Emergency Preparedness Training
Updated April 2010

I. Purpose

- To promote staff safety and readiness in the event of an emergency or disaster
- To insure consistency in care delivery and promote client safety, in circumstances where agency operations may be disrupted, such as inclement weather, power outages, natural and unnatural disasters
- To insure continuation of core functions during an emergency or disaster

II. Policy

1. The agency is committed to promoting the safety of its employee and clients. Staff will be provided with education on emergency preparedness for use on the job.

2. In the event of inclement weather, natural or man made disasters, employees will be encouraged to listen to your local radio station and or TV channel for weather updates, road conditions and any possible announcements concerning office closings and public safety.

3. Staff who is working outside the office will be asked to listen to voicemail, activated pagers/cell phones and respond promptly to pages and/or calls. It is the responsibility of each individual employee to contact clients, customers and colleagues with whom they had visits or meetings scheduled.

III. Procedure

Fire response

Fire response plan
All staff is trained on effective response to fire.

Fire response Procedures

1. Rescue- removes from the danger of fire and/or smoke.
2. Alert- verbally notifies others in the work site in person.
3. Confine- isolates the fire as much as possible by closing doors within the work site. Do not place yourself in danger attempting to do this.
4. Extinguish- extinguish the fire only if you are capable of doing so without placing yourself in danger.

If fire is uncontrollable, call 911 immediately.
Tornado/ Severe Weather

1. Field staff are encouraged to listen to the radio while driving and heed severe weather warnings and alerts.
2. If in client residence, assist the client and take shelter in the basement or a small central room in the lowest level of the building. Bathrooms and closets are good potential shelters.
3. If outside and no building available, lie in low spot using your arms and hands to protect your head.

Safety of Field Staff

1. The following general preventative actions for home visits situations will be practiced at all times:
   a. Take responsibility for your own safety
   b. Recognize that there is always the potential for violence or threat of violence
      - never enter a vacant house
      - do not enter a home or apartment building if you have doubts
   c. Always be prepared with your own safety plan in case violence or the threat of violence is present.
      - carry identification with you
      - dress appropriately
      - do not carry large sums of money with you
   d. Communicate any information concerning potential for violence to your supervisor and other affected staff
   e. Discuss with your supervisor the option of refusing, suspending, or altering services if the potential for danger exists or persists.
   f. Leave a location, such as a client residence immediately if you are asked to leave or feel threatened.
   g. When in a new situation, be careful where you choose to sit or stand, always giving yourself an exit.
   h. If there is any reason to believe that a client is likely to be agitated or the situation may be unsafe, consider a co-visit with another employee or your supervisor.
   i. Know exactly where you are going before leaving your home, leaving for or exiting a visit.
   j. Be sure your car is in good working order and that you have sufficient gas.
      - keep doors locked
      - carry a spare car key
      - park as close to your destination as possible. If dark, try to park under a street lamp.
   k. Avoid carrying a purse. Lock your purse or other valuables in your trunk before leaving the house for visits.
Throughout life, you will be faced with injuries of every kind; whether it is a simple paper cut or a severe chemical burn, every accident must be dealt with in the right way. On this site we will deal with a few major categories of accidents: soft tissue wounds, like the typical bruises, cuts and scrapes of everyday life, along with the not-so-typical, more life threatening accidents like puncture wounds, spurring cuts and amputations; burns, from mild sunburn to third-degree; poisoning; choking; and, of course, "natural" encounters - bee stings, poison ivy, and the dangers of anaphylactic shock.

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### Types of Wounds

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<th>Name</th>
<th>Description</th>
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<td>avulsion</td>
<td>In an avulsion, a portion of skin is torn. This can be partial, with a portion of skin remaining as a &quot;flap.&quot; In a total avulsion, a body part is completely torn off.</td>
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<tr>
<td>bruise</td>
<td>Bleeding that occurs under the skin causes discoloration, swelling. The area begins as red but may turn into a &quot;black and blue mark.&quot;</td>
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<tr>
<td>cut</td>
<td>A cut is a split in the skin caused by a sharp object, such as a knife, or even a dull...</td>
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Caring for a Minor Open Wound

After a long day of being cooped up in a stuffy classroom listening to your teachers ramble on about the rise of the Communist party and the conjugations of the verb "estar," you decide that you're in the mood for a quick game of roller hockey with some equally stir-crazy friends. As you swoop in to fire a slap shot at the goal, the unthinkable happens: you hit a rock. And not just a pebble; this is a big, trip-you-up rock that you didn't see because your eyes were locked on that ball. So, before you know it, you've slid about five feet on your poor, unprotected knees. Your first thought is, "Did I make the shot?" Your second thought comes quickly with the hot sting as you look down and see the red streaks of blood appear where your skin once was. "OW!!!" What do you do?

Stop the bleeding by applying pressure with a clean, absorbent cloth, or if cloth is unavailable, your fingers.

If the blood soaks through, apply a second bandage on top. Do not take off the first bandage because it will disturb the clotting that has already taken place.

If bleeding still doesn't stop, raise the wound above heart level.

Once bleeding stops, clean the wound gently with soap and water, or just water. It is very important to get all debris or dirt out.

Apply an antibiotic ointment such as bacitracin or a triple antibiotic ointment. Remember, some people are allergic to these ointments, so contact your doctor if you have any doubts.

Wrap the wound firmly in a cloth or a bandage. Do not cut off circulation!

Caring for a Major Open Wound

That Sunday remains the most vivid day in Cynthia's memory. She was cutting the bagels that John brought home, as she did every Sunday, when the knife slipped....The wash of bright, red blood was sudden and frightening. Thankfully, she and John knew exactly what to do.

Covering the wound with a clean dressing, press against it firmly with your hand.

Elevate the wound above the level of the heart.

The clean dressing should then be covered over with a roll bandage (like an Ace) to hold the dressings in place.

If bleeding still does not stop, add additional dressings over the roll bandage.

Squeeze a pressure point, the artery against the bone. This is in the bottom upper arm, or where the leg bends at the hip.
Once the bandages and pressure point are being maintained, have someone call EMS if they have not already.

Special Problems

When part of the body has been torn off...
  Try to find the part
  Wrap it in a clean dressing and place in a plastic bag.
  Put the bag on ice, but don't freeze.
  Take the part to the hospital.

When an object is impaled in a wound...
  Do not remove it. You could reveal an open artery which would then be awfully hard to deal with, a.k.a. nearly impossible.
  Bandage many dressings around the object to immobilize it and support it in its position in the wound.

Splinters...
  A small splinter in the skin should be removed with tweezers.
  For a splinter in the eye, seek emergency help immediately, do not touch it.

Nosebleeds...
  Have the victim sit with his or her head tilted a little bit forward while pinching his or her nostrils together.
  One could also place an ice pack on the bridge of the nose.

Injury to the mouth...
  If the injury does not involve the head, neck, or spine, have the victim sit with the head slightly tilted forward. If the victim is unable to reach this position, place the victim on his or her side. This ensures that blood drains from the mouth.
  If the injury has broken the lip, place a clean rolled dressing between the lip and gum. Applying cold can also help.

If a tooth is knocked out...
  Place a small roll of sterile gauze in the gap left by the tooth that was knocked out.
  Pick up the tooth not by the root, but by the crown, the part you see when you smile in the mirror. If you can, place the tooth back how it belongs in the socket.
  If you can't put the tooth back in, put the tooth in a container with cool, fresh milk. If this cannot be done, use water.

The most important things to remember are the signs of major damage:
  If the bleeding is bright red, or spurts from the wound, CALL EMS.
  If the wound is very deep or large, CALL EMS.
If the victim is in severe pain or you suspect serious damage, CALL EMS.
If you can't wash all the debris out of the wound, call your doctor immediately.
If you think you may need stitches (if the wound is in a place where you would want to minimize scarring) call your doctor immediately.

If you see any signs of a serious infection - redness, soreness, swelling, red streaks, weeping of pus, or redness that extends more than a finger width beyond a cut - call your doctor immediately.

Ah, a hot summer morning, perfect for the beach. After a nice brisk swim in the refreshing tide, you curl up on your beach chair with your headphones and a book. As you sit contentedly, your eyes slowly fall shut in a mid-day nap. When you awake, the sun is a little lower in the sky, the people next to you have left, and your exposed skin is starting to look a suspicious shade of bright red. Will you know what to do?

You are babysitting the neighbor's kids, and as you are preparing dinner you turn around for a moment to rinse off the spoon. Suddenly you hear a clatter of pans and a high pitched yelp, not the "my-brother-pulled-my-hair" yelp, but a cry that sends your adrenaline into overdrive. You spin around and see the little girl clutching her hand, her tears streaming from her eyes, the tell-tale pot of hot dog water spilled on the ground. Will you know what to do?

A burn can be caused by heat (flames, hot grease, or boiling water), the sun (solar radiation), chemicals or electricity. When a burn breaks the skin, infection and loss of fluid can occur; burns can also result in difficulty breathing. If a burn victim has trouble breathing, has burns on more than one part of the body, or was burned by chemicals, an explosion, or electricity, call EMS immediately. Burns caused by flames or hot grease usually require medical attention as well, especially if the victim is a child or an elderly person.

Types of Burns

Superficial Burn (First Degree)

A first degree burn involves only the top layer of skin. The skin is red and dry and usually painful. The burned area may also swell. Most sunburn are superficial burns. This type of burn usually heals in 5-6 days without any permanent scarring.

Partial-Thickness Burn (Second Degree)

A second degree burn involves the top layers of skin. The skin is red with blisters that may open and weep clear fluid, giving the skin a wet appearance. The area may also appear mottled. The burn is usually painful and often swells. This type of burn usually heals in 3-4 weeks, and scarring may occur.
Full-Thickness Burn (Third Degree)
A third degree burn destroys all layers of skin and any or all of the underlying structures (fat, muscles, bones and nerves). The burn appears brown or black (charred) with the tissues underneath sometimes appearing white. This type of burn can be extremely painful or relatively painless if the burn destroys the nerve endings. This burn is critical and requires immediate medical attention.

Care for Burns

General Care / Thermal Burns
1. Stop the burning. Put out flames or remove the victim from the source of the burn.
2. Cool the burn. Use large amounts of cool water to cool the burn. Never use ice except on small superficial burns, because it causes body heat loss. If the area cannot be immersed, like the face, you can soak a clean cloth and apply it to the burn, being sure to continue adding water to keep the cloth cool.
3. Cover the burn. Use dry, sterile dressings or a clean cloth to help prevent infection and reduce pain. Bandage loosely. Do not put any ointment on a burn unless it is very minor. Do not use any other home remedies, and do not break any blisters. For minor burns or burns with broken blisters that are not severe enough to require medical attention, wash the burned area with soap and water, keep it clean and apply an antibiotic ointment. Remember, some people can be allergic to topical ointments, so if you have any doubts, call your doctor for advice. For a victim of severe burns, lay him or her down unless he or she is having trouble breathing. Try to raise the burned areas above the level of the victim's heart if possible, and protect the victim from drafts.

Chemical Burn
Call EMS in any case of a chemical burn. Remove the chemical from the skin or eyes immediately by flushing the area with large amounts of cool running water until EMS arrives. Remove any clothes with chemicals on them, and be careful not to spread the chemical to other body parts or to yourself. Chemical burns can be caused by chemicals used in manufacturing or in a lab, or by household items such as bleach, garden sprays or paint removers.

Electrical Burns
Call EMS in any case of an electrical burn. Do not go near the victim unless you are sure the power source has been turned off. The burn itself will not be the major problem. If the victim is unconscious, check breathing and pulse. Check for other injuries, and do not move the victim because he or she may have spinal injuries. Cover an electrical burn with a dry, sterile dressing. Do not cool the burn. Prevent the victim from getting chilled. There may be two wounds, one where the current entered the body and one where it left, and they may be deep. Electrical burns can be caused by power lines, lightening, defective electrical equipment, and unprotected electrical outlets.

Solar Radiation Burn
Burns caused by solar radiation may be painful and may also blister. Cool the burn. You may want to put a product designed specifically for sunburn on the area; these products usually contain aloe vera and help cool the area and reduce the pain. Protect the burn by staying out of the sun. If you must go in the sun, wear a sunscreen with an SPF of at least 15 and reapply it frequently. Be sure to cover up any existing sunburn if you are going to be outside again.

library.thinkquest.org
Okay, so maybe you weren't thinking. I mean, you are 17...for all intents and purposes (except maybe voting), an adult. You should have known better than to try to climb to your bedroom window by shinnnying up the drainpipe. But you didn't, and now you're lying on the ground with intense pain radiating from your left leg, a.k.a. your landing site. "I'll bet anything it's broken," you think with a small inner grin, remembering that lucky kid whose crutches and gym pass were the envy of all. A sharp pain quickly dissolves those bittersweet memories, as you remember that there is no such thing as a gym pass in summer and right now you have, no doubt, a couple of painful hours to go before you will be the envy of anyone. Wincing in a unique combination of embarrassment and outright pain, you bite the bullet: "Mommy!" Better hope Mommy's read up...

What are the types of injuries? | What is the proper treatment? | When should I call EMS?

What did I do?

Your body consists of over 200 bones of all different shapes and sizes. All of these bones in addition to muscles and the tendons and ligaments that put them together form the skeleton, which serves to protect many of the organs your body uses to function normally. Bones are dense and very strong, and they tend not to break easily, except in elderly people who have developed osteoporosis, a gradual weakening of the bones. Bone injuries are often quite painful, and they may bleed, as all bones have an ample amount of blood and nerves. The two types of bone injuries are fractures, which may be open or closed, and dislocations, which involve muscles and joints as well. The body has over 600 muscles, which are soft tissue. Injuries to the brain, the spinal cord or nerves can affect a person's muscle control, and when a muscle is injured, a nearby muscle may take over for the injured one. A joint is formed where the ends of two or more bones come together in one place. The bones are held together by ligaments, which tear when a joint is forced beyond its normal range of movement. A sprain is the tearing of ligaments at a joint. A strain is a stretching and/or tearing of muscles or tendons.

An open fracture occurs when an arm or a leg twists in such a way that the broken bone ends tear through the skin, causing an open wound. In a closed fracture the skin is not broken; this type of fracture is much more common than an open fracture. An open fracture brings with it a chance of infection and also severe bleeding. Fractures can be life-threatening if they sever an artery, affect breathing, or occur in very large bones such as the femur in the thigh. A motor vehicle accident or any fall from a height may cause a fracture.

A dislocation is typically more noticeable than a fracture. A dislocation occurs when a bone moves away from its normal position at a joint. A violent force tears the ligaments that hold the bone in place at a
joint, and the joint will no longer function. Usually, the displaced bone causes an obviously abnormal bump, ridge or hollow.

**Sprains** may swell but typically heal quickly. Pain may be minimal and the victim may be active soon, in which case the joint won't heal properly and will remain weak. It is likely to be reinjured more severely, possibly involving a fracture or dislocation of the bones at the joint. The most easily injured joints are at the ankle, knee, wrist and fingers.

**Strains** are frequently caused by lifting a very heavy object or working a muscle too hard. They usually involve muscles in the neck, back, thigh or back of the lower leg. Strains tend to reoccur, especially those located in the neck or back.

An x-ray is the best way to assess the extent of damage to a bone, muscle or joint. However, you may be able to judge how serious the injury is by its appearance. The area may be red, bruised, swollen, twisted, or have bumps, ridges or hollows. The area may be painful to touch as well as to move, or the victim may be unable to move it. If you compare an injured body part with an uninjured one, you may be able to locate any abnormalities; this works well with an arm, a leg, a shoulder, a knee...you get the idea. Sometimes the victim may have heard a snap, crackle or a pop when the injury occurred, or he or she may feel bones grating. Also, the victim's hands and fingers or feet and toes may tingle or feel numb.

**What do I do?**

It does not matter whether the injury was to a bone, muscle or joint—you don't need to know specifically what the injury is in order to care for it! The formula for proper care is rest, ice and elevation. Make the victim as comfortable as possible, and apply ice to reduce pain and swelling. Minimize movement of the injured part by supporting it with something like a pillow.

Do not try to move a patient with a severely broken bone unless it is absolutely necessary. Calling EMS is the best course of action in this case. However, if you must move the patient you must immobilize the injured body part. One way is to splint it, but do this only if it can be done without hurting the victim, and always attempt to splint the part in the position you found it. Splint the injured area and the joints above and below the injured area. You may use another body part, like an injured leg to an uninjured one, or an injured arm to a chest; this is called an anatomic splint. Make a soft splint from folded blankets or towels, or use a triangular bandage to make a sling, another type of soft splint, which is used to support an injured arm, wrist or hand. Use folded magazines and newspapers, cardboard or metal strips to support the injured body part with a rigid splint. Use several folded triangular bandages to secure the injured body part to the splinting material, tying them securely but not too tightly. Apply ice and raise the injured part, and prevent the victim from getting chilled or overheated. Remember to be reassuring!

If:

- the victim has sustained injuries to the head, neck or back
- the victim is having trouble breathing
- the victim is unable to move or use the injured body part without experiencing pain
- the injury appears to be a severely broken bone.

If you think the victim may have a head or spine injuries, **DO NOT** move him or her; leave the victim lying flat. EMS will be able to move and treat the patient without causing further injury to the victim.

Beware of signs that indicate head and spine injuries. These include:
changes in consciousness; vision and breathing problems; nausea and vomiting; inability to move a body part; steady headache; tingling or loss of sensation in hands, fingers, feet or toes; blood in the ears or nose; seizures, severe pain, pressure or bleeding in the head, neck or back; bruising of the head; and loss of balance

If you see these signs in a victim, call EMS immediately, and DO NOT attempt to move the victim or you may injure him or her further. Minimize movement of the head and spine, maintain an open airway (use a chin lift but NO head tilt unless you want to paralyze the victim!!!), check consciousness and breathing, control any bleeding, and prevent the victim from getting chilled or overheated.

Abdominal Thrusts

Adult | Child | Infant | Pregnant Woman or Obese Person

Adult Choke Adult Choke Child Choke Infant Choke Infant Choke Obese

Conscious Adult

If a person is clutching his or her throat with both hands, he or she is making the universal sign for choking. If the person can cough or talk, encourage him or her to continue coughing. Once the victim can no longer talk or cough, you must clear the obstructed airway. To clear the obstructed airway that causes choking, you must perform the Heimlich maneuver, also known as abdominal thrusts. Stand behind the conscious choking adult, wrapping your arms around his or her waist. With one hand, make a fist. Place the thumb side of the fist against the victim's abdomen just above the bellybutton. Be sure your hand is far below the tip of the breastbone. Put your other hand over the fist and give quick upward thrusts into the victim's abdomen. Continue giving thrusts until the object blocking the airway is dislodged and the victim begins to breathe, or until the victim becomes unconscious.

Unconscious Adult

If, during the primary survey, your breaths will not go in an unconscious adult, and you retilted the head and tried again but the breaths still would not go in, you must assume the victim's airway is obstructed.

If the victim is a conscious choking adult who became unconscious, you must lower him or her to the floor on his or her back. Perform a head tilt and chin lift to try to open the airway, and attempt to remove the obstruction by sweeping it out of the victim's mouth with your finger. This is called a finger sweep. Always use a hooking action, being careful not to lodge the object in further.
Perform a head tilt and a chin lift and give 2 slow breaths. If the breaths still do not go in, go to abdominal thrusts.

Straddle one or both of the victim's thighs. Place the heel of one hand on the victim's abdomen, just above the bellybutton yet far below the tip of the breastbone. Place your other hand on top of the first, interlacing your fingers, and give 5 quick upward thrusts. Then do a finger sweep and give 2 slow breaths. If air still will not go in, continue giving 5 abdominal thrusts, a finger sweep and 2 slow breaths. Continue giving thrusts until the object is dislodged, air goes into the victim, or trained medical personnel takes over. If the victim is not breathing but has a pulse, you must perform Rescue Breathing. If the victim is not breathing and does not have a pulse, go to CPR.

**Choking Child**

Conscious Child

If the child can cough or talk, encourage him or her to continue coughing. If the child cannot cough or talk, ask if he or she is choking. Perform abdominal thrusts. Stand behind the victim, wrap your arms around his or her waist, and make a fist with one hand. Place the thumb side of the fist against the child's abdomen, above the bellybutton yet far below the tip of the breastbone. Put your other hand over the fist and give quick upward thrusts into the victim's abdomen. Continue giving thrusts until the airway is cleared and the child begins to breathe, or until the child becomes unconscious.

Unconscious Child

If the child was a conscious choking victim who became unconscious, lower the child down onto his or her back. Or, you may have determined during the primary survey that air would not go in, even after you retilted and tried again. You must give the child 5 abdominal thrusts, do a finger sweep if you see the object, and open the airway with a head tilt and a chin lift and give 2 slow breaths. If the breaths still will not go in, continue giving abdominal thrusts, a finger sweep and 2 slow breaths until the object is expelled, the child starts to breathe or cough, or EMS takes over. If the child is not breathing but has a pulse, you must perform Rescue Breathing. If the child is not breathing and does not have a pulse, go to CPR.

**Choking Infant**

Conscious Infant

During the primary survey, you may determine that the infant is conscious and cannot breathe, cough or cry. You must give 5 back blows and 5 chest thrusts.

Place the infant face up on your forearm. Put your other arm on top of the infant. Use your thumb and fingers to hold the infant's jaw, sandwiching the infant between your forearms. Turn the infant over, facedown on your forearm. Place your arm down on your thigh, being sure that the infant's head is lower than his or her chest. Using the heel of your hand, give 5 back blows between the infant's shoulder blades. Be sure to hold the infant's jaw with your thumb and fingers to stabilize his or her head.

You must turn the infant back over to give chest thrusts. Place your free hand and forearm across the infant, sandwiching it between your forearms and supporting his or her head. Turn the infant over onto his or her back and place your arm down on your thigh, making sure the infant's head is lower than his or her chest. Imagine a line across the infant's chest between the nipples. Place your ring finger on the infant's breastbone just below the imaginary line. Place the pads of the next two fingers just under the line. Raise your ring finger, and if you can feel the notch at the tip
of the infant's breastbone, move your fingers up a little bit. Compress the infant's breastbone 1/2-1 inch with the pads of your fingers and then let the breastbone return to its normal position. Give 5 compressions. Continue giving back blows and chest thrusts until the infant can breathe or cough, or until the infant becomes unconscious.

Unconscious Infant

If the infant was a conscious choking victim who became unconscious, place the infant down on its back. Or, you may have determined during the primary survey, even after retilting the head and trying again, that air would not go in. Perform 5 back blows and then 5 chest thrusts. Do a foreign body check: open the infant's mouth, holding the tongue and lower jaw and lifting them upward, and look for an object; if you do see an object, do a finger sweep to remove it with your little finger. Then give 2 slow breaths. If air still will not go in, continue doing back blows, chest thrusts, foreign body check and 2 slow breaths until the infant starts to breathe or cough or air goes in. If the infant is not breathing but has a pulse, you must perform Rescue Breathing. If the infant is not breathing and does not have a pulse, go to CPR.

Choking Pregnant Woman or Obese Person

Conscious Adult

If a choking conscious adult is noticeably pregnant or too obese for you to wrap your arms around in order to perform abdominal thrusts, you must give chest thrusts instead. Stand behind the victim, placing your arms under the victim's armpits and around his or her chest. Make a fist with one hand and put the thumb side of the fist against the center of the victim's breastbone. Make sure your thumb is on the breastbone, not the ribs, and that you are not near the tip of the breastbone. Put your other hand over the fist and give quick inward thrusts. Continue giving thrusts until the object is dislodged, or until the victim becomes unconscious.

Unconscious Adult

If the victim was a conscious choking pregnant woman or obese person who became unconscious, lower the victim gently onto his or her back on the floor. Or, you may have determined during the primary survey, even after retilting the head and trying again, that air would not go into your pregnant or obese victim. You must give chest thrusts. Kneel beside the victim, placing one hand on the center of the victim's breastbone and then placing your other hand on top of it. Give 5 quick thrusts, compressing the chest 1 1/2-2 inches. Do a finger swipe, open the airway with a head tilt and a chin lift, and give 2 slow breaths. If air still will not go in, continue giving chest thrusts, finger sweeps and 2 slow breaths until the object is expelled and air goes in. If the victim is not breathing and has a pulse, go to Rescue Breathing. If the victim is not breathing and does not have a pulse, go to CPR.
A poison is a substance that causes injury or illness when it gets into a person's body. The four ways a person can be poisoned are: ingestion (swallowing it), inhalation (breathing it), absorption (absorbing it through the skin), and injection (by having it injected into the body). Ingested poisons include foods, alcohol, medication, household and garden items, and certain plants. Inhaled poisons may be gases, like carbon monoxide from car exhaust, carbon dioxide from sewers, and chlorine from a pool, or fumes from household products like glue, paint, cleaners, or drugs. Absorbed poisons enter the body through the skin; they may come from plants, fertilizers or pesticides. Injected poisons enter the body through bites or stings of insects, spiders, ticks, marine life, snakes, and other animals, or medications injected with a hypodermic needle.

**Ingestion**

If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. Signs of poisoning are: nausea, vomiting, diarrhea, chest or abdominal pain, difficulty breathing, changes in consciousness, seizures, or burns around the lips or tongue or on the skin. If you believe someone may have swallowed a poison, try to determine what type of poison was ingested, how much was taken, and when it was taken. If you find a container, bring it to the telephone with you when you make your emergency call. Do not give the victim anything to eat or drink unless medical professionals tell you to. If you are unsure of what the poison was and the victim vomits, save some of it so that the hospital may analyze it and determine what the poison was.

**Inhalation**

If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. Signs of poisoning by inhalation may include pale or bluish skin. Remove the victim from the source of the toxic fumes so he or she can get some fresh air as soon as possible.

**Absorption**

If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. If poison, such as dry or wet chemicals, gets on the skin, flush the area with large amounts of water, and continue flushing the area with water until EMS arrives. If you have simply had a run-in with poison ivy, poison oak or poison sumac, there is no need to call EMS. Wash the affected area with soap and water. If you develop a rash, put a paste of baking soda and water on the area several times a day, or use an anti-itch lotion or an antihistamine to relieve the itchiness. Be aware that some people can have allergic
reactions to even over-the-counter drugs to stop itching...use caution and if you have any doubts about whether you are allergic, talk to you doctor!. See a doctor if the condition gets worse, affecting large areas of the body or face.

WELCOME TO THE JUNGLE

Insect Stings | Spiders | Everything Else Including Snakes

Injection-Stings and Bites

If someone is stung by an insect, such as a bee, remove the stinger by scraping it away from the skin with your fingernail or a plastic card, or use tweezers. Wash the area with soap and water, cover it to keep it clean, and apply ice to reduce pain and swelling. If the victim begins to have trouble breathing, he or she may be experiencing an allergic reaction and his or her body is going into anaphylactic shock. You must CALL EMS immediately or the victim's airway may constrict, preventing breathing and killing the victim.

Scorpions and Spiders

Only a few species of scorpions are known to cause death. Scorpions live in dry regions of the southwestern U.S. and Mexico, under rocks, logs and the bark of certain trees. They are most active at night. If you are stung by a scorpion, you would be wise to call EMS unless you are positive that the one that bit you is not poisonous.

Only two spiders in the U.S. have bites that can make you seriously ill or kill you. The black widow spider is black with a reddish hourglass shape on the underside of its body. The brown recluse spider is light brown with a darker brown, violin-shaped marking on the top of its body. Both prefer dark, out-of-the-way places, and bites usually occur on the arms or hands of people rummaging in dark garages or attics or in wood piles (In other words, don't go looking for them and they won't bite you!).

Symptoms of spider bites and scorpion stings are: nausea, vomiting, difficulty breathing or swallowing, sweating and salivating profusely, severe pain in the bite/sting area, a mark indicating a bite/sting, and swelling of the area. If you suspect you have been bitten by a black widow or a brown recluse or stung by a scorpion, wash the wound, and apply ice to the area, and call EMS immediately. Antivenins, medications that block the effect of the poison, are available.

Marine Life, Snakes and Other Animals

The stings of some different types of marine life, such as sting rays, sea anemones and jellyfish may make you sick. If you are stung, soak the affected area in salt water and apply a paste of baking soda or meat tenderizer, or even ice, as soon as possible to reduce swelling. If you are unsure what stung you, have a history of allergic reactions to marine life stings, are stung on the face or neck, or are having difficulty breathing, call EMS immediately.

Only four kinds of snakes found in the U.S. are poisonous: rattlesnake (distinctive rattling sound before it strikes), water moccasin, copperhead, and coral snake (distinctive red, yellow and black markings). If you are bitten by a snake, call EMS immediately. Wash the wound and immobilize the area, keeping it lower than the heart if possible. DO NOT apply ice, DO NOT cut the wound, and DO NOT apply a tourniquet. Get yourself medical attention quickly.

If you are bitten by a wild or domestic animal, you may get an infection and you will have injury to the soft tissue. The most serious possible consequence is rabies, which is transmitted through the saliva of diseased animals, including dogs, cats, raccoons, skunks, cattle, and bats. Infected animals may behave strangely; for example, a nocturnal animal like a raccoon may be active during the day, or the animal may drool, appear partially paralyzed, or act irritable, mean, or quiet. Rabies is fatal if it is not treated
promptly. If you suspect that you have bitten by a rabid animal, call EMS immediately. Get away from
the animal. DO NOT try to catch or hold it. Wash the wound with soap and water if it is minor, control
bleeding and apply an antibiotic ointment and a dressing. If the wound is bleeding heavily, do not try to
wash it; just try to control the bleeding, and call EMS. Try to remember what the animal looked like, as
well as where you last saw it. Call EMS and inform them, and they will get the proper authorities
involved.

Who needs to worry about this? | Heat | Cold

Who is at risk?
People who work or exercise outdoors or indoors where the temperature is poorly regulated, elderly
people, young children, people with health problems, a respiratory or cardiovascular disease or poor
circulation, people who take medications to eliminate water from the body, and people who have a history
of heat or cold-related illness in the past are at risk for heat or cold-related illnesses.

Heat-Related Illnesses

Heat Cramps
Heat cramps, heat exhaustion and heat stroke are the three conditions caused by overexposure to heat.
Heat cramps are painful muscle spasms. They result from a combination of fluid and salt loss caused by
heavy sweating. Heat cramps usually occur after strenuous exercise or work outdoors in warm
temperatures. They tend to occur in the legs and the abdomen. They are an indication of a more severe
problem to come if proper care is not given shortly.

Care for Heat Cramps
Have the victim rest comfortably in a cool place, and provide him or her with cool water or a
sports drink. Stretch the muscle gently and massage the area. Once the cramps stop, the victim
may resume physical activity, but he or she should be sure to drink plenty of fluids during and
after activity.

Heat Exhaustion

library.thinkquest.org
Heat exhaustion, the most common heat-related illness, typically occurs after strenuous exercise or work in a hot environment. The victim loses fluid through sweating, and blood flow to the skin increases, thus reducing blood flow to the vital organs. The victim therefore goes into mild shock. Symptoms of heat exhaustion are: normal or below normal body temperature; pale, moist, cool skin; headache; nausea; dizziness; weakness; and exhaustion. If heat exhaustion is allowed to progress, the victim's condition will worsen until he or she has heat stroke.

Heat Stroke
Heat stroke, the least common heat-related illness, occurs when heat exhaustion symptoms are ignored. The body systems become overwhelmed by heat. Sweating stops, and the body can no longer cool itself. Body temperature rises rapidly, and the brain and other vital organs will begin to fail. Convulsions, coma and death may result. Signs of heat stroke are: high body temperature; hot, red, dry skin; progressive loss of consciousness; rapid, weak pulse; and rapid, shallow breathing.

Care for Heat-Related Illnesses
Call EMS immediately if the victim's condition is so bad you suspect heat stroke. If heat-related illness is recognized in the early stages, it can usually be reversed. Move the victim to a cool area and give him or her cool water to drink. Remove any tight or heavy clothing and cool the body however you can; apply cool, wet cloths to the skin, fan the victim, or place ice packs on the victim's wrists and ankles, in each armpit and on the neck in order to cool the large blood vessels. DO NOT apply rubbing alcohol—it prevents heat loss. Do not let the victim drink too much too quickly, 4 ounces every 15 minutes is good. If the victim vomits, stop giving fluids and position the victim on his or her side, keep the airway clear and monitor breathing and pulse. Keep the victim lying down, and continue cooling the body until EMS arrives.

Cold Emergencies
Frostbite
Frostbite is the freezing of body tissues. It usually occurs in exposed areas of the body, affecting superficial or deep tissues. Frostbite is quite serious. Water inside and between the body's cells freeze and swells, damaging or destroying the cells. Frostbite often results in the loss of fingers, hands, arms, toes, feet, and legs. Symptoms of frostbite are: lack of feeling in the area, a waxy appearance to the skin, skin that is cold to the touch, and skin that is discolored (flushed, white, yellow or blue).

Care for Frostbite
Handle the area very gently, and DO NOT rub the affected area. Warm the area by soaking it in water no warmer than 100-105 degrees Fahrenheit, using a thermometer to check the water temperature if possible. DO NOT let the affected body part touch the bottom or sides of the container holding the water. Leave the frostbitten area in the water until it is red and feels warm. Bandage the area with a dry, sterile dressing, placing cotton or gauze between frostbitten fingers or toes. Avoid breaking any blisters, and seek medical attention as soon as possible.

Hypothermia
When hypothermia occurs, the entire body cools because its warming mechanisms fail. If proper care is not promptly administered, the victim will die. Body temperature drops below 95 degrees Fahrenheit in hypothermia, the heartbeat becomes erratic and finally stops, and the victim dies. Symptoms of
hypothermia are: shivering; a slow, irregular pulse; numbness; a glassy stare; and apathy along with decreasing levels of consciousness. People can develop hypothermia even when the temperature is only moderately cold. Elderly people in poorly heated homes, homeless or ill people, or people with certain medical conditions are more susceptible to hypothermia. Anyone submerged in cold water or remaining in wet clothes for a prolonged period of time may develop hypothermia quite easily.

Care for Hypothermia

If you suspect a victim may have hypothermia, call EMS immediately. Care for any life-threatening problems. Remove any wet clothing, dry the victim, and warm the body gradually by wrapping the victim in blankets. Move the victim to a warm place. You can use hot water bottles or heating pads to help re-warm the body, but be sure to put a barrier, like a blanket, towel or clothing, between the heat source and the victim to keep from burning him or her. DO NOT warm the victim too quickly, and DO NOT immerse the victim in warm water. Handle the victim very gently. In cases of severe hypothermia, the victim may be unconscious. Monitor the victim's breathing and pulse until EMS arrives.
Medicare Advantage and Part D Fraud, Waste and Abuse Compliance Training 2009

Overview

• This Medicare Advantage and Part D Fraud, Waste and Abuse Compliance Training for first-tier, downstream and related entities has been developed by Blue Cross and Blue Shield of Minnesota, First Plan of Minnesota, HealthPartners, Metropolitan Health Plan, Medica, UCare, PrimeWest Health, South Country Health Alliance and Itasca Medical Care in collaboration with the Minnesota Council of Health Plans Fraud Waste and Abuse Training Workgroup.*

• The Centers for Medicare & Medicaid Services (CMS) requires annual fraud, waste and abuse training for organizations providing health, prescription drug or administrative services to Medicare Advantage (MA) or Prescription Drug Plan (PDP) enrollees on behalf of a health plan.**

• As MA and PDP Sponsors, Minnesota health plans are committed to following all applicable laws, regulations and guidance that govern these programs.

*Other plan sponsors may use this training with permission of the Minnesota Council of Health Plans.

**(See 42 CFR Section 422.504(b)(4)(vi)(c) and/or Section 423.504(b)(4)(vi)(c)).
Overview & Objectives

- **What:** New federal requirements you must know
- **Why:** Detect, prevent and correct fraud, waste and abuse; raise awareness about the issue
- **How:** Plan Sponsors must implement an effective compliance plan including measures to detect, prevent and correct fraud, waste and abuse
- **When:** Complete this training now and yearly thereafter
- **Who:** You

Definitions

- **Plan Sponsor:** An entity that has a contract with CMS to offer one or more of the following Medicare Products: Medicare Advantage (MA) Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans (PDP) and 1876 Cost Plans.
- **First Tier Entity:** A party that enters into a written arrangement, acceptable to CMS, with a Plan Sponsor to provide administrative services or health care services for a Medicare eligible individual under the MA or Part D programs. Examples include Pharmacy Benefits Manager (PBM), contracted hospitals, clinics and allied providers.
- **Downstream Entity:** A party that enters into a written arrangement, acceptable to CMS, with persons or entities involved in the MA or Part D benefit, below the level of the arrangement between a Plan Sponsor and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include pharmacies, marketing firms, quality assurance companies, claims processing firms and billing agencies.
- **Related Entity:** An entity that is related to the Plan Sponsor by common ownership or control and performs some of the Plan Sponsor’s management functions under contract or delegation; furnishes services to Medicare enrollees under an oral or written agreement; or leases real property or sells materials to the Plan Sponsor at a cost of more than $2,500 during a contract period.
First Tier and Downstream Example

Requirements

- Federal law requires MA and PDP Sponsors to have a Compliance Plan
- An MA or PDP Sponsor must:
  - Create a Compliance Plan that incorporates measures to detect, prevent, and correct fraud, waste and abuse
  - Create a Compliance Plan that must consist of training, education and effective lines of communication
  - Apply such training, education and communication requirements to all entities which provide benefits or services under MA or PDP programs
  - Produce proof (attestations and copies of training logs) from first-tier, downstream and related entities to show compliance with these requirements

What is a Compliance Plan?

An effective Compliance Plan includes 7 core elements:

1. **Written Standards of Conduct**: development and distribution of written Standards of Conduct and Policies & Procedures that promote the Plan Sponsor’s commitment to compliance and that address specific areas of potential fraud, waste and abuse

2. **Designation of a Compliance Officer**: designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program

3. **Effective Compliance Training**: development and implementation of regular, effective education and training, such as this training

4. **Internal Monitoring and Auditing**: use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem areas

5. **Disciplinary Mechanisms**: policies to consistently enforce standards and address dealing with individual or entities that are excluded from participating in CMS programs

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Compliance Plan (continued)

6. **Effective Lines of Communication**: between the compliance officer and the organization’s employees, managers and directors and members of the compliance committee, as well as first tier, downstream and related entities
   - Includes a system to receive, record and respond to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality
   - First tier, downstream, and related entities must report compliance concerns and suspected or actual misconduct involving the MA or Part D programs to the Plan Sponsor

7. **Procedures for Responding to Detected Offenses and Corrective Action**: policies to respond to and initiate corrective action to prevent similar offenses including a timely, reasonable inquiry
Why Focus on Fraud, Waste and Abuse

• Scams alone cost the health care industry more than $100 billion annually
• Fraud, waste and abuse programs save Medicare dollars and that benefits taxpayers, government, health plans and beneficiaries
• Detecting, correcting and preventing fraud, waste and abuse requires collaboration between:
  ➢ You
  ➢ Providers of services such as physicians, nurses and pharmacies
  ➢ State and federal agencies
  ➢ Beneficiaries

Fraud, Waste and Abuse Defined

• **Fraud:** an intentional act of deception, misrepresentation or concealment in order to gain something of value. Examples include:
  ➢ billing for services that were never rendered
  ➢ billing for services at a higher rate than is actually justified
  ➢ deliberately misrepresenting services, resulting in unnecessary cost to the Medicare program, improper payments to providers or overpayments

• **Waste:** over-utilization of services (not caused by criminally negligent actions) and the misuse of resources

• **Abuse:** excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. Examples include:
  ➢ charging in excess for services or supplies
  ➢ providing medically unnecessary services
  ➢ billing for items or services that should not be paid for by Medicare
Fraud, Waste and Abuse

**Prescriber Examples**

- **Illegal Payment Schemes**
  - Prescriber is offered, paid, solicits or receives unlawful payment to induce or reward the prescriber to write prescriptions for drugs or products.

- **Script Mills**
  - Prescribers write prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the prescriber.

- **Theft of Prescriber’s Drug Enforcement Agency (DEA) Number or Prescription Pad**
  - Prescription pads and/or DEA numbers stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications.

**Source:** Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (Rev.2, 04-25-2006), Section 70.1.4

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**Wholesaler Examples**

- **Counterfeit, Impure Drugs through Black Market**
  - Black Market includes fake, diluted, expired, illegally imported drugs, etc.

- **Diversers**
  - Individuals who illegally gain control of discounted medicines and mark up the prices and move them to small wholesalers.

- **Inappropriate Documentation of Pricing Information**
  - Submitting false or inaccurate pricing or rebate information.

**Source:** Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (Rev.2, 04-25-2006), Section 70.1.5
Fraud, Waste and Abuse

**Beneficiary Examples**

- **Identify Theft**
  - Using a member’s I.D. card that does not belong to that person to obtain prescriptions, services, equipment, supplies, doctor visits, and/or hospital stays.

- **Doctor Shopping**
  - Visiting a number of doctors to obtain multiple prescriptions for painkillers or other drugs. Might point to an underlying scheme (stockpiling or black market resale).

**Source:** Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (Rev.2, 04-25-2006), Section 70.1.7

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Fraud, Waste and Abuse

**Pharmaceutical Manufacturer Examples**

- **Illegal Off-label Promotion**
  - Promotion of off-label drug use

- **Illegal Usage of Free Samples**
  - Providing free samples to prescribers knowing and expecting prescriber to bill Medicare for the sample

- **Kickbacks, Inducements, Other Illegal Payments**
  - Inappropriate marketing or promotion of products reimbursable by federal health care programs
  - Inappropriate discounts or educational grants

**Source:** Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (Rev.2, 04-25-2006), Section 70.1.6
Fraud, Waste and Abuse

Plan Sponsor Examples

• Payments for Excluded Drugs
  ➢ Receiving payment for drugs not covered by the Plan Sponsor’s formulary

• Marketing Schemes
  ➢ Offering beneficiaries a cash payment as an encouragement to enroll in a Medicare Plan
  ➢ Unsolicited door-to-door marketing
  ➢ Use of unlicensed agents
  ➢ Enrollment of individual in a Medicare Plan without such individual’s knowledge or consent
  ➢ Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (Rev.2, 04-25-2006), Section 70.1.1

Fraud, Waste and Abuse

Pharmacy Benefits Manager (PBM)/Pharmacy Examples

• Prescription Drug Switching
  ➢ PBM receives a payment to switch a beneficiary from one drug to another or influence prescriber to switch patient to a different drug

• Prescription Drug Splitting or Shorting
  ➢ PBM mail order pharmacy intentionally provides less than the prescribed quantity, does not inform the patient or make arrangements to provide the balance and bills for the fully-prescribed amount
  ➢ Splits prescription to receive additional dispensing fees

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (Rev.2, 04-25-2006), Section 70.1.2
Fraud, Waste and Abuse

Billing Examples

- Inappropriate Billing Practices
  - Billing for services not provided
  - Misrepresenting the service that was provided
  - Billing for a higher level than the service actually delivered
  - Billing for non-covered services or prescriptions as covered items

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (Rev.2, 04-25-2006), Section 70.1.3

Federal Fraud, Waste and Abuse Laws

- False Claims Act: Prohibits any person from knowingly presenting or causing a fraudulent claim for payment.
- Anti-Kickback Statute: Makes it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a Federal health care program.
- Self-Referral Prohibition Statute (Stark Law): Prohibits physicians from referring Medicare patients to an entity with which the physician or a physician’s immediate family member has a financial relationship — unless an exception applies.
Reporting Potential Fraud, Waste and Abuse

Everyone has the right and responsibility to report possible fraud, waste or abuse. Report issues or concerns to:

• Your organization's compliance officer or compliance hotline and/or
• The compliance officer or compliance hotline of the applicable Plan Sponsor(s) with whom you participate; compliance hotline numbers are available on each Plan Sponsor's websites and/or
• 1-800-MEDICARE

Remember:
You may report anonymously and retaliation is prohibited when you report a concern in good faith.

Fraud, Waste and Abuse Resources

Federal government websites are sources of information regarding detection, correction and prevention of fraud, waste and abuse:

• Department of Health and Human Services Office of Inspector General: http://oig.hhs.gov/fraud.asp

• Centers for Medicare & Medicaid Services (CMS): http://www.cms.hhs.gov/MDFraudAbuseGenInfo/

• CMS Information about the Physician Self Referral Law: www.cms.hhs.gov/PhysicianSelfReferral
Training Completed

- Congratulations! You’ve completed the compliance training.
- Please report back to your organization that you have completed this training. This step is important. Your organization is required to keep a log of who completed the training.
Definitions

“Abuse” means any of the following:

1. Physical abuse
2. Emotional abuse
3. Sexual abuse
4. Treatment without consent
5. Unreasonable confinement or restraint

“Caregiver” means a person who has assumed responsibility for all or a portion of an individual’s care voluntarily, by contract, or by agreement, including a person acting or claiming to act as a legal guardian.

“Elder adult at risk” means any person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation.

“Elder-adult-at-risk agency” means the agency designated by the county board of supervisors to receive, respond to, and investigate reports of abuse, neglect, self-neglect, and financial exploitation.

“Emotional abuse” means language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonable could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.

“Financial exploitation” means any of the following:

1. Obtaining an individual’s money or property by deceiving or enticing the individual, or forcing, compelling, or coercing the individual to give, sell at less than fair market value, or in other ways convey money or property against his or her will without his or her informed consent.
2. Theft
3. The substantial failure or neglect of a fiscal agent to fulfill his or her responsibilities.
4. Unauthorized use of an individual’s personal identifying information or documents.
5. Forgery
6. Financial transaction card crimes

“Neglect” means the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual’s physical or mental health.
“Physical abuse” means the intentional or reckless infliction of bodily harm.

“Self-neglect” means a significant danger to an individual’s physical or mental health because the individual is responsible for his or her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

“Treatment without consent” means the administration of medication to an individual who had not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.

“Unreasonable confinement or restraint” includes the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his or her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint.

**Purpose**

1. To protect individuals who, because of physical or mental disability or dependence on home health services, are particularly vulnerable to abuse or neglect.
2. To ensure a safe living environment for vulnerable individuals who are receiving services.
3. To identify within the client's home all potential areas that might contribute to vulnerability and include corrective measures in the care plan.
4. To provide protection to individuals reporting abuse or neglect within the parameters of the law.

**Policy**

It is the policy of this agency to protect clients who are vulnerable to neglect, abuse, or maltreatment due to physical or mental disability. It is also our policy to comply fully with the Wisconsin Statutes and to cooperate with the State Department of Human Services or other investigative authorities in the course of any investigation regarding vulnerable persons. Staff members are aware of physical handicaps and weaknesses of the clients and are responsible for their safety and comfort at all times during the normal day. This includes assisting other staff members when acts of vulnerability occur that can only be handled with additional help and physical assistance.
All agency staff, including volunteers and temporary workers are mandated reporters. A mandated reporter is anyone who comes in contact with a vulnerable adult.

All clients receiving care are considered to be vulnerable adults / children / elder adults at risk.

The agency will develop an individual abuse prevention plan for each vulnerable adult / elder and vulnerable minor receiving services. The plan will contain an individualized assessment of the person’s susceptibility to abuse (including self-abuse), and a statement of the specific measures to be taken to minimize the risk of abuse to that person.

The individualized assessment of each client will include:

(1) The person’s susceptibility to abuse by other individuals, including other vulnerable adults; and
(2) The person’s risk of abusing other vulnerable adults; and
(3) Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

**Procedure**

**ASSESSMENT:**

When staff are entering a client's environment, staff should naturally assess the environment for any issues or concerns of safety. If any issues are noted, the staff should try to discuss the concern with the client and ways to reduce the risk. If the client does not want to discuss, document in the progress notes the issue and communicate with your supervisor for further follow-up.

1. Assessment
   a) Assessment of physical environment
      1. Doors accessible and in good repair.
      2. Bed - clean, in good condition.
      3. Furniture - chairs, table, equipment appropriate to individual needs.
      4. Electrical items - lamps, cords, lights, switches (proper working order).
      5. Faucets in working order.
      6. Bathroom - toilet bowl and utensils clean and in good working order.
      7. Kitchen - refrigerator proper temp and foods fresh; garbage control; sink drain working, range clean and in good working order.
      8. Temperature of room - comfortable for client.
   b) Assessment of individual
      1. Client’s susceptibility to abuse by other individuals, including other vulnerable adults
2. The client’s risk of abusing other vulnerable adults
3. Physical evidence of welts, bruises, untreated sores or injuries.
4. Injuries inadequately treated or untreated.
5. Evidence of poor overall care.
6. Given inappropriate food, drink or medication.
7. Inadequate supervision.
8. Behaviors which may be indicative of abuse or neglect, such as: excessive fear, crying, apathy, anxiety, behavioral extremes, depression.

**c) Assessment of psychosocial - cultural**

1. Family history of abuse or neglect.
2. High stress levels within the past year.
3. Family lacks knowledge and understanding of norms and needs of vulnerable individual.
4. Violation of rights of vulnerable individual including misuse of funds.
5. Family lacks social support network such as neighbors, friends, and relatives.
6. Cultural values stigmatize person with handicap, mental illness or other not defined as their "norm."
7. Family refers to vulnerable individual in abusive or derogatory manner

**INTERNAL REPORTING PROCEDURE**

Any employer, or employee, or delegate of the client who has knowledge of the abuse or neglect of a vulnerable individual and has reasonable cause to believe that a vulnerable individual is being or has been neglected must verbally report said incident to the Administrator.

The mandated reporter should report the alleged maltreatment to his/her immediate supervisor (SEE BELOW FOR TIME LINE FOR REPORTING)

The supervisor will also complete an Incident Report (to be kept in a separate file from the clinical record).

The report must include:

- The name and location of the person and the program
- Nature of the maltreatment.
- Pertinent dates and times
- Any history of maltreatment
- Name and address of the alleged perpetrator
- Name and address of the reporter
- Whether or not the reporter wishes to receive notification of the initial and final reports
- Any other information that may be helpful
The report must be made immediately to the supervisor, after the mandated reporter becomes knowledgeable of the incident. The supervisor will report the incident to the Common Entry Point (CEP). It is the reporter's responsibility to ensure that the report reaches appropriate outside investigative authorities.

The written report will be on the appropriate form and will identify the vulnerable individual, person providing care, nature and extent of suspected abuse or neglect including evidence of any previous abuse or neglect, reporter's name and address in conjunction with any additional information to assist with the investigation.

The person reporting will NOT discuss the incident with anyone else.

The supervisor investigates and determines WITHIN 24 HOURS probable maltreatment, abuse or neglect or not.

If maltreatment, abuse, or neglect is suspected, a report is completed and called in to the County.

If an employee is the suspected abuser, the employee is removed from the home and will be removed from any other scheduled home care services as the supervisor investigates and determines WITHIN 24 HOURS either probable maltreatment, abuse or neglect or not.

Employee will be immediately notified that he or she is placed on temporary leave of absence while the incident is under investigation.

When probable maltreatment, abuse or neglect is indicated: the report will be processed as described in the internal reporting procedure. The supervisor will submit a written report WITHIN 48 HOURS to the Internal Control / Compliance Director who will discuss the situation with the President/CEO.

If no evidence of maltreatment is found, the suspected employee will be given written notification of such.

The reporter shall be informed when a report has been forwarded so the CEP.

The person(s) responsible for conducting the internal investigation is the Director of Compliance and/or the President/CEO and/or another designated individual by the CEO.

**EXTERNAL REPORTING PROCEDURE**

1. All internal reports shall be promptly reviewed by the supervisor and forwarded to the Corporate Office – Compliance Director. If the agency finds there is reason to believe maltreatment has occurred or the individual has sustained injury which is not reasonably explained, it will promptly report to the appropriate County where the client lives.
2. Agency staff have the option of bypassing internal reporting procedures and reporting directly to the County. The County will sort and refer all vulnerable adult calls and will take the information on a standard intake form. However, it is the policy of the company to have incidents are reported internally to protect the clients and the staff.

3. If an Agency employee has reasonable cause to believe that a vulnerable adult has died as a direct or indirect result of maltreatment, he/she shall report that information internally which and to the County.

4. Agency personnel should use reasonable judgment in reporting, making sure that the maltreatment is apparent, and not merely hearsay.

CONFIDENTIALITY

1. All stages of the reporting process are considered confidential information and are not to be discussed with any person not directly involved or affected by the issue. However, should any portion of the issue be brought to a court of law any or all of the information may become public.

2. Any person making a report in good faith will have immunity from any civil or criminal liability that otherwise might result from this reporting or participating in the investigation.

3. A mandated reporter who negligently or intentionally fails to report is liable for damages caused by the failure.

4. Failure to report is a misdemeanor and exposes the non-reporter to potential civil damages.

5. Any person who intentionally makes a false report is guilty of a misdemeanor and shall be liable for any actual civil damages suffered by the reported facility, and for any punitive damages up to $10,000 and attorney fees.

AGENCY RESPONSIBILITIES

1. To admit clients for whom care can be safely provided. Clients shall be discharged when they are in a safe environment or under the care of an appropriate caregiver or agency.

2. To do background investigations of all individuals providing direct services to clients.

3. To provide staff education regarding Vulnerable Adult Protection policy:
   a) Education shall be included in orientation to all new employees.
b) Inservice training shall be provided to all employees as new information becomes available.

c) Vulnerable adult assessments shall be reviewed during the quarterly clinical record review process.

d) Agency personnel shall cooperate fully with those assigned to investigate suspected adult maltreatment.

e) Agency personnel shall maintain client confidentiality and rights during the reporting and investigation process, as appropriate.

4. Complete report form and call report to County.

5. Compliance Director and/or President/CEO reviews all reports and makes sure resolution has been reached.

PREVENTION

1. All personnel are required to assess each client individually to determine the client's vulnerability to abuse or neglect, and develop a specific plan to minimize the risk of abuse to that client.

2. The following clients need to be assessed:
   a) Those who are physically frail or have severe functional limitations.
   b) Those who show evidence of decreased mental functioning.
   c) Those with identified environmental hazards/safety concerns.
   d) Those who lack family support.
   e) Those lacking basic food, clothing, shelter, health care, or supervision.

3. Preventive measures include but are not limited to:
   a) There must be a reasonable expectation that the client's needs can be met in the client's place of residence.
   b) Care plan - specific measures outlined following initial and ongoing assessment.
      1) Periodic review - to update and revise care plan.
   c) Identify high-risk situations with interventions of teaching and referral to appropriate community agencies.

4. Staff selected to provide care to clients shall be screened and interviewed to assure they have proper qualifications, reliable references, and adequate training. Employee orientation and ongoing education will be designed to enhance the skills and knowledge necessary to provide safe, quality care to clients and to carry forth the policies dealing with vulnerable adults/children.
INDIVIDUAL CONSIDERATIONS

1. For the physically frail or clients with severe functional limitations:
   a. Nurse observation of the client’s ability to meet basic needs. For example, observe transfers, meal preparation, etc.
   b. If there are questions regarding the client’s abilities, consult with the physician, the health care team members, and the caregiver (with the client’s permission).
   c. Request a physical therapy evaluation to assess rehabilitation potential.
   d. Establish what neighborhood and caregiver supports are available.
   e. When independent living is no longer appropriate, help the client and caregiver with problem solving.
   f. Arrange for paraprofessional help, based on the client’s needs and existing supports.
   g. Instruct the client on use of the 9-1-1 emergency telephone system.

2. For working with clients with decreased or decreasing mental functioning:
   a. The assessment is important in determining whether it is safe for the client to live independently. Concerns from caregivers, friends, or health care providers are important areas to examine.
   b. The assessment may have to take place over a period of time. For example, the nurse may monitor medication compliance and set up a reminder system for the caregiver or nurse to supervise.
   c. The nurse/social worker may acquaint the caregiver with respite care or senior-sitting services if a client cannot be left alone in the house.
   d. The agency staff may monitor the client’s eating habits by weighing the client to see if the client has lost weight. The staff may then arrange for home-delivered meals.
   e. The Nurse should assess whether changes in mental functioning have happened recently. Has a medical examination been done? Could medical treatment be the cause?
   f. When the client’s mental functioning is limited, include the caregiver in the problem-solving process to decide what alternatives are available. If a caregiver isn’t available or if the caregiver lacks interest, refer the case to Social Services.

3. For addressing environmental hazards/safety concerns present in the home environment:
   a. Conduct a thorough assessment of the client’s living areas using visual inspection and document findings.
   b. Educate the client to the hazards or potential problem areas that are present in his/her home environment.
   c. Refer safety concerns, such as basic housing repair or weatherization needs to the proper community resources.
   d. Talk with caregivers about needed repairs and safety precautions for the elderly who are not able to do the repairs (not low income).
   e. Encourage clients to report hazards to landlords or housing inspectors.

4. For addressing the lack of caregiver support and identifying alternatives in the community to broaden the client’s support base:
   a. Arrange for a volunteer/friendly visitor.
   b. Link the client up with community senior groups, congregate dining,
   c. Retired Volunteer Senior Program, Home Delivered Meals.
   d. Arrange for volunteer transportation.
   e. Check the client’s religious preferences and see what resources are available through local churches.
   f. The Registered Nurse/Therapist can monitor on a health supervision basis.
g. Refer the client to Social Services for supervision and/or money management services.
h. Assist the client in sorting through whether he/she is able to continue in his/her present living situation. Recommend possible alternatives.
i. When a caregiver is available, see if he/she is aware of the client’s needs and encourage the caregiver to give whatever support he/she can.

5. For adults lacking basic food, clothing, shelter, health care, or supervision:
   a. Have the client screened for public assistance.
   b. Refer the client to food shelves and Free Store for immediate food and clothing needs.
   c. Refer the client to Social Services Intake through the client’s county to meet emergency shelter needs.
   d. Refer the client to appropriate community resources or to Social Services Intake (county) to meet emergency health care needs if no financial resources are available.