Blue Mountain Home Health Care, Inc.

Training & Competency Assessment for Direct Care Workers

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Section 1: Confidentiality

Patient confidentiality is one of the most important pillars of home care. Protecting the personal and medical details of a patient is not just a matter of moral respect, it is essential in retaining the important bond of trust between the care giver and the patient. Patient confidentiality isn't just a good idea; it's the law. Under the Health Insurance Portability and Accountability Act (HIPAA), patient's medical records and other health information is privileged information. The home care agency, its management and its entire direct care staff cannot share patient information without patient consent, unless the safety and welfare of others is at stake.

What is HIPAA?
"HIPAA", is an acronym for the Health Insurance Portability & Accountability Act.

HIPAA is a Federal law enacted to:

- Protect the privacy of a patient's personal and health information.
- Provide for the physical and electronic security of personal health Information.
- Simplify billing and other transactions with standardized code sets and Transactions.
- Specify new rights of patients to approve access/use of their medical information.

What are the HIPAA requirements?

- To protect the privacy and security of an individual's Protected Health information (PHI)
- To require the use of "minimum necessary"
- To extend the rights of individuals over the use of their PHI

What Patient Information Must We Protect?
We must protect an individual's personal and health information that:

- Is created, received, or maintained by a health care provider
- Is written, spoken, or electronic
- And includes at least one of the 18 personal identifiers in association with health information.

PHI 18 Identifiers defined by HIPAA

- Name
- Postal address
- All elements of dates except year
- Telephone number
- Fax number
- Email address
- URL address
- IP address
- Social security number
- Account numbers
- License numbers
- Medical record number
- Health plan beneficiary number
- Device identifiers and serial numbers
- Vehicle identifiers and serial numbers
- Biometric identifiers (finger and voice prints)
- Full face photos and other comparable images
- Any other unique identifying number, code, or characteristic

How to Use or Disclose PHI
The Home Health Agencies must give each patient a **"Notice of Privacy Practices"** that:

- Describes how the centers may use and disclose the patient's PHI and
- Advises the patient of his/her **privacy rights**
- Each center must attempt to obtain the patient's signature acknowledging receipt of the Notice, EXCEPT in emergency situations. If a signature is not obtained, BMHHC must document the reason it was not.

For Purposes other than treatment, payment, operations
Unless required or permitted by law, the Home Health Agency must obtain written authorization from the patient to use, disclose or access patient information:

- Patient authorization: allows for Home Health Agencies to disclose information for other purposes.
- Minimum necessary applies to all uses and disclosures for payment and all Health care operations.

State and Federal Laws Mandate all PHI be protected in the following formats
All personal and health information that exists for EVERY individual in ANY form:

- Written
- Spoken
- Electronic

Who Uses PHI at Blue Mountain Home Health Care, Inc.?

- Anyone who works with or may see health, financial, or confidential information with HIPAA PHI identifiers
- Everyone who uses a computer or electronic device which stores and/or transmits information

Such as:

- Clinician and Therapy Staff
- Administrative staff with access to PHI
- Almost Everyone at one time or another!

Why is protecting privacy and security important?

- We all want our privacy protected.
- It's the right thing to do.
- HIPAA and Pennsylvania laws require us to protect a person's privacy.
- The Blue Mountain Home Health care, Inc.'s policy requires everyone to follow privacy and security policies.

Do not look at, read, use or tell others about an individual's information (PHI): unless, it is a part of your job.

Always Remember

- Use only if necessary to perform job responsibilities
- Use the minimum necessary to perform your job
- Follow the BMHHC policies and procedures for information, confidentiality and security.

What does this mean for me as an employee?

All nurses, doctors, and staff must comply with these laws and regulations to ensure the privacy of our patients' protected health information (PHI). Any employee who violates HIPAA will be subject to the corrective action process, up to and including termination.

Incidental Use and Disclosure
Covers communication needed to provide effective patient care, such as:
- Healthcare providers discussing patient care
- Doctors conferring with patients' families

Health care providers are to make reasonable efforts to protect the privacy and dignity of all patients'.
- Avoid public areas, when discussing patient care.
- When talking to patients, draw curtains, and speak softly not to be overheard.
- You are permitted to discuss a patient in a public area if necessary, but you cannot use the patient's name.
- Healthcare employees are not permitted to access a friend's PHI.
- Healthcare staff is allowed to keep patients' charts at bedsides, as long as the PHI is protected, the patient's name may be on the chart.
- If you leave a message, leave your name and number to confirm an appointment, or ask for a call back,
- Sign-in sheets are permitted, but limit the sign-in data to protect privacy.

You Can Protect PHI/Electronic PHI by;
- Verbal Awareness
- Written Paper/Hard Copy Protections
- Safe Computing Skills
- Reporting Suspected Security Incident

HIPAA Security Reminders
- Password protect your computer
- Backup your electronic information
- Send email securely
- Keep office secured
- Keep disks locked up
- Run Anti-virus, anti-spam, anti-spyware

Be Aware that Electronic PHI is everywhere
- Email (incoming and outgoing)
- Faxes (incoming and outgoing)
- PDA's, cell phones
- Laptops
- Zip disks, CDs, floppies, flash drives, memory sticks

We need to protect the entire lifecycle of PHI
- From Intake/creation of PHI
- Storage of PHI
- Destruction of PHI for any format of PHI

HIPAA's Impact on Clinical Practice, Treatment, Referrals and Payment
Patient authorization is not required when doctors, nurses, therapists, dieticians, and others use

information about patients to determine what services they should receive or to review the quality of their care. PHI may also be used without patient authorization to bill patients (or their insurance companies) for the services they received or to fulfill other necessary administrative and support functions. Disclosure is also permitted without authorization in a number of other situations, such as where disclosures are required by law. Below is a list of some common situations where PHI can be released without a patient's authorization:

Reasons for Releasing PHI

There are certain situations in which BMHHC may release PHI without the patient's authorization. These include:

- Providers are required to report certain communicable diseases to state health agencies, even if the patient doesn't want the information reported.
- The Food and Drug Administration requires that certain information be reported about medical devices that break or malfunction.
- The courts have the right to order providers to release patient information with appropriate certifications or court orders.
- Under limited circumstances, health care providers may disclose PHI to police (such as reporting certain wounds or injuries, or to comply with a court-ordered warrant or grand jury subpoena).
- When physicians or other people providing patient care suspect child abuse or elder abuse, they must report it to state agencies.
- The hospital or provider reports information to coroners and funeral directors in cases where patients die.

Patients can also request release of their information by signing an authorization which includes all the statements required under the regulations.

When responding to an authorization from another organization for release of protected health information, the authorization must also meet the HIPAA requirements. If there is any doubt, the Privacy Office can provide assistance in reviewing the validity of the document.

Psychotherapy Notes

Psychotherapy notes receive stronger protection than other protected health information under the HIPAA privacy rule because of their potential sensitivity. Psychotherapy notes are defined as the notes of a mental health professional which document or analyze the contents of a counseling session and which are stored separately from the rest of the medical record. Except in certain limited circumstances, use or disclosure of psychotherapy notes is permissible only if the patient signs a separate authorization that encompasses only psychotherapy notes and no other PHI.

Psychotherapy notes exclude:

- Medication prescription and monitoring
- Counseling session start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests
- Any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, or progress to date

Accounting for Disclosures

HIPAA requires that, upon request, patients be provided with a listing of who has had access to or been provided a copy of their records (1) for reasons other than treatment, payment, healthcare operations -unless such disclosures are made from an electronic health record. or (2) without the patient's authorization. In order to meet this requirement, accounting logs must be maintained by the medical

record personnel responsible for the record. The logs must include who had access, for what reason and when access was provided.

Everyday Steps for Protecting Privacy

Here are some common ways that clinical staff members can protect patient privacy:

- Talk on the phone in closed quarters, and be careful what you disclose aloud
- Close patient room doors when discussing treatments and administering procedures. Close curtains and speak softly in semi-private rooms when discussing treatments and administering procedures.
- Do not leave messages on answering machines regarding patient conditions or test results.
- Avoid paging patients using identifiable information, such as their condition, name of physician, or unit that could reveal their health issues.
- Avoid leaving a patient's medical file on your computer screen when you leave your desk. It is best to log off when leaving a workstation or iPads. In public areas, point computer monitors so that visitors or people walking by cannot view information

Who Are Business Associates?

- HIPAA defines business associates as entities outside of BMHHC that perform or assist BMHHC in performing activities that require the use or disclosure of PHI. The information includes claims processing, data analysis, billing, or practice management.
- Business associates include lawyers, actuarial professionals, accountants, healthcare consultants, transcription agencies, computer support, and billing companies. If you have a contract with someone helping you to do your job, he or she probably qualifies as a business associate.

Disclosure of PHI Requires a Contract

- A confidentiality clause that holds the business associate accountable for protecting PHI.
- A statement that the business associate cannot use or further disclose the information in a manner that violates the Privacy Rule.
- A statement that the business associate must safeguard the information as if it were the covered entity under the law.
- At the termination of contracts, business associates must return or destroy all protected health information within a reasonable amount of time.
- Monitoring Compliance by Business Associates

A good rule of thumb: Limit information provided to business associates to what's needed to do the job. If possible, provide de-identified data instead of patient-identifiable data.

Section 2: Patient Rights

All humans, regardless of the health condition are entitled to some basic rights. These basic rights of expression, decision making, independence, personal dignity and respect become more important when we deal with a patient.

The following are patient rights when dealing with home health care agency:

1. The patient has the right to be informed of their rights.
2. The home health agency must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.
3. The home health agency must maintain documentation showing compliance of the rights listed above.
4. The patient has the right to exercise his or her rights as a patient of the home health agency.
5. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.
6. The patient has the right to have his / her property treated with respect.
7. The patient has the right to have his or her cultural, psychosocial, spiritual and personal values, beliefs and preferences respected.
8. The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so.
9. The home health agency must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency and must document both the existence of the complaint and the resolution of the complaint.
10. The patient has the right to be informed, in advance, about the care to be furnished and any changes in the care to be furnished.
    a. The home health agency must advise the patient in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished.
    b. The home health agency must advise the patient in advance of any change in the plan of care before the change is made.
11. The patient has the right to participate in the planning of the care.
12. The home health agency must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.
13. The home health agency has written policies and procedures regarding advance directives. The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law.
14. The patient has the right to formulate an Advance Directive for medical care which will be honored by the Agency to the extent provided by law, as long as the Agency is provided with a copy of the document for the medical record.
15. The patient has the right to confidentiality of the clinical records maintained by the home health agency.
16. The home health agency must advise the patient of the agency's policies and procedures regarding disclosure of clinical records. "Patient's written consent is required for release of information not authorized by law."
17. The patient has the right to be advised before care is initiated, of the extent to which payment for the home health agency services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.

18. Before care is started, the home health agency must inform the patient, orally and in writing, of:
    a. The extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided programs known to the home health agency.
    b. Charges for services that will not be covered by Medicare and charges the individual may have to pay.
19. The patient has the right to be advised orally and in writing of any changes in the information previously given to them.
20. The home health agency/hospice must advise the patient of these changes orally and in writing as soon as possible, but no later than 30 calendar days from the date that the home health agency becomes aware of a change.
21. The patient has a right to choose their health care providers.
22. The patient has the right to receive the information necessary to give an informed consent prior to receiving care.
23. The patient has the right to refuse treatment within the confines of the law and to be informed of the consequences of their actions.
24. The patient has a right to refuse experimental treatments and/or to participate in research.
25. The patient has a right to receive a timely response from the Agency to their request for service.
26. The patient has a right to appropriate and professional care and will only be admitted to service if the Agency has the ability to provide safe and professional care at the level the patient requires.
27. The patient has the right to be informed within a reasonable time of anticipated termination of service or plans to transfer to another Agency. The patient will be informed of any financial benefit to the referring Agency.
28. The patient has the right to appropriate assessment and management of pain. As a patient of this home care agency, you can expect:
    a. Your reports of pain will be believed
    b. Information about pain and pain relief measures
    c. A concerned staff committed to pain prevention and management
    d. Health professionals who respond quickly to report of pain
    e. Effective pain management

Section 3: Aging Process & Independent Living Philosophy

A. The Aging Process

The aging process begins when a person is born and it continues until death. At the beginning of our lives, the aging process brings about rapid changes as we grow older. These changes eventually plateau for a while before we begin a gradual decline to death. Aging is associated with changes in dynamic biological, physiological, environmental, psychological, behavioral, and social processes. Some age-related changes are benign, such as graying hair. Others result in declines in function of the senses and activities of daily life and increased susceptibility to and frequency of disease, frailty, or disability. Behavioral and psychological factors—for example, physical activity, smoking, and other health behaviors, cognitive and social engagement, personality, and psychosocial stress—play a critical role in health across the lifespan. If you understand how the body ages, you can assist the individuals you support in the healthiest way possible.

As we age, our bodies go through a lot of changes. On the outside we change physically, but there are a lot of internal changes that occur too. Knowing what to expect and how to slow some of those changes can help you stay as comfortable and active as possible.

Heart

Your heart pumps all day and night, whether you are awake or asleep. It will pump more than 2.5 billion beats during your lifetime! As you age, blood vessels lose their elasticity, fatty deposits build up against artery walls and the heart has to work harder to circulated the blood through your body. This can lead to high blood pressure (hypertension) and atherosclerosis (hardening of the arteries). Taking care of your body with the right types of fuel will help you keep your heart healthy and strong. You can take care of your heart by exercising and eating heart-healthy foods.

Bones, Muscles & Joints

As we age, our bones shrink in size and density. Some people actually become shorter! Others are more prone to fractures because of bone loss. Muscles, tendons, and joints may lose strength and flexibility. Exercise is a great way to slow or prevent the problems with bones, muscles and joints. Maintaining strength and flexibility will help keep you strong. In addition, a healthy diet including calcium can help your bones strong. Be sure to talk to your doctor about what types of diet and exercise are right for you.

Digestive System

Swallowing and digestive reflexes slow down as we age. Swallowing may become harder as the esophagus contracts less forcefully. The flow of secretions that help digest food in the stomach, liver, pancreas and small intestine may also be reduced. The reduced flow may result in digestive issues that weren't present when you were younger.

Kidneys and Urinary Tract

Kidneys may become less efficient in removing waste from the bloodstream because your kidneys get smaller as they lose cells as you age. Chronic diseases such as diabetes or high blood pressure can cause even more damage to kidneys. Urinary incontinence may occur due to a variety of health conditions. Changes in hormone levels in women and having an enlarged prostate in men are contributing factors that lead to urinary incontinence.

Brain and Nervous System

As we age, we naturally lose cells. This is even true in the brain. Memory loss occurs because of the number of brain cells decreases. The brain can compensate for this loss by increasing the number of

connections between cells to preserve brain function. Reflexes may slow down, distraction is more likely and coordination is affected.

Eyes and Ears
There are many vision changes that occur as we age. We may need help seeing objects that are closer as our lens stiffens. We may have a more difficult time seeing in low-light conditions, and colors may be perceived differently. Our eyes may be less capable of producing tears and our lenses may become cloudier. Common eye problems associated with age include cataracts, glaucoma and macular degeneration.
Excessive noise throughout your lifetime can cause hearing loss as you age. Many older adults have difficulty hearing higher pitched voices and sounds, trouble hearing in busy places and more frequently accumulating earwax.

Hair, Skin, and Nails
As you age, your skin becomes more dry and brittle, which can lead to more wrinkles. The fat layer under the skin thins, which results in less sweating. This may seem like a good thing, but it makes you more susceptible to heat stroke and heat exhaustion in the summer. Hair and nails grow slower and become brittle. Hair will thin and turn gray.

Weight
Decreasing levels of physical activity and a slowing metabolism may contribute to weight gain. Your body may not be able to burn off as many calories as it once could, and those extra calories will end up being stored as fat.

While you can't prevent aging, you can prepare yourself for the various effects of aging, both outside and inside the body.

B. Independent Living Philosophy
Ninety percent of seniors prefer to remain in their own homes during their golden years; however, the reality is that successful independent living requires certain skills. If just one of these vital skills is missing, self-care can be a serious problem, leading to safety, comfort and health issues.Living independently encompasses more than just a basic ability to care for oneself. Here are five skills we feel are indispensable.

Physical strength to prevent falls and handle self-care
Falls are dangerous. They lead to life-threatening injuries, hospitalization, even death. They're also a common trigger for declining health, which undermines our ability to take care of ourselves.
Balance issues that lead to falls happens as a result of poor muscle strength in our lower body, so it's very important to avoid letting them become weak. It can easily happen from a sedentary lifestyle. Taking fitness and activity seriously enough to maintain a basic amount of body strength is essential for fall prevention.

Are all falls a result of body weakness? No, but many of them are, so basic body strength maintenance is a skill that can't be avoided. Even five or ten minutes a day can make a difference, although the ideal is thirty minutes or more every day.

To complement body strength, taking steps to modify our home to be a safe environment as our needs change is also important. It might not be a personal skill, but it is critical for a better outcome.
As our physical needs change, we need to adapt our environment to accommodate those changes. Even someone who goes for a daily walk to keep their body strong can benefit at some point from grab bars in the bathroom, reachable items in kitchen cabinets, or an easier way to manage stairs.

Stronger muscles also ensure we can dress and undress, get in and out of bed, bathe and attend to other personal hygiene tasks without requiring assistance from others. How effectively we can accomplish these tasks (with or without supportive resources to accomplish them) determines whether we can live at home safely and comfortably on our own.

The ability to obtain food and prepare meals.
It's unavoidable… We all need a certain amount of food to survive and balanced nutrition keeps us far healthier than a constant diet of processed meals. It's impossible to remain independent without the right fuel. The ability to feed ourselves a healthy meal is essential.
Remaining independent doesn't require becoming a gourmet cook, however. If grocery shopping or preparing meals is a struggle, putting resources in place to deliver ingredients or prepared healthy meals are readily available to fill the gap. However, we must be able to handle basics of warming the food and feeding ourselves to remain independent.
Can we hire private duty home care or family caregivers to provide meals and serve them? Yes, but someone who needs this higher level of care may require a care environment for their own safety, especially if they live alone.

Available transportation for activities outside of the home
Everyone needs to leave the house occasionally. Doctor visits, physical therapy, socializing with family or friends and other activities are important components to our wellbeing and health.
Even someone who prefers to be less social must be able to manage important activities out of the home. It's also critical in providing companionship and reducing isolation, which impacts mental and physical health. If someone is unable to provide their own transportation or arrange for it, or doesn't have the stamina required to leave the home, they're not able to live independently.

Age-appropriate cognitive abilities
A small amount of dementia or memory challenges are normal once we're past a certain age, but going beyond these norms can mean a loss of the ability to live independently. Confusion impacts self-care, transportation or the ability to arrange it, and every other aspect of our life, from simple logistics of getting through the day to physical and mental health. If we are influenced by a major change in cognitive abilities, our ability to remain home can be involuntarily lost… exchanged for a memory care environment.
For those proactively focused on remaining home, pursuing brain fitness activities and a healthy lifestyle helps us retain cognitive abilities that are normal for our age, even prevent or delay dementia. Much of its onset or avoidance is within our power to control.

A preference for a lifestyle of health and wellness
Attitude is everything when it comes to successful aging in place. Strong attitudes and a preference for health, wellness and wellbeing drive the very activities more likely to keep us independent longer. It also allows us to prevent isolation, depression and loneliness that can add to our decline.
Much of successful aging is determined by the choices we make every day. Do we eat the salad or the sandwich, the fries or the apple? Take the stairs or the elevator? Skip our annual exam and dental cleaning or do them? Buy the prescription or pocket the money? Have dinner with friends or stay home? Small decisions accumulate into a larger state of wellness.
If you're serious about living independently, proactive behavior and prevention determine your future. It's the smart path.

At Blue Mountain, we focus on providing the care you want and the freedom you deserve. We support your independence by promoting your ability to choose, your desire to control and your right to dignity encompassing all aspects of your day-to-day living. We believe that all individuals have the right to be independence in all aspects of their daily lives and be able to:

- Make decisions about their own lives
- Be active in their communities
- Actively choose their home care services
- Live with dignity
- Get the support they need at home
- Make ongoing choices while controlling their home care services
- Expect equal access to social, economic and political opportunities
- Here's how we put our philosophy into action:
- Truly independent living

Your home care is both critical and personal, so you deserve to work with people who are directly involved with that care. At Blue Mountain, you will interact with your local office who understand your needs and how to help. We're comprised of a network of local offices backed by a corporate organization. That means a personal and caring experience for you, but also one that is courteous, professional and as easy as possible for you and your family.

The right people
Without compassionate, skilled caregivers, our independent living philosophy rings hollow. Our rigorous screening process helps us identify only the best home caregivers. Plus, our comprehensive hiring, orientation and training programs to ensure OSH caregivers are truly the best individuals to care for your needs.

Your involvement
That's right — the most important person in the process of planning for your home care is YOU. You will be involved in every step of the planning: from deciding which services are needed to providing ongoing guidance and feedback as we help care for your needs or the needs of your family member, your choices are the most critical.

All individuals have the right to:
- Make their own decisions
- Complete participation in their individualized service plan
- Control and direct their care service
- Have proper support in their homes
- Live with dignity and respect
- Participate as an active member in their communities
- Have proper support in maintaining employment
- Equal access to economic, educational, social and political opportunities

Section 4: Activities of Daily Living (ADL) / Instrumental Activities of Daily Living (IADL)

Professionals who work in aging often want to know whether an older person needs any help with "ADLs or IADLs". These terms stand for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). They represent key life tasks that people need to manage, in order to live at home and be fully independent. If you're a family caregiver, it can be good to familiarize yourself with these terms and the related skills.
Difficulties with ADLs and IADLs often correspond to how much help, supervision, and hands-on care an older person needs. This can determine the cost of care at a facility, whether someone is considered "safe" to live at home, or even whether a person is eligible for certain long-term care services.

Activities of Daily Living (ADLs)
These are the basic self-care tasks that we initially learn as very young children. They are sometimes referred to as "Basic Activities of Daily Living" (BADLs). They include:

- Walking, or otherwise getting around the home or outside. The technical term for this is "ambulating."
- Feeding, as in being able to get food from a plate into one's mouth.
- Dressing and grooming, as in selecting clothes, putting them on, and adequately managing one's personal appearance.
- Toileting, which means getting to and from the toilet, using it appropriately, and cleaning oneself.
- Bathing, which means washing one's face and body in the bath or shower.
- Transferring, which means being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.

If a person is not fully independent with ADLs, then we usually include some information about the amount of assistance they require. For each ADL, people can vary from needing just a little help (such as a reminder or "stand-by assist") to full dependency, which requires others to complete the task for them.

Instrumental Activities of Daily Living (IADLs)
These are the self-care tasks we usually learn as teenagers. They require more complex thinking skills, including organizational skills. They include:

- Managing finances, such as paying bills and managing financial assets.
- Managing transportation, either via driving or by organizing other means of transport.
- Shopping and meal preparation. This covers everything required to get a meal on the table. It also covers shopping for clothing and other items required for daily life.
- House Cleaning and home maintenance. This means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.
- Managing communication, such as the telephone and mail.
- Managing medications, which covers obtaining medications and taking them as directed.

Why ADLs and IADLs matter
Generally, older adults need to be able to manage ADLs and IADLs in order to live independently without the assistance of another person. Geriatricians assess ADLs and IADLs as part of assessing an older person's "function." Problems with ADLs and IADLs usually reflect problems with physical health and/or cognitive health. Identifying functional difficulties can help us diagnose and manage important health problems. But most importantly, we try to identify functional difficulties because we want to

make sure older adults are getting the help and support they need to compensate for, or overcome, these difficulties. We also want to help any family caregivers who might be struggling to assist a relative who needs help.

Section 5: Identifying Behavior Changes in Patients

When serving aging patients one must be wary of certain signs that indicate a changing health situation. These include but are not limited to decreased capabilities in:

Behavior	**Example**
Memory	Failure to remember event from earlier in morning sporadically
Communication & language	Slurred speech and simplified vocabulary
Express feelings & emotion	Behaving emotionless, flat throughout the entire day
Ability to focus and pay attention	Hyperactivity and mania
Reasoning and judgment	Poor and uncharacteristic decision-making
Visual perception	Abnormal difficulty reading or seeing TV
Planning skills	Inability to create lists or complete errands
Breathing	Uncharacteristic coughing, wheezing, shallow breath
Eating	Difficulty swallowing, refusal to eat usual foods, vomiting

If these degenerative changes are noticed, the source should be explored and identified in order to remedy them through solutions such as environmental and lifestyle changes.

Section 6: Dealing with difficult behaviors

If the person you care for must rely on others for their daily care, they may feel a loss of control over their life. They may feel frustrated or helpless at times. Their personality and behavior may change because of the emotional and physical changes they experiences.
A person who has always had a difficult personality may become even more difficult with the stress of an illness or disability. When a person becomes sick or disabled, not only their life but the lives of those around them change dramatically. If you can recognize the reasons a person is difficult and learn methods to cope, it will help you both maintain a healthier relationship and get through the trying times.

Coping With A Difficult Behavior

- You can't always control the other person's behavior but you can control your response to it.
- Focus your response on the behavior, avoid blaming it on their personality or condemning them as a "bad" person.
- Don't take the angry behavior personally.
- You're doing the best that you can do in a difficult situation; blaming yourself won't help solve the problem.

Excessive Complaints And Angry Behavior Illness and disability affect everyone differently. Some people who need help from others become easily irritated. They may seem petty and demanding at times. The person may fly into a rage because you put too much cream in their coffee. When they are losing control over parts of their life, they may be desperately looking for something he can still control.

What Can You Do When Someone Acts Unreasonable Or Makes Angry Demands On You?

- Don't downplay their feelings.
- Saying "It's no big deal" won't help, it may even make them more angry. Instead, try something like, "You seem really frustrated. What can we do next time to make it better?"
- Let them talk about their anger. "What's making you feel so bad?" "You seem upset, can I help?"
- Make an effort to respect demands that may seem petty to you but seem very important to them. Remember, if they could they would change the volume on the radio themselves.
- Find something to agree about. "Yes, the mail carrier hasn't been coming as early as he used to." "You're right, these sheets are all wrinkled up."

Give them Chances To Make Decisions And Be In Control.

- "What should we have for breakfast today, oatmeal or eggs?"
- "Do you like your bath before breakfast or after?"

Look For Patterns To The Angry Behavior. Maybe the outbursts always come in the late afternoon when they are more irritable or on days when you're in a hurry or stressed.
Try To Break The Pattern. If you can avoid the triggers that lead up to an angry outburst you can reduce frustration for both of you.
Choose Your Battles. If you're making a lot of demands on them about eating, moving, or resting, they may become resentful. Choose what's really important and let some things go. Anybody could get angry if told to eat everything on their plate.
Take A Breather. If either of you is losing control of the situation, walk away. Take several deep breaths, count to 10, or give a silent scream while both of you cool off. Anxious Or Demanding Behavior Chronic illness or disability may make the ill person more anxious than usual. They may worry about small details of their medications, their blood pressure or their blood sugar levels. They may make

constant or unreasonable demands. They may refuse to allow anyone but you to straighten their bed sheets.
Anxiety may make them feel restless or dizzy, they may have hot flashes or chills, or they may feel like their heart is pounding. Anxiety can also cause irritability, depression, insomnia and poor concentration.

If You Care For Someone Who Is Overly Anxious Try The Following:

- Try to identify in the environment what could make someone anxious (too much caffeine; watching crime shows on television) and decrease those things.
- Look for the feelings behind the demands. A person with breathing problems may demand that windows are open on a cold day because he feels he can't get enough air.
- Use gentle touch to calm them. Reassuring them that things are under control while stroking their hand or the back of their neck may help ease the anxious feelings.
- Accept their need for control. They may insist that things are kept in a certain place on their bedside table because he doesn't have the energy to get up and get them.
- Offer reassurances such as "we have enough time" not "everything will be okay".
- Give them privacy and personal space.

Behavior Issue 1: Elderly Rage, Anger and Yelling

Age and illness can intensify longstanding personality traits in some unpleasant ways. For example, an irritable person may frequently become enraged, or an impatient person may become demanding and impossible to please. Unfortunately, the primary caregiver is often an angry elder's main target.

Tips for Care Givers:

- Try to identify the root cause of their anger. The aging process is not easy. It can spark resentment in seniors who are living with chronic pain, losing friends, experiencing memory issues, and all of the other undignified things that come with getting older.
- Alzheimer's disease and other forms of dementia can also cause these behaviors. With dementia, it is important to remember that the patient doesn't have full control over their words or actions. As a caregiver, the best thing you can do is not take it personally. Focus on the positive, ignore the negative and take a break from caregiving when you can by finding respite. Get some fresh air, do something you love or call a friend.
- Elders often reserve their worst behavior for those they are closest to, like family members. In this case, it may be beneficial to hire in-home care or consider adult day care. Their bad behavior might not surface in front of a stranger, and you get a much-need break.

Behavior Issue 2: Abusive Individual

Occasionally, seniors will lash out at the person who is making the biggest effort to take care of them. Left unchecked, the anger and frustration described above can become so severe that it results in abuse of the caregiver. Stories of mental, emotional, even physical abuse to family members providing care are all too common. In some cases, abuse may stem from a mental illness, such as narcissistic and borderline personality disorders. In other situations, parents turn on the adult child who is showing the most love because they feel safe enough to do so. They don't consciously abuse this son or daughter, but they lash out to vent frustration.

Tips for Care Givers:

- Try explaining how their behavior makes you feel. Unfortunately, many caregivers don't get very far by talking. If the abuse is verbal or emotional, try to make them realize all that you do for them by not doing it for a while. Bring in outside help if your loved one requires supervision and assistance in order to be safe in your absence. Removing yourself from the situation may drive home the point that abusive behavior will not be tolerated. Your loved one

may come away from the experience with renewed appreciation for what you do. In the meantime, you'll get some valuable respite time.

- If physical abuse is the issue, then seek professional help. This may consist of a phone call to the authorities, attending counselling, or permanently handing over your loved one's care to professional caregivers or a long-term care facility.

Behavior Issue 3: Elders who Refuse ADL

The issue of elders refusing to take showers, change their clothes and take care of personal hygiene is far more common than most people think. It's also very frustrating for caregivers.

Sometimes depression is the cause, and another factor could be control. As people age, they lose more and more control over their lives, but one thing they generally can control is dressing and showers. The more you nag them to take a bath and put on fresh clothes, the more they resist.

A decreased sense of sight and smell may be contributing to the problem as well. Our senses dull as we age, so seniors may not detect their own body odor or see how soiled their clothes are. If memory issues are involved, they may lose track of time and not realize how long it's been since they showered.

Lastly, fear and discomfort can play a huge role in their resistance. Many older individuals develop a fear of falling and slipping in the tub, and they are often too embarrassed to ask for help.

Coping Tip

The first step is to determine why they have stopped bathing. If depression is the cause, speak with their doctor. Therapy and medications can help. If modesty is a problem and the elder doesn't want a family member helping them bathe, they may be open to having a professional caregiver provide bathing assistance.

If they are afraid of the water (or slipping in the tub), there are many types of shower chairs, showerheads and other products that can help. If the person has dementia and is afraid of bathing, then you must be gentle. Don't insist on a full shower or bath. Begin with a small request, like asking if you can simply wipe off their face. As they get used to this, you can gradually add cleaning other parts of the body. Be sure to chat with them during the process and let them know what you are doing as you go.

Do your best to keep your parent clean, but keep your expectations realistic. Too much nagging is counter-productive, and at the end of the day, you may have to lower your standards and adapt your definition of cleanliness.

Behavior Issue 4: Senior Swearing, Offensive Language and Inappropriate Comments

When a senior suddenly begins spouting the worst profanities, using offensive language or saying inappropriate things, family members are often baffled as to why and what they can do about it. Caregivers have shared countless stories in the forum about elders who used to be mild-mannered and proper suddenly cursing at them or calling them insulting names. When it happens in public, it's embarrassing, and when it happens in private, it's hurtful.

Coping Tip

When this behavior is out of character for an elder, the start of Alzheimer's or another form of dementia is a likely cause. If the onset is quite sudden, a urinary tract infection (UTI) is another common culprit. UTIs present very differently in seniors, and symptoms include behavioral changes like agitation.

But if dementia is not an issue and a senior is just plain crass, how do you deal with swearing and rudeness? You can try to set firm ground rules for them. Make it perfectly clear that you will not tolerate such language, especially in public settings. A little bit of guilt may be effective in getting them to realize that their behavior is unacceptable and offensive to other people. Try something like "Dad, if Mom was here right now, she would be appalled by your language," or "You would never want your grandchildren to hear you speaking like that, would you?"

When a swearing tirade sets in, another technique is to use distraction. Their fit may end once they're focused on something else. Try bringing up happy times from the old days. Elders love to reminisce,

and prompting them to change the subject and tap into their long-term memory will likely cause them to forget about whatever it is that set them off. If none of these suggestions work, your best bet is to learn not to take this behavior personally. Back off, disappear and wait for it to blow over.

Behavior Issue 5: Paranoia and Hallucinations in the Elderly

Paranoia and hallucinations in the elderly can take many forms. Seniors may accuse family members of stealing, see people and things that aren't there, or believe someone is trying to harm them. These behaviors can be especially difficult for caregivers to witness and try to remedy.

Coping Tip

Hallucinations and delusions in elders are serious warning signs of a physical or mental problem. Keep track of what your loved one is experiencing and discuss it with their doctor as soon as possible. This behavior could be something as simple as be a side effect of a medication they are taking, or it could point to a UTI.

Oftentimes, paranoia and hallucinations are associated with Alzheimer's disease or dementia. When this is the case, caregiving experts seem to agree that the best thing to do is just relax and go with the flow. Do not, try to talk them out of a delusion. Validation is a good coping technique, because what the elder is seeing, hearing or experiencing is very real to them. Convincing them otherwise is fruitless. Acknowledge the senior's concerns and perception of reality in a soothing voice. If they are scared or agitated, assure them that they are safe and you will help them through experience.

Behavior Issue 6: Seniors with Strange Obsessions

Saving tissues, worrying if it's time to take their meds, constantly picking at their skin, and hypochondria, are all types of obsessive behaviors that can disrupt the daily lives of seniors and their caregivers. Obsessions are sometimes related to an addictive personality, or a history of obsessive-compulsive disorder (OCD).

Coping Tip

View your parent's obsessive-compulsive behaviors as a symptom, not a character flaw. Obsessive behavior can be related to a number of disorders, including anxiety, depression, dementia, or other neurological issues. It is important to discuss a senior's symptoms with their doctor, especially if they are interfering with their happiness and daily routines. Therapy and/or medication may be the answer.

Watch for things that trigger your parent's obsessive behavior. If their compulsions seem to be related to a specific event or activity, avoid it as much as possible. Do not participate in their obsessions. If you have helped with rituals in the past, change this pattern immediately. Try to find ways to minimize or eliminate triggers if possible. For example, dry, itchy skin may feed a senior's compulsion to pick and scratch. Keeping their skin moisturized and covered with clothing may help minimize the issue. Distraction and redirection can also be helpful.

Behavior Issue 6: Hoarding and Aging Adults

When a senior hoards (acquires and fails to throw out a large number of items), once again, the onset of Alzheimer's or dementia could be at fault. Someone's pre-Alzheimer's personality may trigger increased hoarding behavior at the onset of the disease.

For example, an elderly parent who was already anxious about aging and the possibility of outliving their resources, may begin to collect things and save money due to their feeling overwhelmed by what lies ahead. Others hold on to items because they fear their memories will be lost without tangible evidence of the past.

Coping Tip

You can try to reason with them and even talk about items to throw out or give away. Creating a memory box or an organizational method for keeping "special things" may help tame the chaos. With extreme hoarders, medication and family counseling could make a big difference in how you cope. In

some cases, you may need help from adult protective services (APS) if the senior's behavior has led to unsafe or unsanitary living conditions.

Behavior Issue 7: Refusing to Let Outside Caregivers into The House

It is an important milestone when family caregivers decide to hire in-home care for their loved ones, but this plan is often derailed when seniors refuse to let the caregivers in. Other elders will let the professionals in only to tell them that they are fired!

Coping Tip

The presence of an outsider suggests to the elder that their family can't (or doesn't want to) take care of them. It also magnifies the extent of their needs and makes them feel vulnerable. Work to understand your loved one's reasons for resisting. This could be fear, embarrassment, resentment, or some mix of the three. Talk to them about their feelings, and work together to find solutions that everyone can live with. For example, if Mom hates the thought of letting a stranger into her home, arrange for her to meet the professional caregiver at the home care company's office or at a café for coffee first.

Ask your loved one to simply give home care a try on a temporary basis. Instead of immediately introducing full days of hands-on care, it may help to have someone come in for one day a week for a few hours just to do light housekeeping, like vacuuming and washing clothes. Experienced home care companies know how to handle situations like this, so consult them when necessary. Once the senior gets used to having someone in the house and establishes trust with a caregiver, they will be more comfortable with accepting additional help.

Behavior Issue 8: Senior Over-Spending or Extreme Frugality

Many caregivers are pulling out their hair over their loved ones' spending habits. Some seniors rack up debt, gamble, or send money to charities and scammers, while others refuse to spend a single penny on things they actually need—like medications and long-term care.

Money is already a bit of a taboo topic of discussion, but questioning a parent's ability to handle their finances complicates things even further. This issue is directly tied to their power and independence. When seniors lose independence in some areas, they often try to make up for this loss in another way. Spending (or saving) is one of those ways.

Coping Tip

If you choose to address this issue, seniors will usually insist there is no problem. It's their money and they can spend it as they choose. They do have a right to manage their own finances, but if they are not competent (or you have suspicions of cognitive decline), it is crucial to tackle this head on. For many seniors, mismanaging money is one of the first signs of dementia.

When carelessness or excessive penny pinching is the culprit, bringing in a third party can help. This could be a financial adviser, a spiritual leader, a friend—anyone whose opinion the senior will respect. For over-spenders, present the total amount spent on their shopping sprees. Sometimes they need to see the effects of their behavior in black and white terms.

On the other end of the spectrum, money hoarders' behaviors may be the result of having lived through the Great Depression and other hardships. Seniors who once feared being able to pay bills and take care of their family likely don't want to see a family member go through financial hardships on their behalf either. Showing them the out-of-pocket expenses regarding their care that you are paying might help open their eyes.

Behavior Issue 9: Elders who Demand Undivided Attention

Once a family member becomes a caregiver, the care recipient might construe this commitment as a 24-hour full-time job. However, family caregivers have other obligations and priorities like work, family, and their own physical and mental health. Seniors who are still capable of doing things for themselves can easily become completely dependent on a caregiver for all of their physical and emotional needs. It is one thing when they truly need extensive assistance, but when this dependency

is elective, it can make their demands even more frustrating. Some seniors even go so far as to "sabotage" their caregivers' plans for activities other than providing care, including work, vacations, and family time. This is unacceptable.

Coping Tip

You must make yourself a priority. Caregiving can easily turn into a full-time job if you let it. Setting boundaries with a demanding senior is crucial, and failing to do so is a recipe for caregiver burnout. Do whatever you need to do to get your parent involved in activities and socialization that does not directly involve you. Depending on their capabilities, adult day care, book clubs, volunteer opportunities, and art classes, could all be viable options for getting a loved one out of the house and focused on something other than your attention. They will probably go kicking and screaming, but having other people to interact with combats loneliness and makes them less dependent on you. If your parent is housebound, enlist other family members, friends, fellow churchgoers, or a hired companion to visit on a regular basis and give you a break. Home companions are available through home care companies.

Section 7: Infection Control and Universal Precautions

Standard precautions are meant to reduce the risk of transmission of blood borne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients.
Hand hygiene is a major component of standard precautions and one of the most effective methods to prevent transmission of pathogens associated with health care. In addition to hand hygiene, the use of personal protective equipment should be guided by risk assessment and the extent of contact anticipated with blood and body fluids, or pathogens.
In addition to practices carried out by health workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health-care settings. The control of spread of pathogens from the source is key to avoid transmission. Among source control measures, respiratory hygiene/cough etiquette, developed during the severe acute respiratory syndrome (SARS) outbreak, is now considered as part of standard precautions.
Worldwide escalation of the use of standard precautions would reduce unnecessary risks associated with health care. Promotion of an institutional safety climate helps to improve conformity with recommended measures and thus subsequent risk reduction. Provision of adequate staff and supplies, together with leadership and education of health workers, patients, and visitors, is critical for an enhanced safety climate in health-care settings.

Important Advice

- Promotion of a safety climate is a cornerstone of prevention of transmission of pathogens in health care.
- Standard precautions should be the minimum level of precautions used when providing care for all patients.
- Risk assessment is critical. Assess all health-care activities to determine the personal protection that is indicated.
- Implement source control measures for all persons with respiratory symptoms through promotion of respiratory hygiene and cough etiquette.

Checklist

Health Policy

- Promote a safety climate.
- Develop policies which facilitate the implementation of infection control measures.

Hand Hygiene

- Perform hand hygiene by means of hand rubbing or hand washing (see overleaf for detailed indications).
- Hands should always be washed with soap and water if hands are visibly soiled, or exposure to spore-forming organisms is proven or strongly suspected, or after using the restroom. For other indications, if resources permit, perform hand rubbing with an alcohol-based preparation.
- Ensure availability of hand-washing facilities with clean running water.
- Ensure availability of hand hygiene products (clean water, soap, single use clean towels, alcohol-based hand rub). Alcohol-based hand rubs should ideally be available at the point of care.

Personal Protective Equipment (PPE)

- Assess the risk of exposure to body substances or contaminated surfaces BEFORE any health-care activity. Make this a routine!
- Select PPE based on the assessment of risk:
    - Clean non-sterile gloves.

- Clean, non-sterile fluid-resistant gown.
- Mask and eye protection or a face shield.

Respiratory Hygiene and Cough Etiquette

- Education of health workers, patients and visitors.
- Use of source control measures.
- Hand hygiene after contact with respiratory secretions.
- Spatial separation of persons with acute febrile respiratory symptoms.

Health-care Recommendations for Universal Precautions

Hand Hygiene

Summary technique:

- Hand washing (40–60 sec): wet hands and apply soap; rub all surfaces; rinse hands and dry thoroughly with a single use towel; use towel to turn off faucet.
- Hand rubbing (20–30 sec): apply enough product to cover all areas of the hands; rub hands until dry.

Summary indications:

- Before and after any direct patient contact and between patients, whether or not gloves are worn.
- Immediately after gloves are removed.
- Before handling an invasive device.
- After touching blood, body fluids, secretions, excretions, non-intact skin, and contaminated items, even if gloves are worn.
- During patient care, when moving from a contaminated to a clean body site of the patient.
- After contact with inanimate objects in the immediate vicinity of the patient.

Gloves

- Wear when touching blood, body fluids, secretions, excretions, mucous membranes, nonintact skin.
- Change between tasks and procedures on the same patient after contact with potentially infectious material.
- Remove after use, before touching non-contaminated items and surfaces, and before going to another patient. Perform hand hygiene immediately after removal.

Facial Protection (Eyes, Nose & Mouth)

- Wear a surgical or procedure mask and eye protection (face shield, goggles) to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

Gown

- Wear to protect skin and prevent soiling of clothing during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
- Remove soiled gown as soon as possible, and perform hand hygiene.

Prevention of needle stick injuries

Use care when:

- handling needles, scalpels, and other sharp instruments or devices
- cleaning used instruments
- disposing of used needles.

Respiratory hygiene and cough etiquette

Persons with respiratory symptoms should apply source control measures:

- Cover their nose and mouth when coughing/sneezing with tissue or mask, dispose of used tissues and masks, and perform hand hygiene after contact with respiratory secretions.

Environmental cleaning

- Use adequate procedures for the routine cleaning and disinfection of environmental and other frequently touched surfaces.

Linens

Handle, transport, and process used linen in a manner which:

- prevents skin and mucous membrane exposures and contamination of clothing.
- avoids transfer of pathogens to other patients and or the environment.

Waste disposal

- Ensure safe waste management.
- Treat waste contaminated with blood, body fluids, secretions and excretions as clinical waste, in accordance with local regulations.
- Human tissues and laboratory waste that is directly associated with specimen processing should also be treated as clinical waste.
- Discard single use items properly.

Patient care equipment

- Handle equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment.
- Clean, disinfect, and reprocess reusable equipment appropriately before use with another patient.

Section 8: Importance of Clean Environment

Numerous studies have found a correlation between a clean home and physical fitness. Researchers have also found participants with cleaner homes exercised more. There has been consensus that the interior condition of a house has a direct effect on the physical activity in it.
The question remains: do fit people have more energy to clean their homes, or are they simply disciplined in terms of their fitness and house cleanliness? Regardless, keeping a clean home has its benefits – a potentially fit body being just one.
Some of the reasons to keep a clean home include:

Lowering stress and fatigue
When you live in a messy home, you are subconsciously reminded of work that needs to be finished and visually, your eyes do not rest. Too much clutter can cause tremendous stress and fatigue. When things take longer to find, or can't be found, stress levels rise, and so does your risk for illness.

Reducing allergy and asthma symptoms
Not staying tidy in areas with carpeting, upholstery or bedding, or in areas that are naturally damp, such as basements and garages, can worsen allergies and asthma.
Dust mites, pet dander and mold lurk in physical possessions, which can trigger allergic reactions, decrease air quality and increase potential asthma problems. The more stuff you have in your home, the harder it is to clean. Messy and cluttered areas increase the potential for dust, pet dander and mold to accumulate which result allergens which trigger asthma related illnesses.

Improving safety
Falls and fires are two leading causes of injuries and deaths inside the home. Tripping over objects and slipping on slick surfaces can cause head injuries and broken and sprained limbs, which can result in a trip to the hospital emergency room.
Anything that blocks doorways and hallways is also a fire hazard. Clutter can easily hasten the spread of fire and hinder your ability to escape or to be rescued.
It's important to keep your home picked up and free from spills to make your environment physically safer.

Lessening the spread of germs
Although most people think of bathrooms as the most germ-ridden spots in the house, findings indicate the kitchen is the biggest area of concern.
The kitchen is a prime area for germs because of the many crevices that can hold water or splatters of food. In order to lessen the spread of germs, counter tops should be made of an impervious material that can be cleaned with bleach after preparing raw meats and fish, and that cleaning sponges and cloths, which support the growth of pathogens, should be sanitized after each use.
According to the U.S. Centers for Disease Control and Prevention, gastrointestinal illness can be spread by contaminated food, and food-poisoning is less likely in kitchens that have been properly cleaned and sanitized.
It is also important to pay attention to the bathrooms. The toilet and flush and faucet handles are easily contaminated with potential dangerous germs and need to be disinfected. These are a major focus of environmental cleaning in the hospital and need to be in the home.

Keeping pests away
Bugs and rodents can multiply and easily hide in messy homes. They are attracted to liquid spills, food debris and dirty pet bowls. Their presence is trouble, as they spread disease, bacteria, germs and allergies.

Insects like cockroaches are not just annoying, but can spread dangerous germs to humans. They are a well-established cause of asthma, carry numerous bacteria and parasites and they spread germs that can cause gastroenteritis.
Mice can also be a problem for many homes. They can spread diseases to humans, including Lymphocytic Choreomeningitis, Salmonella and Hantavirus. It is very important for the health of the entire family to prevent pest infestations.
Regular cleaning, including putting all food away in air-tight containers after each meal, and daily trash removal help to keep pests away and uncover them before they become a serious issue.

Improving your diet and waistline
Research has shown that women eat more sweets and high-fat foods when faced with daily hassles or professional stress. Research has also found that a chaotic physical environment may promote unhealthy diet. Numerous studies have shown that people living in organized living environment are generally healthy and have better diets than those who live in chaotic home environment.

Section 9: Responding to Emergencies

Risk Assessment
Unique to the home-based care environment is the fact that each setting is different from the next. That means you will need to be prepared for anything and know how to react. Your organization must perform an assessment to identify the potential hazards that you may face, and it must be incorporated into the emergency preparedness plan.
Additionally, your agency must identify potential emergencies that would affect employees and clients with vulnerabilities and create plans to address them. The Centers for Disease Control and Prevention (CDC) published a guide that offers some advice. It says that all agencies should:

- Develop preparedness plans with the issues and needs of older adults in mind.
- Cite appropriate legal authorities.
- Define the categories of disasters and emergencies and how they might affect older adults.
- Ensure attention to all special needs during each phase of the emergency response.

Emergencies
There are many potential hazards that you face because you work in the home setting, and you must know and understand them. However, the emergencies that would require the *emergency preparedness plan* to be activated include:

- Mass casualty
- Hazardous waste spill or exposure
- Power or communications failure
- Disease outbreak or pandemic
- Natural disasters including
    - Earthquakes
    - Tornadoes
    - Hurricanes
    - Typhoons
    - Tsunamis
    - Avalanche
    - Volcano
    - Flooding
    - Mud and rock slides
    - Wildfires
    - Any type of severe weather such as thunder storms, high winds, hail, winter storms, and extreme heat, drought, or cold

Planning
A key part of planning for such emergencies includes identifying the likelihood of occurrence and the types of risks presented by each. Your organization's emergency plan should contain a list of the emergencies and natural disasters that are most likely to occur in your area and instructions about what to do when they occur.

The Emergency Preparedness Plan
Your organization will use risk assessment, communication needs, and training and testing requirements to aid in the creation of an emergency plan. An emergency preparedness plan is created by your employer so that you will know what to do when an emergency occurs, and coordinates the different actions that are to be carried out within an organization during an emergency. This plan is made for your specific region and work setting. It usually encompasses considerations regarding:

- Administrative duties

- Supplies, including food and water
- Communication
- Staffing
- Power supply
- Utilities
- Finances
- Record keeping and protection
- Client education
- Transportation
- Service capacity

The emergency preparedness plan should be stored where it is easily accessible to all employees in an emergency, and it will be organized in such a way that classifies and prioritizes clients for the emergency response, taking into consideration the impact the assigned designations will have. Those organizational policies and procedures will guide your practice and strive to keep you and those you care for safe. Be sure you understand them and know how to react in potentially uncomfortable, dangerous, or emergency situations, and take extra time to discuss your concerns as they arise with your supervisor.

The Response

During an emergency, your administration will establish a command center and a chain of command. The communication plan that your organization creates must be coordinated *within* the organization and *with* outside healthcare providers, local and state health departments, and emergency management agencies across the system of emergency support.

With the activation of the emergency plan, you will follow the policies and procedures and perform the tasks indicated by the plan concerning:

- Initial steps
- Administrative support
- Supplies
- Utilities such as water and power
- Record protection
- Documentation
- Billing
- Continuity of services
- Communication
- Caseload
- Staffing
- Education
- Transportation

The initial steps that you should take during an emergency are important because they set the stage for successful management of the emergency.

A Team Effort

Emergency preparedness and management are critical components of your responsibility as a professional in home-based care. You must know and understand the precautions to take, use good judgment, and follow your agency's emergency plan. Remember that this plan will identify the specific types of emergencies that might affect your agency and a *specific plan* for those emergencies.

You need to know the steps to take in the event of an emergency to ensure continued care and maintain the safety of all, including special populations. The emergency preparedness plan is there for you to use to effectively fulfill your role during any emergency response. There may be government resource limitations, and you and your clients should work together during any crisis. It takes a team effort to effectively plan, respond, and recover!

Section 10: Abuse and Neglect

Many elderly adults are abused in their own homes, in relatives' homes, and even in facilities responsible for their care. If you suspect that an elderly person is at risk from a neglectful or overwhelmed caregiver, or being preyed upon financially, it's important to speak up. Everyone deserves to live in safety, with dignity and respect. Learn about the warning signs of elder abuse, what the risk factors are, and how you can prevent and report the problem.

What is elder abuse and neglect?

Elder abuse includes physical, emotional, or sexual harm inflicted upon an older adult, their financial exploitation, or neglect of their welfare by people who are directly responsible for their care. In the U.S. alone, more than half a million reports of elder abuse reach authorities every year, and millions more cases go unreported.

As older adults become more physically frail, they're less able to take care of themselves, stand up to bullying, or fight back if attacked. Mental or physical ailments can make them more trying companions for those who live with them. And they may not see or hear as well or think as clearly as they used to, leaving openings for unscrupulous people to take advantage of them.

Elder abuse tends to take place where the senior lives: where their abusers are often adult children, other family members such as grandchildren, or a spouse or partner. Elder abuse can also occur in institutional settings, especially long-term care facilities.

Types of elder abuse

Abuse of elders takes many different forms, some involving intimidation or threats against the elderly, some involving neglect, and others involving financial trickery. The most common are:

- **Physical elder abuse** – The non-accidental use of force against an elderly person that results in physical pain, injury, or impairment. Such abuse includes not only physical assaults such as hitting or shoving but the inappropriate use of drugs, restraints, or confinement.
- **Emotional elder abuse** – The treatment of an older adult in ways that cause emotional or psychological pain or distress, including:
    - Intimidation through yelling or threats
    - Humiliation and ridicule
    - Habitual blaming or scapegoating
    - Ignoring the elderly person
    - Isolating an elder from friends or activities
    - Terrorizing or menacing the elderly person
- **Sexual elder abuse** – Contact with an elderly person without their consent. Such contact can involve physical sex acts, but activities such as showing an elderly person pornographic material, forcing the person to watch sex acts, or forcing the elder to undress are also considered sexual elder abuse
- **Elder neglect** – Failure to fulfill a caretaking obligation. This constitutes more than half of all reported cases of elder abuse. It can be intentional or unintentional, based on factors such as ignorance or denial that an elderly charge needs as much care as they do.
- **Financial exploitation** – The unauthorized use of an elderly person's funds or property, either by a caregiver or an outside scam artist. An unscrupulous caregiver might:
    - Misuse an elder's personal checks, credit cards, or accounts
    - Steal cash, income checks, or household goods
    - Forge the elder's signature
    - Engage in identity theft

Typical scams that target elders include:

- Announcement of a "prize" that the elderly person has won but must pay money to claim
- Phony charities
- Investment fraud

- **Healthcare fraud and abuse** – Carried out by unethical doctors, nurses, hospital personnel, and other professional care providers. This can include:
  - Not providing healthcare, but charging for it
  - Overcharging or double-billing for medical care or services
  - Getting kickbacks for referrals to other providers or for prescribing certain drugs
  - Overmedicating or undermedicating
  - Recommending fraudulent remedies for illnesses or other medical conditions
  - Medicaid fraud

Warning signs of elder abuse

Signs of elder abuse can be difficult to recognize or mistaken for symptoms of dementia or the elderly person's frailty—or caregivers may explain them to you that way. In fact, many of the signs and symptoms of elder abuse do overlap with symptoms of mental deterioration, but that doesn't mean you should dismiss them on the caregiver's say-so.

Frequent arguments or tension between the caregiver and the elderly person or changes in the personality or behavior in the elder can be broad signals of elder abuse. If you suspect abuse, but aren't sure, you can look for clusters of the following warning signs.

- **Physical abuse warning signs:**
  - Unexplained signs of injury, such as bruises, welts, or scars, especially if they appear symmetrically on two sides of the body
  - Broken bones, sprains, or dislocations
  - A report of drug overdose or an apparent failure to take medication regularly (a prescription has more remaining than it should)
  - Broken eyeglasses or frames
  - Signs of being restrained, such as rope marks on wrists
  - Caregiver's refusal to allow you to see the elder alone

- **Emotional abuse warning signs:**
  - Threatening, belittling, or controlling caregiver behavior
  - Behavior from the elder that mimics dementia, such as rocking, sucking, or mumbling to themselves

- **Sexual abuse warning signs:**
  - Bruises around breasts or genitals
  - Unexplained vaginal or anal bleeding
  - Torn, stained, or bloody underclothing

- **Elder neglect or self-neglect warning signs:**
  - Unusual weight loss, malnutrition, dehydration
  - Untreated physical problems, such as bed sores
  - Unsanitary living conditions: dirt, bugs, soiled bedding and clothes
  - Being left dirty or unbathed
  - Unsuitable clothing or covering for the weather
  - Unsafe living conditions (no heat or running water; faulty electrical wiring; other fire hazards)

- Desertion of the elder at a public place

- **Financial exploitation warning signs:**
  - Significant withdrawals from the elder's accounts
  - Sudden changes in the elder's financial condition
  - Items or cash missing from the senior's household
  - Suspicious changes in wills, power of attorney, titles, and policies
  - Addition of names to the senior's signature card
  - Financial activity the senior couldn't have undertaken, such as an ATM withdrawal when the account holder is bedridden
  - Unnecessary services, goods, or subscriptions

- **Healthcare fraud or abuse warning signs**
  - Duplicate billings for the same medical service or device
  - Evidence of overmedication or under-medication
  - Evidence of inadequate care when bills are paid in full
  - Problems with the care facility: poorly trained, poorly paid, or insufficient staff; crowding; inadequate responses to questions about care

Risk factors for elder abuse

It's difficult to take care of a senior who has many different needs, and it's difficult to be elderly when age brings with it infirmities and dependence. Both the demands of caregiving and the needs of the elder can create situations in which abuse is more likely to occur.

Many nonprofessional caregivers—spouses, adult children, other relatives and friends—find taking care of an elder to be satisfying and enriching. But the responsibilities and demands of caregiving, which escalate as the elder's condition deteriorates, can also cause significant stress. The stress of elder care can lead to mental and physical health problems that leave caregivers burned out, impatient, and more susceptible to neglecting or lashing out at the elders in their care.

In addition to the caregiver's inability to manage stress, other risk factors for elder abuse include:

- Depression in the caregiver
- Lack of support from other potential caregivers
- The caregiver's perception that taking care of the elder is burdensome and without emotional reward
- Substance abuse by the caregiver
- The intensity of the elderly person's illness or dementia
- Social isolation—the elder and caregiver are alone together almost all the time
- The elder's role, at an earlier time, as an abusive parent or spouse
- A history of domestic violence in the home
- The elder's own tendency toward verbal or physical aggression

Even caregivers in institutional settings can experience stress at levels that lead to elder abuse. Nursing home staff may be prone to elder abuse if they lack training, have too many responsibilities, are unsuited to caregiving, or work under poor conditions.

Preventing elder abuse and neglect

If you're a caregiver to an elderly person and feel you are in danger of hurting or neglecting them, help and support are available. Perhaps you're having trouble controlling your anger and find yourself screaming louder and louder or lashing out at the person in your care? Or other people have expressed concern with your behavior or the tension between the two of you? Or maybe you simply feel emotionally disconnected or overwhelmed by the daily needs of the elderly person in your care? Recognizing that you have a problem is the biggest step to getting help and preventing abuse.

As a caregiver, the following steps can help you prevent elder abuse or neglect:

- **Take immediate steps to relieve stress and burnout**
  Stress is a major contributor to elder abuse and neglect. You can help reduce your stress levels by regularly practicing stress-relieving techniques such as yoga, meditation, or deep breathing exercises.
- **Request help**
  From friends, relatives, or local respite care agencies or find an adult daycare program. Every caregiver needs to take regular breaks from the stress of caring for an elder and to attend to their own needs, if only for a couple of hours.
- **Learn techniques**
  For getting your anger under control.
- **Take care of yourself**
  If you are not getting enough rest, you are much more likely to succumb to anger. Eat a healthy diet, get regular exercise, and take care of your own medical needs.
- **Seek help for depression**
  Family caregivers are especially at risk for depression, but there are plenty of things you can do to boost your mood and outlook and overcome the problem.
- **Find a support group for caregivers of the elderly**
  Sharing your concerns and experiences with others facing the same challenges can help relieve the isolation you may be feeling as a caregiver. It can also be a great place to gain valuable tips and insight into caring for an elder.
- **Get help for any substance abuse issues**
  It's never easy, but there are plenty of actions you can take to address drug or alcohol abuse.
- **Get professional help**
  If you can't seem to stop yourself no matter how hard you try, it's time to get help by talking to a therapist.

If you're a concerned friend or family member, the following can also help to prevent abuse of an elderly person.

- **Call and visit as often as you can,** helping the elder to see you as a trusted confidante.
- **Offer to stay with the elder so the caregiver can have a break**—on a regular basis, if possible.
- **Monitor the elder's medications** to ensure the amounts being taken correspond with the prescription dates.
- **Watch for financial abuse** by asking the elder if you can check their bank accounts and credit card statements for unauthorized transactions.
- **Identify the warning signs** of abuse or neglect and report it without delay.

Reporting elder abuse

If you are an elder who is being abused, neglected, or exploited, tell at least one person. Tell your doctor, a friend, or a family member whom you trust. Or call one of the helplines listed below. If you see an older adult being abused or neglected, don't hesitate to report the situation. And if you see future incidences of abuse, continue to call and report them. Each elder abuse report is a snapshot of what is taking place. The more information that you can provide, the better the chance the elder has of getting the quality of care they need. Older adults can become increasingly isolated from society and, with no work to attend, it can be easy for abuse cases to go unnoticed for long periods.

Many seniors don't report the abuse they face even if they're able. Some fear retaliation from the abuser, while others view having an abusive caretaker as better than having no caretaker and being forced to move out of their own home. When the caregivers are their children, they may feel ashamed that their children are inflicting harm or blame themselves: "If I'd been a better parent when they were younger, this wouldn't be happening." Or they just may not want children they love to get into trouble

with the law. In any situation of elder abuse, it can be a real challenge to respect an older adult's right to autonomy while at the same time making sure they are properly cared for.
In the case of an elder experiencing abuse by a primary caregiver, such as an adult child:

Do not confront the abuser yourself. This may put the older person in more danger unless you have the elder's permission and are able to immediately move them to alternative, safe care.

Find strength in numbers. If a family caregiver is suspected of abuse, other family members may have the best chance of convincing the older adult to consider alternative care.

Feelings of shame can often keep elder abuse hidden. You may not want to believe a family member could be capable of abusing a loved one, or you may even think that the older adult would be angry at you for speaking up. But the earlier you intervene in a situation of elder abuse, the better the outcome will be for everyone involved.
In the case of self-neglect:

Even if the elder refuses your help, keep checking in with them. Enlist others to express their feelings of concern to them. Sometimes a peer or a neutral party, such as a geriatric care manager, may have a better chance of getting through.

Make sure the older adult is connected with medical services. Since self-neglect can have medical causes, share your concerns with the elder's doctor if possible.

Offer the elder home services on a trial basis. This can help them see the positive changes they can experience, and open them up to considering alternative care. For example, encourage them to try housekeeping help for a month or a meal delivery service for a few weeks.

Tour assisted living or other senior housing facilities without any immediate pressure to move. This may help dispel any myths or eradicate the older person's fears about moving.

Consider legal guardianship. If you are concerned that a person's ability to take care of themselves safely is compromised, you can look into legal guardianship or legal conservatorship. If there is not an appropriate family member available, a guardian can be appointed by the court.

Where to turn for help
If an elderly person needs immediate assistance, call 911 or your Area Agency on Aging's emergency service number.

Some Regulations to Protect Elders from Abuse
Older Adults Protective Services Act (OAPSA) and Adult Protective Services Act (APS)

- Provide for the detection, prevention, reduction and elimination of abuse, neglect, exploitation and abandonment
- Require a program of protective services for adults in need of them
- Require a uniform statewide reporting and investigative system
- Prescribe penalties
- Utilize least restrictive alternatives and ensure services are provided in the most integrated setting

Legislative provisions of both laws

- Adults who lack capacity and are at imminent risk must have access to services necessary to protect their health, safety and welfare

- Adults have the right to make choices even when those choices present risks to themselves or their property
- Adults have the right to refuse some or all protective services
- Information should be provided in a safe place and understandable manner
- Services shall be in the least restrictive environment, most integrated setting and encourage consumer choice

OAPSA

- OAPSA was enacted to provide protective services to individuals age 60 and over
- Provides legal authority to investigate cases of abuse, neglect or exploitation and abandonment
- Pennsylvania Department of Aging administers at state level (funding, oversight)
- Area Agencies on Aging implement at the local level (intake, investigation and services)

If the adult is age 60 or over and you suspect abuse:

- Call 911 if the person is in immediate danger
- Call the Area Agency on Aging (AAA) or the Statewide Elder Abuse Hotline 1-800-490-8505
- File an incident report in SAMS for Aging Waiver participants
- File an incident report in EIM for over 60 participants in other waivers
- Cooperate with OAPSA

Section 11: Critical Incident Management

All employees of Blue Mountain Home Health Care must report all critical incidents as described below to their immediate supervisor and/or the office manager.

Definitions:

- Abandonment: The desertion of an older adult by a caretaker.
- Abuse: An act or omission that willfully deprives a participant of rights or human dignity, or which may cause or causes actual physical injury or emotional harm to a participant including a critical incident and any of the following:
  - Sexual harassment of a participant
  - Sexual contact between a staff member and a participant
  - Using restraints on a participant
  - Financial exploitation of a participant
  - Humiliating a participant.
- Administrator: The person responsible for the administration of a facility. The term includes a person responsible for the employment decisions or an independent contractor
- Adult: A resident of the Commonwealth between the ages of 18 and 59 years of age with a physical or mental impairment that substantially limits one or more major life activities
- Caretaker: Any person who is an owner, operator, manager or employee of a nursing home, personal are home, domiciliary care home, community residential facility, intermediate care facility of the mentally retarded, adult daily living center, home health agency or home health service provider whether licensed or unlicensed; a person who provided care to a care-dependent person in the setting described above or has an obligation to care for a care-dependent person for monetary consideration.
- Department: The Department of Human Services
- Exploitation - An act or course of conduct by a caregiver or other person against an adult or an adult's resources, without the informed consent of the adult or with consent obtained through misrepresentation, coercion or threats of fore that results in monetary, personal or other benefit, gain or profit for the perpetrator or monetary or personal loss to the adult
- Neglect: The failure to provide for oneself or the failure of a caregiver to provide goods, care or services essential to avo id a clear and serious threat to the physical or mental health of an adult. The term does not include environmental factors that are beyond the control of an adult or the caregiver, including, but not limited to, inadequate housing, furnishings, income, clothing or medical care
- Physical Abuse: A physical act by an individual that may cause physical injury to a participant
- Psychological Abuse: An act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean a participant
- Restraint: Any physical, chemical or mechanical intervention that is used to control acute episodic behavior that restricts the movement or function of the individual or portion of the individual's body. Use of restraint and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights
- Serious Bodily Injury: An injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body member or organ
- Serious Physical Injury: An injury that causes a person severe pain or significantly impairs a person's physical functioning, either temporarily or permanently
- Service Interruption: Any event that results in the participant's inability to receive services that

places their health or safety at risk. This includes involuntary termination by the agency and failure of the participant's back up plan. In the occurrence of these events, the provider agency must have a plan for temporary stabilization

- Sexual Abuse: Intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, in decent assault or incest .
- Suspicious Death: A death that would arouse suspicion or is questionable
- Verbal Abuse: Using words to threaten, coerce, int imidat e, degrade, demean, harass, or humiliate a participant

Procedures:

- **It is important to differentiate complaints, program fraud and financial abuse, and critical incidents as there will be separate protocols and actions taken, depending on the distinction.**

- **Complaints:**
  - Complaints are defined as any dissatisfaction with any aspect of program operations, activities, or services received or not receive d. These are not considered critical incidents
  - All com plaint s should be directed to a participant's Program Coordinator
  - When issues cannot be resolved or a participant is not comfortable discussing the complaint with the Program Coordinator, the participant may contact the Director of Adult Services or the Office of Long Term Living Quality Assurance Helpline at 1-800-757-5042

- **Program Fraud and Financial Abuse:**
  - Can include claims submitted for services or supplies that were not provided and excessive charges for services and supplies
  - Reporting requirements can be found in the OLTL Fraud and Financial Abuse bulletin (No. 05-11-04, 51-11-04, 54-11-04, 55-11-04, 59-11-04 issues and effective on August 8, 2001)
  - These are not considered critical incidents

- **Critical Incidents are defined as an occurrence of an event that jeopardizes the participant's health and/or welfare. This includes, but is not limited to the following:**
  - Death that is suspicious or of unexplained causes (other than by natural causes), serious injury, and hospitalization. (This does not include planned hospital stays)
  - Provider and staff misconduct that is deliberate, willful, unlawful or dishonest
  - Abuse defined as the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse, exploitation of a participant. This includes, but is not limited to physical abuse, psychological abuse, sexual abuse, and verbal abuse
  - Neglect
  - Exploitation
  - Service Interruption
  - Medication errors that require medical intervention such as an emergency room visit or hospitalization.

- **Mandatory Reporting: It is mandatory that employees of Blue Mountain Home Health Care report critical incidents related to individuals who receive home and community based services and supports from our agency. In instances where the service coordination agency**

discovers or has independent knowledge of the critical incident, it is their responsibility to report to OLTL.

- Mandatory Reporting applies to any critical incidents that occur during the time the Agency is providing services, any critical incidents that occur during the time the Agency is contracted to provide services but fails to do so, and any critical incidents that occur at times other than when the Agency is providing or is contracted to provide services (if an employee becomes aware of such incidents).
- Participants shall not be terminated or threatened with loss of services because they file complaints or critical incident reports of any kind. They have the right to report alleged incidents at any time and should be encouraged, but are not required to do so. Participants may report alleged incidents by calling the Participant helpline at 1-800-757-5042. A participant's decision not to report an incident does not remove the responsibility of the Agency from reporting it

➢ **Process of Reporting: It is the responsibility of the person that discovers the critical incident or as knowledge of the critical incident to report it immediately and directly to their supervisor of the Director of In-Home Services. It is then the responsibility of the supervisor or Director of In-Homes Services to ensure the appropriate Service Coordination Agency is notified to investigate and report the alleged critical incident to OLTL.**

➢ **Reporting of Incidents:**

- An employee or administrator Blue Mountain Home Health Care is required to report critical incidents. Prior to reporting the incident, steps must be taken to safeguard the health and welfare of the participant. In addition, a call should be made to 911 if the participant is in a life-threatening situation prior to contacting agencies below

- All employees should first make contact with the office immediately within 24 hours to understand if an incident is reportable. Oral reports must be immediately made to the following agencies and to the Service Coordinator within discovery of a known alleged incident. The Service Coordinator should also be contacted if the participant is in immediate need of an intervention and 911 has not been called

  - **Adult Protective Services Act (APS):** Covers reporting suspected abuse, neglect, exploitation or abandonment of persons with disabilities between age 18 and 59 years old. Staff must immediately make an oral report to the statewide Protective Services Hotline by calling (800) 490 8505 and applicable law enforcement officials, the fire department or other authorities as appropriate. Once the report is made, it will be referred to and handled by Liberty Healthcare. **Covers Reporting: Abuse, Neglect, Exploitation, Abandonment, Sexual Abuse, Serious Injury or Suspicious Death**

  - **Older Adults Protective Services Act (OAPSA):** Covers reporting suspected abuse for adults age 60 and older. Staff must make an oral report to the local Area Agency on Aging (AAA) or Statewide Elder Abuse Hotline (800) 490 8505 and local law enforcement officials, the fire department or other authorities as appropriate. **Covers reporting: Abuse, Sexual Abuse, Serious Bodily or Physical Injury, Suspicious Death**

  - **To Coroner:** For report which concerns the death of a recipient, if there is reasonable cause to suspect that the recipient died as a result of abuse, the agency shall give the oral report and forward a copy of the written report to the appropriate coroner within 24 hours

- **To PDA:** If report involves sexual abuse, serious physical injury, serious bodily injury, or suspicious death - the employee/administrator must make an oral report to PDA (717) 265 7887 during the current business day or at the opening of the next business day, if the incident occurred after hours

- Within 48 hours of making the initial discovery of critical incident, employees and administrators are required to complete and submit written reports approved by the department to OLTL. If the incident occurs over the weekend, a written report must be entered by Blue Mountain Home Health Care into Enterprise Incident Management (EIM) if participant is covered under APS or through the ***RA-incendt@pa.gov*** if participant is covered under OAPSA. Reports should be completed on appropriate forms issued by the department specific to APS and OAPSA

- Employees should be prepared to gather and provide at a minimum the following information when making a report:
  - Name, age, waiver program and address of the recipient
  - Name and address of the recipient's guardian or next of kin
  - Name and address of the facility
  - Description of the alleged incident
  - Any specific comments or observations that are directly related to the alleged incident and the individual involved
  - Actions taken to immediately secure the recipient's well-being

- Notification to Participant: The agency staff that is aware of the critical incident shall notify the participant and representative if requested by the participant that a critical incident report has been filed. This notice must be within 24 hours and in a cognitively and linguistically accessible format. If a participant's representative is suspected to be involved in the critical incent the representative should not be notified.

  Within 48 hours of the conclusion of the critical incident investigation, agency staff must inform the participant of the resolution and measures implemented to prevent recurrence. The participant has the right to provide input into the resolution and measures implemented to prevent recurrence of the critical incident. This notice of the participant and representative if requested by participant must be documented in the critical incident report. All information must be provided in a cognitively and linguistically accessible format

- Participant Involvement: In order to respect an individual's autonomy, a participant has the right to not report incidents and has the right to decline further interventions. Participants also have a right to refuse involvement in the critical incident investigation. The participant has the right to have an advocate present during any interviews and/or investigations resulting from a critical incident report

  In the event that a participant chooses not to report an incident or declines further intervention, the critical incident must still be reported and the Service Coordinator must investigate. Documentation is needed to indicate the lack of participation and decline by participant. The Service Coordinator will then inform the participant of their duties as required by law and the risk they are imposing

- **Investigation of Critical Incidents: Service Coordinators are responsible for investigation reports of critical incidents. They have 24 hours to begin the investigation of an incident upon its discovery or after it has been submitted by Blue Mountain Home Health Care. The allegation is reviewed to determine next action steps needed to protect the health and welfare of the participant.**

  All employees and administrators are expected to cooperate fully with any investigation. Investigations can be done on-site or by telephone to gather information. Investigative action taken, resolution, and measures implemented to prevent recurrence must be completed upon conclusion of investigations but no later than 30 business days from the time of discovery of the incident

- **Employee Removal or Suspension: Cases involving Blue Mountain Home Health Care employee may require the employee to be removed from all OLTL-HCBS/ln-Home Care Programs. This may include requiring the employee have no contact with the participant or suspending the employee until the investigation is completed. This suspension may be with or without pay based upon the circumstances, the alleged incident, and the employment policies of the agency**

- **Report Incident: Utilizing the electronic system prescribed by the OLTL, all critical incidents must be documented and initial reports must include reporter information, participant demographics, OLTL program information, event details and type, and description of incident**

  Direct care workers must also include the above information in a service note provided to Program Coordinator or the Director of In-Home Services

- **All employees will have mandatory initial training in Critical Incident Management during their orientation process**

  All employees will receive yearly mandatory training in these subject areas as well

- **Treatment:** All treatment of participants will be in conformance with the care dependent person's right to accept or refuse services

Quality Management of Critical Incidents

Quarterly Consolidation: Critical Incidents must be tabulated on a quarterly basis. The incidents need to be categorized as preventable or non-preventable incidents.

The quarterly critical incident data will be consolidated at year end and will be part of the Annual Quality Management Plan. The Annual QMP will compare results with previous years goals and based on the analysis next year goals will be established.

Section 12: Complaint Resolution

What is a Complaint?

A general consumer complaint is an expression of dissatisfaction with service delivery. Participants and personal care assistants are encouraged to contact their Administrator with concerns so that they may be addressed in the best possible manner. Care givers may be asked to document the concern on the Customer Complaint Form and/or service note in the charting system. The following examples may be considered a consumer complaint and do not meet the criteria for a critical incident or grievance:

- Dissatisfaction with any aspect of program operations, activities or services received or not received
- Reduction in hours or services due to program funding out of the agency's control
- Reduction or termination of services due to unsafe or unsanitary conditions in the home, illegal or prohibited activities in the home, or failure to follow the service plan

What is a Grievance?

The difference between a complaint and a grievance is that a grievance is a more serious from of complaint. A grievance is a formal statement of complaint that cannot be addressed immediately and involves matters of a more serious nature e.g. the service is in breach of a policy or the service did not meet the expectations of a consumer. Blue Mountain Home Health Care has outlined an internal policy to address how a complaint/grievance is resolved and the steps are as follows:

- The first step is for the consumer or someone acting on behalf of the consumer to present the grievance orally to the Administrator. The grievance must be presented within five (5) working days of the event or of the consumer's knowledge of event
- Upon receiving the oral grievance the Administrator must make a written report.
- The written report must contain the following information:
    - Name of Participant
    - Nature of Complaint
    - Date of Complaint
- The Administrator shall provide a written response to Consumer's grievance within five (5) working days from receipt of the written grievance
- The response must include Administrators actions to resolve the complaint
- The resolution should be presented to the participant and participants satisfaction or non-satisfaction must be recorded
- Complaints that are no resolved to the satisfaction of the participant must be reported to the Office of Long-Term Living

Quality Management of Complaints

Quarterly Consolidation: Complaints must be tabulated on a quarterly basis. The complaints need to be categorized as resolved to participant's satisfaction or not resolved to participant's satisfaction.

The quarterly complaints data will be consolidated at year end and will be part of the Annual Quality Management Plan. The Annual QMP will compare results with previous years goals and based on the analysis next year goals will be established.

Section 13: Quality Management Plan (QMP)

Blue Mountain Home Health Care

Quality Management

Policy Statement

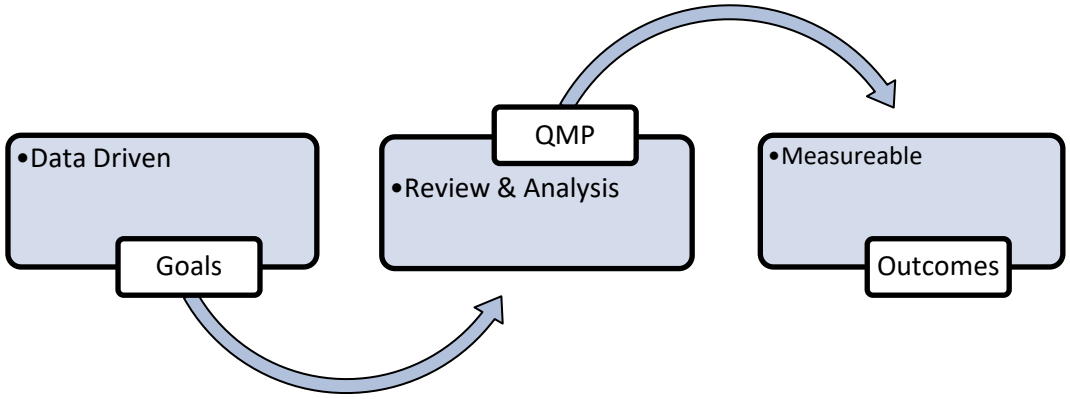
Blue Mountain Home Health Care has a Quality Management plan to ensure regulatory compliance, safeguarding health and safety of individuals receiving services, implement best practices and offer highest quality of service. The Quality Management system is built to ensure continuous improvement in services. Blue Mountain Quality Management Plan is set up to ***Discover*** quality of service or care issues, come up with plan (action items & responsibilities) to ***Remediate*** the issues and ***Improve*** the quality of care.

Procedure

The Quality Management Team (QMT) shall consist of Medical Director and senior management group. The QMT shall meet once every year. The individual senior management shall review and analyze data every quarter. The QMT will ensure that Quality Management Plan consists of measurable goals and data driven outcomes are achieved as defined by Section 52.24

Quarterly and Annual Reviews

The Administrator will gather data on a quarterly basis. This includes data from Incidents, Complaints, Surveys, Policy reviews and Internal Audits. The Administrator will check if the quarterly data meets the quality goals that were set at the beginning of the year. The management will meet on an annual basis to review the quarterly results and measure if the year-end results meet the goals.



Blue Mountain Home Health Care has a Quality Management plan to ensure regulatory compliance, safeguarding health and safety of individuals receiving services, implement best practices and offer highest quality of service. The Quality Management system is built to ensure continuous improvement in services.

Section 14: Fraud & Financial Abuse

There are things you can look for if you suspect that financial abuse of an elderly loved one has occurred, and various steps you can take to assure that their finances are recovered and properly managed in the future. It's important to know the signs and behaviors that may be exhibited when elderly financial abuse is occurring.
Those who perpetrate financial abuse against an elderly patient often engage in the following behaviors:

- Forging the elderly person's signature on checks or other documents
- Forcing the elderly person to sign a will, deed, or power of attorney listing the perpetrator as the one who is responsible for the elderly person or who will gain when the individual dies
- Stealing property or money from the elderly person
- Promising to give the elderly person lifelong care only if they give them money or their property
- Using the possessions or property of the elderly person without their permission
- Perpetrating fraud, which is the use of trickery, false pretenses, deception or other dishonest acts in order to gain the person's finances
- Perpetrating cons or other confidence games in order to gain the trust of the elderly person
- Perpetrating telemarketing scams in which the elderly person is called and deception, exaggerated claims or scare tactics are used to get the elderly person to send them money
- Charging things against the elderly person's credit cards without the authorization of the cardholder

The Perpetrators of the Crime

The main perpetrators of financial abuse against the elderly can be relatives of the elderly person, their spouse, or someone else they hold in their confidence. These people will likely have the following characteristics:

- They feel like the elderly person's belongings are rightfully theirs, and they stand to inherit money or possessions when the elderly person dies.
- They have financial difficulties, a tendency to gamble or have problems with illicit drugs or alcohol.
- They may express fears that the elderly person will use up all of their savings money to care for illnesses, depriving the perpetrator of their inheritance.
- They may feel negatively toward siblings or other family members and want to keep them from inheriting the possessions of the elderly person.

Predators may have other qualities that allow them to seek out and find vulnerable elders, intending to exploit them of their money or property. They may have these characteristics:

- They may looking at obituaries to find those who have recently lost loved ones or may drive through neighborhoods, looking for people who are isolated and alone.
- They may say that they love the older person to gain their confidence.
- They may move around to different communities in order to avoid becoming detected.
- They may try to gain access by finding jobs caring for elderly persons or masquerading as counselors.
- They may use trusted positions as a way to gain the confidence of the elderly person.
- They may use unfair business practices in order to deceive the elderly person.
- They may charge too much for products or services the elderly person needs.

The Elderly Person at Risk

There are various risk factors that would put an elderly person at a higher chance of experiencing financial abuse. Characteristics of elderly people who are likely to be financial abused include:

- They may be lonely
- They may be isolated
- They may have mental or physical disabilities
- They may have lost someone recently
- They may be unfamiliar with matters dealing with money
- They may have relatives that are not employed but who have problems with substance abuse

Why Target The Elderly?

The elderly are attractive targets for financial abuse because they have the following characteristics:

- They may be unfamiliar with technology and have problems managing their finances.
- Perpetrators may assume that the elderly person is so frail that they won't survive long enough to intervene legally once they are exploited.
- The elderly may be severely debilitated so that they aren't likely to take actions against the perpetrators.
- The elderly may be embarrassed to go to authorities.
- They may have predictable patterns and receive their social security checks at the same time of the month. Perpetrators can predict when the elderly person will be flush with cash.
- The elderly person may have a disability that creates dependence on others. Those who help them may also be perpetrators of financial fraud against the elderly person.
- The elderly person may not recognize that their assets have increased in value (particularly the value of their homes)
- Older people tend to have more wealth than younger people.

Indicators of Financial Abuse against the Elderly

An indicator is a sign or clue that suggests abuse against an elder has occurred. Financial exploitation has its indicators as well. Exhibiting just one indicator may not be suggestive of a full-blown abuse, but if you see several, it may mean your loved one is being financially exploited.

Signs of financial abuse against the elderly include the following:

- Canceled checks or bank statements that go to the perpetrator's home
- Large bank withdrawals or transfers between different accounts that can't be explained
- Eviction notices, evidence of unpaid bills or utilities being discontinued due to nonpayment
- The perpetrator refers to the elder as their new "best friend"
- The elder person's care is substandard even when they can pay for it
- There are ATM withdrawals the elderly person could not have made or other unexplained withdrawals
- The elderly person is coerced to sign powers of attorney or other legal documents they didn't understand.
- The perpetrator shows an inordinate interest in how much money the victim is spending
- There are missing belongings or property that is missing
- There are forgeries on legal documents or on checks
- Financial arrangements are sketchy and lack documentation
- The explanations about the elder's finances as explained by the perpetrator are implausible.
- The elderly person does not know or understand their own financial situation.

Financial exploitation can be prevented by having a trusted lawyer manage the individual's funds or by a family member being in charge of how the funds are allotted.

Section 15: Importance of Adequate Nutrition

Nutrition has a huge impact on the physical health and wellbeing of older adults. Many people may not realize that nutrition needs vary depending on a person's age. Just like toddlers have different dietary needs than teenagers, nutritional needs for elderly folks are much different than that of younger adults. Unfortunately, senior nutrition doesn't get the attention it deserves.
Not only does healthy eating for seniors contribute to physical health, but it also has a huge bearing on memory and mental function.
Here's why nutrition for older adults is so important and how to ensure seniors receive adequate nutrition.

The Importance of Healthy Eating for Seniors
Believe it or not, seniors are extremely susceptible to malnutrition. This happens for a few reasons.

- Metabolism – and appetite – slows down with age
- Less caloric intake means less opportunity for nutrients
- The body's ability to absorb nutrients (especially specific important nutrients) decreases with age

You might think that a slower metabolism and decreased appetite would be somewhat healthy. Less food intake means less opportunity to digest unhealthy fats and sugars, right? While that may be true, it also means that seniors have a smaller opportunity to absorb nutrients. When they eat, they need to get the most bang for their buck.

Healthy eating for seniors is exponentially important for several reasons. Nutrition impacts health in several ways.

- **Organ function**: eyes, kidneys, liver, and digestion
- **Brain function**: memory and cognitive ability
- **Managing chronic illnesses** like high blood pressure, diabetes, cancer, and dementia
- **Strengthening the immune system** and promoting proper healing
- **Muscle and bone health**: preventing fractures and falls, maintaining mobility, strength, flexibility, and posture

Special Nutritional Needs for Elderly Folks
Nutrition for older adults is important for supporting cellular function throughout the body, strengthening the immune system, and warding off physical and mental illness.

Fiber
This important aspect of senior nutrition has a few benefits. Fiber is essential for maintaining proper digestive health and avoiding constipation. Plus, many fiber-rich foods like whole grains are vital for supporting heart health.
Protein
Younger adults need protein to stay fit and ward off high cholesterol. Nutritional needs for elderly folks are similar in this respect, but the main reason seniors need protein is for muscle strength. Muscle mass decreases with age so protein is vital. Atrophied muscles can lead to falls and a loss of mobility. Seniors require just as much – if not more – protein than younger adults.
Vitamin B12
Vitamin B12 deficiency affects up to 15% of adults over 60. Why? The digestive system's ability to absorb protein-bound vitamin B12 decreases with age. Lack of this vital nutrient has a huge impact on both the blood and central nervous system.

While young people are certainly susceptible, the effects are even more pronounced in the elderly. This can include anemia, tingling or numbness in the extremities, fatigue, poor balance, and memory loss.

Calcium, Vitamin D, and Magnesium

All three of these nutrients are essential for maintaining strong bones and muscles. Strong bones and muscles are crucial for avoiding falls and fractures associated with age as well as osteoporosis.

These vitamins and minerals all work together: bones require calcium for strength, vitamin D helps the body absorb calcium, and magnesium helps available calcium make its way through the blood stream.

Potassium

The entire body needs adequate potassium levels for several reasons. This mineral is vital for cellular function across the body including the heart, muscles, nervous system, blood.

Nutrition for older adults should always include good levels of potassium to maintain strong muscles and healthy blood pressure levels.

Omega 3 Fatty Acids

Most people already know that omega 3 fatty acids are important for maintaining heart health. They may not realize, however, that these fatty acids are also crucial for supporting brain health in several ways. Low levels of omega 3s can cause memory loss, reduced immune function, and even mental health conditions like depression. Omega 3s are especially important when it comes to healthy eating for seniors with dementia.

How to Ensure Adequate Nutrition for Older Adults

It's not always easy to eat healthy. This is especially true for older adults. When seniors eat meals, they need to ensure each bite is packed with as many nutrients as possible.

Here are some of the best foods to include as well as some tips for meeting the nutritional needs for elderly folks.

1. Add flavor with spices and herbs. Avoid high cholesterol and high sodium flavorings like butter and bacon.
2. Stick with fresh or frozen fruits and vegetables: canned goods contain high levels of sodium and sugar.
3. Encourage several small meals instead of three large meals.
4. Include dark leafy greens like kale, spinach, and collard greens – these are packed with vitamins and minerals.
5. Stick with complex carbohydrates like oats, brown rice, and whole grain pastas or breads.
6. Choose bright colored fruits and veggies like peppers and cranberries – these contain lots of antioxidants.
7. Include lean protein with every meal like chicken, ground beef, and beans.
8. Avoid refined sugars and simple carbs like baked goods, white bread, and white rice – these spike blood sugar levels and don't have much in the way of nutritional value.
9. Make sure to add multivitamins and supplements for well-rounded senior nutrition.
10. Don't forget to stay hydrated.

Section 16: Meal Preparation & Feeding

Proper nutrition is important for all of us. Home Health Aides/Personal Care Aides have very important roles to fill with regard to helping their patients obtain proper nutrition. This module will explore the basics of nutrition. We will discuss all the important types of food that should be in a patient's diet. We will also talk about the type of food that should be avoided. We will learn how to use the USDA's nutrition guidelines by learning how to plan meals using ChooseMyPlate guidelines. We will talk about food preparation and safe food handling. We will also explore what different types of diets mean and what foods should and should not be included in those special diets.

The Major Nutrients

All living things require nutrients in order to survive and to grow and develop normally. Nutrients are components (parts) of food that provide nourishment in order for us to survive. Nutrients provide our bodies with energy, help build and maintain body tissues, organs, bones, and teeth, and help regulate body functions such as metabolism and blood pressure. Nutrients include protein, carbohydrates, fats, vitamins and minerals.

The Care Plan will direct a HHA/PCA as to what the patient's dietary requirements and restrictions are. Home Health Aides/Personal Care Aides should always be sure to follow these as they are in place to best promote good health for the patient. If they are ever in doubt about whether a patient can have a certain food, they should seek guidance from their supervisor.

Protein

Proteins are the essential (necessary) building blocks that our body needs in order to properly function. We need protein in order to build and repair body tissues, such as muscles, organs, and skin. Sources of protein include poultry, meat, fish, eggs, milk, cheese, nuts and nut butters, peas, dried beans, and soy products. Our bodies can also use protein as an energy source or convert it to fat. The amount of protein that a person needs depends on their body size, age, activity level, and their general well-being. People who are sick, undernourished, and healing generally require higher amounts of protein in order to help the body's tissues heal.

Sources of Protein:

- Poultry (chicken, turkey)
- Beef (steak, ground beef, stew meat, hamburgers, hot dogs)
- Fish (tuna, salmon, trout, bass, cod)
- Shellfish (shrimp, lobster, crab)
- Milk
- Eggs
- Soy products (tofu, tempeh, veggie burgers)
- Legumes (beans such as white beans, kidney beans, chickpeas)
- Peas
- Nuts (almonds, pistachios, walnuts, cashews, peanuts)
- Seeds (pumpkin, sunflower, squash seeds)
- Peanut butter and other nut butters

Carbohydrates

Carbohydrates are the essential nutrients our body needs in order to provide us with energy. Carbohydrates are the major way our body gets energy in order to effectively function. Carbohydrates provide our body with sugar, starch, and fiber. Starches include grains, potatoes, beans, and peas. Sugars include fruits, vegetables, and sweeteners. Foods that have fiber in them include whole grain foods such as cereals and breads, fruits, and, vegetables. Fiber is important as it helps aid in

digestion, helps to lower cholesterol, and helps us to feel fuller longer. Fiber is also necessary to aid with bowel elimination.
There are two basic types of carbohydrates: complex and simple.
Complex carbohydrates are found in grain products such as bread, cereal, pasta, rice, and vegetables. **Simple carbohydrates** are foods found in sugars, sweets, syrups, and jellies.
Complex carbohydrates have more nutritional value than simple carbohydrates.
The body uses sugars and starches for energy. Extra carbohydrates or carbohydrates that we take in but do not need at the time, are converted to fat, which are then stored. A diet in excess of carbohydrates can lead to obesity (being over the ideal weight for a person's body size).
Sources of Carbohydrates:

- Grains
- Breads of all kinds
- Potatoes
- Beans
- Peas
- Oatmeal
- Rice (white, wild, brown)
- Breakfast cereals
- Tortillas
- Grits
- Pasta, noodles
- Popcorn
- Quinoa
- Crackers (all kinds)
- Couscous
- Muesli

Fats
Fats are essential nutrients in our diets. Even though we tend to think of fats as bad for us, we do need a certain amount of fat in our diets. Fat helps to protect our organs, is necessary for all the membranes in most the cells in our body, for brain and nerve function, is used to insulate the body and help us prevent heat loss, and is a carrier for other nutrients. Extra fat can also be used as energy for the body, or it can be stored.
While we need a certain amount of fat in our diet, caution must be taken to not eat too much fat. A diet high in fat can lead to serious complications such as high cholesterol, myocardial infarction (heart attack), coronary artery disease, and cerebrovascular accidents (strokes). Sources of fat include oils, butter, margarine, salad dressings, and animal fats found in meat, fish, and milk.
Some fats are healthier options than others. For example, choosing to eat a handful of nuts is a healthier option than choosing to eat a handful of potato chips. There are three main types of fats: monounsaturated fats, polyunsaturated fats and saturated fats.
Monounsaturated fats include vegetable fats such as olive oil and canola oil.
Polyunsaturated fats include corn, soy, safflower, and sunflower oils, and omega-3-fatty acids. Saturated fats include butter, bacon, lard, coconut oil, and peanut oil. Saturated fats are less healthy options than monounsaturated and polyunsaturated fats. They should be consumed in limited quantities.
Sources of Fat:

- Oils (all kinds)
- Butter
- Milk
- Eggs
- Fish

- Meat
- Nuts and seeds
- Avocados
- Margarine
- Salad dressings
- Olives
- Peanut butter
- Animal fats found in meat

Vitamins

Vitamins are essential to help our body use other nutrients we take in, and they also help to promote tissue growth. There are several kinds of vitamins, all of which have a specific purpose and which we need every day. With the exception of Vitamin D and Vitamin K, our body needs to obtain vitamins through our diets. We make a certain amount of Vitamins D and K within our bodies. While most people who eat a well-balanced diet do not need to take vitamin supplements, other people may need a daily supplement in order to meet their nutritional needs. The patient's physician will discuss the specific vitamin supplements the patient needs, if any. If the patient has a question about a vitamin, Home Health Aides/Personal Care Aides should inform their supervisor about the patient's question.

Vitamin A: Is necessary to help keep the skin in good condition and also supports eye health. Vitamin A can be found in dark green, yellow, and orange vegetables.

Vitamin B: Is needed to help the nervous and digestive systems function properly. It also is important for protein, carbohydrate, and fat metabolism. Metabolism is the process by which the body converts (changes) what we eat and drink into usable energy. Foods high in vitamin B are those found in animal products such as meat, milk and milk products, green leafy vegetables, and fortified grain products. When foods are fortified, they have nutrients added to them in order to make them more nutritious. For example, many grain or bread products are fortified, or enriched with extra minerals and vitamins for extra nutrition.

Vitamin C: Helps to strengthen blood vessel walls and aids in the healing of wounds and bones. It also helps the body to absorb iron. Foods rich in vitamin C include fruits such as oranges, strawberries, grapefruit, and vegetables like broccoli, Brussel sprouts, and green cabbage.

Vitamin D: Is needed for our body to build strong bones and teeth. Sources of vitamin D include milk, butter, salmon, sardines, tuna, liver, fish liver oils, and fortified orange juice. We also synthesize (make) our own vitamin D when we get sunlight on our skin.

Vitamin E: Is an antioxidant, which is a substance used to remove potentially damaging agents called free radicals. This helps to promote a good immune system. Sources of vitamin E are wheat germ, fish, fruits, vegetables, cereals, and nuts.

Minerals

Our bodies also require a number of minerals in order to best function. Minerals are compounds that our body needs in order to perform a variety of functions. There are a number of essential minerals that our bodies need. For example, we need calcium, which is a mineral, in order to help keep our bones and teeth strong. There are a number of minerals that we need to take in through eating a well-balanced diet. Calcium, potassium, chloride, sodium, phosphorus, and magnesium are known as major minerals. Iron, fluoride, zinc, copper, selenium, chromium, and iodine are known as minor minerals. Whether a mineral is major or minor has to do with the amount we need in our diets. We need a greater amount of calcium within our diet as compared to zinc, for example.

Calcium: Is a mineral that is needed for bone and teeth strength, blood clotting, proper muscle contraction, and a healthy heart. Milk and milk products such as cheese, ice cream, yogurt, leafy green vegetables, and canned fish, such as sardines (which have soft bones) are good sources of calcium.

Potassium: Helps the heart to function properly, helps muscles to contract, and is necessary for good nerve conduction. Foods high in potassium include tomatoes, potatoes, squash, dried apricots, yogurt, and bananas.

Iron: Iron combines with protein to make hemoglobin, which is a part of our red blood cells that carries oxygen. Good sources of iron include red meat, chicken, pork, dark green leafy vegetables such as spinach, iron fortified cereals and grain products, and dried fruits such as raisins.
Iodine: is needed for proper functioning of the thyroid gland. The thyroid is important for our body's metabolism. Sources of iodine in the diet can include cod, shrimp, canned tuna, iodized table salt and even milk and yogurt.
Sodium: Helps our body to maintain normal fluid balance. Foods high in sodium include most processed food, many canned food such as meats and soups, olives, pickles, packaged mixes, and canned foods such as vegetables. While we need sodium in our diet, we should limit the amount of sodium we take in.

Water

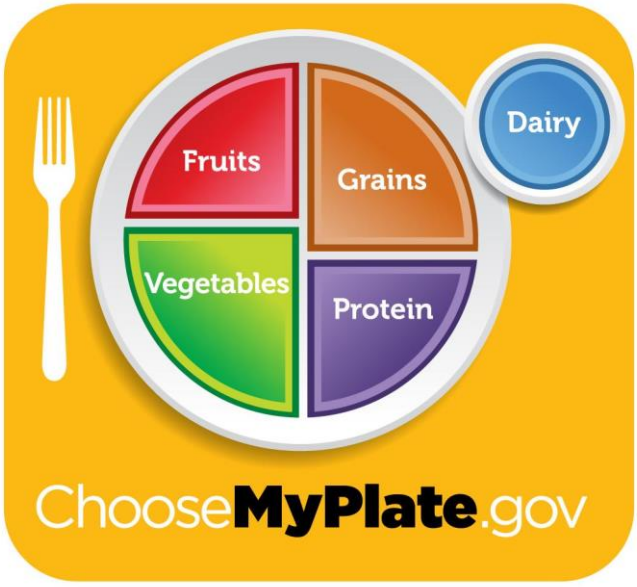
Water is essential to all life, including human life. Without it, we cannot survive. We could only live for a few days without water. We need water for digestion, elimination, and control of our body temperature. The majority of our body is made up of water. We need about 8 glasses, or 64 ounces, of water each day to stay adequately hydrated. Liquids such as coffee, tea, juices, milk, and soda also provide us with fluid we need. However, it is healthier to select drinks such as water, milk, or juice rather than soda.
It is important to remember to keep a patient hydrated. Some patients may not be able to or may forget to ask for a drink of water. It is a good idea for Home Health Aides/Personal Care Aides to offer a drink of water at least once every two hours. When turning and positioning a bedridden patient, offer them a glass of water at that time.

Nutrients Work Together

It is important to have a well-balanced diet. While each of the individual nutrients discussed above are important, it is important that a person take in a combination of all of them to make a well-balanced diet. Together they work to keep the body working at its optimum (best) level.

Well-Balanced Diet

A well–balanced diet means a diet in which all the nutrients our body needs for proper functioning and energy are taken in. A well-balanced diet contains a variety of foods from all the food groups, as well as all the necessary vitamins and minerals we need. It also means taking in an adequate supply of water for adequate health. A well-balanced diet can be planned by selecting healthy foods from each of the food groups.



USDA's ChooseMyPlate Dietary Guidelines

The United States Department of Agriculture (USDA) developed healthy eating guidelines for Americans to follow to help them make healthy food choices. According to the USDA, The ChooseMyPlate icon (symbol) serves as a reminder for people to help them build a healthy plate at meal times. The emphasis is on the five food groups that are necessary for good health: vegetables, fruits, grains, proteins, and low-fat dairy foods. ChooseMyPlate.gov is a scientifically based and up-to-date resource which can provide Home Health Aides/Personal Care Aides with useful information for planning meals and educating their patients about healthy food choices and physical activity. All recommended daily servings and food group sources discussed in this module are according to the guidelines set forth by the USDA and can be downloaded from www.choosemyplate.gov.

Proper Feeding Skills

Feeding Skills for Carers of Frail Elderly

Elders with chronic illness and impaired mobility may suffer from various degrees of feeding problems. It is therefore important for carers of these elders to provide appropriate assistance according to the elders' individual needs.

Objectives:

- To maintain a healthy diet and balanced nutrition.
- To prevent complications such as aspiration pneumonia induced by choking.
- To encourage and assist elders with eating problems so as to maximize their independence and self-care ability.
- To make eating an enjoyable experience to improve their quality of life.

Preparation before Feeding

Environment

- Ensure that the eating area is well-ventilated, with adequate lighting and free from distractions so as to enhance the elders' concentration and to prevent choking.

Feeding Utensils

- Ensure the utensils are clean. Use non-slip mat to fix utensils on the table for easier feeding. Replace any broken utensils.
- Choose appropriate feeding utensils. e.g. fork or spoon instead of chopsticks.
- Use smaller spoons to control feeding amount and minimize the risk of choking.
- Use straws or specially designed cups to control the amount and flow of fluids during drinking.
- Consult occupational therapist if necessary for advice on the choice of feeding devices, e.g. spoon and fork with enlarged handles, adapted chopsticks, a bowl with a raised curved lip which enhances scooping of the food.

The carer

- A warm and caring attitude is always important. Explain to the elder what you are doing and try to gain their cooperation.
- Good personal hygiene should be observed, wash hands thoroughly with water and soap.
- Assist the elder in hand washing before every meal. If needed, perform oral care such as rinsing the mouth before meals to stimulate appetite.
- Assess the elder's chewing and swallowing abilities. Give appropriate assistance if required.
- Communicate with the elders before feeding, e.g. discuss the menu with demented elders to enhance their cognition and stimulate their interest. For elders with visual impairment, guide them along by informing them the food types and position of the food and utensils. Ensure all the food and necessary feeding aids are within their reach.

Choice of food

- Individual's food preference, religion and health status should be taken into consideration during preparation of meals. e.g. Diabetic, low salt and vegetarian diet etc.
- Choose nutritious food which are easy and safe to swallow. Change menus regularly to stimulate appetite.

- Prepare food according to individual's chewing and swallowing abilities. e.g. purée, porridge or fluid diet. Remove the bones and skin of meat to decrease the risk of choking. Chop up the food into smaller pieces for easy chewing.
- Avoid foods which are sticky and difficult to chew and swallow so as to prevent choking, e.g. glutinous dumplings.

The elder

- Assist the elder in wearing dentures if required.
- Ensure the elder is sitting comfortably in an upright position to facilitate safe swallowing. The seat should be adjusted to a suitable height.

Safety Tips on Feeding

- Ensure that the elder is fully alert during feeding.
- Ensure proper positioning of the elder. Sitting with head slightly flexed and chin down which reduces the risk of choking.
- Serve food at the right temperature, e.g. not too hot.
- Do not rush, allow plenty of time for feeding. If the elder refuses to eat, try to find out the reason and provide assistance accordingly.
- Observe for any signs of swallowing difficulties, e.g. cough, dribbling, aspiration of food back into the nose, etc. In case of choking or aspiration, keep calm and call for help at hospital.
- Signs and symptoms of aspiration are:
  - Breathing difficulty
  - Engorged face and neck veins
  - Face turning blue, loss of consciousness in severe cases.
- Ensure adequate fluid intake for elders who cannot feed themselves so as to prevent dehydration.

After Care

- After feeding, check the mouth for any food debris and apply oral care and wipe the mouth with wet towel and maintain good personal hygiene. Cleanse the dentures.
- Remove the utensils, apron and serviettes. Let the elder rest comfortably.
- Avoid lying down right after feeding. Remain sitting in an upright position for at least 20 to 30 minutes to prevent aspiration.
- For those elders who are particularly frail, observe their mental state after feeding and monitor for signs of aspiration and choking.

Section 17: Importance of Safe Techniques in Patient Care

There is now overwhelming evidence that significant numbers of patients are harmed from their health care either resulting in permanent injury, increased length of stay (LOS) in hospitals and even death. We have learned over the last decade that adverse events occur not because bad people intentionally hurt patients/client but rather that the system of health care today is so complex that the successful treatment and outcome for each patient/client depends on a range of factors, not just the competence of an individual health-care provider. When so many people and different types of health-care providers (doctors, nurses, pharmacists, social workers, dieticians and others) are involved this makes it very difficult to ensure safe care, unless the system of care is designed to facilitate timely and complete information and understanding by all the health professionals.

Patient/Client Safety is an issue for all countries that deliver health services, whether they are privately commissioned or funded by the government. Prescribing antibiotics without regard for the patient's underlying condition and whether antibiotics will help the patient, or administering multiple drugs without attention to the potential for adverse drug reactions, all have the potential for harm and patient injury. Patients are not only harmed by the misuse of technology, they can also be harmed by poor communication between different health-care providers or delays in receiving treatment. Patient safety is a broad subject incorporating the latest technology such as electronic prescribing and redesigning hospitals and services to washing hands correctly and being a team player. Many of the features of patient safety do not involve financial resources; rather, they involve commitment of individuals to practice safely. Individual doctors and nurses and care givers can improve patient safety by engaging with patients/clients and their families, checking procedures, learning from errors and communicating effectively with the health-care team. Such activities can also save costs because they minimize the harm caused to patients/clients. When errors are reported and analized they can help identify the main contributing factors. Understanding the factors that lead to errors is essential for thinking about changes that will prevent errors from being made.

Critical In-Home Safety Practices:

De-clutter your house to make sure you have plenty of space to walk around

- Make sure all rugs have anti-slipping pads
- Cover furniture corners to prevent injuries if you accidentally bump into them
- Make sure every room has proper lighting, including walk-in closets. Use nightlights to make it easy to see at night
- To prevent fall risks, use cord covers for all cords and cables, or secure them out of the way, behind furniture
- Use handrails for all staircases
- Remove all carpets from stairs and staircases to prevent slipping
- Place a light (such as a lamp) close to your bed and make sure you can reach it easily
- Have all the items that you use frequently within easy reach in the kitchen – don't place them on high shelves that are hard to access
- Install grab bars in your bathroom for safety
- Use rubber mats in your shower or bathtub to prevent slipping
- Avoid stepping on wet or damp surfaces – promptly clean up any spills on the floor
- Have a cordless phone at home and keep it within easy reach, to prevent having to rush to answer when the phone rings
- Use shower seats if you have trouble standing while showering
- Wear anti-slip slippers or socks when walking around your home, especially on slippery surfaces such as polished hardwood floors or tile

Precautions to Take During a Visit:

- Use basic safety precautions. Be alert and watch for signals of violence, such as substance abuse, threats, the presence of weapons. Have knowledge of the activities of the neighborhood in advance and avoid visits when the risk may be higher such as times of increased drug or alcohol use.
- Maintain behavior that helps to defuse anger. Exude a calm and caring demeanor, don't match threats or give orders, and always acknowledge the other person's feelings.
- Avoid behaviors that may be interpreted as aggressive - getting close, speaking loudly, moving quickly.
- Know where the bathrooms and exits are, and make sure there is always a clear path to them.
- Trust your judgment and avoid situations that don't feel right.
- If you're being verbally abused, ask the abuser to stop. If the abuse doesn't stop, leave and then notify your agency. Don't be afraid to shorten a visit if things get out of control or you feel threatened.
- Keep your cell phone in your pocket - not away from you in a bag or purse or the car. Maintain the phone turned on during visits.
- Do your paperwork and documentation in the home before you go to your car. Don't linger in your car if you can help it.
- Encourage patients to put lights on their porches or by their front doors.
- Carry a flashlight and use it when you walk to and from your car in dark areas.

Avoid Overexertion:

Back injuries from lifting or moving patients are one of the biggest risks to home health aides, nurses and other home health workers. To help prevent such injuries, some home health agencies use a buddy system that allows two workers to team up to provide care for heavy or hard-to-transfer patients. If you're working alone, practice good body mechanics. Take full advantage of transfer systems and other assistive devices. Also, keep a reasonable pace and some flexibility in your daily schedule so you aren't tempted to take injury-inducing shortcuts.

General Safety Tactics:

- Buddy System - consider working in pairs, either in high-crime areas or on night visits, or know that you can request an escort from local law enforcement in some situations.
- Notify your employer if you see unlicensed weapons in the home.
- If possible, conduct visits during the daylight hours (especially visits to high-crime areas).
- Let your employer know if a situation seems dangerous.
- Consider taking a self-defense course.
- Consider carrying a personal alarm and/or a noise-making device such as a whistle.
- Only carry a minimal amount of cash.
- Always carry ID.
- Make sure your cell phone battery is fully charged before you head to your visits.
- Let someone know when you're done and when you're expected home.
- Dress to protect yourself. Wear shoes and clothes that make it easy for you to move quickly. Avoid wearing expensive jewelry or carrying a purse. Avoid any accessory that could potentially be dangerous such as necklaces or scarves

Prohibited techniques:

- Locking a resident in a room.
- Using loud noises to scare a resident.
- Pushing or grabbing a resident.
- Giving a resident medicine to make him/her quiet or sleepy.
- Using something like a pillow or tie to keep a resident from moving.

- Holding a resident with your hands so that he/she can't move.

Emergency Procedures: Create and Practice a Fire Escape Plan:
In the event of a fire, remember that every second counts, so you and your family must always be prepared. Escape plans help you get out of your home quickly.

A) Smoke Alarms:

- Replace batteries in battery-powered and hard-wired smoke alarms at least once a year (except non-replaceable 10-year lithium batteries).
- Install smoke alarms on every level of your home, including the basement, both inside and outside of sleeping areas.
- Replace the entire smoke alarm unit every 8-10 years or according to manufacturer's instructions.

B) Smoke Alarm Safety for People with Access or Functional Needs

- Audible alarms for visually impaired people should pause with a small window of silence between each successive cycle so that they can listen to instructions or voices of others.

During a Fire

- Crawl low under any smoke to your exit - heavy smoke and poisonous gases collect first along the ceiling.
- If you can't get to someone needing assistance, leave the home and call 9-1-1 or the fire department. Tell the emergency operator where the person is located.

Fire Escape Planning for Older Adults and People with Access or Functional Needs

- Live near an exit. You'll be safest on the ground floor if you live in an apartment building. If you live in a multi-story home, arrange to sleep on the ground floor, and near an exit.
- If you use a walker or wheelchair, check all exits to be sure you get through the doorways.
- Make any necessary accommodations, such as providing exit ramps and widening doorways, to facilitate an emergency escape.

After a Fire

- Contact your local disaster relief service, such as The Red Cross, if you need temporary housing, food and medicines.
- Check with the fire department to make sure your residence is safe to enter. Be watchful of any structural damage caused by the fire.
- The fire department should see that utilities are either safe to use or are disconnected before they leave the site. DO NOT attempt to reconnect utilities yourself.
- Try to locate valuable documents and records. Refer to information on contacts and the replacement process inside this brochure.
- Begin saving receipts for any money you spend related to fire loss. The receipts may be needed later by the insurance company and for verifying losses claimed on income tax.

Items to Incorporate in a Disaster Supplies Kit

- Food and water
- Flashlight
- Battery-powered or hand-crank radio
- Extra batteries
- First aid kit
- Medications and medical items
- Multi-purpose tool
- Copies of personal documents

- Sanitation and personal hygiene items
- Emergency blanket
- Insect repellent and sunscreens
- Baby supplies (bottles, formula, baby food, diapers)
- Rain gear
- Planning ahead reduces anxiety. Prepare now for a sudden emergency and remember to review your plan.

Section 18: Bathing (Bed Bath, Sponge, Tub, Shower)

Bathing keeps the skin healthy and can help prevent infections. It's a good time to check the skin to look for sores or rashes. Bathing also helps your loved one feel fresh and clean.
The amount of help your loved one needs when bathing depends on how well he or she can move. You may be caring for someone who has short-term trouble with self-care because he or she is recovering from an illness or a surgery. Or you may be taking care of an older person who has memory problems. The person may not remember how to bathe. Or you could be caring for someone who has a long-term inability to move, such as a person who is paralyzed. This person will need much more of your care when bathing.
A person who has to stay in bed for a short time and who can move a little may be able to take a shower with some help once or twice a week. Or the person may prefer a partial bath at the sink or with a basin every day.
A person who can't move well or who can't move at all needs a bed bath. This is often called a sponge bath, but washcloths are often used too. You can give a full bath in bed without getting the bed sheets wet.
For older adults, you can give a bed bath 2 or 3 times each week. Bathing more often may put the person at risk for skin problems, such as sores. Younger people can bathe more often if they want to and they have no problems with blood flow.
Let your loved one clean himself or herself as much as possible. As you help to undress and bathe the person, act straightforward but relaxed. Bath time can be awkward and embarrassing for you and your loved one. This may be especially true if you are caring for an opposite-sex parent. If you don't act embarrassed or upset, your loved one may feel less self-conscious or embarrassed.
How do you give a bed bath?

Gather your materials
To give a bed bath, you will need:
- Four or more washcloths or bath sponges.
- Three or more towels.
- Two wash basins (one for soapy water, one for rinsing).
- Soap (a bar of soap, liquid soap, or wipes).
- "No-tears" or baby shampoo or no-rinse shampoo.
- Body lotion.
- A waterproof cloth to keep the bed dry.
- A table or stand to hold the materials.

Get ready for the bath
- Ask the person if the room is too warm or too cool, and change the temperature if needed.
- Make sure that the bed is high enough so that you don't hurt your back. If it is low, it is okay to put your knee on the bed to reach over and bathe the person.
- Place a waterproof mat or sheet under the person to keep the bed dry.
- For privacy, make sure the door is shut and the blinds or drapes are closed.

Some things to remember
- After you or your loved one washes an area, turn the washcloth so you can use a new, clean part of it for the next area. Use a new washcloth when you need one.
- As you help your loved one wash, check the skin for redness or sores. Pay special attention to areas with creases, such as beneath the breasts or the folds on the stomach. Also look at the groin area and bony areas, such as the elbows and shoulders.

How to help with or give the bath

1. Fill two basins with warm water. One is for soaping up a washcloth and wringing it out. The second basin holds clear, warm water for rinsing off the soap with a washcloth.
2. Wash and dry your hands.
3. Use the back of your hand to test the water to make sure it's not too hot.
4. Think about whether to wear gloves, especially if the person has been vomiting or has had diarrhea. It's a good idea to wear a mask if the person has a contagious illness, such as the flu.
5. Let the person undress and wash as much as he or she is able. Remove clothing only from the area you are going to wash. For example, uncover an arm, wash and dry it, and then put it back into a shirt or gown.
6. Wash with the washcloth and soapy water or wipes, and then rinse using another washcloth and the clear water.
7. Start with the cleanest areas of the body and finish with the areas that are less clean. Get the washcloth ready for your loved one to wash himself or herself. Or you can gently wash the person if he or she can't do it.
    - Wash the eyelids, starting from the inside and moving out.
    - Wash the face, ears, and neck.
    - Wash the arms one at a time, and then the hands.
    - Wash the chest and belly, including the belly button.
    - Wash one leg, and then the other.
    - Wash the feet and in between the toes.
    - Help the person roll on his or her side so you can wash the back side. (If you can't roll a person by yourself, get someone to help you so that you don't hurt your back.) Then help the person roll on his or her back.
    - Pour out the water (which by now may be cold) and replace it with fresh warm water.
    - Using a new washcloth, clean the genital area first and then the anal area.
8. Remove gloves if you are wearing them. Change the water and wash the hair. You can use water and "no-tears" or baby shampoo or a no-rinse shampoo. Look carefully at the scalp for any redness or sores.
9. Apply an unscented body lotion to protect the skin and keep it from becoming dry. Don't put lotion on areas that can become moist, such as under the breasts or in the folds of the groin.
10. Help the person as needed to finish dressing.
11. Put away your supplies and wash your hands.

Implementing a Routine

With Patients suffering from Alzheimer's and other forms of dementia, the time of day can play a huge role in how an individual responds to certain activities. For this reason, try to base daily personal care and bathing around those times that the patient is most alert and agreeable (typically in the mornings).

Section 19: Shaving, Grooming and Dressing

Skin Care

People who are ill or who must stay in bed or in a wheelchair are at risk for pressure ulcers, sometimes called bed sores. Pressure ulcers are a serious problem, but in most cases they can be prevented by following the steps listed here.

- Make sure the person is eating a healthy diet and getting plenty of fluids. Well-nourished skin is healthier and less likely to break down.
- Keep the skin clean and dry.
- Clean off urine or feces immediately with soap and water. Wear disposable latex gloves.
- Use disposable bed pads to keep the linen dry, if the person is incontinent. If eligible for Medicaid, Medicaid will pay for incontinence supplies; ask your physician for a prescription. Be sure the pharmacy you use will accept Medicaid payment for supplies.
- Check the skin regularly for red areas. Make this a routine part of bath time.
- Every 2 hours change the position of a person who is bed or wheelchair-bound.
- Avoid dragging the person when you move them in bed. Friction can cause skin breakdown.
- Apply lotion to dry skin regularly (except between the toes where it can cause fungal growth.) Give a light massage while rubbing in the lotion.
- If eligible for Medicaid, Medicaid may cover the cost of appliances with a doctor's prescription. Be sure to ask.

If A Red Area Develops On The Skin:

- Remove pressure from the area immediately.
- Clean and dry areas soiled with urine or feces. Wear disposable latex gloves.
- Do not massage the area.
- Recheck the skin in 15 minutes. If the redness is gone, no other action is needed.
- If the redness does not disappear after 15 minutes, consult your health care professional about better ways to relieve pressure from the skin.
- If a blister or open area develops, contact your health care professional immediately.

Shaving

- Use an electric shaver when shaving another person; it's safer and easier.
- Put dentures in the person's mouth before shaving him.
- Have him in a sitting position if possible.

Dressing

- Be flexible. Wearing a bra or pantyhose may not be important to her, especially if it's an added hassle.
- Allow enough time for the person to do as much as she can for herself. If she can put clothing on but only needs help for buttons or shoes, give her time to do it.
- Let the person choose what to wear. You can lay out two choices to simplify this for someone who is confused.
- Be sure shoes or slippers are well-fitting and do not have gum soles, which can cause people to trip.
- Consider easy-to-use clothes with large front fasteners (zippers or Velcro,) elastic waistbands and slip-on shoes. This type of clothing is available through health product catalogs like Sears or J. C. Penney.
- To minimize the stress on a person's weak side, put the painful or weak arm into a shirt, pullover or jacket before the strong arm. When taking them off, take out the strong arm first.

Section 20: Hair, Nail, Skin and Oral Hygiene

Hair Care
Getting out to a barbershop or beauty shop is enjoyable for many people who are ill or disabled. If possible, it's often worth the extra effort to take the person out for a haircut or shampoo. Many shops will make a special effort to meet the client's needs, especially if they know the client or family. Beauty schools may do hair care for no or low cost, as a way for students to get experience.
You may also be able to find someone to come into the home. Try calling a local nursing home for the name of someone who makes home visits. Or place an ad in a church or other community bulletin board for what you need.

Hair Care Tips

- Keep hair short and in an easy-care style.
- Wash hair in the kitchen sink if the tub or shower is too difficult.
- Consider using one of the dry shampoo products found in drug stores if hair washing is impossible.
- If hair must be washed in bed, you can make a simple device to catch the water by making a U-shaped towel pad and putting it inside a large plastic bag. Place the open end of the U over the edge of the bed where it can drain into a bucket.

Skin Care
It is very important that the elderly take care of their skin because they are more susceptible to skin infection and skin disease due to the changes that take place to skin as we age. It becomes less supple, thinner and dryer. It injures easier and heals more slowly. As a result, seniors are prone to skin problems ranging from itching, scaling and mild dryness to grave skin conditions such as infection and ulcerations. A severe skin infection or non-healing wound in the elderly can be very serious, even fatal.

Skin Care tips for the Elderly
In general, the elderly have special skin care needs because aging skin is so thin and dry. If it becomes too dry, it is prone to cracking and dermatitis, which allows for penetration of bacteria that can result in infection.

The elderly should:

- Avoid hot baths and frequent showers.
- Use only mild soaps, and gently apply moisturizers to the skin after every shower or bath.
- Take extra care to avoid developing bedsores, particularly for those who are incontinent or bed-ridden. These individuals need to be turned frequently to avoid pressure-sensitive ulcers. And it is imperative that absorbent products and catheters be changed frequently.

To promote good skin health, seniors should also:

- Not smoke or quit smoking
- Never expose themselves to the sun without sunblock
- Keep properly hydrated by drinking more liquids
- Use a room humidifier during the winter and in dry climates
- Avoid hot and dry places, such as saunas

Nail Care
While it becomes difficult for elderly men and women to bend over and take care of their own feet and toenails, there are a number of diseases and conditions that become more serious and are more prevalent among the elderly. Common foot disorders among the elderly include diabetic ulcers,

ingrown nails, fungus, arthritis and corns and calluses. When aging adults can no longer take care of their own feet and toenails, there are steps you can take to mitigate foot problems and keep patients mobile and comfortable.

Nail Care involves the following steps:

- Inspect the feet on regularly. By noticing irregularities and when it's time for routine maintenance, you can help to prevent more serious problems. The circulation slows down during the aging process, and many elderly patients don't feel their feet as well as they used to and may not notice problems that would have bothered them in the past.
- Keep the feet warm and dry to avoid fungal infections and reduced circulation. Make sure to thoroughly dry an elderly person's toes and between the toes after bathing. Put on clean cotton socks after you've dried the feet.
- Wash their feet with a mild soap that won't dry the skin as quickly as harsh soaps. Apply lotion to feet when dry to prevent cracking and itching.
- Cut toenails straight across without curving on the edges. When the nail breaks through the skin after cutting nails too close, then ingrown toenails can develop. Use clippers to cut nails to make an even cut.
- Check that the elderly person has proper fitting shoes. Poorly fitting shoes are responsible for a number of conditions, such as spurs, corns and calluses and can contribute to fungal infections.
- Give your elderly charges a footstool to use when seated. Doctors at the National Institute on Aging report that by keeping their feet elevated, the elderly can maintain better foot circulation. Remind your senior not to sit with her legs crossed for extended periods of time either to avoid cutting the circulation off.

Mouth Care

- Clean teeth at least once a day.
- Check dentures regularly for cracks.
- Remove dentures for cleaning and store in liquid when out of the mouth.
- Have dentures checked if they aren’t fitting properly (a common cause of eating problems).

Section 21: Safe Transfer Techniques, Ambulation & Mechanical Devices

When patients are recovering from illness, they may require assistance to move around in bed, to transfer from bed to wheelchair, or to ambulate. Changing patient positions in bed and mobilization are also vital to prevent contractures from immobility, maintain muscle strength, prevent pressure ulcers, and help body systems function properly for optimal health and healing. The amount of assistance each patient will require depends on the patient's previous health status, age, type of illness, and length of stay.

Types of Assistance
At times, patients are assessed and given a "level of assistance" required for transferring. This is most common in residential care settings. The level of assistance is based on the patient's ability to transfer and stand. The terms describing different levels of assistance are used by healthcare providers to communicate with each other so everyone understands what type of assistance is required. The assistance needed is usually charted on the patient's Kardex, above the head of the bed, and/or on the patient's chart. Table below describes different types of assistance in the hospital and community setting.

Level of Assistance	
Level of Assistance	**Description**
Independent	The patient is able to transfer independently and safely.
Standby supervision	The patient requires no physical assistance but may require verbal reminder. This type of patient may also be learning to transfer independently using a wheelchair, walker, or cane.
Minimal assist	The patient is cooperative but needs minimal physical assistance with the transfer.
One-person standing pivot	The patient can bear weight on one or both legs and is cooperative and predictable. The patient also can sit with minimal support on the side of the bed.
Two-person standing pivot	The patient can assist with weight bearing, but may be inconsistent. The patient is cooperative and predictable.
One-person assist with transfer board	The patient is cooperative, follows directions, and has good trunk control. The patient can use their arms, but cannot bear weight on both legs.
Two-person assist with transfer board	The patient is cooperative and can follow directions. The patient can use their arms, but cannot bear weight on both legs. The patient does not have good trunk control. The patient's wheelchair has removable arms.

Mechanical stand	The patient may have some ability to stand, but is unreliable. The patient may be unpredictable (due to cognitive changes, medications). The patient is a heavy two-person transfer and requires toileting or pericare. The patient does not have severe limb contractures or injuries where movement is medically contraindicated (e.g., spinal injury). Use of a mechanical lift.

If the patient is cooperative, able to bear weight, and has some balance to sit, the health care provider must decide how much assistance the patient needs. Table below provides guidelines to consider.

Assistance Required for Transfer	
Assess	**Description**
Minimal	One-person transfer with gait belt The patient is able to perform 75% of the required activity on their own.
Moderate	Two-person transfer with a gait belt, a stander, or a two-person transfer with a slide board and a gait belt The patient is able to perform 50% of the required activity on their own.
Maximum	Stander or a two-person transfer with a slide board and gait belt The patient is able to perform 25% of the required activity on their own.

Special considerations:

- The weight, height, and general physical, mental, or emotional condition of the patient all influence the potential for injury.
- If the patient is uncooperative or unable to follow commands, there is an increased risk for injury. It is recommended that a mechanical lift or assistive device be used to prevent injury to the health care provider and patient.
- If there is any question about the patient's ability, always reassess.

Types of Transfers

Four types of transfers exist: mechanical lifts, sliding board, stand pivot and squat pivot transfers, which are addressed below:

- **Mechanical lift**
  Use a mechanical lift to complete a transfer if a patient is dependent or needs maximal assistance for sitting balance. Mechanical lifts are also necessary when patients have weight-bearing restrictions on bilateral lower extremities or are restricted to perform active transfers by the physician. A mechanical lift and a body sling are required for the lift transfer.
  Two primary types of slings exist, which may, or may not, include support for the head. A full body sling covers the posterior surface of the patient from the shoulders to the back of the thighs/knees. A second type of sling also supports the patient's body, but has divided legs that cross between the patient's legs and support him on the posterior surface of the thighs.
  To complete the mechanical lift transfer from the bed to the wheelchair, place the sling under the patient by rolling him from side to side. For safety reasons, make sure the sling is in the correct position. Next, place the wheelchair at a 90-degree angle from the bed, with the back of the wheelchair placed against the foot of the bed. Make sure the brakes are locked. If the wheelchair is a recliner or a tilt-in-space, it should be reclined/tilted for easier positioning into the chair. Place the widened base of the lift under the bed and lower the arm to attach the sling.

The chains or hooks of the lift are attached to the net with the shorter length of chain/loops at the head/shoulders of the sling. The longer length of chain/loops are attached at the lower end of the sling. This will encourage a seated position. Certain types of slings have loops made out of the material as part of the sling, instead of chains and metal stays.
The lift is raised and moved 90 degrees to straddle the wheelchair. The legs of the base of the hoyer should be positioned behind the back wheels of the wheelchair and the front casters. The patient is lowered into the wheelchair with the assisting person pressing on the person's knees to encourage the pelvis and hips to land correctly in the wheelchair. The pelvis should be placed toward the back of the seat.

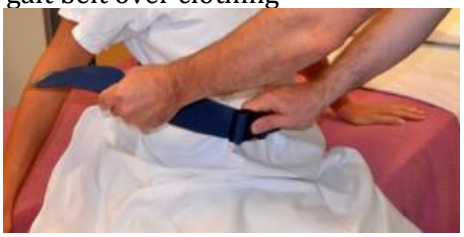
- **Sliding board**
  The sliding board transfer is used when a patient has the upper extremity and trunk strength to maintain a sitting posture and can assist in lifting weight off the buttocks to scoot. Clinicians need a gait belt and sliding board.
  To perform a transfer from the bed to the wheelchair, place the wheelchair at a 30-degree angle to the bed, with the brakes locked. Have the patient sit on the edge of the bed with assistance, if needed. Place the gait belt on the patient, and remove the armrest of the wheelchair closest to the bed.
  Then have the patient lean away from the wheelchair and place the board under the buttocks and upper thigh area, taking care not to pinch the patient's skin. Have the person return to the upright seated position and place his feet on the floor slightly behind the knees.
  The transfer requires a series of push-ups by leaning forward and away from the wheelchair to unweight the body, straightening the upper extremities, and depressing the shoulders to lift the buttocks and scoot toward the wheelchair. Multiple scoots should be used to complete the transfer. The patient shouldn't slide or be pulled across the board, since sliding places shearing friction on the patient's skin. This increases the patient's risk of skin breakdown.
  The assisting person can help the patient by lifting his buttocks and assisting with the lateral movement to scoot.
  The patient needs to reposition the hands and feet to gain a firm surface to push before each scoot during the transfer. To avoid pinching, make sure the fingers or hands aren't under the board.
  Once in the wheelchair, the patient should lean away from the bed so the board can be removed to complete the transfer. The armrest should be returned to the chair.

- **Stand pivot**
  Commonly practiced on a rehab unit, the stand pivot transfer is used with patients who can stand for a short time, have adequate hip, knee and ankle range of motion and strength, and good sitting balance. Clinicians need a gait belt.
  To complete a stand pivot transfer, put the gait belt on the patient. Place the wheelchair next to the bed at a 30-degree angle, with the brakes locked. Help the patient scoot forward to the edge of the bed. The patient's feet should be placed flat on the floor just behind the knees, and the person assisting the transfer should cue the patient so the two move together as a team. The patient should come to a standing position.
  Then have the patient pivot the feet, moving the buttocks toward the wheelchair. The patient's feet must pivot with the body to eliminate twisting at the knee and ankle. The patient slowly lowers to sit in the wheelchair. If he has a weak leg, the staff person assisting should guard the leg to make sure it doesn't collapse during the transfer.

- **Squat pivot**
  A modification of the stand pivot transfer is the squat pivot transfer, for which a patient must have good sitting balance and upper extremity strength. During this transfer, aide employs the

same steps as in the stand pivot transfer, except that the patient doesn't come to a full standing position. Instead, he maintains a squat position while lifting the hips, using the upper extremities to move from one surface to another.
Use the squat pivot transfer with patients who have limited trunk control, and limited knee or hip extension strength. The squat pivot transfer also can be used with patients who have limited knee or hip extension range of motion that inhibits them from being able to maintain a standing position.

Ambulating a Patient
Ambulation is defined as moving a patient from one place to another. Once a patient is assessed as safe to ambulate, determine if assistance from additional health care providers or assistive devices is required. Checklist given reviews the steps to ambulating a patient with and without a gait belt.

Ambulating a Patient	
Steps	Additional Information
1. Ensure patient does not feel dizzy or lightheaded and is tolerating the upright position. Instruct the patient to sit on the side of the bed first, prior to ambulation. Ensure proper footwear is on patient, and let patient know how far you will be ambulating. Proper footwear is non-slip or slip resistant footwear. Socks are not considered proper footwear.	Proper footwear is essential to prevent accidental falls.
2. Apply gait belt snugly around the patient's waist if required.	Gait belts are applied over clothing Apply gait belt over clothing  Gait belt should be snug, not tight
3. Assist patient by standing in front of the patient, grasping each side of the gait belt, keeping back straight and knees bent.	The patient should be cooperative and predictable, able to bear weight on own legs and to have good trunk control. Apply gait belt if required for additional support.

4. While holding the belt, gently rock back and forth three times. On the third time, pull patient into a standing position.	This action provides momentum to help patient into a standing position.  Rock back and forth to provide momentum Pulled to a standing position
5. Once patient is standing and feels stable, move to the unaffected side and grasp the gait belt in the middle of the back. With the other hand, hold the patient's hand closest to you. If the patient does not require a gait belt, place hand closest to the patient around the upper arm and hold the patient's hand with your other hand.	Standing to the side of the patient provides assistance without blocking the patient.  Assisting ambulation with a gait belt
6. Before stepping away from the bed, ask the patient if they feel dizzy or lightheaded. If they do, sit patient back down on the bed. If patient feels stable, begin walking, matching your steps to the patient's. Instruct patient to look ahead and lift each foot off the ground.	Always perform a risk assessment prior to ambulation. Walk only as far as the patient can tolerate without feeling dizzy or weak. Ask patient how they feel during ambulation.
7. To help a patient back to bed, have patient stand with back of knees touching the bed. Grasp the gait belt and help patient into a sitting position, keeping your back straight and knees bent.	Allowing a patient to rest after ambulation helps prevent fatigue.

8. When patient is finished ambulating, remove gait belt and settle patient into bed or a chair.	This provides a safe place for the patient to rest. Remove gait belt

Transfer from Bed to Wheelchair

Patients often need assistance when moving from a bed to a wheelchair. A patient must be cooperative and predictable, able to bear weight on both legs and take small steps. If any of these criteria are not met, a two-person transfer or mechanical lift is recommended. See Checklist for the steps to transfer a patient from the bed to the wheelchair.

Bed to Wheelchair Transfer	
Steps	Additional Information
1. One health care provider is required.	The patient should be assessed as a 1-person assist.
2. Perform hand hygiene. Explain what will happen during the transfer and how the patient can help. Apply proper footwear prior to ambulation	This step provides the patient with an opportunity to ask questions and help with the positioning. Explain procedure to patient Proper footwear
3. Lower the bed and ensure that brakes are applied. Place the wheelchair next to the bed at a 45-degree angle and apply brakes. If a patient has weakness on one side, place the wheelchair on the strong side.	Ensure brakes are applied on the wheelchair
4. Sit patient on the side of the bed with his or her feet on the floor. Apply the gait belt snugly around the waist (if required). Place hands on waist to assist into a standing position	The patient's feet should be in between the health care provider's feet. 

5. As the patient leans forward, grasp the gait belt (if required) on the side the patient, with your arms outside the patient's arms. Position your legs on the outside of the patient's legs. The patient's feet should be flat on the floor.	 Assist to a standing position using a gait belt
6. Count to three and, using a rocking motion, help the patient stand by shifting weight from the front foot to the back foot, keeping elbows in and back straight.	Weight shift to back leg by health care provider
7. Once standing, have the patient take a few steps back until they can feel the wheelchair on the back of their legs. Have patient grasp the arm of the wheelchair and lean forward slightly.	Ensure the patient can feel the wheelchair on the back of the legs prior to sitting down. 

8. As the patient sits down, shift your weight from back to front with bent knees, with trunk straight and elbows slightly bent. Allow patient to sit in wheelchair slowly, using armrests for support.	This allows the patient to be properly positioned in the chair and prevents back injury to health care providers. 

Special considerations:

- Do not allow patients to place their arms around your neck. Have them place their arms around your hips.
- Avoid lifting patients. Let them stand using their own strength.
- Stay close to your patient during the transfer to keep the patient's weight close to your center of gravity
- If the patient has weakness on one side of the body (e.g., due to a cerebral vascular accident, CVA or stroke), place the wheelchair on the strong side.

Use of Mechanical Devices

- **Transfer from Sitting to Standing Position - Lifts**
  Description: Powered sit-to-stand or standing assist devices.
  When to Use: Transferring residents who are partially dependent, have some weight-bearing capacity, are cooperative, can sit up on the edge of the bed with or without assistance, and are able to bend hips, knees, and ankles. Transfers from bed to chair (wheel chair, Geri or cardiac chair), or chair to bed, or for bathing and toileting. Can be used for repositioning where space or storage is limited.
  Points to Remember: Look for a device that has a variety of sling sizes, lift- height range, battery portability, hand-held control, emergency shut-off, and manual override. Ensure device is rated for the resident weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow smoother movement for the resident and less physical exertion by the caregiver.

- **Transferring from Sitting to Standing Position - Chairs**
  Description: Lift cushions and lift chairs.
  When to Use: Transferring residents who are weight-bearing and cooperative but need assistance when standing and ambulating. Can be used for independent residents who need an extra boost to stand.
  Points to Remember:
  Lift cushions use a lever that activates a spring action to assist residents to rise up. Lift cushions may not be appropriate for heavier residents. Lift chairs are operated via a hand-held control that tilts forward slowly, raising the resident. Residents need to have physical and cognitive capacity to be able to operate lever or controls. Always ensure device is in good working order before use and is rated for the resident weight to be lifted. Can aid resident independence.

- **Hoyer/Mechanical Lifts**
  Description: Portable lift device (sling type); can be a universal/ hammock sling or a band/ leg sling.
  When to Use: Lifting residents who are totally dependent, are partial- or non-weight bearing, are very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a resident fall.
  Points to Remember: More than one caregiver may be needed. Look for a device with a variety of slings, lift-height range, battery portability, hand-held control, emergency shut-off, manual override, boom pressure sensitive switch, that can easily move around equipment, and has a support base that goes under beds. Having multiple slings allows one of them to remain in place while resident is in bed or chair for only a short period, reducing the number of times the caregiver lifts and positions resident. Portable compact lifts may be useful where space or storage is limited. Ensure device is rated for the resident weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow a smoother movement for the resi- dent, and less physical exertion by the caregiver. Enhances resident safety and comfort.

- **Repositioning in Chair**
  Description: Variable position Geri and Cardiac chairs.
  When to Use: Repositioning partial- or non- weight-bearing residents who are cooperative.
  Points to Remember: More than one caregiver is needed and use of a friction- reducing device is needed if resident cannot assist to reposition self in chair. Ensure use of good body mechanics by caregivers. Wheels on chair add versatility. Ensure that chair is easy to adjust, move, and steer.
  Lock wheels on chair before repositioning. Remove trays, footrests, and seat belts where appropriate. Ensure device is rated for the resident weight.

- **Ambulation**
  Description: Ambulation assist device.
  When to Use: For residents who are weight bearing and cooperative and who need extra security and assistance when ambulating.
  Points to Remember: Increases resident safety during ambulation and reduces risk of falls. The device supports residents as they walk and push it along during ambulation. Ensure height adjustment is correct for resident before ambulation. Ensure device is in good working order before use and rated for the resident weight to be lifted. Apply brakes before positioning resident in or releasing resident from device.

- **Ceiling Mounted Devices**
  Description: Ceiling mounted lift device.
  When to Use: Lifting residents who are totally dependent, are partial- or non-weight bearing, very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a resident falls. A horizontal frame system or litter attached to the ceiling-mounted device can be used when transferring residents who cannot be transferred safely between 2 horizontal surfaces, such as a bed to a stretcher or gurney while lying on their back, using other devices.

  Points to Remember: More than one caregiver may be needed. Some residents can use the device without assistance. May be quicker to use than portable device. Motors can be fixed or portable (lightweight). Device can be operated by hand-held control attached to unit or by infrared remote control. Ensure device is rated for the resident weight. Increases residents' safety and comfort during transfer.

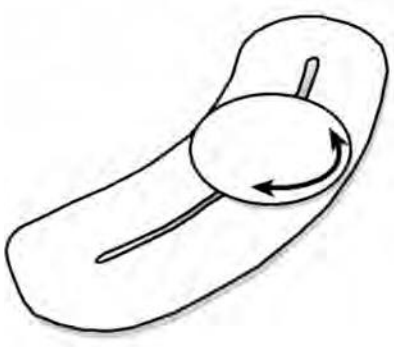
- **Lateral Transfer – Sheets & Boards**
  Description: Devices to reduce friction force when transferring a resident such as a draw sheet or transfer cot with handles to be used in combination slippery sheets, low friction mattress covers, or slide boards; boards or mats with vinyl coverings and rollers; gurneys with transfer devices; and air-assist lateral sliding aid or flexible mattress inflated by portable air supply.
  When to Use: Transferring a partial- or non-weight bearing resident between 2 horizontal surfaces such as a bed to a stretcher or gurney while lying on their back or when repositioning resident in bed.

  Points to Remember: More than one caregiver is needed to perform this type of transfer or repositioning. Additional assistance may be needed depending upon resident status, e.g., for heavier or non-cooperative residents. Some devices may not be suitable for bariatric residents.
  When using a draw sheet combination use a good hand-hold by rolling up draw sheets or use other friction-reducing devices with handles such as slippery sheets. Narrower slippery sheets with webbing handles positioned on the long edge of the sheet may be easier to use than wider sheets. When using boards or mats with vinyl coverings and rollers use a gentle push and pull motion to move resident to new surface.

Look for a combination of devices that will increase resident's comfort and minimize risk of skin trauma. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back. Count down and synchronize the transfer motion between caregivers.

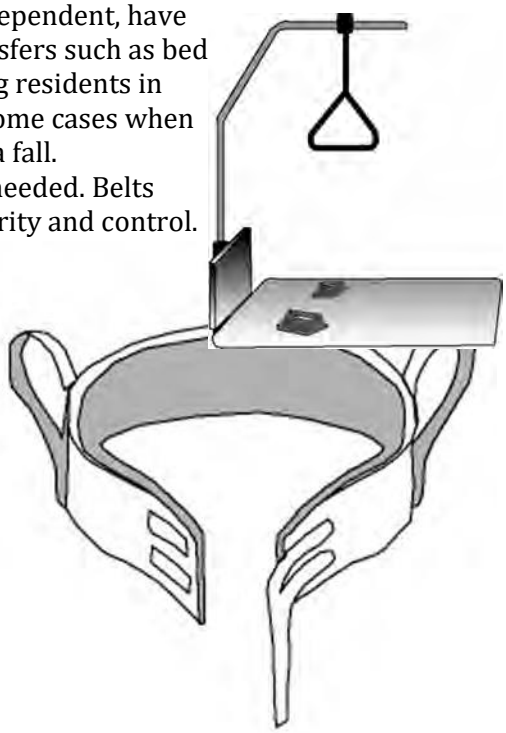
- **Lateral Transfer – Convertible Chairs**
  Description: Convertible wheelchair, Geri or cardiac chair to bed; beds that convert to chairs.
  When to Use: For lateral transfer of residents who are partial- or non-weight bearing. Eliminates the need to perform lift transfer in and out of wheelchairs. Can also be used to assist residents who are partially weight bearing from a sit-to-stand position. Beds that convert to chairs can aid repositioning residents who are totally dependent, non- weight bearing, very heavy, or have other physical limitations.
  Points to Remember: More than one caregiver is needed to perform lateral transfer. Additional assistance for lateral transfer may be needed depending on residents status, e.g., for heavier or non-cooperative residents. Additional friction-reducing devices may be required to reposition resident. Heavy duty beds are available for bariatric residents. Device should have easy-to-use controls located within easy reach of the caregiver, sufficient foot clearance, and wide range of adjustment. Motorized height adjustable devices are preferred to those adjusted by crank mechanism to minimize physical exertion. Always ensure device is in good working order before use. Ensure wheels on equipment are locked. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back

- **Lateral Transfer – Boards**
  Description: Transfer boards – wood or plastic (some with movable seat).
  When to Use: Transferring (sliding) residents who have good sitting balance and are cooperative from one level surface to another, e.g., bed to wheelchair, wheelchair to car seat or toilet. Can also be used by residents who require limited assistance but need addi- tional safety and support.
  Points to Remember: Movable seats increase resident comfort and reduce incidence of tissue damage during transfer. More than one caregiver is needed to perform lateral transfer. Ensure clothing is present between the resident's skin and the transfer device. The seat may be cushioned with a small towel for comfort. May be uncomfortable for larger residents. Usually used in conjunction with gait belts for safety depending on resident status. Ensure boards have tapered ends, rounded edges, and appropriate weight capacity. Ensure wheels on bed or chair are locked and transfer surfaces are at same level. Remove lower bedrails from bed and remove arms and footrests from chairs as appropriate.



- **Transfers – Belts**
  Description: Gait belts/transfer belts with handles.

When to Use: Transferring residents who are partially dependent, have some weight-bearing capacity, and are cooperative. Transfers such as bed to chair, chair to chair, or chair to car; when repositioning residents in chairs; supporting residents during ambulation; and in some cases when guiding and controlling falls or assisting a resident after a fall.

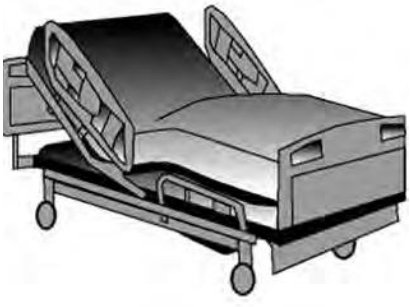


Points to Remember: More than one caregiver may be needed. Belts with padded handles are easier to grip and increase security and control. Always transfer to resident's strongest side. Use good body mechanics and a rocking and pulling motion rather than lifting when using a belt. Belts may not be suitable for ambulation of heavy residents or residents with recent abdominal or back surgery, abdominal aneurysm, etc. Should not be used for lifting residents. Ensure belt is securely fastened and cannot be easily undone by the resident during transfer. Ensure a layer of clothing is between residents' skin and the belt to avoid abrasion. Keep resident as close as possible to caregiver during transfer. Lower bedrails, remove arms and foot rests from chairs, and other items that may obstruct the transfer.

For use after a fall, always assess the resident for injury prior to movement. If resident can regain standing position with minimal assistance, use gait or transfer belts with handles to aid resident. Keep back straight, bend legs, and stay as close to resident as possible.

If resident cannot stand with minimal assistance, use a powered portable or ceiling-mounted lift device to move resident.

- **Repositioning - Beds**
  Description: Electric powered height adjustable bed.
  When to Use: For all activities involving resident care, transfer, repositioning in bed, etc., to reduce caregiver bending when interacting with resident.
  Points to Remember: Device should have easy-to-use controls located within easy reach of the caregiver to promote use of the electric adjustment, sufficient foot clearance, and wide range of adjustment. Adjustments must be completed in 20 seconds or less to ensure staff use. For residents that may be at risk of falling from bed some beds that lower closer to the floor may be needed. Heavy duty beds are available for bariatric residents. Beds raised and lowered with an electric motor are preferred over crank-adjust beds to allow a smoother movement for the resident and less physical exertion to the caregiver.

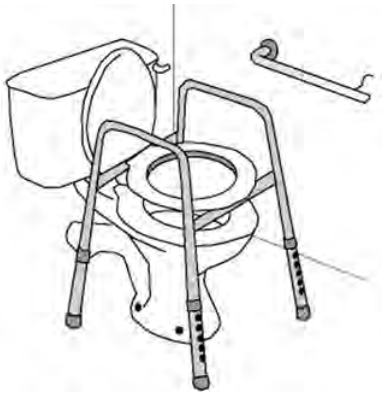


- **Repositioning - Beds**
  Description: Trapeze bar; hand blocks and push up bars attached to the bed frame.
  When to Use: Reposition residents that have the ability to assist the caregiver during the activity, i.e., residents with upper body strength and use of extremities, who are cooperative and can follow instructions.
  Points to Remember: Residents use trapeze bar by grasping bar suspended from an overhead frame to raise themselves up and reposition themselves in a bed. Heavy duty trapeze frames

are available for bariatric residents. If a caregiver is assisting, ensure that bed wheels are locked, bedrails are lowered, and bed is adjusted to caregiver's waist height. Blocks also enable residents to raise themselves up and reposition themselves in bed. Bars attached to the bed frame serve the same purpose. May not be suitable for heavier residents. Can aid resident independence.

- **Positioning – Bath & Shower Chairs**
  Description: Shower and toileting chairs.
  When to Use: Showering and toileting residents who are partially dependent, have some weight bearing capacity, can sit up unaided, and are able to bend hips, knees, and ankles.
  Points to Remember: Ensure that wheels move easily and smoothly; chair is high enough to fit over toilet; chair has removable arms, adjustable footrests, safety belts, and is heavy enough to be stable; and that the seat is comfortable, accommodates larger residents, and has a removable commode bucket for toileting. Ensure that brakes lock and hold effectively and that weight capacity is sufficient.

- **Positioning – Toilet Seat & Seat Risers**
  Description: Toilet seat risers.
  When to Use: For toileting partially weight-bearing residents who can sit up unaided, use upper extremities (have upper body strength), are able to bend hips, knees, and ankles, and are cooperative. Independent residents can also use these devices.
  Points to Remember: Risers decrease the distance and amount of effort required to lower and raise residents. Grab bars and height-adjustable legs add safety and versatility to the device. Ensure device is stable and can accommodate resident's weight and size.



Fall Prevention Strategies
All clients should be assessed for risk factors, and necessary prevention measures should be implemented as per agency policy. Table below lists factors that affect patient safety and general measures to prevent falls in health care.

Fall Prevention Strategies	
Prevention Strategies	**Safety Measures**
Look for fall risk factors in patients.	Identifying specific factors helps you implement specific preventive measures. Risk factors include age, weakness on one side, the use of a cane or walker, history of dizziness or lightheadedness, low blood pressure, and weakness.
Clear the Clutter	Keep your home neat and tidy. Remove all clutter, such as stacks of old newspapers and magazines, especially from hallways and staircases
Repair or remove tripping hazards	Sometimes home fixtures can contribute to falls, which can then lead to back pain and other injuries. Examine every room and hallway, looking for items such as loose carpet, slippery throw rugs, or wood floorboards that stick up. Then repair, remove, or replace those items for more effective fall prevention.
Install grab bars and handrails	These safety devices are crucial for going up and down stairs, getting on and off the toilet, and stepping in and out of the bathtub without injuring yourself. Installing grab bars by toilets and bathtubs and handrails in stairways and hallways
Ensure patient has proper footwear	Proper footwear prevents slips. Socks may be comfortable, but they present a slipping risk. Preventing falls at home can be as simple as wearing shoes. You can also purchase non-slip socks that have grips on the soles of the feet if shoes are too uncomfortable
Avoid loose clothing	You want to feel comfortable at home, but baggy clothes can sometimes make you more likely to fall. Opt for better-fitting and properly hemmed clothing that doesn't bunch up or drag on the ground
Home Lighting	Inadequate lighting is another major hazard. To create a home that's more suitable for the elderly, install brighter light bulbs where needed, particularly in stairways and narrow hallways. Add night-lights in bedrooms and bathrooms for better guidance at night.
Make it Non Slip	Bathtubs and showers, as well as floors in kitchens, bathrooms, and porches, can become extremely dangerous when wet. To prevent falls on slick surfaces install nonslip mats

Section 22: Toileting & Elimination

The person you're caring for may need help using the toilet, or she may have lost control over their bladder or bowel (incontinence.) You may be uncomfortable providing this kind of care. This chapter gives suggestions that will help her maintain as much independence as possible and make your job an easier one.
Incontinence is not a normal part of aging or most illnesses. If incontinence develops, it's very important to ask the physician for a complete evaluation. Many causes of incontinence are treatable.

If The Person Needs Help Getting To the Bathroom

- Set up the bathroom to make it as easy as possible for the person to get on to and off of the toilet, e.g. having a raised toilet seat and grab bars.
- Notice when the person gives a sign about needing to use the toilet, e.g. agitation, fidgeting, tugging on clothing, wandering, touching the genital area. Have a routine and take the person to the bathroom on a regular schedule, e.g. every two hours. You may have to respond quickly if someone indicates they need to use the bathroom. Suggest going to the bathroom on a frequent, scheduled basis. Rushing after the urge strikes will increase the chance of accidents. Every 2 hours is too often for most people; start with every 3–4 hours.
- Make sure the hallway and bathroom are well-lighted.
- If the care receiver needs help removing clothes, help him/her by moving slowly and encouraging him/her to help. Remind the person that they need to pull down their pants before sitting down. Clothes that are easy to remove will help, such as those with elastic waistbands.
- Remove throw rugs, which could trip someone.
- Install grab bars and/or use a raised toilet seat for more ease getting on and off the toilet.
- Don't rush the person; allow time for them to empty their bowel and bladder. It may take a little time to get started. Walk away and come back in a few minutes or stand just outside the door.
- Assist as needed to pull pants back up. Sometimes the person will walk away without pulling pants up, which is a fall hazard. Provide as much privacy and modesty as possible.

If The Person Occasionally Has Accidents

- Remember that accidents are very embarrassing for the person.
- Stay calm and reassure them that it's "okay."
- Keep a matter-of-fact approach. "Let me help you get out of these wet things."
- Monitor them for urinary tract infections. Any fever lasting more than 24 hours should be evaluated.

If Accidents Happen Regularly

- See a doctor for a thorough evaluation and treatment recommendations.
- Establish a regular schedule for using the toilet.
- Avoid caffeine, alcohol, citrus juice or other bladder irritants.
- Offer 6–8 glasses of fluids every day to prevent strong urine that can irritate the bladder.
- Find out if they is taking any medications that affect the bladder. Common over-the-counter products like aspirin and Excedrine contain caffeine, which stimulates the bladder. A few high blood pressure medications can irritate the bladder.
- Be aware that incontinence can be a trigger for skin breakdown and pay special attention to skin care.

Avoid Constipation

- Offer foods high in fiber such as fruits, nuts, beans, vegetables, bran and most cereals. Add high fiber foods gradually if the person isn't used to them.
- Make sure there is adequate liquid in the diet; 6–8 classes of liquid each day are recommended (unless otherwise instructed by the physician).
- Encourage daily exercise to stimulate bowel activity.

Helpful Supplies

- Commodes are available to buy or rent if it's too hard to get to the bathroom. Commodes are especially helpful during the night.
- Use a commode or urinal by the bed at night so the person doesn't have to get up and walk to the bathroom, which increases the risk of falls and incontinence. Have a night light if the person does go to the bathroom at night. If a person has urgency when needing to urinate, a commode or urinal by the chair in the living room can also be helpful.
- Bedpans and urinals may be needed if she can't get out of bed. They can be purchased at medical supply stores and larger drugstores.
- Using incontinence pads in the underwear might be a way to reassure someone that they don't have to rush or panic when they have the urge to urinate.
- Disposable pads, briefs, and undergarments are an expensive but effective way to protect clothing and bedding.

Controlling Stains And Odor

- Include cranberry juice in the diet to help control urine odor.
- Protect the mattress with rubber or plastic sheets. Consider a breathable, washable layer like sheepskin between the sheet and the waterproof to avoid excess sweating or a "sticky" feeling.
- Remove soiled bed linens and clothing quickly. If it's impossible to launder them immediately, rinse them in cold water. Soak stained items in dishwashing detergent to loosen stains.
- Clean bedpans, urinals, and commodes with household cleaners.
- Avoid odors on furniture or other household items by cleaning soiled areas with a mild dilution of cold water and white vinegar.
- Protect furniture with disposable or other waterproof pads.

Section 23: Assistance with Self-Administered Medications

Your Abilities

Before you can assist with the self-administration of medications, there are specific abilities that you must be able to perform. These abilities include:

- Read and understand a prescription label.
- Know what approved abbreviations your organization uses and use only those.
- Assist with oral (mouth), topical (skin), ophthalmic (eye), otic (ear) nasal (nose), and inhaled forms of medications.
- Measure liquid medications, break scored tablets, or crush tablets as directed.
- Recognize when to clarify an "as needed" prescription order.
- Recognize an order that requires judgment or discretion.
- Safely store medications.
- Complete a medication observation record or other required documentation.
- Recognize general signs of adverse reactions to medications and report such reactions.

In addition, you must be aware of and follow scope of practice guidelines and organizational policies and procedures. Be mindful of the fact that practice guidelines and regulations do vary from state to state and from organization to organization. Be sure you understand how state laws govern your practice, and check with your supervisor for clarification if you have questions.

Before You Begin

Before assisting someone with taking their medications, you must remember to:

- Ensure this task is within your scope of practice.
- Check the individual's plan of care and your organization's policies and procedures.
- Give medications within 1 hour of the scheduled dose or within 30 minutes if a time-critical medication.
- Administer medications immediately after preparing them.
- Encourage individuals to perform as much of the procedure as they are able.
- Review the basic rights for medication administration while holding the medications.
- Consult a drug reference to familiarize yourself with unknown medications.
- Discuss the purpose and side effects with the individual prior to administration.
- Follow all manufacturer's guidelines for medication administration, including if medications need to be given at a different time than other medications.
- Compare the medication label to the medication administration record (MAR) 3 times.
- Check the expiration date for the medications the individual is taking.
- Gather all necessary supplies.
- Verify the individual's identity using two identifiers.
- Explain the procedure and provide for privacy.
- Perform hand hygiene.

Other Considerations

Because some medications can cause problems with constipation and dehydration, providing adequate amounts of fluid is often essential. Be sure to check the manufacturer's guidelines for recommendations for fluid intake with certain medications and follow them. The same is true when giving medications that must be taken with food.

Remember that everyone has the right to privacy. It is your responsibility to make sure that all medications are administered in a private environment. For example, before giving a medication in front of another person, make sure the individual taking the medication is comfortable with this. You may need to ask visitors to leave the room or take the individual to a private location before assisting

with the self-administration of medications. Remember, those who are not able to communicate or have mental or cognitive impairments should also have their privacy and dignity protected.
Other considerations include:

- Follow organizational policy and procedure for the disposal of all medical waste.
- Administer each medication separately by using individual medication cups to hold each one apart from the others.
- Recognize that certain forms of medications must usually be given by nurses or licensed personnel, including those placed into a body cavity and those that are injected through the skin.
- Acknowledge that certain pre-medication administration procedures must usually be performed by nurses or licensed personnel, including assessment, blood glucose testing, and measurement of heart rate, pulse, respiratory rate, and blood pressure.

Be Mindful

There are many things you must be mindful of as you assist individuals with self-administration of medications. They include abilities and knowledge that you must demonstrate before assisting with self-administration of medication, strategies you should use during the process, and things to watch for and report. Always be aware of and stay within your scope of practice, job description, and capabilities to ensure the safety of the people you care for.

Section 24: Range of Motion (ROM)

Range of Motion (ROM) is the full movement potential of a joint, usually its range of flexion and extension. ROM exercises help improve joint function. These exercises help you move each joint through its full range of motion. Movement can help keep your joints flexible, reduce pain, and improve balance and strength.

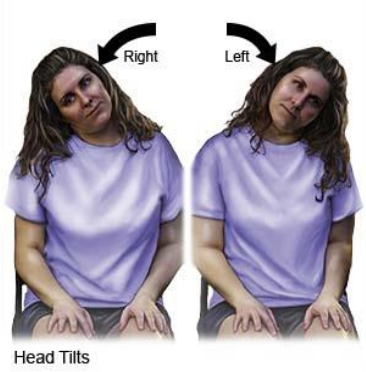
Neck exercises:
Starting position: You may sit or stand. Face forward. Your shoulders should be straight and relaxed.

Head tilts, forward and back: Gently bow your head and try to touch your chin to your chest. Raise your chin back to the starting position. Tilt your head back as far as possible so you are looking up at the ceiling. Return your head to the starting position.

Head tilts, side to side: Tilt your head to the side, bringing your ear toward your shoulder. Do not raise your shoulder to your ear. Keep your shoulder still. Return your head to the starting position.

Head turns: Turn your head to look over your shoulder. Tilt your chin down and try to touch it to your shoulder. Do not raise your shoulder to your chin. Face forward again.

Head Tilts



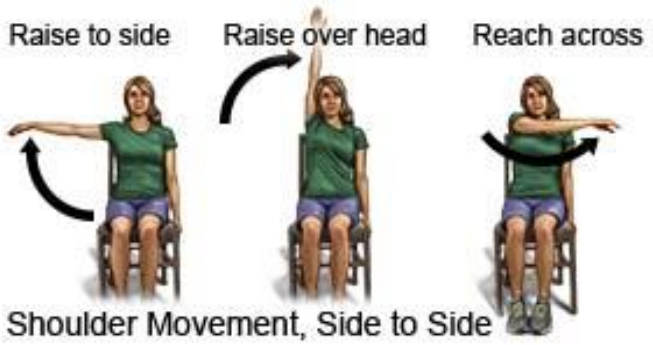
Head Tilts


Head Turns

Shoulder and elbow exercises:
Starting position: Stand or sit. Hold your arm straight down at your side. Face palms in toward your body. It is best to use a chair without arms if you are in a sitting position.

Shoulder movement, up and down: Raise your arm forward and then up over your head. Try to raise it so that your inner arm touches your ear. Bring your arm back down to your side. Bring it back as far as possible behind your body. Return your arm to the starting position.


Shoulder Movement, Up and Down

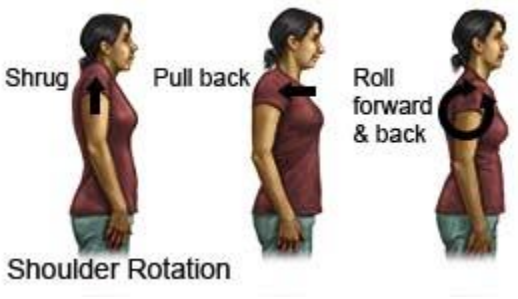


Shoulder Movement, Side to Side

Shoulder movement, side to side: Raise your arm to the side and then up over your head as far as possible. Return your arm to your side. Bring your arm across the front of your body and reach for the opposite shoulder. Return your arm to the starting position.

Shoulder rotation: Raise both shoulders up toward your ears, as if you were trying to shrug. Lower them to the starting position, and relax your shoulders. Pull your shoulders back. Then relax them again. Roll your shoulders in a smooth circle. Then roll your shoulders in a smooth circle in the other direction.

Elbow bends: With your palm facing forward, bend your elbow. Try to touch your shoulder with your fingertips. Return your arm to the starting position.



Arm and wrist exercises:
Starting position: Sit down. Bend your elbow and rest your forearm on a flat surface, such as a table or your lap. Make sure your wrist hangs loosely over the side.

Wrist bends: Bend your hand back toward your wrist so that your fingers point toward the ceiling. Then bend your hand down so that your fingers point toward the floor.

Wrist rotation: Move your hand from side to side. Then roll your hand in circles in one direction. Roll your hand in circles in the other direction.

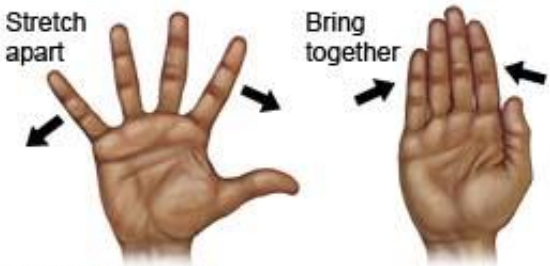
Palm up, palm down: Stay in the same position, but tuck your bent elbow against your side. Face your palm down. Turn your palm so that it faces up toward the ceiling. Then turn your palm so it faces down.

Hand and finger exercises:
Starting position: Sit or stand. Place your hand out in front of you.

Finger bends: Make a tight fist. Then open and relax your hand.

Finger spreads: Open your hand and stretch the fingers as far apart as possible. Bring your fingers together again.

Finger Bends



Finger Spreads

Finger-to-thumb touches: One at a time, touch each fingertip to the pad of your thumb.

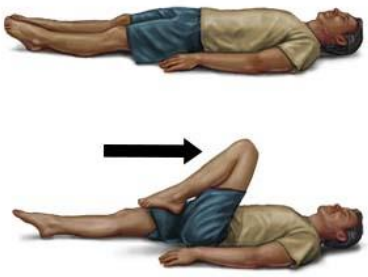
Thumb-to-palm stretches: Move your thumb and rest it across your palm. Move it out to the side again.


Finger to Thumb Touches


Thumb to Palm Stretches

Hip and knee exercises:
Starting position: If you have had a hip injury or surgery, only do the hip exercises directed by your healthcare provider. Lie flat on the bed with your legs flat and straight.

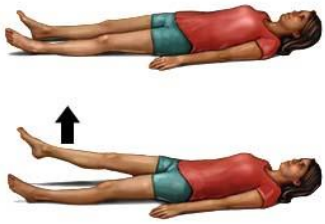
Hip and knee bends: Point your toes. Slowly bend your knee up as close to your chest as possible. Straighten your leg and return it to a flat position on the bed.


Hip and Knee Bends

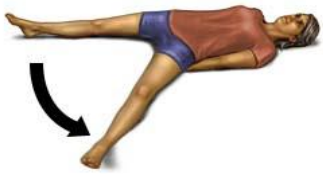
Leg lifts: Raise your leg so that your foot is 6 to 12 inches (15 to 31 centimeters) off the bed. Hold it in the air for a few seconds. Return your leg to the bed.

Leg movement, side to side: Flex your foot so your toes point up toward the ceiling. Move your leg out to the side as far as possible. Bring your leg back to the middle.

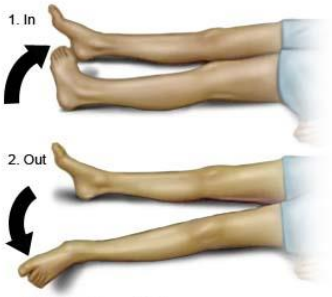
Leg rotation, in and out: Put your leg flat on the bed. Roll your leg toward the middle so your big toe touches the bed. Then roll your leg out and try to make your smallest toe touch the bed.



Leg Lifts

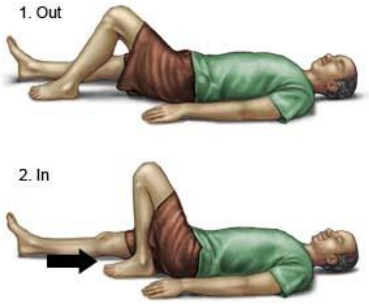


Leg Movement Side to Side



Leg Rotation In and Out

Knee rotation, in and out: Lie on your back on the bed. Bend your knee so the bottom of your foot is flat on the bed. Slide your heel towards your buttocks. Return your foot to the starting position.



Knee Rotation In and Out

Ankle and foot exercises:
Starting position: Sit in a chair with both feet flat on the floor.

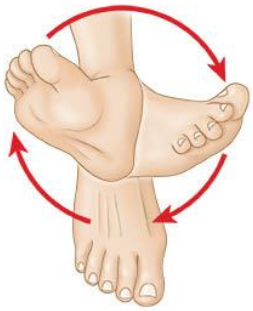
Ankle bends: Keep your toes on the floor and raise your heel as high as you can. Lower your heel. Then keep your heel on the floor and raise your toes as high as you can.

Ankle rotation: Raise your foot slightly off the floor. Roll your ankle in circles. Then roll your ankle in circles in the other direction.

Toe bends: Curl your toes down toward the sole (bottom) of your foot. Straighten them. Curl them up toward the ceiling. Then straighten them again.

Toe spreads: Spread your toes apart. Bring them together again.

Ankle Rotation



Section 25: Communication Skills

Every time you visit your clients, you build important physical and emotional connections with them. Now it's time to strengthen those connections by optimizing your communication skills, so you can effectively convey vital information and instructions.
Effective communication requires you to think from your clients' perspectives, so you can tailor your strategy to each individual. Here are some patient communication tips to follow when you're working with different types of clients.

Suggestions for Communicating with Elderly Patients
Communicating with elderly patients requires a gentle approach. You should:

- **Take your time.** Allow for extra time with elderly patients, offering the time and the attention they deserve and need. Although they're generally eager for information, they may lack focus and attention. Be prepared to repeat instructions, and speak in a slow, clear manner.
  Accommodate special needs. If your client suffers from vision or hearing loss, sit closely and face-to-face. This lets the client focus on what you're saying and reduces distractions. Although you might need to raise your voice for them to hear you, remember: There's a difference between talking loudly and shouting.
  Keep it simple. Use short sentences and simple words to get your message across. Avoid using medical or technical language that the client may not understand.

Communicating with Patients from Different Cultures
Keep in mind that patients from different countries and cultures may have significantly different communication styles. In these instances, you must:

- **Appreciate English's complexity.** English isn't a simple language even for those of us who speak it natively (think *through*/*though*). Imagine how difficult it must be for a non-native English speaker to receive complex medical instructions and diagnoses in English. Use simple sentence structures, and be mindful of your word choices.
  Remember that silence is sometimes golden. Some people are uncomfortable with awkward silences. But when you're working with clients who speak another language, that pause may indicate they're translating and processing what you've just told them. Make sure they've understood what you've said — and don't take a nod or a simple "Yes" as affirmation. It's possible they're just being polite. Ask follow-up questions and evaluate their response for comprehension.
  Avoid acronyms and expressions. Even something as simple as "10 a.m." could be confusing for a non-English speaker. Avoid using acronyms and idioms that might be unclear or could be misunderstood. Instead, try saying, "10 in the morning."

Tips for Communicating with End-of-Life Patients
When a patient nears the end of his life, stress and emotions can run high — with the patient, family, and caregiver. When communicating with end-of-life patients:

- **Don't evade bad news.** You must be able to objectively and unemotionally break bad news to clients and their families — and then be prepared to answer their questions.
  Be clear. Communicate the expected course of the illness and what the patient can expect in terms of treatment options.
  Be sensitive to cultural and religious beliefs. Understand that the end of life is treated differently by different cultures and religions; be empathetic to their beliefs.
  Be patient. Patients near the end of life will likely experience a range of emotions, extreme fatigue, and increased stress. If they exhibit erratic behavior, consider how their frustrations

and fears of the unknown are contributing to that behavior.

Involving Families in the Communication Loop

Communicating effectively with families of patients — keeping them involved and informed — is just as important as communicating with clients. When you speak with them, remember to:

- **Be a good listener.** Remind family members that being a good listener is an important part of being a good communicator. Teach them to not just ***listen*** to the patient but also to really ***hear*** what they're saying.
  Be brave. Encourage families to be unafraid to ask uncomfortable questions, such as those surrounding finances, wills, and advance legal directives. Although they're difficult to talk about, clarifying these things now will alleviate future stress and uncertainty.
  Gather all family members. Any family member who's involved in the care of your patient in any way should be involved in routine meetings. Discuss not just the illness, but also how loved ones are feeling and what they can expect. Use email or videoconferencing to keep those who can't attend in the loop.

Patient Communication Tips for All Client Types

The communication strategies offered below can be applied to all types of patients. Regardless of the patient or family member you're talking with, remember to:

- **Ask open-ended questions.** Avoid asking questions that can be answered with a nod of the head or a simple yes/no because you'll walk away wondering if they really understood you. Asking open-ended questions—they often start with *who*, *what*, *when*, *where,* or *why*— requires the client to give you a more complete answer.
  Instruct, pause, repeat. One of the easiest ways to ensure you've gotten your message across is to have the client repeat what you've just said in their own words.
  Write down instructions. After you've verbally communicated instructions to your patients, consider supplementing them with written instructions. Keep them simple — for example, use bullet points to reduce confusion. You can also use pictures, diagrams, and charts to clarify and enhance your message.
  Give them a turn. Don't forget to give clients an opportunity to ask questions, get clarification, and express their emotions.

Improving Communication Skills to Improve Outcomes

Communication skills involve more than just talking. Body language, listening, hearing — they all have an impact on the message you're trying to convey. When you effectively communicate your client's medical information to them, they can use that information to improve their outcomes.

Section 26: Department Issued Policies & Procedures

For OLTL issued policies and procedures pls. refer to the following sites:

- OLTL Bulletins:
  https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx

- OLTL Policies and Procedures:
  https://www.aging.pa.gov/publications/policy-procedure-manual/Pages/default.aspx