Halvorson Home Visit

Preamble

Physician home visits are no longer a routine part of the physician work schedule. Hospital stays have become shorter. Medical care has become increasingly complex resulting in patient non-compliance or inability to follow the outlined treatment plan. Further, the number of medical services available to patients is continually expanding; however, patients are unfamiliar with services available with consequent underutilization of resources. The goal of the Halvorson Home Visit program is to follow high-risk patients as they transition from the hospital to their home environment. Home visits provide a unique interface between physician, patient and support system, allowing physicians to provide care in the patient’s environment, observe barriers to care that has been outlined, and insure appropriate utilization of health care resources. This program will work closely with existing healthcare resources such as Home Health, Respiratory Services, Yorhom and Social Services to provide a comprehensive home plan. As the U.S. population continues to age, the demand for home visits will increase exponentially. Utilization of an effective home visit program will reduce the number of readmissions to the hospital by assessing home safety medication management and coordination of appropriate services, allowing patients to continue to live in their home environment. The Home Visit Program provides Family Medicine Residents an invaluable interface to increase knowledge regarding care medical care of complex patients in the home environment.

Goals

Patient – improved care

- Resolution of conflicting-confusing hospital discharge instructions
- Removal of unnecessary or conflicting medication
- Rationalization of medications with patient’s economic resources
- Recognition of potential hazards at home
- Recognition of obstacles to further care
- Continuity of inpatient and outpatient services
- Utilization of appropriate health care resources
- Clarify advance directives
Physician – improved capability

- Increased awareness of the ‘total’ patient, unobtainable from the most detailed hospital admission history, including an understanding of the patient’s environment and support system.
- Improved, individualized care plans
- Strengthened sense of purpose and identity

Procedure

- PGY-3 residents will have a 6-8 week home visit rotation. Addendum A
  - Residents may take no greater than one week of vacation during their rotation. Halvorson Home Visits will not occur in the absence of the resident scheduled for the rotation.
  - The FMR PCMH nurse is responsible for blocking the Halvorson Home Visit schedule in the anticipated absence of the resident.
- Predictive analytics and physician gestalt will determine which FPTS patients require a home visit.
  - Home visits than cannot be accommodated utilizing the “Halvorson Home Visit” will be completed with an order placed for the “Hospital Transition Program.”
- Home visits will occur in a 15 mile radius of Grand Forks.
- The need for a home visit will be communicated to staff at IDT by the Chief Resident
- Order will be placed in EPIC: “Halvorson Home Visit”
- Appointment for the home visit will be scheduled by the HUC. Appointments will be available at 9, 10, and 11AM, Monday thru Thursday. Patients will be notified this is +/- 30 minutes.
- The chief resident will notify the FMR Medical Home nurse
- The medical home nurse and PGY-3 home visit resident will visit the patient in their home.
  - The first two home visits performed by a resident will have direct supervision from FMR faculty
  - Questions regarding medical care of the patient should first be directed to PCP. If PCP is unavailable, the resident should consult with a precepting physician at FMR
  - Documentation for the home visit will occur via standardized EPIC template and sent to the PCP (Addendum B)
- Venipuncture may be performed at the time of the home visit.
  - BSQ certification for “venipuncture” must be completed prior to starting the Halvorson Home Visit rotation.
• Suggested resident conduct
  • Understand your position as a guest in the home
  • Take off shoes
  • Sit a patient’s bedside – move furniture as needed and replace when done
  • Establish closeness and degree of intimacy
  • Lay on hands and listen
  • Comment on photographs and memorabilia that seem to be of significance

• Materials required for home visit
  • Alcohol hand rub
  • Gloves
  • Dressing change material if appropriate
  • Protective gowns
  • Masks
  • Infection Control Kit (refer to Home Care Infection Policy)
  • Canister Sani-Cloth
  • Stethoscope
  • Otoscope and tips
  • Tongue depressor
  • BP cuffs
  • Pulse oximeter
  • Copy of the after-visit summary (AVS)
  • Tablet with hot-spot

All participants should recognize the following addenda:
• Addendum C: Hand Hygiene Policy
• Addendum D: Home Care Infection Control Policy
• Addendum E: Other considerations

If All Else Fails
I will practise my profession with conscience and dignity:
The health of my patient will be my first consideration; I will respect the secrets that are confided in me, even after the patient has died. I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I will maintain the utmost respect for human life.
(Declaration of Geneva 1948)
DATE OF SERVICE: @ED@

PATIENT: @NAME@
DOB: @DOB@
MRN: @MRN@

Hospital Discharge Diagnosis:

Subjective:
***

Current Outpatient Medications:
@MED@

Medications reviewed with the patient, compared to hospital AVS and reconciled in EPIC. The above list reflects medications the patient is currently taking.

Safety Evaluation
--Mobility:
--Fall since discharge:{YES***/NO:20013}
--Current therapies: {REFERRAL OPTIONS:25882}
--Obvious hazards:
--Recommendations:

Nutrition:

Support System
--{Rehab support system:30079}

Physical Exam
@PHYSEXAM@

Assessment:
***

Plan:
***

Follow up:
***

@ME@

ADDENDUM C
PURPOSE
To describe theory, practice and products related to hand hygiene at Altru Health System. Hand hygiene is one of the most important measures to reduce the transmission of disease-causing organisms on hands and to reduce the spread of infections.

DEFINITIONS
- **Antimicrobial soap**: a soap containing an antiseptic agent which when applied to the skin reduces the number of microbial flora (i.e. alcohol, chlorhexidine gluconate, iodine, triclosan).
- **Alcohol handrub (AHR)**: AHR when applied to all the surfaces of the hands will reduce the number of microorganisms present. Must contain > 60% alcohol.
- **Antimicrobial handwash**: washing hands with soap and water, however, the soap contains an antiseptic agent to reduce the number of microorganism present such as CHG. Antimicrobial soaps can be more harsh to skin than alcohol handrub (AHR).
- **CHG**: chlorhexidine gluconate. CHG is an antimicrobial agent that is persistent, binds to skin layers, and continues to kill microorganisms in the presence of organic material. It is more effective with repeated use.
- **HAI**: healthcare associated infection.
- **Hand antisepsis**: using antiseptic handwash or antiseptic handrub to reduce the number of microorganisms present.
- **Hand hygiene**: a general term that includes:
  - Use of plain soap for handwashing
  - Alcohol hand rubs or antimicrobial soap and water
  - Surgical scrubs for scrubbing hands prior to surgery
- **Handwashing**: washing hands with soap and water.
- **Patient Space**: the immediate surroundings of the patient, including equipment such as IV poles, computer, furniture, etc.
- **Plain soap**: a soap product that does not contain antimicrobial agents
- **Surgical scrub (or surgical hand antisepsis)**: antiseptic handwash or antiseptic handrub performed preoperatively by surgical personnel to eliminate transient and reduce resident hand flora. Antiseptic detergent preparations often have persistent antimicrobial activity.
- **Visibly soiled hands**: hands showing visible soil or visibly contaminated with body substances.

BACKGROUND
Microorganisms carried from patient to patient via hands can cause infections. Both “transient” and “resident” microorganisms live on normal skin. Transient flora is picked up on the hands of healthcare workers during direct contact with patients or contaminated environmental surfaces near the patient. Transient flora includes the germs most often associated with HAIs. Transient flora can be removed by routine handwashing because it is on the external layers of skin only. Resident flora lives within the deeper layers of the skin and can never be completely removed.
2

Resident flora is less likely to be associated with transmission of infection; however, resident flora may be a factor for some infections, such as device-associated infections.

Factors which contribute to hand contamination:
• Direct patient contact, for example, care of the respiratory tract
• Duration of patient care
• "Clean procedures" (touching intact skin of patients)
• Touching infected or draining wounds
• Touching heavily colonized body areas (for example, perineal or inguinal areas, axilla, trunk and upper extremities (including the hands)
• Touching immunocompromised patients (for example: persons with diabetes, dialysis patients, and persons with chronic skin dermatitis.
• Touching the patient environment (for example: soiled gowns, bed linens, bedside furniture and other objects in the immediate environment)

PRODUCT CHOICE: Alcohol Hand Rub (AHR) or Soap and Water?
1. If hands are not visibly soiled, use AHR for routine hand hygiene.
2. Wash hands with soap and water when visibly soiled or contaminated with blood or body fluids.
3. Use AHR in all areas where handwashing facilities are not optimal.
4. Do not wash or re-use gloves. Do not use AHR on gloves to replace hand hygiene or regloving.
5. Clostridium difficile. Enhanced Contact Isolation is used for patients with Clostridium difficile infection, which includes doing antimicrobial soap and water after leaving the patient’s environment. Alcohol hand rub can be used prior to entering the room and during cares.

INDICATIONS FOR HAND HYGIENE
1. During Patient Care - The 5 Moments of Hand Hygiene
   1. Before patient contact
      • Prior to entering the room or patient space of any patient, whether or not gloves are required.
      • Prior to touching clean medications, patient equipment, food, drinks, etc.
   2. Donning and removing PPE:
      • Prior to gloving and after gloves are removed Note: Contaminated gloves must not touch clean areas such as elevator buttons, or one’s own face.
      • Prior to donning a face mask or respirator and after removal of face mask or respirator.
   3. Before aseptic task
      • When moving from a contaminated body site to a clean body site during patient care
      • Before donning gloves when inserting any intravenous catheter.
      • Before inserting indwelling urinary catheters or other invasive devices.
   4. After body fluid exposure risk
      • After contact with blood, body fluids, secretions, excretions, non-intact skin, mucous membranes or wound dressings, whether or not gloves were worn.
   6. After contact with patient or patient space
      • After any contact with a patient or the patient's intact skin (for example: taking a pulse, bathing the patient, taking a blood pressure, or lifting a patient, etc.).
• After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
• After removing gloves.
• After leaving the patient’s room, bay, or space

II. During Personal Cares
• Toileting
• Covering coughs, blowing nose
• Touching the face, hair, eyeglasses or other parts of the body before touching the patient
• Prior to eating, drinking, applying lip balm, touching contact lenses.

HAND HYGIENE PROCEDURES
I. Soap and Water Technique
1. Wet hands with water and apply enough soap (3-5ml.) to cover all hand surfaces
2. Using friction, rub hands vigorously, palm to palm, palm to back of hand, fingers interlaced
3. Pay special attention to thumbs, under nails, back of hands, wrists.
4. Rub skin surfaces for 15 seconds.
5. Rinse with tepid water.
6. Use a paper towel and gently dry hands and use the paper towel to turn off faucet.
7. Use hospital-approved lotion frequently to moisturize skin.

II. Alcohol handrub (AHR) Technique
1. If hands are visibly soiled, handwash with soap and water.
2. Apply product to the palm of one hand (Avagard use 1 pumpful; Alcare 1 palmful).
3. Rub hands together, covering all surfaces of hands and fingers, until hands are dry.

III. NICU/FBC hand antisepsis
Staff and visitors will observe the following hand antisepsis procedure before touching infants:
1. Staff are not allowed to wear jewelry (rings, watches, etc) in NICU or when in C-section.
2. Using plain soap and water and a nail pick to clean under the fingernails, wash hands from fingertip to elbow for 15 seconds. Dry hands with a paper towel.
3. Apply alcohol hand antiseptic (Avagard D) from fingertip to elbow; to dry.

IV. Surgical Hand Antisepsis and Products See Surgery Policy “Scrubbing, Gowning, Gloving”
Purpose:
The purpose of surgical hand antisepsis/hand scrub is to:
• remove debris and transient microorganisms from the nails, hands and forearms
• reduce the resident microbial count to a minimum; and
• Inhibit rapid rebound growth of microorganisms.

Applies to: Surgery, Family Birthing Center, Interventional Radiology, Cardiology, and the Surgery Departments at Altru South Campus and the Truyu Aesthetic Center.
Principles:
1. Bacteria on the hands of surgeons may cause wound infections if introduced to the operative field during surgery.
2. Rapid multiplication of bacteria occurs under surgical gloves if hands are washed with a non-antimicrobial soap, whereas bacterial growth occurs more slowly following preoperative scrubbing with an antiseptic agent.
3. Reducing resident skin flora on the hands of the surgical team for the duration of the procedure reduces the risk of bacteria being released into the surgical field if gloves are punctured or torn during surgery.

**Surgical scrub products:**
- must be FDA-approved and labeled as a surgical scrub
- significantly reduce microorganisms on intact skin
- contain non-irritating, antimicrobial preparations
- are broad-spectrum antiseptics
- are fast-acting
- have persistence

The following antiseptic agents are listed in order of decreasing antimicrobial activity (Note that the efficacy of PCMX has not been thoroughly substantiated):
1. 60-90% isopropyl alcohol combined with chlorhexidine gluconate
2. Chlorhexidine gluconate
3. Iodophors
4. Triclosan
5. Plain soap

The following applies to ALL surgical scrub products:
- Nails must be cleaned with a nail pick during the first scrub of the day.
- Brushes are not required to reduce bacterial counts on hands*
- If plain brush is used, apply adequate amount of soap product to brush.
- All surgical scrub products must be used as directed by the manufacturer.
- Hands must be washed with soap and water after removing gloves at the end of a surgical operation or if hands become visibly soiled.

*NOTE: brushes are not required to reduce bacterial counts on hands especially if alcohol-based products are used. Use of brushes is associated with increased gram-negative bacteria and Candida on the skin and with increased skin cell shedding (see Surgery Department Policy “Scrubbing, Gowning and Gloving”).

**Important Safety Consideration:** Alcohol-based products used in Surgery must be used away from high-temperature, sparking devices, or flames including cautery and laser.

**KEEP SKIN IN GOOD CONDITION:** damaged skin sheds bacteria

Frequent and repeated use of hand hygiene products, particularly soaps and detergents, can cause chronic irritant contact dermatitis among health care workers. Complaints include dryness, burning, rough skin, erythema, scaling and fissures. Any Altru staff with hand dermatitis should consult Employee Health. Solutions include: alternative hand hygiene products and or gloves, allergy or dermatology consultation, barrier lotions (“Gloves in a Bottle”), etc. Refer to the Employee Health Policy "Management of Occupational Dermatitis". Prevent dermatitis by applying the available, hospital-approved hand lotion. Hospital-approved hand lotions are compatible with hand hygiene products and gloves. Take care of hands while away from work and during cold weather.
HAND HYGIENE PRODUCTS

General Considerations
- Alcohol hand rub products must contain >60% alcohol.
- Do not refill or “top-off” empty soap dispensers or transfer any product from one container to another.
- Storage of 5 gallons or more of alcohol-containing product requires use of an approved, flammable storage cabinet. No more than 10 gallons of alcohol-containing product may be located per fire smoke compartment. Maximum size of container for alcohol-containing product is 1.2 liters.
- Location of AHR will be coordinated with infection control and Life safety. If installed in a facility with carpet, the containing smoke compartment must be 100% sprinkled. Dispensers and brackets will be installed by Altru Maintenance.
- Spacing of fluid dispenser's must be a minimum of 48 inches from each other
- Placement- Dispensers are not to be installed:
  - Above an ignition source within 1 inch horizontal distance from each side of the ignition source
  - To the side of an ignition source within 1 inch horizontal distance from the ignition source
  - Beneath an ignition source within 1 inch horizontal distance from the ignition source

NOTE: CMS has added a requirement not found in NFPA 101 regarding inappropriate access. From CMS conditions of participation§ 482 (b) (7) “A hospital may install alcohol – based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access”
- Percentage of alcohol content shall not exceed 95% alcohol by volume
ADDENDUM D

Altru Health System
Grand Forks, ND

**Standard Policy**

**Title:** HOME CARE INFECTION CONTROL POLICY

**Departments:** ALTRU’S HOME HEALTH/HOSPICE AND SPECIALTY SERVICES

Issued by: Infection Control
Reviewed by: Manager

Revised: 12/08, 11/09, 8/10, 1/11, 6/11, 5/12, 12/12, 5/13, 4/14, 6/15, 3/16, 11/16, 5/17, 8/17
Reviewed: 12/04, 5/05, 7/05, 6/06, 6/07, 7/08, 3/09, 4/10, 8/10, 6/11, 7/11, 5/12, 12/12, 5/13, 4/14, 6/15, 11/16, 12/16

**A. PURPOSE**

The purpose of this document is to provide department specific details of compliance with the Altru Infection Control Program. This document describes persons at risk of occupational exposure to blood borne pathogens and other significant organisms, and methods of protection from these organisms. The remainder of the document describes cleaning and disinfection of department equipment and environmental surfaces, care of the patient with a multiple drug resistant organism (MDRO) and miscellaneous infection control issues/concerns specific to Home Care.

**B. RELATED DOCUMENTS**

Related Documents
- AHS- IC-Standard Precautions Policy
- AHS-IC- Exposure Control Plan for Bloodborne Pathogens
- AHS-IC- Infectious Control Program Plan
- AHS-IC-Cleaning Disinfection and Sterilization
- AHS-IC- Hand Hygiene, Including Hand Washing and Hand Antisepsis
- Home Health/Hospice Hand Hygiene Process
- AHS- IC-Tuberculosis: Early Identification, Isolation, and Infection Control Measures for Mycobacterium Tuberculosis in the Healthcare Setting
- Home Health/ Hospice Cleaning and Disinfecting Telemonitor, Peripherals, and Accessories
- AHS-HR-3100 Professional Appearance/ Image Policy
- AHS-IC- Creutzfeldt-Jacob Disease (CJD) and Other Prion Diseases, Management of Policy
- AHS-IC- 2529 Management of Occupational Blood and Body Fluid Exposures to Healthcare Workers Policy
- AHS-5302 Handling and Disposal of Hazardous and Infectious Waste Policy
- Infection Control Surveillance Procedure
- AHS- 5600 Medical Equipment Management Plan
- Home Care Contact Precautions: Active Clostridium Difficile Procedure

**C. BLOODBORNE PATHOGEN COMPLIANCE**

General Statement: When it is anticipated that there will be contact with blood, body fluids, excretions, secretions, non-intact skin, mucous membranes or contaminated equipment, all personnel will use appropriate engineering controls, work practices and personal protective equipment to prevent cross contamination and/or personal exposure and risk of infection.

1. **Staff "AT RISK" of occupational exposure to blood borne pathogens:**

   **Home Health/ Hospice**
   - Camp Good Mourning Coordinator
   - Case Manager
   - Clinical Data/Utilization Review Coordinator
   - Home Health /Hospice Manager
   - Home Health /Hospice Supervisor
· Home Health/ Hospice Nurse Aide
· Hospice Care Coordinator
· Hospice Chaplain
· Occupational Therapist, Registered (OTR/L)
· Occupational Therapy Assistant
· Physical Therapist
· Physical Therapy Assistant
· Therapy Supervisor
· Registered Nurse
· Education Coordinator
· Social Work/Bereavement Coordinator
· Social Worker
· Speech Language Pathologist
· Volunteer Coordinator
· Volunteer Supervisor
· Volunteers

**Specialty Services**
· Assistive Technology Professional
· Customer Service Representative Crookston
· Decentralized Pharmacy Technicians
· Equipment Technician I & II
· Home Infusion LPN
· Home Infusion Pharmacist
· Home Infusion Registered Nurse
· Home Infusion Supervisor
· Home Respiratory Care Assistant
· Home Respiratory Care Coordinator
· Home Respiratory Care Equipment Technician
· Home Respiratory Care Supervisor
· Home Respiratory Representative
· Home Respiratory Therapist
· Lead Certified Rehabilitation Technician
· Operational Support Supervisor
· Regional Customer Service Coordinator
· Rehab Technology Coordinator
· Rehabilitation Assistant
· Rehabilitation Technician
· Repair Technician – Non-Certified
· Warehouse Coordinator

2. **Engineering Controls:** Controls (usually devices) that isolate or remove the blood borne hazard from the workplace.
· Red Garbage Containers
· Lancets
· Sharps Containers
· Needleless IV System
· Hepatitis B Vaccine
· BD safety injection needles
· BD safety butterfly needles
· BD transfer device
· Transport of Lab Specimens: Clean the outside of specimens if soiled. All specimens must be secured and enclosed in a zip top bag, then double bagged with a biohazard label and transported in a puncture resistant biohazardous labeled container, and hand carried to the lab.
· Designated areas for clean and contaminated equipment (see clinician bag, p. 6)

3. Work Practices: (Controls that reduce the likelihood of exposure by altering the manner in which a task is performed.)
· Universal precautions: use with every patient all the time
· Hand hygiene
· Use of personal protective equipment: gloves, gown, face/eye protection, and N-95 respirator or PAPR*
· Separation of clean and contaminated equipment
· Regular and medical waste generated during the visit is disposed in a plastic bag, tied and discarded by the family
· Sharps containers disposed of when ¾ full.
· Sharps containers disposed of in the hospital collection sites.
· Do not transport the patient’s personal sharps containers.
· Spill cleanup protocol (see cleaning and disinfection policy)
· Contaminated equipment and clothing is contained in clear plastic bags, tied, and labeled as biohazardous
· Laundry managed at patient’s home

4. Personal Protective Equipment
Availability and location of personal protective equipment: 3

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<td>Home DME</td>
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ADDENDUM E

GENERAL SAFETY GUIDELINES:

Workplace
- Use safety in all work-related activities.
- Utilize an appropriate time-frame to accomplish assigned tasks.
- Report all unsafe conditions to a supervisor immediately.
- Be aware of safety risks in the surrounding environment.
- Be alert to safety hazards that can be controlled in the work area.
- Drive defensively and wear seat belts at all times.
- The employee is to keep their vehicle doors locked at all times and check the rear seat area before opening the vehicle to enter.
- You may not use a cell phone or other wireless communication device hand-held or hands-free while driving if any of the following five conditions exist:
  - You are driving a company car.
  - You are driving a personal car but on company business.
  - You are driving on company property.
  - You are using a company-supplied phone.
  - You are using your own phone for company business.
- Use proper body mechanics when working with patients or equipment.
- Maintain appropriate emergency gear (winter survival kit, PPE, cell phones, first aid kit) in your vehicle.
- Employees working after hours at Altru Home Services are provided a level of security commensurate with the crime level in the area. This includes but is not limited to:
  - Having all entryways securely locked.
  - Insuring the parking area is well lighted.
  - Having security personnel available on Medical Park.
- Fully report any incident involving a staff member’s security to Altru Post-hospital Transition Program management and complete a written Incident/Safety Hazard Report, if so requested, by Altru Home Services or by local authorities.

Adverse Conditions: Weather Related
- Inaccessibility due to impaired/water-covered roads.
- Inclement weather causing unsafe travel.

Process: Determine inability to travel safely in identified weather conditions. If unable to travel safely, contact patients/families scheduled for home visits that day and review their emergency backup plan. Inform them that when the weather conditions improve, we will call them and schedule a visit. Any decisions regarding traveling to or from work during adverse weather, must be discussed with the Manager/Supervisor.

In the Home Setting Environment

Process: The visiting staff will assess the level of safety in a home on an on-going basis. After discussion with a Supervisor, Manager and the Physician, service may be denied or terminated to a client who is determined to be in an unsafe situation or when staff safety is jeopardized. Appropriate referrals will be made and/or a Vulnerability Report made.

Definition of Unsafe Home Situation: An unsafe situation exists when the visiting staff determines that a client cannot safely receive or be provided care due to the presence of but not limited to any of the following conditions:
- Problems relating to the patient:
  - Displays behavior that is a danger to self or others
• Refusal or inability to comply with recommended/established plan of care.

• **Problems relating to the primary caregiver:**
  • Displays behavior that is a danger to others.
  • Refusal or inability to comply with recommended/established plan of care.

• **Problems relating to the formal support system:**
  • Inability to provide minimum necessary service.
  • Inaccessibility/unavailability of needed services.
  • Inability to ensure the safety of staff delivering services.

• **Problems relating to the environment:**
  • Substandard shelter jeopardizing safety of visiting staff.
  • Inadequate sanitation jeopardizing safety of visiting staff.
  • Patient refuses to confine pets.

**Identified Risk Factor/Imminent Danger in the Home Setting That Endangers the Safety of Staff.**

**Procedure:**
- Immediately remove self from the home/grounds.
- Contact the Police Department to request assistance if a life threatening situation is present.
- Or, contact the patient/family and request that they remove the risk factor. When the staff member is satisfied that the environment is safe, he/she may return to the home.
- Contact the Supervisor to report the situation and your interventions.
- Complete a Risk Reporting Form and/or Employee Incident Report process if employee/volunteer were injured.

**Oxygen Safety**

**PURPOSE:** Precautions to take when Home Oxygen is in use.

**PROCEDURE:**
- When oxygen is administered, certain precautions must be taken to prevent explosions, fire, etc.

  - Oxygen Safety include the following:
    - Functional Smoke detector
    - Functional Fire extinguisher
    - Carbon Monoxide detector
    - No smoking with oxygen in use or around oxygen containers
    - Flammables should be kept away from the heat source.
    - Clinician should observe the patient’s O2 and ensure the setting is as ordered by the patient’s physician.

- When non-compliance is witnessed by Post Hospital Transition Program - the oxygen vendor and the patient’s ordering physician must be notified.

- When further resources are needed for the patient, always begin by calling the ordering physician first.

- If the ordering physician is unavailable, proceed through the call down list in order provided below
• Call the ordering physician’s on-call service
• Social work, case managers
• In case of emergency, call 911 for assistance