# CLINICAL ADDENDUM TO PRIVATE DUTY PERSONNEL POLICIES

These are required standards for care during clinical assignments.

## GUIDELINES FOR CONDUCT IN THE HOME

The following are considered professional behaviors that help to foster successful working relationships with the client and family:

- BE ON TIME

  Private Duty: Shifts are established based on client/family needs and physician orders. You will be required to report to work as scheduled. The job of the health care professional is to provide a comfortable, secure environment for the client and family and not to create unnecessary stress and worry. If you discover you are going to be late, if even just 10 or 15 minutes, call the office so we can notify the client/family. **DO NOT CALL THE CLIENT/FAMILY DIRECTLY!**

  Home Visits: Always call the client/family before the visit, preferably the day before. Arrival time should be anticipated and the client/family called if you are going to be late.

- ACKNOWLEDGE PRIVACY

  You are a professional health care provider in the client/family's private home. **You are a guest in the home**. Observe the client/family's right to their privacy and lifestyle. Never enter a closed room without first knocking and identifying yourself.

- BRIEF AND NEAT MEAL TIMES

  On private duty assignments, you are entitled to meal breaks. The time should be appropriated for the client. Ask the family where they would prefer you to eat. You must provide all the food and beverages you consume while working your shift. Be sure to promptly clean up after your meals. You are not to ask the family for food or beverages. Most families have no objection to your use of their refrigerator or microwave. You are not to leave the home for breaks/meals.

- HOUSE RULES

  Respect for client/family "house rules" is an important component to home care. At the onset of care, the management team or designee determines the client/family's preferences and expectations for individual "house rules" as they relate to Community Care staff. Respect and caring for the client includes Community Care staff adhering to these guidelines. You should learn these guidelines before you provide care to the client by asking a management team member or other staff member during orientation. Some of these items are:

  - Meal Times/Preparation

- Parking
- What entrance to use
- Use of bathrooms
- Use of telephones
- Climate control

- SMOKING
  There will be no smoking in a client's home during scheduled work time. The odor of smoke on clothing may have an adverse affect on the client or family members. If possible refrain from smoking while on duty. Smokers should be alert to the smell of tobacco on their breath and/or clothes. Many clients/families find it offensive.

- PERFUME/COLOGNE
  Due to respiratory sensitivity of our clients, it is important that all staff refrain from wearing strong perfumes, colognes, after-shave products, or scented lotions.

- SCHEDULING AND FAMILY
  Some families may choose to be more involved or less involved in their family member's care depending on their needs and schedules. Caregivers are not to make judgments on how family members should spend their time. Also, families should not be expected to be flexible for your convenience and should never be confronted about a change in scheduling. All scheduling issues and changes should be directed to the Greensburg office.

  All overtime must be authorized and pre-approved by the Greensburg office before being worked. The payer does not reimburse Community Care Inc. for overtime.

- BECOMING COMFORTABLE IN THE CLIENT'S HOME
  At times, especially during a long-term private duty assignment, caregivers may begin to feel and be treated like part of the family or a close friend. You must always remember to maintain a professional relationship with the family. Remember, you are employed by CCI, not the family. You should not borrow or lend money to anyone in the family. You should not sell/or buy commercial products from/to the family (Tupperware, Avon, Mary Kay, etc… You should not give your home telephone number or cell phone number to the family. You must also not give out the client's phone number or address to anyone. Always keep in mind that you are a professional caregiver in the home, employed to provide care to the client and support to the family. You must remain objective at all times and remember that you are a guest in the home.

  Employees **are not** to take patients to their home or have their family members/friends visit them in patient homes under any circumstances. Employees are not to live with patients/families nor have patients/families live with them. This conduct will result in termination.

  If a family member is requesting or pressuring you to do something that is not on the care plan or that you are not comfortable with, please let the office know so that we can intervene for you.

- CONFIDENTIALITY
  The Health Insurance Portability and Accountability Act (HIPAA) prohibits the sharing of information about the client with anyone that is not specifically designated by the client/guardian. You should always learn from the admitting staff member the names of persons with whom you may share protected health information about the client.

If issues concerning a client warrant discussion notify the office and a client care conference may be arranged. Remember that the client has access to all information in the medical record. Documentation should be appropriate and objective and related to care, treatment and responses to cure.

# CLINICAL PRACTICE GUIDELINES

Clinical staff is expected to adhere to their professional standards of practice and respective Practice Act. The following guidelines are meant to be a quick reference for limited situations. Each staff member is responsible for learning about the policies and procedures of the agency that refer to the client care they are providing.

Change in Client Condition

If the family is not present when an emergency occurs, they should be notified after the client is stable and responsibility for his/her care is turned over to other health team professionals. Pertinent charting regarding the emergency situation such as cause, development, results, etc, must be completed.

Should the client's condition necessitate admission to the hospital, the caregiver is given permission to sign off the shift when:

A. The emergency care professionals assume the care of the client.
B. The CCI nursing supervisor is fully informed of the entire situation and resultant actions.
C. All charting necessitated by the situation is complete.
D. The family has verbalized personal stability and security.

Notify the CCI office of the emergency as soon as possible. An incident report may need to be completed. Your supervisor will let you know.

### *Cardio-pulmonary Resuscitation*

Unless otherwise specifically authorized by written physician's "NO CODE" or "DNR" orders on a client's chart, caregivers are to initiate CPR. For this reason CPR skills are to be kept current and documented in your personal files. You may not work without a current CPR card.

### *Transport*

If necessary to accompany your client in a transport either in an emergency or for a routine appointment, be sure that you take with you (if pertinent to the individual):

A. Ambu bag
B. Suction machine and catheters
C. Extra trachs
D. Oxygen
E. Ventilator (even if the client is not normally on the vent at this time of day)
F. Client's chart
G. Any other equipment/supplies needed for safe client care

# DOCUMENTATION

The client record is a legal document. The clients record is not to leave the home. You must complete documentation in the home. Your notations should be concise, complete, objective, and accurate. All information and the record itself should be treated in a confidential and privileged fashion. Refer to your clients plan of care for specific orders and chart accordingly.

CCI requires documentation on all clients regarding care provided. Remember if it is not charted, it is considered not done. CCI does not utilize the "charting by exception" concept.

All staff must mail clinical documentation to the New Stanton office on a weekly basis. A stamped, self-addressed envelope is provided for mailing. If paperwork is outstanding greater that one (1) week payroll for that employee will not be processed until all paperwork is received by the New Stanton office.

**PENNSYLVANIA CHILDLINE: 1-800-932-0313**

**Suspected child abuse—mandated reporting requirements.**

(a) *General rule*. Under 23 Pa.C.S. § 6311 (relating to persons required to report suspected child abuse), Board regulated practitioners who, in the course of their employment, occupation or practice of their profession, come into contact with children shall report or cause a report to be made to the Department of Public Welfare when the Board regulated practitioners have reasonable cause to suspect on the basis of their professional or other training or experience, that a child coming before them in their professional or official capacity is a victim of child abuse.

(b) *Staff members of public or private agencies, institutions and facilities*. Board regulated practitioners who are staff members of a medical or other public or private institution, school, facility or agency, and who, in the course of their employment, occupation or practice of their profession, come into contact with children shall immediately notify the person in charge of the institution, school, facility or agency or the designated agent of the person in charge when they have reasonable cause to suspect on the basis of their professional or other training or experience, that a child coming before them in their professional or official capacity is a victim of child abuse.

All suspected abuse must be reported to Supervisor and the Social Worker will be responsible for reporting to Pennsylvania Childline immediately as per the Event Reporting website of the Department of Health. Local child protective services will be notified at that time. Any delay in reporting could cause harm to the child and termination from Community Care.

- **EXTENDED HOURS SERVICE - PRIVATE DUTY RN/LPN CHARTING**
  Nurses are required to document in the client's chart at least every two (2) hours on cases. You are required to do a complete physical assessment of your client at the beginning of your shift. Documentation in the client chart must be performed utilizing objective data and using quotations (" ") when quoting a client or family member. Please include the following in your documentation:

  A. Complete physical assessment
  B. Current client condition/changes in condition
  C. Client response to all medications, therapies, and treatments
  D. Teaching/education of client and/or family members
  E. Psychosocial status of the client and/or family members
  F. Physician contact
  G. Lab results
  H. Communications with physician or other providers

I. It is company policy to document at the beginning and end of your shift. For example, if you are working 3:00 PM – 11:00 PM your charting may read:

3:00 PM – Report received from mom/family caregiver.
11:00 PM – Report given to mom/family caregiver.

J. Intake and Output (I&O)
K. Administration of all medications, oxygen, treatments and therapies
L. Vital signs
M. Sign the bottom of flow sheet and past each entry on progress notes

Documentation in a client's chart must be completed in a timely manner, utilizing standard abbreviations, X-ing out blank spaces and placing the time and your signature with your title for every entry. Errors should be marked with one "strike-out" line and ME for mistaken entry and nurse's initials. ME SW date

EX: Pt's skin cool to touch but ~~pale~~ flushed.

All documentation must relate to the care ordered and being provided. Documentation should reflect the skilled care provided with response to that care and to the education of the patient/family. Documentation should be focused and accurate in an objective manner without value judgment. It should be oriented to skills that are ordered and include objective assessment of the patient's condition and treatment response.

- **VISIT SERVICE - HOME VISIT DOCUMENTATION**
  Follow admission and visit documentation requirements described in applicable policies.

- **PHYSICIAN TELEPHONE ORDERS** - complete with name of physician giving order, sign your name and title. Notify your supervisor when any new order is received from the physician. If accompanying client to the physician's office, take the CCI Physician Order form with you and have the physician write and sign his/her order on premises. As a licensed nurse, you may only receive orders only within your scope of practice and from a licensed physician. If you are not accompanying the client on the physician's visit and there are additional orders that would be helpful, prepare a form for the client/family to take on the visit including any summary information that may be helpful to the physician.

- **PROGRESS NOTES** - chart at least every two (2) hours. You should document date, time with signature, and title on all entries. Be sure to document nursing observations and interventions – not custodial care, i.e., do not say "child on floor playing" instead, "child on floor with #2 Shiley trach intact, color pink with no increase in breathing effort; playing with toys-bringing hands mid line, transferring toys from hand to hand." You are caring for this child as a professional, not baby-sitting and third-party-payers must be able to recognize the need for your care and expertise. Documentation must be able to support reimbursement. Must be mailed weekly in provided envelopes to the Greensburg office.

- **MEDICATION ADMINISTRATION RECORD** - Please document in military time. Complete on all sheets "page 1 of 1, page 2 of 2, page 3 of 3" as appropriate. Document allergies on all sheets. Medication Administration Record must be checked and signed by two nurses before implementing each month. All meds must be on MAR regardless of the time they are given. . Any missed medication must be reported to Supervisor and Physician. The supervisor will complete an incident report.

- **CLEANING AND MAINTENANCE OF EQUIPMENT** - List all care necessary on all equipment including how often. Complete according to each client's needs, i.e., "checked $O_2$ for proper amount in tank, trach taped at bedside, suction machine emptied and cleaned, trach humidity at proper temp, etc." Must be mailed at the end of each month.

- **NON-SKILLED CARE- HHA/CNA-** All HHA/CNA working on a non-skilled homecare case regardless of payer (private, VA, PDA, or insurance pay) **MUST** complete Home Health Aide Activity Record and Progress Notes for each shift worked.