# Adio Home Health Services Inc

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# Adio Home Health Services Inc

## PAS PERSONNEL FILE CHECKLIST

Employee Name: _____

Date of Hire: _____

Position: _____

**1. EMPLOYEE INFORMATION**
_____Employee Information Form
_____Employee Emergency Form

**2. APPLICATION/RESUME**
_____Application
_____Resume (Optional)
_____References (2)

**3. LICENSE/ CREDITIALS**
_____License Verification Form ( For HHA / CNAs)
_____Social Security Card
_____Driver's License
_____NAR & EMR Registry Verification Form
_____HHA Certificate or Equivalent ( For HHA / CNAs)
_____Auto Insurance
_____CPR (Optional)

**4. HEALTH**
_____Hepatitis B Consent/Declination
_____TB Sympton Survey (Updated Annually)

**5. JOB DESCRIPTION**
_____Salary Acceptance Form
_____Job Descriptions

**6. HR FORMS**
_____Attendant Orientation Checklist
_____Universal Precautions
_____Employee Acknowledgement Statement
_____Statement of Employability
_____Employee Handbook Receipt
_____W4 Forms
_____I-9 Forms
_____TX Employer New Hire Form
_____Criminal History Report - Separate Manual
_____OIG - Separate Manual

**7. EVALUATIONS**
_____Performance Evaluations
_____Counsel/Disciplinary Actions

**8. EDUCATION**
_____Inservice Records
_____Skills Checklist ( For HHA / CNAs)
_____HHA / CNA Tests
_____Attendant Tests
_____OSHA/Bloodboorne Pathogens Test

# Adio Home Health Services Inc

## EMPLOYEE INFORMATION FILE

**Employee Name:** _____

**Employee Number:** _____

**Date of Hire:** _____ **Position:** _____

## EMPLOYEE DATA

**Last 4 Social Secuirty No.:** _____

**Date of Birth:** _____

**Home Phone No.:** _____

**Alternate Phone No.:** _____

_____

**Cell Number:** _____

## FILE UPDATE

| Type of update: (Include Month/Day/Year) | Revised by: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# Adio Home Health Services Inc

## EMERGENCY CONTACT FORM

**Employee Name:** _____

**Home Address:** _____

**Home Phone:** _____

**Alt. Phone:** _____

**Cell:** _____

### IN CASE OF EMERGENCY, PLEASE NOTIFY:

**Name:** _____

**Relationship:** _____

**Address:** _____

**Telephone Numbers:** **Home:** _____

**Work:** _____

**Other:** _____

**Family Doctor:** _____

**Number:** _____

**Hospital of Choice:** _____

**Allergies:** _____

**YEARLY UPDATE AND BY:** _____

# Adio Home Health Services Inc

## APPLICATION FOR EMPLOYMENT

Date: _____

### PERSONAL INFORMATION

Full Name: _____

Last 4 Social Security No: _____

Present Address: _____

City: _____ State: _____ Zip: _____

Phone No: _____ Cell No: _____

Permanent Address: _____

Notify in case of an emergency:

Name: _____

Address: _____

Phone No: _____

Are you 18 years or older? YES NO

Have you ever been convicted of a felony? YES NO
If YES, please explain: _____

_____

_____

Please note that we are required by Texas law to perform a Criminal Conviction History Check on all Unlicensed personnel and are prohibited from permanently employing any person whose check reveals certain past criminal convictions.

Referral Source:

Friend (Name): _____ Relative (Name: _____

Newspaper: _____ Walk-in: _____

Employment Agency: _____

Other: _____

## EDUCATION

| SCHOOL NAME & ADDRESS | YEARS COMPLETED | GRADUATE? | AREA OF STUDY DEGREE RECEIVED |
|---|---|---|---|
| High School | 1 2 3 4 | YES NO | |
| College | 1 2 3 4 | YES NO | |
| Trade, Business or Vocational School | 1 2 3 4 | YES NO | |

U.S. Veteran? YES NO Dates of Service: _____

Nature of Duty or Training: _____

Other Job Related Skills: _____

Knowlegde of a Foreign Language: _____

## PROFESSIONAL LICENSES AND/OR CERTIFICATIONS

| TYPE & NUMBER | ISSUED BY WHICH STATE OR ORGANIZATION | DATE ISSUED/EXPIRATION |
|---|---|---|
| | | |
| | | |
| | | |

## EMPLOYMENT DESIRED AND AVAILABILITY

Position Desired _____ Salary Desired _____

_____ _____

_____ _____

Date Available _____

Are you willing and able to work? Weekends? YES NO
Holidays? YES NO

Do you have responsibilities that would limit your ability to work?

YES NO If YES, please explain: _____

_____

Do you have your own reliable transportation? YES NO

Driver's License No & State: _____ Auto Insurance? YES NO

## EMPLOYMENT RECORD

Are you currently employed? YES NO

WE ROUTINELY CONTACT AN APPLICANT'S CURRENT EMPLOYER FOR REFERENCE CHECKS. WOULD
We routinely contact an applicant's current employer for reference checks. Would this pose any particular difficulty for you? YES NO

If YES, please explain: _____

LIST PREVIOUS EMPLOYMENT INFORMATION:

**Current or Last Employer**

Dates Employed From: _____to _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for Leaving: _____

**Previous Employer**

Dates Employed From: _____to _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for leaving: _____

**Previous Employer**

Dates Employed From: _____to _____

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Position/Duties: _____

Supervisor: _____ Hourly Wage: _____

Reason for Leaving: _____

Please explain all periods of unemployment: _____

Have you ever been terminated from employment? YES NO

If YES, please explain: _____

Use this space to give us other information about your personal qualities, work style, interpersonal skills or communication skills which would assist us in placing you:

## REFERENCES

| NAME | ADDRESS | PHONE | YEARS KNOWN |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

## PRE-EMPLOYMENT MEDICAL HISTORY AND MOBILITY EVALUATION

**SECTION 1**: APPLICANT INFORMATION STATEMENT (TO BE READ BY APPLICANT)

Before an offer of employment can be made, the section below must be completed.

***PtoTouch Healthcare Consulting Inc, is an equal opportunity employer who affirmatively seeks to employ qualified handicapped individuals. The following evaluation will assist us in efforts to reasonably accommodate our work environment to your needs.***

**SECTION 2**: MEDICAL HISTORY

a. State any physical defects or limitations that you have:

b. Employment for the company requires all employees to be fit to perform any physical activities related to theit job, as well as to appear regularly and on time for work as assigned. In that regard, do you have any of the following ailments?

| | |
|---|---|
| _____ BACK TROUBLE | _____ HEART TROUBLE |
| _____ BREATHING PROBLEMS | _____ HERNIA |
| _____ DIABETES | _____ TRICK JOINTS |
| _____ DIFFICULTY BENDING | _____ ULCERS |
| _____ DIZZINESS/BLACKOUTS | _____ CANCER |
| _____ EPILEPSY | _____ ALCOHOL ADDICTION |
| _____ HIGH BLOOD PRESSURE | _____ DRUG ADDICTION |
| _____ CIRCULATORY PROBLEMS | _____ ANY COMMUNICABLE DISEASE |

Describe any checked answers. List any prescribed medications you are now using:

**Please Review and Sign**

In making application for employment:

I certify that the information in this application is true and complete for all practical purposes. It may be verified by the facility or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the facility or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate discharge without recourse.

I understand that an investigative report may be made by a consumer reporting agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I understand that I will receive notice that such report has been requested, and that I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

I understand and agree that if I am offered employment by the facility, my employment will be for no definite term and that either I, or the facility will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the facility.

I understand, if I am an unlicensed person who has face-to-face patient/client contact, that the agency will perform a criminal history check per State Regulations as well as a check of the Nurse Aide Registry and Employee Misconduct Registry. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in DADS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Department of Aging and Disability Services (DADS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All DADS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, **unemployable**.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant Signature: _____ Date: _____

**FOR OFFICE USE ONLY**

____ Interview(s)
_____References Checked

**If Hired:** Position:_____ Start Date: _____

Salary:_____ FT/PT/Per Visit:_____

Pre-Emplyoyment Interview:_____

_____

_____

_____

_____

# Adio Home Health Services Inc

## EMPLOYEE REFERENCE CHECK

**TO:**
Company: _____

_____

ATTN: _____
TITLE: _____
PHONE: _____
FAX: _____

**FROM:**
Adio Home Health Services Inc

## TO BE FILLED OUT BY APPLICANT:

I have made application for employment with the above listed employer. I hereby request and authorize you to furnish the above listed employer with any information concerning my employment record, character, habits and ability. I do hereby release the addressed entity and individuals concerned from any claims, suits and liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the giving if such information.

Name while employed: _____

Last 4 Social Security No: _____

Dates of Employment: _____ to _____

Hire Position: _____ Dept.: _____

Salary: $_____ Immediate Supervisor: _____

End Position: _____ Dept. _____

Salary: $_____ Immediate Supervisor: _____

Signature: _____

## TO BE FILLED OUT BY PREVIOUS EMPLOYER:

Was the applicant employed by your company? YES NO

Is all the information stated above correct? YES NO

If not, what is correct? _____

_____

_____

What were the applicant's responsiblilities? _____

_____

_____

Please rate the applicant's performance in the following areas:

| | ABOVE AVERAGE | AVERAGE | BELOW AVERAGE | COMMENTS |
|---|---|---|---|---|
| Attendance | | | | |
| Cooperation | | | | |
| Job Knowledge | | | | |
| Initiative | | | | |
| Productivity | | | | |
| Reliability | | | | |
| Quality of Work | | | | |

What are the applicant's strength's? _____

What are the applicant's weaknesses? _____

Would you rehire the applicant? YES NO

Why? _____

What is the applicant's reason for leaving? _____

Additional Comments: _____

Completed by: _____ Date: _____

Company: _____

# Adio Home Health Services Inc

## REFERENCE REQUEST

Date: _____ Check method of gathering referenced data: [ ] Verbal [ ] Mail

Name of person giving reference: _____

Facility: _____

The individual named below is applying for a position as: _____
and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance: _____
Name of Company Representative

**Applicant Release**

Applicant: _____
Last First Middle Maiden

Position Held: _____

Last 4 SSN#: _____ Dates Employed: From _____ to _____

I hereby release from all liability the company or person completing this form and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant Signature Date

1) Please confirm the applicant's employment. From _____ to _____

2) Please comment on the applicant's attributes using the following scale:
4=Excellent 3=Good 2=Fair 1=Poor N/A= Not applicable

Quality of work: _____ Cooperation: _____
Knowledge & Skills: _____ Competence: _____
Reliability & Attendance: _____ Supervisory ability & capacity: _____
Grooming: _____

3) Please indicate specialty areas in which applicant has had experience: _____

4) Please indicate any special considerations necessary when giving assignments to this individual:

5) Is applicant eligible for rehire? [ ] Yes [ ] No If, No, why not? _____

Please attach additional Comments.

_____ _____ _____
PTHC0709 Signature Position/Title Date

# Adio Home Health Services Inc

## HHA MISCONDUCT REGISTRYAND EMR VERIFICATION FORM

Name: _____ Date of Hire: _____

Last 4 SS #: _____ Certificate #: _____

## For Office Use Only

Reported/Verified Certificate #: _____

Certificate Active? [ ] YES [ ] NO

**EMPLOYEE MISCONDUCT STATUS:**

HHA in Good Standing? [ ] YES [ ] NO

Name found on Misconduct Registry? [ ] YES [ ] NO

Abuse, Neglected or Exploited a Client or Customer? [ ] YES [ ] NO

Misappropriated a Client or Customer's Property? [ ] YES [ ] NO

| | | | |
|---|---|---|---|
| Verified by: | | Date Verified: | |
| Re-verified by: | | Date Re-verified: | |
| Re-verified by: | | Date Re-verified: | |
| Re-verified by: | | Date Re-verified: | |
| Re-verified by: | | Date Re-verified: | |
| Re-verified by: | | Date Re-verified: | |
| Re-verified by: | | Date Re-verified: | |

# Adio Home Health Services Inc

## EMPLOYEE CONSENT FORM FOR HEPATITIS B VACCINATION

### Consent of Hepatitis B Vaccination

I _____, as an employee of Adio Home Health Services Inc, consent to take the Hepatitis B Vaccinations. I have been informed that this involves a series of three (3) vaccinations. I have also been informed of the possible side effects and complications as well as the benefits of injections. I understand that the medication will be administered free of cost to me.

Print Name _____ Social Security No. _____

Signature _____ Witness Signature _____

Date _____

### Declination of Hepatitis B Vaccination

I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring the Hepatitis B (HBV) Infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to myself. However, I decline the Hepatitis B Vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious liver disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatits B Vaccine, I can receive the vaccination series at no charge to me.

Print Name _____ Social Security No. _____

Signature _____ Witness Signature _____

Date _____

# Adio Home Health Services Inc

## EMPLOYEE TB SYMPTOM SURVEY

Date: _____ Annual Update: Y or N

Employee/Contractor Name: _____

Address: _____

City, State, & Zip: _____

Phone Number: _____

Date of Birth: _____ Social Security No: _____

(PARENTAL CONSENT IS REQUIRED FOR ALL PERSONS UNDER 18 YEARS OF AGE)

The purpose of the PPD (Purified Protein Derivative) Intradermal Skin Test is to aid in the detection and diagnosis of Tuberculosis or the Exposure to Tuberculosis.

**PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS**

| | | |
|---|---|---|
| 1. Have you ever had the disease Tuberculosis (TB)? | YES | NO |
| 2. Have you ever had a positive reaction to a TB skin test? | YES | NO |
| 3. Have you ever had an allergic reaction to a TB skin test? | YES | NO |
| 4. Have you ever been immunized against TB with BCG or other? | YES | NO |
| 5. Have you ever received any of the medications used in the treatment of TB? | YES | NO |
| 6. Have you taken steroids during the last 4 weeks? | YES | NO |
| 7. Have you had a viral infection during the last 4 weeks? | YES | NO |
| 8. Have you had any type of vaccine during the last 4 weeks? | YES | NO |
| 9. Are you pregnant? | YES | NO |
| | YES | NO |

Circle YES or NO to any of the following symptoms you have had persistently:

| | | |
|---|---|---|
| Productive Cough | YES | NO |
| Weight Loss | YES | NO |
| Lethargy | YES | NO |
| Night Sweats | YES | NO |
| Coughing Up Blood | YES | NO |
| Loss of Appetite | YES | NO |
| Weakness | YES | NO |
| Fever | YES | NO |

**[ ] To the best of my knowledge, the above answers are true.**

This skin test will not be valid until the results are reported to and recorded in the employee personnel file. All employee health records are kept confidential.

# Adio Home Health Services Inc

## TUBERCULOSIS TESTING RECORD

I hereby give permission for the administration of the Tuberculin Skin Test to test me. The purpose of the Tuberculin skin test is to detect the Tuberculosis infection.

I acknowledge there is no history of having a previous positive TB Skin Test. If there is a history of positive TB Tests, please explain:

_____

The possible adverse effects of the TB Test have been explained to me and I have been given the opportunity to have questions answered to my satisfaction.

I also understand that any positive TB Test results will require follow-up and may be reported to the department of health.

_____ _____
Employee/Contractor Signature Date

**FOR OFFICE USE ONLY**

Manufacturer: _____ Lot No. _____
Expiration Date: _____
.10 ML (PPD) Intradermal Site: _____

**RESULTS MUST BE READ IN 48-72 HOURS OR ELSE TEST MUST BE RE-ADMINISTERED.**
**NO TEST WILL BE GIVEN ON THURSDAYS.**

Results:

_____ Non-Reactive _____ Reactive _____ Allergic

_____ mm Induration

Chest X-Ray Referral:
To whom: _____ Date: _____

Results: _____

**FOR POSITIVE RESULTS:**

Referred for Chest X-ray: _____ Where: _____

Follow-up: _____

_____ _____
Signature of Professional Administering PPD Test Date of Administration

_____ _____
Signature of Professional Readinf/Reporting Resulting Date of Reading

# Adio Home Health Services Inc

## EMPLOYEE TB SYMPTOM SURVEY AND PPD TEST

Name: _____ Hire Date: _____

TB Test Reason [ ] Employment [ ] Exposure [ ] Symptomatic [ ] Scheduled (3, 6, 9, 12 Mo.)

**A. Screening Questions for TB Test:**

1. Have you ever had a PPD Test? YES NO

If YES, date of test: _____ (If NO, skip to Section B)

2. If you answered YES to #1, what were the results?
[ ] Negative [ ] Positive [ ] N/A
(If results were negative, skip to Section B)

3. If results were positive, did you have a chest X-ray? YES NO

4. If answers to #3 is YES, what were the chest X-ray results?

_____
(Please submit a copy of the chest X-ray results)

5. Did you or are you taking TB preventive medications? YES NO

**B. Symptom Survey (Currently experiencing any of these symptoms, mark all that apply)**

_____ Persistent Cough (Lasting 3 weeks) _____ Easily Fatigued
_____ Fever (Low Grade & Persistent) _____ Night Sweats
_____ Unexplained Weight Loss _____ Bloody Sputum
_____ Loss of Appetite _____ None of these symptoms

I understand that a history of BCG or a previous positive result to the Mantoux TB can cause a significant reaction to the Mantoux TB test and hereby attest that I have no history of either BCG vaccinations or a positive Mantoux TB.

I have been counseled and voluntarily agree and consent to the Mantoux test for TB.

_____
Signature of Employee

**OFFICE USE ONLY**

0.1 ML/5 US UNITS OF TUBERCULIN PPD (MANTOUX) ADMINISTERED INTRADERMALLY TO
0.1 ML/5 US Units of Tuberculin PPD (Mantoux) Administered intradermally to the inner forearm of the _____ arm.
Lot #: _____ Manufactured by: _____
Expiration Date: _____

_____ _____
Signature of Person Administering Test Date

_____ _____
Signature of Person Reading Test Date of Reading

Results in Millimeters (MM) _____

# Adio Home Health Services Inc

## UNIVERSAL PRECAUTIONS

Because the infectious status may not be known for every client, it is important to prevent exposure to the blood and body fluids of all patients. This approach will limit any potential HIV/HBV exposures.

All health care workers should routinely use appropriately barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient are anticipated.

Gloves must be worn for touching blood and body fluids, mucous membranes or non-intact skin of all clients and for handling items or surface soiled with blood or body fluids. Gloves must also be worn for performing venipuncture and during vascular access procedures and should be changed after contact with each patient. Hands must be washed immediately upon removal or damaging of gloves.

Masks face shields and protective eyewear should be worn during procedures that are likely to generate droplets of mucous membranes of the mouth, nose and eyes. Long sleeve fluid repellant disposable gowns and/or aprons should be worn and removed immediately if contaminated with blood or other body fluids.

All sharp items should be considered potentially infectious and handled with extraordinary care. Used needles are not to be recapped, broken or purposely bent. All needles and sharps shall be placed in puncture resistant containers.

## OSHA RISK EXPOSURE

**CATEGORY I**: Tasks that involve exposure to blood, body fluids or tissue.

All procedures or other job-related tasks that involve an inherent potential for mucous membrane or skin contace with blood, body fluids or tissue or a potential for spills or splashes of them, are Category I Tasks. Use of appropriate protective measures is required.

**CATEGORY II**: Tasks that involve no exposure to blood, body fluids or tissue, but employement may require performing unplanned Category I Tasks.

The normal work routine involves no exposure to blood, body fluids or tissues but exposure or potential exposure may be required as a condition of employment. Appropriate measures should be readily available to every employee engaged in Category II Tasks.

## EMPLOYEE ACKNOWLEDGEMENT STATEMENT

I have read the above and have been instructed in the techniques of universal precautions and the Adio Home Health Services Inc, exposure control plan for bloodborne pathogens. If I choose to disregard the above standards, I realize I am doing so against Adio Home Health Services Inc, policy and OSHA standards.

I understand the potential dangers of recapping needles and of the failure to take adequate precautions to prevent or decrease the risk of exposure to blood and body fluids.

I also understand infractions of this policy will result in disciplinary action against me ranging from verbal counseling to termination.

_____ _____

Employee Signature Date

# Adio Home Health Services Inc

## SALARY ACCEPTANCE FORM

Date: _____

I have accepted the position of:

| | | |
|---|---|---|
| ____ Administrator | ____ HHA | _____Companion |
| ____ Alt Administrator | ____ Caregiver | |
| ____ PAS Supervisor | ____ Sitter | |
| ____Attendant | ____Homemaker | |

at Adio Home Health Services Inc I have been provided with a copy of the job description for the above position.

In accordance with my position, my rate of pay will be:

| | |
|---|---|
| $_____ Annual Salary | $_____ semi-monthly gross wages |
| $_____ per visit | $_____ per hour |

I have accepted the above stated position with Adio Home Health Services Inc I agree with and accept the salary as stated above.

_____
Printed Name of Employee

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date

# Adio Home Health Services Inc

## ATTENDANT ORIENTATION CHECKLIST

The following orientation will be used for all full-time, part-time & per-diem workers.

| | | DATE | INITIALS |
|---|---|---|---|
| **I** | **Introduction** | | |
| | About the Agency | | |
| | What Attendants Do | | |
| | Organizational Structure/ Who you report to | | |
| | Communication | | |
| | Confidentiality / HIPAA | | |
| | Emergency Preparedness | | |
| **II** | **Exposure Control/Standard Precautions** | | |
| | Standard Precautions/OSHA/ Hazardous Waste/Infection Control/HIV | | |
| | Hand Washing | | |
| | Safety | | |
| **III** | **Human Resource Policies** | | |
| | Dress Code | | |
| | Evaluation Policy | | |
| | TB (according to agency policy) | | |
| | Hepatitis Consent/Declination | | |
| | On The Job Injury | | |
| | Pay Schedule | | |
| | Employee Illness | | |
| | Inclement Weather | | |
| | Progressive Discipline Policy | | |
| | Employee Grievance Procedure | | |
| | Non-Discrimination Policy | | |
| | Illegal Remuneration | | |
| | Fraud and Abuse | | |
| | Abuse, Neglect and Exploitation | | |
| **IV** | **Attendants** | | |
| | Situations Attendants must report to Supervisor | | |
| **V** | **General Policies and Procedures** | | |
| | Client Supplies | | |
| | Agency Paperwork | | |
| | Schedules/Timeframes | | |
| | Out-of-Hospital DNR/Advanced Directives | | |
| | Client Rights, Rights of the Elderly | | |

Employee Signature _____ Date _____

Employee Printed Name _____

Human Resource Director Name/Signature & Date _____

# Adio Home Health Services Inc

## EMPLOYEE ACKNOWLEDGEMENT

### CONFIDENTIALITY

Adio Home Health Services Inc maintains confidentiality of operations, acitivities, and business affairs of Adio Home Health Services Inc and the clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of the work, each employee will gain, directly or indirectly, sensitive and confidential informaton on clients/patients and staff members. The health care professional safeguard the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain infotmation may be shared, s/he should consult with his/her supervisor.

### DRUG TEST POLICY

Adio Home Health Services Inc conduct "on hire and random/for cause" drug testing on its employees. Adio Home Health Services Inc maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs and alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverage while in the workplace or on Company paid time. Violation of this policy can result in disciplinary action, up to and including termination of employement. I acknowledge I have received a copy of Adio Home Health Services Inc policy on drug testing.

### HARASSEMENT POLICY

Adio Home Health Services Inc is committed to providing a work environment, that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employement. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager of Human Resources.

### NON SOLICITATION/ILLEGAL REMUNERATION

Adio Home Health Services Inc does not reimburse or provide incentives to employees, physicians, durable equipment providers, family or other health professional for patient referrals for home health services. Employees found in violation of this policy will be subject to discipline up to termination of employment.

### NON-DISCRIMINATION

Adio Home Health Services Inc does not discriminate against clients or employees based on race, color, religion, age, sex, national origin, martial status, or disability.

### ABUSE, NEGLECT, AND EXPLOITATION

Adio Home Health Services Inc employees will report suspected abuse, neglect and/or exploitation to the state departments of both the Texas Department of Family and Protective Services, the Department of Aging and Disability Services, and Adio Home Health Services Inc management. Adio Home Health Services Inc employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

### WORKERS' COMPENSATION

Adio Home Health Services Inc is a non-subscriber to workers' compensation insurance. An employee who incurs an injury on the job that requires emergency medical treatment or is life threatening should proceed to the nearest emergency room. Emergency medical treatment (non life threatening) or non-emergency treatment should be referred to Adio Home Health Services Inc designated clinic. Notify Adio Home Health Services Inc of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God, and/or acts of a third party.

### DISCIPLINARY ACTION POLICY

Adio Home Health Services Inc utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes verbal warning, written warning and final warning, Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

### AGENCY POLICIES

I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines. I understand that copies of the policy and procedure manuals are available, and that it is my responsibility to read, understand and confirm to all applicable agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

Employee Signature _____ Date _____

# Adio Home Health Services Inc

## STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Adio Home Health Services Inc and agree that Adio Home Health Services Inc, may conduct a State of Texas Criminal History Check and search the Nurse Aide Registry and the Employee Misconduct Registry to determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this agency.

**[ ] Criminal History Check:**

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the Criminal History Check.

**CONVICTIONS BARRING EMPLOYMENT:**

(A) A person for whom the facility is entitled to obtain Criminal History Information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:

- An offense under Chapter 19, Penal Code (*Criminal Homicide* )
- An offense under Chapter 20, Penal Code (*Kidnapping & Unlawful Restraint* )
- An offense under Section 21.02, Penal Code *(Continuous sexual ause of a young child or children)*
- An offense under Section 21.08, Penal code *(Indecent exposure)*
- An offense under Section 21.11, Penal Code (*Indecency with a Child* )
- An offense under Section 21.12, Penal Code *(improper relationship between educator and student)*
- An offense under Section 21.15, Penal Code *(Improper photography or visual recording)*
- An offense under Section 22.011, Penal Code *(Sexual Assault)*
- An offense under Section 22.02, Penal Code (*Aggravated Assault* )
- An offense under Section 22.021, Penal Code *(Aggravated sexual assault)*
- An offense under Section 22.04, Penal Code (*Injury to a Child, Elderly Individual or a Disabled Individual* )
- An offense under Section 22.041, Penal Code (*Abandoning or Endangering a Child* )
- An offense under Section 22.05, Penal Code *(Deadly conduct)*
- An offense under Section 22.07, Penal Code *(Terroristic threat)*
- An offense under Section 22.08, Penal Code (*Aiding Suicide* )
- An offense under Section 25.031, Penal Code (*Agreement to Abduct from Custody* )
- An offense under Section 25.08, Penal Code (*Sale or Purchase of a Child* )
- An offense under Section 28.02, Penal Code (*Arson* )
- An offense under Section 29.02, Penal Code (*Robbery* )
- An offense under Section 29.03, Penal Code (*Aggravated Robbery* )
- An offense under Section 33.021, Penal Code *(Online solicitation of a minor)*
- An offense under Section 34.02, Penal Code *(Money Laundering)*
- An offense under Section 35A.02, Penal Code *(Medicaid fruad)*
- An offense under Section 42.09, Penal Code *(Cruelty to animals)* OR
- A conviction under the laws of another state, federal law or the Uniform Code of Military Justice for an offense containing elements that are substaintially similar to the elements of an offense listed by this subsection.
- An offense the Agency determines to be contraindicted to employment with the consumers the agency serves

(B) A person may also be barred from employment the duties of which involve direct contract with a client in a facility if convicted of any of the following crimes within the past 5 years:

- An offense under Section 22.01, Penal Code (*Assault* ), that is punishable as a Class A misdemeanor or as a Felony
- An offense under Section 30.02, Penal Code (*Burglary* )
- An offense under Section 31, Penal Code (*Theft* ), that is punishable as a Felony
- An offense under Section 32.45, Penal Code (*Misapplication of Fiduciary Property or Property of a Financial* Institution), that is punishable as a Class A Misdemeanor or a Felony; or
- An offense under Section 32.46, Penal Code *(Securing Execution of a Document by Deception)* that is punishable as a Class A Misdemeanor or a Felony.
- An offense under Section 37.12, Penal Code *(False identification as a peace officer) or*
- An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (Disorderly conduct)

(C) In addition to the prohibitions on employment prescribed by Subsections (A) & (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- Of an offense under Section 30.02, Penal Code (Burglary); or
- Under the laws of another state, federal law or the Uniform Code of Miltary Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

(D) In addition to the prohibitions on emploment prescribed by Subsections (A), (B) and (C), a nurse aide listed as unemployable per amendment to TAC 40, §94.10 (I) and §94.11 ( c) (d) and is listed on the NAR or EMR stating a finding of abuse, neglect or misappropriation will not be recertified therefore, is unemployable.

(E) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and recieves a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential. I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Signature of Applicant _____ Date _____

**For Agency Use Only: Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR) Check**

[ ] Criminal History Check completed on-line [ ]Other Convictions identified on Criminal History. ( Document reason hiring)

[ ] NAR and EMR checked online at http://www.dads.stat.tx.us/providers/employability/search.cfm

[ ] Applicant employable [ ] Applicant not employable [ ] Comments: _____

Verified by: _____ Date: _____

# Adio Home Health Services Inc

# EMPLOYEE HANDBOOK

PTHC0709

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# I. PHILOSOPHY

The owners and management of Adio Home Health Services Inc operate on the principle that the services we provide are an expression of the dignity and worth of every employee. We exist to meet the physical and emotional needs of our clients, to the full extent of our education, training and licensing.

# II. MISSION STATEMENT

**Adio Home Health Services Inc's mission is:**

1. To provide a broad base of services based on our client's needs, involving clients in establishing, implementing & evaluating services.
2. To maintain clients in their homes as long as possible by providing nursing care and related health services.
3. To assist clients in using all restorative methods, tools and procedures to return to their normal pattern of living as soon as possible.
4. To provide cost competitive, quality services.
5. To develop a relationship with referral sources to effectively meet the home care needs of clients.
6. To serve as a link between clients and available community resources.

# III. VISION STATEMENT

We value our clients above all. As the driving force behind our mission, our clients and their caregivers are to be treated with compassion, respect and integrity by a highly trained team of health care professionals who treat them as they would members of their own family.

# IV. INTRODUCTION

This Employee Handbook is a brief description of the personnel policies, benefits, rules of conduct and safety regulations of Adio Home Health Services Inc It is designed as a guide; subject to the terms and conditions of other standard operating procedures, medical guidelines, insurance policies and various regulations. These policies, practices and benefits are continuously reviewed and may change from time to time.

Nothing in this Employee Handbook creates an implied or expressed contract of employment. The employment relationship may end at any time by Adio Home Health Services Inc or any employee in accordance with the "at will" doctrine of Texas.

# V. EMPLOYMENT GUIDELINES

## PROBATIONARY PERIOD

All employees will be subject to a ninety (90) day probationary period from their date of hire. Probationary periods may be extended at the discretion of Adio Home Health Services Inc An employee is not eligible for benefits during this probationary period.

At this time the agency does not provide compensation for vacation and sick leave. Full-time office and field staff are eligible for vacation and sick leave benefits. Vacation time and sick leave will accrue from the date of hire. However, an employee may not take advantage of sick benefits until after the ninety (90) day probationary period and vacation benefits after six (6) months from the date of hire.

During the probationary period, Adio Home Health Services Inc may terminate any employee who has not met the expectations of Adio Home Health Services Inc or fulfilled their job responsibilities.

## ORIENTATION

New employees will receive a comprehensive orientation and review of personnel policies, benefits, procedures, job descriptions, safe practices, universal precautions, work rules, forms and other matters. This orientation will start the first week of employment and include a variety of documents, schedules, forms, affidavits and instructions. All employees to assure that changes are communicated and understood, will attend staff meetings.

## CRIMINAL HISTORY CHECK, EMPLOYEE MISCONDUCT & NURSE AIDE REGISTRY

Applicants for employment and new employees who are non-licensed will have their criminal history checked within 72 hours of date of hire. A Criminal History Check (CHC) will be done to determine the employability of the individual and management will review the response from the Texas Department of Public Safety (TDPS). Adio Home Health Services Inc, will not keep an unlicensed employee who was convicted of an offense as specified in Section 250.006, Convictions Barring Employment, or if the facility determines there is a contradiction of employment. Employees may appeal to the Texas Department of Public Safety (TDPS) Error Resolution Center at (512) 465-2520, if it is felt that the information provided is not correct.

The agency will also conduct a search of the Employee Misconduct and the Nurse Aide Registry prior to the offer of employment for all unlicensed staff that has direct contact with the agency's clients. If an individual is listed in these registries as having committed an offense of abuse, neglect or exploitation, the agency will not hire this individual.

## DRESS CODE POLICY

Non-compliance with the dress code will result in disciplinary action or termination by the Agency.

Apparel in General:

Any employee may not wear the following while on duty during business hours:
Hair rollers, house slippers, midriff tops, thongs, spaghetti strap, platform shoes, tube tops, T-shirts, or any shirts containing printed matter of obscene jesters or logos.

The agency's management staff reserves the right to determine if the employee's attire is appropriate.

FEMALES:

1. Dress length should be no shorter than 2 inches above the knee.
2. Slacks are acceptable when made of material heavy enough so as to not be transparent and fitting loosely enough to permit freedom of movement and showing good taste.

MALES:

1. Street clothes clean and free of holes and tears.

DRESS CODE BY CLASSIFICATION:

1. Field Staff - scrubs, traditional uniforms, or street clothes with lab coat. Nametags required.
2. Office Personnel - street clothes
3. All professional field staff will be provided with a nametag.

## TRAINING AND MEETINGS

Staff meetings, seminars, in-service training and continuing education workshops will be offered and scheduled periodically. They serve the purpose of improving communication, enhancing knowledge, improving skills for the delivery of home health services and licensing.

a. Other personnel may attend seminars that relate to their specific job duties as assigned.

b. Management Personnel may attend meetings, seminars and classes that improve their ability to supervise and administer their areas of responsibility, or that enhance government, provider or public relations. Reading newsletters, journals, periodicals and regulations is an on-going part of staying current.
c. Licensed Staff are required to maintain a current licensure. The expense of maintaining compliance with employees appropriate Board is the responsibility of the employee.
d. Home Health Aides must receive twelve (12) hours of in-service training per calendar year. In-service may be in or out of the office, but is subject to the approval of management.

Attendance records and certificates must be turned into the office upon receipt. Adio Home Health Services Inc will reimburse for one (1) continuing education workshop per year for full-time licensed personnel. Such training is usually scheduled during regular work hours. For meetings or workshops that are out of town or require overnight stays, eight (8) hours of pay will apply, mileage will be reimbursed and hotel costs will be paid.

## PERSONNEL RECORDS

It is a requirement that Adio Home Health Services Inc keep accurate employee files. Please notify the office whenever there is a change in any of the following:

a. address or phone number
b. marital status/name change
c. number of dependents
d. tax changes for IRS taxes
e. auto insurance information
f. person to notify in emergency
g. beneficiary for life insurance
h. completion of training/education
i. driver's license status
j. licenses or medical condition

Confidential personnel records are maintained on each employee. An employee may review his/her personnel file by requesting an appointment with the Administrator that does not interfere with work. All files are property of Adio Home Health Services Inc, and are treated as confidential information. All personnel records must be maintained in a locked filing cabinet at all times.

## PERFORMANCE EVALUATION

A written performance review will be scheduled annually from the employee's initial date of hire. These evaluations will be completed by the employee's immediate supervisor and reviewed/approved by the Administrator. Adio Home Health Services Inc's, personnel must make arrangements to complete mandatory orientation with the Director of Nurses or designee at least thirty (30) days before their probationary period ends.

## RESIGNATION

An employee who decides to leave the agency, must give two (2) weeks written notice. The letter should include:

1. The reason for leaving
2. The last day of work
3. Future Plans
4. Signature and date

A terminating employee must return all equipment, supplies, files, keys, identification pin and any and all materials to Adio Home Health Services Inc Resignation without notice is discouraged because of its disruption to the services we provide. Terminating employees will be paid for accumulated vacation leave only if two (2) weeks written notice is given and they are leaving under favorable circumstances. Employees who are terminated for acts of dishonesty, violence, drug abuse or other serious causes will not be paid until all notes are turned in correctly. The last day actually worked is always the official termination date. The Administrator or designated representative will conduct an Exit Interview with the departing employee.

## TELEPHONE CALLS

Every call should be answered promptly and clearly. Adio Home Health Services Inc, telephones are to be used for business purposes only. Personal telephone calls are discouraged and must be kept to a minimum. Personal visits at work should also be limited. Please tell family and friends of this policy. Personal long distance telephone calls are not permitted and fees will be collected from the employee. Management may monitor telephone calls in order to assure that Adio Home Health Services Inc's quality standards are maintained. Telephone records and billing records may also be analyzed in order to insure compliance with this policy.

# VI. PAY PRACTICES

**Adio Home Health Services Inc, believes in "pay for performance." Wages and salaries are based on education, training, skill level, experience, licensing, certification, performance evaluation and other factors. Compensation will not be paid during natural disasters or if there is any interruption to our business and we cannot provide patient services.**

## PAYROLL PERIOD

The payroll period is every two weeks. Paychecks will be distributed on the Friday one (1) week after the end of the pay period. If the payday falls on a holiday, the paychecks will be distributed on the day prior to the holiday. If the payday falls on a Saturday, checks will be distributed on Friday; if on Sunday, they will be distributed on Monday.

## TIME SHEETS

Employees are required to record working time on a time/activity sheet. Any delay in submitting time sheets may cause a delay in providing payroll paychecks. Adio Home Health Services Inc, depends on the accuracy of time sheets. The employee and supervisor before turning in the time/activity sheet must initial errors, changes or exceptions. Falsifying payroll records is a serious matter that will result in disciplinary action.

## SCHEDULING

**Adio Home Health Services Inc's business hours are 9:00 AM to 5:00 PM, Monday through Friday. However, patient care may be required at other times. If a nurse or aide has a normal patient load, all visits should be completed within an eight (8) hour time frame. Certain conditions require a patient load to be seen prior to 9:00 AM and after 5:00 PM, these patients visits will be included in the patient load and time should be scheduled accordingly to accommodate the difference in hours.**

## OVERTIME PAY

Certain jobs, such as executive, administrative and professional are excluded from overtime regulations, in accordance with the U.S. Department of Labor and the Fair Labor Standards Act of 1938, as amended. Hourly employees are not permitted to work overtime unless scheduled and approved in advance by their supervisor.

## ON-CALL

There will be an RN and On-Call from 5:00 PM until 8:00 AM the following morning every day. On-Call duty will be assigned on a rotating basis. On-Call nurses must carry a beeper, mobile phone and an on-call box. Their responsibilities include documenting all calls, performing visits as required and submitting reports. For this, they will get compensated.

## PAYROLL DEDUCTIONS

Certain payments will be automatically deducted from each paycheck, as required by law and others for the convenience of the employee:

a. Federal Withholding Tax
b. Social Security Tax
c. Medicare Insurance Tax
d. Group Life/Health Insurance Premiums
e. Court-Ordered Child Support, IRS Taxes or Bankruptcy Payments

# VII. TIME AWAY FROM WORK

When it becomes necessary for employees to be away from work, absences may be paid or unpaid time, depending on the circumstances. Part-time and temporary employees do not receive paid absences or other benefits.

## HOLIDAYS

At this time, the agency does not provide compensation for paid Holidays.

The following days are observed as paid holidays for full-time employees:

New Years Day
Good Friday
Independence Day
Memorial Day
Labor Day
Thanksgiving Day
Christmas

Holiday pay is calculated as an eight (8) hour day at regular pay rate for full-time hourly and salaried employees. The office will be closed on holidays, however when a holiday falls on a weekend, employees will be granted another day off. Hourly employees will be paid at a regular rate of pay; if the employee works on the holiday, he/she will also be paid an hourly rate for any visits performed on the holiday. RNs are paid a fee per visit rate in addition to the holiday. In order to receive Holiday pay, employees must work their regular schedule on the day before and after the holiday. Adio Home Health Services Inc will make every effort to accommodate employee requests for time off on holidays by rotating staff to meet patient needs. However, management retains the right to schedule work in accordance with operational needs.

## PAID LEAVE

At this time, the agency does not provide compensation for Paid Leave.

A. Employees will accumulate vacation time at the rate of six (6) hours per pay period. Employees are eligible to use vacation time after six (6) months of employment.
B. An employee that is determined by administration to cause a hardship with his/her absence may be paid vacation in lieu of days off. This pay will be regular base pay and will not be considered overtime when paid. This action will be determined by the administrator in conjunction with the employee's supervisor.
C. Requests for vacation time off and/or vacation time paid, must be requested at least two weeks in advance. This is for administration to process paperwork for pay.

## SICK LEAVE

At this time, the agency does not provide compensation for Sick Leave.

**Adio Home Health Services Inc, will require medical evidence of illness when the employee has been out for three (3) consecutive days or more through a written physician's statement before granting pay for sick leave, however Adio Home Health Services Inc, reserves the right to require medical evidence at any time.** The Administrator and/or DON must be notified by the employee of absence due to illness before 9:00AM on the first sick day and on each day of illness thereafter. Clinical employees must notify the DON or RN On-Call one (1) hour prior to work schedule. RN On-Call will be responsible for scheduling any visits needing to be made before 9:00AM and will notify staffing personnel at 9:00AM of employee's absence and request remaining visit(s) be rescheduled. Clinical personnel must then notify the DON of absence during business hours. Failure to report can result in leave without pay.

Sick pay shall be granted for illness of the employee, spouse or children. Sick leave cannot be carried over. There is NO sick leave entitlement during the initial probation period.

## PERSONAL LEAVE WITHOUT PAY

Full time employees may be granted an unpaid leave of absence for valid personal reasons after paid leave has been exhausted. Management on an individual basis will consider each request, which must be in writing. New employees are not eligible for Personal Leave Without Pay during the first year. Group health insurance premiums for the employee and the employee's dependants must be paid in advance through payroll deduction.

## MEDICAL LEAVE OF ABSENCE

A Medical Leave of Absence shall be granted after the Administrator approves it only after medical evidence is submitted by a licensed physician indicating that it is necessary. The maximum amount of time allowed for a Medical Leave of Absence is three (3) months. Any employee on Medical Leave who is not able to return to work after this period must have an extension approved by the Administrator. When an employee is on Medical Leave of Absence, he/she may return to work only with the consent of the attending physician in writing. Employee benefits do not accrue during the time an employee is on Medical Leave of Absence.

## JURY DUTY

At this time, the agency does not provide compensation for Jury Duty.

When a full time employee is required to serve on a jury, Adio Home Health Services Inc, will continue to pay regular pay based on eight (8) hours per day up to forty (40) hours per week. Notify the Administrator or DON as soon as being informed about a jury appearance and continue to call in daily if you are selected to serve on a jury. Such duty must be noted on the time sheet and a copy of the jury summons and a letter of service from the Clerk of the Court must be turned in to the office. Employees are expected to return to work as soon as released from duty, including partial days and all fees paid by the court shall be submitted to the agency in order to receive compensation for Jury Duty leave pay.

## FUNERAL LEAVE

At this time, the agency does not provide compensation for Funeral Leave.

An employee will be granted up to three (3) days of leave with pay, for time off due to family death of spouse, child(ren), mother, father, brother, sister, grandparents, father-in-law, or mother-in-law. Proper notification will be required.

## MILITARY LEAVE OF ABSENCE

At this time, the agency does not provide compensation for Military Leave of Absence.

Military Leave of Absence is granted as required by the Military Selective Service Act of 1974, the Veterans Re-Employment Rights Law of 1994 and other applicable regulations. Such leave is excused and without pay.

# VIII. INSURANCE

## GROUP HEALTH, DENTAL & LIFE INSURANCE

At this time, the agency does not provide Health, Dental or Life Insurance.

Full time employees are eligible for Health, Dental and Life Insurance after ninety (90) days of employment. The cost of insurance for each employee is paid by Adio Home Health Services Inc, and may occasionally change due to regulations, claims experience or economic conditions. Dependant coverage is available at the employee's expense.

## HEALTH INSURANCE CONTINUATION (COBRA)

Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and their dependants an option to continue in the group health insurance plan, even after termination of employment. The employee, spouse, or dependants must pay premiums for continuation of the group health insurance. Additional information about continuation of group health insurance under COBRA is available from the Plan Administrator.

## WORKER'S COMPENSATION INSURANCE

At this time, the agency does not provide Worker's Compensation Insurance.

**Adio Home Health Services Inc, is a non-subscriber under the Texas State Insurance regulation. However, every injury, no matter how small must be reported immediately to the Administrator or DON and a written report submitted the same day.**

# IX. BEHAVIORS AND DISCIPLINE

**Adio Home Health Services Inc, is very concerned about its image, reputation and quality of service to its patients, to the general public and to the community. Any action or activity which is determined to hurt Adio Home Health Services Inc, reputation or its normal operation will be reviewed by management. It is not practical to list every type of unacceptable behavior at work, but conduct should be guided by common sense, save work habits and honesty. Behavior that is illegal, unsafe, unethical or non-productive will be cause for disciplinary action. Disciplinary action includes counseling, warning, suspension, demotion, probation or termination. Each employee will receive a copy of the Work Rules and sign an**

## PROFESSIONAL RELATIONSHIPS

Employees who have patient contact are required to maintain a professional relationship at all times. The following guidelines are provided:

a. Refrain from sharing any personal life problems with patients.
b. Refrain from sharing any employment related problems with the patients.
c. Refrain from taking family members or friends to patient's homes. If circumstances require that someone else travel on a patient visit, that person must wait in the car, which should be parked out of view. This is so that the patient will not realize that someone is waiting. Do not inform the patient that someone is waiting.
d. Refrain from accepting tips or gifts of any kind from patients. Adio Home Health Services Inc does not want to be a burden to any of our patients. If it is judged that refusing a token of gratitude would hurt the patient's feelings, then use good judgment and consult the DON or Administrator for advice.

## PROBLEM SOLVING

Complaints, misunderstandings, personality conflicts and other concerns should be taken care of as soon as possible. A complaint is anything that an employee feels is wrong, unfair, illegal or against Adio Home Health Services Inc, policies. Each problem should be discussed within three (3) working days of its occurrence. The DON should be the first to hear about the problem and should be able to solve it within a reasonable time. If the DON does not satisfy the employee or if the DON is part of the problem, then a written explanation of the problem should be submitted to the Administrator.

## DISCIPLINARY ACTION

Failure to perform assigned duties or substandard performance will result in disciplinary action. Agency Work Rules will be enforced on all employees who are subject to disciplinary action. Before a disciplinary action is written, the DON should check the personnel file for any other current disciplinary action on the specific employee. Disciplinary action will not remain in effect for longer than twelve (12) months. Each employee will be interviewed and asked to sign a disciplinary action. The employee's signature does not indicate agreement with the disciplinary action, but only verifies that the interview took place. The employee will be given a copy of the disciplinary action and the original will be placed in the employee's personnel file. The Administrator will review the specific situation along with the employee's entire performance record before termination. The Administrator or DON is the only person with the authority to discharge an employee thus terminating the employee's position with the agency.

# X. SAFETY

It is the intention of Adio Home Health Services Inc to provide a safe and healthy workplace for its employees by the use of modern technology, equipment and facilities and by the training and enforcement of safety rules. Managers are responsible for safety but every employee must develop safe habits and work practices.

## SAFE PRACTICES

No list can include every possible safety rule, the following are but a few:

a. Use protective clothing and devices when required.
b. Follow Adio Home Health Services Inc' policies which relate to fire, hazardous materials, chemicals, blood-borne pathogens, biomedical waste, working conditions and accident prevention.
c. Report every incident of injury, damage, loss or near miss, no matter how small.
d. Use first aid and medical supplies only when necessary.
e. Running, horseplay or practical jokes are not allowed.
f. Good housekeeping is required, keep work areas clean from hazards.
g. Keep aisles, exits and stairways clear at all times.
h. Follow safe practices and regulations for the medical services profession.
i. Use proper lifting procedures.
j. Cooperate fully with accident and injury investigations.
k. Wear seat belts and obey traffic laws while driving on agency business.
l. Use only approved ladders or platforms to climb; do not use boxes, barrels, chairs or other objects.
m. Smoking is not allowed on Adio Home Health Services Inc, premises or in vehicles. If you must smoke, do so only in designated areas.

Comply with informational, instructional, hazard and warning signs. Safety rules must be followed. An unsafe act will result in disciplinary action, which includes counseling, warning, suspension, probation or termination. See Sec. 97.281

## HAZARD COMMUNICATION PLAN

**Adio Home Health Services Inc has established procedures for providing information and training to employees who handle, store or are likely to be exposed to chemical products, blood borne pathogens, biomedical waste or other hazardous materials. This plan is designated to meet the requirements for a written Hazard Communication Program under the Occupational Safety and Health Administration (OSHA) Standard 29CFR 1910, 1200. OSHA designees are responsible for maintaining safe working conditions and for properly instructing each employee in the safe labeling, use, storage and disposal of chemical products found in their work areas. Employees have a personal responsibility to understand, promote and follow safe work practices that ensure they will not cause injury to themselves or to others.**

## TRANSPORTATION

**Adio Home Health Services Inc employees are responsible for their own transportation to and from work. Such transportation must be dependable because of the services performed and the scheduling that is done in advance. Employees are required to provide proof of auto insurance in accordance with Texas State Laws. Adio Home Health Services Inc is not responsible for traffic related accidents, injuries, tickets or fines. Employees who travel on Adio Home Health Services Inc's business will be reimbursed at the current established rate per mile. However, in keeping with IRS regulations, reimbursement cannot include commuter miles, which are miles that would have normally been traveled by the employee to get to the office and to return home. In order to receive mileage reimbursement, an employee must properly complete and submit travel records.**

## MATERIALS SAFETY DATA SHEETS (MSDS)

MSDS are maintained in a central file at the main office and are available in each area where hazardous materials are used or stored. Each MSDS includes the safety and health precautions to be followed for the safe application of the product, as well as its contents, exposure, reactivity, fire and explosions characteristics, medical treatment and disposal. OSHA designees will maintain a current inventory of MSDS for products in their areas of responsibility and make them available in the work area to employees who request them.

## CONCEALED WEAPONS

The possession of a handgun under the authority of Texas Concealed Handgun Permit Law, Texas Civil Status, Article 4413 (29ee), is prohibited on Adio Home Health Services Inc's premises. If at any time, Adio Home Health Services Inc has a reasonable suspicion that a concealed weapon or firearm is being carried, maintained or stored in violation of this policy, Adio Home Health Services Inc reserves the right to conduct a reasonable search of the person or property which it suspects to posses or contain a concealed firearm. The violation of this policy may lead to termination of employment as set forth in the established work rules of Adio Home Health Services Inc This policy is also a term and condition on continued employment.

## SMOKING IN THE WORKPLACE

Smoking has become a recognized health hazard and an irritant to many people. Adio Home Health Services Inc's policy is to control the quality of indoor air, to provide for health, safety and comfort of all employees and limit the use of tobacco at work.

a. Smoking is not permitted in any Adio Home Health Services Inc facilities or vehicles, including meetings.
b. Smoking material must be disposed of properly in approved outside containers.
c. Smoking is limited to outdoor areas only.

## DRUG FREE WORKPLACE

The manufacture, distribution, dispensing, possession, sale, purchase or use of a controlled substance on Adio Home Health Services Inc, property is prohibited. Being under the influence of alcohol or illegal drugs on company property is prohibited. The unauthorized use or possession of prescription drugs on Adio Home Health Services Inc, property is also prohibited. It is the responsibility of all Adio Home Health Services Inc employees to report to their immediate supervisor or to higher management any persons in violation of this policy. A positive test shall mean either the presence of drugs and/or alcohol and will be the basis for discharge. Refusing a drug test is grounds for discharge.

Employees testing may be conducted when:

a. Employees are not drug tested at the time of hire but employees who operate vehicles for Adio Home Health Services Inc and transport clients will be tested on a random basis.
b. Individual testing shall be required when there is reasonable suspicion that drugs or alcohol is affecting job performance and conduct in the workplace.
c. Any employee involved in an on the job accident may be tested.
d. All employees may be tested on a random basis by urine test at a designated clinic.

# XI. PROGRESSIVE DISCIPLINARY PLAN

The following set of work rules are designed to serve as a guideline. The guidelines are subject to everyday common sense. The spirit of these rules is to create a safe, healthy and productive work environment at **Adio Home Health Services Inc.**

**Adio Home Health Services Inc realizes that no single set of rules in isolation can cover every** aspect of conduct on the job. Therefore, the intent of these rules is to represent a common sense guide and that those specific cases outside these rules will be considered and weighed on an equal and fair basis after which corrective actions will be administered.

## ADMINISTRATION

a. Before a disciplinary action is written, Management should check with the Human Resources Department for any current disciplinary action on the specific employee.
b. Counseling actions will not remain in effect for longer than twelve (12) months.
c. Each employee will be counseled and be asked to sign the counseling form. The employee's signature does not indicate agreement with the content of the counseling but only verifies that the counseling took place.
d. The employee will be given a copy of the counseling and the original will be placed in the employee's personnel file.

## MULTIPLE VIOLATIONS

If the employee violated more than one of these rules, the employee may be charged with one, more than one or all of the violations. Discipline may be only based on one of the violations to be decided by management. These rules will remain in effect until changed or replaced by Adio Home Health Services Inc management's failure tomanagement's failure to enforce these rules or to impose the prescribed disciplinary actions, will not cancel, amend or waive any rulesactions, will not cancel, amend or waive any rules as written or implementation of these work rules, past practice will have no bearing on future discipline.

## EFFECT AND USE OF FINAL WARNING

Final Warning notice may be issued:

a. In connection with any violation of the work rules whereby repetition of the offenses could result in discharge.
b. In connection with the issuance of any two (2) work rule violations within a twelve (12) month period.

FINAL WARNING will remain in effect for twelve (12) months from the date the final warning is issued. A repeat of the same offense will naturally result in termination. Also during this time, the receipt of another Final Warning for any other offense will also result in termination.

GROUP I - Disciplinary Action = Termination

1. Blatant refusal to perform assigned work or any form of insubordination.
2. Threatening, intimidating or abusive language or behavior towards Management, Employees, Patients or Visitors.
3. Carrying weapons of any kind on company premises.
4. Conviction of a felony while employed with Adio Home Health Services Inc
5. Possession or use of intoxicants and/or illegal drugs during work hours or reporting for work under the influence of, as determined by management.
6. Theft of patient, employee or agency property.
7. Collusion between or among employees to give false evidence or testimony.
8. Falsification of any reports required by the agency.
9. Falsification of time sheets or production records required by the agency.
10. Racial epithets, ethnic slurs or sexual harassment.
11. Endangering a patient's safety or well being with adverse outcome.
12. Unprofessional behavior as deemed by management.
13. Sleeping during assigned duties.
14. Any willful behavior that endangers an employee of the agency and/or the agency's good standing.
15. Any disclosure of confidential information regarding a patient or employee of Adio Home Health Services Inc

GROUP II - Disciplined by:
a. Verbal Warning
b. Written Warning
c. Written/Discharge

1. Profanity or discourtesy towards any employee, patient, customer or visitor.
2. Failure to complete work assignments completely and/or accurately unless approved by management.
3. Negative attitude demonstrated by lack of cooperation with another employee or management.
4. Failure to follow orders or instructions of a supervisor.
5. Failure to attend mandatory Education programs.
6. Blatant invasion of privacy of property on company premises.
7. Failure to report a personal injury/accident immediately to immediate supervisor.

GROUP III - Disciplinary action same as GROUP II occurring within a calendar year

1. Absenteeism: Defined as missing one or more hours of one's scheduled work shift.
2. Occurrence: Defined as one or more consecutive work hours away from the job. An employee will get an occurrence for each time he/she is absent from work when their sick leave benefits have been exceeded . An occurrence does not include vacations, holidays, jury duty, on the job injury, funeral leave or authorized leave of absence.

3. Tardiness: Defined as arriving five (5) minutes after scheduled starting time.

   4 occurences/tardies = Verbal Notice
   8 occurences/tardies = Written Warning
   12 occurences/tardies = Written/Discharge
4. Failure to have adequate transportation to perform assigned work duties, without prior notice to Adio Home Health Services Inc
5. Failure to submit completed Nursing notes/activity sheets within time frame established by policies and procedures.
6. Failure to provide notice to agency of unavailability to work within 48 hours, unless an emergency situation exists.
7. Failure to report potential or identify problems to immediate supervisor.
8. Failure to complete doctor's orders.
9. Failure to be prepared for patient's care visit.
10. Failure to document patient complaints.
11. Any breach of company policies.
12. Failure to answer pages within twenty (20) minutes.

# Adio Home Health Services Inc

## RECEIPT OF EMPLOYEE HANDBOOK

I have received a copy of the Adio Home Health Services Inc, Employee Handbook. This handbook contains policies, procedures, practices and regulations which I have read and understand and will comply with during my employment with Adio Home Health Services Inc

I understand that no supervisor, manager or representative of Adio Home Health Services Inc other than the Administrator of Adio Home Health Services Inc has the authority to make any agreement contrary to the terms of this handbook.

I understand that the information contained in this handbook applies to all employees of Adio Home Health Services Inc,

I further understand that it is presented as a matter of information only and its contents should not be interpreted as a contract between Adio Home Health Services Inc and any of its employees.

I hereby agree not to discuss, copy, print or distribute data about any patient, supplier or employee unless it is for official business purposes. Salaries, wages, expenses, funding sources, medical information and any other such data are not to be discussed under any circumstances. This information can only be used within the context of professional discussions, official business and legitimate need to know.

Employee Signature

Date

# Adio Home Health Services Inc

## PERSONAL CARE ATTENDANT TEST

**1. When the blood circulation of elderly personal generally improves when their:**

A. Clothing is kept clean
B. Liquid intake is increased
C. Room temperature is kept around 70 degrees F
D. Activity is increased

**2. A normal axillary (under the arm) temperature is?**

A. 92
B. 91
C. 97.6
D. 105

**3. The universal sign of choking is:**

A. Jumping
B. Sneezing
C. Doing nothing
D. Hands at throat

**4. The loss of fatty tissue is a normal part of the aging process that makes the elderly more likely to develop which of the following conditions:**

A. Pressure ulcers
B. Fractured hips
C. Skin cancers
D. Constipation
E. All of the Above

**5. In giving foot care to a patient who has Diabetes Mellitus, the nursing assistant should NOT take which of these actions?**

A. Clean the toenails
B. Cut the toenails
C. Soak the patient's feet for 5 minutes in a warm basin of water
D. Put lotion on the patient's feet after drying them

**6. The Nursing assistant finds Mr. Rose sitting up in bed and vomiting bright red blood into an emesis basi Which of these actions should the nursing assistant take FIRST?**

A. Elevate the head and knee rest of Mr. Rose's bed
B. Stay with Mr. Rose and call for help
C. Go to the desk and ask for the nurse in charge to call mr. Rose's doctor
D. Remove the emesis basin from Mr. Rose's view and empty it

**7. Person with Parkinson's Disease frequenty do not eat as much food as they need to maintain their weight at a normal level because:**

A. They have difficult in chewing and swallowing
B. They have no sense of smell or taste
C. They have no appetite
D. They are unaware of the importance of maintaining their weight, and are looking for ways to attract attention

**8. A patient is near death and does not respond to verbal request. The patient is incontinent of urine and feces. When providing the care of this patient, the nursing assistant should assume that the patient:**

A. Has no pain
B. Will not be aware of being touched
C. Can hear
D. Wound prefer that the room be darkened

**9. Skin care is provided to patients to increase circulation**

A. TRUE
B. FALSE

**10. Soft restaints are only recommended for children**

A. TRUE
B. FALSE

**11. Standard precautions are not necessary unless a patient has HIV**

A. TRUE
B. FALSE

**12. If a patient in on fluid I & O, solid stool is also measure for output.**

A. TRUE
B. FALSE

**13. In CPR, ambu-bag ventilations are more effective than mouth-to-mouth.**

A. TRUE
B. FALSE

**14. While giving a bed bath to a patient with a Nasogastric (NG) tube, the tape should be replaced daily with new adhesive tape.**

A. TRUE
B. FALSE

**15. A patient with a colostomy drainable pouch should have their appliance changed daily for proper skin ca**

A. TRUE
B. FALSE

**16. A normal blood pressure is 120/80**

A. TRUE
B. FALSE

**17. The second set in CPR is to check for pulse.**

A. TRUE
B. FALSE

**18. To log roll a patient means to roll them as a unit, keeping their back in a straight line.**

A. TRUE
B. FALSE

**19. When performing two-man CPR, the compressor usually calls for the change.**

A. TRUE
B. FALSE

**20. When performing two-man CPR, the compressor usually calls for the change.**

A. TRUE
B. FALSE

**21. An overhead bar and trapeze is frequently used with recovering stroke patients.**

A. TRUE
B. FALSE

**22. While performing one man CPR on an adult, the compression to ventilation ratio is 10:2.**

A. TRUE
B. FALSE

**23. Hand washing is the first line of defense in controlling infection.**
A. TRUE
B. FALSE

**24. When lifting a heavy object, you should always bend from the waist, keeping your knees locked.**
A. TRUE
B. FALSE

**25. The purpose of the Heimlich maneuver is to induce a bowel movement.**
A. TRUE
B. FALSE

**26. If a patient stops breathing, you should immediately call for help, stay with the patient, and start CPR.**
A. TRUE
B. FALSE

**27. Following surgery, patients are able to ambulate to avoid blood clots in their legs which could lead to a clot in their lungs.**
A. TRUE
B. FALSE

**28. Patient on oxygen and being transported to X-Ray, may be transported without oxygen as long as oxygen is immediately hooked up upon arrival the X-ray department.**
A. TRUE
B. FALSE

**29. A pulse rate of 60 to 100 is considered normal for an adult**
A. TRUE
B. FALSE

**30. According to standard precautions, soiled linen should be placed in a red plastic bag marked isolation.**
A. TRUE
B. FALSE

**31. Emesis is included in the calculation of fluid I & O**
A. TRUE
B. FALSE

**32. Normal respirations for an adult are 30-45 breath per minute.**
A. TRUE
B. FALSE

**33. A patient on berets for a period of time frequently will be dizzy when first ambulating.**
A. TRUE
B. FALSE

**34. When ambulating a patient with a foley catheter, the drainage bag should always be secured above the level of the bladder.**
A. TRUE
B. FALSE

**35. Alzheimer's patients frequently have difficulty sleeping during the night.**
A. TRUE
B. FALSE

**36. The Hoyer lift is not a safe method to move a patient from bed to a chair.**

A. TRUE
B. FALSE

**37. There are numerous types of restrains, chemical, environmental and physical.**

A. TRUE
B. FALSE

**38. A paraplegic patient can be taught to transfer themselves from the bed to a chair with the aid of a transfer board.**

A. TRUE
B. FALSE

**39. In figuring calculations one ounce is 45cc's**

A. TRUE
B. FALSE

Name: _____

Date: _____

SCORE: _____

# Adio Home Health Services Inc

## PERSONAL CARE ATTENDANT TEST ANSWER SHEET

**Name:** _____ **Date:** _____

1. _____
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36. _____
37. _____
38. _____
39. _____

# Adio Home Health Services Inc

## PERSONAL CARE ATTENDANT TEST ANSWER KEY

| | |
|---|---|
| 1. | D |
| 2. | C |
| 3. | D |
| 4. | A |
| 5. | B |
| 6. | B |
| 7. | A |
| 8. | C |
| 9. | A |
| 10. | B |
| 11. | B |
| 12. | B |
| 13. | B |
| 14. | B |
| 15. | B |
| 16. | A |
| 17. | B |
| 18. | A |
| 19. | A |
| 20. | B |
| 21. | A |
| 22. | B |
| 23. | A |
| 24. | B |
| 25. | B |
| 26. | A |
| 27. | A |
| 28. | B |
| 29 | A |
| 30. | B |
| 31. | A |
| 32. | B |
| 33. | A |
| 34. | B |
| 35. | A |
| 36. | B |
| 37. | A |
| 38. | A |
| 39. | B |

# Adio Home Health Services Inc

## OSHA TEST

### I. BLOOD BORNE PATHOGENS

**1. What is asepsis?**

A. A systemic infection caused by asbestos
B. A no-touch technique for dressing changes
C. Environmental pollution
D. Absence of pathogens

**2. Which of these are guiding prinicples of asepsis?**

A. Keep clean & dirty times separate
B. Use a 1:10 bleach solution to bath your patients
C. Wear gloves for all patient contact
D. Work in the direction of cleaner to dirtier
E. A, C, and D
F. B and C

**3. Which of these statements reflect the principles of Universal Precautions?**

A. You can only get infections from patients with AIDS, Hepatitis B, Staph or Strep infection
B. All used needles can infect you
C. Only bodily fluids which contain blood can infect you
D. All of the above

**4. Which of these practices are dictated by Universal Precautions?**

A. Recap all needles before disposal
B. Wear gloves during a dressing change procedure
C. Wear gowns during all patient contact
D. Wear gloves only when handling bodily fluids of an AIDS patient

**5. When should you wash your hands?**

A. Before eating lunch
B. Before leaving your job to go home
C. After emptying an emesis basis
D. All of the above

**6. Which of these principles will apply to handling wastes & disposables?**

A. Flush feces down the toilet
B. Break the needle off a syringe before disposing of it
C. Double bag all syringes
D. All of the above

**7. Which of these principles will apply to changing linens soiled with blood?**

A. Fan & shake linens to remove dust
B. Throw dirty linens on the floor to avoid contaminating furniture
C. Hold linens away from your uniform
D. All of the above

**8. What are some signs of a wound infection?**

A. Skin that is mottled and cool
B. Diarrhea
C. Generalized body aches
D. Elevated body temperature and pulse
E. C and D
F. All of the above

**9. Which of these principles will apply to changing a dressing?**

A. Wear one pair of gloves to remove the old dressings and put on the new
B. Don't look at the wound or you may experience nausea and vomiting
C. Double bag all soiled dressings
D. All of the above

## II. INFECTION CONTROL IN THE HOME

**1. What is the single most effective method of infection control?**

A. Wearing gloves for all contact with patients
B. Handwashing
C. Double bagging all linens and disposables
D. Using gowns, masks and goggles during care delivery

**2. How can infection be transmitted during care delivery?**

A. Through the nurse's homecare bag
B. Through the patient's linens
C. Through direct contact with the patient
D. All of the above

**3. When should you wear gloves?**

A. To perform incontinent care
B. To prepare the patient's breakfast
C. To perform ROM excercises for the patient
D. To collect a sputum specimen
E. A and D
F. All of the above

**4. It is the policy of this agency that all staff shall utilize proper bag techniques when conducting home visits. Which statement is correct?**

A. Bags are to be cleaned and restocked at a minimum of one time each week
B. Place the disposable paper under the bag
C. Disposable aprons or gowns are to be worn when performing any procedure
D. Disposable paper, paper towels, soap & antiseptic cleansers shall be kept in the outside bag pocket
E. All of the above

## III. SAFETY AND FIRE

**1. Your patient says he fell last night, what do you do?**

A. Since you did not witness this, you do not need to do anything
B. Ask the patient what happened, if injured, did he go to the ER. Then call this information into your supervisor.
C. Fill out an incident report and turn this into your supervisor within 24 hours
D. B and C

**2. Which of these principles apply to proper and safe lifting?**

A. Hold the object at arm's length from the body
B. Use the stringer muscles of the back lift
C. Tighten stomach muscles during the lift
D. Bend the knees and hips
E. A and B
F. C and D

**3. Which of these actions will help prevent fires in the house?**

A. Test smoke detectors yearly
B. Don't smoke in bed
C. Keep potholders on the stove for handling hot pans
D. All of the above

**4. Which of these actions apply to an escape plan in case of fire?**

A. Adapt the plan for the person in the wheelchair
B. Have everyone gather in the hallway for a headcount before leaving the house
C. Do not use the upstairs window exits
D. A and C
E. All of the above

**5. Which of these factors contributes to the safe use of appliances?**

A. Unplug appliances when not in use
B. Use only a quartz portable heater in the bathroom
C. Remove the grounding prongs on the plugs

D. Wear gloves when handling electric appliances

**6. You go to the patient's house, he's cleaning his gun:**
A. You should help the patient clean the gun
B. Ask the patient to put the gun away until you leave
C. If he refuses, leave the home, call the supervisor or on-call personnel
D. Fill out an incident report
E. B, C and D

## IV. RESPIRATOR PROTECTION

**1. Tuberculosis is most commonly found in:**
A. The skin
B. The kidneys
C. The lungs

**2. Usually, tuberculosis infection is screened by first using a:**
A. Chest X-ray
B. Skin Test
C. Sputum smear

**3. The bacteria that cause tuberculosis are transmitted in:**
A. Blood
B. Droplet nuclei
C. Tuberculin

Name: _____

Date: _____

SCORE: _____

# Adio Home Health Services Inc

## OSHA TEST ANSWER KEY

**Name:** _____ **Date:** _____

**I. BLOOD BORNE PATHOGENS**

1.D

2.E

3.D

4.B

5.D

6.A

7.C

8.D

9.A

**II. INFECTION CONTROL IN THE HOME**

1.B

2.C

3.E

4.E

**III. SAFETY AND FIRE**

1.B

2.F

3.B

4.D

5.A

6.E

**IV. RESPIRATOR PROTECTION**

1.C

2.B

3.B

# Adio Home Health Services Inc

## OSHA TEST ANSWER SHEET

**Name:** _____ **Date:** _____

**I. BLOOD BORNE PATHOGENS**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

**II. INFECTION CONTROL IN THE HOME**

1. _____
2. _____
3. _____
4. _____

**III. SAFETY AND FIRE**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**IV. RESPIRATOR PROTECTION**

1. _____
2. _____

**IV. RESPIRATOR PROTECTION**

1. _____
2. _____
3. _____

3. _____

# Adio Home Health Services Inc

## BLOOD BORNE PATHOGENS QUIZ

| TRUE | FALSE | Circle the correct answer. |
|---|---|---|
| **T** | **F** | 1. Hepatits B virus is easily cured. |
| **T** | **F** | 2. HIV and HBV may be present in body fluids other than blood. |
| **T** | **F** | 3. Broken glass & the exposed ends of dental wires are considered sharps. |
| **T** | **F** | 4. Facial acne is a potential route of entry into the body for blood borne pathogens. |
| **T** | **F** | 5. Contaminated environmental surfaces are a major mode of HIV spread in certain settings, particulary hemodialysis units. |
| **T** | **F** | 6. To consult a copy of your employer's Exposure Control Plan, check at your local library. |
| **T** | **F** | 7. Universal Precautions means treating the blood & body fluids of anyone aged 18-65 as if they were known to be infected with HIV, HBV, or other blood borne pathogens. |
| **T** | **F** | 8. No single approach to controlling the spread of blood borne infections is 100% effective. |
| **T** | **F** | 9. When recapping needles is allowed, it is important to use both hands. |
| **T** | **F** | 10. Every time you remove your gloves, you must wash your hands with soap & running water as soon as you possibly can. |
| **T** | **F** | 11. Once blood goes on your hands, it's too late to take any preventive measures. |
| **T** | **F** | 12. It's okay to store food next to blood if the food is in a bag. |
| **T** | **F** | 13. The type of protective equipment appropriate for a given task depends on the degree of exposure you can anticipate. |
| **T** | **F** | 14. You don't have to wear any gloves if you are allergic to latex or nylon. |
| **T** | **F** | 15. You don't have to wear personal protective equipment if it is annoying or uncomfortable. |
| **T** | **F** | 16. If utility gloves are damaged, you should patch any holes before reusing. |
| **T** | **F** | 17. Hepatitis B vaccines used in the U.S. cannot transmit blood borne diseases. |
| **T** | **F** | 18. Good housekeeping is the sole responsibility or environmental staff services. |
| **T** | **F** | 19. Contaminated laundry should be rinsed & placed in appropriate bags or containers where it is used. |
| **T** | **F** | 20. If you are exposed you should report the incident to your supervisor immediately. |

Name: _____

Date: _____ SCORE: _____

PTHC0709

# Adio Home Health Services Inc

## BLOOD BORNE PATHOGENS QUIZ ANSWER KEY

1. F
2. T
3. T
4. T
5. F
6. F
7. F
8. T
9. F
10. T
11. F
12. F
13. T
14. F
15. F
16. F
17. F
18. F
19. F
20. T

# Adio Home Health Services Inc

## BLOOD BORNE PATHOGENS QUIZ ANSWER SHEET

**Name:** _____ **Date:** _____

1. _____
2. _____
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19. _____
20. _____

# Adio Home Health Services Inc

## COUNSELING FORM

Employee Name: _____ Date: _____

[ ] Verbal Warning [ ] Written Counseling [ ] Termination

Identified Area Needing Improvement and/or Incident/Problem Area (include dates):

People Involved:

Employee Input:

Recommended Plan for Improvement/Disciplinary Action:

Date Improvement Expected: _____

Other: _____

[ ] Undesirable behavior may lead to termination of employment from the Agency.

_____ _____

Supervisor Signature Date

_____ _____

Employee Signature Date

PTHC0709

# Adio Home Health Services Inc

## PAS IN-SERVICE RECORD

YEAR: _____ DATE OF HIRE: _____

EMPLOYEE NAME: _____ TITLE: _____

| **IN-SERVICE TITLE** ***Mandatory:*** | **JAN** | **FEB** | **MAR** | **APR** | **MAY** | **JUN** | **JUL** | **AUG** | **SEP** | **OCT** | **NOV** | **DEC** | **TOTAL HOURS** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk Management | | | | | | | | | | | | | |
| Infection Control Program | | | | | | | | | | | | | |
| Standard Precaution | | | | | | | | | | | | | |
| TB/Airborne Pathogen Program | | | | | | | | | | | | | |
| Body Mechanics | | | | | | | | | | | | | |
| Advance Directives | | | | | | | | | | | | | |
| Safety in the Home Care Environment | | | | | | | | | | | | | |
| Chemicals in the Workplace | | | | | | | | | | | | | |
| Confidentially/HIPAA | | | | | | | | | | | | | |
| Bill of Rights/Rights of the Elderly | | | | | | | | | | | | | |
| Abuse, Neglect, and Exploitation | | | | | | | | | | | | | |
| Hand Washing Technique | | | | | | | | | | | | | |
| Emergency Preparedness | | | | | | | | | | | | | |
| Communication Skills | | | | | | | | | | | | | |
| **OTHERS:** | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | |
| **TOTAL HOURS** | | | | | | | | | | | | | **TOTAL FOR THE YEAR** |

PTHC0816
ALF

# Adio Home Health Services Inc

## AUTHORIZATION FOR MAILING PAYCHECKS

I, _____ *(please print name).*
authorize Adio Home Health Services Inc to mail my paycheck to the address currently in the payroll files.

I will not hold Adio Home Health Services Inc responsible if my paycheck gets lost in the mail. I understand there is a $25 charge that I will need to pay to place a stop payment if the check is lost. Once stop payment is verified, another check will be re-issued.

Please check one of the following options:

| | |
|---|---|
| ❑ | Please mail my paycheck **EVERY PAY DAY**. |
| ❑ | Please mail my paycheck **ONLY** when I call and ask for it to be mailed. Otherwise, I will come by the office and pick it up. |

Signature: _____

Date: _____

Witness: _____

# Adio Home Health Services Inc

## DAY OFF REQUEST FORM

Today's Date: _____ Employee No: _____

Employee Name: _____

**Circle One:**

VACATION PERSONAL OFF without PAY PAID DAY OFF

Date(s) & Day(s) Requested:

_____

_____

_____

Reason: _____

_____

_____

**FOR OFFICE USE ONLY**

**APPROVED** **DENIED** **PENDING**

Date(s) Approved for: _____

Reason for Denial: _____

_____ _____

Supervisor's Signature Date

***Approval based on availability of patient coverage, dates requested and seniority.***

# Adio Home Health Services Inc

## ELECTRONIC VISIT VERIFICATION (EVV) DISCLOSURE STATEMENT

I, _____ understand that Adio Home Health Services Inc and their employees must use Electronic Visit Verification (EVV) effective as of June 1, 2015 to comply with the Department of Aging and Disability Services requirements for documentation of information.

I understand that EVV is a telephone and computer-based system that electronically verifies that service visits occur and documents the precise time service provision begins and ends.

I, _____ have been orientated and instructed on the following: (Please initial below):

_____EVV replaces paper timesheets.

_____All hours worked must be documented in EVV or I will not be paid.

_____All hours worked must be authorized by Adio Home Health Services Inc

_____Adio Home Health Services Inc will extract information from the EVV system to calculate my total time worked for the pay period to calculate payroll.

_____EVV documentation must be entered when work time begins and entered when work time ends every visit.

_____If the EVV device is malfunctioning or the consumer's telephone is inoperable, Adio Home Health Services Inc must be notified immediately in order to be paid.

_____If hours worked are not inputted into the EVV system, I understand I will not be paid.

_____The EVV token in the patients home must be entered at the time of clock in and clock out. In the event that you cannot enter the code, I will notify the agency immediately or I will not be paid.

_____ _____

Employee's Name Date

_____ _____

Employee's Signature Date

# Adio Home Health Services Inc

## DAILY VISIT RECORD

**Employee Name:** _____ **Week Of:** _____

| DATE | PATIENT NAME | TIME IN/OUT | VISIT TYPE | PATIENT SIGNATURE |
|---|---|---|---|---|
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I certify that the information on this form contains no willful misrepresentation and that the information is true and complete to the best of my knowledge.

_____ _____

Employee Signature Date

# Adio Home Health Services Inc

## CONFIDENTIALITY OF ELECTRONIC INFORMATION

I, _____ plan to utilize electronic documentation of patient care.

I will ensure confidentiality and security of patient information by password protecting the device or program utilized.

I agree to change the password at least quarterly or following a breach of security.

I will not provide my password to anyone.

Encryption passwords and similar devices are not allowed unless authorized by Adio Home Health Services Inc The employee is responsible for keeping his/her unique identifier confidential. The employee should not use another employees unique identifier under any circumstances. This will be looked at as a breach of confidentiality and the employee could be dismissed.

I have been informed of the Agency's Confidentiality Policy and Safe guarding of Medical Records Policy and I agree to abide by these policies.

| | |
|---|---|
| Employee's Name | Date |
| Employee's Signature | Date |

# Adio Home Health Services Inc

## HOME HEALTH AIDE COMPETENCY SKILLS EVALUATION

**MUST BE COMPLETED BY AN RN WHO OBSERVES THE FOLLOWING TASKS PERFORMED ON A PATIENT BY THE HOME HEALTH AIDE**

| TASK | DATE | SATSIFACTORY | UNSATISFACTORY | SIGNATURE |
|---|---|---|---|---|
| I. Temperature, Pulse & Respiration (overall rating) | | | | |
| A. temperature (only 1 type required)<br>Oral<br>Rectal<br>Axillary | | | | |
| B. Pulse (only 1 type required)<br>Radial<br>Apical<br>Other: | | | | |
| II. Bed Bath<br>Comments: | | | | |
| III. Partial Bath (only 1 type required)<br>A. Sponge<br>B. Tub<br>C. Shower<br>Comments: | | | | |
| IV. Shampoo (only 1 type required)<br>A. Sink<br>B. Tub<br>C. Bed<br>Comments: | | | | |
| V. Nail & Skin Care<br>Comments: | | | | |
| VI. Oral Hygiene<br>Comments: | | | | |
| VII. Toileting & Elimination<br>Comments: | | | | |
| VIII. Safe Transfer Techniques and Ambulation<br>Comments: | | | | |
| IX. Range of Motion & Positioning<br>Comments: | | | | |
| X. Universal Precautions<br>Bad Technique<br>Guideline<br>Comments: | | | | |

| TASK | DATE | SATSIFACTORY | UNSATISFACTORY | SIGNATURE |
|---|---|---|---|---|
| Demonstrate Blood Pressure IAW C.C. Policy | | | | |
| Other Optional Skills per agency's policy-unsuccessful completion of these tasks do not affect certification. The Home Health Aide should not be assigned these optional tasks until successful completion of the task has occurred. | | | | |
| XI. Nutrition/Hydration<br>A. Food:<br><br>B. Fluids:<br><br>C. Other: | | | | |

_____ out of the ten (10) required tasks have been successfully completed.

Final Score

_____ _____

Signature of Registered Nurse Date