Welcome!

CMC - Embrace Hospice

Onboarding Orientation

On behalf of

Embrace Hospice House

working with

Conway Medical Center

Embrace Hospice was founded in 2012

Our Mission:

To be the leader in end of life care throughout the communities we serve. We strive to enhance the quality of life of our patients and families by providing spiritual guidance and quality-focused care while emphasizing patient choice and dignity.

Tag Line: Spiritually Driven, Quality Focused Care

Kevin McHugh, RN, MSN, CHPCA
Executive Director

- Retired U.S. Army veteran with twenty-seven (27) years of outstanding service to his country.
- Kevin has been a hospice nurse and executive for many years and with several different agencies throughout the southeastern United States.
- Has helped open, build, and operate a number of successful hospice programs and inpatient facilities.
- Has served numerous years on the Board of Directors for the South Carolina Home Care and Hospice Association and continues to participate and provide support.

Christy Richardson
Director of Nursing

- Bachelor's Degree in Nursing from Clemson University.
- 20+ years Nursing experience.
- 10+ years Administrative experience.
- 10 years Hospice experience.
- Die hard Clemson Fan and Mama of three amazing kids!

Allie Bennett
Assistant Administrator

- Bachelor's Degree in English with a concentration in Technical Editing, from Coastal Carolina University.
- Currently in 3rd Semester of Nursing School for Associate Degree in Nursing at Horry-Georgetown Technical College.
- 2 years experience as a Certified Nursing Assistant.
- Currently starting CMC – Embrace Hospice (Home Hospice) as Administrator.

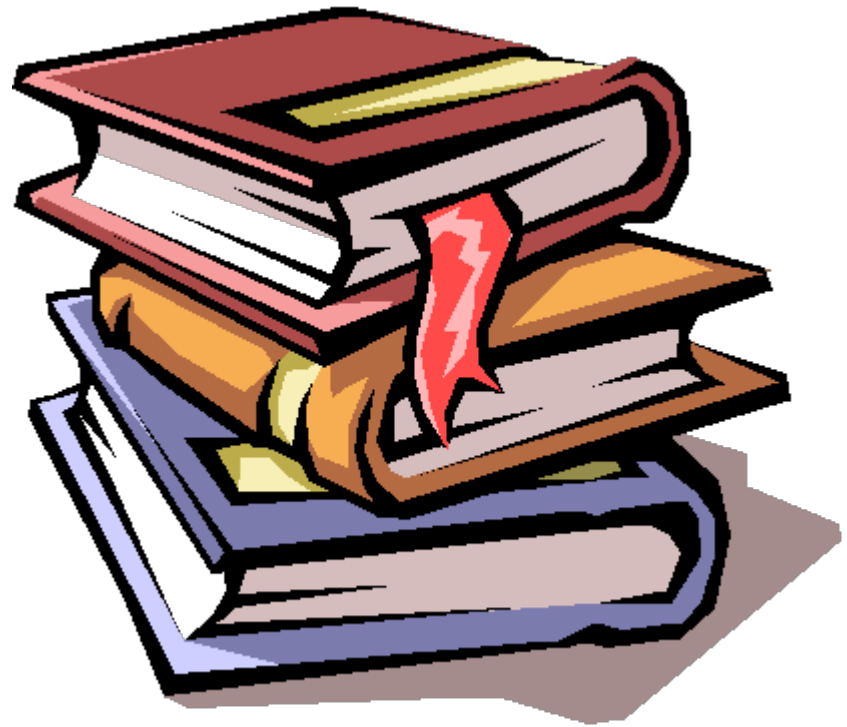
Who We Are:

- Owned and operated by hospice nurses and veterans in concordance with Conway Medical Center
- Leadership team of nurses and hospice professionals
- Hospice-certified staff and Medical Directors
- Mentality of “Necessity vs. Profitability”
- Staff availability & expertise
- Faith-based & Spiritual Care Coordinator honors all beliefs and religions without judgement
- ACHC Accredited

Embrace Veterans Program

- As an organization working closely with and lead by veterans, we take great pride and honor in serving our local veterans through community involvement as well as end-of-life care.
- We are proud members of the “We Honor Veterans” program, established by the NHPCO and other veteran organizations, and we therefore appreciate the unique needs of our veterans and their families.
- Through our involvement with such programs, we can utilize the resources our professional associates provide to continue educating our team so they can deliver the very best care possible for our veterans.
- Donations designated to the CMC Foundation veterans fund help to provide engraved pavers placed in our Memorial Garden for every Veteran who passes in our facility. To donate please visit https://www.cmcfoundationsc.com/

Hospice 101



At Embrace Hospice We Believe:

- Hospice affirms life, health, and the dignity of persons in situations of terminal illness.
- It is possible that the period of terminal illness can be one of achievement, reconciliation, and fulfillment of the dying patient and family.
- Hospice care should be available to any person regardless of race, color, creed, handicap, age, sex, religion, or economic status.
- When a cure is no longer an appropriate goal, palliative care and support become the appropriate goal.
- The hospice program of care can provide support and aid in the alleviation of human suffering.
- The terminally ill patient should be maintained as pain-free and alert as medically possible in his/her home environment.

Goals of Hospice Care

- Help a person live as fully and comfortably as possible without unnecessary invasive procedures and life support systems.
- Minimize pain and suffering.
- Encourage home like care and support the family as the basic unit of care.
- Provide services through a multi-disciplinary team approach.

Features of the Hospice Program

- The patient and family represent the primary unit of care.
- Care will be provided by the Hospice Administrative Team Monday-Friday 8am-5pm, and by Clinical Team 24hrs/day, 7days/week.
- Due to hospice philosophy, services are palliative rather than curative, and resuscitative measures are not used.
- Quality of life is promoted through pain control, symptom control, and management. Emotional and spiritual support are also available.
- If the resident leaves our facility, our Hospice House team will no longer provide care or support.
- The patient and family are encouraged to take active part in the plan of care.
- Bereavement support initially follows the patient's death in the form of a sympathy card.
- Services are provided without regard to reimbursement.

Hospice Services

- Nursing Care
- Personal Care Services (Hospice Aide)
- Social Worker
- Spiritual Care
- Physician
- Volunteer Services
- Other Services (OT, PT, ST, DT, and RT as ordered by the physician for palliative care)

Conveying of Charges

- Embrace is approved to accept payments for services from Medicare, Medicaid, and other Private Insurance, as well as Private Pay. We recognize that hospice patients/families have unique needs; therefore, individualized consideration is given to all patients.
- Private pay patients may be eligible for a fee reduction based upon income, assets and family size (Self-pay Sliding Fee Scale Assessment).
- No patient will ever be refused care based upon an inability to pay.
- Embrace assumes the responsibility of billing insurance companies directly for the care provided to the patient.

Admission Criteria

- ✓ Limited life expectancy (generally less than six months
- ✓ Physician recommendation and agreement to work with contracted Hospice Provider team
- ✓ Patient and family agree with Hospice care, philosophy, services, and goals
- ✓ Evaluation by Hospice Provider team

Hospice 101

Admission Criteria (for Hospice Provider) – Stroke & Coma

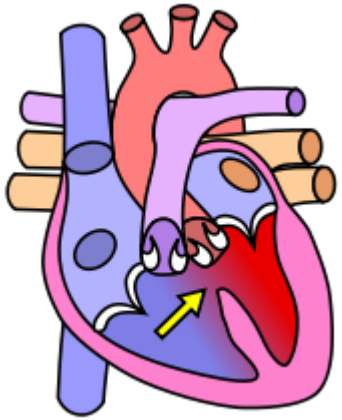
- **Acute Phase** – Immediately following an ischemic or hemorrhagic stroke
  - Coma
  - Severe dysphagia
  - Severe myoclonus
  - Poor results from MRI or CT
- **Chronic Phase**
  - Age 70 or greater
  - K 50% or less
  - Post stroke dementia
  - Poor nutritional status

- Medical Complications
  - Aspiration pneumonia
  - Upper UTI
  - Sepsis
  - Recurrent fevers after antibiotics
  - Decubitus, stage 2-4

Hospice 101

Admission Criteria (for Hospice Provider) – Heart Disease

- Symptoms of CHF
- Pt is on optimal levels of diuretic and vasodilator therapy
- EF 20% or less
- Signs of decreased survival:
  - Arrhythmias resistant to therapy
  - Hx of cardiac arrest
  - Hx of syncope
  - Cardiogenic brain embolism
  - Co-morbids

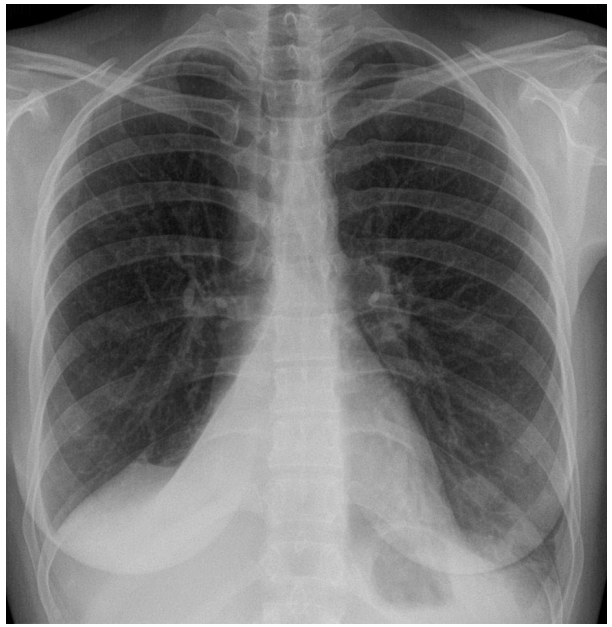


Patient is not a candidate for invasive procedures and/or declines any such intervention

Hospice 101

Admission Criteria (for Hospice Provider) – Pulmonary Disease

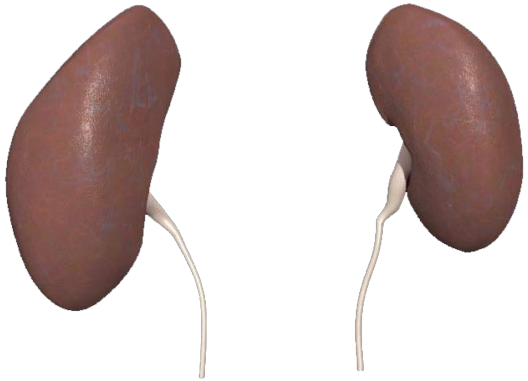
- Symptoms
  - Dyspnea @ rest
  - Dyspnea with exertion,
  - Copious sputum
  - Severe cough
  - Recurrent infections
  - House/chair bound
- Poor response to bronchodilators
- Increased hospitalizations
- Increased ER visits
- Hypoxemic at rest on O2
- Resting tachycardia



Hospice 101

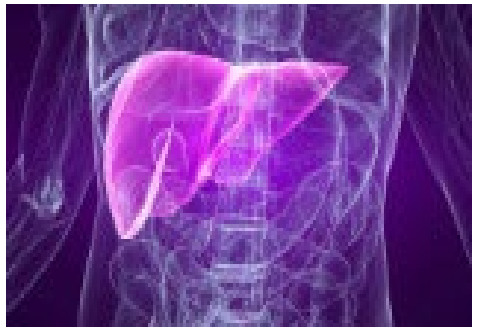
Admission Criteria (for Hospice Provider) – Renal Disease

- Patient should NOT be seeking dialysis or renal transplant
- Creatine and serum levels must indicate renal failure
- Clinical signs:
  - Uremia
  - Oliguria
  - Intractable hyperkalemia
  - Uremic pericarditis
  - Hepatorenal syndrome
  - Intractable fluid overload



Hospice 101

Admission Criteria (for Hospice Provider) – Liver Disease

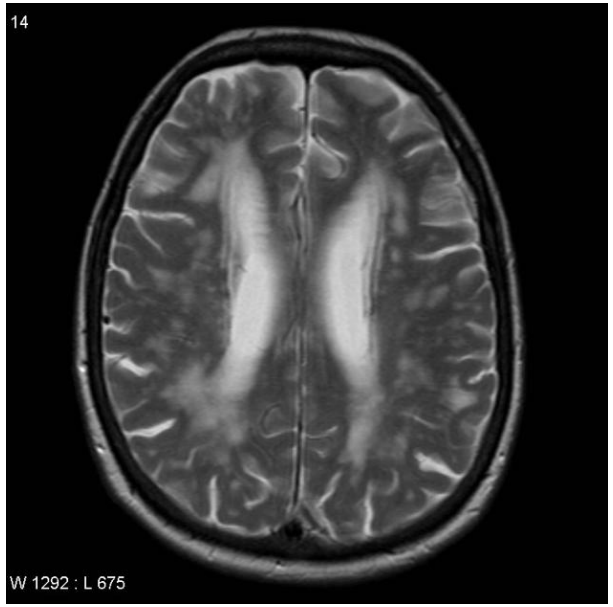


- Patient is NOT a candidate for liver transplant
- Lab indicators
  - Serum albumin 2.5 gm/dl
  - PT prolonged more than 5 seconds over control
- Clinical factors
  - Ascites
  - Spontaneous bacterial peritonitis
  - Hepatorenal syndrome
  - Hepatic encephalopathy
- Other symptoms – decreased LOC, depression, slurred speech, emotional lability, sleep disturbance.

Hospice 101

Admission Criteria (for Hospice Provider) – Dementia

- FAST at or beyond stage 7 (Alzheimer's Dementia)
- Inability to communicate needs
- Has one or more of the following:
  - Aspiration pneumonia
  - Upper UTI
  - Septicemia
  - Recurrent fevers
  - Decubitus, stage 3-4
  - Inability or unwilling to take food or fluid
  - Documented impaired nutritional status

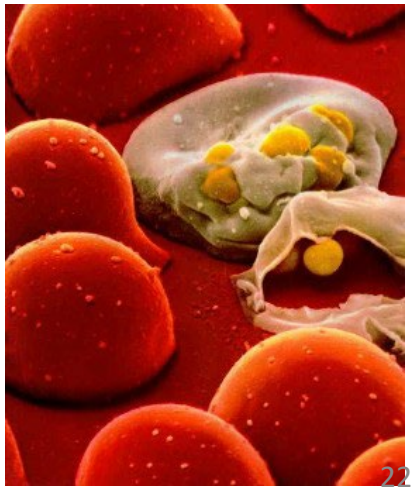


Hospice 101

Admission Criteria (for Hospice Provider) – HIV

- CD4 count <25 cells/mm3 or persistent viral load >100,000 copies/ml plus one of the following:
  - CNS lymphoma
  - Muscle wasting
  - Mycobacterium avium complex
  - Progressive multifocal leukeoencephalopathy
  - Systemic lymphoma
  - Visceral Kaposi's sarcoma
  - Renal failure
  - Cryptosporidium infection
  - Toxoplasmosis
  - CMV infection
- PPS 50% or less

- Documentation of the following factors will support eligibility:
  - Chronic persistent diarrhea
  - Serum albumin <2.5
  - Active substance abuse
  - Age 50 or more
  - Absence of antiretroviral, chemo, and prophylactic drug therapy
  - Advanced AIDS dementia complex
  - Toxoplasmosis
  - CHF



Hospice Appropriateness (for Hospice Provider)

1. Findings are discussed with the team and a decision regarding appropriateness is based upon signs and symptoms, records, agreement with the hospice philosophy, etc. Many factors come into play during this step.
2. If the patient is deemed inappropriate *by the evaluating nurse* then a superior nurse must evaluate as well.
3. If the PCC or other superior nurse do not feel the patient is appropriate, it is discussed with a member of the corporate staff who may also perform an evaluation.
4. Once all of the above steps are complete, if the person is currently not appropriate, they initiate follow-ups with the marketer/liaison in accordance with their trajectory of illness.

Hospice Care vs. Palliative Care

Hospice Care

- Patient is terminally ill and treatment is no longer curative
- Life expectancy is 6 months or less if disease takes its normal course
- Focus on managing the patient's pain and other symptoms (comfort care)
- Quality of life is as important as length of life
- Takes place in the patient's home or home-like setting
- Addresses the patient's physical, emotional, social, and spiritual needs

Palliative Care

- Goal is to help people with serious illnesses feel better
- May be given *when the illness is diagnosed, throughout treatment,* during follow-up, and at the end of life
- Can begin at the time of diagnosis and can continue during attempts to cure illness
- Manages emotional, social, physical, and spiritual problems associated with illness
- Takes place in hospitals, cancer centers, rehab facilities, and home health agencies

Hospice care is part of palliative care. Not all palliative care is hospice.

Patient Rights

General

A patient deciding to enter hospice must be informed of his/her rights, both verbally and in writing. Direct care staff need to be aware of all patient rights in order to implement them and maintain compliance.

- The patient/family must be informed of their rights during the initial assessment, prior to providing care.
- The patient/family must be informed of their rights in a language they can understand both verbally and in writing.
- We are required to make all reasonable efforts to secure professional translators for hospice-patient communication.
- Family members or friends as translators should ONLY be used as a last resort.
- Advance directive information must be available to the patient/family.
- We must obtain the patient's or representative's signature confirming that they have received a copy of the notice of rights and responsibilities

Patients have the right to:

- Exercise their rights
- Be treated with respect
- Voice grievances
- Be protected from discrimination or reprisal for exercising their rights

Hospice must:

- Report violations to the Executive Director (ED)
- Investigate violations and complaints
- Take corrective action if violation is verified
- Report verified significant violations to state/local bodies within five (5) days of becoming aware of incident

Rights of the Patient Include:

- Pain management and symptom control
- Participation in development of the plan of care
- Refusal of care or treatment
- Choosing the attending physician
- Confidential clinical records; HIPAA
- Free from any form of abuse
- Receive information about the hospice benefit
- Relocation to a different hospice
- Choosing to cease hospice care

Advance Directive

Advance Directive – A written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

- Executing and implementing an Advance Directive is not a one-time event.
- Embrace staff will keep the patient, family/caregiver, and the patient's representative up to date concerning the patient's medical condition.
- Embrace staff will discuss the patient's preferred course of treatment as his/her condition changes.
- Discussions should be documented in the clinical record.

Advance Directive

Living Will

- YOU state your wishes concerning medical treatment at the end of life
- YOU decide what should be done in the future without knowing exactly what the circumstances will be when the decision is put into effect
- Tells the doctor what to do if you are permanently unconscious or if you are terminally ill and close to death
- States what treatments you DO NOT want

Healthcare POA

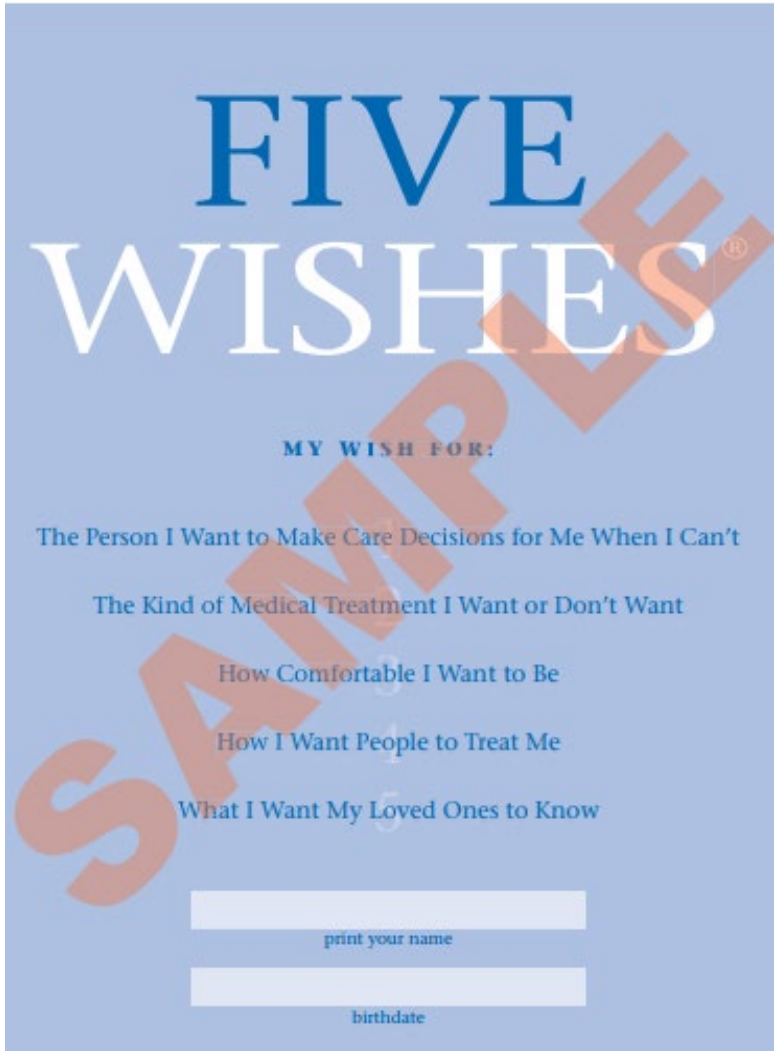
- The person you choose is not limited to the circumstances in a living will
- States what treatment you DO want, as well as what you do not
- The person you choose will make decisions when the need arises, and will know what the circumstances are

Five Wishes

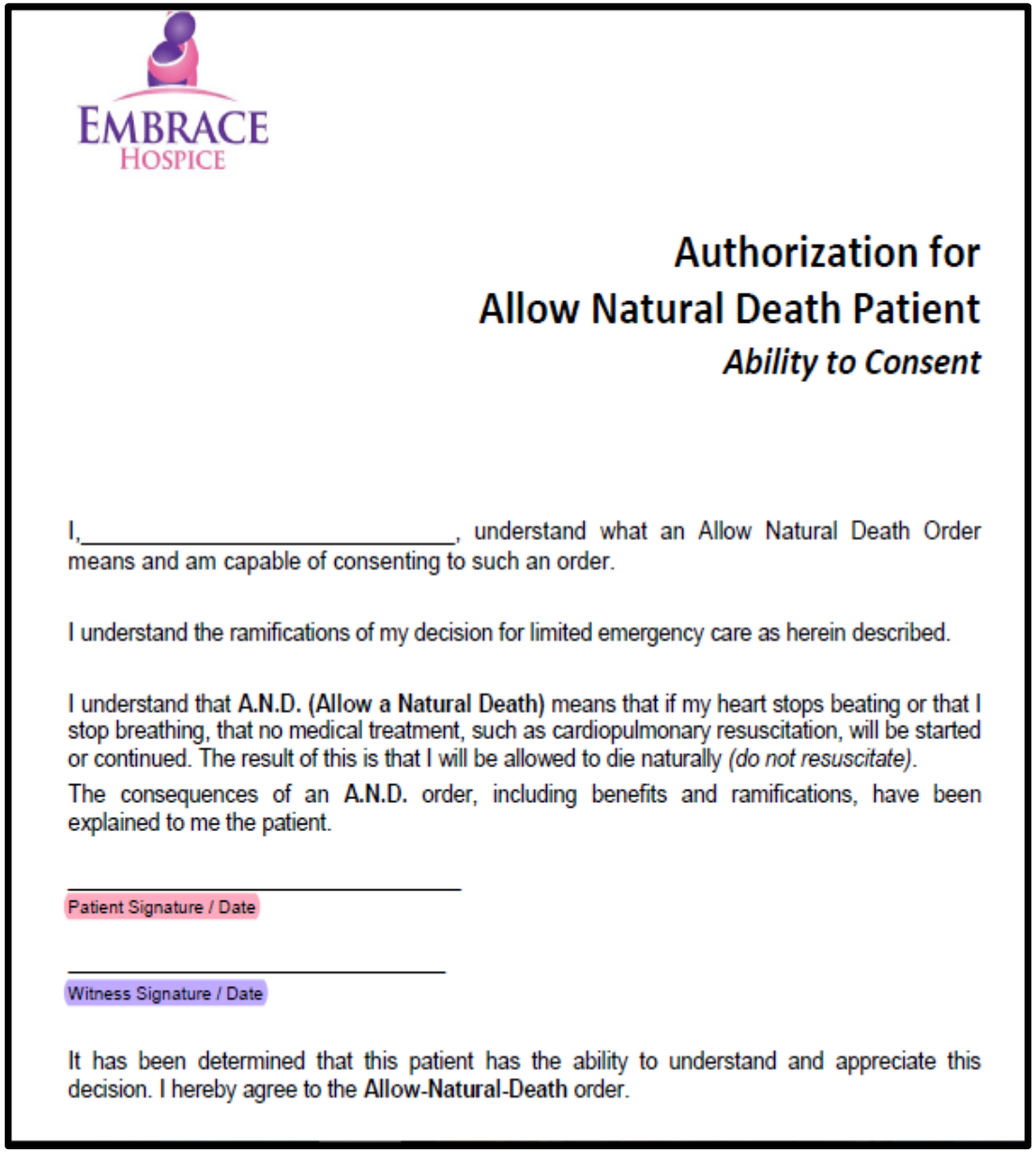
- Easy, legal document
- Lets your family and doctors know which person you want to make health care decisions for you when you can't make them
- States the kind of medical treatment you want or do not want
- Explains how comfortable you want to be and how you wish to be treated
- You can give details as to what you want your loved ones to know

Advance Directive

Five Wishes



Advance Directive



EMBRACE HOSPICE

Authorization for
Allow Natural Death Patient
Ability to Consent

I,_____, understand what an Allow Natural Death Order means and am capable of consenting to such an order.

I understand the ramifications of my decision for limited emergency care as herein described.

I understand that **A.N.D. (Allow a Natural Death)** means that if my heart stops beating or that I stop breathing, that no medical treatment, such as cardiopulmonary resuscitation, will be started or continued. The result of this is that I will be allowed to die naturally *(do not resuscitate)*.

The consequences of an **A.N.D.** order, including benefits and ramifications, have been explained to me the patient.

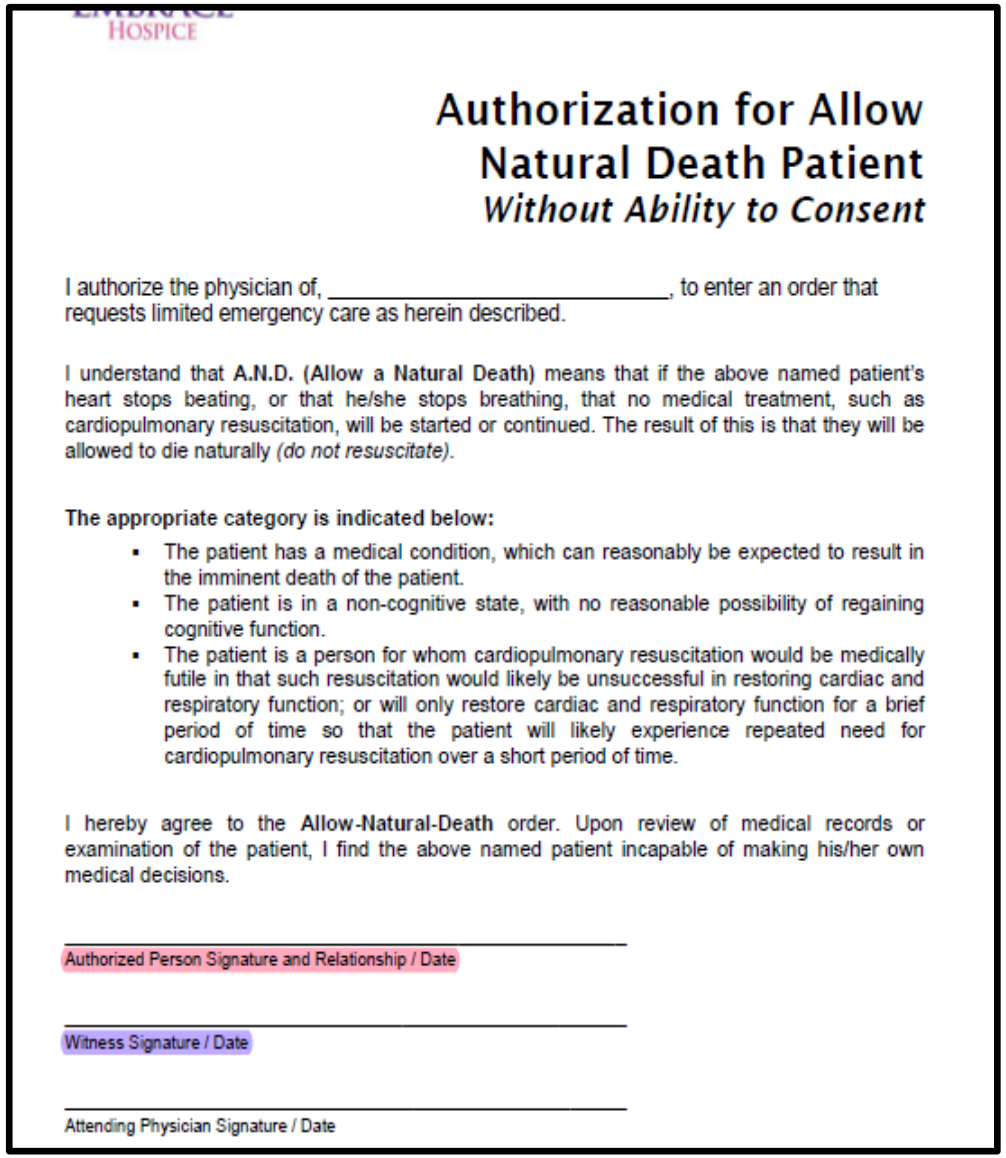
_____
Patient Signature / Date

_____
Witness Signature / Date

It has been determined that this patient has the ability to understand and appreciate this decision. I hereby agree to the **Allow-Natural-Death** order.

Embrace Hospice
Allow Natural Death (Ability to Consent)
Form

Advance Directive



HOSPICE

Authorization for Allow Natural Death Patient
Without Ability to Consent

I authorize the physician of, _____, to enter an order that requests limited emergency care as herein described.

I understand that **A.N.D. (Allow a Natural Death)** means that if the above named patient's heart stops beating, or that he/she stops breathing, that no medical treatment, such as cardiopulmonary resuscitation, will be started or continued. The result of this is that they will be allowed to die naturally *(do not resuscitate)*.

The appropriate category is indicated below:

- The patient has a medical condition, which can reasonably be expected to result in the imminent death of the patient.
- The patient is in a non-cognitive state, with no reasonable possibility of regaining cognitive function.
- The patient is a person for whom cardiopulmonary resuscitation would be medically futile in that such resuscitation would likely be unsuccessful in restoring cardiac and respiratory function; or will only restore cardiac and respiratory function for a brief period of time so that the patient will likely experience repeated need for cardiopulmonary resuscitation over a short period of time.

I hereby agree to the **Allow-Natural-Death** order. Upon review of medical records or examination of the patient, I find the above named patient incapable of making his/her own medical decisions.

_____

Authorized Person Signature and Relationship / Date

_____

Witness Signature / Date

_____

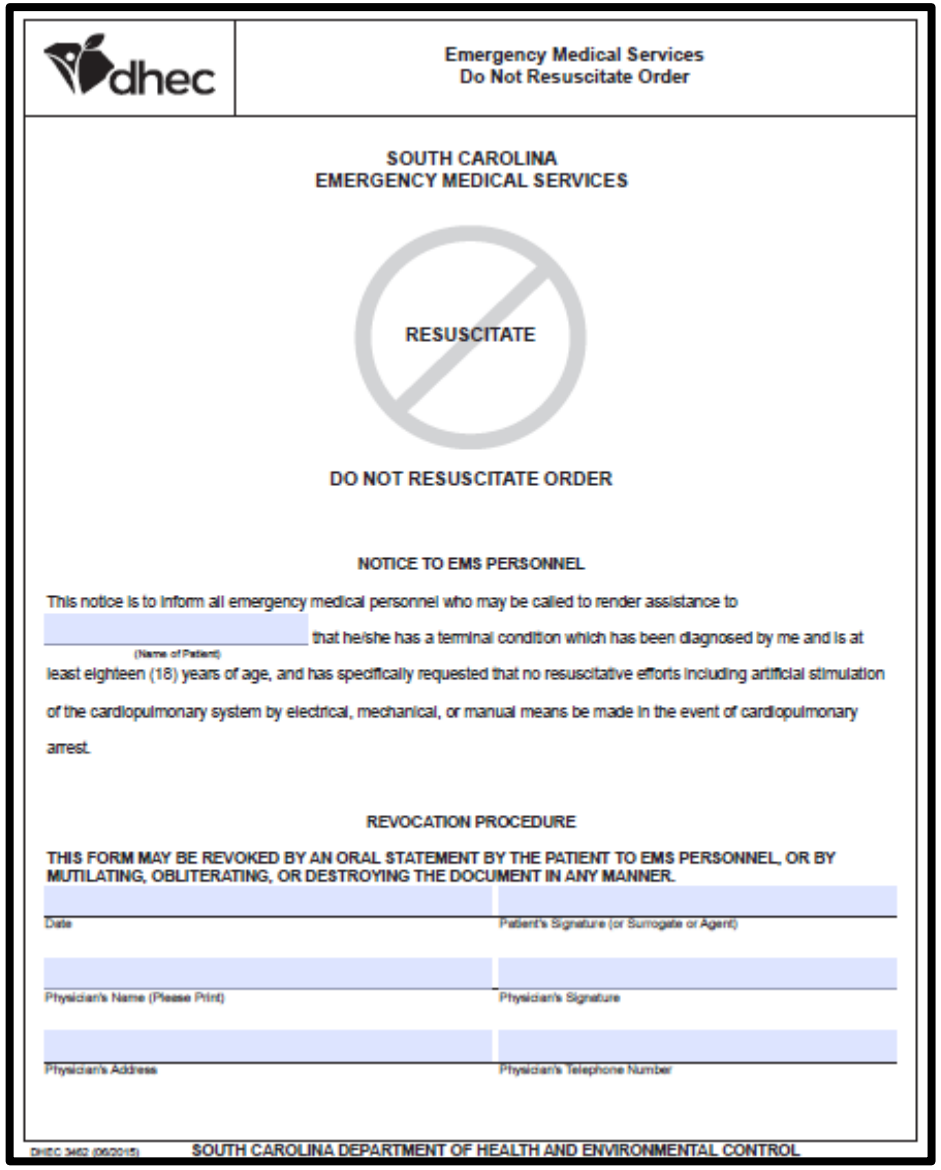
Attending Physician Signature / Date

Embrace Hospice

Allow Natural Death (Without Ability to Consent)

Form

Advance Directive



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Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA
EMERGENCY MEDICAL SERVICES

RESUSCITATE

DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to _____ (Name of Patient) that he/she has a terminal condition which has been diagnosed by me and is at least eighteen (18) years of age, and has specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date | Patient's Signature (or Surrogate or Agent)

Physician's Name (Please Print) | Physician's Signature

Physician's Address | Physician's Telephone Number

DHEC 3462 (06/2015) SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

DHEC

(SC Department of Health and Environmental Control)

Do Not Resuscitate

Order

Abuse, Neglect, Misappropriation of Property

- Every patient has the right to be free from abuse, neglect, and misappropriation of property.
- Embrace wishes to do all that is within our control to prevent abuse, neglect, and misappropriation of property for our patients.
- Embrace depends on each employee to assist in the identification of patients whose personal histories and or current actions indicate they may be at risk.

Abuse, Neglect, Misappropriation of Property

- **Abuse** – willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish
  - Physical (hitting, punching, kicking, any controlling behavior)
  - Verbal (oral, written, or gestured communication)
  - Mental (humiliation, harassment, deprivation, threats)
- **Neglect** – failure to provide care necessary to avoid harm or mental anguish
- **Misappropriation of property** – deliberate misuse of patient's belongings or money
- **Involuntary Seclusion** – confinement against a patient's will; not as a therapeutic intervention defined by the plan of care

Elder Abuse & Neglect

Defined-The physical, sexual, or emotional abuse of an elderly person, usually one who is disabled or frail.

Elder Abuse usually takes place where the senior lives; this is most often in the home where abusers are often adult children, other family members such as grandchildren, or a spouse/partner of the elder.

Institutional settings especially long-term care facilities can also be sources of elder abuse.

Elder Abuse & Neglect

Types

- ***Physical:*** **The willful (non- accidental) infliction of physical pain or injury; may also be the inappropriate use of drugs, restraints, or confinement.**
- ***Sexual:*** **The infliction of non-consensual sexual contact of any kind.**
- ***Emotional or Psychological:*** ***T*****he infliction of mental or emotional anguish, verbal or nonverbal.**
- ***Self-Neglect:*** **Characterized as the behavior of an elderly person that threatens his/her own health or safety.**

- ***Neglect:*** **The failure of a caretaker to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness (can be active or passive)**
- ***Healthcare Fraud and Abuse:*** **Carried out by unethical doctors, nurses, hospital personnel, and other professional care providers**
- ***Financial or Material Exploitation:*** **The improper act or process of an individual, using the resources of an older person, without his/her consent, for someone else's benefit, either by a caregiver or an outside scam artist.**

Elder Abuse & Neglect

Signs and Symptoms

General/Physical

- Frequent arguments or tension between the PCG and the elderly person
- Signs of being restrained (rope marks on wrists or ankles)
- PCG/Visitor refuses to allow you to see the resident alone
- Unexplained bruises, whelps, scars, broken bones, sprains, and/or dislocations

Emotional

- Threatening, belittling, or controlling caregiver behavior that you witness
- Behavior from resident that mimics dementia such as rocking, sucking or mumbling to oneself, but resident does not have dementia

Sexual

- Bruises around breasts or genitals
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained, or bloody underclothing

Elder Abuse & Neglect

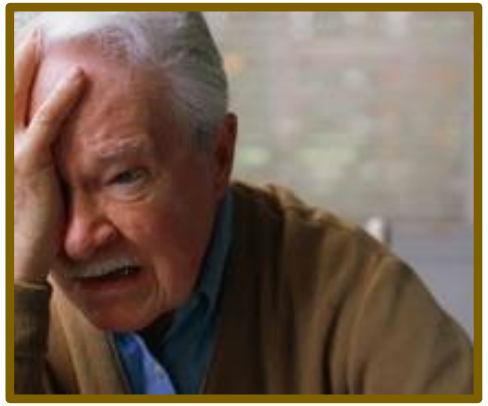
Signs and Symptoms

Neglect

- Untreated problems such as bedsores
- Unsanitary living conditions: dirt, bugs, soiled bedding and clothes
- Left dirty or unbathed
- Unsuitable clothing or covering for the weather
- Unsafe living conditions: no heat, running water, faulty wiring, or fire hazards

Financial

- Items or cash missing from their person
- Misuse of the elder's personal checks or credit cards
- Suspicious changes in wills, power of attorney, titles, or policies
- Forgery of the elder's signature



Healthcare Fraud

- Not providing healthcare but charging for it
- Overmedicating or under medicating
- Duplicate billing for the same service

Elder Abuse & Neglect

Risk Factors

Factors that can influence are not an excuse!

Although caring for the elderly can be rewarding it can also be stressful for many caregivers. The demands and responsibilities increase as the elder's condition declines and this can lead to caregiver burnout causing them to become impatient and lash out against elders in care. Even caregivers within a facility can experience levels of stress that lead to elder abuse.

- Visitor inability to cope with stress
- Depression
- Lack of support
- Substance abuse
- Intensity of the patient's illness or dementia
- Social isolation
- History of domestic violence
- Elder's tendency toward verbal or physical aggression

Elder Abuse & Neglect

Intervention and Prevention

Although the elder may find themselves in an abusive setting, they too often will not report the abuse due to the fear of retaliation or the fear that no one else will take care of them. When the caregivers are their children, they may be ashamed that their children are behaving abusively, blame themselves, or may not want children they love to get in trouble with the law.

- **Educate the caregivers:**
  - Instruct to report the need for assistance
  - Encourage breaks, if only for a couple of hours
  - Offer suggestions such as an adult day care, or in home caregivers
  - Encourage to stay healthy and get medical care for themselves
  - Teach stress reduction techniques
  - Encourage counseling for depression, or support groups
- **Listening to the seniors and their caregivers to pick up on early signs and symptoms**
- **Educating others on ways to recognize and report abuse**
- **Trust your instincts**

Abuse, Neglect, Misappropriation of Property

Identifying and Reporting Abuse per Embrace Policy and Procedure

- Any and **ALL** suspected abuse, neglect, exploitation and/or misappropriation of property of patients will be ***reported to your supervisor immediately***!
- A verbal report of the suspected abuse/neglect will be provided to the proper authorities as defined by state law within 24 hours of the incident.
- Supervisor will notify the ED immediately.
- ED will review information immediately with Senior Management – a follow-up investigation will be conducted.
- All information regarding suspected abuse/neglect will be held in strict confidence.
- Any confirmed abuse/neglect will result in immediate termination of employee or volunteer.

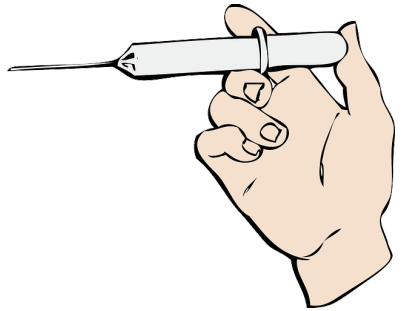
Restraints

General

All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff member, or others and must be discontinued at the earliest possible time. *L737 418.110 (M) Standard: Restraint or seclusion*

Restraints

Types of Restraints



Physical Restraints

- Nonviolent, Non-Self-Destructive Behavior
  - Wrist or ankle restraints, waist restraint, tucking sheets tightly, all side rails raised, trays or tables blocking exit, bars or belts—keeps patient from moving certain body parts and/or immobile
- Violent, Self-Destructive Behavior
  - Emergent situation, preventing patient from hitting staff or injuring themselves

Chemical Restraints

- Medication is used in a method that is NOT approved standard for the patient condition

Seclusion

- Placed in a room involuntarily and prevented from leaving

Restraints

Risks of Restraint Use

- Cuts, bruises, lacerations
- Pressure sores
- Functional incontinence
- Fear
- Anxiety and/or agitation
- Depression
- Loss of Dignity
- Circulation problems
- Muscle wasting
- Bone Wasting
- Malnutrition/ Weight loss
- Dehydration
- Strangulation
- Death

Restraints

Regulations

- Must have documentation of prior methods to control symptoms without success
- Only to be used when less restrictive interventions have been determined to be ineffective
- Type or technique of restraint must be least restrictive
- Written order from a physician is required
- No order can be written as needed (PRN) or as a standing order
- Plan of care must be updated to include Restraint
- Must be discontinued at the earliest possible time, regardless of time identified on the written order
- Restraints must not be used in a manner that causes undue physical discomfort, harm, or pain to the patient

Restraint education and training are presented in detail during Hospice House Clinical Orientation

Staff/Patient Safety

Safe Medical Device Act (SMDA)

What is the SMDA?

- Imposed production, distribution, and sales rules on medical device manufacturers.
- Designed so that the FDA could be quickly informed of dangerous medical products and could then track or recall the product.
- Requires nursing homes, hospitals, and other health care facilities that use medical devices to report to the FDA any incidents suggesting that a medical device probably caused or contributed to a patient's death, serious illness, or serious injury.

Safe Medical Device Act (SMDA)

Examples of Medical Devices:

- Hospital beds
- Wheelchairs
- O2 equipment
- Walkers
- Suction
- Air mattresses
- Hoyer lifts
- Tube feeding pumps

Safe Medical Device Act (SMDA)

What is my responsibility regarding SMDA?

- Always inspect medical devices each shift.
- Instruct patients and visitors not to use medical equipment when broken or not working properly. They should notify staff immediately.
- Staff and/or volunteers should report any devices that are not working properly to the appropriate DME (durable medical equipment) company.
- If you see or learn that a medical device has caused, or may have caused, death or serious injury to a patient, report it to your supervisor immediately!

To review Embrace Policy and Procedure for Safe Medical Device Act, see policy No. 6-070

Durable Medical Equipment and Supplies

Policy 7-150 (for complete Policy, see *CMC-Embrace Policy & Procedure* book)

- ❑ Equipment and supplies will be obtained through designated vendors holding contracts with Embrace Hospice. DME vendors will educate the staff and/or patient of proper use of the medical equipment, as well as, provide education to staff as needed.
- ❑ Contracted Vendor: Allcare Medical, Medline
- ❑ Contracted equipment vendors will:
  - Maintain the supplies and equipment in good working order.
  - Ensure the safe handling and storage of supplies and equipment to ensure function and cleanliness.
  - Instruct the patient and/or visitors on the use of the equipment.
  - Provide maintenance to equipment as needed and per manufacturer's guidelines.
  - Replace supplies and equipment as needed for the care of the patients.
- ❑ All equipment requires a physician order.

Body Mechanics

Personal Safety

All Staff Members

Self-protection to enhance personal safety is the responsibility of all personnel; this includes every discipline. Listed below, you will see general precautions for all staff members.

- Be aware of surroundings – look for the unexpected
- Carry ID
- Consider having a spare set of keys
- Do not carry excessive amounts of cash
- Be cautious when walking alone
  - Avoid groups of people lingering on corners
  - Avoid narrow or confined spaces
  - Carry keys in your hand
- Know basic self-defense measures

Personal Safety

Home Care Team

Getting to and from Work:

- Have your car serviced regularly
- Have keys out and ready
- Keep gas in your car
- Check your backseat before entering the car
- Look under and around the car
- Be aware of surroundings
- Observe windows, alleys, and doorways for loiterers
- Keep doors locked with driving

During the Visit:

- Be Alert
- Assess for signs of violence
- Diffuse anger
- Avoid aggressive behaviors
- If you feel threatened, leave
- Any unsecured weapons and you do not feel safe, leave
- If patient is smoking and wearing oxygen, ask to refrain

Professional Boundaries

Caregiver-Client Relationship

Boundary Crossing

- ✓ Sharing personal information
- ✓ Not seeing behavior as symptomatic
- ✓ Nicknames/endearments
- ✓ Touch
- ✓ Unprofessional demeanor
- ✓ Gifts, tips, favors
- ✓ Over-involvement
- ✓ Romantic or sexual relationships
- ✓ Secrets

Getting back in-bounds

- ✓ Talk to a trusted colleague
- ✓ Talk to a supervisor
- ✓ Consider a re-assignment
- ✓ Draw a line between work and personal life

Reducing Stress

Signs and Symptoms

- Anxiety and irritability
- Apathy, loss of interest in work
- Sleep problems
- Fatigue
- Trouble concentrating
- Muscle tension, headaches
- Social withdrawal
- Coping with alcohol or drugs
- Digestive problems

Reducing Stress

Tips and Tidbits

- Don't pull the trigger on stress.
- Manage your work-life balance.
- Take care of you.
- Manage your time.
- Get and stay organized.
- Resist perfectionism.
- Adopt a positive attitude.
- Talk it over with a trusted listener.
- Ask for help.
- Take a time-out.

Special Care

Basic First Aid

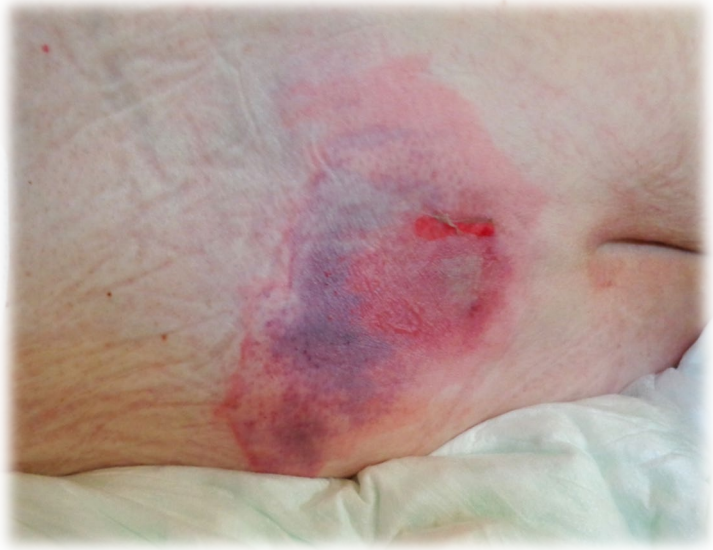
- Falls – Assess; Do not leave patient alone; Call for assistance (use Distress Button)
- Bleeding – Utilize PPE as necessary; Cover; Apply pressure; Elevate; Wrap
- Nosebleed—Pinch nostrils; Apply ice to bridge of nose; Tilt head back
- Broken Bones – Assess; Avoid movement (Immobilize); Apply ice; Call MD
- Head or spinal injury – Assess for changes in neuro status; N/V; call MD
- Heart Attack—Assess; Loosen clothing around neck; Speak in a calm and reassuring tone; No food or drink
- Seizures – Assess; Move patient to a safe area; Do not restrain or place anything in the mouth
- Wound—Assess; Provide wound care; Seek further medical attention for uncontrollable bleeding, bones pushed through the skin, human/animal bites, and/or need for stitches
- Broken teeth—Assess; Have patient to bite sterile dressing; Call dentist
- Bruises—Apply ice pack; Elevate
- Burns—Assess; Immerse in cool water, Cover with non-adhesive dressing
- Choking—If unable to speak/cough, use Heimlich Maneuver

Pressure Ulcer Prevention

Forms when the skin and soft tissue press against a harder surface for a prolonged period of time.

Who is at risk?

* Patient who spends most of the day in bed/chair
* Overweight or underweight
* Incontinent
* Decreased feeling in an area of the body



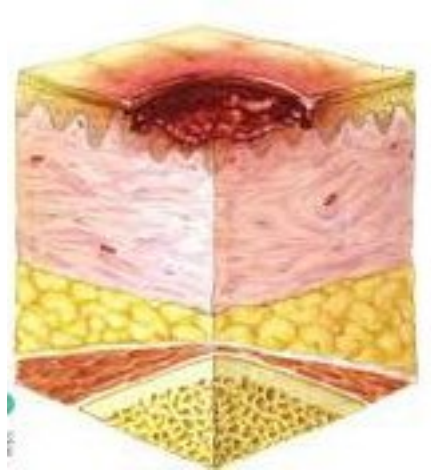
Pressure Ulcer Prevention

Most common areas:

- Heels and ankles
- Knees
- Hips
- Spine
- Tailbone area
- Elbows
- Shoulders, shoulder blades
- Back of the head
- Ears

Early signs:

- Skin redness
- Warm areas
- Spongy or hard skin
- Breakdown of the top layers of skin



Pressure Ulcer Prevention

Tips and Tidbits:

- ❑ REPORT EARLY SIGNS IMMEDIATELY!!!
- ❑ Use skin protectants; there is a standing order for Calazime for everyone.
- ❑ Keep skin clean and dry (especially under breasts and in the groin area).
- ❑ Bathing daily can dry out skin; if appropriate give partial baths every other day.
- ❑ Do NOT use talc or strong soaps.
- ❑ Check incontinent patients regularly.
- ❑ Use pillows for placement/positioning (under heels, tailbone, shoulders, elbows).
- ❑ Never drag a patient to reposition (friction).
- ❑ Reposition every 2 hours.
- ❑ Sheets and clothing should be dry and smooth; wrinkle free.
- ❑ Remove any objects from the bed (pins, pencils, coins, food, etc.).

Dementia

What is Dementia?

Dementia is not a specific disease. It's an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. There are many types of Dementia.

What causes Dementia?

Dementia is caused by damage to brain cells.

Is there any treatment for Dementia?

Treatment of dementia depends on its cause. In the case of most progressive dementias, there is no cure and no treatment that slows or stops its progression. But there are drug treatments that may temporarily improve symptoms. We treat the symptoms that are being presented.

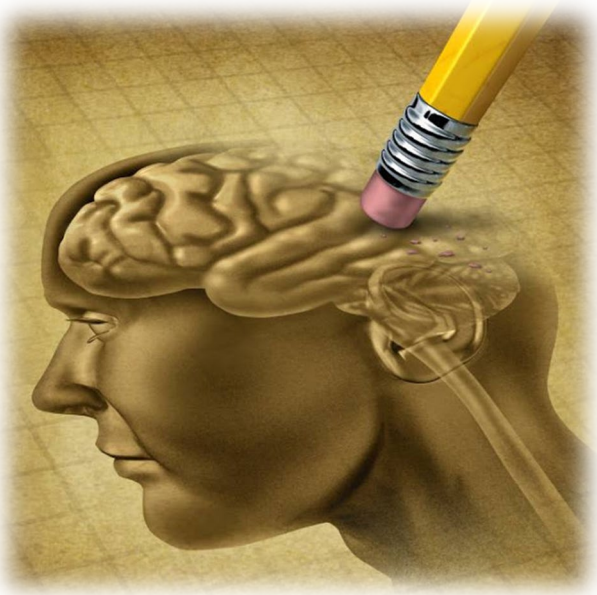
Dementia

Types of Dementia

- **Alzheimer's**--most common form; develops slowly; progressive; can live an average of 8 years; plaques build up between nerve cells, and tangles build up inside cells; develops in a predictable pattern (FAST SCALE); mild, moderate, and severe staging.

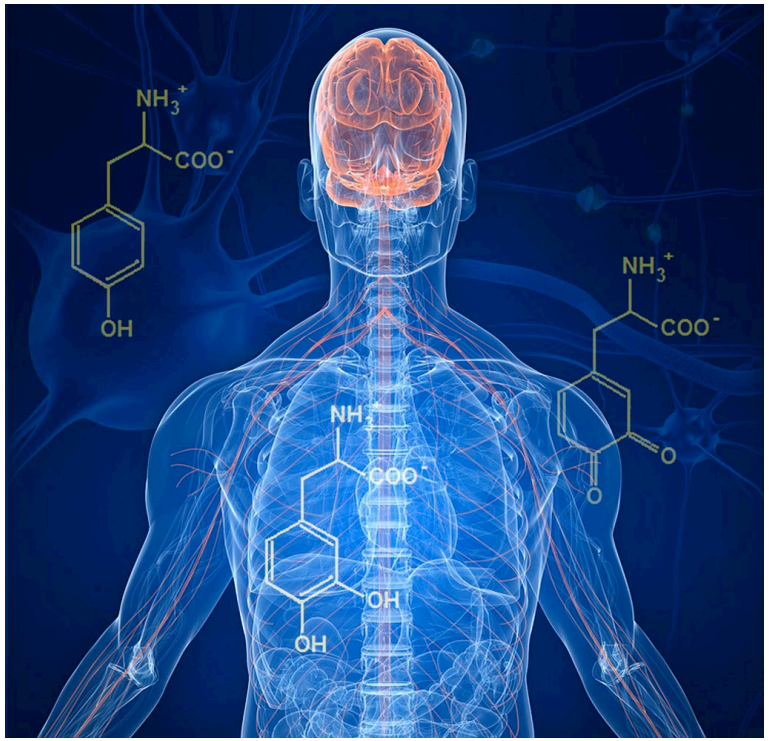
- **Vascular**--can develop after a stroke; high blood pressure, high cholesterol, and smoking increase the risk; symptoms vary and may overlap with Alzheimer's; symptoms may be most clear-cut after following a series of strokes or mini-strokes; brain cells are deprived of oxygen and die.

- **Mixed Dementia**--abnormalities characteristic of more than one type of dementia occur simultaneously; most common form is Alzheimer's and Vascular.



Dementia

Types of Dementia (cont)



- **Dementia with Lewy Bodies**--progressive decline in mental abilities; Lewy bodies are also found in Alzheimer's and Parkinson's Dementia; protein deposits (Lewy Bodies) develop in nerve cells in the brain region involved in thinking, memory, and movement; aggressive behavior.

- **Parkinson's Disease Dementia**--affects memory, ability to pay attention, make sound judgement, and plan the steps needed to complete a task; linked with Lewy body Dementia and Alzheimer's Dementia; Lewy bodies deposits are found in the region of the brain that play a key role in movement.

Dementia

What can I do to help the Dementia patient?

- ❑Approach from the front and maintain eye contact
- ❑Speak at eye level
- ❑Keep things simple
- ❑Do not interrupt
- ❑Use a calm, relaxed tone of voice
- ❑Repeat instructions as often as needed
- ❑Keep a routine
- ❑Encourage non-verbal communication
- ❑Eliminate distractions
- ❑Establish regular eating times
- ❑Limit choices
- ❑Schedule toileting
- ❑Prevent wandering and elopement
  - Activities during times of wandering
  - Ensure basic needs are met
  - Reassure if he/she feels lost or disoriented

*** Always be patient and compassionate***

General Inpatient (GIP)

GIP is intended for short-term care when the physician and hospice IDG team believe the patient needs pain control or symptom management that cannot be provided in other settings.

GIP requirements:

- GIP is NOT intended for custodial or residential care
- Once symptoms are stabilized, the patient must return to a routine level of care
- Prior to GIP, measures must be taken to control pain/symptoms in the patient's home care setting. These measures MUST be documented.

General Inpatient (GIP)

When is GIP care appropriate?

- ***Uncontrolled*** **pain**
- ***Intractable*** **nausea and vomiting**
- ***Advanced*** **open wounds**
- ***Uncontrolled*** **respiratory distress**
- ***Severe*** **agitation, anxiety or delirium**
- **Other *uncontrolled* symptoms**
- **Imminent death ONLY if skilled nursing needs are present**

Death and Dying

Signs of Approaching Death

One to Three Months

- Withdrawal from the World and People
- Decreased Food Intake
- Increase in Sleep
- Going Inside One's Self
- Less Communication

One to Two Weeks

- Disorientation
- Agitation
- Talking with the Unseen
- Confusion
- Picking at Clothes

Physical

- Decreased Blood Pressure
- Pulse Increase or Decrease
- Color Changes to Pale Bluish
- Increased Perspiration
- Respiration Irregularities
- Congestion
- Sleeping but not Responding
- Complaints of Tired and Heavy Body
- Not Eating, Taking Fewer Fluids
- Body Temperature Hot/Cold

Days or Hours

- Intensification of One to Two Week Signs
- Surge of Energy
- Decrease in Blood Pressure
- Eyes Glassy, Tearing, Half Open
- Irregular Breathing, Stops/Starts
- Restlessness or No Activity
- Blotchy, Purplish Knees, Feet, and Hands
- Pulse weak or hard to read
- Decreased Urine Output
- May Wet or Stool in Bed

Minutes

- "Fish out of water" breathing
- CANNOT BE AWAKENED

Death and Dying

All dying experiences are unique but there are some physical changes that are fairly common. Essentially, the body is shutting down and what may be abnormal when a person is healthy, is *normal and expected* during the dying process. For families of a dying person, this may be one of the most important but difficult ideas to accept.

Death and Dying

Hospice Responsibilities

- Make the patient as comfortable as possible. This may include positioning, medications, music, and/or a calming voice.
- Make the family comfortable with the changes that are taking place and educating them on the normal processes.
- We do NOT frequently take measured vital signs such as blood pressure readings, 02 saturations, and heart rates. The family will focus on the number and not their loved one. If the family requests we take vital signs, this is okay; however, we want to refrain as much as possible.

Death and Dying

Remember that the person dies at just the right moment whether it is alone or surrounded by others. Some individuals may seem to hold off or bring on the moment of death…that is, dying just after a close relative arrives from out-of-town or after an anticipated event such as a birthday occurs. Likewise, for someone who has been private or independent in life, death may come when everyone steps out of the room momentarily. Sometimes people die at a time that spares certain loved ones from the actual dying event.

Understanding Cultural Diversity and End-of-Life

"Strength lies in differences, not in similarities" *–Stephen R. Covey, cultural connoisseur and author*

What is Cultural Diversity?

The existence of a variety of cultural or ethnic groups within a society

- Culture—a particular group's values, beliefs, and customs
- Ethnicity—one's self-identified group

Importance of Cultural Diversity

- Affects everyone
- Provides an opportunity for us to be aware of those things that set us apart
- Allows us to understand and accept others for who they are

Cultural Diversity at End-of-Life

Discussing

African Cultures: Harmful to speak about death

Asian Cultures: Actively protect dying family members from knowing their prognosis

North American Cultures:

- Discussing is acceptable for most
- Independence is encouraged
- Native Americans-some believe in not speaking of a person's death because it might invite sadness or bad luck

Pain Management

- Culture may affect a person's response to pain, both in meaning and expression.
- Culture may influence the initiative a patient takes in asking for pain medication.

Decision Making

African Cultures:

Whole family should be involved with the male family member being the final decision maker

Asian Cultures:

Expect the eldest son to make the final decision

Family and extended family participate in discussions and decision making

North American Cultures:

Shared approach that includes the physician and family members

South American Cultures:

May request a visit by a priest to receive the "Sacrament Anointing of the Sick".

Diverse End-of-Life Customs

Buddhist

- Family of the deceased wears white during the services; red is forbidden
- Attendees light incense and bow to the family to show respect and sympathy

Hindu

- Hindu priest conducts the service within 24 hours after death
- A ceremony is held within 10 days after death to liberate the soul; visitors will bring fruit

Mormon

- Service is typically 60-90 minutes; a bishop conducts
- Floral tributes are encouraged and appropriate

Muslim

- Islamic law decrees that burial should take place immediately after death
- Palm branches of individual flowers are placed on the grave

Protestant-Lutheran, Methodist, Presbyterian, Episcopalian, and Baptist

- Services celebrate the deceased's life with testimonials and remembrances
- Family and friends are expected to attend the visitation and final service

Roman Catholic

- Before the final service, Catholics hold a vigil, also called "a Wake"
- At the mass, lighting a candle to honor the decease comforts the mourners

Understanding Cultural Diversity and End-of-Life

"Diversity is the one true thing we have in common" –*Anonymous*

Appreciating different cultures keeps our world interesting and helps us achieve personal growth.

Cultural Communication

- ✓ Clinicians who understand their patient's cultural values, beliefs, and practices are more likely to have positive interactions with their patients and provide culturally acceptable care.

- ✓ Every person is unique. Put yourself in the patient's shoes and consider their beliefs, needs, and concerns as you interact with them. Treat your patients as *they* would like to be treated.

Cultural Communication

Help Your Patients Feel Comfortable

- Ask if this is the first time they have truly discussed hospice. If so, explain our mission, our philosophy, hospice services , the roles of the interdisciplinary team, etc.
- If English is the patient's second language, or the patient is deaf/hard of hearing or has vision impairment, make sure to involve an interpreter in all of your care discussions. Do NOT rely on family members to translate health information.
- The patient may include family members in the care and care decisions.
- When appropriate, use the terms "partner" or "spouse" rather than "husband" or "wife" to avoid making assumptions about sexual orientation

Cultural Communication

Establish a Relationship with Your Patients

- Ask about preferences before acting
- Pay attention to patient cues and follow their lead
- If they do not establish eye contact or refuse to shake your hand, a cultural custom or spiritual belief may be guiding their behavior
- Set the tone for your patient visits by asking questions:
- How would you like to be addressed? (*Remember to continue calling them by their preferred name.)*
- What are your goals for end-of-life?
- What do you know about your disease and prognosis?

Cultural Communication

Provide Health Information and Treatment Recommendations in a Way That Your Patients Will Accept:

- ✓ What cultural, religious, spiritual, or lifestyle beliefs may impact the kind of health care you want to receive? *Remember to document these preferences so others can honor them.*
- ✓ Who else in your life needs to be involved in making medical decisions about your care? *An example: Health Care Power of Attorney*
- ✓ Would you like your plan of care and treatment discussed with any of your family members or would you like to keep that information confidential? *If patient responds yes, ask who and document that person.*

Cultural Communication

Maintain Good Communication with Your Patients

- Acknowledge and respect your patient's interpretations of their illnesses.
- Use open-ended questions (instead of yes/no questions).
- Tell your patients what you are writing as you take notes. After you have completed your notes, review and allow the patient to add any information omitted or did not feel comfortable discussing in the beginning.
- Tell your patients what you are doing and what they will feel if you are doing and exam, procedure, or other care that involves physically touching them.
- Listen carefully:
  - Nodding your head that you understand
  - Maintaining eye contact if that is the norm, *or* avoiding eye contact if that is their norm
  - Remaining on the same physical level as much as possible—avoid standing over the patient, which may be condescending

Show Your Patients Respect

Many cultural norms may influence your patient's behavior and appearance. Understanding, accepting, and respecting differences in lifestyle, beliefs, and customs is essential for building trusting interactions with your patients.

These are some norms that may be determined by the patient's culture and beliefs:

- *Beliefs about causes of illnesses, effects of treatment*
- *Physical distance to maintain*
- *Eye contact*
- *Touching*
- *Decision making*
- *Religious customs*
- *Being alone*

Communication

(For complete policy see Embrace Policy & Procedure Communication/ Language Barriers—Policy 2-090)

Policy:

Embrace Hospice does not discriminate against any person because of language or sensory impediments. Personnel will treat all patients with respect and dignity and will use forms of communication appropriate to meet the patient's needs.

Written materials will be made available in the recognized major languages in the area. Written materials will contain the telephone number of the local TDD telephone relay number. Organization personnel will consistently and clearly communicate with patients in a language or form they can reasonably understand. The organization will facilitate communication by using special devices, interpreters or other communication aides.

Procedure:

Embrace procedure contains detailed instructions in regards to assessment of a patient that is unable to communicate properly. There are specific steps to follow when a patient is visually, hearing, communicatively, manually impaired and for those patients who require an interpreter.

Fire Safety & Evacuation Plan

Fire Evacuation Procedure if YOU find the fire

- **R—Rescue** any person in immediate danger from the fire

Any staff, patient, volunteer, or family member in/near the fire should be removed from danger.

- **A—Activate** the fire alarm system

Active the alarm system by immediately pulling the nearest pull station. Personnel should report to the area of the fire with firefighting equipment in hand.

- **C—Contain** the fire

After rescuing the patient from the room, the fire should be contained in the are it is in by closing door(s) and windows to that area.

- **E—Extinguish** or **Evacuate**, as necessary

If the fire is small and contained, like a fire in a trash can, extinguish the fire as quickly as possible, using the closest appropriate fire-fighting equipment. Evacuate for safety.

If the fire is not extinguishable, nursing should institute a partial evacuation to the nearest safe area behind fire walls/doors and notify Administration if not already aware of the situation.

Fire Safety & Evacuation Plan

Procedure if Patient or Co-worker is on Fire

Stop, drop and roll consist of 3 components:

- **STOP**—The fire victim must cease any movement.
- **DROP**—The fire victim must 'drop' to the ground, lying down if possible.
- **ROLL**—The fire victim must roll on the ground in an effort to extinguish the fire by depriving it of oxygen.

The effectiveness of stop, drop and roll may be further enhanced by combining it with other firefighting techniques, including the use of a fire extinguisher, dousing with water, or fire beating (blanket, rug, towel, etc.).

Fire Safety & Evacuation Plan

Fire Extinguishers

Fire extinguishers are located throughout the office and facility to extinguish and/or control a fire until the Fire Department arrives.

Types of Fires *(Extinguishers are rated for the type of fire they are made to extinguish)*

- Type A Fire

  Ordinary combustible materials such as wood, paper, etc.

- Type B Fire

  Flammable liquids such as gas, oil, grease, and other petroleum products

- Type C Fire

  Electrical fires

Fire Safety & Evacuation Plan

Fire Extinguishers

Type “A” Extinguisher

- Lasts about 1 minute
- Use on mattresses, upholstery, combustibles, liquids, wood, paper, trash, and/or persons on fire.
- Not effective on “grease” fires

Type “BC” Extinguisher

- May slow a Type A fire, but will not extinguish
- Hold by the black handle only (if not, could result in frostbite)
- Do not let the cone come in contact with the fire
- Use on kitchen and electrical fires—fuel, oil, gas, paint, grease, electrical equipment, fuse boxes, electrical wiring, and/or applicance

Type “ABC” Extinguisher

- Effective for ALL types of fire
- Holds 10lbs of non-toxic dry chemical
- Lasts 1 ½ minutes
- User should stand back 8-12 feet from the fire

Fire Safety & Evacuation Plan

Procedure for Using Fire Extinguishers—**PASS**

- **P—Pull** the pin at the top of the extinguisher.

  The pin releases a locking mechanism and will allow you to discharge the extinguisher.

- **A—Aim** at the base of the fire, NOT the flames.

  This is important!!! In order to put out the fire, you must extinguish the fuel.

- **S—Squeeze** the lever slowly.

  This will release the extinguishing agent in the extinguisher. If the handle is released, the discharge will stop.

- **S—Sweep** from side to side.

  Using a sweeping motion, move the extinguisher back and forth until the fire is completely out. Operate the extinguisher from a safe distance. Move towards the fire once it starts to diminish.