VigorCare
pediatric services

Annual Competency & Compliance Training

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HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was a sweeping set of health care reforms, HIPAA was signed into law during the Clinton administration on August 21, 1996, HIPAA provides legislation to protect Team Members who leave their jobs from losing their ability to be covered by health insurance (portability). The Act also protects the integrity, security and privacy of individually identifiable health care information (accountability). This training focuses on the privacy and security of individually identifiable health care information.

Overview
Remember HIPAA has two distinct sections:
The **portability** portion of HIPAA allows a person to keep his/her health insurance when he/she loses or leaves a job,

The **accountability** portion deals with transaction and code sets, security and privacy.
The accountability portion of HIPAA encompasses four main areas:

- Transaction standards and code sets
- Unique identifiers
- Privacy Regulation
- Security Regulation

Glossary:
PHI Protected Health Information in electronic format, paper and/or verbal
EPHI Electronic Protected Health Information
HHS Department of Health and Human Services
HIPAA Health Insurance Portability & Accountability Act
OCR Office of Civil Rights
CMS Centers for Medicare and Medicaid Services

The Privacy Regulation in brief:

- Limits the non-consensual use and release of PHI
- Gives patients new rights to access their medical records and know who else has accessed them
  Restricts disclosure of PHI to the minimum needed
- Establishes criminal and civil penalties for improper use or disclosure
- Establishes new requirements for access to records by researchers and others

What information is protected?

Individually identifiable Health Information (IIHI): Any health information, including demographic information, collected from an individual that:

- Is created or received by a health care provider, health plan, employer, or clearinghouse; AND
- Relates to an individual's;
- Past , present; or future physical/mental health or condition, or
- Receipt of health car, or
- Past, present, or future payment For care (or services); AND
- Identifies the individual or can reasonably be expected to identify him or her.

PHI (Protected Health Information)= **Individually Identifiable Health Information that is:**

- Transmitted by electronic media, or
- Maintained in any electronic medium, or
- Transmitted or maintained in any other form or medium,

Important Note: Not all health information is PHI. It must also be individually identifiable. This means that someone seeing or hearing the health information could potentially identify the person, a reasonable basis for determining a person's identity means that, without taking any extraordinary measures, someone could link health information to a specific person.

Six basic rules for identifying PHI

1. PHI can be written or oral
2. PHI can be recorded on paper
3. Information that reveals the state of a person's health can be PHI

The Privacy Regulation allows for incidental Uses or Disclosures of PHI that occur as a by-product of another permissible or required use or disclosure, as long as the Covered Entity has applied reasonable safeguards and has implemented the Minimum Necessary Standard, with respect to the use or disclosure.

Reasonable Safeguards

Reasonable safeguards are appropriate administrative, technical, and physical safeguards that guarantee the privacy of PHI from ay and all potential risks. Incidental uses or disclosures of PHI that result from or are a by-product of a permitted use or disclosure are allowed.

Examples of reasonable safeguards are:

- Speaking quietly when discussing a patient's condition.
- Avoiding the use o patients' names in public hallways and elevators and reminding coworkers of our obligation.

- Locking file cabinets that contain PHI or medical records room
- Never sharing passwords

Examples of Incidental Uses or Disclosures of PHI are:

- Disclosures about a patient that might be overheard by personnel not involved in the patient's care
- White boards in direct view of the public
- Speaking loudly when discussing a client whether on the phone or in person

Remember, when VigorCare Pediatric Services accesses, utilizes, or discloses PHI, it should only be the amount of information necessary to get the job done.

Can a Covered Entity Use or Share PHI?

HIPAA is intended to improve Healthcare as well as more closely protect the privacy of individuals' PHI. It is not intended to remove the ability of Healthcare providers to conduct business. Certain uses and disclosures of PHI in the course of doing business such as treatment, payment, and operations (TPO) are allowed without authorization from the individual,

Treatment: Treatment means the listed activities undertaken by any health care provider, not just a covered health care provider, Consultation between health care providers relating to a patient and the referral of a patient for health dare are considered to be treatment. A health plan can disclose PHI to any health care provider to assist the provider's treatment activities and a health care provider may use PHI about an individual to treat another individual (e.g., a provider may use PHI from former patients as well as current patients).

Treatment refers to activities undertaken on behalf of a single patient, not a population. Activities are considered treatment only if delivered by a health care provider or a health care provider working with

- The right to see and get copies of his/her PHI;
- The right to get a list of the PHI disclosures that have been made;
- The right to correct or update his/her PHI; and
- The right to receive a paper copy of the Notice of Privacy Practices (NOP) or request and receive one electronically
- Each individual has the right to receive adequate notice of how VigorCare Pediatric Services, as a Covered Entity, uses and discloses PHI and notification of the individual's rights with respect to that information. This notification is called the Notice of Privacy Practices (NOP).

Notice of Privacy refers to the right for individuals to receive adequate notice of how Covered Entities use and disclose their protected health information, and of the individual's rights with respect to that information.

VigorCare Pediatric Services obligations related to NOP's:

- Make the NOP available and post it at the physical delivery site.
- Distribute the NOP on the date of first service delivery following April 14, 2003.

- Provide the NOP to any person upon request, even non-patients.
- Make a good faith effort to obtain a written acknowledgment of the patient's receipt of: the NOP.
- Make the NOP available after revisions.
- Making available and distributing the NOP by e-mail is permitted.
- The NOP must be pasted on VigorCare Pediatric Services Internet Website
- The use or disclosure of PHI inconsistent with the NOP is not permitted.
- The NOP and all written acknowledgments from the patient or documentation establishing
- VigorCare Pediatric Services good faith efforts to obtain such acknowledgment) in paper or electronic form should be retained for 6 years from the date issued.

Do's and Don'ts:

VigorCare Pediatric Services first line of defense is the front-line team member who interacts with the patient, creates, accesses and files his/her information, and passes it along to others in the delivery chain. VigorCare Pediatric Services must create a health care delivery environment that is conscientious, diligent and thorough in its protectiveness of privacy rights, security of data, and confidentially of health care information.

- Patient information should not be discussed where others can overhear, such as in hallways, elevators, at home or social events
- Be aware of your surroundings when discussing PHI, even at your desk
- Confidential papers, reports, and computer printouts should be kept in a secure place
- Confidential papers must be appropriately disposed of (e.g. torn or shredded)

Occupational Hazards

Occupational hazards in the workplace vary based on your work setting. Having an awareness of the hazards in your work setting prepares you to manage these hazards effectively. Caring for patients in the home involves challenges that are not present in hospital or other inpatient settings.

Slips, Trip, and Falls

Accidents resulting from slips, trips, and falls are a real possibility in any work environment. You need to be aware of and eliminate the conditions that can cause slips, trips, and falls.

Common hazards include:

- Cords/cables under desks and across walkways
- Crumpled, wrinkled, or uneven rugs
- Torn or frayed carpet
- Items stored in walkways
- Spills and wet surfaces
- Transitions from one type of flooring to another, such as tile to carpet
- Using chairs or desks as a stepladder to reach objects stored on high shelves

Strategies to eliminate hazards:

- Report unsafe conditions immediately
- Never stand on a chair, table, or desk. Use appropriate ladder or step stool
- Make sure all cords are tied securely out of the way and never allow a cord to run across a walkway
- Straighten crumpled rugs
- Report frayed carpet so that it can be repaired
- Clean up spills immediately and post wet floor signs di' barriers until the site is dry
- Be aware of your surroundings and pay attention when you are walking

Hazard awareness and appropriate safety behaviors are critical to preventing slips, trips, and falls in the workplace. Evaluate your work area and correct any hazards present. Do your best to correct any unsafe habits you might have, such as standing on chairs or texting while walking

Utility Failure

If you experience a power outage in the office, take the following steps:

- Report the outage to the building management company
- Evacuate, if necessary, following fire evacuation procedures
- Use the stairs

Animals

Many home health workers voice concern about being bitten or otherwise injured by animals in the client's home. Homecare providers routinely require reasonable restraint of animals as a condition of providing care.

Recommendations for workers:

- Wait outside until the pet is restrained
- If you see fleas or other pests, discuss appropriate control measures and contact your supervisor
- If the client or family is not receptive to pest control measures and you feel your client is not safe, notify your supervisor

Home Temperature

The home healthcare worker may discover temperature extremes in client homes. Recommendations for workers:

- Dress in layers
- Stay hydrated
- Contract your supervisor or director to refer to family to the appropriate social service agency

Hygiene

Hygiene is the most frequently voiced concern among home healthcare workers. Unsanitary homes may harbor pests including rodents, lice, bedbugs, scabies, or termites. These unsanitary conditions can cause contamination of medical supplies and equipment, as well as spread disease and infection. They present a significant risk to the home healthcare worker and patient.
Recommendations for workers:

- Place equipment and supplies on clean pads with plastic on one side
- Take only necessary items in the home
- Avoid setting purses and bags on a carpeted floor
- Practice hand hygiene regularly

Lack of Water

No running water or water that is of poor quality is another hazard home healthcare workers may come across. Some homes may use bottled water for drinking and have access to cisterns for flushing and bathing.

Recommendations for workers:

- Use hand sanitizer and limit the use of the toilet
- Make a referral to local social service agency, if appropriate

Severe Weather

Home healthcare workers can be exposed to extreme weather conditions at any time. Severe weather can come without warning. The home healthcare worker can find themselves in a position of seeking safety for themselves and their patient. In instances where severe weather is predicted, such as hurricanes or blizzards, the healthcare worker should make all attempts to assure that the patient's care is turned over to the primary caregiver. In instances where the weather is not predictable, the healthcare worker follows safety strategies as available to both him and the patient. Recommendations for workers are provided by the Federal Emergency Management Agency (FEMA). The healthcare worker should perform these recommended steps while assuring the safety of their patient:

Tornado

- If the area is under a tornado warning, seek shelter immediately
- Go to a designated shelter area, safe room, basement, storm cellar, or the lowest building level
- If there is no basement, go to the interior room away from windows, doors, and outside waifs
- Put as many walls between you and outside as possible
- Do not open windows
- If you are in a mobile home, leave and go to a shelter area if it is safe to do so.

Hurricanes

- Turn the care of the client over to the primary caregiver
- Follow local evacuation orders
- If you are in a mobile home, leave and go to a shelter area if it is safe to do so

Earthquakes

- Be aware that some earthquakes are actually foreshocks and a larger earthquake might still occur
- If you and your patient are indoors
- Drop to the ground

- Take cover by getting under a sturdy table or other piece of furniture
- Wait until the shaking stops
- Stay away from windows, walls, and anything that could fall, such as light fixtures or furniture
- If you are outdoors
- Stay there
- Move away from buildings, streetlights, and utility wires
- If you are in a moving vehicle:
- Stop as quickly as safety permits and stay in the vehicle. Avoid stopping near or under buildings, trees, overpasses, and utility wires.
- Proceed cautiously once the earthquake has stopped. Avoid roads, bridges, or ramps that might have been damaged or destroyed by earthquake

Blizzard or Ice storm

- Drive only if necessary. If you must drive, do the following:
- Travel during daylight hours
- Keep others informed of your location
- Stay on main roads
- Use snow tires or chains when appropriate
- If a blizzard or ice storm traps you in the car, do the following:
- Turn on hazard lights and hang a distress flag from the radio antenna or window
- Remain in your vehicle where rescuers are most likely to find you
- Do not set out on foot unless you can see a building close by

Chemical Spills and Acts of Terrorism

Home healthcare workers may find themselves in a neighborhood that has been affected by a chemical spill or an act of terrorism. The following protective measures are recommended by FEMA in the event of a chemical or hazardous material emergency or acts of terrorism.
While assuring the safety of the patient, you should:

- Evacuate the area immediately if asked
- Stay tuned to a radio or television for information
- Follow the routes recommended by the authorities – shortcuts may not be safe
- If you are told to seek shelter and you are in a vehicle, stop and seek shelter in a building
- If you must remain in your car, keep car windows and vents closed
- If you are requested to remain indoors, do the following:
- Close and lock all exterior doors and windows
- Close vents, fireplace dampers, and as many interior doors as possible
- Turn off air conditioners and ventilation systems
- Stay in a room that is above ground and has the fewest openings to the outside

- Seal gaps under doorways and windows with wet towels or plastic sheeting and duct tape

For a chemical spill in the home:

- Refer to the manufacturer's label on the product for handling and cleaning information
- Contact local poison control services in the event of an accidental ingestion, inhalation, or spill onto your skin, eyes, or mucous membranes
- For a chemical spill in the clinic:
- Material Safety Data Sheets (MSDS) are in a binder at each facility in the kitchen area
- Each notebook contains first aid information on all hazardous chemicals with in the facility, from cleaning solutions to markers and whiteout, in the event of an emergency

Bomb Threat

Any person receiving a telephone call or other notification of a bomb or explosive alleged to be in the area shall take the following actions:

- Be calm
- Be courteous
- Listen to the caller
- Do not interrupt the caller
- Call 911
- Notify the administrator
- Be prepared to evacuate

Violence in the workplace

Workplace violence has become a more common problem in today's society. It is defined as any threat or act of physical violence, harassment, intimidation, or other threating disruptive behavior that occurs at the worksite, and can involve employees, clients, or visitors, it ranges from threats and verbal abuse to physical assaults.

VigorCare has a zero-tolerance policy for all incidents of violence. VigorCare will investigate all reports violence and provide follow-up information to those involved. In order to do this, each employee must report all incidents of violence or threats of violence.

- The identity of the individual making a report will be protected as much as possible
- VigorCare will not retaliate against employees making good-faith reports of violence, threats, or suspicious individuals or activities
- VigorCare may suspend employees suspected of workplace violence or threats of violence, either with or without pay, pending investigation, in order to maintain workplace safety
- Anyone found to be responsible for threats of, or actual violence or other conduct that is in violation of these guidelines will be subject to prompt disciplinary action, up to and including termination of employment
- VigorCare encourages employees to bring their disputes to the attention of their supervisors or the Human Resources department before the situation escalates

While not all threats and violence are preventable, you may be able to help prevent situations from escalating into violence by doing the following:

- Present a calm, non-threating demeanor
- Do not match threats
- Avoid behaviors that can be interpreted as aggressive, such as moving rapidly or getting too close, touching unnecessarily, or speaking loudly
- Walk away if you feel threatened
- Notify your supervisor immediately
- Contact 911 if you feel that your safety is as risk

Fire Safety

No one wants to be involved in a fire, whether at home or at work. If one should occur, be prepared by having the necessary information to exit the building safely and help prevent injury to others. It is important to become familiar with your building's fire and life safety systems.

- Know which of the following your building has, as well as their location
- Manual pull alarms, smoke detectors, or voice alarm
- Sprinklers
- Fire extinguishers and how to use them
- Exit doors and stairwells
- Fire doors
- Know where your building's escape plan is posted
- Determine a designated safe meeting place once outside
- Treat every fire alarm and fire drill as though it is a real emergency

Preventing Fires

Preventing fires is everyone's job. We all need to be alert to do anything that could cause a fire and take responsibility to report any problems so that they can be corrected. Fire safety should always be a concern.

- Keep your work area free of waste paper, trash and other items that can easily catch fire. Clutter contributes to fires y providing fuel and blocking emergency exits
- Check electrical cords. If you find a damaged cord, contact the appropriate service to have it replaced
- Keep heat-producing equipment away from anything that might catch on fire. This includes copiers, coffee makers, and computers.
- Perform preventative maintenance on machinery to prevent overheating
- Maintain free access to all electrical control panels
- Report electrical hazards
- Obey smoking rules and no smoking signs
- Extinguish cigarettes and matches completely and only in designated containers
- Never block sprinklers, firefighting equipment, or emergency exits. Observe clearance requirements when stacking materials
- Know how to use a fire extinguisher

What to do in Case of a Fire

Race when you encounter a fire:

- R = Rescue – Rescue anyone in immediate danger from the fire if it is safe for you to do so. If not, exit the building as quickly as possible and let fire fighters know there is someone that needs help.
- A = Alarm-Activate the nearest fire alarm pull stations. Call 911 and/or tell someone else to call. Do not hang up from the emergency responder until told to do so
- C = Contain-Close all doors and windows that you can safely reach to contain the fire. During evacuation, close the doors behind you
- E = Extinguish – Only attempt to extinguish the fire if it is safe for you to do so. Retrieve the nearest fire extinguisher and follow the "PASS" procedure:
    - P-Pull the pin breaking the plastic seal
    - A-Aim at the base of the fire
    - S-Squeeze the handles together and
    - S-Sweet from side to side

If you are unable to leave the building create an area of refuge:

- Seal the room – use wet cloths to stuff around cracks in doors and seal up vents to protect against smoke
- Stay low under the smoke – The freshest air is near the floor. Keep a wet cloth over your nose and mouth
- Signal for help – Use the telephone or hang something in the window

Musculoskeletal Disorders and Back Safety

The goal of safe lifting is to maintain your back's natural posture during the lift. Your back forms three natural curves, one in the neck one in the middle of your back, and one in the lower back. Maintaining these curves in your posture while lifting minimizes pressure on your discs and give you maximum lifting strength.

- Back injuries are the most common and costly injuries suffered in the workplace
- An estimated 80% of Americans will suffer a back injury at some time in their life
- Low back pain most commonly occurs in individuals ages 30 to 50 years old
- You are the most likely to suffer an injury to your back in the morning hours

Causes of back injury

- Improper lifting
- Poor posture
- Prolonged or sustained postures
- Rapid or sudden movements
- Repetitive motion
- Overuse of certain muscles and joints
- Stress and fatigue
- Trauma
- Poor general health
- Lack of physical fitness

Pre-disposing factors

- Poor sitting posture causes overstretching of tissues, making them weak and prone to injury
- Loss of extension – 80% of patients presenting with low back pain have a moderate loss of extension, which leads to faulty sitting, standing, and walking postures and increases intra-disc pressure
- Frequency of flexion – Most people spend the majority of their day in flexed postures sitting or bending forward and rarely extend their spine.

Muscle Injury

Improper positioning during a lift can put a great deal of stress on the lower back muscles. Too mucyh stress can cause small tears in the muscle, commonly known as muscle strain. Muscle strain is the most common form of back injury

Disc Injury

The inter-vertebral discs act like ball bearings and cushions between the bones in the spine. The discs are comprised of fibrous rings, which can bulge, break open, or rupture when the disc is injured. A disc injury in the lower back can cause pain to radiate down into the buttocks and legs.

Joint Injury

There are many joints where bones meet bones in the back. Normally, these joints are quite capable of enduring the stress of lifting. Improper lifting techniques can irritate these joints and may cause them to become "locked"

Body Mechanics and Posture

To sit properly, you should let yourself fully slouch, then over correct and release the strain. The focus is on moving your loser back form a convex curve to a concave curve. To get in the habit of good sitting posture, you should slouch and correct 10 times, three times a day, until you naturally assume good posture. Proper body mechanics involves maintaining the three natural curves present in the spine while lifting. To accomplish this, you should always straddle the load you are lifting. Keep your head up, trunk and arms straight, and bend at the knees while lifting or lowering the load. The load should always be kept against the body at all times during a transfer.

- Proper body mechanics and posture apply to all activities
- When lifting, you are lifting both the load and your own body weight
- Poor body mechanics during a lift will increase the potential damage to your joints
- Maintaining a neutral posture is vital to reducing fatigue
- Proper posture results in greater strength and endurance

Stretching

Prior to any physical activity, you should always stretch. A healthy back will both fully flex and extend without limitations of movement. Routine exercise will strengthen your body and can help reduce the risk of injury,

- Keep your muscles warmed up and ready for movement
- Increases circulation and endurance
- Increases energy level
- Increases body strength
- Be sure to perform stretches slowly

Preventing back injuries

- Avoid long periods of sustained posture
- Perform standing back bends after prolonged periods of sitting greater than 1 hour or prior to lifting
- Perform flexion exercises after prolonged periods of standing or working overhead
- Test the weight of the object prior to moving it by lifting a corner of the object If it is too heavy, stop and get help.
- Always utilize good sitting posture
- Lunge or squat to retrieve objects from the floor
- Maintain a healthy lifestyle

Safe Lifting Techniques

- Check the path of travel or destination of the load to make sure it is clear
- If an item is too heavy or awkward to carry alone, request assistance from a co-worker
- Push heavy objects instead of pulling them
- Bend at the knees or hips, not at the waist
- Bring the load as close to your body as possible and no more than waist high
- Keep your head and shoulders up as you begin the lifting motion
- Lift with your legs and stand up slowly, moving in a smooth, even motion
- Avoid twisting your back
- Never try to adjust your hold on the object while carry it. If the load is slipping, put it down and get a better grip
- Use the strength of your legs to lift the load

Lowering the Load

- Put the load down as carefully as you picked it up
- Squat straight down using only your let muscles
- Lower the load slowly, bending your knees
- Place the load on the edge of the surface and slide it back

Patient Transfers

- Make sure the patient's feet are flat on the floor
- Squat so that you are eye level with the patient and squeeze the patient's knees slightly between your legs
- Bend the patient from the waist towards you and have them push up, if possible
- Using a gait belt, lift, pivot, and lower the patient to the desired location

Latex Sensitivity

Most people who are sensitive to latex are not born with the sensitivity. They develop it after repeated exposures to products that contain latex. Although many products may expose workers in different professions, workers in the healthcare industry are at increased risk due to their repeated exposure.

The FDA requires that all natural rubber products that come in contact with humans be labeled for natural rubber latex content and that they may cause allergic reactions, The American Latex Allergy Association maintains lists of latex-free medical, dental, and consumer products that may be considered for substitution.

Three types of reactions can occur when using latex:

- Irritant Contact Dermatitis – The most common reaction to latex. Symptoms include dry, itchy, irritated skin-most often on the hands
- Allergic Contact Dermatitis – This latex reaction looks like a rash from poison ivy and usually shows up to 24-96 hours after contact
- Severe Latex Allergy – Usually happens within minutes of exposure, but symptoms can also show up a few hours later. Can start with mild symptoms such as redness and itching, it will progress to symptoms that are more serious and life-threating, sneezing, shortness of breath, hives, drop in blood pressure, loss of consciousness and can lead to shock. Life-threatening reactions are seldom the first sign of sensitivity

Reducing latex exposure:

- Ask for reduced-protein, powder-free gloves
- Avoid oil-based creams or lotions when using latex gloves. They may cause the gloves to break down.
- Use non-latex gloves for activities that are likely not to involve contact with infectious materials
- Wash hands with a mild soap and dry hands completely after using gloves

Infection Control and Standard Precautions

One of the most prevalent workplace hazards for health care workers is exposure to infections. You can avoid getting an infection, as well as passing one along to others, if you know how they are spread. The steps we taketo prevent the spread of infection are called infection prevention and control measures. Certain things must happen in order for infections to spread from one person to another. You can prevent germs from spreading if you stop any one of the links in the chain of infection from happening.

Chain of Infection

Certain elements must be present for an organism to cause illness and be passed on to others. These things are listed in the order that they have to occur:

- Germ – It all starts with one little organism
- Reservoir – The germ needs a place to grow and multiply
- Mode of transmission – The germs need a way to get from one place to another. There are six different modes of transmission:
    1. Direct contact – Germs are transferred from one person to another by directly touching each other
    2. Indirect contact – Germs are placed on a surface such as a handle or equipment and then picked up by the next person who touches the surface
    3. Droplet – Germs are spread through the air when someone sneezes, coughs, or suctions a patient
    4. Airborne – Germs are spread through the air in much smaller particles that can travel much further distances than droplets. These germs can spread through ventilation systems
    5. Vehicle – One contaminated source causes an outbreak, such as incidents of food poisoning on cruise ships or restaurants caused by contaminated foods
    6. Vector-borne – Germs are spread by insects or animals, such as mosquitoes or bats
- Mode of Entry – The germ has to get inside of your body. They can get in through open cuts and sores, your nose, mouth, eyes, or any mucous membrane.
- Susceptible host – The germ has to be able to make you sick

Organism Growth

Just like any other living thing, germs need certain things to be able to grow and multiply:

- Food – Germs need food, which can come from bodily secretions and be located anywhere if an individual has not washed their hands after contact
- Moisture – Germs love moist places. They can be found in standing pools of water, moise areas of the body, or damp clothing or linen
- Temperature – Most germs can survive in temperatures between 40 and 100 degrees Fahrenheit. It takes extreme temperatures to kill germs

- Darkness – Most germs like the dark. Sunlight often reduces or kills germs

In order to prevent or control the spread of infection, special procedures must be followed in the workplace, regardless of the type of infection. These special procedures are referred to as Standard Precautions. Standard precautions are a set of safety measures designed to prevent the spread of infections. You should assume that every person you care for is infected with an organism that you could catch and spread to others. You must apply these precautions to all patients, regardless of wy you are caring for them.

Standard precautions include:

- Hand washing (hand hygiene)
- Personal protective Equipment (PPE) – Gowns, gloves, masks, eye wear, and face shields

When to apply Standard Precautions

- Standard precautions are to be used when there is any opportunity of being exposed to any germ that can cause an infection. The precautions should be used when handling any bodily fluids such as blood, urine, stools, saliva, sputum, vaginal secretions, and mucous.

Hand washing

- Hand washing is the single most effective way to prevent the spread of infection. Hand washing and hygiene are general terms that simply refer to washing your hands with soap and water or using an alcohol-based hand rub.
- Hand Washing Technique
- Rinse hands using generous amounts of running water
- Apply nickel-sized amount of hand rub/soap to the palm of hand
- Vigorously rub hands together, scrubbing between fingers and up to wrists for 30 seconds
- Rinse hands thoroughly using generous amounts of running water
- Wipe hands dry using a clean towel – Do NOT blow or wave hands dry
- Since hand washing is the most important thing you can do to reduce the risk of infection, you need to know when to wash your hands. Most people know that they should wash their hands when they are visibly dirty. There are other times when it is important that you wash your hands:
- At the beginning of your shift
- At the end of your shift
- Before and after caring for the patient
- After assisting the patient in the bathroom, handling a urinal or bedpan, and after changing diapers
- Between tasks
- Before putting on gloves and after taking the gloves off
- After removing trash

- After your own personal care such as eating, using the restroom, or blowing your nose

Alcohol-based Hand Rubs

VigorCare allows the use of alcohol-based hand rub to clan hands when providing patient care. The recommended way to apply the product is to pour the directed amount into the palm of one hand and rub your hands together, covering all surfaces of hands and fingers, including around and under the nails. Rub for 30 seconds or until hands are dry.

- Alcohol-based hand rubs will not remove dirt
- Should not be used prior to handling medical gas cylinders because of the risk of ignition
- Is NOT effective against C-difficile and Norovirus. When caring for patients with either of these organisms, hands must be washed with soap and water
- Must be left to dry naturally on the skin
- Wash hands with soap and water after several consecutive applications of hand rub

Additional Hand Hygiene Guidelines

- Gloves do not replace the need for hand washing or alcohol gel use
- Artificial nails, nail polish, and nail extenders have been associated with infections. Do not wear them when providing any patient care
- Rings and wrist jewelry can harbor and transmit germs. They should not be work when you are providing patient care
- Proper hand washing technique should be taught to patient and home caregivers

Transmission Based Isolation Precautions

Transmission-based isolation precautions are designed to prevent the spread of an organism based on the way the germ spreads. They must always be used in conjunction with standard precautions. Isolation precautions are designed to protect the patient, caregiver, and visitors.

Three types of transmission-based isolation precautions:

- Contract
- Droplet
- Airborne

Contact Isolation Precautions

Contact isolation is needed when germs are spread by touching. C difficile diarrhea is an example of when contact isolation precautions should be used.

In addition to standard precautions, precautions for contact insolation include:

- The patient should stay in one room
- Equipment such as blood pressure cuffs and stethoscopes should be left in the patient home
- Gown and gloves should be worn for all care that requires contact with patient or items in the patient's room and removed or thrown away before leaving the room
- Mask and eye protection should be used if there is a risk of splashing of contaminated fluids

Droplet Isolation Precautions

- Droplet isolation is used when germs are spread through the air in the form of a large droplet. Large droplets can travel about 3 feet from the patient from a cough or a sneeze. Influenza, whooping cough, and mumps are spread through droplets.
- In addition to standard precautions, precautions for droplet isolation include:
- The patient should stay in one room
- Equipment such as blood pressure cuffs and stethoscopes should be left in the patient home
- Gown, gloves, and mask must be work when providing any patient care
- Masks are required for all caregivers and visitors
- The patient should always cover their mouth and nose when they cough

Airborne Isolation Precautions

- Airborne isolation is used when germs are spread through the air and can travel for long distances. This type of germ is very small and is inhaled. Measles, chickenpox, and tuberculosis are spread through these particles
- In addition to standard precautions, precautions for airborne isolation include:
- The patient should stay in one room and wear a mask when they leave that room
- Door to the patient room should be closed at all times
- Caregivers and visitors need to wear an N-95 respirator mask
- Gloves must be worn when contact with nasal fluids occurs, such as wiping the patient's nose or throwing away tissues
- Gowns should be worn to prevent the organisms from being transmitted on the clothing of the caregiver
- Equipment such as blood pressure cuffs and stethoscopes should be left in the patient's home
- The patient should always cover their mouth and nose when they cough

Special Handling

- When working with patients in isolation it is important to remember that the germs can be spread by contact with supplies, equipment, trash, and linen. Always remember to use the proper PPE when handling these items and carefully wash your hands when you are done. Trash and linen used for an isolation patient need to be handled in a way that prevents others from

coming into contact with the germs. Check the care plan for special procedures for removing linens, trash, or any infectious materials. Be sure to identify the correct waste containers and locate appropriate biohazard bags.

Infection Control and Employee Illness

One way to prevent the spreadof infection is to limit the risk of emplo9yees bringing germs into the workplace. When you may feel well enough to work, you might still be able to pass germs onto others. Some infections must be reported when an employer becomes aware that an employee is sick. For that reason, you may be asked several questions when you call in sick so that employer can determine if you have an illness that must be reported.

Exposure to Blood Borne Pathogens

The Blood borne pathogen standard defines an occupational exposure as a "reasonably anticipated skin, eye, mucous membrane, or parenteral (breaking the skin) contact with blood or other potentially infectious materials that may result from the performance of an employee."

Healthcare workers can be exposed to blood borne pathogens in blood and other body fluids. The use of Standard Precautions and other healthcare safety controls greatly r3educes this risk of contamination Each worker must use safety tools made available for their safety to practice disinfection, sanitization, and contamination safety while caring for the patient.

Needles ticks and other sharps injuries aer a serious and hazard in any medical care situation. They are the most frequently reported exposure events. Contract with contaminated needles, scalpels, broken glass, and other sharps expose healthcare workers to blood that may contain infectious pathogens.

It is essential to treat all body fluids as a threat to your health. The most important physical protection is the use of personal protective equipment (PPE), which may be as simple as putting on gloves. Other PPE that may be needed include goggles, face shields, surgical masks, and protective gowns. Simply being aware and taking a few seconds to put on and use PPE properly can protect you from serious illness. Employers are responsible for obtaining and maintaining PPE reasonable for each home environment.

To limit your exposure to infection and illness,

- Follow standard precautions practices consistently
- Keep antiseptic soap at a hand-washing station or have liquid hand sanitizer available
- Transport biological samples in appropriately labeled, leak-proof containers
- Have supplies readily available to rinse eyes
- Avoid using needles whenever safe and effective alternatives are available
- Never recap or bend needles

- Make sure there is a standard-labeled, leak-proof, puncture resistant sharps container in the client's home. If there is not, notify the DME company
- Promptly dispose of used needle devices and sharps in the sharps containers
- Plan for the safe handling and disposal of sharps before use
- Dispose of full sharps containers properly

State and community requirements for disposal of sharps vary depending on location. It is important to check with local waste departments or health departments before disposing of full sharps containers to see which methods are available for your community.

What to do if you are exposed:

- If you experience a needle stick, sharps injury, or are exposed to the blood or other body fluid during the course of your work, immediately follow these steps:
- Wash needle sticks and cuts with soap and water
- Flush splashes to the nose, mouth, or skin with water
- Irrigate eyes with clean water, saline, or sterile irrigates
- Report the incident to your supervisor

ANE-Abuse, Neglect, Exploitation

In an effort to ensure the safety and well-being of our patients, each state has enacted laws that require you to report any behavior or activities that are potentially harmful to your patient. These laws identify employees of a patient care provider as mandatory reporters, placing a legal, moral, and professional responsibility on you to report.

MANDATORY REPORTING

Anyone who interacts with patients in the course of their professional duties, such as teachers, home health aides, nurses, doctors, coaches, and therapists is required to report suspicions of ANE. As an employee of VigorCare Pediatric Services, you must act as an advocate for our clients.

You can be held criminally liable and have financial penalties assigned if you do not report an abusive, neglectful, or exploitative situation. In short, not reporting is a crime.

You cannot be held criminally liable for reporting your suspicions in good faith.

WHAT TO REPORT

Abuse

- Physical abuse – a physical injury that results in physical harm to the client. Signs include temporary redness of the skin that lasts more than 24 hours; welts, bruises, fractures, internal injuries, and cuts.
- Sexual abuse – sexual conduct harmful to a person's mental, emotional, or physical welfare. Sexual abuse includes exposure to pornography or sexual acts, regardless of the individual's level of participation in the act.
- Emotional abuse – an action that results in a marked impact on a child's growth, development, or an adult's psychological functioning. Emotional abuse includes extreme forms of punishment, such as isolation, belittling, making-disparaging comments or name calling, to the point that it affects the individual's ability to function.

Neglect

- Neglectful supervision – placing an individual in a situation that requires judgment or actions that are beyond the physical or mental capabilities of that individual. Leaving impaired individuals that need assistance to care for themselves home alone, allowing children to care for themselves or others in the home, and placing individuals in dangerous situations are all examples of neglectful supervision

- Mental neglect – Failing to obtain or follow up with medical care for an individual when thelack of care results in physical injury or a decline in functional abilities

- Medical neglect – Failing to obtain or follow up with medical care for an individual when the lack of care results in physical injury or a decline in functional abilities.
- Physical neglect – Failure to provide a client with the adequate food, clothing, or shelter necessary to sustain their life or health. Physical neglect can include a situation where the home environment presents a health or safety threat to the individual

Exploitation

- Illegal/improper act or process of a caregiver/family member/others – using the client's resources for monetary/personal benefit, profit, or gain without the client's permission or legal entitlement to do so.

Signs of abuse

- Bruises, pressure marks, broken bones, abrasions, and burns can be signed of physical abuse or neglect
- Unexplained withdrawal from normal activities, a sudden change in alertness, and unusual depression may signify emotional abuse
- Sudden changes in financial situations may be the result of exploitation
- Bedsores, unattended medical needs, poor hygiene, and unusual weight loss are indicators of possible neglect
- Behavior such as belittling, threats, and other use of power and control by parents, caregivers, or spouses are indicators of verbal or emotional abuse
- Strained or tense relationships, frequent arguments between the caregiver and elderly person are also concerning signs

How to report

VigorCare requires that you report suspicious of ANE to your direct supervisor. Suspicions of ANE must also be reported to your local human services agency such as child or adult protective services, local police or county sheriff, or a child or adult abuse reporting hotline. The reporting process varies by state. It is your responsibility to ensure that you know the process for your state.

ADDITIONAL RESOURCES

U.S. Department of Health and Human Services, Child Welfare Information Gateway
https://www.childwelfare.gov
https://www.childwelfare.gov/system1de/1aws policies/statutes/manda.pdf

U.S. Department of Health and Human Services, Administration on Aging

http://www.aoa.gov
Texas mandatory reporting laws and process (adult and child)

http://www.dfps.state.tx.us/ContactUS/report abuse.asp

Safe Medical Device Act 1990

What is it?

In 1990, Congress enacted the **Safe Medical Act (SMDA)** to increase the information that the FDA Food and Drug Administration and manufacturers receive about serious problems with medical devices.

Under SMDA, device user facilities and manufacturer must report deaths and serious injuries to which a device has or may have caused or contributed and must establish and maintain adverse event files.

A device user facility is defined as a hospital, an ambulatory surgical facility, or an outpatient diagnostic facility which is not a physician's office.

A medical device is any item that is used for the diagnosis, treatment, or prevention of a disease, injury, or other condition and is not a drug.

On June 16, 1992, the President signed into law the Medical Device Amendments of 1992, amending certain provisions (section 519) of the Food, Drug and Cosmetic Act relating to the reporting of adverse events.

History:

The Safe Medical Device Act of 1990 (P.L. 101-629), which amended the Federal Food, Drug and Cosmetic Act, (FFD&C) (21 U.S.C. 201 et seq.), was signed into law on November 28, 1990.

The SMDA Act was most recently changed to the **Food and Drug Administration Modernization Act of 1997**, (the Modernization Act contained provisions related to all products under FDA's jurisdiction.

Who reports what??

Who reports SMDA events?

The following must report that event regardless of the nature or location of the medical services provided from outpatient to inpatient hospitals, ambulatory care facilities, nursing homes, manufacturers, outpatient diagnostics and treatment facilities, home healthcare and physician offices.

Everyone within healthcare owned and operated within the US except foreign facilities that do not operate with US laws.

Authority to Enforce

The FDA has been given additional authority to order the recall of medical devices and the notification of users, to temporarily suspend premarket approval of a device and to impose both criminal and civil penalties to enforce the Medical Device Reporting requirements.

Criminal Money Penalties

Section 303(f) of the Safe Medical Devices Act of 1190 authorized FDA, after an appropriate hearing to impose criminal money penalties for violations of the FD&C Act that relates to medical devices.

Criminal Penalties may be up to $1,000 fine and one year imprisonment for the first offense if the offense was unintentional, and up $10,000 and three years of imprisonment for subsequent offenses, or for intentional offenses.

Report Types

Reporter Report What To Whom When

User Facility-Report deaths to FDA/Manufacturer within 10 Days and requirement of 2years to maintain files

Serious Injuries-Manufacturer reports. If Manufacturer unknown, submit to FDA. Within 10 days of event and requirement of 2 years to maintain files

Semiannual r3eport of deaths and serious injuries reported to FDA. Report from January 1 and July 1 and maintain files for two years.

Manufacturers Deaths, serious injuries and malfunctions.

Reported to FDA within 30 days of reported event. Files kept for life of Device.

Advance Directives

Purpose is to ensure that patients/clients and their legal representatives are informed of patrient rights under federal and state law to make and direct decisions concerning medical care; including the right to accept or r3efuse medical or surgical treatment and the right to formulate advance directives such as a “Living Will”, “Medical Power of Attorney”, “Out-Of-Hospital DNR” or “Declaration of Mental Health Statement”. It is also meant to guide agency staff in implementing the provisions of the Patient Self-Determination Act and Texas’ Advance Directives Act and to provide for education of staff and the community on issues concerning advance directives and related advance care documents.

VigorCare staff will not provide any medical treatment that the patient has not consented to receive.

VigorCare recognizes the right of a patient and their legal representative under federal and state law to make decisions regarding medical care, including the right to formulate advance directives.

Nursing Ethics

Ethics is the study of practical reasoning. Nurses face ethical dilemmas on a daily basis. Ethical behavior is determined by many factors. What one person considers ethical may be vastly different from a person approaching a situation with a different point of view

The word ethics is derived from the Greek word for character. Nurses are charged with using ethical concepts in their delivery of client care.

Ethical concepts include providing care which is good, correct, and rational. Clients need to be provided opportunities to express their freedom of choice in procuring services and determining how they want to be cared for. The ethical nurse recognizes that he or she is obligated to provide individualized care which will assist the client reach and/or maintain his or her highest level of wellbeing. Ethical nursing care is based upon rational science and decision making.

There are four core concepts which are essential to a professional nursing practice. They are respect for client

- autonomy
- the duty to act with beneficence
- nonmaleficence
- justice

Nurses provide respect for client autonomy by recognizing and enhancing a client's freedom of choice, respecting patient choices, and providing privacy, The National League for Nursing issued a statement which document's client rights. Nurses are expected to uphold the rights of clients and advocate for clients' who are not able to advocate for themselves.

Nurses demonstrate beneficence by helping people reach their highest level of wellbeing. This may be achieved by providing care directly to an individual client or developing health care polices which affect a large population.

Nurses are obligated not to harm clients. This is the principal of non-maleficence. Nurses often do have to perform procedures which make clients' feel uncomfortable. An example is administering an injection. A client needs medication to relieve a symptom, however, in order to relieve a symptom, the nurse may cause discomfort. Non-maleficence must be balanced by beneficence, while providing care. The intent of the nurse provides a treatment which benefits the client must outweigh the discomfort caused. The nurse's intent must be to help, not harm.

Human dignity – A principle that addresses the inherent value and intrinsic worth of each human being

Justice and fairness in nursing care is often related to the delivery of services. The current health care reform plan is a result of people recognizing that the current health care system needs revision. Controversy arises over what is fair, equitable, and economically feasible.

Nurses are involved at every level of the healthcare system, making decisions, and assisting with policy development.

Many experts state that the nursing concept of ethical care is an exceptional one which needs to be implemented throughout healthcare. It is similar to the medical model of ethics in that it deals with life and death issues. The nursing model is one of individual client empowerment. Ethical nurses lead the way for health care reform which emphasizes healing even when curing is impossible. It places quality of life in the forefront.

Ethical dilemmas which nurses face are vast in scope. Examples include diverse topics such as staffing ratios, and end of life care. Dilemmas may occur while caring for clients with disabilities which may place them at risk for self-harm. For example, an elderly client may want to walk without supervision. The nurse desires to promote independence, but the risk of client injury due to falls may be great. The dilemma is how to balance the contrasting issues. Which is more important – independence or safety? Each client, family, and healthcare team faces challenges such as this on a daily basis. Larger challenges may be encountered while working with families who have newborns with physical or mental disabilities. Is it ethical to subject a child to an unproven procedure which will cause pain if it gives them their only chance of survival? Is it best to prolong life when the quality of life is poor?

As caregivers on the front lines of health care, nurses are faced with ethical dilemmas at growing rate. Technology is enabling sick people to survive serious illnesses. Yet recent studies indicate that people are surviving, yet not living well. Nurses have a role in implementing educational and clinical practices which address the issues that high tech care presents.

There are not enough health care resources available in the world. The resources are unequally distributed. Nurses have a role in ensuring that distribution is fair.

Clients and families with various cultural backgrounds and personal experiences may present with diverse opinions of what is ethical. The nurse can serve as a resource to ensure that each person feels that their opinion counts.

Agency Compliance

The purpose of this policy is to enable the Home Health Agency to demonstrate integrity and honesty as a participant in federally and state funded health care programs and its compliance with applicable laws and regulations. It is also the intent of the compliance program to prevent and detect any criminal, fraudulent and other unethical and improper conduct and take appropriate actions for this purpose. It is the policy of VigorCare to use its best efforts to avoid fraud, waste and abuse and to adhere to all guidelines and regulations governing federally and state funded health care programs. Policies outlining standards of conduct shall be distributed to all individuals who are affected by the specific policy at issue, along with new and amended or revised compliance policies when available.

No gifts, free services, or other incentives shall be offered to patients, r3elatives of patients, physicians, hospitals, contractors, assisted living facilities, or other individuals or entities who would be in a position to refer patients to the Home Health Agency.

Any report or evidence of a suspected violation of law, regulations or applicable standards of conduct shall be forwarded to the Compliance Officer who shall review the report or evidence and determine whether there is any basis to suspect that a violation has occurred. It is not required to go through the chain of command to report any suspected abuse. Individuals who make a good faith report of known or suspected violations of law to the compliance program will be protected from retaliation.

Code of Conduct

The purpose of the standards of conduct is to establish uniformity in the conduct of our employees under the compliance program. Al VigorCare employees must comply with all federal, state and local laws and government regulations. Employees must immediately and directly report to their supervisor or the compliance officer any actual or suspected violation of standards of conduct, any related law or regulation, the compliance program, or any other agency policy. Ignorance of the law will not be tolerated. VigorCare makes every effort to reconcile and submit accurate bills to the appropriate payor sources by implementing processes for proper claim development and reimbursement documentation. Employees are expected to submit accurate and factual documentation for services rendered.

Employees must strictly safeguard all confidential information with which they are entrusted and not discuss information outside the normal and necessary course of business, financial, personnel, commercial, or technical information unless authorized in writing by management.

Vigor Care
pediatric services

To ensure INCLUSION, FREEDOM, AND RESPECT for all, it's time to embrace

People First Language

By Kathie Snow, www.disabilityisnatural.com

Did you know that people with disabilities constitute our nation's minority group (one in five Americans) has a disability)? It's also the most inclusive and most diverse group: all ages, genders, religions, ethnicities, sexual orientations, and socioeconomic levels are represented. Contrary to conventional wisdom, individuals with disabilities are not:

- People who *suffer* from the *tragedy of birth defects.*
- *Paraplegic heroes* who *struggle* to become *normal* again.
- *Victims* who *fight to overcome* their *challenges.*

Nor are they *the retarded, autistic, blind, deaf, learning disabled, etc. – ad nauseam!*

They are *people*: moms and dads; sons and daughters; employees and employers; friends and neighbors; students and teachers; scientists, reporters, doctors, actors, presidents, and more. People with disabilities are people *first.*

They do not represent the stereotypical perception; a homogenous sub-species called "the handicapped" or "the disabled." Each person is a unique individual.

The only thing they may have in common with one another is being on the receiving end of societal ignorance, prejudice, and discrimination. Furthermore, this largest minority group is the only one that any person can join at any time: at birth or later – through an accident, illness, or the aging process. When it happens to you, will you have more in common with others who have disability diagnoses or with family, friends, and co-workers? How will you want to be described and how will you want to be treated?

WHAT IS A DISABILITY?

Is there a universally-accepted definition of disability? No! First and foremost, a disability descriptor is simply a medical diagnosis, which may become a sociopolitical passport to services or legal status. Beyond that, the definition is up for grabs, depending on which service system is accessed. The "disability criteria" for early intervention is different from early childhood, which is different from special education, which is different from vocational-rehabilitation, which is different from worker's compensation, which is different from the military, and so on. Thus, "disability" is a governmental sociopolitical construct, created to identify those entitled to specific serves or legal protections.

-THE POWER OF LANGUAGE AND LABELS -

Words are powerful. Old, inaccurate descriptors and the inappropriate use of medical diagnoses perpetuate negative stereotype and reinforce a significant and incredibly powerful attitudinal barrier. And this invisible, but potent, force – not the diagnosis itself – is the greatest obstacle facing individuals who have conditions we call disabilities.

When we see the diagnosis as the most important characteristic of a person, we devalue her as an individual. Do *you* want to be known or your psoriasis, arthritis, diabetes, sexual dysfunction, or any other condition?

Disability diagnoses are, unfortunately, often used to define a person's value and potential, and low expectations and dismal future are the predicted norm. Too often, we make decisions about how/where the person will be educated, whether he'll work or not, where/how he'll live, and what services are offered, based on the person's medical diagnosis, and instead of the person's unique and individual strengths and needs.

With the best of intentions, we work on people's bodies and brains, while paying scant attention to their hearts and minds. Far too often, the "help" provided can actually cause harm- *and ruin people's lives*- for "special" services usually result in lifelong social isolation and physical segregated recreational activities, and more. Are other people isolated, segregated, and devalued because of *their* medical conditions? No.

-INACCURATE DESCRIPTORS -

"Handicapped" is an archaic term (no longer used in federal legislation) that evokes negative images of pity, fear, and worse. The origin of the word is from an Old English bartering game, in which the loser was left with his "hand in his cap" and was said to be at a disadvantage. It was later applied to other people who were thought to be "disadvantage." A *legendary* origin of the word refers to a person with a disability being with his "cap in his hand." Regardless of origin, this antiquated term perpetuates the negative perception of the people with disabilities are homogenous group of pitiful, needy people! But others who share a certain characteristic are not all alike, and individuals who happen to have disabilities are not all alike. In fact, people with disabilities are *like* people *without* disabilities than different!

"Handicapped" is often used to describe modified parking spaces, hotel rooms, restrooms, etc. But these usually provide access for people with physical or mobility needs – and they may provide no benefit for people with visual, hearing, or other conditions. This is one example of the misuse of the H-word as a *generic descriptor*. (The accurate term is modified parking spaces, hotel rooms, etc. is "accessible.")

"Disable" is also not appropriate. Traffic reporters often say, "disabled vehicle." They once said, "stalled car." Sports reporters say an athlete is on" the disabled list." They once said, "injured reserve." Other uses of this word today mean "broke/non - functioning." *People with disabilities are not broken!*

If a new toaster doesn't work, we say it's "defective" or "damaged", and either return it or throw it away. Shall we do the same to babies with "birth defects" or adults with "brain damage"? The accurate and respectful descriptors are "congenital disability" and "brain injury".

Many parents say, "My child has special needs." This term generates pity, as demonstrated by the usual response: "Oh, I'm *so sorry*," accompanied by a sad look or a sympathetic pat o the arm. *(Gag!)* A person's needs aren't "special" to him – they're ordinary! Many adults have said they detested this descriptor as children. Let's learn from them, and *stop using this pity-larden term!*

"Suffers from," "afflicted with," "victim of," "low/high functioning," and similar descriptors are inaccurate, inappropriate, and archaic. A person simply "has" a disability or a medical diagnosis.

-DISABILITY IS NOT THE "PROBLEM"-

We seem to spend more time talking about the "problems" o a person with a disability than anything else. People *without* disabilities, however, don' constantly talk about *their* problems. Tis would result in a inaccurate perception, and would also be counterproductive to creating a positive image. A person who wears glasses, or example, doesn't say, "I have a problem seeing." She says, "I wear [or need] glasses."

What is routinely called a "problem" actually reflects a *need.* Thus, Susan doesn't "have a problem walking", she "needs/uses a wheelchair." Ryan doesn't "have behavior problems", he "needs behavior supports."

Do you want to be known by our "problems" or by the man positive characteristics that make you the unique individual you are? When will people *without* disabilities begin speaking about people *with* disabilities I the respectful way they speak about themselves?

Then there's the use of "wrong" as in, "We knew there was something wrong because…" What must if fell like when a child hears his parents repeat this over and over and over again? How would you feel if those who are supposed to love and support you constantly talk about what's "wrong" with you? Isn't it time to stop using words that cause harm?

THE REAL PROBLEMS ARE ATITDUINAL AND ENVIROMENTAL BARIERS

The real problem is *never* a person's disability, but the attitudes of others! A change in our attitudes leads to change in our actions. Attitudes drive actions.

If educators believed I the potential of all children, and if they recognized that boys and girls with disabilities need a quality education so they can become successful in the adult world or work, millions of children would no longer be *segregated and undereducated* in special ed classrooms. If employers believe adults with disabilities have (or could learn) valuable job skills, we would' have an estimated (*and shameful)* 75 percent unemployment rate of people with disabilities. If merchants saw people with disabilities as customers with money to sped, we wouldn't have so many inaccessible stores, theaters, restrooms, and more.

If the service system identified people with disabilities as "people we serve," instead of "clients, consumers, recipients," perhaps those employees in the field would realize they are dependent on people with disabilities for their livelihoods, ad would, therefore, treat people with disabilities with greater respect deference.

If individuals with disabilities and family members say *themselves* as first-class citizens who can and should be fully included in all areas or society, we might focus on what's really important: living a *Real Life in the Real World,* enjoying ordinary relationships and experiences, and dreaming big dreams (like people without disabilities), instead of living a *Special, Segregated Life in Disability World,* where services, low expectations, poverty, dependence, and hopelessness are the norm.

-A NEW PARADIGM-

"DISABILTY IS A NATURAL PART OF THE HUMAN EXPERIENCE…"
U.S. Development Disabilities/Bill of Rights Act

Like gender, ethnicity, and other traits, a disability is simply one of many natural characteristics of being human. Are you defined by your gender, ethnicity, religion, age, sexual orientation, or other trait? No! So how can we define others by a characteristic that is known as a "disability?"

Yes, *disability is natural,* and it an be *redefined* as "a body part that works differently." A person with a spina bifida may have legs that work differently, a person with Down syndrome may learn differently, and so forth. And the body parts of people *without* disabilities are also different- it's the way these differences impact a person that creates the eligibility for services, entitlements, or legal protections.

In addition, a disability is *often a consequence of the environment.* For example, many children with attention-deficit disorder (ADD) and similar conditions ae not diagnosed until they enter public school. Why then? Perhaps when they were younger, their learning styles where *supported* by parents and preschool teachers. But once in public school, if the child's learning style doesn't match an educator's teaching style, the child is said to have a "disability," and is shipped off to the special ed department. Why do we blame the child, label him, and segregate him in a special classroom? Shouldn't we, per special ed law, modify the regular curriculum and/or provide supports so he can learn in ways that are best for him? It seems that ADD and other conditions may be "environmentally-induced disabilities!

When a person is in a welcoming, accessible environment, with appropriate supports, accommodations, and tools, where she can be successful, does she still have a disability? No. *Disability* is *not a constant state.* The diagnosis may be constant, but whether it's a disability is more a *consequence of the environment* than what a person body or brain can/cannot do. We don't need to change people with disabilities through therapies or interventions. We need to change the *environment*, by providing devices, supports, and accommodations to ensure a person's success.

USING PEOPLE FIRST LANGUAGE IS CRUCIAL

People First Language puts the person before the disability, and describes what a person *has*, not who a person *is.*

Are you myopic or do you wear glasses?
Are you cancerous or do you have cancer?
Is a person handicapped/disabled
Or does she have a disability?

If people with disabilities are to be included in all aspects of society, and it they're to be respected and valued as our fellow citizens, we must stop using language that marginalizes and sets them apart. Numerous historical examples of horrific treatment by the "majority" toward a "minority" demonstrate that the process *begins* with language that devalues and makes others "less than."

The use of disability descriptors is appropriate only in the service system, at IFSP, IEP, ISP meetings, and/or in medical or legal settings. Medical diagnoses have no place – and they should be irrelevant – within families, among friends, and in the community.

Many people share a person's diagnosis in an attempt to provide helpful information, as when a parent says, "My child has Down syndrome," hoping others will understand what the child needs. But this can lead to disastrous outcomes! The diagnosis can scare people, generate pity, and/0r set up exclusion ("We can't handle people like that…") thus in certain circumstances, and *when it's appropriate,* we can simply hare information about what the person needs in a respectful, dignified manner, and *omit the diagnosis.*

Besides, the *diagnosis is nobody's business!* Have individuals with disabilities given us permission to share their personal information with others? If not, how dare we violate their trust? Do *you* routinely tell every Tom, Dick, and Harry about the boil on your spouse's behind? (I hope not!) And we often talk about people with disabilities *in front of them, as if they're not there.* Let's stop this demeaning practice.

My son, Benjamin is 28 years old. His interests, strengths, and dreams are more important than his diagnosis. He loves politics, American history, classic rock, and movies; he's earned two karate belts, performed in plays, and won a national award for his *Thumbs Down to Pity film.* Benji has earned his Master's degree and is on the job hunt. He has blonde hair, blue eyes, and cerebral palsy. His diagnosis is just one of many characteristics of his whole persona. *He is not his disability, and his potential cannot be predicted by his diagnosis.*

When I meet new people, I don't whine that I'll never be a prima ballerina. I focus on what I can do, not what I can't. Don't you do the same? So when speaking about my son, I don't say, "Benji can't write with a pencil." I say, "Benji writes on his computer." I don't say, "He can't walk." I say, "He uses a power chair." It's a simple. But *vitally important*, matter of perspective. If I want others to know what a great young men he is – more importantly, *if I want him to know what a great young man he is* – I must positive and accurate descriptors that portray him as a wonder, valuable, and respected person.

The words used about a person have a powerful impact on the person for generations, the hears and minds of people with disabilities have been crushed by negative, stereotypical descriptors that , in turn, led to segregation, abuse, devaluation, forced sterilization, and worse. We must stop believing and perpetuation the myths – *the lies*- of labels. Children and adults who have conditions called "disabilities" are unique individuals with unlimited potential, like everyone else!

The Civil Rights and Women's Movements prompted changes in language, attitudes, and actions. The Disability Rights Movement is following in those important footsteps. People First Language was created by individuals who said, "We are *not* disabilities; we are people first." It's not "political correctness," but good manners and respect.

We can create a new paradigm of disability. In the process, well change ourselves and our world – and also generate positive change in the lives of people with disabilities. It's time to care about how our words impact the people were talking about, and to be mindful of the attitudes and actions generated by the words we use.

Isn't it time to make this change? If not now, *when*? If not you, *who*? Using People First Language is the right thing to do, so let's do it!

EXAMPLES OF PEOPLE FIRST LANGUAGE

SAY…	INSTEAD OF
People with disabilities	The handicapped or disabled.
Paul has a cognitive disability (diagnosis)	He's mentally retarded.
Kate has autism (or a diagnosis of)	She's autistic.
Jose has Down syndrome (or a diagnosis of)	He's downs; a Down's person; mongoloid.
Sara has a learning disability (diagnosis)	She's learning disabled.
Bob has a physical disability (diagnosis)	He's quadriplegic/is crippled.
Maria uses a wheelchair/mobility chair	She's confined to/is wheelchair bound.
Tom has a mental health condition	He's emotionally disturbed/mentally ill.
Ryan receives special ed services	He's in special ed; is a sped student/inclusion student
LaToya has a developmental delay	She's developmental delayed.
Children without disabilities	Normal/healthy/typical kids.
Communicates with her eyes/devices/etc	Is non-verbal.
People we serve/provide services to	Client, consumer, recipient, etc.
Congenital disability	Birth defect.
Brain Injury	Brain damaged.
Accessible parking hotel room, etc	Handicapped parking, hotel room, etc.
She needs…or she uses	She has a problem with…/she has special needs.