre-loss actions include:

- Evaluate location of operations; flood-prone areas or coastal areas may not be the best location from a risk management perspective.
- Evaluate building sites for flood potential.
- Analyze existing structures in flood zones for their ability to withstand normally expected events.
- Use temporary levees shutters for building openings, and barriers.
- Stock disaster supplies, including portable power equipment, to maintain vital utility services.
- Place main electrical service equipment on upper floors of buildings above historical flood stage heights.

Pre-loss actions for minimizing fire loss exposures include:

- Allow no open flames or electrical wiring that is not waterproof near or in a flood-exposed structure.
- Protect flammable gas piping where exposed to mechanical damage and install shutoff or disconnects above normally expected flood heights.
- Prevent flood water from entering buildings either by having no lower-level openings or by covering those openings against water entry.

Post-loss actions include:

- The Disaster Recovery Coordinator should monitor the floor advisories by the National Oceanographic and Atmospheric Administration (NOAA) and decide if the conditions warrant a shut down. Precautions should be taken and appropriate actions implemented as soon as a flood advisory has been announced.
- If a disaster crew is to remain on the premises during the flood, adequate shelter, nonperishable food, first aid equipment, lighting, radio receivers, and stored drinking water should be provided at a safe elevation.

When the flood waters recede:

- An immediate damage assessment should be made. Particular attention should be given to undermining or other damage to foundations.
- Special attention should be paid to possible impairment of fire protection equipment.
- Any opening made in a building by debris should be temporarily repaired.
- Salvage operations should be initiated.
- Care should be exercised around damaged or submerged power lines. The utility Alliance should be advised of necessary repairs.
- Drains should be cleared of debris.
- Disaster crews and salvage teams should be cautioned not to smoke or use heat-producing devices if a possibility of flammable liquids or gases exists.
- Electric motors, switchgear and cables should be thoroughly inspected, cleaned, dried as need before energizing. Even if it is not immersed, electrical equipment can absorb sufficient moisture to reduce its insulation resistance to a dangerously low level.
- Steam and process lines and any refractory-containing equipment should be examined for wet insulation. In some cases, if insulation is contaminated, it must be stripped and restored rather than dried in place.
- Sources of boiler, process feed, and cooling water, and any materials in underground storage take should be tested for contamination before use.
- Mechanical equipment should be cleaned with sassing opened for inspection. Shafting should be checked for alignment and lubricating systems flushed.

HAILSTORM

Precipitation in the form of irregular ice pellets are known as hail.

Pre-loss actions include:

- Design structures to withstand hailstorms; concrete and some heavy gauge steel are acceptable. Roof structures are very susceptible to hail damage. Metal, concrete tile and certain types of built-up styles often withstand the effects of hail better than slate, tiles, and asphalt shingles.
- Provide anti-hail blinds, shutters, or covers for exposed building features such as windows, skylights, and other features susceptible to damage.
- Protect yard stocks and equipment or move them inside a substantial structure.

Post-loss actions include:

- Use spare materials such as plywood panels, plastic sheet and tarpaulins to cover openings or equipment and bracing materials and other building supplies, or make temporary repairs to building structures.

- Assign personnel to handle disaster operations such as clearing roof drains, removing hailstone accumulation on the roof (because this is a prime cause of collapse losses), and salvage or cleanup. At no time should individuals be exposed to falling hail.

ICE STORM

An ice storm is a winter storm in which a substantial glaze accumulates from freezing rain and drizzle falling on a surface that has a temperature below 32°F.

Pre-loss actions include:

- Design structures to adequately withstand anticipated ice loading.
- Properly maintain building roofs and structural supports.
- Stock materials for temporary structural bracing and disaster repairs.
- Trim tree branches that overhang power lines.
- Maintain disaster power equipment to provide utility services, maintain protection systems, and use portable fuel-fired heaters to meet space heating requirements and to reduce ice accumulations on building surfaces.
- Train personnel and assign them to handle disaster operations, including placing temporary structural supports, removing ice accumulations, and operating disaster equipment.

Post-loss actions include:

- Make disaster repairs as soon as possible to limit further damage; cover damage opening with plywood sheets, tarpaulins, and plastic covers to protect equipment and stocks from weather and moisture.
- Start salvage and cleanup operations and restore building protection to full and proper operation.

LANDSLIDE / MUDSLIDE

A Landslide is the dislodging and fall (or slide) of a mass of earth and rock. A mudslide combines landslide with water and usually occurs after a substantial rainfall.

Pre-loss actions include:

- Have a professional survey the site.
- Alter the slope or configuration of the area to reduce the loss exposure.
- Install natural features to deflect the slide, such as rock barriers, earth dikes, swales, or trenches; stabilize the surface of the slide area with deep-rooted plants or rainfall-deflecting ground cover.
- Increase structural supports for exposed building to withstand the impact and dynamic/static loading.
- Relocate the structure to a more geologically stable location.

Post-loss actions include:

- Provide temporary supports for stressed building members exposed to landslide or mudslide material.
- Inspect any facility in a landslide area for damage and protect it against further harm.
- Begin salvage and cleanup as soon as possible and inspect components and equipment exposed to damage before use. High moisture levels could damage the internal wiring of a motor even if this is not visible from the outward appearance.
- Coordinate all activities with public authorities.

SEVERE COLD WEATHER

A cold wave brings a rapid drop in air temperature within a short time period, requiring special procedures and protection for all operations. Cold waves depend on the relative temperature drops and minimum temperatures, which vary by location.

Wind chill index:

- The wind chill index is the cooling effect of wind speed in colder weather that can drastically reduce the stated temperature as indicated by a thermometer.

- A 20mph wind occurring when the outside air temperature is 30°F can feel like 4°F. The effects of that lowered temperature can be more pronounced than the nominal temperature without wind chill factor.
- The danger comes from extended periods of abnormally low temperatures.

Pre-loss actions include:

- Install building installation adequate for the cold weather climate to reduce heat loss and also provide a barrier against cooler outside air temperatures.
- Use properly designed heating systems of adequate size.
- Install backup diesel generations to keep furnaces operations during a power outage.
- Position buildings to exploit natural terrain features that modify sever weather influences and design buildings with minimal openings on the prevailing weather side.
- Stock disaster supplies such as plywood panels and installs curtains and plastic sheets to cover exposed openings.
- Provide temporary heating devices to maintain temperatures, shut off exposed systems, and keep protection systems in service.
- Maintain plant facilities and buildings in state of good repair.
- Practice energy conservation measures.
- Design and prepare fire protection equipment for subfreezing temperatures.

Post-loss actions include:

- Isolate damaged areas and complete temporary repairs.
- Cover any building openings to minimize further weather damage.
- Start salvage operations and permanent repairs as soon as practicable and restore protection systems.

SOIL DETERIORATION

Soil deterioration is usually a problem for after other structures are built in the immediate area around the original structure. This weakening of the soil support capacity can create instability below building foundations and other supports, collapsing the construction placed on it.

Pre-loss actions include:

- Investigate surface and subsurface conditions thoroughly; take borings and samples for analysis.
- Have qualified geologist and licensed mining engineer perform a detailed study to determine soil integrity acceptability.
- Avoid soil contamination on the property, especially around building foundations, with chemicals or other compounds that break down the soil.
- Protect the soil by following recommended land management practices.
- Inspect building foundations and support pads on a regular basis for evidence of settling or soil instability; be alert for changes.

Post-loss actions include:

- Shore up structures; using wider footings, and/or bracing the structural load on a more stable formation (for example, use pilings where shafts are sunk to ensure more stable underground structures).
- Remove and fill areas with more stable material such as concrete rock.

THUNDERSTORM

A thunderstorm is a severe electrical storm accompanied by moderately heavy rainfall.

Pre-loss actions include:

- Design structures to adequately withstand high winds.
- Properly maintain building roofs, guy-wire supports for outside structures, and use tie downs for structures of light construction.

- Move yard stocks inside a substantial structure or protect them against high winds.
- Provide lightning protection systems for the building structure and services.
- Evaluate lost exposure characteristics such as building construction and occupancy on a case-by-case basis.

Post-loss actions include:

- Make temporary repairs to damaged portions of the building to prevent further loss.
- Use spare construction materials to board up the structure with plywood panels and use tarps and plastic sheets to reduce further exposure to the elements.

TORNADO

A tornado, or cyclone, is a rotating column of air in a funnel-shaped vortex. The Tornado extends downward from a cloud and rotates at speeds of up to 300 mph.

- Over half of all tornadoes occur between April and June, although they can happen at any time throughout the year, and they can cause extensive property damage.
- Nothing can prevent property losses from direct tornado contact. Bodily injury can be reduced by taking shelter.
- Tornadoes exhibit the following characteristics:
    - Generally occur between 3:00 PM and 7:00 PM
    - Move from the southwest to northeast
    - Travel about four miles along a from 300-400 yards long
    - Travel at 25-40 mph
    - Have wind velocities of 200-300 mph
    - Last about six to ten minutes

Tornado Watch

- The National Weather Service will issue a Tornado Watch if there is the possibility of tornadoes forming.

Tornado Warning

- A tornado warning is an alert by the National Weather Service confirming a tornado sighting and location.
- The weather service will announce the approximate time of detection and direction of movement.
- Wind will be 75 mph or greater.
- A public warning will come over the radio, TV or by the Civil Defense warning system (steady five-minute blasts of sirens).
- When one is sighted or a warning alert is issued by the National Weather Service, all employees should immediately move to areas designated by the Disaster Coordinator.

Actions to take

- Get away from the perimeter of the building and exterior glass.
- Leave your exterior office and close the door.
- Go to your designated shelter area.
- Stairwells are safe. If crowded, move down to a lower level for shelter.
- Do not go to the first-floor lobby or outside the building.
- If you are trapped outside the center corridor, keep calm and take cover!
- Keep your radio or television set tuned to a local station for information.
- Do not use the telephone to get information or advice.
- Follow the directions of your Floor Warden and ALLIANCE officials.

TORNADO AND CIVIL DEFENSE DESIGNATED SHELTER PLAN
A diagram of designated shelter areas for all building occupants is located on the Floor Evacuation Plan.

Each Floor Warden and Alternate has a copy, and copies may be made for occupants, if desired. All Floor Wardens and Alternates should be able to account for occupants under their control. Once in your designated refuge area, keep all talking to a minimum to avoid excessive noise and confusion.

Make sure to remain in designated areas until an "all-clear" is given. No one may leave the building. Keep notes regarding missing persons or those who refused to leave their work area, or decided to leave the building.

After the tornado has passed:

- Start search and rescue operations immediately.
- Prepare a damage report and initiate repairs to prevent further damage
- Pay special attention to possible fire, flooding, or impairment of fire protection equipment.
- Temporarily repair openings on the building or cover the contents of the building with tarpaulins to minimize rain damage.
- Initiate salvage operations.
- Exercise care around damaged power lines. The utility Alliance should be advised of necessary repairs.
- Clear roof drains of debris to prevent water from pooling on the roofs which could lead to roof collapse.
- Caution disaster crews and salvage teams not to smoke or us heat-producing devices if there is a possibility that flammable gases are present.

WINDSTORM
A windstorm is a storm with high winds or violent gusts of wind with little or no rain.

Pre-loss actions include:

- Design buildings and outside structures to withstand anticipated wind loads. The design should reflect location conditions in which wind velocities might exceed the average.
- Provide storm shutters and blinds for windows and other openings rated to handle higher wind loads.
- Maintain roof and wall systems, including roof tie-downs in good repair and provide adequate supports for outside structures.
- Secure materials and equipment located in areas surrounding the facility.

Post-loss actions include:

- Use spare construction materials such as plywood panels, tarpaulins, and plastic sheets to repair damage to buildings and to reduce further loss exposure of the building and equipment to the elements.
- Patrol premises to prevent looting and vandalism.

WINTER STORM
Snowstorms are characterized by heavy snowfall and are typically accompanied by high winds. Severe snowstorms are typically called blizzards when combined with high winds and intense cold. Snow loads on roofs generally pose the greatest risk; that is structural collapse.

Pre-loss actions include:

- Design all buildings and structures to withstand at least the anticipated snow loads, and carefully evaluate local conditions before completing any design or building activities.

In planning for winter storms, the Safety Committee should:

- Decide when the Disaster Control Center should be activated.
- Assign specific internal tasks such as:
    - Plowing and shoveling.

    - Installing snow fences and marker poles at hydrants and fire protection control valves.
- Establishing a tour to inspect:
    - Outside air dampers and other possible sources of outside air leakage that could result in freezing.
    - Steam tracing and electric heating systems for outside vessels and piping.
    - Heating systems in remote area.
- Establish procedures for calling in outside plowing contractors and other assistance.
- Stock or arrange a reliable source of portable heaters, heating blankets or other auxiliary or disaster anti-freezing devices as may be prudent.
- Plan for disaster generators and other equipment that may be needed to assure continued functioning of heating systems, realizing that electric utility lines are frequent casualties of winter storms.

During a major winter storm, the Safety Committee should/may:

- Recommend early closing or delay opening.
- Request outside plowing assistance as needed.
- Establish communication with employees on the premises, snow plow operators, and disaster crews.
- Continue to monitor National Weather Service advisories.
- Initiate cleanup procedures on a continuing basis. Particular emphasis should be placed on:
    - Clearing snow from exits, fire protection apparatus, and utilities for accessibility.
    - Removing snow from roofs in areas of drifting. Typically, at the junction of different roof heights.
    - Inspecting roof drains and roof-mounted cooling equipment to be sure there is no ice buildup.
    - Checking all areas of the facility to be certain that sufficient heat is being maintained to prevent sprinkler systems, process equipment and piping and utility systems from freezing.
    - Giving attention to those areas most likely to freeze first, such as the concealed space above suspended ceilings that contains sprinkler system piping or sprinkler-protected entry ways and remote stair towers.
    - Cooling jackets on engines and compressors in remote locations are especially vulnerable. Attention must also be given to less obvious sources of freeze damage such as water in air system drains or gas drip legs.

After the storm has ended:

- Assess damage immediately and make temporary repairs.
- Remove the remaining snow, with priority given to valves, hydrants, pump houses and fire department access routes.
- Promptly inspect areas within the facility most likely to have suffered freeze damage to detect as early as possible any cracks or leaks in piping. Such actions can help prevent major damage when liquids are released from thawed and damaged pipes.

EARTHQUAKE

A sudden movement of a portion of the earth’s surface that is sometimes sufficient to cause property damage, injury, and death.

How long will it last?

- The shaking may last only a minute or two.
- There may be after-shocks (over several hours/days/weeks/months).

What are the dangers?

- Falling objects (pictures, items in cupboards and on shelves, ceiling tiles and fixtures. furniture, file cabinets and bookshelves).
- Swinging doors and broken windows.
- Many things may stop working (lights, telephones. elevators, heat and air conditioning).
- Possible fires (from broken natural gas lines, electrical short circuits, or other causes).

- Electrical shock hazards (be aware of potential damage to electrical equipment).
- The motion may be severe. If you are standing, you may be thrown to the ground.
- Visibility may be poor inside due to dust in the air.

During the earthquake:

- Remain calm.
- Take cover under a desk or table. Protect your head and neck from falling objects.
- Face away from the windows and get out of their proximity.
- Stay away from objects that could fall on you.
- Stay where you are. Do not run outside. Falling debris may cause injury.
- If outdoors, stay in an open area. Do not enter a building.
- If operating an appliance: turn it off at the first sign of shaking. Then take cover quickly.
- Do not be surprised if:
    - The electricity goes out.
    - The elevator stops.
    - The fire alarm goes off or the sprinkler system goes on.

When the earthquake stops

- Follow the direction of the Floor Warden, or local procedures.

Power failure

- Remain calm and in place.
- Follow direction of emergency personnel.
- If available, turn on a battery powered radio to find out what is happening in your area.

EARTHQUAKE EVACUATION

When the earthquake stops:

1. Check yourself for injuries.
2. Check others for injuries.
3. Call out, asking if anyone is injured or trapped.
4. Begin assembling people in small groups near supporting columns.
5. Make a rapid assessment of the damage to determine if evacuation is possible (safer than staying), or practical. Look outside, if possible, to see what ground damage occurred. If some, or all, of the ceiling has collapsed, it may be necessary to climb over it. Watch out for all electrical wires.
6. When and only while there is no shaking, have one group at a time carefully exit via a stairwell. When the group reaches the exit, first check that no loose debris is hanging above the exit path. Have members of the group exit one at a time quickly, and get at least as far away from the building.
7. Do not touch anything that is hanging down or damaged.
8. After everyone is assembled at an evacuation area, get a count of deceased, trapped, injured, missing, and accounted for individuals.
9. Stay at your designated refuge area until otherwise directed by a Floor Warden, the fire or police department or ALLIANCE officials.

WATER DAMAGE

This type of damage can occur because of many disasters. It is a direct consequence of burst water pipes, floods and, is often a result of fire-fighting activities. It is frequently an indirect consequence of tornadoes (often accompanied by rain). Structural failure can cause broken water, sewer, and fuel lines causing chemical damage or fires. Often the severest impacts of an earthquake are not due to building failure itself, but rather to fires and flooding which occur because of that failure. Wooden and other organic objects affected by water may warp, split, check, and rot; the

corrosion of metals will be accelerated; stone and masonry may erode. In addition, water enhances bacterial action, supports mold growth, dissolves pigments and finishes, and may deposit chemicals and fuels onto objects, causing other forms of secondary damage.

Water damage can occur many ways in buildings. Most of these will be the result of a break in a water or steam pipe. Normally, this should cause no problem, because most rooms used have floor drains that will allow extraction of any water. However, floodwater might affect laboratory, office or repository materials before reaching the floor drains. This can occur if a steam pipe would break in the space above the affected objects. Floor drains might back up and flood the floor level.

POWER FAILURE
In the event of commercial power failure, the emergency lighting in the main hallway should come on in about 10-15 seconds. During the normal workday, ALLIANCE will be aware of any power failure immediately.

After hours and on weekends and holidays, the building maintenance staff should be notified. NOTE: Exit lights work only with commercial or battery power. If both fail, nothing in the building will work.

BOMB THREATS
All bomb threats MUST be taken seriously. In the event of a bomb threat, the person receiving the call should do the following.

- Remain calm.
- Do not try to transfer the call.
- Ask the caller the following questions:
  - When is the bomb going to explode?
  - Where is it right now?
  - What type of bomb is it?
  - What does it look like?
  - What will cause it to explode?
  - Did you place the bomb? Why?
  - What is your address?
  - What is your name?
- Notify the police department by calling or texting "911"
- The Floor Warden should notify ALLIANCE officials.

NOTE: The building staff may be asked to search public areas.

Do not touch suspicious objects!

Additional instructions

- If the caller is familiar with the building and specific about the location of the bomb, the call should be regarded with a high degree of urgency.
- The management office will advise the other tenants, as appropriate, that a bomb threat has been made on the building.
- Emergency instruction or false alarm will be phoned to the Floor Warden.
- Tenants are not encouraged to leave their office except at the direction of the Police or the Fire Department, although it is up to the tenant to make the decision.
- If you are to evacuate, please take purses and briefcases out of the building with you to facilitate the search for the unusual item. Follow the directions of your Floor Warden during the evacuation.

Bomb Threat Report
In addition to the questions to be asked, document the following information to the best of your ability.

Background information:
Sex of caller: Race: Age:
Length of call: min. Number at which the call is received:

Time ☐ am ☐ pm Date:

Callers Voice:

☐ Calm	☐ Clearing throat	☐ Slurred	☐ Raspy
☐ Excited	☐ Deep breathing	☐ Nasal	☐ Rapid
☐ Soft	☐ Cracked voice	☐ Normal	☐ Deep
☐ Laughter	☐ Angry	☐ Stutter	☐ Ragged
☐ Distinct	☐ Slow	☐ Loud	☐ Crying
☐ Lisp	☐ Familiar	☐ Disguised	☐ Accent

If voice is familiar, whom did it sound like?

Never discuss a bomb threat with anyone other than the Floor Warden, Security, or your supervisory personnel.

Background Sounds:

☐ Static	☐ Street noise	☐ Music	☐ Motor
☐ Clear	☐ Animal noise	☐ House noise	☐ Local
☐ Voices	☐ PA System	☐ Long distance	☐ Booth
☐ Factory Machinery	☐ Office Machinery	☐ Other	

Threat Language

☐ Foul	☐ Well-spoken (educated)	☐ Irrational	☐ Taped
☐ Coherent		☐ Message read by threat maker	

Remarks:

As SOON AS POSSIBLE, notify the Police at 911.
A bomb threat of any type is to be immediately referred to the Police: Call 911.

If a suspicious object is found or a threat is received after hours or on weekends or holidays, call the Police -- call 911.

Evacuation may be to the designated refuge area, your home, or other location. A Floor Warden or the Fire or Police department shall give direction. Everyone should stay at the designated refuge area until released, to facilitate a roll call.

GUIDE FOR HANDLING BOMB THREATS

Employee responsibilities

Bomb threats to governmental buildings and private companies or equipment are of continuing concern throughout the country. Because of the need for uninterrupted services to the public, everyone should share in the concern for the safety of employees and the security of ALLIANCE offices.

This guide outlines briefly the procedures to follow if a bomb threat of any kind is received by an employee. This procedure is in effect 24 hours a day.

Bomb threat received by telephone

An employee receiving a call that indicates that a bomb has been placed in an Alliance building or equipment should:

1. Get as much information as possible from caller:
    a. Type of bomb
    b. Male or female
    c. Accent or dialect
    d. Background noises
    e. Name and address if possible
    f. Motive for placing bomb
    g. Keep caller talking, notify supervisor if possible and start trace of call
2. After receiving a bomb threat, dial 911 immediately and advise the operator that you have received a bomb threat.
3. Give all available information about the threat and stay on the line unless released by the operator.
4. Fill out bomb threat form while information is fresh in your mind.

Bomb threat received by written message

1. As soon as possible after receiving a bomb threat by note or letter, dial 911. Tell the operator you have received a bomb threat. NOTE: do not handle the message more than necessary so as not to destroy fingerprints or other identifying marks.
2. Give all available information to the operator and stay on the line unless released by the operator.

Suspicious envelope or parcel received by mail

1. If an employee has reason to be suspicious of an envelope or parcel, notify the Floor Warden immediately.
2. Under no circumstances should the employee or supervisor attempt to open or inspect a questionable item.

NOTE: Refer to following page for letter bomb detection guide.

Evacuation of building in event of bomb threat

1. When directed to evacuate, employees will walk, not run, to the nearest available exit.
2. Money, safes, etc., in each office will be secured.
3. Operating machines will be turned off if possible.
4. Security directors and wardens will insure that their section is cleared (restrooms, storerooms, conference rooms, etc.), and floor doors will be closed.
5. The Floor Warden provides for the evacuation of disabled/handicapped employees using the buddy system.

The Police Department is responsible for coordinating bomb searches in ALLIANCE buildings. Floor wardens are responsible for security of their assigned areas. They are responsible for moving personnel away from suspicious objects and for evacuation of part or the entire floor according to the severity of the situation.

LETTER BOMB DETECTION GUIDELINE

Suspicious media should be checked for the following:

1. Address
    a. No return address
    b. Addressed to officer level executive by name, title, or department
    c. Title for the executive is incorrect.
    d. Poorly typed or handwritten address
2. Thickness
    a. Not uniform
    b. For medium-size envelopes, the thickness of a small book and rigid
    c. For large envelopes, bulkiness, an inch or more in thickness
    d. Rigidity
    e. Greater than normal, particularly along its center length
3. Envelopes
    a. Oil stains ("sweating" of plastic explosives).
    b. Appears to have been opened and re-glued, or is taped, or otherwise tampered with
    c. Strange odor
    d. Wires or strings sticking out or attached
    e. Feeling of springiness in the sides, bottom, or top
4. Packages
    a. Excessive use of tape, cord, or both
    b. Not packaged or wrapped in a professional manner
    c. Excessive postage or unusual class of mail
5. Writing
    a. Marked personal, confidential or private
    b. Marked airmail, registered, certified, or special delivery
    c. Misspelled words
6. Stamps
    a. More postage than required to mail the item
7. Postmark
    a. Foreign country
    b. Sent from a small U. S. city or town

8. Move suspicious items to a safe area
    a. Carefully set the item down and make sure it is not touched by anyone
    b. Notify Police Department

HAZARDOUS MATERIALS

Hazardous materials are chemicals or substances that are physically hazardous or present other health hazards, whether the materials are in a usable or waste condition.

Hazardous materials include:

Classification	Hazard
Toxic Chemicals	Can be a gaseous, liquid, or solid and can cause illness or death if not handled properly.
Dangerous Liquids	**Give off vapors that can form an explosive mixture when mixed with air.**
Dangerous Gases	Can be corrosive, combustible, flammable, explosive, poisonous, or all of these.
Explosives	**Mixtures or compounds that can cause an explosion.**
Corrosives	Can destroy living issue and other substances.

How to handle hazardous materials

* Before handling, obtain proper training, read the labels and warnings, and follow all recommended precautions.
* Know what to do if the substance leaks or spills. This information is available on the Material Safely Data Sheet (MSDS). DO NOT attempt to handle leaks or spills without proper training.
* Consider unknown substances hazardous until you can identify their contents.
* Handled carelessly, hazardous substances can cause injury, illness or even death.
* Hazardous substance emergencies can affect large areas and many people.

In case of a spill or leak

- Immediately evacuate the area
- Call the ALLIANCE Safety Committee and give them the following information:
  - Building Name & Address
  - Room Number or Area
  - Other pertinent information about the hazardous emergency
  - Follow their instructions
  - If injuries occur, call the Police Department -- 911 or immediately and provide the same information

HAZARDOUS MATERIAL SPECIAL INSTRUCTIONS

In a hazardous material incident in the building,

1. If the agent is migratory, the entire building must be cleared and secured.
2. If the agent is radiant, move occupants out of range and prohibit proximity.
3. If the agent is stationary, prohibit contact.

If ordered to evacuate, go to your designated Refuge Area, as directed by a Floor Warden, fire or police department, or ALLIANCE official.

Some indications of hazardous material spill are as follows:

1. A liquid giving off an odor when exposed to air.
2. A liquid foaming when spilled.
3. A liquid staining floor or carpeting when spilled.
4. A haze in the air or visible fumes or odors from a spill.
5. Sudden headaches or fainting of several or many occupants.
6. Itchiness, rashes, choking, eye tearing, or runny noses of several or many occupants.

These symptoms may not appear suddenly. They may occur gradually over hours, days, or weeks, depending on the size and type of material. A few, several, all, or none of the occupants may acquire symptoms.
If there is a question as to the status of any material, call the ALLIANCE Safety Committee.

If there is any suspicion about any material that has spilled, clear the immediate area and call the ALLIANCE Safety Committee.

Try to use good judgment about any spill, but above all, play it safe.

Keep in mind that hazardous materials are not used or stored at this facility in significant amounts to constitute a hazardous area. What few materials are used, are in containment areas, and in small amounts. All flammable materials are stored in flame resistant storage cupboards. Eyewash Stations are available for use where most chemical usage occurs. Material Safely Data Sheets (MSDS) of all chemicals used by the ALLIANCE are in room(s), of the Building, and are on file and available for review in Room.

NEVER ATTEMPT TO CLEAN UP A HAZARDOUS SPILL UNLESS YOU HAVE THE PROPER TRAINING AND PROTECTIVE CLOTHING.

HAZARD INDICATORS
Any abnormal, obvious conditions should be reported to the Floor Warden or ALLIANCE immediately.

"Obvious conditions" apply to a smell or scent, sound, or visual observation, by some or all occupants in an area, rather than sensitivity by one person to a specific thing.

Abnormal obvious conditions would be:

- Eye irritation.
- Persistent symptoms or illnesses.
- An odor of gas, sewer, electrical, or another odor.
- A haze in the air.
- Visible dust clouds or fumes.
- A vibration.
- A crack developing in a structural wall, floor, or ceiling.
- An unusual hot spot in a wall, floor, or ceiling.
- Hissing or grating sounds that cannot be explained.
- A sudden pop or bang sound that cannot be explained.
- Any suspected water leaks.
- Anything dripping from the ceiling.
- Dirt or grit falling from the ceiling.

In order to ensure hazardous conditions do not occur, or are corrected as soon as possible, the Floor Warden shall inspect the building at a minimum of once a year. Items needing correction by building staff shall be completed as soon as possible after being noted. Items the building staff cannot correct shall be brought to the attention of the building maintenance staff.

PEST MANAGEMENT
The damage caused to objects by pests is usually irreversible. Once an object becomes infested, the options for eliminating the infestation without further damaging or altering the object are limited. Many of the chemicals traditionally used to manage infestations have been found to damage or somehow alter the material from which the object has been made. Therefore, it is preferable to prevent pests from gaining access to or becoming established. This can be accomplished with an Integrated Pest Management (IPM) program for the building. Through an effective IPM program, those elements essential to pest survival (e.g., food, moisture and habitat) are minimized.
The basic components of any IPM program are monitoring and identification, inspection, habitat modification, good housekeeping, treatment, evaluation, and education. These components are ongoing and cyclical in nature. For the ALLIANCE'S IPM program, these components are used in five activities:

- Determination of Biological Activity.
- Prevention of pests from gaining access to and surviving in the building.
- Establishment of thresholds for pest activity.
- Treatment to modify conditions that permit pest access and survival.
- Action taken when an infestation is discovered.

Determination of Biological Activity
Monitoring is the key to developing an effective IPM Program. Monitoring provides base line information on the biological activity and climate conditions in the building, where the pests are, how they came into the building, and why they are surviving. It can also help to determine strategies to eliminate future access and survival of pests in the building. Finally, monitoring can help evaluate the effectiveness of any treatment.

For basic IPM, there are two types of monitoring: monitoring for pests in the storerooms and environmental monitoring. Environmental monitoring not only provides information critical to the protection of documents against climatic

damage, but also provides information about the interior climatic conditions of the building that might help to support an infestation.

Monitoring for pests is accomplished through the documentation of biological populations within the building. Monitoring relies on the use of a variety of techniques such as direct observation, population sampling, routine inspections and passive trapping. Depending upon the target pest, different techniques are used. Since most insect pests of documents are small, shun people and are nocturnal, one of the easiest ways to document their populations in buildings is to use traps placed throughout the area to be monitored. Traps are passive and denote the presence of pests when no one is present. Traps are also useful because they can document the distribution of the insect population over time.

The most effective all-purpose insect trap currently available is a "sticky" trap commonly known as a "roach motel." These come from a variety of manufacturers and usually in two shapes, a box and a tent. Both shapes consist of cardboard with an adhesive layer tacky enough to catch insects. For a wide variety of insects, the tent-shaped trap may be best. These traps contain a food bait attractant.

Inspect the traps on a regular schedule and record in a logbook or on a form the following information: the trap number, the location of the trap, the date inspected, the species of insects and number of individuals per species found in the trap. Also useful is a notation of the life stage of the species found, unusual conditions (e.g., leaky pipe, maintenance work), and replacement date for a trap. During the initial phase of the monitoring period -- usually the first 3 to 6 months -- inspect the traps weekly.

As the trapping routine becomes more regular, refinements in trap placement and inspection periods can be made depending upon the structure and the evidence found in the traps. An understanding of the biology of the pest will assist in the placement and scheduling for the maintenance of the traps. It is important, however, not to leave the traps unattended too long because the dead insects caught in the trap can become attractive as food sources for other insects and rodents, which may feed on the dead insects in the trap without being caught. Replace traps at least every 2 months, when they become full, or when the adhesive loses its tackiness, whichever comes first.

Another important activity in monitoring for insects is making routine, thorough inspections for insect evidence of all the interior spaces of the structure, including the collections themselves. Gain a familiarity with the structure(s) housing museum collections. At least once a week the following areas should be checked for insects:

- *Window Sills:* Sills are a common repository for insects attracted to light. This is especially important for determining if a carpet beetle problem exists since after pupation, the adults are attracted to light and attempt to go outside to feed on pollen and breed.
- *Door Jambs*: Look for evidence of spider webs. If there are gaps around the doors, insects are likely to enter the building through these gaps. Spiders are likely to spin their webs so they can trap any insects entering the building through the gaps.

Inspect the storeroom documents at least every six months. Look for cast larval skins of demisted beetles, holes in textiles, piles of woodborer frass developing beneath wooden material. All evidence should be thoroughly documented.

Document what was found, where it was found and when it was found. If possible, identify the species of the insect. Without proper documentation, monitoring is not effective.

The identification of the insect and its life stage are critical to determining what is happening in the areas being monitored. Assistance with identifying insects can be obtained from entomologists through the cooperative Extension Service, U.S. Forest Service, State Departments of Food and Agriculture, and museums of natural history. Monitoring for rodents uses a combination of techniques, including the use of traps. Sticky traps known as glue boards are available for rats and mice. These are usually shallow plastic trays filled with an adhesive onto which the rodent walks and is stuck. In addition, effective for rodents are old-fashioned snap traps that can be baited with cotton batting (an attractive nesting

material, preferable for use in buildings to food bait, which can attract insects). Inspections using a variety of tools are also part of a rodent monitoring program.

ACTION TO TAKE WHEN AN INFESTATION IS DISCOVERED

If an infestation is discovered in the building, immediately initiate the below listed actions. These actions include steps to isolate and identify the infestation, develop a treatment strategy, and review the effectiveness of the existing IPM.

Isolating and Identifying the Problem

A. Isolate the infested material: Heavy polyethylene plastic (6-mill minimum) is useful. Small objects can be placed in re-sealable bags (e.g., Ziploc bags). For larger objects, a polyethylene tent can be made using tape or heat-sealing equipment. Make sure the plastic is completely sealed.
B. Identify the pest.
C. Based on the habits of the pest, determine the extent of the infestation. Start at the site where the first infested object was found and inspect the collections/areas in ever-widening circles. Isolate infested material as it is found and document the findings.
D. Determine the source of the problem. If the problem is structural, make structural repairs to the building. If infested material was brought into the building, evaluate and modify the policies and procedures that permitted this to occur.

Treating the Problem

E. Develop a treatment strategy. A treatment strategy includes the following steps.
   1. Identify the pest and the stage in its development that is found on the materials.
   2. Identify the media of the infested material (e.g., what is the material composition of the object/specimen?).
   3. Based on an understanding of the biology of the pest, their life stages when found, and the material of the object, answer the following questions:
      - Can you disinfect the infested material through removing the pest?
      - Are eggs present?
      - What is the least damaging approach to treatment?
   4. Treatment decisions must incorporate the identification of the pest, the infested materials, and the condition of the object. Choose an effective treatment that will cause the least amount of damage to the object and to the environment. Treatment options range from simple cleaning to fumigation.
   5. Document treatments made. After treatment, clean the objects, with all the removable evidence of the infestation documented and removed, and any pest damage documented and added to the building records.
   6. Evaluate the treatment to determine if it was effective.

Reviewing IPM Program

F. Review the established IPM Program to determine how it can be modified to prevent a similar infestation from occurring in the future.
G. As necessary, modify the IPM procedures. Document any modifications.

CIVIL DISTURBANCE

1. In a building, or on any floor, actually involved:
   A. Notify the Floor Warden immediately.
   B. Secure records, disconnect office machines, and lock doors, time permitting.
   C. Report suspected presence of incendiary or explosive materials to Floor Warden.
   D. Avoid contact with dissident parties.
   E. If order is given to evacuate floor or building, remove handicapped and injured persons first.

2. Near a building or on a floor not actually involved:

A. Notify Floor Warden immediately.
B. Remain in your office or area for further instructions.
C. Be alert for suspect persons in your area.

3. In the event of an explosion in an area already evacuated, report the occurrence to your Floor Warden and do not reenter the area until cleared to do so.

4. As soon as possible, the Floor Warden will notify the security director at building operations.

Safety and security are basic responsibilities of every building occupant.

If you see something unsafe that is within your power to correct, do so. If not, at least call someone to get it fixed. The key to security is awareness. Be aware of what is going on around you always. A door ajar, a window unlocked, a light off that should be on, a stranger's actions, are only a few signals. If you ever notice a peculiarity in an otherwise normal situation, call someone.

VIOLENCE IN THE WORKPLACE

Violence in the workplace can happen anywhere resulting in a multitude of negative outcomes such as property damage, loss of work time and even death. Everyone deserves a safe workplace. We cannot create a flawless job site; however, by taking precautionary steps we can help reduce the possibility of violence by making all employees more aware of this alarming occurrence.

ALLIANCE is cognizant of its responsibility to provide a safe work environment. While respecting individual rights is important, priority certainly must be given to the safety and welfare of all employees. It is for this reason ALLIANCE has instituted the following conditions:

1. All employees, with the exception of law enforcement personnel, are strictly prohibited from possessing deadly weapons while occupying any facility owned, leased or rented by any ALLIANCE entity. This also applies to ALLIANCE motor vehicles and any other equipment. A "Deadly weapon" includes but is not limited to a firearm, explosive or incendiary material, or other device or substance, which in the manner it is used or is intended to be used is reasonably capable of producing death or serious bodily injury." Any employee found to be in violation of this directive will be subject to disciplinary action for any or all of the following: Insubordination, Misconduct, and Unsatisfactory Work Performance. ALLIANCE will use all available resources in determining and applying appropriate disciplinary action.
2. Employees communicating threats to other employees, clients, vendors or constituents will be subject to disciplinary measures for any or all of the following: Insubordination, Misconduct, and Unsatisfactory Work Performance. All management positions are responsible for insuring incidents of this nature are reported to the Human Resource Director immediately. At that time, the Human Resource Director will conduct an investigation of such occurrence prior to any disciplinary action. Information will be sought from all known parties.
3. If threats are communicated by clients or constituents, employees should not respond in kind. Remain calm and assuming the threat is verbal in nature, contact your supervisor and/or the section manager and division administrator. If the conflict involves a weapon in the building or elsewhere at ALLIANCE, contact the Police Department immediately. Division administrators should make sure each office site is familiar with this process. If escalation occurs, evacuate the building using the plans presented above. Staff awareness is of great importance. Natural disaster evacuation plans should serve hostile action as well.

SHUT DOWN PROCEDURES

Shut down procedures are steps taken when a severe loss temporarily closes all or part of an organization’s facilities. Standard shut down procedures that apply when the facility needs to be routinely closed for such things as maintenance, vacations, anticipated labor union strikes, or model changeovers. The purpose of these non-disaster shutdown procedures is to protect the facilities from damage or deterioration and to be able to resume production with minimal time.

The same goals and actions of other disaster procedures should be the basis for disaster shutdown procedures, with the added constraints that the disaster might shorten the time available for an orderly shutdown and that the damage created by the disaster might preclude desirable shutdown procedures.

Highest priority should go to shutdown procedures that, it not taken, would cause greater loss of future ability to operate. The next priority is often the safeguard property loss against fire, theft, vandalism, or other causes of loss which would idle; unoccupied properties tend to be particularly susceptible. Another priority is to notify customers and suppliers (including utility companies) of the shutdown so they can find alternative sources or cease their own supply activities.

One necessary part of shutdown procedures is to inform employees of the status of the premises and of their continuing employment status and benefits. To promptly reopen the facilities, personnel must be ready to return to work. In addition, some personnel might be required to enter the premises after it has been shut down to inspect production machinery or to verify that fire and burglar alarms remain operational. A procedure should be established for admitting only authorized personnel to the premises during the shutdown and for documenting their entry and exit. It might also be appropriate to station guards (the organizations own employees or hired guards) at the perimeter of the premised, particularly if looting, vandalism, or sabotage is significant dangers.
Transferring operations to temporary substitute facilities becomes as essential aspect of the disaster recovery response. The disaster recovery plan must therefore include (1) and early and ongoing senior management evaluation of whether the organization can continue operating on its primary premises or whether it must transfer to some other location and (2) of recovery plans that provide for a tolerable brief shutdown should include procedures for relocating to temporary facilities.

NO TEST FOR THIS SECTION, SIGN AND RETURN SIGNATURE PAGE LABELED "EMERGENCY PREPAREDNESS" PACKET B

2260 Cliff Road
Eagan, MN 55122
P: 651.895.8030 F: 651.895.8070

VULNERABLE ADULTS AND MALTREATMENT OF MINORS

INTRODUCTION
In our community, there are adults experiencing maltreatment who need our help. Examples of maltreatment include abuse, neglect and financial exploitation. To help them find safety and security, the community needs to know about these problems and what to do about it.

This training is designed to help you learn more about the maltreatment of vulnerable adults and what you can do to help. If you are a mandated reporter, it will help you learn more about your duty to report suspected maltreatment. If you are a relative, friend, neighbor, or other interested person, this training will help you understand the adult protection system and assist you in finding protective services for someone in need.

Anyone of us may need protective services at some point in life. As you help your vulnerable clients, relatives, friends and neighbors, remember that you are strengthening a system that you too may need.

DEFINITIONS
Who is a vulnerable adult?
A “vulnerable adult” is any person, 18 years of age or older, who is a resident or patient of a facility such as a hospital, group home, nursing home, day service facility, day activity center, adult foster care home, or a person who receives services during the day from an agency that is licensed/certified by the Minnesota Department of Human Services or the Minnesota Department of Health such as a home care agency or a personal care services.

A vulnerable adult also includes a person who, regardless of where they live or what type of services they receive, possess a physical or mental infirmity or other physical, mental, or emotional dysfunction that impairs the individual’s ability to provide adequately for their own care without assistance **AND** because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect themselves from maltreatment.

Who is a minor?
A “minor” is any person, 17 years of age or younger, which in MN legally demarcates childhood from adulthood.

Conservatorship
Conservatorship is when legal proceeding in which one person is appointed to act as a substitute decision-maker for another person. Conservatorship does not presume that the incapacitated person is incompetent in all areas of his/her life. It can be tailor-made to meet the needs of the individual. Additionally, persons under conservatorships can be voluntary or involuntary and can be of the person and/or estate.

Guardianship
Guardianship is when legal proceeding in which a person is appointed to act as a substitute decision-maker for another person. This is the most restrictive option. A person under guardianship loses **all** rights. The guardian becomes responsible for all aspects of the incapacitated person’s life.

MALTREATMENT
1. **Neglect**
    - Failure or omission by caregiver to provide for basic needs such as: food, health care, clothing, shelter and supervision
    - Neglect may be committed by: caregiver or self

- It is not neglect for an authorized person to make decision in good faith to give or withhold health care, feeding or spiritual means of healing
- It is not neglect for a vulnerable adult to make decision on their own behalf which place them at risk when they understand the consequences of the decision
- Criminal penalties are in effect for some kinds of neglect

2. **Abuse**
    - Conduct producing pain or injury: verbal abuse, hitting, slapping, kicking, corporal punishment, etc., Rule 40 violations (unauthorized use of aversive or deprivation procedures for persons with mental retardation or developmental disabilities), involuntary confinement, deprivation, chemical restraints, assault, sexual abuse
    - Use of drugs to injure or facilitate a crime
    - Promotion of prostitution
    - Staff/facility sexual contact: unless pre-existing consensual sexual relationship, unless consensual sexual relationship with a Personal Care Attendant (PCA)
    - Criminal penalties now are in effect for abuse

3. **Financial Exploitation**
    - When there is a legal financial relationship (such as Guardians, Power of Attorney, Conservators): unauthorized use of a vulnerable adult and/or minor's money or assets, failure to use a vulnerable adult and/or minor's money and assets resulting in harm to the vulnerable adult/minor
    - In absence of legal authority: willful use, withholding or disposal of a vulnerable adult/minor's money and assets, obtaining control of a vulnerable adult/minor's money and assets by fraud, coercion or harassment
    - There are criminal penalties for financial exploitation

REPORTING
"Mandated Reporters" include professionals or professional delegates while engaged in "the care of vulnerable adults and/or minors." Some of the professions identified as mandated reporters include: law enforcement, education and most health-care related professional including nursing home administration, nursing, medicine, social work and psychology.

A mandated reporter who has reason to believe a vulnerable adult and/or minor is being or has been maltreated, or has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately (within 24 hours) report.

ANY employee or volunteer of a public or private facility or agency caring for vulnerable adults, including employees not generally involved with patient care (maintenance and food services staff, etc.) must comply with this law.

ANY person concerned about the well-being of a vulnerable adult and/or minor may report known or suspected maltreatment.

Where do I report maltreatment?
Any incident of known or suspected maltreatment of a vulnerable adult should be reported either internally to HR or the DON, or to MAARC (Minnesota Adult Abuse Reporting Line). MAARC is reachable 24/7/365 at 1(844) 880-1574. You can also make an online report by visiting mn.gov/dhs/reportadultabuse/. Nothing in the law prevents a reporter from also reporting to a law enforcement agency. Any incident of known or suspected maltreatment of a child should be reported to the police department for the city in which the incident was witnessed or suspected to have taken place.

A mandated reporter may also fulfill their reporting requirements by reporting internally, to their RN Case Manager. Any employee can choose the course of action they think is best – reporting internally, externally or both – as long as the report is made immediately (within 24 hours of suspicion of maltreatment).

A mandated reporter may meet the reporting requirements by reporting to an internal reporting system; however, the facility remains responsible for complying with immediate reporting requirements. A facility may not prohibit a mandated reporter from reporting externally and is prohibited from retaliating against a mandated reporter who reports in good faith.

How do I report suspected maltreatment and is my report confidential?
Mandated reporters must make oral reports to MAARC or through their internal reporting system. To the extent possible, all reporters should be prepared to identify the vulnerable adult/minor and the caregiver; the nature and extent of the suspected maltreatment; and any evidence of previous maltreatment; the time, date and location of the incident; and other information regarding the situation.

Written reports are no longer required, nor are they a substitute for a call to MAARC.

The identity of the reporter may not be released unless the reporter has given consent or by a court order.

Are there any exemptions from the reporting requirements?
Federal law specifically prohibits release of patient-identifying information without patient consent in certain federal-funded programs such as chemical dependency programs.

Resident to resident physical or verbal abuse, of self-abusive behavior not causing serious harm.

Accidents: sudden, unforeseen and unexpected event which is not likely to occur, event which could not have been prevented by exercise of due care, when caregiver/facility is in compliance with relevant rules and laws.

Individual's single mistake: when providing therapeutic conduct, no injury or harm which reasonably requires care of physician or mental health professional, if reported internally and documented for outside review

What is the penalty for failing to report suspected maltreatment?
If you are mandated by law to report suspected maltreatment and negligently or intentionally fail to report, you can be held liable for any damages or harm caused by your failure to report the maltreatment. There are also criminal charges for failure to report.

Are there protections for reporting maltreatment?
Immunity from civil or criminal liabilities for good faith reports. Identity of reporter is not released without consent of the reporter or by a court order. There are penalties for retaliation against reporter. There is civil protection for good faith investigation activities.

What happens when a report is filed?
If MAARC determines maltreatment to a vulnerable adult or minor has occurred, the report will be referred to either the county where the abuse occurred, the Minnesota Department of Health or the Minnesota Department of Human Services. Law enforcement may also be contacted if there is reason to believe criminal activity has taken place.

What are the penalties for adult maltreatment?
An individual may:
- Lose the right to work in a facility or agency
- Lose professional license
- Be subject to criminal penalties

What are some of the protective services available to vulnerable adults?

- A restraining order
- A court order for removal of the perpetrator from the residence of the vulnerable adult
- The appointment of a guardian or conservator by a court
- The replacement of a guardian or conservator suspected of maltreatment
- A referral to the prosecuting attorney for possible criminal prosecution of the perpetrator

Adult and Child Protection Workers cannot solve every problem. Even vulnerable adults have the right to make decision, possibly bad ones. Protection workers may follow an individual case for months before they are able to establish a pattern and intervene in the person's best interests.

HELPFUL TIPS

The following is a list of tips to help individuals safely maintain their independence in the community:

1. Learn about and utilize resources
    - Home care agencies, social contacts, community and public health agencies
    - Crime prevention activities
    - Banks and banking services (assistance in balancing chickening and savings accounts)
    - Physician, physician's assistants, nurse practitioners
    - Church and ministerial services
    - Mental health services
2. Keep accurate and complete records of your time spent with the client
3. Keep valuables put away
4. Do not sign documents without the advice of an attorney, advocate, or trusted friend
5. Keep involved with social activities (church, friends, social clubs, etc.)
6. Develop a "buddy system"
    - Make use of a weekly or daily contact by telephone or face-to-face visit with a friend or several friends
7. Do not leave your home unattended or unlocked or leave messages on your door
8. Review your Will periodically
9. Do not accept personal care in return for a transfer of property or assets unless you have a trusted person (lawyer or advocate) act as a witness
10. Do not give up control of your property/assets unless YOU decide you cannot manage them any longer.

TEST FOR THIS SECTION IS LOCATED IN PACKET B UNDER "VA AND MOMA"

HOME CARE BILL OF RIGHTS

PER MINNESOTA STATUTES, SECTION 144.A.44, EXCEPT LANGUAGE IN BOLD PRINT WHICH REPRESENTS ADDITIONAL CONSUMER RIGHTS UNDER FEDERAL LAW. TO BE USED BY MEDICARE CERTIFIED AGENCIES.

Statement of Rights

A person who receives home care services has these rights and the provider must provide for the following rights:

*Provider means Medicare Certified Home Health Agency or HHA
*Client means Patient
1. The provider must provide written information about rights during the initial visit, and in advance of the provider furnishing care to the client. The written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities, including what to do if rights are violated.

2. The provider must provide contact information of the provider's administrator, including the administrator's name, business address, and business phone number in order to receive complaints.

3. The provider must provide verbal notice of the client's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary.

4. The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services.

5. The right to be told before receiving services and the right to participate in, be informed about, and consent or refuse care in advance of and during treatment, with respect to:

   a. Other choices that are available for addressing home care needs and the potential consequences of refusing these services.
   b. Completion of all assessments.
   c. The care to be furnished, based on the comprehensive assessment.
   d. Establishing and revising the care plan.
   e. The disciplines that will furnish care.
   f. The frequency of visits.
   g. Expected outcomes of care, including client-identified goals, and anticipated risks and benefits.
   h. Any factors that could impact treatment effectiveness.
   i. Any changes in the care to be furnished.

6. The right to be told in advance of any recommended changes by the provider in the service plan and to take an active part in decisions about changes to service plan.

7. The right to receive all services outlined in the plan of care.

8. The right to refuse service or treatment.

9. The right to know, before receiving services or during the initial visit, any limits to the services available from a home care provider.

10. The right to be told, before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs or other sources including Medicare and Medicaid, or any other Federally-funded or Federal aid program known by the provider, if known; what charges the client may be responsible for paying, and any changes to payment information as soon as possible, in advance of the next provider visit.

11. The right to know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.

12. The right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, or other health programs.

13. The right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information, including an Outcome and Assessment Information Set (OASIS) privacy notice for all clients for whom the OASIS data is collected.

14. The right to access the client's own records and written information from those records in accordance with sections 144.291 to 144.298.

15. The right to be served by people who are properly trained and competent to perform their duties.

16. The right to be treated with courtesy and respect, and to have the client's property treated with respect.

17. The right to be free from verbal, mental, sexual and physical abuse, including injuries of unknown source, neglect, financial exploitation/misappropriation of property, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.

18. The right to reasonable, advance notice of changes in services or charges, in advance of a specific service being furnished, if the provider believes that the service may be noncovered care, or in advance of the provider reducing or terminating on-going care.

19. The right to know the provider's reason for termination of services.

20. The right to be informed of the provider's policies and procedures for transfer and discharge, in a language that the client can understand, and is accessible to individuals with disabilities, within 4 business days of the initial evaluation visit. The provider may only transfer or discharge the client if:

a. The transfer or discharge is necessary for the client's welfare because the provider and the physician who is responsible for the plan of care agree that the provider can no longer meet the client's needs, based on the client's acuity. The provider must arrange a safe and appropriate transfer to other care entities when the needs of the client exceed the providers' capabilities;

b. The client or payer will no longer pay for the services provided;

c. The transfer or discharge is appropriate because the physician who is responsible for the plan of care and the provider agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the provider and the physician who is responsible for the plan of care agree that the client no longer needs the services;

d. The client refuses services, or elects to be transferred or discharged;

e. The provider determines, under a policy set by the provider for the purpose of addressing discharge for cause that meets the requirements of this section, that the client (or other persons in the client's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the client or the ability of the provider to operate effectively is seriously impaired.

The provider must do the following before it discharges a client for cause:
1. Advise the client, representative (if any), the physician(s) issuing orders for the plan of care, and the client's primary care practitioner or other health care professional who will be responsible for providing care and services to the client after discharge from the provider (if any) that a discharge for cause is being considered;
2. Make efforts to resolve the problem(s) presented by the client's behavior, the behavior of other persons in the client's home, or situation;
3. Provide the client and representative (if any), with contact information for other agencies or providers who may be able to provide care; and
4. Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records;

f. The client dies; or
g. The Provider agency ceases to operate.

21. The right to at least ten days' advance notice of the termination of a service by a provider, except in cases where:
a. The client engages in conduct that significantly alters the terms of the service plan with the home care provider;
b. The client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or
c. An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

22. The right to a coordinated transfer when there will be a change in the provider of services.

23. The right to complain about services, treatment or care provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property. The right to be advised of the MN Adult Abuse Reporting Center (MAARC), that its purpose is to receive complaints and the state toll free home health telephone hot line, its contact information, hours of operation for questions about local providers.

24. The right to know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance.

25. The right to know the name and address and telephone numbers of the state or county agency to contact for additional information or assistance and, if applicable, federally funded entities that serve the area where the client resides. 26. The right to assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation, and be free from any discrimination or reprisal for exercising his or her rights for voicing grievances to the provider or other outside entity.

27. The right to be informed of the right to access auxiliary aids and language services and how to access these services.

Resources
MN ADULT ABUSE REPORTING CENTER (MAARC) (For Complaints) Phone: 1-844-880-1574 STATE TOLL-FREE MEDICARE CERTIFIED HOME HEALTH AGENCY TELEPHONE HOTLINE (For Questions) (Business hours: M-F, 8:00 a.m. - 4:30 p.m., message can be left 24/7)
Minnesota Department of Health Office of Health Facility Complaints 85 East Seventh Place, Suite 220 P.O. Box 64970 St. Paul, Minnesota 55164-0970 Phone: 651-201-4201 or 1-800-369-7994 Fax: 651-281-9796
http://www.health.state.mn.us/divs/fpc/ohfcinfo/contohfc.htm health.ohfccomplaints@state.mn.us
MID-MINNESOTA LEGAL AID/MINNESOTA DISABILITY LAW CENTER (Protection and Advocacy Systems) 430 First Avenue North, Suite 300 Minneapolis, MN 55401-1780 1-800-292-4150 intake number mndlc@mylegalaid.org

MINNESOTA DEPARTMENT OF HUMAN SERVICES (Medicaid Fraud and Abuse-payment issues) Surveillance and Integrity Review Services PO Box 64982 St Paul, MN 55164-0982 1-800-657-3750 or 651-431-2650 (metro) DHS.SIRS@state.mn.us
SENIOR LINKAGE LINE (Aging and Disability Resource Center/Agency on Aging) Minnesota Board on Aging PO Box 64976 St. Paul, MN 55155 1-800-333-2433 senior.linkage@state.mn.us
Centers for Independent Living https://mn.gov/deed/job-seekers/disabilities/partners/cils/ See website for names, addresses and telephone numbers.
KEPRO (Medicare Beneficiary and Family Centered Care Quality Improvement Organization) 5201 West Kennedy Boulevard, Suite 900 Tampa, Florida 33609 Attention: Medicare Beneficiary Complaints 855-408-8557 beneficiary.complaints@hcqis.org
OFFICE OF OMBUDSMAN FOR LONG-TERM CARE PO Box 64971 St. Paul, MN 55164-0971 1-800-657-3591 or 651-431-2555 (metro) MBA.OOLTC@state.mn.us
OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES 121 7th Place East Metro Square Building St. Paul, MN 55101-2117 1-800-657-3506 or 651-757-1800 (metro) Ombudsman.mhdd@state.mn.us
STRATIS HEALTH (Quality Improvement Organization) 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525 Telephone: 952-854-3306 Toll-free: 1-877-STRATIS (787-2847) Fax: 952-853-8503 info@stratishealth.org

Licensee Name: Alliance Health Care Phone: (651) 890-8030 Email: alanaf!alliancehealthcare.com Address: 2260 Cliff Road, Eagan MN 55122 Name/Title of person to whom problems or complaints may be directed: Alana Fiala (Administrator), Shalon Fiala (Qualified Designee) at 651-895-8030, or any Board of Directors at the same number.

A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or providers licensed under sections 144A.43 to 144A.482.
Minnesota Department of Health, Health Regulation Division 85 E. 7th Place PO Box 64970 St. Paul, MN 55164-0970 651-201-4101 www.health.state.mn.us
Rev. 8/15/18 To obtain this information in a different format, call: 651-201-4101.

*** TEST FOR THIS SECTION, IS LOCATED IN PACKET B UNDER "HOME CARE BILL OF RIGHTS" IN PACKET B***

2260 Cliff Road
Eagan, MN 55122
P: 651.895.8030 F: 651.895.8070

GRIEVANCE POLICY

POLICY:

It is the policy of Alliance Health Services to ensure that people served by this program have the right to respectful and responsive services. We are committed to providing a simple complaint process for the people served in our program and their authorized or legal representatives to bring grievances forward and have them resolved in a timely manner.

Definition: Grievances may be related but not limited to: Treatment of care, Maltreatment, neglect or verbal, mental, physical or sexual abuse. Misappropriation of client property by anyone furnishing services on clients behalf of the HHA agency. HHA is responsible for asking the necessary questions to determine cause of any injuries including injuries of unknown sources.

PROCEDURE:

A. Service Initiation

A person receiving services and their case manager will be notified of this policy, and provided a copy, within five working days of service initiation.

B. How to File a Grievance/Complaint

1. The person receiving services or person's authorized or legal representative:
    a. should talk to a staff person that they feel comfortable with about their complaint or problem;
    b. clearly inform the staff person if they are filing a formal grievance or just an informal complaint or problem; and
    c. may request staff assistance in filing a grievance.
2. DON/Clinical Manager to fill out grievance/complaint form with any grievances or complaints verbalized by clients
3. If the person or person's authorized or legal representative does not believe that their grievance has been resolved they may bring the complaint to the highest level of authority in the program, the Board of Directors; they can be reached at 2260 Cliff Road, Eagan MN or at 651-895-8030.

C. Response by Alliance

1. Upon request, staff will provide assistance with the complaint process to the service recipient and their authorized representative. This assistance will include:
    a. the name, address, and telephone number of outside agencies to assist the person; and
    b. responding to the complaint in such a manner that the service recipient or authorized representative's concerns are resolved.
2. Alliance will respond promptly to grievances that affect the health and safety of service recipients.
3. All other complaints will be responded to within 14 calendar days of the receipt of the complaint.
4. All complaints will be resolved within 30 calendar days of the receipt.
5. If the complaint is not resolved within 30 calendar days, Alliance will document the reason for the delay and a plan for resolution.
6. Once a complaint is received, Alliance is required to complete a complaint review. The complaint review will include an evaluation of whether:
    a. related policy and procedures were followed;
    b. related policy and procedures were adequate;
    c. there is a need for additional staff training;
    d. the complaint is similar to past complaints with the persons, staff, or services involved; and
    e. there is a need for corrective action by the license holder to protect the health and safety of persons receiving services.

7. Based on this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.
8. Alliance will provide a written summary of the complaint and a notice of the complaint resolution to the person and case manager that:
    a. identifies the nature of the complaint and the date it was received;
    b. includes the results of the complaint review; and
    c. identifies the complaint resolution, including any corrective action.

D. The complaint summary and resolution notice must be maintained in the person’s record.

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OMBUDSMAN & ADVOCACY SERVICES

What Is the Office of Ombudsman for Long-Term Care?
A program of the Minnesota Board on Aging, the Office advocates for person-directed living, throughout the health care continuum, which respects individual values and preferences and preserves individual rights.

Regional ombudsmen and volunteers, work with consumers, citizens, nursing homes, hospitals, home care and social service agencies and public agencies to enhance the quality of life and services for individuals receiving health care and supportive services at home, in hospitals, in nursing homes and boarding care homes, and in other community settings such as housing with services (assisted living, customized living), adult foster care and adult day centers.
The Office also works to enhance the quality of life and services for consumers by advocating for reform in the health care and social services delivery systems through changes in state and federal law and administrative policy.

What Is An Ombudsman?
An ombudsman is an independent consumer advocate. Ombudsmen investigate complaints concerning the health, safety, welfare and rights of long-term care consumers, work to resolve individual concerns, and identify problems and advocate for changes to address them, at no charge to the consumer. Ombudsmen also offer information and consultation about nursing home, boarding care home, housing with services, assisted living, customized living, home care and hospital services, rights and regulations. Additionally, ombudsmen work with providers of long-term care services to promote a culture of person-directed living.

Who Do The Ombudsman Serve?

- Residents of nursing homes and boarding care homes
- Residents of other adult care homes (i.e., housing with services, assisted living, customized living or foster care)
- Persons receiving home care services
- Medicare beneficiaries with hospital access or discharge concerns
- Anyone seeking consultation about long-term care services

How Does The Ombudsman Help?
Ombudsmen provide information and consultation about consumer rights and the regulations that apply to long-term care facilities, home and community-based settings, and home care services.

Ombudsmen help to resolve disputes between consumers and providers of long-term care services, regardless of where those services are provided.

Ombudsmen handle complaints and problems relating to:

- Quality Care/Services
- Quality of Life
- Rights Violations
- Access to Services
- Service Termination
- Discharge or Eviction
- Public Benefit Programs

More About the Ombudsman
The Office of Ombudsman for Long-Term Care makes available an annual report in order to provide comprehensive information about the Ombudsman Program; the consumer's the Ombudsman serve through complaint investigations, program activities such as Ombudsman presence in facilities, measuring outcomes, and recognizing the importance of volunteers to accomplish our mission.

In 2012, the Legislature directed the Minnesota Board on Aging's Office of Ombudsman for Long-Term Care to:

1) Research the existence of differential treatment based on source of payment in assisted living settings;
2) Convene stakeholders to provide technical assistance and expertise in studying and addressing these issues, including but not limited to consumers, health care and housing providers, advocates representing seniors and younger persons with disabilities or mental health challenges, county representatives, and representatives of the Departments of Health and Human Services; and
3) Submit a report of findings to the legislature with recommendations for the development of policies and procedures to prevent and remedy instances of discrimination based on participation in or potential eligibility for medical assistance.

How Is an Ombudsman Reached?

The state office staff and the regional ombudsmen serving the 7-county metropolitan area are located in the Office of Ombudsman for Long-Term Care's state office in downtown St. Paul, Minnesota. Nine regional offices are located statewide.

The Ombudsman toll-free number is: 1-800-657-3591 (TDD/TTY, please call 711). This toll-free number operates out of the state office. The local phone number is (651)431-2555. When calling for an ombudsman in any region, you will be directly transferred to that Ombudsman.

The Ombudsman can additionally be contacted by letter at:
Office of Ombudsman for Long-Term Care
P.O. Box 64971
St. Paul, MN 55164-0971

Consider Volunteering with the Ombudsman's Office

Volunteer Advocates and Volunteer Associates are trained visitors and problem-solvers who work in local nursing homes, housing with services residences and assisted living residences. Call the Office for information.

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ALZHEIMER'S & DEMENTIA

ALZHEIMER'S DISEASE

Alzheimer's (AHLZ-high-merz) is a disease of the brain that causes problems with memory, thinking and behavior. IT is not a normal part of aging. Alzheimer's gets worse over time. Although symptoms can vary widely, the first problem many people notice is forgetfulness severe enough to affect their ability to function at home or at work, or to enjoy lifelong hobbies. The disease may cause a person to become confused, get lost in familiar places, misplace things or have trouble with language. It can be easy to explain away unusual behavior as part of normal aging, especially for someone who seems physically health. Any concerns about memory loss should be discussed with a doctor.

More than 5 million American's have Alzheimer's disease, which is the most common form of dementia accounting for 60 to 80% of all cases. That includes 11% of those age 65 and older, and one-third of those 85 and older. The disease also impacts more than 15 million family members, friends and caregivers.

DEMENTIA

Dementia is a general term for the loss of memory and other intellectual abilities serious enough to interfere with daily life. There are many types of dementia, a few of which we will cover here.

Vascular Dementia is a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of vital oxygen and nutrients. These changes in thinking skills sometimes occur suddenly following strokes that block major brain blood vessels. It is widely considered the second most common cause of dementia after Alzheimer's disease.

Mixed Dementia is a condition in which abnormalities characteristic of more than one type of dementia occur simultaneously. Symptoms may vary, depending on the types of brain changes involved and the brain regions affected, and may be similar to or even indistinguishable from those of Alzheimer's or another dementia.

Parkinson's Disease Dementia is an impairment in thinking and reasoning that eventually affects many people with Parkinson's disease. As brain changes gradually spread, they often begin to affect mental functions, including memory and the ability to pay attention, make sound judgments and plan the steps needed to complete a task.

Dementia with Lewy Bodies is a type of progressive dementia that leads to a decline in thinking, reasoning and independent function due to abnormal microscopic deposits that damage brain cells.

Huntington's Disease Dementia is a progressive brain disorder caused by a defective gene. It causes changes in the central area of the brain, which affect movement, mood and thinking skills.

Creutzfeldt-Jakob Disease is the most common human form of a group of rare, fatal brain disorders knowns as prion diseases. Misfolded prion protein destroys brain cells, resulting in damage that leads to rapid decline in thinking and reasoning as well as involuntary muscle movements, confusion, difficulty walking and mood changes.

Frontotemporal Dementia (FTD) is a group of disorders caused by progressive cell degeneration in the brain's frontal lobes (the areas behind the forehead) or its temporal lobes (the regions behind the ears).
Normal Pressure Hydrocephalus is a brain disorder in which excess cerebrospinal fluid accumulates in the brain's ventricles, causing thinking and reasoning problems, difficulty walking and loss of bladder control.

Down Syndrome Dementia develops in people born with extra genetic material from chromosome 21, one of the 23 human chromosomes. As individuals with Down Syndrome age, they have a greatly increased risk of developing a type of dementia that's either the same as or very similar to Alzheimer's disease.

Korsakoff Syndrome is a chronic memory disorder caused by severe deficiency of thiamine (vitamin B-1). It is most commonly caused by alcohol misuse, but certain other conditions can also cause the syndrome.

Posterior Cortical Atrophy (PCA) is the gradual and progressive degeneration of the outer layer of the brain (the cortex) located in the back of the head (posterior). It is not known whether PCA is a unique disease or a possible variant form of Alzheimer's disease.

HOW ALZHEIMER'S AFFECTS THE BRAIN

The changes that take place in the brain begin at the microscopic level long before the first signs of memory loss. The brain has 100 billion nerve cells call neurons. Each nerve cell connects to many others to form communication networks. In addition to nerve cells, the brain includes cells specialized to support and nourish other cells.

Groups of nerves have special jobs. Some are involved in thinking, learning and memory. Others help us to see, hear, smell and tell our muscles when to move. Brain cells are like tiny factories. They receive supplies, generate energy, construct equipment and get rid of waste. Cells also process and store information and communicate with other cells. Keeping everything running requires coordination as well as large amounts of fuel and oxygen.

Scientists believe Alzheimer's disease prevents parts of a cell's factory from running well. They are not sure where the trouble starts. But just like a real factory, backups and breakdowns in one system cause problems in other areas. As damage spreads, cells lose their ability to do their jobs and, eventually, die.

THE ROLE OF PLAQUES AND TANGLES

The brains of individuals with Alzheimer's have an abundance of plaques and tangles. Plaques are deposits of a protein fragment called beta-amyloid that build up in the spaces between nerve cells. Tangles are twisted fibers of another protein called tau that build up inside cells.

Though autopsy studies show that most people develop some plaques and tangles as they age, those with Alzheimer's tend to develop far more. They also tend to develop them in a predictable pattern, beginning in the areas important for memory before spreading to other regions. Scientists do not know exactly what role plaques and tangles play in Alzheimer's disease. Most experts believe that they disable or block communication among nerve cells and disrupt processes the cells need to survive.

The destruction and death of nerve cells causes memory failure, personality changes, problems in carrying out daily activities and other symptoms of Alzheimer's disease.

CAUSES AND RISK FACTORS

While scientists know that Alzheimer's disease involves the failure of nerve cells, why this happens in still unknown. However, they have identified certain risk factors that increase the likelihood of developing Alzheimer's.

Age

The greatest known risk for Alzheimer's disease is increasing age. Most individuals with the illness are 65 and older. One in nine people in this age group has Alzheimer's. Nearly one-third of people age 85 and older have Alzheimer's.

Family History

Another risk factor is family history. Research has shown that those who have a parent, brother or sister with Alzheimer's are more likely to develop the disease than individuals who do not. The risk increases if more than one family member has the illness.

Familial Alzheimer's and Genetics
Two categories of genes influence whether a person develops a disease: risk genes and deterministic genes. Risk genes increase the likelihood of developing a disease but do not guarantee it will happen. Deterministic genes directly cause a disease guaranteeing that anyone who inherits one will develop a disorder.

Researchers have found several genes that increase the risk of Alzheimer's. APOE-e4 is the first risk gene identified and remains the one with the strongest impact. Other common forms of the APOE gene are APOE-e2 and APOE-e3. Everyone inherits a copy of some form of APOE from each parent. Those who inherit one copy of APOE-e4 have an increased risk in developing Alzheimer's; those who inherit two copies have an even higher risk but not a certainty.

Rare deterministic genes cause Alzheimer's in a few hundred extended families worldwide. These genes are estimated to account for less than 1% of cases. Individuals with these genes usually develop symptoms in their 40's or 50's.

Latinos and African-Americans
Research shows that older Latinos are about one-and-a-half times as likely as older whites to have Alzheimer's and other dementias. Older African-Americans are about twice as likely to have Alzheimer's and other dementias as older whites. The reason for these differences is not well understood, but researchers believe that higher rates of vascular disease in these groups may also put them at greater risk for developing Alzheimer's.

Other Risk Factors
Age, family history and genetics are all risk factors we can't change. Research is beginning to reveal clues about other risk factors that we may be able to influence. There appears to be a strong link between serious head injury and future risk of Alzheimer's. It is important to protect your head by buckling your seatbelt, wearing a helmet when participating in sports and proofing your home to avoid falls. One promising line of research suggests that strategies for overall healthy aging may help keep the brain healthy and may even reduce the risk of developing Alzheimer's. These measures include eating a healthy diet, staying socially active, avoiding tobacco and excess alcohol, and exercising both body and mind.

Some of the strongest evidence links brain health to heart health. The risk of developing Alzheimer's or vascular dementia appears to be increased by many conditions that damage the heart and blood vessels. These include heart disease, diabetes, stroke, high blood pressure and high cholesterol. Work with your doctor to monitor your heart health and treat any problems that arise.

Studies of donated brain tissue provide additional evidence for the heart-head connection. These studies suggest that plaques and tangles are more likely to cause Alzheimer's symptoms if strokes or damage to the brain's blood vessels are also present.

HOW TO FIND OUT IF IT'S ALZHEIMER'S DISEASE
Not everyone experiencing memory loss or other possible Alzheimer's warning signs recognizes that they have a problem. Signs of dementia are sometimes more obvious to family members or friends. The first step in following up on symptoms is finding a doctor with whom a person feels comfortable. There is no single type of doctor that specializes in diagnosing and treating memory symptoms nor Alzheimer's disease. Many people contact their regular primary care physician about their concerns. Primary care doctors often oversee the diagnostic process themselves. In some cases, the doctor may refer the individual to a specialist such as a:

- Neurologist who specializes in diseases of the brain and nervous system
- Psychiatrist who specializes in disorders that affect mood or the way the mind works
- Psychologist with special training in testing memory and other mental functions

There is no single test that proves a person has Alzheimer's. The workup is designed to evaluate all over health and identify any conditions that could affect how well the mind is working. When other conditions are ruled out, the doctor can then determine if it is Alzheimer's or another dementia. Experts estimate that a skilled physician can diagnose

Alzheimer's with more than 90 percent accuracy. Physicians can almost always determine that a person has dementia, but it may sometimes be difficult to determine the exact cause.

STEPS TO DIAGNOSE

Understanding the Problem

Be prepared for the doctor to ask; what kind of symptoms have occurred, when they began, how often they happen, if they have gotten worse.

Reviewing Medical History

The doctor will interview the person being tested and others close to him or her to gather information about current and past mental and physical illness. It is helpful to bring a list of all the medications a person is taking. The doctor will also obtain a history of key medical conditions affecting other family members, especially whether they may have or had Alzheimer's disease or other dementias.

Evaluating Mood and Mental Status

Mental status testing evaluates memory, the ability to solve simply problems and other thinking skills. This testing gives an overall sense of whether a person; is aware of symptoms, knows the date, time and where he or she is, can remember a short list of words, follow instructions and do simply calculations. The doctor may ask the person his or her address, what year it is or who is serving as president. The individual may also be asked to spell a word backward, draw a clock or copy a design. The doctor will also assess mood and sense of well-being to detect depression or other illnesses that can cause memory loss and confusion.

Physical Exam and Diagnostic Tests

A physician will; evaluate diet and nutrition, check blood pressure, temperature and pulse, listen to the heart and lungs, perform other procedures to assess overall health. The physician will collect blood and urine samples and may order other laboratory tests. Information from these tests can help identify disorders such as anemia, infection, diabetes, kidney or liver disease, certain vitamin deficiencies, thyroid abnormalities, and problems with the heart, blood vessels or lungs. All of these conditions may cause confused thinking, trouble focusing attention, memory problems or other symptoms similar to dementia.

Neurological Exam

A doctor will closely evaluate the person for problems that may signal brain disorders other than Alzheimer's. They physician will also test; reflexes, coordination, muscle tone and strength, eye movement, speech, sensation. The doctor is looking for signs of small or large strokes, Parkinson's disease, brain tumors, fluid accumulation on the brain and other illnesses that may impair memory or thinking.

The neurological exam may also include a brain imaging study. The most common types are magnetic resonance imaging (MRI) or computed tomography (CT). MRIs and CTs can reveal tumors, evidence of small or large strokes, damage from severe head trauma or buildup of fluid. Researchers are studying other imaging techniques so they can better diagnose and track the progress of Alzheimer's.

WHEN THE DIAGNOSIS IS ALZHEIMER'S

Once testing is complete, the doctor will make an appointment to review results and share his or her conclusions. A diagnosis of Alzheimer's reflects a doctor's best judgement about the cause of a person's symptoms, based on the testing performed. You may want to ask the doctor; why is the diagnosis Alzheimer's, where the person may be in the course of the disease, what to expect in the future. Find out if the doctor will manage care going forward and, if not, who will be the primary doctor. The doctor can then schedule the next appointment or provide a referral.

Alzheimer's disease is life-changing for both the diagnosed individual and those close to him or her. While there is currently no cure, treatments are available that may help relieve some symptoms. Research has shown that taking full advantage of available treatment, care and support options can improve quality of life. Consider; how to provide

increasing levels of care as the disease progresses, how the individual and family members will cope with changes in the person's ability to drive, cook and perform other daily activities, how to ensure a safe environment. It is also important to begin making legal and financial plans. A timely diagnosis often allows the person with dementia to participate in this planning. The person can also decide who will make medical and financial decisions on their behalf in later stages.

STAGES OF THE DISEASE

Alzheimer's disease typically progresses slowly in three general stages: mild (early), moderate (middle), and severe (late). The symptoms of Alzheimer's worsen over time, but because the disease affects people in different ways, the rate of progression varies. On average, a person with Alzheimer's lives for to eight years after diagnosis, but can live as long as 20 years, depending on other factors.

Changes in the brain related to Alzheimer's begin years before any signs of the disease. This time period, which can last years, is referred to as preclinical Alzheimer's disease. The following stages provide an overall idea of how abilities change once symptoms appear and should be used as a general guide. Stages may overlap, making it difficult to place a person with Alzheimer's in a specific stage.

Mild Alzheimer's Disease (Early-stage)

In the early stage of Alzheimer's, a person may function independently. He or she may still drive, work and be part of social activities. Despite this, the person may feel as if he or she is having memory lapses, such as forgetting familiar words or the location of everyday objects. Friends, family or neighbors begin to notice difficulties. During a detailed medical interview, doctors may be able to detect problems in memory or concentration.

Common difficulties include:

- Problems coming up with the right word or name
- Trouble remembering names when introduced to new people
- Having greater difficulty performing tasks in social or work settings
- Forgetting material that was just read
- Losing or misplacing a valuable object
- Increasing trouble with planning or organizing.

Moderate Alzheimer's Disease (Middle-Stage)

Moderate Alzheimer's is typically the longest stage and can last for many years. As the disease progresses, the person with Alzheimer's will require a greater level of care. You may notice the person with Alzheimer's confusing words, getting frustrated or angry, or acting in unexpected ways, such as refusing to bathe. Damage to nerve cells in the brain can make it difficult to express thoughts and perform routine tasks.

At this point, symptoms will be noticeable to others and may include:

- Forgetfulness of events or about one's own personal history
- Feeling moody or withdrawn, especially in socially or mentally challenging situations
- Being unable to recall their address or telephone number or the high school or college from which they graduated
- Confusion about where they are or what day it is
- The need for help choosing proper clothing for the season or the occasion
- Trouble controlling bladder and bowels in some individuals
- Changes in sleep patterns, such as sleeping during the day and becoming restless at night
- An increased risk of wandering and becoming lost
- Personality and behavioral changes, including suspiciousness and delusions or compulsive, repetitive behavior like hand wringing or tissue shredding

Severe Alzheimer's Disease (Late-stage)

In the final stage of this disease, individuals lose the ability to respond to their environment, to carry on a conversation and, eventually, to control movement. They may still say words or phrases, but communicating pain becomes difficult.

As memory and cognitive skills continue to worsen, personality changes may take place and individuals need extensive help with daily activities. At this stage, individuals may:

- Require full-time, around-the-clock assistance with daily activities and personal care
- Lose awareness of recent experiences as well as of their surroundings
- Experience changes in physical abilities, including the ability to walk, sit and, eventually, swallow
- Have increasing difficulty communicating
- Become vulnerable to infections, especially pneumonia

TREATING THE SYPTOMS

Currently, there is no cure for Alzheimer's and no way to stop the underlying death of brain cells. But drugs and non-drug treatments may help with both cognitive and behavioral symptoms. A comprehensive care plan for Alzheimer's disease; considers appropriate treatment options, monitors treatment effectiveness as the disease progresses, changes course and explores alternatives as necessary, respects individual and family goals for treatment and tolerance for risk.

Cognitive Symptoms

Three types of drugs are currently approved by the FDA to treat cognitive symptoms of Alzheimer's disease. The first type, cholinesterase (KOH-luh-NES-ter-ays) inhibitors, prevents the breakdown of acetylcholine (a-SEA-til-KOH-lean), a chemical messenger important for memory and learning. By keeping levels of acetylcholine high, these drugs support communication among nerve cells. The second type of drug works by regulating the activity of glutamate, a different messenger chemical involved in information processing. The third type is a combination of cholinesterase inhibitor and glutamate regulator. The effectiveness of the types of treatments varies from person to person. While they may temporarily help symptoms, they do not slow or stop the brain changes that cause Alzheimer's to become more severe over time.

Behavioral Symptoms

Many find behavioral changes like anxiety, agitation, aggression and sleep disturbances to be the most challenging and distressing effect of Alzheimer's disease. These changes can greatly impact the quality of life for individuals living in both family situations and long-term residential care. As with cognitive symptoms of Alzheimer's, the chief underlying cause of behavioral and psychiatric symptoms is the progressive damage to brain cells. Other possible causes of behavioral symptoms include drug side effects, medical conditions, and environmental influences.

HOPE FOR THE FUTURE

The Alzheimer's Associate is the world's largest nonprofit funder of Alzheimer's research. When Alois Alzheimer first described the disease in 1906, a person in the United States lived an average of about 50 years. Few people reached the age of greatest risk. As a result, the disease was considered rare and attracted little scientific interest. That attitude changes as the average life span increased and scientists began to realize how often Alzheimer's strikes people in their 70's and 80's. The Centers for Disease Control and Prevention recently estimated an average person's life expectancy to be 78.7 years.

Today, Alzheimer's is at the forefront of biomedical research, with 90% of what we know discovered in the last 20 years. Some of the most remarkable progress has shed light on how Alzheimer's affects the brain. Better understanding of its impact may lead to better treatments. Scientists are constantly working to advance research. But without clinical research and the help of human volunteers, we cannot treat, prevent or cure Alzheimer's. Clinical trials test new interventions or drugs to prevent, detect or treat disease for safety and effectiveness. Clinical studies are any type of clinical research involving people. Clinical studies can also look at other aspects of care, such as improving quality of life. Every clinical trial or study contributes valuable knowledge, regardless if favorable results are achieved.

HELPLINE

The Alzheimer's Association 24/7/365 Helpline at **1(800) 272-3900** provides free, reliable information and support to all those who need assistance – people with dementia, caregivers, health care professionals and the public. This helpline features confidential care consultation provided by master's-level clinicians who can help with decision-making support,

crisis assistance and education on issues and can help in a caller's preferred language. The helpline also provides referrals to local community programs, services and ongoing support.

TEST FOR THIS SECTION IS LOCATED IN PACKET B UNDER "ALZEIMER'S AND DEMENTIA"

INFECTION CONTROL TECHNIQUES, STANDARDS, & DISEASE REPORTING

WHAT IS UNIVERSAL PRECAUTIONS & INFECTION CONTROL
Taking precautions to protect your clients and yourself. In essence, this means preventing disease transmission by consistently using infection control practices with all patients in all healthcare settings.

BLOODBORNE PATHOGENS
Bloodborne pathogens are capable of causing disease. They can be carried, replicated and/or transmitted in blood or other blood products. Bloodborne pathogens can be found in human blood and other potentially infectious materials (OPIM) and should be considered infectious. They can be carried by people that you serve or by you, the caregiver. So always remember the simplest rule of thumb; "Protect your client from your potential infections and, in turn, you will protect yourself from their potential infections."

HEALTHCARE ASSOCIATED INFECTIONS
The Centers for Disease Control and Prevention (CDC) provides a vast amount of information concerning Healthcare Associated Infections (HAI). The CDC estimates that these account for 1.7 million infections and 99,000 associated deaths each year in American hospitals. Of these infections:

- 32% are urinary tract infections
- 22% are surgical site infections
- 15% are lung infections (e.g. pneumonia)
- 14% are bloodstream infections

Healthcare Associated Infections (HAI) are also known as Hospital-Acquired Infections and as Nosocomial Infections (from the Greek words for "disease" and "to take care of"). These would include;

- Bloodborne pathogens (including HIV/AIDS, Hepatitis B & C)
- MRSA (Methicillin-Resistant Staphylococcus Aureus)
- Pneumonia
- Influenza
- Norovirus
- Varicella (chickenpox), mumps, C. diff (Clostridium Difficile), TB and a host of others

THE BIG THREE
Much of the driving force for the recommendations and regulations regarding HAI has stemmed from concern over these three diseases (though they certainly aren't the only bloodborne pathogen infections with the potential to circulate in healthcare settings):

- HIV/AIDS
- Hepatitis B (HBV)
- Hepatitis C (HCV)

TRANSMISSION OF HAI
Communicable diseases, that is those diseases which are transmitted to a recipient from a host, make their "leap" through one or more of the following pathways:

- Direct physical contact (including touching and sexual means)
- Indirect contact (via fomite on an inanimate object)
- Vector (recipient is bitten by an insect or an animal)
- Fecal-oral (from contaminated food or drink)

- Droplet (expelled through coughing, sneezing, talking)
- Airborne (pathogen hitches a ride on dust or evaporated droplets)

Note that bloodborne pathogens (those in blood or other bodily fluids) may be transmitted by sexual or direct contact through fomites – for example surgical instruments or dried blood on an object.

WHO PROTECTS CAREGIVERS

The answer is YOU, but there are a couple of federal agencies deeply committed to setting standards and regulating healthcare practice for the safety of your clients and you. The CCS has the mission statement of, "To collaborate to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats." In the 1980's, the DCD instigated universal precautions in response to the HIV/AIDS epidemic to prevent the spread of pathogens responsible for diseases such as HIV/AIDS, HBV and HCV. These diseases are transmitted in blood and other bodily fluids containing blood such as semen & vaginal secretions. These precautions also apply to tissues, cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids. Saliva is included if visibly contaminated with blood.

The more recent CDC recommendations are called the "Standard Precautions". Standard precautions combine the major features of Universal Precautions (UP) and Body Substance Isolation (BSI) and are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered.

The Occupational Safety & Health Administration (OSHA) is all about regulating standards of occupational health including those related to injuries, fatalities and illnesses. It is an agency of the US Department of Labor. In 2001, OSHA updated its standards to include "Universal Precautions", making them not just a recommendation but an enforceable set of regulations concerning infections control and bloodborne pathogens in particular.

CONFIDENTIALITY

Whatever you might learn about a patient's health status is private and protected information not to be shared beyond the circle of those involved in the patient's care. The US Department of Health and Human Services have specifics available to those who inquire about information privacy, specifically regarding the Health Insurance Portability and Accountability Act HIPAA). Alliance expects all employees to follow the confidentiality section found in their employee handbook.

PRIMARY CATEGORIES OF PROTECTION

Engineering Controls

Engineering controls aim to isolate or remove the hazard. This includes sharps disposal containers, self-sheathing needles, sharps with sharp injury protection, needleless systems, hand washing sinks being readily available and/or appropriate antiseptic hand cleaner or towelettes.

Work Practice Controls

Work practice controls aim to make protection a habit in the workplace. Hand washing should be done prior to and after each client care interaction, changing gloves with every new care. Again, hand washing should also occur immediately or as soon as feasible after removing gloves or other Personal Protective Equipment (PPE). When washing with soap and water, wet your hands with clean running water and apply soap. Use warm water when available. Rub your hands together to make a lather and scrub all surfaces. Continue rubbing your hands for 15-20 seconds, or imagine singing "Happy Birthday" twice through to a friend. Rinse your hands well under running water. Dry your hands using a paper towel or air dryer. If possible, use your paper towel to turn off the faucet. Hand hygiene should be practiced before contact with a client, before performing an aseptic task (e.g. performing wound care), after contact with the client or objects in the immediate vicinity of the client, after contact with blood or OPIM or contaminated surfaces, when moving from a contaminated body site to a clean body site during patient care, and after removal of PPE.

Alcohol-based hand sanitizers are not effective when hands are visibly dirty or contaminated with blood or fecal matter, as examples. In these instances, washing with antimicrobial soap and water is best. When using alcohol-based hand sanitizer, apply the product to the palm of one hand. Rub your hands together and continue to rub the product over all surfaces of hands and fingers until your hands are dry. When you're able to, it is still advised to use soap and water for a thorough cleaning, even after using alcohol-based hand sanitizer.

Sharps should not be bent, recapped, sheared nor broken. Sharps disposal needs to be done immediately after use and in an appropriate sharps container that is puncture resistant, leak proof and labeled with the Universal Biohazard symbol.

Training facilitator should observe and skill staff out on proper glove application and removal during next step

Personal Protective Equipment (PPE)
Gloves are worn to prevent the health care worker's hands from becoming contaminated with blood or body substances.
Gloves should be worn for:

- Procedures involving direct contact with the blood and body substances of any patient
- Procedures where contact with blood and body substances might be expected to occur
- Procedures involving direct or potential contact with the mucous membranes of any patient
- Procedures involving direct or potential contact with the non-intact skin of any patient
- Procedures involving providing care to a client or in managing equipment when the healthcare worker has cuts, scratches or other breaks in the skin on his or her hands

Sterile gloves should be used for all sterile procedures and for activities that involve contact with areas of the body that are normally sterile. There should be an adequate supply of clean disposable gloves on the standard precautions stations or in other locations that are convenient to each patient's room. Gloves used in patient's care should be worn only for contact with the patient. Once used, gloves must be discarded before leaving the patient's room.

Gloves and other forms of PPE should be discarded in a waste receptacle, unless they are contaminated with blood or OPIUM. The rule of thumb is, if the blood or OPIM could potentially soak through a paper bag (like a lunch sack), it should be discarded in a specified Hazardous Waste bag and not in a traditional waste basket. You will not transport any hazardous nor potentially hazardous materials.

If you are unsure of where to find these items, contact your Staffing Coordinator. All items of PPE are available to all of our staff through Alliance Medical Supply. Please place all orders for PPE at least 5 business days in advance of needing the item(s), so that we are able to order any needed items that might not be actively in stock. It is the responsibility of each Home Health Aide to keep track of their PPE materials and notify their supervisor when they are in need.

REMINDERS
There should be no eating, drinking, applying cosmetics, handling contacts, or touching of the eyes, nose or mouth when there is potential for contact with infectious material. In addition, there should be no storage or food nor drink for human consumption in the same area as storage for human specimens.

It is a job requirement that you protect yourself and your client using Universal/Standard Precautions and Infection Control guidelines. Please remember the rule of thumb, that we will always use protection and treat every situation as if it has a potential for infection.

Remember, it's not always easy to identify the risks or potential risks of infectious diseases. Many infections cannot be seen with the naked eye and require medical testing to be confirmed. Some observations that would be cause for concern, documentation, and discussion with the RN Case Manager include:

- Clinical record review for infectious diseases

- Staff reporting procedures
- Review of data from physician's and medical team
- Identification of symptoms by surveilling the client over time

If you notice any change in your client that might be indicative of a potentially infectious disease, it is your responsibility to document these changes and notify the RN Case Manager immediately. Failure to do so could be considered client neglect. Additionally, if any accident occurs during the provision of services that could result in your health being compromised (e.g. needle stick, contact without use of PPE), it is the expectation that you will notify HR immediately to begin proper procedures for further protection. Our HR Department tracks the occurrence of potential infectious incidents over time to review the viability of our infection control planning and training.

TEST FOR THIS SECTION IS LOCATED IN PACKET B UNDER "INFECTION CONTROL TECHNIQUES, STANDARDS & REPORTING OF COMMUNICABLE DISEASES"

SKIN INTEGRITY

Promoting skin integrity and preventing pressure sores is everyone's responsibility. Alliance's goal is zero pressure sores or areas of skin breakdown on any individual that we serve. This will require quick recognition and interventions when breakdown occurs. After this training, all Home Health Aides will have the knowledge, skills and ability to provide for the needs of even the most vulnerable individuals using a team approach.

Healthy skin is very important! Skin is the largest organ in the body. Skin prevents infection from outside sources entering into the body. The skin protects us from heat, cold and the elements. The skin helps to regulate body temperature and permits the sensations of touch, heat and cold. The skin stores fat and water to help with shock absorption and to prevent dehydration. It is important to have clean, well lubricated skin to prevent skin from breaking down and becoming torn and/or infected. Bathing often and cleaning all parts of the skin with mild soap and water is essential. Applying a lubricating cream or lotion per a health care provider's prescription is important. Inspecting the skin and seeking treatment from a medical professional for changes in the skin can reduce long term complications.

Why do skin infections happen? A number of reasons, including:

- Poor skin hygiene
- Poor housekeeping practices
- Long term use of antibiotics
- Germs transmitted from person to person by direct or indirect contact
- Build up of bacteria and other germs on or within the skin
- Germs get into cracks or breaks in the skin causing infection that can affect the whole body

Pressure sores, also known as pressure ulcers and/or bed sores, are injuries to the skin and underlying tissue resulting from prolonged pressure and/or friction on the skin. Pressure against the skin reduces the blood flow to the skin and nearby tissue, stopping the flow of oxygen. This reduced blood flow causes the skin to redden, then open, causing a wound which can be very deep and difficult to heal. Be aware that there are areas on the bod that are at higher risk of breaking down due to pressure and friction. Common pressure points when lying on their back include heels, tailbones, elbows, shoulders and the back of the head. Common pressure points when lying on their side include ankles, knees, hips, shoulders and ears. Common pressure points when sitting include shoulder blades, buttocks, heels and the ball of the foot.

Friction is the resistance of motion. This may occur when skin is dragged across a surface, such as changing positions. If the skin is moist, the friction is worse and can cause significant skin and tissue damage. Objects that commonly create pressure and friction include splints, rolls, abdominal binders, medical tubing, oxygen tubes, CPAPs, G-tubes, catheters, socks, clothing, sheets, towels, draw sheets when wrinkled or bunched, and hand-held objects.

Who is at risk for pressure sores? A number of individuals, including:

- Those with poor health and/or chronic health conditions
- Individuals who take eight or more medications
- Paralysis, heavy sedation or those who are in a coma
- Individuals who are post-surgery or have recently had a medical procedure where they are not less mobile
- People with fragile skin, skin tears and chronic skin problems
- Older adults
- Those with a lack of sensory perception (spinal cord injuries, neurological disorders, etc.)

- Those experiencing weight loss during prolonged illness
- Individuals who are immobile
- Those with poor nutrition and hydration
- Those with excess skin moisture or with skin dryness
- Bowel and urinary incontinence
- Those with medical conditions such as vascular diseases and diabetes
- Smokers

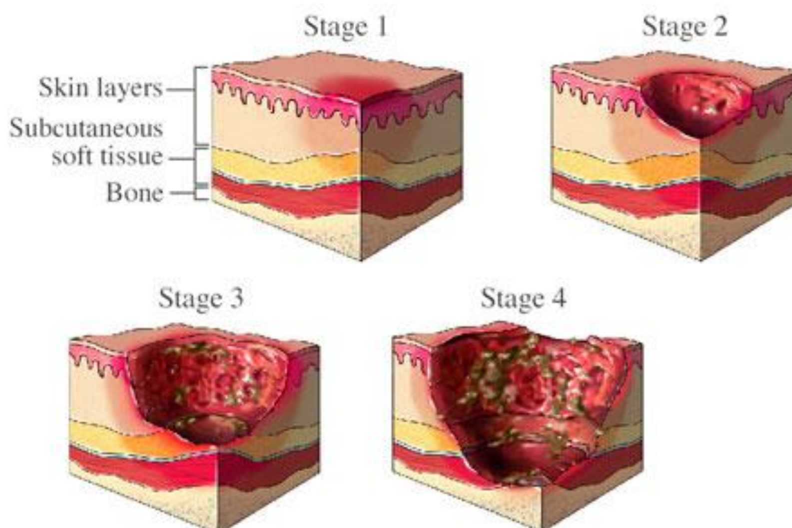
Complications from pressure sores can occur quickly and get worse fast. Cellulitis is an infection of the skin and connected tissues. It can cause severe pain, redness and swelling. People with nerve damage often cannot feel this pain. Cellulitis can lead to life threatening complications. Call your RN Case Manager immediately upon observing any symptoms of possible cellulitis. Infections from these sores can travel into bones and joints. This can damage cartilage and may reduce the function of the joints and limbs.

Sepsis is a severe complication from a skin sore and can lead to death. Sepsis is a complication caused by the body's overwhelming and life-threatening response to an infection, which can lead to tissue damage, organ failure and death. Sepsis is often associated with infections of the lungs (e.g. pneumonia), urinary tract (e.g. kidney), skin and gut. A CDC evaluation found that more than 90% of adults and 70% of children who developed sepsis had a health condition that may have put them at risk. There is no single sign or symptom of sepsis. It is, rather, a combination of symptoms. Since sepsis is the result of an infection, symptoms can include infection signs like diarrhea, vomiting, sore throat, etc. as well as any of the following symptoms:

- Shivering, fever, or very cold
- Extreme pain or discomfort
- Clammy or sweaty skin
- Confusion or disorientation
- Shortness of breath
- High heart rate

If you notice your client is experiencing any of these symptoms, get help immediately by contacting your RN Case Manager for that client and document the observed symptoms.

When skin break down happens, medical professionals talk about it in terms of "Stages". There are different Stages of pressure ulcers. Stage 1 is the least serious and Stage 4 is the most serious condition. Examples of these stages are on the following page.



Stage 1
A persistent area of skin redness that does not disappear when pressure is removed. The skin is not broken and it appears red. Skin my not lighten when lightly pressed or touched. The site may be tender, painful, firm, soft and warm or cool compared to surrounding skin.

Stage 2
The outer layer of skin and the inner layer of skin is damaged or lost. The wound's open area may be shallow and pinkish or red. The wound may look like an abrasion, a fluid-filled blister, or a shallow crater.

Stage 3
The full thickness of skin is lost. The loss of skin usually exposes the fat layer. The ulcer/sore looks like a crater. The bottom of the wound may have yellowish tissue. The damage may extend beyond what you see to below layers of healthy skin.

Stage 4
The pressure sore is very deep, reaching into muscle and bone and causing extensive damage. Damage occurs to deeper tissues, tendons, and joints. This wound will likely have a foul/rotten odor to it.

RN Case Managers are able to complete assessments for individuals and do so before every client enters our program. Part of this assessment is gathering a complete health history and assessing risks for skin integrity based on an individual's health status. If a risk is identified, plans for prevention are put into place.

There are a number of things you can do to prevent sores from occurring. First and foremost, follow all doctor's orders as written. Reposition your clients and encourage them to change positions at minimum every two hours. Use pillows, wedges, and cushions on pressure points to prevent sores. If your client is in a wheelchair, encourage repositioning every 15 minutes (if the wheelchair has a "tilt" function, encourage them to tilt every hour). You can also support the environment that your client is in. Special ordered air mattresses are available to those who are deemed medically necessary. Wedges, cushions and pillows can be ordered by therapists to assist with proper prevention as well. Keep their skin clean and dry – patting the skin dry after cleaning. Apply lotions and ointments as prescribed to promote skin integrity, using a "figure 8" motion with your fingertips. Never massage over an area of skin that is reddened or where there is a skin breakdown. Inspect the skin on every visit and report any changes to the RN Case Manager. Manage incontinence with your client – this will help to keep the affected area clean. Assess wheelchairs and mobility aids on each visit for stability and cleanliness. Inspect cushions for wear and proper placement, inspect brakes, arm resets, foot rests, head rests, wheels and belts and contact Staffing Coordinator if repairs are needed. Make sure that any attachments are clean and in good working order. Encourage a health diet for your clients, including drinking enough fluids.

Prevention and early detection and treatment saves lives and human suffering!

Clearly document any time you notice a potential issue with skin integrity. What did you notice? What did you do? Whom did you contact? What instructions did they give you? How did you implement those instructions? What was the result? If the result was not effective, what did you do? What is your ongoing plan?

TEST FOR THIS SECTION IS LOCATED IN PACKET B UNDER "SKIN INTEGRITY"

WORKING WITH THE DEAF & HARD OF HEARING

More than 1/3 of the US populations have a significant loss of hearing by the age of 65. An estimated 500,000 Deaf & hard of hearing people reside in Minnesota alone. The purpose of this training is for you to gain an understanding of the culture and communication needs of Deaf and hard of hearing individuals and to learn how to provide accommodations and accessible services.

Terminology

What do you call a person who can't hear? Use of appropriate terminology is a good indicator of respect and understanding. Which terminology is appropriate?

- **Deaf** with a "big D" focuses on a group of people who share a language (ASL), common life experiences, a history and values. These individuals are part of Deaf Culture and they associate themselves as such.
- **deaf** with a "little d" focuses on a group of people who have the inability to understand speech with or without amplification. It highlights the association of disability. Many individuals who become deaf later in life associate themselves with this category.
- **Hard of Hearing** refers to those who have some hearing, are able to use it for communication purposes, who feel reasonably comfortable doing so. Often times, hard of hearing individuals have been hearing their entire life up until this point.

Communication and Language

Each individual who is Deaf or hard of hearing will have their own preference for how they like to communicate. We can only know this by asking them their preferences, and respecting their response. It's important to understand the effects of linguistic differences on one's view of the world and ability to communicate. Our education system is based on the English language and isn't often accessible for those who grow up Deaf, speaking ASL. Like many languages, ASL does not always have literal translations into the English language, and vice versa.

Though ASL is the third most used language in the United States, it is purely a visual language while English is a spoken and written language. This requires most Deaf people to be bi-lingual – speaking ASL and reading and writing English. A common misconception is that Deaf individuals or those who are hard of hearing are "rude". There are cultural behaviors that play a role in this that we must understand.

DEAF/HARD OF HEARING	HEARING
Attention getting devices: flickering the lights, stomping their feet, throwing things, etc.	Attention getting devices: "Hey" or "Hello" or using someone's name, pausing music or TV, etc.
Facial expressions: standing close and holding eye contact, using exaggerated emotional expressions	Facial expressions: generally using a "poker face", perhaps smiling and or appearing to concentrate
Pointing is permitted and used often	Pointing is considered "rude"
Hugging after introductions	Shaking hands after introductions
Talks while in the middle of chewing	Talking while chewing is "rude"
Does not talk while driving	Talks to passengers while driving
Interrupts when they can't see someone's lips	Any interruption is considered "rude"

Hard of Hearing
As we get older, we lose our hearing. Some people get an age-related hearing loss earlier than others. Age-related hearing loss is also called Presbyacusis. Statistically, we begin to lose our hearing in our 30s and 40s. Most people with age-related hearing loss first experience a decline in their ability to hear high frequency sounds. Speech contains these sounds, so often the first sign of Presbyacusis is difficulty hearing what people are saying. The speech sounds with the highest frequencies are the consonants, such as s, t, k, p and f. There is no cure for age-related hearing loss. If left untreated, age-related hearing loss can lead to larger issues such as increased incidence of dementia, falls, subsequent hospitalizations, isolation and depression.

Hard of hearing individuals often still use English as their primary language. This comes to include, for them, voice pattern recognition and lip reading. Hard of hearing individuals are more likely to depend on technology, such as hearing aids, in order to maximize the use of residual hearing. The personal perspective of having hearing loss is significantly different than that of Deaf perspective. Those who are hard of hearing tend to immerse themselves among hearing individuals and do not culturally identify themselves with a hard of hearing group. For this and other reasons, individuals who are hard of hearing are often overlooked.

Hearing loss is measured in decibels and discriminations. Decibels, or the loudness of something, is tested to see how loud a noise must be in order for an individual to hear it. Discrimination is measured to find out what an individual understands of the speech that they could hear. This allows audiologists to discern level of hearing ability.

Only 25% of the English language is visible on the mouth. Many words and combinations of letters sound a look alike when used, and intonation for things like sarcasm, question asking, oxymoron use, etc. is lost on those individuals who are unable to hear tone. Often times, those who are hard of hearing or Deaf are presumed to be less intelligent and more dependent on others, but this is often due to cultural misunderstanding and not due to actual cognitive impairment nor lack of intelligence.

Many of the phrases that we use in the English language do not make sense if we stop to think about them. Additionally, words are spelled the same but often mean very different things contingent on vocal emphasis. This is confusing to those who are Deaf. Say the following phrases and watch your mouth while you say them, to see if you could read lips.

- “He could lead if he would get the lead out.”
- “The bandage was wound around the wound.”
- “Pretty ugly.”
- “Act naturally.”
- “Good grief.”
- “Found missing.”

Tips for Communication
There are a number of things that we can keep in mind when communicating with an individual who is Deaf or hard of hearing. Here are some tips to take into the field:

- Be aware of the environment – it should be well lit with no visual distractions
- Make sure that you get the individual’s attention by waving your had or tapping on their shoulder
- Face the person when speaking to them
- Maintain your voice level, shouting can result in speech distortion and is a negative experience for your listener
- Be aware of your facial expressions, use your entire face to display emotion congruent with what you say
- If the person nods, do not assume that means understanding – often it just means “I’m listening”
- Be patient

If you are writing notes to communicate, keep the message short and simple. Don’t try and prove how smart you are or how beautifully you can write, often those “extra” words confuse the message. Try to minimize the notes by asking yes or no questions. Avoid putting two ideas in one sentence. Use visual representations and acting out whenever possible.

Use an interpreter whenever preferred. Alliance works with many interpreter agencies, contact your Staffing Coordinator to get one set up if the need arises.

If there are specific questions or duties you will perform when with the Deaf or hard of hearing individual, it's helpful to give them a written copy of the questions or procedure well beforehand, giving them ample time to look it over and understand what to expect.

There is no "one size fits all" for communication. Possible accommodations include; interpreter, assistive listening devices, pocket talkers, real-time captioning, TTY, voice amplified phone, relay services, VRS/VRI, email, instant messaging or text, Ubiduo machines, etc. If using an interpreter service, it's important to plan your visit well in advance and speak directly to the person who is Deaf or hard of hearing. Interpreters facilitate communication, they do not speak for the Deaf person. Make sure to maintain a well-lit environment where only one person speaks at a time, speak clearly and in a normal tone of voice.

Remember, attitude is everything! You have more in common with these individuals than you do differences.

TEST FOR THIS SECTION IS LOCATED IN PACKET B UNDER "DEAF AND HARD OF HEARING"

BASIC FIRST AID RESPONDING

Accidents happen anywhere and anytime. The first response to an accident is the most important. Often times, first aid given at the scene can improve the victim's chances of survival and a good recovery. The right response is better than an incorrect quick one. Any response, even if it is wrong, is better than none at all. ***Keep in mind that when in doubt as to the severity of the injuries call 911 or the local emergency number immediately.***

SHOCK

Shock can threaten the life of the victim of an injury if it is not treated quickly. Even if the injury doesn't directly cause death, the victim can go into shock and die. Shock occurs when the body's important functions are threatened by not getting enough blood or when the major organs and tissues don't receive enough oxygen. Some of the symptoms of shock are a pale or bluish skin color that is cold to the touch, vomiting, dull and sunken eyes, and unusual thirst. Shock requires medical treatment to be reversed, so all you can do is prevent it from getting worse.

Assessing for Severe Shock

- **STEP 1:** Observe the injured person's temperament: Is he or she confused or disoriented? If so, assume severe shock.
- **STEP 2:** Evaluate the injured person's level of consciousness: Is he or she unconscious or unresponsive? If so, assume severe shock.
- **STEP 3**: Take the person's pulse: Is it irregular or increasing progressively? If so, assume severe shock.
- **STEP 4:** If none of the above signs of severe shock are confirmed, check for earlier stages of shock using the following steps.

Tips & Warnings

Shock deprives blood flow to the brain and heart. An increased heart rate is a sign that the body is trying to compensate for blood loss to organs. Assume the person's condition is worsening. Evacuate immediately.

Assess for Early Signs of Shock

Instructions:

- **STEP 1:** Look at and feel the injured person's skin: Is he or she pale and clammy, first in the extremities and then in the trunk? If so, assume shock.
- **STEP 2:** Take the injured person's pulse: Is it rapid, steady or irregular? If so, assume shock (see "How to Measure Heart Rate").
- **STEP 3:** Take the injured person's respiratory rate: Is it shallow or rapid? If either, assume shock (see "How to Measure Respiratory Rate").
- **STEP 4:** Observe the injured person's temperament: restless, agitated or irritable? If so, assume shock.
- **STEP 5:** Ask the injured person how he or she feels. Any complaints of thirst or nausea? If so, assume shock.
- **STEP 6:** Continue rechecking for shock and evacuate immediately if any the above signs are present.

Tips & Warnings

- Shock kills! Treat every injured person immediately for shock, regardless of whether or not they are exhibiting signs and symptoms.
- Wilderness treatment of shock is limited, and a person in shock can spiral downward fast! Seek professional medical care if an injured person exhibits any of the signs and symptoms of shock. Evacuate immediately.

Wounds & Controlling Bleeding

Types of Wounds

Name	Description
Avulsions	In an avulsion, a portion of skin is torn. This can be partial, with a portion of skin remaining as a "flap." In a total avulsion, a body part is completely torn off.
Bruise	Bleeding that occurs under the skin causes discoloration, swelling. The area begins as red but may turn into a "black and blue mark."
Laceration	A laceration is a split in the skin caused by a sharp object, such as a knife, or even a dull object. A laceration can have either a jagged or smooth edge.
Puncture	A puncture wound is caused when a sharp object pierces the skin. Included in this category are gunshot wounds, impaled objects, and an object that passes totally through a part of the body.
Abrasion	An abrasion is very common, and occurs when skin is rubbed or scraped away.

Caring for a Minor Open Wound

- Stop the bleeding by applying pressure with a clean, absorbent cloth, or if cloth is unavailable, your fingers.
- If the blood soaks through, apply a second bandage on top. Do not take off the first bandage because it will disturb the clotting that has already taken place.
- If bleeding still doesn't stop, raise the wound above heart level.
- Once bleeding stops, clean the wound gently with soap and water, or just water. It is very important to get all debris or dirt out.
- Apply an antibiotic ointment such as bacitracin or a triple antibiotic ointment. Remember, some people are allergic to these ointments, so contact your doctor if you have any doubts. YOU MUST HAVE MED CERTIFICATE!
- Wrap the wound firmly in a cloth or a bandage. Do not cut off circulation!

Caring for a Major Open Wound

- Covering the wound with a clean dressing, press against it firmly with your hand.
- Elevate the wound above the level of the heart.
- The clean dressing should then be covered over with a roll bandage (like an Ace) to hold the dressings in place.
- If bleeding still does not stop, add additional dressings over the roll bandage.
- Squeeze a pressure point, the artery against the bone. This is in the bottom upper arm, or where the leg bends at the hip.
- Once the bandages and pressure point are being maintained, have someone call EMS if they have not already.

Special Problems

When part of the body has been torn off...

- Try to find the part
- Wrap it in a clean dressing and place in a plastic bag.
- Put the bag on ice, but don't freeze.
- Take the part to the hospital.

When an object is impaled in a wound...

- Do not remove it. You could reveal an open artery, which would then be awfully hard to deal with, a.k.a. nearly impossible.
- Bandage many dressings around the object to immobilize it and support it in its position in the wound.

Splinters...

- A small splinter in the skin should be removed with tweezers.
- For a splinter in the eye, seek emergency help immediately. Do not touch it.

Nosebleeds...

- Have the victim sit with his or her head tilted a little bit forward while pinching his or her nostrils together.
- One could also place an ice pack on the bridge of the nose.

Injury to the mouth...

- If the injury does not involve the head, neck, or spine, have the victim sit with the head slightly tilted forward. If the victim is unable to reach this position, place the victim on his or her side. This ensures that blood drains from the mouth.
- If the injury has broken the lip, place a clean rolled dressing between the lip and gum. Applying cold can also help.

If a tooth is knocked out...

- Place a small roll of sterile gauze in the gap left by the tooth that was knocked out.
- Pick up the tooth *not* by the root, but by the crown, the part you see when you smile in the mirror. DO NOT place the tooth back in the socket.
- Put the tooth in a container with cool, fresh milk. If this cannot be done, use water.

The most important things to remember are the signs of major damage:

- IF the bleeding is bright red or spurts from the wound, ***CALL EMS.***
- IF the wound is very large or deep, ***CALL EMS***.
- IF the victim is in severe pain or discomfort or you suspect serious damage, ***CALL EMS.***
- IF you cannot control the bleeding effectively, ***CALL EMS.***
- IF you cannot wash all of the debris out of the wound, ***CALL YOUR DOCTOR IMMEDIATELY.***
- IF you think the wound requires stitches, ***CALL YOUR DOCTOR IMMEDIATELY.***
- If you see any of the signs of a serious infection - redness, soreness, swelling, red streaks, weeping of pus, or redness that extends more than a finger width beyond a cut, ***CALL YOUR DOCTOR IMMEDIATELY.***

BURNS AND SCALDS

A burn can be caused by; heat (flames, hot grease, or boiling water), the sun (solar radiation), chemicals or electricity. When a burn breaks the skin, infection and loss of fluid can occur; burns can also result in difficulty breathing. If a burn victim has trouble breathing, has burns on more than one part of the body, or was burned by chemicals, an explosion, or electricity, ***CALL EMS*** immediately. Burns caused by flames or hot grease usually require medical attention as well, especially if the victim is a child or an elderly person.

TYPES OF BURNS

Superficial Burn (First Degree)

A first-degree burn involves only the top layer of skin. The skin is red and dry and usually painful. The burned area may also swell. Most sunburn are superficial burns. This type of burn usually heals in 5-6 days without any permanent scars.

Partial-Thickness Burn (Second Degree)

CALL EMS. A second-degree burn involves the top layers of skin. The skin is red with blisters that may open and weep clear fluid, giving the skin a wet appearance. The area may also appear mottled. The burn is usually painful and often swells. This type of burn usually heals in 3-4 weeks, and scarring may occur.

Full-Thickness Burn (Third Degree)

CALL EMS. A third-degree burn destroys all layers of skin and any or all of the underlying structures (fat, muscles, bones and nerves). The burn appears brown or black (charred) with the tissues underneath

sometimes appearing white. This type of burn can be extremely painful or relatively painless if the burn destroys the nerve endings. This burn is critical and requires ***immediate*** medical attention.

CARE FOR BURNS

General Care / Thermal Burns

1. Stop the burning. Put out flames or remove the victim from the source of the burn.
2. Cool the burn. Use large amounts of cool water to cool the burn. Never use ice except on small superficial burns, because it causes body heat loss. If the area cannot be immersed, like the face, you can soak a clean cloth and apply it to the burn, being sure to continue adding water to keep the cloth cool.
3. Cover the burn. Use dry, sterile dressings or a clean cloth to help prevent infection and reduce pain. Bandage loosely. Do not put any ointment on a burn unless it is very minor. Do not use any other home remedies, and do not break any blisters. For minor burns or burns with broken blisters that are not severe enough to require medical attention, wash the burned area with soap and water, keep it clean and apply an antibiotic ointment. Remember, some people can be allergic to topical ointments, so if you have any doubts, call your doctor for advice. For a victim of severe burns, ***CALL EMS***, lay him or her down unless he or she is having trouble breathing. Try to raise the burned areas above the level of the victim's heart if possible, and protect the victim from drafts.

Chemical Burn

Call EMS in any case of a chemical burn. Remove the chemical from the skin or eyes immediately by flushing the area with large amounts of cool running water until EMS arrives. Remove any clothes with chemicals on them, and be careful not to spread the chemical to other body parts or to yourself. Chemical burns can be caused by chemicals used in manufacturing or in a lab, or by household items such as bleach, garden sprays or paint removers.

Electrical Burns

Call EMS in any case of an electrical burn. Do not go near the victim unless you are sure the power source has been turned off. The burn itself will not be the major problem. If the victim is unconscious, check breathing and pulse. Check for other injuries, and do not move the victim because he or she may have spinal injuries. Cover an electrical burn with a dry, sterile dressing. Do not cool the burn. Prevent the victim from getting chilled. There may be two wounds, one where the current entered the body and one where it left, and they may be deep. Electrical burns can be caused by power lines, lightening, defective electrical equipment, and unprotected electrical outlets.

Solar Radiation Burn

Burns caused by solar radiation may be painful and may also blister. Cool the burn. You may want to put a product designed specifically for sunburn on the area; these products usually contain aloe vera and help cool the area and reduce the pain. Protect the burn by staying out of the sun. If you must go in the sun, wear a sunscreen with an SPF of at least 15 and reapply it frequently. Be sure to cover up any existing sunburn if you are going to be outside again.

BROKEN BONES

Treat all injuries to bones, joints, ligaments, tendons, and muscles as if it was a fractured limb. For fractured limbs, take the following precautions until EMS arrives. Place the injured part in as natural a position as possible without causing discomfort to the patient. If the patient must be moved to a medical facility, protect the injured part from the further injury. Do not splint an injury unless the victim must be moved. If the victim must be moved apply a splint long enough to extend well beyond the joints above and below the fracture. Use firm material, such as a board, pole, or metal rod, as a splint. Pad the splints with clothing or other soft material to prevent skin injury. Fasten splints with a bandage or cloth at the above and below the injury. If the injury occurs in a bone, fasten splints at the joint above and below the injury. Should the injury be to a joint, fasten the splint to the bone above and below the injured joint. Use pressure and bandage to control any bleeding.

For very serious fractures involving injuries to the body, neck, or back observe the following: Do not move the victim without medical supervision, unless absolutely necessary, and then only if the proper splints have been applied. If a

victim with a suspected neck or back injury must be moved, keep the back, head, and neck in a straight line, preventing them from being twisted or bent during movement. Use a board or stretcher to support the victim, if available.

SPINAL INJURIES

Take special care when helping a spinal injury victim. All damage to the spinal cord is permanent, because nerve tissue cannot heal itself. The result of nerve damage is paralysis or death.

Do not move the limbs or body of a victim with a suspected spinal injury unless the accident scene is such that there is imminent danger of further injury or unless it is necessary to establish breathing. The victim's body should be stabilized to prevent any movement of the head, neck or body. Be aware that any movement of a victim with spinal injury may result in paralysis or death.

If the victim must be moved, keep the neck and torso of the body as straight as possible and pull in a direction that keeps the victim's spine in a straight line. Pull the body from the feet or shoulders (using both feet, both shoulders, or both arms pulled over the shoulders). It is also possible to pull the victim by the clothing. Grab the victim by the collar of the shirt and support the victim's head with your forearms while pulling. The clothing drag is preferred because the victim's head is supported while being moved. Do not pull the body sideways.

When providing patient care, it may be necessary to roll the victim over on his or her back to clear an airway or evaluate breathing. When rolling the victim over, the head, neck and torso should be moved together so that no twisting occurs.

CHOKING

Choking occurs when food or a foreign object obstructs the throat and interferes with normal breathing. The following steps are advised if the choking victim is unable to speak or cough forcefully.

For adults and children over one year of age:

1. Ask, "Are you choking?"
2. Shout, "Help!" Call for help if the victim cannot cough, speak or breath or is coughing weakly, is making high-pitched noises.
3. Phone emergency staff for help. Send someone to call an ambulance.
4. Place the victim's head in a downward position on the rescuer's forearm with the head and neck stabilized.
5. With the heel of the rescuer's hand, administer five rapid back blows between the victim's shoulder blades.
6. Do abdominal thrusts: Wrap your arms around the victim's waist. Make a fist. Place the thumb side of the fist on the middle of the victim's abdomen just above the navel and well below the lower tip of the breastbone. Grasp the fist with the other hand. Press the fist into abdomen with a quick upward thrust.
7. Repeat abdominal thrusts five times. Repeat the cycle of five back blows and then five abdominal thrusts until the object is either ejected, EMS arrives, or the victim becomes unconscious.
8. If the victim becomes unconscious, lower the victim onto the floor.
9. Do a finger sweep. Grasp the tongue and lower jaw and lift jaw. Slide the finger down inside of the cheek to base of tongue. Sweep the object out.
10. Open the airway. Tilt the head back and lift the chin.
11. Give two full breaths. Keep the head tilted back, pinch the nose shut, and seal your lips tight around the victim's mouth. Give two full breaths for one to one and a half seconds.
12. Give five abdominal thrusts. If the air will not go in, place the heel of one hand against the middle of the victim's abdomen. Place the other hand on top of the first hand. Press into the abdomen with quick upward thrusts.
13. Repeat step six through nine until the airway is cleared or the ambulance arrives.

For infants one year or younger:

1. Place the victim's head in a downward position on the rescuer's forearm with the head and neck stabilized.
2. With the heel of the rescuer's hand, administer five rapid back blows between the victim's shoulder blades.
3. If the obstruction remains, turn the victim face up and rest on a firm surface.
4. Deliver five rapid thrusts over the breastbone using two fingers.
5. If the victim is still not breathing normally, administer mouth-to-mouth resuscitation as specified for an infant.

Repeat the above steps as necessary. If the obstruction cannot be removed, call for medical help immediately.

PREVENTION IS NO ACCIDENT!!!!

Adults:
* Cut food into small pieces.
* Chew food slowly and thoroughly, especially if wearing dentures.
* Avoid laughing and talking during chewing and swallowing.
* Avoid excessive intake of alcohol before and during meals.

Infants and Children:
Keep marbles, beads, thumbtacks, and other small objects out of their reach and prevent them from walking, running, or playing with food or toys in their mouths

POSIONING
Simple rules of thumb:

- Call your local Poison Control Center or 911 for immediate medical attention.
- Antidotes on labels may be wrong!! Do not follow them unless instructed by a physician.
- Never give anything by mouth (milk, water, Ipecac, etc.) until you have consulted with a medical professional.
- Keep a one-ounce bottle of Ipecac on hand at all times in case of an emergency, and give only when instructed by a physician.
- If the poison is on the skin, flush skin with water for 15 minutes, then wash and rinse with soap and water.

A poison is a substance that causes injury or illness when it gets into a person's body. The four ways a person can be poisoned are: *ingestion* (swallowing it), *inhalation* (breathing it), *absorption* (absorbing it through the skin), and *injection* (by having it injected into the body). Ingested poisons include foods, alcohol, medication, household and garden items, and certain plants. Inhaled poisons may be gases, like carbon monoxide from car exhaust, carbon dioxide from sewers, and chlorine from a pool, or fumes from household products like glue, paint, cleaners, or drugs. Absorbed poisons enter the body through the skin; they may come from plants, fertilizers or pesticides. Injected poisons enter the body through bites or stings of insects, spiders, ticks, marine life, snakes, and other animals, or medications injected with a hypodermic needle.

Ingestion
If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. Signs of poisoning are: nausea, vomiting, diarrhea, chest or abdominal pain, difficulty breathing, changes in consciousness, seizures, or burns around the lips or tongue or on the skin. If you believe someone may have swallowed a poison, try to determine what type of poison was ingested, how much was taken, and when it was taken. If you find a container, bring it to the telephone with you when you make your emergency call. Do not give the victim anything to eat or drink unless medical professionals tell you to. If you are unsure of what the poison was and the victim vomits, save some of it so that the hospital may analyze it and determine what the poison was.

Inhalation
If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. Signs of poisoning by inhalation may include pale or bluish skin. Remove the victim from the source of the toxic fumes so he or she can get some fresh air as soon as possible.

Absorption
If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. If poison, such as dry or wet chemicals, gets on the skin, flush the area with large amounts of water, and continue flushing the area with water until EMS arrives. If you have simply had a run-in with poison ivy, poison oak or poison sumac, there is no need to call EMS. Wash the affected area with soap and water. If you develop a rash, put a paste of baking soda and water on the area several times a day, or use an anti-itch lotion or an antihistamine to relieve the itchiness. Be aware that some people can have allergic reactions to even over-the-counter drugs to stop itching…use caution and if you have any doubts about whether you are allergic, talk to you doctor! See a doctor if the condition gets worse, affecting large areas of the body or face.

Injection
If possible, remove stinger by scraping it off with a blunt edge (e.g. credit card). Clean wound and apply cold compress to reduce swelling. Remove tight clothing and jewelry from areas near the bite in case swelling occurs. Watch for signs of shock or allergic reaction. Signs include swelling or itching at the wound site, dizziness, nausea or difficulty breathing. Seek medical attention immediately if any of these signs occur. Continue monitoring victim for shock until medical help arrives. Check victim's Airway, Breathing, and Circulation (ABC's). If ABC's are impaired then call 911 and begin CPR.

IMPORTANT: only a trained & qualified person should administer CPR.

THE ELEMENTS
Who is at risk?
People who work or exercise outdoors or indoors where the temperature is poorly regulated, elderly people, young children, people with health problems, a respiratory or cardiovascular disease or poor circulation, people who take medications to eliminate water from the body, and people who have a history of heat or cold-related illness in the past are at risk for heat or cold-related illnesses.

HEAT-RELATED ILLNESSES
Heat Cramps
Heat cramps, heat exhaustion and heat stroke are the three conditions caused by overexposure to heat. Heat cramps are painful muscle spasms. They result from a combination of fluid and salt loss caused by heavy sweating. Heat cramps usually occur after strenuous exercise or work outdoors in warm temperatures. They tend to occur in the legs and the abdomen. They are an indication of a more severe problem to come if proper care is not given shortly.

Care for Heat Cramps
Have the victim rest comfortably in a cool place, and provide him or her with cool water or a sports drink. Stretch the muscle gently and massage the area. Once the cramps stop, the victim may resume physical activity, but he or she should be sure to drink plenty of fluids during and after activity.

Heat Exhaustion
Heat exhaustion, the most common heat-related illness, typically occurs after strenuous exercise or work in a hot environment. The victim loses fluid through sweating, and blood flow to the skin increases, thus reducing blood flow to the vital organs. The victim therefore goes into mild shock. Symptoms of heat exhaustion are: normal or below normal body temperature; pale, moist, cool skin; headache; nausea; dizziness; weakness; and exhaustion. If heat exhaustion is allowed to progress, the victim's condition will worsen until he or she has heat stroke.

Heat Stroke
Heat stroke, the least common heat-related illness, occurs when heat exhaustion symptoms are ignored. The body systems become overwhelmed by heat. Sweating stops, and the body can no longer cool itself. Body temperature rises rapidly, and the brain and other vital organs will begin to fail. Convulsions, coma and death may result. Signs of heat stroke are: high body temperature; hot, red, dry skin; progressive loss of consciousness; rapid, weak pulse; and rapid, shallow breathing.

Care for Heat-Related Illnesses
Call EMS immediately if the victim's condition is so bad you suspect heat stroke. If heat-related illness is recognized in the early stages, it can usually be reversed. Move the victim to a cool area and give him or her cool water to drink. Remove any tight or heavy clothing and cool the body however you can; apply cool, wet cloths to the skin, fan the victim, or place ice packs on the victim's wrists and ankles, in each armpit and on the neck in order to cool the large blood vessels. DO NOT apply rubbing alcohol-it prevents heat loss. Do not let the victim drink too much too quickly-4 ounces every 15 minutes is good. If the victim vomits, stop giving fluids and position the victim on his or her side, keep the airway clear and monitor breathing and pulse. Keep the victim lying down, and continue cooling the body until EMS arrives.

The best defense is PREVENTION.

Here are some precautions you can take…

- Wear **lightweight, light-colored loose-fitting** clothing.
- **Apply sunscreen** with a Sun Protection Factor *(SPF)* rating of at least "SPF 15" to exposed portions of the body.
- **Limit exposure** during the hottest hours: 10 a.m. to 4 p.m.
- If possible, **avoid** strenuous work or exercise outside.
- **Take advantage of shade** in the environment and/or wear a **wide-brimmed hat**.
- Stay in **air-conditioned** areas or use cooling **fans** to speed sweat evaporation.
- Stay indoors and, if at all possible, stay in an air-conditioned place. If your home does not have air conditioning, go to the shopping mall or public library-even a few hours spent in air conditioning can help your body stay cooler when you go back into the heat. Call your local health department to see if there are any heat-relief shelters in your area.
- Electric fans may provide comfort, but when the temperature is in the **high 90s or above**, fans **will not** prevent heat-related illness. Taking a cool shower or bath, or moving to an air-conditioned place is a much better way to cool off.
- **Drink lots of cool, non-alcoholic fluids.** If you're exercising or working, drink 2 to 4 glasses of water an hour. If you lose a lot of fluid on a hot day, sports drinks are preferred over water because they will replenish sodium. Check with your doctor if you have health problems that require you to **limit** fluid intake or you're taking diuretics — ask him/her how much you should drink while the weather is hot.
- **Don't wait until you're thirsty to drink.**
  Drink more fluids *(nonalcoholic)* **regardless of your activity level**.
  Don't rely upon **thirst** as an **indicator** of your need for water; it's not reliable in very high heat.
- **Don't drink** liquids that contain **caffeine**, **alcohol**, or large amounts of **sugar** —these actually cause you to lose more body fluid. Also, avoid very cold drinks, because they can cause stomach cramps.
- **Avoid hot foods**, and **keep meals light** — Put less fuel on your inner fires. Foods *(like proteins)* that increase metabolic heat production also increase water loss *(the body has to work harder – and use more blood – to digest heavy foods)*.
- **NEVER leave anyone** in a closed, parked vehicle. Certainly, **don't leave children or pets in a vehicle**, even for "a few minutes." Heat builds up rapidly to exceptionally high temperatures in a closed vehicle, and it doesn't take much exposure to make children or pets very ill.

Pay attention to warning signs:

- Red, hot sweaty skin, cramps, lightheadedness and fatigue will occur long before heatstroke.
- Get out of the heat immediately and seek medical attention before serious harm is done.

COLD EMERGENCIES

Frostbite

Frostbite is the freezing of body tissues. It usually occurs in exposed areas of the body, affecting superficial or deep tissues. Frostbite is quite serious. The water in and between the body's cells freezes and swells, damaging or destroying the cells. Frostbite often results in the loss of fingers, hands, arms, toes, feet, and legs. Symptoms of frostbite are: lack of feeling in the area, a waxy appearance to the skin, skin that is cold to the touch, and skin that is discolored (flushed, white, yellow or blue).

Care for Frostbite

Handle the area very gently, and DO NOT rub the affected area. Warm the area by soaking it in water no warmer than 100-105 degrees Fahrenheit, using a thermometer to check the water temperature if possible. DO NOT let the affected body part touch the bottom or sides of the container holding the water. Leave the frostbitten area in the water until it is red and feels warm. Bandage the area with a dry, sterile dressing, placing cotton or gauze between frostbitten fingers or toes. Avoid breaking any blisters, and seek medical attention as soon as possible.

Hypothermia

When hypothermia occurs, the entire body cools because its warming mechanisms fail. If proper care is not promptly administered, the victim will die. Body temperature drops below 95 degrees Fahrenheit in hypothermia, the heartbeat becomes erratic and finally stops, and the victim dies. Symptoms of hypothermia are: shivering; a slow, irregular pulse; numbness; a glassy stare; and apathy along with decreasing levels of consciousness. People can develop hypothermia even when the temperature is only moderately cold. Elderly people in poorly heated homes, homeless or ill people, or people with certain medical conditions are more susceptible to hypothermia. Anyone submerged in cold water or remaining in wet clothes for a prolonged period of time may develop hypothermia quite easily.

Care for Hypothermia

If you suspect a victim may have hypothermia, call EMS immediately. Care for any life-threatening problems. Remove any wet clothing, dry the victim, and warm the body gradually by wrapping the victim in blankets. Move the victim to a warm place. You can use hot water bottles or heating pads to help rewarm the body, but be sure to put a barrier, like a blanket, towel or clothing, between the heat source and the victim to keep from burning him or her. DO NOT warm the victim too quickly, and DO NOT immerse the victim in warm water. Handle the victim very gently. Monitor the victim until EMS arrives.

FAINTING

Before losing consciousness, the victim may complain of…

- Lightheadedness
- Weakness & nausea
- Pale and clammy skin

If a person begins to feel faint, he should…

- Lean forward
- Lower head toward knees; as the head is lowered below the heart, blood will flow to the brain.

If someone becomes unconscious, put them in the recovery position:

- Keep the victim lying down on their side with knees bent, head on arm and mouth open
- Loosen any tight clothing
- Apply cool, damp cloths to face and neck
- In most cases, the victim will regain consciousness shortly after being placed in this position.

After the victim regains consciousness, do not let him get up until you have questioned him (Who are you? Where are you? Do you know what day it is?) to be sure he has completely recovered.

DIABETIC EMERGENCY

The condition in which the body does not produce enough insulin or does not use insulin effectively is called *diabetes mellitus*. If the person is conscious and able to swallow, give him or her sugar in the form of fruit juice, candy, a non-diet soft drink or table sugar, either dry or dissolved in a glass of water. If the person is not able to swallow or a form of sugar is not readily available, call EMS immediately.

SEIZURES

When injury, disease, fever, poisoning, or infection disrupts normal functions of the brain, the electrical activity of the brain becomes irregular. This irregularity can cause a sudden loss of body control known as a seizure. If a person is having a seizure, protect him or her from injury. Remove nearby objects that could cause injury, especially protect the person's head. Call EMS if any of the following situations occur; the seizure lasts for more than five minutes, the person has repeated seizures without regaining consciousness, the person has other injuries, the person has diabetes or is pregnant, or the person fails to regain consciousness after a seizure.

STROKE

A stroke, also called a "brain attack", is a blockage of blood flow to a part of the brain. It can cause permanent damage to the brain if the blood flow is not restored. Sudden signals of a stroke include; weakness or numbness on one side including face or arm or leg, difficulty speaking or slurred speech, sudden dizziness, blurred vision or sudden severe headache.

For a brain attack think **S.T.R.O.K.E.!**

- **Smile** and check for one sided weakness
- **Talk** and check for slurred speech
- **Open mouth & wiggle tongue** and check for weakness
- **Keep calm** and reassure them you're there to help
- **Emergency services** must be notified immediately that you suspect a stroke

Stay with the person and monitor his or her breathing and other signs of life. If the person is conscious, check for non-life-threatening conditions, and if you see signals of a stroke, call ***EMS IMMEDIATELY***.

ALLERGIC REACTIONS

Insect bites or stings or contact with certain drugs, medications, foods, and chemicals can cause an allergic reaction. If the person is suffering a severe allergic reaction from an insect bite or sting, or from eating a certain type of food contact ***EMS immediately***. The person may have a medical kit (such as an epinephrine auto-injector) to treat a severe allergic reaction known as anaphylaxis. Assist the person as needed with using the kit until help arrives.

TEST FOR THIS SECTION IS LOCATED IN PACKET B UNDER "BASIC FIRST AID RESPONDING"

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BOUNDARIES AND RAPPORT BUILDING

The boundaries training helps health care workers recognize and maintain professional behavior toward clients. The following statements reflect attitudes that may be held by personnel that the boundaries trainings are designed to counter. Do you need healthier boundaries? Answer the questions truthfully below, no one will see your answers.

1. I only feel appreciated at work.
2. I can't do enough for my client.
3. I disclose more information about myself to my client than is necessary in the course of treatment.
4. Nobody else cares about this client.
5. Only I can help this client.
6. This client really needs me.
7. Why shouldn't I take this $20 from the family? Nobody will ever know, and they don't pay me enough anyway.
8. It's my birthday (or Christmas). It was nice of them to get me a gift. Why shouldn't I keep it?

Staff members who harbor these types of feelings could benefit from boundaries training, in which they learn the principles listed below:

1. I won't have to seek emotional fulfillment on the job if I meet my personal needs in my private life, on my own time.
2. If my job is my life, than I don't have a whole life.
3. Personal sharing is not professional caring.
4. Professional boundaries protect the client's right to professional care.
5. Encouraging my clients to be dependent means that I, in turn, am codependent.
6. Needing to be needed makes me needy.
7. Accepting more than a "thank you" from clients makes me a caretaker, not a caregiver.

Helping Staff Set Professional Boundaries

We often use the *negative field* method of telling staff how to set boundaries – "Don't be their friend, don't tell them about yourself, don't get involved, and don't breach the boundaries." Unfortunately, giving inexperienced people only things *not* to do, isn't very helpful. When they have to make judgments about issues not directly addressed by policy, they either have to guess, based on their own experiences, or you must have an exhaustive policy.

This is a dilemma for staff. They know that they need to make a connection with the person they are working with, or they seem uncaring. In our personal lives, we connect by sharing our story. When we are prevented from making a connection in this way, many of us are stumped. When we try to find a way around this, we tread on dangerous ground.

So the troubled, but well-meaning staff says, "I want to be friendly and make a connection; what *can* I say about me?" That isn't the question, because this isn't about *you*. **The question should be**: *"How do I form a partnership with this person that will help our professional relationship?"*

When we recognize that the base of our relationships is confined to the professional partnership we have created to get the job done, the things we should share become much clearer. The categories we share in any long-term relationship are much the same:

- Who am I?
- What do I need?
- How do I feel?
- What do I prefer?

In a personal relationship, the answers we share can cover all of the ground of our life. In a professional relationship, the answers are much more limited. One reason is that most of our personal life simply isn't relevant to the task at hand. These are the kinds of things we should be sharing:

- Who am I? – I am a helper, and I want to be helpful.
- What do I need? – I need you to be here.
- How do I feel? – I am optimistic, compassionate, energized.
- What do I prefer? – Cooperative, engaged, pleasant, and helpful people.

Two other major points:

1. Staff often breach boundaries when they don't know what to say in response to something someone says. When you don't know what to say, **don't talk; listen!**
2. Staff also breach boundaries when they are following their own instructions of sharing their story. Remember, you are not here for your own therapy, but theirs. Let them share their story – and be interested and engaged.

The final point is this: your personal story and information is not relevant. It is first and foremost about the client, their life and their story, and your professional relationship.

The Top 10 Tips for Setting Boundaries

Boundaries are an important part of creating relationships that work well for you. Boundaries are lines of protection that you draw in your life. You decide what is and isn't ok and then hold people and yourself to these boundaries. Developing this skill is an important part of living a life you enjoy. The first step is to decide that you value yourself enough to draw these lines and the second is that you value others enough to teach them how to relate to you.

1. **Be Compassionate.**
   Setting boundaries can be an act of compassion. You are a teacher . . . teaching others how to interact with you and modeling an important skill for effective communication. Being compassionate and setting boundaries can go together. Empathize with where they are coming from and set the boundary.

2. **Neutral Tone of Voice.**
   When you are setting a boundary it is critical that your voice be neutral in tone. If there is a negative tone to your communication then the message can get lost and the clarity of the boundary becomes clouded. Practice speaking without a negative tone in your voice so it feels natural.

3. **4-Step Model.**
   Use this 4-step model to set boundaries. It is simple and effective and can keep your communication on track and guide you through the process of setting and holding to your boundary. After you have defined your boundary follow these steps in order as necessary: (1) Inform the person that you have set a boundary, (2) Request that the boundary be respected, (3) Insist that the boundary be respected and (4) Leave or end the interaction with the person at this time.

4. **Practice.**
   Find someone with whom you can practice setting a boundary. Practice your new skill and when you get more confident then start setting boundaries with others in your life. Start setting boundaries with people who will offer little resistance and then move up to more challenging people. Get a feel for what it is like to draw the line.

5. **Body Language of Confidence.**
   Watch your body language. Do your shoulders slump? Do you look down when you are talking? Do you mumble? Do you fidget? Start becoming aware of how others perceive you. You want your body language to communicate confidence, so challenge yourself to hold your shoulders back, sit up straight and make direct eye contact.

6. **Use "I" Statements.**
   When you are speaking, be responsible for the words coming out of your mouth. Make "I" statements that reflect how things affect you, what you believe, or your ideas. "You" statements can put people on the defensive and detract from effectively communicating a boundary.

7. **Don't Take Things Personally.**
   How other people behave, act, and think often has nothing to do with you. It has to do with their life experiences, their beliefs and how they define themselves as members of society. You can be responsible for your own communication and yet not take it personally.

8. **Find Your Own Words.**
   Listen to how others talk, learn different ways to communicate what you want to say and read how others communicate and set boundaries. Then develop your own style of expression. That way it will be natural for you.

9. **Don't Assume Responsibility for Others.**
   Don't assume responsibility for other people's feelings. Again, this has much more to do with them and their views of the world. Create clear direct ways of communicating and allow others to feel how they choose.

10. **Be Aware of Your Own Sensitivity.**
    When you first begin setting boundaries you might be very sensitive to what people ask of you or how they relate to you. You have opened up a new awareness and you may be viewing your communication in a completely new light. This is great, but it can also get in the way if you jump ahead in the 4-step model or your new sensitivity affects the charge of your voice.

TAKING CARE OF YOURSELF & SETTING BOUNDARIES

Setting boundaries is about learning to take care of ourselves, no matter what happens, where we go, or who we are with. Boundaries emerge from deep personal decision about what we believe we deserve, and don't deserve; what we need, like and dislike. Our personal rights, especially the right we have to take care of ourselves and to be ourselves, become very important.

We begin to set boundaries in dealing with others as we learn to value, trust, and listen to ourselves. The purpose of setting boundaries is to gain security and sense of "self", which will allow us to be close to others. An important step in setting boundaries is learning to:

Recommendations for Professional Boundary Setting

1. Increase awareness of boundary vulnerabilities and ongoing boundary issues with clients. If you own boundary work isn't done you won't know where you stop and the clients begins. You won't be able to see the differences and may not see the client's pathology or distress.
2. Clearly set limits with clients and colleagues, regarding:
    - Calls at home, both from clients and colleagues
    - Friendships with clients
    - Confidentiality
    - Personal questions from clients
    - Working harder than the client
    - Sharing personal information
    - Physical boundaries
3. Keep attending training to increase skill and knowledge level.
4. Do your own therapy when necessary.
5. Get your ego needs met away from your clients.
6. Obtain good clinical supervision, preferably a group.
7. Notice your own feelings in response to client behavior.
8. Talk about, with colleagues and/or supervisor, any client situation which trigger:
    - Uneasiness
    - Shame and guilt
    - Feeling "special" toward a client
    - Especially difficult transference or counter-transference situations
    - A sense of being in a double bind
    - Protectiveness of your client
    - A tendency to not follow established rules (session times, phone calls, etc.)
9. Give specific feedback to client about what has happened.
10. Transfer the client to someone else if the need arises.

DO I NEED HELP WITH BOUNDARIES?

Boundary programs help health care workers recognize and maintain professional behavior toward clients. The following statements reflect attitudes that may be held by staff and that boundaries workshops are designed to counter.

1. I only feel appreciated at work.
2. I can't do enough for my clients.
3. I disclose more information about myself to my client than is necessary in the course of treatment.
4. Nobody else cares about this client.
5. This client really needs me.
6. Only I can help this client.

BOUNDARIES

HEALTHY	UNHEALTHY
People feel free to talk about inside feelings	People compulsively protect inside feelings
All feelings okay	Only “certain” feelings okay
Person more important than performance	Performance more important than the person
All subjects open to discussion	Many taboo subjects, lots of secrets
Individual differences accepted	Everyone must conform to strongest persons’ ideas and values
Each person responsible for own actions	Lots of control and criticism
Respectful criticisms and appropriate consequences for actions	Punishment shaming
Few” should”s	Lots of “should”s
Clear flexible rules	Unclear, inconsistent and rigid rules
Atmosphere is relaxed	Atmosphere is tense
Joyous	Lots of anger and fear
Faces and works through stress	Avoids stress
People have energy	People feel tired
People feel loving	Hurt and disappointed
Growth is celebrated	Growth is discouraged
People have high self-worth	People have low self-worth
Strong parental coalition	Coalitions across generations

NO TEST FOR THIS SECTION, SIGN AND RETURN SIGNATURE PAGE LABELED “BOUNDARIES AND RAPPORT BUILDING” PACKET B

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1.00 HOUR

FRAUD, WASTE & ABUSE

Each new Home Health Aide is required to go through our online Fraud, Waste & Abuse training and sign off on the form as instructed. This training takes place at orientation and annually thereafter. Below are instructions for finding the form on the Alliance website.

STEPS:

1.) Visit www.alliancehealthcare.com
2.) Scroll all the way down to the "Quick Links" section (in grey)
3.) Select "Medicare Training Completion Form"
4.) Click on the link to "Medicare Parts C and D Fraud, Waste and Abuse Training" and read it thoroughly
5.) Click on the link to "Medicare Parts C and D General Compliance Training" and read it thoroughly
6.) When Step 4 & Steph 5 have been completed, submit the online form & sign the form attached to your packet

NO ITEMS IN PACKET B FOR THIS TRAINING – ONLINE SUBMISSION ONLY

PLEASE SUBMIT COMPLETED FRAUD TRAINING FORM ONLINE AT WWW.ALLIANCEHEALTHCARE.COM

COMMUNICATION & DOCUMENTATION

Why is it important to communicate & document? ***If you don't, then it didn't happen***.

Documentation is a measure of protection for you, the employee, as well as the client. It substantiates compliance with auditors, measures client outcomes, reminds you and other staff about past events, creates an accurate history of behavioral patterns and enhances the quality of services that we provide.

Always:
Documentation must be written clearly in blue or black ink and must be written objectively. Documentation cannot include any name except for the client's name. All others must be referred to generally (e.g. "staff" or "friend" or "peer", etc.). Documentation should always be written in third person. No portions of documentation may be left blank during your shift, please mark "N/A" for "Not Applicable" for anything that you cannot document observing. Staff will follow each entry with their signature and title.

Documentation should include both of the following:

P-I-R

Problem(s) – *"Megan slipped and fell while getting out of bed…"*
Intervention(s) – *"Staff assisted Megan to her feet and administered First Aid…"*
Response(s) – *"Megan stated she was 'Fine' and agreed to leave her slippers near her bed at night to avoid slippery socks on hardwood floors…"*

G-I-R-P

Goal(s) – *"Megan's Physical Therapist asked that she participate in ROME daily…"*
Intervention(s) – *"Staff prompted Megan four times to participate in ROME…"*
Response(s) – *"Megan agreed to on the fourth prompt when staff offered to play music while Megan did ROME exercises…"*
Plan(s) – *"Staff recommends always offering workout music for Megan when prompting her to participate in ROME…"*

Remember to include instances of positive and neutral behavior in documentation and not just negative behaviors.

Avoid:
Documentation should not include abbreviations at any time. Any spelling errors, etc. that must be crossed out in documentation should be crossed out by a single line drawn through the word(s) followed by the staff initials. Do not use whiteout on documentation. Avoid using any diagnoses that have not been verified by a medical provider, talk instead about symptoms expressed. Omit details of the scenario unless they are relevant to the care plan or behavior. Avoid all objective writing.

Examples of objective vs. subjective writing:

Subjective: angry, in a bad mood, feisty, happy, negative, hungry, misbehaving, etc.
Objective: spoke in loud tones, expressed frustration verbally, stated they felt happy, or broke two plates in the kitchen when asked to wash dishes, etc.

Include:
Highlight the client's strengths, supports and coping mechanisms. Don't just report facts as you've been told. Instead, specify where the information came from (client reports/states, etc.). Each page should have client's name or identification.

Plan of Care:
The Plan of Care and our documentation of following the Plan of Care is the main source of communication between yourself and the RN Case Manager. The purpose of a Plan of Care is to structuralize the reporting system agency-wide. Plans of Care allow Home Health Aides to document their observations appropriately and completely. A Plan of Care will be given to each Home Health Aide as they begin new client(s), and when any changes are made. A copy of the Plan of Care will also be kept in the client's home for referencing. Home Health Aides will use the Plan of Care as a guide to the services that they will provide while in the home to ensure that assigned duties outlined on the care plan are followed through with. Upon starting a first shift with a client, Home Health Aides will introduce themselves and explain each procedure from the Plan of Care prior to initiating it. Additionally, HHA's will explain procedures on a continual basis for any clients with cognitive or memory issues that require repetition-based learning. Any cares you believe are necessary that are not listed on the Plan of Care, discuss this need with the RN Case Manager prior to beginning the new care.

Accurate Timecard Recording:
Adherence to the schedule and accurate timecard recording is of the utmost importance. Dishonest or otherwise inaccurate timekeeping is a form of fraud and you can be prosecuted against for falsifying timecard documentation. Accurate timekeeping ensures that our clients can maintain the services that they need on an ongoing basis. Timecards must be turned in to the main office every Monday, and can be mailed, faxed, emailed, or dropped off in person (after hours drop box located to the left of the main entrance doors). Any cares that are signed for on the timecard <u>must</u> match the cares assigned on the care plan. On the Home Health Aide timecard, <u>everything</u> except for the "For Office Use Only" section on the bottom right corner is an area that will be filled out by the HHA prior to turning it in. This includes the comments section.

Communication and Healthy Boundaries:
The boundaries training helps health care workers recognize and maintain professional behavior toward clients. The following statements reflect attitudes that may be held by personnel that the boundaries trainings are designed to counter.

1. I only feel appreciated at work.
2. I can't do enough for my client.
3. I disclose more information about myself to my client than is necessary in the course of treatment.
4. Nobody else cares about this client.
5. Only I can help this client.
6. This client really needs me.
7. Why shouldn't I take this $20 from the family? Nobody will ever know, and they don't pay me enough anyway.
8. It's my birthday (or Christmas). It was nice of them to get me a gift. Why shouldn't I keep it?

Staff members who harbor these types of feelings could benefit from boundaries training, in which they learn the principles listed below:

1. If my job is my whole life, then I don't have a whole life.
2. Personal sharing is not professional caring.
3. Professional boundaries protect the client's right to professional care.
4. Encouraging my clients to be dependent means that I, in turn, am codependent.
5. Needing to be needed makes me needy.
6. Accepting more than a "thank you" from clients makes me a caretaker, not a caregiver.

SETTING PROFESSIONAL BOUNDARIES
We often use the *negative field* method of telling staff how to set boundaries – "Don't be their friend, don't tell them about yourself, don't get involved, and don't breach the boundaries." Unfortunately, giving inexperienced people only things *not* to do, isn't very helpful. When they have to make judgments about issues not directly addressed by policy, they either have to guess, based on their own experiences, or you must have an exhaustive policy.

This is a dilemma for staff. They know that they need to make a connection with the person they are working with, or they seem uncaring. In our personal lives, we connect by sharing our story. When we are prevented from making a connection in this way, many of us are stumped. When we try to find a way around this, we tread on dangerous ground.

The troubled, but well-meaning staff says, "I want to be friendly and make a connection; what *can* I say about me?" That isn't the question, because this isn't about *you*. The question should be, "How do I form a partnership with this person that will help our *professional relationship*?" When we recognize that the base of our relationships is confined to the professional partnership we have created to get the job done, the things we should share become much clearer.

The Top 10 Tips for Setting Boundaries

Boundaries are lines of protection that you draw in your life. You decide what is and isn't ok and then hold people and yourself to these boundaries. Developing this skill is an important part of living a life you enjoy.

11. **Be Compassionate.** Setting boundaries can be an act of compassion. You teach others how to interact with you. Empathize, don't sympathize, and set your boundary.
12. **Neutral Tone of Voice.** When you are setting a boundary, it is critical that your voice be neutral in tone. If there is a negative tone to your communication then the message can get lost and the clarity of the boundary becomes clouded.
13. **4-Step Model.** This is simple and effective and can keep your communication on track: (1) Inform the person that you have set a boundary, (2) Request that the boundary be respected, (3) Insist that the boundary be respected and (4) Leave or end the interaction with the person should they continue to disrespect your boundary.
14. **Practice.** Practice your new skill and when you get more confident then start setting boundaries with others in your life. Start setting boundaries with people who will offer little resistance and then move up to more challenging people. Get a feel for what it is like to draw the line.
15. **Body Language of Confidence.** Watch your body language. Do your shoulders slump? Do you look down when you are talking? Do you mumble? Do you fidget? Start becoming aware of how others perceive you. You want your body language to communicate confidence, so challenge yourself to hold your shoulders back, sit straight and make eye contact.
16. **Use "I" Statements.** When you are speaking, be responsible for the words coming out of your mouth. Make "I" statements that reflect how things effect you, what you believe, or your ideas. "You" statements can put people on the defensive and detract from effectively communicating a boundary.
17. **Don't Take Things Personally.** How other people behave, act, and think often has nothing to do with you. It has to do with their life experiences, their beliefs and how they define themselves as members of society. You can be responsible for your own communication and yet not take it personally.
18. **Find Your Own Words.** Listen to how others talk, learn different ways to communicate what you want to say and read how others communicate and set boundaries. Develop your own style of expression. That way it will be natural for you.
19. **Don't Assume Responsibility for Others.** Don't assume responsibility for other people's feelings. Again, this has much more to do with them and their views of the world. Create clear direct ways of communicating and allow others to feel how they choose.
20. **Be Aware of Your Own Sensitivity.** When you first begin setting boundaries you might be very sensitive to what people ask of you or how they relate to you. You have opened up a new awareness and you may be viewing your communication in a completely new light. This is great, but it can also get in the way if you jump ahead in the 4-step model or your new sensitivity affects the charge of your voice.

TEST FOR THIS SECTION IS LOCATED IN PACKET B UNDER "COMMUNICATION AND DOCUMENTATION"