DREAM HOME HEALTH CARE, INC.

PERSONNEL FILE CHECKLIST

Employee Name_____ Date of Hire_____

APPLICATION/RESUME

- ☐ Application for Employment
- ☐ Job Description
- ☐ Telephone Reference/Authorization to Release Information
- ☐ Letter of Acceptance
- ☐ Conflict of Interest

LICENSURE/CERTIFICATION

- ☐ Verification from the Licensure Board
- ☐ License/ Certificate
- ☐ CPR (N/A for office staff)
- ☐ Auto Insurance (copy)
- ☐ Driver's License (copy)
- ☐ Social Security card (copy)
- ☐ Liability Insurance
- ☐ Permanent Resident ID (if applicable)
- ☐ Credentials/Diploma

STATE REQUIREMENTS

- ☐ Universal Precautions
- ☐ Confidentiality Statement
- ☐ Child Abuse
- ☐ Sexual Abuse
- ☐ Adult Abuse
- ☐ Patient Rights
- ☐ Infection Control
- ☐ Code of Conduct
- ☐ Employee Disclosure Form

SKILLS/ORIENTATION/PERFORMANCE EVAL

- ☐ Information for Injury Prevention
- ☐ Acknowledgement of Employee Handbook
- ☐ Acknowledgement of Understanding of Policies
- ☐ Staff Orientation & Training on HIPPA Program
- ☐ Orientation checklist/Staff Orientation
- ☐ Skills Inventory (Initial Competency)
- ☐ Competency Evaluation (Core Competency)
- ☐ Glucometer Competency Quiz/ Competency Test
- ☐ Performance Evaluation

EMPLOYMENT ELIGIBILITY

- ☐ I-9 Form
- ☐ W-4 Form
- ☐ Background check

PHYSICAL EXAM ENVELOPE

- ☐ Physical Exam
- ☐ TB Test
- ☐ Chest X-Ray (TB positive)
- ☐ Hep B Vaccine
- ☐ Flu vaccination

DREAM HOME HEALTH CARE, INC.

EMPLOYMENT APPLICATION

Name: _____ Social Security Number _____

Other Names Used in Employment: _____

Address: _____

Email Address: _____

Home Phone: _____ Business Phone: _____

Position Applied for: _____

License/ Certification Number: _____ Expiration Date: _____

Driver's License Number: _____ Expiration Date: _____

To qualify for employment, you must be either (a) a citizen of the United States of America, or (b) a registered alien with government permission to work in this country. Does either statement (a) or (b) describe your status as a resident of this country? ❑ Yes ❑ No

Have you ever been fired or asked to resign? ❑ Yes ❑ No

Have you ever been convicted, fined (excluding minor traffic offenses), placed on probation, or given a suspended sentence in any court? ❑ Yes ❑ No (If "Yes" to question 11, please attach explanation)

EDUCATION

Name and address of Colleges or School Attended	Dates Attended	Major Subject or Course	Degree or Certificate Received
	From To		
	From To		
	From To		
	From To		
	From To		
	From To		

JOB EXPERIENCE

Job Title	Employer and Address	Duration of Work	Job Responsibilities	Reason for Leaving
		From To		
		From To		
		From To		
		From To		
		From To		

May we contact your former employer(s) for references? ❑ Yes ❑ No

Can we conduct a Criminal Background Check on you? ❑ Yes ❑ No

Please note that this agency is an equal opportunity employer and that this agency does not discriminate on the basis of sex, race, ethnicity color, or creed.

Certification of the applicant:
I certify that all statements made in this application are true and complete to the best of my knowledge. I understand that any false statement of material facts or omissions may be subject to my disqualification or dismissal.

Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

TELEPHONE REFERENCE CHECK

Applicant Name: _____ SS#: _____

Position Applied for: _____

Date of Telephone Reference Check: _____Contact Number: _____

Employer Contact Person: _____ Position: _____

Employment dates: from: _____ to _____

Position: _____

Reason for Leaving: _____

Would You Rehire: ❑ Yes ❑ No If No, Please Explain: _____

Please rate the applicant on the following:

Attendance	❑ Poor	❑ Average	❑ Above Avenge
Cooperation	❑ Poor	❑ Average	❑ Above Avenge
Initiative	❑ Poor	❑ Average	❑ Above Avenge
Job Knowledge	❑ Poor	❑ Average	❑ Above Avenge
Tolerance with people	❑ Poor	❑ Average	❑ Above Avenge

Does the applicant have any work habits or personality traits that may negatively affect his/her work?

_____

_____

Additional Comments: _____

_____

Person Completing the Telephone Reference Check:

Name _____ Title _____

DREAM HOME HEALTH CARE, INC.

CONFLICT OF INTEREST STATEMENT

DREAM HOME HEALTH CARE, INC. Policy and Procedures on Conflicts of Interest states that if a conflict on interest exists when there is a disjuncture between staff personal interests, financial or otherwise, or a professional interests, and his/her fiduciary obligations to the organization. Conflict of Interest Policy is attached. Please provide the following information:

1. I am currently involved in the following: (please list or indicate "none")

   a. Employment

   b. Partnership or controlling interest in the following business or other commercial activities.

   c. Directorships

2. I confirm that I have recently read the DREAM HOME HEALTH CARE, INC. policy, guidelines and procedures on conflict of interest and understand that it is my responsibility to avoid conflicts of interest and to make full, timely and ongoing disclosure of conflicts when they arise.

3. I understand that I have a continuing obligation to update the information in this statement and agree that I will do so when any circumstances change.

4. Any additional information you wish to provide:

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

ORIENTATION CHECKLIST

Employee Name: _____

_____ 1. Introduction to Office Staff
_____ 2. Service Agreement and Position Description
_____ 3. Documentation and Forms
_____ 4. Agency Policies and Procedures
_____ 5. Personnel Policies
_____ 6. Illness and Injury Prevention Program
_____ 7. Infection Control
_____ 8. Function of and Referral to Other Disciplines
_____ 9. Title XXII, Chapter 6 and Medicare Conditions of Participation
_____ 10. Reporting of Significant Changes in the Patient's condition
_____ 11. Case Conferences
_____ 12. In-Service Education
_____ 13. Quality Management Program
_____ 14. Patient/ Staff and Agency Confidentiality
_____ 15. Fire Safety/Emergency Preparedness
_____ 16. Employee Handbook

Acknowledgment:

1. ***I have been oriented to the above.***
2. ***I have received a copy of my position description.***
3. ***I have completed orientation.***

Employee/ Contractor Signature: _____ Date: _____

Agency Representative Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

EMPLOYEE HANDBOOK
ACKNOWLEDGEMENT RECEIPT

This is to acknowledge that I received a copy of DREAM HOME HEALTH CARE, INC.'s, Employee Handbook and understand that it sets forth the terms and conditions of my Employment as well as the rights, duties, responsibilities and obligations of employment with the Company. I understand and agree that it is my responsibility to read, familiarize myself and abide with the provisions of this handbook.

I further understand that this is not an employment contract or a legal document.

Employee/ Contractor Name: _____ Title: _____
Please Print

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

ACKNOWLEDGEMENT & UNDERSTANDING OF POLICIES & ORIENTATION PROCEDURES

1. Acknowledge receipt & understanding of the following:
    - Employee handbook
    - Job description
    - Child abuse & neglect reporting policy & procedure
    - Elder & dependent adult abuse reporting policy & procedure
    - Confidentiality policy & acknowledgement

2. I understand that in accordance with DREAM HOME HEALTH CARE, INC.'s, standards, state & federal regulation, it is my responsibility to provide DREAM HOME HEALTH CARE, INC. with my current license, CPR, health certificate and other job-related materials as directed.

3. I will assume responsibility and submit all required documents to DREAM HOME HEALTH CARE, INC. within 10 business days from today's date.

4. I will assume responsibility and provide an update of my health certificate, renewal of my CPR certificates and current license renewal, if appropriate.

I understand that failure to complete all of the above will prevent me from being assigned.

Employee/ Contractor Signature: _____ Title: _____

Agency Representative Signature: _____ Date: _____

STAFF ORIENTATION & TRAINING ON HIPPA PROGRAM

Course Objective:

All Agency staff will be educated and able to verbally acknowledge the importance of orientation and training on HIPAA Program. Agency staff will be familiar with privacy policies and procedures, use and disclosure, complaints and breaches, violation and penalties, adopted by the Agency.

Course Outline:

1. The definition and identification of protected health information.
2. The Notice of Privacy Practices from that is provided to all patients.
3. Using and disclosing protected health information for treatment, payment and health care operations.
4. Obtaining authorization for use and disclosure of protected information for purposes other than payment treatment of health care operations.
5. Obtaining a signed acknowledgement of Agency's Notice of Privacy Practices, and Patient Privacy Rights.
6. Procedure for handling suspected violations of privacy policies and procedures.
7. Penalties for violation of privacy policies and procedures.
8. Documentation required by the policies and procedures outlined.
9. Agency staff members will:
    - Receive a summary of the Agency's privacy policies and procedures.
    - Have an opportunity to review the policy and procedures of the Agency

Attached Policies and Procedures:

1) Notice of Privacy Practices

2) HIPAA Staff Roles and Responsibilities

3) Compliance and Sanctions

4) Staff Security and Confidentiality Agreement

Employee/ Contractor Name:: _____ Title: _____
Please Print

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

CONFIDENTIALITY STATEMENT

I, _____, understand that in the performance of my duties as an employee of this Agency. I may have access to, and may be involved in the processing of patient information. I understand that I am obligated to maintain the confidentiality of this patient information at all times, both at work and off duty.

- ☐ I understand that violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subjected to legal action.
- ☐ I understand that I am not to interpret, discuss, or otherwise relay medical or personal information about the patients, unless necessary during the course of fulfilling my job duties.
- ☐ I certify by my signature that I have participated in orientation and training concerning the privacy and confidentiality considerations of member information.

Employee/ Contractor Signature: _____ Date: _____

CHILD ABUSE REPORTING RESPONSIBILITY

Section 11166 of the Penal Code requires that any childcare custodian, health practitioner or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

"Child Care Custodian" Includes teachers; an instructional aide, a teacher's aide or a teacher's assistant employed by any public or private school, who has been trained in the duties imposed by this article if the school district has so warranted to the State Department of Education; a classified employee of any public school who has been trained in the duties imposed by this article, if the school has so warranted to the State Department of Education; administrative officers, supervisors of child welfare and attendance, or certified pupil personnel employees of any public or private school; administrators of a public or private day camp, administrators and employees of any public or private youth centers, youth recreations programs and youth organizations; administrators or employees of public or private organizations whose duties require direct contact and supervision of children and who have been trained in the duties imposed by this article, licenses, administrators and employees of licensed community care of child day care facilities; head start teachers; licensing worker; or licensing evaluators; public assistance workers; employees of a child care institution including, but no limited to, foster parents, group home personnel and personnel of residential care facilities; social workers, probation officers or parole officers; employees of a school district police or security department; or any person who is an administrator or presenter of, or counselor in a child abuse prevention program in any public or private school.

"Health Practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrist, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business & Professional code; marriage, family and child counselors; emergency medical technicians I or II, paramedics, or other persons certified pursuant to Division 25 (commencing with Section 1797) of the Health & Safety code; psychological assistants registered pursuant to Section 2913 of the Business & Professional code: marriage, family and child counselor trainee; as defined in subdivision (C) of Section 4980.03 of the Business & Professional Code: state or county public health employees who treat minors for venereal disease or any other condition: coroners; Paramedics, and religious practitioners who diagnose, examine or treat children.

I, _____ , hereby attest that I understand my obligation to report child abuse as described above and will fulfill this obligation.

Employee/ Contractor Signature: _____ Date: _____

ELDER AND DEPENDENT ADULT ABUSE REPORTING RESPONSIBILITY

The California legislature has adopted mandatory reporting requirements for dependent adult and elder abuse. Two aspects of the law are particular concern to physician:

1. The scope of physician's reporting obligation under the law, and
2. the obligation of all physicians and other employers who employ licensed health care practitioners or other mandated reports to provide these employees with a copy of a statement explaining their reporting obligations, and to obtain a signed statement from those employees hired on or after January 1, 1986, acknowledging these responsibilities.

Mandatory Reporting

Reporting is required of physicians, nurses, pharmacies and all other medical practitioners licensed under Division 2 of the Business and Professional Code. Reporting is also required of certain non-medical practitioners, such as coroners, social workers, psychologists, family counselors, nursing, home ombudsmen, care custodians (certain individuals who work directly with elders or dependent adults as part of their official duties, law officers and probation and welfare personnel). The obligation does not extend to members of physician's office support staff who are not licensed health care providers. One individual may make the required report for an entire group, and facilities may develop reporting protocols, so long as they are consistent with the statutory requirements. However, if a member of a group learns that the designated individual has failed to make the report, he or she must make the report as soon as practically possible.

Abuse Which Must Be Reported:

Those subject to the reporting obligation must reopen when, within their professional capacity or the scope of their employment; they either:

1. Observe an incident that reasonably appears to be physical abuse.
2. Observe a physical injury where the nature of the injury, its location on the body or the repetition of the injury, clearly indicates that physical abuse has occurred;
3. Are told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse.

"Physical abuse" which must be reported includes in addition to physical or sexual assault or barrier, the use of physical or chemical restraints or psychotropic medication, 1) for punishment; 2) for a period of time significantly longer than that for which the restraint or medication was authorized by the instructions of a physician providing medical care to the elder or dependent adult at the time the instructions were given; or 3) for any purpose not consistent with the authorization of the physician. It is the opinion of CMA legal counsel that the law does not require reporting of cases involving the appropriate withholding or removal of life-sustaining treatment as otherwise authorized by law.

_____ **Initials**

"Dependent adults" covered by the law include any person residing in California between the ages of 18 and 64 who have physical or mental limitations which restrict their ability to carry out normal activities and protect their rights, and specifically includes all hospital inpatients

"Elders" covered by the law include all persons residing in California 65 years of age or older.

Discretionary Reporting

Those required to report physical abuse as described above may, but are not required to report known or reasonably suspected instances of other types of elder or dependent adults abuse, including cases of mental abuse, fiduciary abuse, neglect, abandonment, isolation or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

"Isolation" includes:

1. Acts intended to prevent, and that do prevent, an elder or dependent adult from receiving mail or telephone calls.
2. Telling a caller of prospective visitor that an elder or dependent adults is not present, or does not wish to talk with the caller or to meet with the visitor, where the statement is false, contrary to the express wishes of the elder or dependent adult from having contact with family, friends or concerned persons;
3. False imprisonment (as defined in Penal Code 236); and
4. Physical restraint of an elder or dependent adult for the purpose of preventing the person from meeting with visitors.

The above acts are subject to a rebuttal presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician who is caring for the elder or dependent adult and who gives the instructions as part of the person's medical care. Furthermore, the above acts do not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

Reports

Reports by telephone and in writing must be made to:

1. The long term care ombudsman coordinator or local law enforcement agency (the city police or County sheriff's department, or county probation's department) when the abuse is alleged to have occurred in a long-term care facility; or
2. To the county adult protective services agency (County Welfare Department) or a local law enforcement agency when the abuse is alleged to have occurred anywhere else.

_____ **Initials**

Both the telephone and written report should include unless the information is unavailable to the reporter, the name, address, telephone number and occupation of the person making the report, the name and address of the victim, the date, time and place of the incident, other details, including the reporter's observations and beliefs concerning the incident, any statement relating to the incident, and the name of the individuals believed to be responsible for the incident and their connection to the victim. The written report is to be on a standardized form which should be available from County adult protective services agencies, and must be sent within two working days of notice of the abuse.

I, _____ , hereby attest that I understand my obligation to report elder and dependent adult abuse as described above and will fulfill this obligation.

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

CODE OF CONDUCT

To aid Agency in attainment of its mission of providing quality health care to the public in the home care, standards of conduct have been developed and approved by the Board of Directors and the agency's leadership. It is therefore expected that all employees and contracted individuals will thoroughly understand and conduct themselves according to the tenets stated below:

1) The Employee will complete scheduled visit and assignments on a timely basis.
2) The employee will complete required classes, orientation and educational requirements to maintain current licensure and compliance with Agency's policy.
3) The employee will submit accurate records of employment, applications and time cards/route sheets.
4) The employee will conduct themselves in a professional manner in all interactions with supervisors, peers and clients. Licensed and certified employees will hold to the standards of their accrediting board.
5) The employee will present themselves in a professional manner by proper grooming as well as appropriate attire.
6) The employee will respect the right of the property of the Agency, other employees and patients.
7) The employee will refrain from excessive or unexcused absences.
8) The employee will not engage in any of the following:
    a) Negligence,
    b) Possession or being under the influence of alcohol or illegal substances,
    c) Possession of weapons while on duty.
9) The employee will be aware of and practice safety policies and procedures.
10) The employee will perform his/her duties as stipulated in the criteria-based job descriptions.
11) The employee will be aware and adhere to the fraud and abuse laws as stated in the Medicare Act.
12) The employee will refrain from use of prejudicial or offensive language.

This type of disciplinary action which may be taken in response to violation of this Code of Conduct will be determined on an individual basis to include, but not limited to, the following: report incidents to licensing agencies where applicable, oral warning, written warning, suspension without pay, demotion, probation or termination. Violation of the Medicare Fraud and Abuse Laws may result in fines of up to $25,000 and 5 years imprisonment.

I have read and agreed to comply with the above Code of Conduct.

_____	_____	_____
Signature and Title	Print Name	Date

DREAM HOME HEALTH CARE, INC.

EMPLOYEE HEALTH EXAMINATION

I have examined (Mr. / Ms.) _____ who is applying for the position of _____.

I have found no condition that appears to prevent _____ from performing the duties of the position applied for, with the exception or possible exception of the following:

_____

_____

I have found no indication of any condition which might represent a possible hazard to the health of the patients or other employees of this facility.

EXAMINATION

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Family History: Any significant illness in the family? If so, please state the illness and relationship.

Family Members	Illness	Relationship

PPD Test	Date Administered	Date Read	Result: Erythema = _____ mm Induration = _____ mm ☐ Positive ☐ Negative

PHYSICAL EXAMINATION: Report of physician

Adenopathy_____
Reflexes _____
Eyes _____
Hearing _____
Nose _____
Throat _____
Tongue _____
Teeth _____
Abdomen _____
Rectal _____

Chest: Breath Sounds _____ Resonance_____

Heart: Size _____
Murmur _____
Rhythm _____
Arteries _____

MD Signature _____ Date: _____

MD Address _____

DREAM HOME HEALTH CARE, INC.

HEPATITIS B VACCINE POLICY

Name: _____

The Center of Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) recommend immunization for all health care workers in the high-risk category. As healthcare personnel who will be exposed to the patients' blood and body fluid, you will fall into this high risk category.

The CDC immunization practices advisory committee recommends that, if you are NOT vaccinated, you should receive one dose of Hepatitis Immune Globulin Human (H_BIG) and begin a series of Hepatitis B Virus (HBV) vaccine.

Acknowledgment:

I have read the above statement and am aware that if unvaccinated, I am at risk of contracting Hepatitis B during employment. I am declining to receive the vaccination at this time.

_____ _____

Signature of Employee / Contractor Date

Sexual Abuse Policy

DREAM HOME HEALTH CARE, INC., prohibits and does not tolerate sexual abuse in the workplace or in any organization related activity. DREAM HOME HEALTH CARE, INC., provides procedures for employee, volunteers, family members, board members, patients, victims of sexual abuse or others to report sexual abuse and disciplinary penalties for those who commit such acts. No employee, volunteer, patient or third party, no matter his or her title or position has the authority to commit or allow sexual abuse.

The organization has a zero-tolerance policy for any sexual abuse committed by an employee, volunteer, board member or third party. Upon completion of the investigation, disciplinary action up to and including termination of employment and criminal prosecution may ensue.

Sexual abuse is inappropriate sexual contact of criminal nature or interaction for gratification of the adult who is a caregiver and responsible for the patient's or child's care. Sexual abuse includes sexual molestation, sexual assault, sexual exploitation or sexual injury, but does not include sexual harassment. Any incidents of sexual abuse reasonably believed to have occurred will be reportable to appropriate law enforcement agencies and regulatory agencies.

Physical and behavioral evidence or signs that someone is being sexually abused are listed below:

Physical evidence of abuse:

- Difficulty in walking
- Torn, stained or bloody underwear
- Pain or itching in genital area
- Bruises or bleeding of the external genitalia
- Sexually transmitted diseases

Behavior signs of sexual abuse:

- Reluctance to be left alone with a particular person
- Wearing lots of clothing, especially in bed
- Fear of touch
- Nightmares or fear at night
- Apprehension when sex is brought up

Reporting procedure

If you are aware of or suspect sexual abuse taking place, you must immediately report it to the DPCS or Administrator. If the suspected abuse is to an adult, you should report the abuse to your local or state Adult Protective Services (APS) Agency. If it is a child who is the victim, then you should report the suspected abuse to your local or state Child Abuse Agency. If you do not know who your state child abuse agency is, you can call the Child Help's National Child Abuse hotline at 800-422-4453, TDD 800-222-4453. Appropriate family members should be notified of alleged instances of sexual abuse.

DREAM HOME HEALTH CARE, INC., shall report the alleged sexual abuse incident to its insurance agent.

Anti-Retaliation

DREAM HOME HEALTH CARE, INC., prohibits retaliation made against any employee, volunteer, board member or patient who reports a good faith complaint of sexual abuse or who participates in any related investigation. Making false accusations of sexual abuse in bad faith can have serious consequences for those who are wrongly accused. The organization prohibits making false and / or malicious sexual abuse allegations, as well as deliberately providing false information during an investigation. Anyone who violates this rule is subject to disciplinary action, up to and including termination.

Investigation and follow up

DREAM HOME HEALTH CARE, INC., will take all allegations of sexual abuse seriously and will promptly and thoroughly investigate whether sexual abuse has taken place. The organization will cooperate fully with any investigation conducted by law enforcement or other regulatory agencies. It is the organization's objective to conduct a fair and impartial investigation. The organization provides notice that they have the option of placing the accused on a leave of absence or on a reassignment to non-patient contact.

The organization will make every reasonable effort to keep the matters involved in the allegation as confidential as possible while still allowing for a prompt and thorough investigation.

DREAM HOME HEALTH CARE, INC.

ACKNOWLEDGEMENT & UNDERSTANIDNG OF SEXUAL ABUSE POLICY

I acknowledge that I have received and read the sexual abuse policy and / or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have committed sexual abuse.

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of sexual abuse as set forth in the abuse policy, including retaliating against my employee / volunteer exercising his / her rights under the policy.

I, _____ , hereby attest that I understand my obligation to report elder sexual abuse as described above and will fulfill this obligation.

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

YOUR ROLE IN PATIENT RIGHTS

- Be empathetic to the patient, his problems & situation
- Review the patient rights & responsibilities form with the patient
- Treat all information about the patient as confidential, take measures to safeguard the patient's record
- Inform the patient about how to contact the office during and after office hours and of important reasons to contact the office
- Write down the names of the persons who will be making home visits for the patient
- Inform the patient on how he can file a complaint
- When the patient makes a complaint, report back to him on how the problem was resolved
- Teach the patient about his medical condition and the related care and management
- Coordinate patient care by communicating effectively and frequently with the other members of the team involved in the patient's care.

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

YOUR ROLE IN INFECTION CONTROL

- Practice good hand washing before and after all patient contact
- Use universal precautions for all patients
- Instruct patients and caregivers in the infection control measures that are necessary for each individual case (i.e., immunosupressed, IV, wound care) and document
- Handle sharps with extreme care. Do not bend, recap or manipulate in any way
- Double bag, close securely and dispose in the trash any waste soiled with blood fluids
- Place sharps only in a sharps container or a container of impervious plastic which can be closed
- Keep your hands away from your mouth, nose and eyes as much as possible and especially during patient care
- Be careful to keep your skin, especially the skin on your hands intact and healthy
- Report any needle stick or mucous membrane exposure to blood or body fluids immediately to your supervisor
- All members of the team (nurses, aides, homemakers) should be alerted to the signs and symptoms of infection and report them to the Case Manager or MD as appropriate
- Monitor those patients susceptible to infection (wounds, foley, IV, immunosupressed) for signs and symptoms such as fever, swelling or drainage.
- For the patient or caregiver who has been taught a procedure, periodically re-evaluate their technique to assure it is still adequate
- Use good technique with all sterile procedures
- Be certain patients and caregivers are independent and use good technique before having them do procedures on their own

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

SKILLS INVENTORY FOR RN/LVN

Name of Employee: _____ Date of Hire: _____

SKILLS	FEEL CONFIDENT	NEED TRAINING	N/A	COMMENTS
Administration of oral medications				
Administration of IV medications				
Administration of ear drops				
Administration of eye drops				
Administration of suppositories				
Administration of TPN				
Administration of IPPB				
Administration of Oxygen via mask				
Administration of Oxygen via nasal cannula				
Administration of Intramuscular injection				
Administration of subcutaneous injection				
Administration of sublingual medications				
Assisting patient in ambulation by using cane or walker				
Bed bath, sponge bath and shower				
Bladder care				
Bowel care				
Blood withdrawal				
Catheter care				
Catheterization				
Care of Central line				
Care of patient on Ventilator				
Checking for Edema				
Care of Decubitus Ulcer				
Care of Diabetic patient				
Care of Neurological Disorders patient (seizure)				
Cast care				
Care of patient in traction				
Care of patient who underwent cardiovascular bypass				
Care of Hemovac				
Care of Renal Dialysis Patient				
Care of COPD patient				
Care of Dying patient				
Care of Spinal Cord Injury patient				
Care of Head Trauma patient				
Care of patient in splint				
Care of Blind patient				
Care of Stroke (CVA) patient				
Care of patient who wears brace prosthesis				
Care of stump				
Cold compress				
Continuous suctioning via NGT				
Eye irrigation				
Ear irrigation				
Foot care				
Giving an Enema				
Giving NGT Feedings				
Giving GT Feedings				
Gastric irrigation (stomach wash)				

SKILLS	FEEL CONFIDENT	NEED TRAINING	N/A	COMMENTS
Hard Restraints				
Insertion of Heparin Lock				
Insertion of Angio Cath				
IV Therapy				
Insertion of NGT				
Irrigation of Catheter				
Incontinence Care				
Knowledge of Anaphylatic Shock				
Knowledge of Special Diet, i.e., 1500 cal ADA, 2gm NA+, etc.				
Knowledge of Disaster Preparedness				
Knowledge of Home Care				
Knowledge of OASIS				
Knowledge of Treatment Plan				
Knowledge of Title 22 and Medicare Regulations				
Knowledge of Laboratory interpretation				
Knowledge of Autonomic Disreflexia				
Knowledge of Drug and Food Interactions				
Knowledge of Rehabilitation				
Knowledge of S/S of Respiratory Distress				
Knowledge of Dysphagia				
Knowledge of Aphasia				
Knowledge of I & O				
Measure VS				
Mouth Care				
Observation of Neuro Signs (PERRLA)				
Observation of Cardiovascular				
Obtaining Orders from Physician				
Obtaining Specimens				
Orthopedic Care				
Personal Hygiene				
Perform CPR				
Perform Heimlich Maneuver				
Perform Blood Glucose Monitoring				
Patient Teaching				
Post Operative Care				
Post Mortem Care				
Pulmonary Toilet				
Perineal Care				
Range of Motion				
Removal of Sutures				
Suctioning Tracheostomy Tube				
Soft Restraints				
Skin care				
Sitz Bath				
Tracheostomy Care				
Transfer Patient from bed with W/C and from W/C to bed				
Transfer patient from W/C to toilet and from toilet to W/C				
Transfer patient from bed to gurney and from gurney to bed				
Vaginal Douche				
Wound Care				
Wound Irrigation				
Warm Compress				

Employee Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

SKILL AND EXPERIENCE INVENTORY FOR HOME HEALTH AIDE

Name of Employee: _____ Date of Hire: _____

SKILLS	Self Evaluation	Initials of Evaluator	COMMENTS
Key: Self Evaluation: 1 - Very Experienced 2 - Somewhat Experienced 3 - Not Experienced N/A - Not Applicable * - Proficiency demonstration required!			
1 Temperature			
a. Oral	1 2 3 N/A		
b. Rectal	1 2 3 N/A		
c. Auxiliary	1 2 3 N/A		
d. Digital thermometers	1 2 3 N/A		
e. Other:	1 2 3 N/A		
2 Pulse (redial)	1 2 3 N/A		
3 Respiration	1 2 3 N/A		
4 Blood Pressure	1 2 3 N/A		
5 Bed Bath	1 2 3 N/A		
6 Shower/Tub Bath	1 2 3 N/A		
7 Nail Care	1 2 3 N/A		
8 Skin Care	1 2 3 N/A		
9 Oral Care	1 2 3 N/A		
10 Shampoo	1 2 3 N/A		
11 Toileting/Elimination			
a. Urinal	1 2 3 N/A		
b. Bedpan	1 2 3 N/A		
c. Other:	1 2 3 N/A		
12 Transfer techniques:			
a. Bed To Chair	1 2 3 N/A		
b. Chair to Standing	1 2 3 N/A		
c. Assist with Ambulation	1 2 3 N/A		
d. Other:	1 2 3 N/A		
13 Assists with exercise program Range of Motion	1 2 3 N/A		
14 Assistive Devices			
a. Walker	1 2 3 N/A		
b. Cane	1 2 3 N/A		
c. Other:	1 2 3 N/A		
15 Positioning	1 2 3 N/A		
16 Optional Skills			
a. Dry dressing	1 2 3 N/A		
b. Acc bandage wrap	1 2 3 N/A		
c. Medication reminders	1 2 3 N/A		
d. Urinary catheter care	1 2 3 N/A		
e. Gastrostomy site care	1 2 3 N/A		
f. Observe/record intake and output	1 2 3 N/A		
g. Hoyer lift	1 2 3 N/A		
h. Enema	1 2 3 N/A		
i. Urine specimen /test for sugar / acetone	1 2 3 N/A		
j. Other:	1 2 3 N/A		

SKILLS	Self Evaluation	Initials of Evaluator	COMMENTS
Key: Self Evaluation: 1 - Very Experienced 2 - Somewhat Experienced 3 - Not Experienced N/A - Not Applicable * - Proficiency demonstration required!			
17 Documentation Skills: (legible, timely, accurate and complete)			
a. Progress notes, flow charts	1 2 3 N/A *		
b. Incident reporting	1 2 3 N/A *		
c. Relates to Plan of Care	1 2 3 N/A *		
d. Other:	1 2 3 N/A		
18 Observation and Reporting to:			
a. RN /Supervising Nurse	1 2 3 N/A		
b. Other Professionals	1 2 3 N/A		
c. Other:	1 2 3 N/A		
19 Adheres to Plan of Care			
a. Reviews POC prior to care	1 2 3 N/A *		
b. Performs services as ordered	1 2 3 N/A *		
c. Documents according to POC	1 2 3 N/A *		
d. Communicates/coordinates if appropriate	1 2 3 N/A *		
e. Other:	1 2 3 N/A		
20 Infection Control:			
a. Handwashing	1 2 3 N/A *		
b. Proper bag technique	1 2 3 N/A *		
c. Protective equipment	1 2 3 N/A *		
d. Exposure plan	1 2 3 N/A *		
e. Equipment care	1 2 3 N/A *		
f. Other:	1 2 3 N/A		
21 Emergency Procedures	1 2 3 N/A *		
22 Effective Case Coordination			
a. Reports and documents key information to Physician, DC planner, Care coordinator/Case manager, Pharmacist, Supervisor	1 2 3 N/A *		
b. Participates as team member (RN, OT, ST, MSW, LPN/LVN, HHA)	1 2 3 N/A *		
c. Knows community resources, HME Lab, other services	1 2 3 N/A *		
d. Submits written summary reports as indicated	1 2 3 N/A *		
e. Attends case conferences as required	1 2 3 N/A *		
f. Other:	1 2 3 N/A		
23 Patient/Client Safety and Vulnerability	1 2 3 N/A		
24 Meal Preparation			
a. Feeding	1 2 3 N/A		
b. Diabetic diet	1 2 3 N/A		
c. Low sodium	1 2 3 N/A		
d. Low cholesterol/fat	1 2 3 N/A		
25 Light housekeeping	1 2 3 N/A		
26 Linen change/wash clothing	1 2 3 N/A		
27 Other:	1 2 3 N/A		

Employee Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

STAFF ORIENTATION

Name of Orientee: _____ Date of Hire: _____

DAY ONE	DATE COMPLETED	PRECEPTOR INITIALS	ORIENTEE INITIALS	COMMENTS
General company orientation				
Agency history				
Mission / vision / purpose / goals				
Organizational management				
Governance				
Professional advisory group				
Regulatory / licensing bodies				
Medicare				
Conditions of Participation				
State – Title II				
HIPAA Guidelines				
OASIS privacy guidelines				
Look-alike / sound alike drug list				
Advance beneficiary notice				
Overview of all programs (w/ associated patient care resp)				
Nursing				
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Medical Social Service				
Home Health Aide				
Nutrition				
Home Care Policies				
Job Descriptions				
Hours of duty				
Personnel requirements				
Confidentiality				
Grievance policy & procedure				
Department policies				
Dress code				
Mandatory inservices				
Staff meetings				
Paperwork timeliness				
Credentials				
DNR				
Advance Directives				
PI Programs				
Plan				
Measurements				
Utilization Review				
OBQI				
Case mix reports / adverse events				

DAY TWO	DATE COMPLETED	PRECEPTOR INITIALS	ORIENTEE INITIALS	COMMENTS
Medical Equipment / supplies				
Safe & appropriate use				
Storage, handling & access				
Cleaning & disinfection				
Payment Sources / billing				
Medicare				
Private insurance				
Fee for services				
Medi-cal				
Home Care procedures				
Acceptance of patients				
Admission procedure				
Discharge procedure				
Ordering DME / Supplies				
Staffing				
Mechanics of making a visit				
Scheduling visits / itinerary				
Assessments				
Geographical boundaries				
LVN Supervision				
CHHA Supervision every 14 days				
Requirements				
Certification				
Recertification				
Hospitalization				
DAY THREE				
Infection control				
OSHA				
Standard Precautions				
Personal Protective Equipment				
Bag Technique				
Hand Washing				
Safety risk / management				
Emergency preparedness plan				
Communication tree				
Personal safety				
Basic home safety (bathroom, fire, electrical, environment)				
Screening for abuse / neglect				
Medical records				
Plan of care				
Clinical notes				
Documentation of Care				
30 day progress note				
Medication profile requirement				
MD orders / POC update				
Care coordination				
Case conference (Interdisciplinary)				
Discharge procedure				
Education tools				
Chart color coding				
Patient activity board				
Incident report / fall reports				

Orientee Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

LETTER OF ACCEPTANCE

Dear _____,

In signing this contract, You are accepting the Position described below, at the rate of compensation as described below.

The Company offers you the following:

Position : _____
Status: Per Diem / Full Time / Part Time
Salary: _____
To start On: _____

Any concerns that you may be directed to the Governing Board.

Sincerely,

_____
Representative Of Governing Board

I agree to the above terms and to the Policies and Procedures of the Hospice.

Employee/ Contractor Signature: _____ Date: _____

Agency Representative Signature: _____ Date: _____

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UNIVERSAL PRECAUTIONS

TO BE USED IN THE CARE OF ALL PATIENTS

GLOVES

For Touching any patients blood or body fluids
For handling any soiled items
For performing venipuncture
Change after contact

GOWNS

Worn during any procedure likely to generate splashing of blood of body fluids.

MASKS AND PROTECTIVE EYE WEAR

Worn during any procedure likely to generate droplets or body fluids.

HANDS

Wash immediately if contaminated with blood or body fluids
Wash immediately after gloves are removed

To prevent needle stick injuries, needles should not be recapped, purposefully bent, broken or removed from disposable syringes or otherwise manipulated by hand.

Disposable syringes and needles, scalpel blades and other sharp items should be placed into puncture-resistant containers located as close as practical to the areas in which they were used.

To minimize the need for emergency mouth-to-mouth resuscitation mouth pieces, resuscitation bags of other ventilation devices should be available for use in areas where the need for resuscitation is predictable.

I HAVE READ AND UNDERSTOOD ALL PRECAUTIONS

Employee/ Contractor Signature: _____ Date: _____

EMPLOYEE DISCLOSURE FORM

I, _____ an employee of DREAM HOME HEALTH CARE, INC.'s will not refuse care or treatment to a patient based upon my cultural values or my religious beliefs.

Employee/ Contractor Signature: _____ Date: _____

I, _____, hereby inform my employer, _____ that because of my cultural values or religious belief, I may refuse to treat a patient. (on the following lines please explain detail below.)

_____
_____
_____
_____
_____
_____

Employee/ Contractor Signature: _____ Date: _____

DREAM HOME HEALTH CARE, INC.

INFORMATION FOR INJURY PREVENTION

INSTRUCTIONS: The notice must be posted on the company bulletin board and reviewed with each new employee as part of the Orientation process. Signed copy to remain in employees Personnel File.

FOR ANY UNSAFE OR UNHEALTHY WORKPLACE CONDITION OR PRACTICE……

PREVENT	By complying with safe and healthy practices
LEARN	Through the Company Training Program general safe and healthy practices and instructions for specific hazards.
IDENTIFY	Workplace condition / practices that are unsafe or unhealthy.
REPORT	Any unsafe or unhealthy condition / practices to your supervisor.
CORRECT	By contacting the Director of Nursing at _____ anonymously if If desired, if you do not observe timely correction of the condition after reporting it to your supervisor.
COMPY	With safe and healthy work practices for your safety and the safety of other Of others, or disciplinary action may result.
RECOGNIZE	Safe and Healthful work practices by letting your supervisor know when someone has followed safe healthful practices in order to receive a commendation.

INJURY PREVENTION

A. GENERAL
   1. Safe and healthy practices need to be used all times while working.
   2. Every employee is encouraged to inform the company of hazards at the worksite without fear or reprisal.
   3. The company has a safety and health committee which is comprised of the administrator, Director of Nursing, Director of Professional service, UR/QA coordinator and Office Manager.
   4. Any concern regarding safety and health in the workplace may be reported to a member of the local committee. If the issue is not addressed, a member of the company safety and health committee may be contacted, including the administrator.
   5. Members of the company safety and health committees will make periodic inspection to identify unsafe conditions.
      a. When this program is established
      b. Whenever the company is aware of a new or previously un-recognized hazard.
   6. Occupational injury or occupational illness is to be investigated.
   7. Unsafe or unhealthy conditions/ practices / procedures are to be corrected in a timely manner.

a. When observed or discovered, and
b. When imminent hazards exist which cannot be immediately abated without endangering employee (s) and/ or property, removed all existing personnel from the areas except those necessary to correct the existing condition. Employees necessary to correct hazardous condition shall be provided with safeguards.

8. Training and instructions are to be provided.
    a. When program is first established.
    b. To all new employees.
    c. To all employees given new job assignments for which training has not been received
    d. Whenever new substances, process, procedures, or equipment are introduced to the workplace and represent a new wizard
    e. Whenever the employer is made aware of a new or previously un-recognized hazards and;
    f. For supervisors to familiarize them with the safety and health hazards to which employees under their immediate direction and control may be exposed.
9. Review Emergency preparedness plan.

B. OFFICE PERSONNEL

1. Check work station to assure that desk, chairs, and other equipment is in safe working condition. If not, report to the Director of Nursing.
2. Check that equipment in the employee service area, such as a coffee pots, microwave ovens are in safe-working conditions, if not, report it to the Director of Nursing.
3. Should you become aware that furniture, furnishings or equipment is not in safe working order report it to the Director of Nursing.

C. NURSING PERSONNEL

1. Clinicians shall promote safety and minimize hazards related to care whether in the home or in the office. (JCAHO: SI.1)
    a. Basic home safety (JCHO: SI.1.1.1.1.1);
    b. The safety and appropriate use of medical equipment.(JCHO: SI.1.1.1.1.1);
    c. The storage, handling, delivery and access to supplies, medical gases, and drugs, with specific reference, as appropriate to chemotherapeutic agents, controlled substance, parenteral and enteral nutrition solutions needles; (JCHO: SI. 1.1.1.1.4);
    d. The identification, handling, and disposal of hazardous materials and wastes in a safe and sanitary manner, and in accordance with applicable law and regulation. (JCHO: SI. 1.1.1.1.4);

The patient acknowledge and performance of safety procedures is monitored on an ongoing basis through the Plan of Treatment process, appropriate instruction is provided as deficiencies are identified (JACAHO: SI. 1.4)

The staff's knowledge and performance of the safe and appropriate use of equipment related to the care or services provided are monitored on an ongoing basis appropriate instruction is provided. (JCAHO: SI. 1.4)

All accidents and injuries shall be reported to the Director of Nursing or Administrator (JCAHO: SI. 1.5.1) who shall take an incident report for investigation.

All incidents shall be investigated by appropriate Company personnel and shall be copied to the UR/QA Coordinator for review and suitable action (JACAHO: SI. 1.5.1.1.)

2. Infection control:

Measures shall be taken to prevent identify and control infections (JCHAO: SI.2). All cases of reportable disease noted by professional staff of the Hospice shall be reported to the local health officer, including undue prevalence of infections or parasitic disease or infestation (title 22:74725 and 74727).

Review Universal and Body Fluid Precaution under Infection Control Section of Policies and Procedures, including in Orientation Packet.

_____ _____

Signature of Personnel Receiving Training Date

_____ _____

Signature of Personnel Providing Training Date

DREAM HOME HEALTH CARE, INC.

ANSWER SHEET HOSPICE
LVN/RN COMPETENCY TEST

Name: _____ **Date:** _____

Score: _____

1. T F
2. T F
3. T F
4. T F
5. T F
6. T F
7. T F
8. T F
9. T F
10. T F

1. A B C D E
2. A B C D E
3. A B C D E
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50. A B C D E