AccuKare

Annual Training

Section 1

Bloodborne Pathogens

OSHA® FactSheet

OSHA's Bloodborne Pathogens Standard

Bloodborne pathogens are infectious microorganisms present in blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV), the virus that causes AIDS. Workers exposed to bloodborne pathogens are at risk for serious or life-threatening illnesses.

Protections Provided by OSHA's Bloodborne Pathogens Standard

All of the requirements of OSHA's Bloodborne Pathogens standard can be found in Title 29 of the Code of Federal Regulations at 29 CFR 1910.1030. The standard's requirements state what employers must do to protect workers who are occupationally exposed to blood or other potentially infectious materials (OPIM), as defined in the standard. That is, the standard protects workers who can reasonably be anticipated to come into contact with blood or OPIM as a result of doing their job duties.

In general, the standard requires employers to:

- **Establish an exposure control plan.** This is a written plan to eliminate or minimize occupational exposures. The employer must prepare an exposure determination that contains a list of job classifications in which all workers have occupational exposure and a list of job classifications in which some workers have occupational exposure, along with a list of the tasks and procedures performed by those workers that result in their exposure.
- **Employers must update the plan annually** to reflect changes in tasks, procedures, and positions that affect occupational exposure, and also technological changes that eliminate or reduce occupational exposure. In addition, employers must annually document in the plan that they have considered and begun using appropriate, commercially-available effective safer medical devices designed to eliminate or minimize occupational exposure. Employers must also document that they have solicited input from frontline workers in identifying, evaluating, and selecting effective engineering and work practice controls.
- **Implement the use of universal precautions** (treating all human blood and OPIM as if known to be infectious for bloodborne pathogens).
- **Identify and use engineering controls.** These are devices that isolate or remove the bloodborne pathogens hazard from the workplace. They include sharps disposal containers, self-sheathing needles, and safer medical devices, such as sharps with engineered sharps-injury protection and needleless systems.
- **Identify and ensure the use of work practice controls.** These are practices that reduce the possibility of exposure by changing the way a task is performed, such as appropriate practices for handling and disposing of contaminated sharps, handling specimens, handling laundry, and cleaning contaminated surfaces and items.
- **Provide personal protective equipment (PPE), such as gloves, gowns, eye protection, and masks.** Employers must clean, repair, and replace this equipment as needed. Provision, maintenance, repair and replacement are at no cost to the worker.
- **Make available hepatitis B vaccinations to all workers with occupational exposure.** This vaccination must be offered after the worker has received the required bloodborne pathogens training and within 10 days of initial assignment to a job with occupational exposure.
- **Make available post-exposure evaluation and follow-up to any occupationally exposed worker who experiences an exposure incident.** An exposure incident is a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or OPIM. This evaluation and follow-up must be at no cost to the worker and includes documenting the route(s) of exposure and the circumstances

under which the exposure incident occurred; identifying and testing the source individual for HBV and HIV infectivity, if the source individual consents or the law does not require consent; collecting and testing the exposed worker's blood, if the worker consents; offering post-exposure prophylaxis; offering counseling; and evaluating reported illnesses. The healthcare professional will provide a limited written opinion to the employer and all diagnoses must remain confidential.

- **Use labels and signs to communicate hazards.** Warning labels must be affixed to containers of regulated waste; containers of contaminated reusable sharps; refrigerators and freezers containing blood or OPIM; other containers used to store, transport, or ship blood or OPIM; contaminated equipment that is being shipped or serviced; and bags or containers of contaminated laundry, except as provided in the standard. Facilities may use red bags or red containers instead of labels. In HIV and HBV research laboratories and production facilities, signs must be posted at all access doors when OPIM or infected animals are present in the work area or containment module.
- **Provide information and training to workers.** Employers must ensure that their workers receive regular training that covers all elements of the standard including, but not limited to: information on bloodborne pathogens and diseases, methods used to control occupational exposure, hepatitis B vaccine, and medical evaluation and post-exposure follow-up procedures. Employers must offer this training on initial assignment, at least annually thereafter, and when new or modified tasks or procedures affect a worker's occupational exposure. Also, HIV and HBV laboratory and production facility workers must receive specialized initial training, in addition to the training provided to all workers with occupational exposure. Workers must have the opportunity to ask the trainer questions. Also, training must be presented at an educational level and in a language that workers understand.
- **Maintain worker medical and training records.** The employer also must maintain a sharps injury log, unless it is exempt under Part 1904 -- Recording and Reporting Occupational Injuries and Illnesses, in Title 29 of the Code of Federal Regulations.

Additional Information

For more information, go to OSHA's Bloodborne Pathogens and Needlestick Prevention Safety and Health Topics web page at: https://www.osha.gov/SLTC/bloodbornepathogens/index.html.

To file a complaint by phone, report an emergency, or get OSHA advice, assistance, or products, contact your nearest OSHA office under the "U.S. Department of Labor" listing in your phone book, or call us toll-free at **(800) 321-OSHA (6742)**.

U.S. Department of Labor

OSHA®
Occupational Safety and Health Administration

Job Safety and Health
IT'S THE LAW!

All workers have the right to:

- A safe workplace.
- Raise a safety or health concern with your employer or OSHA, or report a work-related injury or illness, without being retaliated against.
- Receive information and training on job hazards, including all hazardous substances in your workplace.
- Request an OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions. OSHA will keep your name confidential. You have the right to have a representative contact OSHA on your behalf.
- Participate (or have your representative participate) in an OSHA inspection and speak in private to the inspector.
- File a complaint with OSHA within 30 days (by phone, online or by mail) if you have been retaliated against for using your rights.
- See any OSHA citations issued to your employer.
- Request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

This poster is available free from OSHA.

Employers must:

- Provide employees a workplace free from recognized hazards. It is illegal to retaliate against an employee for using any of their rights under the law, including raising a health and safety concern with you or with OSHA, or reporting a work-related injury or illness.
- Comply with all applicable OSHA standards.
- Report to OSHA all work-related fatalities within 8 hours, and all inpatient hospitalizations, amputations and losses of an eye within 24 hours.
- Provide required training to all workers in a language and vocabulary they can understand.
- Prominently display this poster in the workplace.
- Post OSHA citations at or near the place of the alleged violations.

FREE ASSISTANCE to identify and correct hazards is available to small and medium-sized employers, without citation or penalty, through OSHA-supported consultation programs in every state.

Contact OSHA. We can help.

1-800-321-OSHA (6742) • TTY 1-877-889-5627 • www.osha.gov

OSHA 3165-04R 2015

Duties of PCA or Homemaker Interfaced with OSHA Regulations

1. *Assist with / perform prescribed exercises and / or delegated therapies that the PCA has been taught by appropriate personnel*

   No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids. The PCA should wash their hands before and after therapy activities. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

2. *Assist with food, nutrition, and diet activities*

   The PCA should wash their hands before and after these activities. Gloving is required if a G-tube feeding is performed. Facial protection such as a face shield is required if the child spits during the eating process. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluids contact these surfaces during these activities.

3. *Assist with / perform dressing and undressing activities*

   No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids.

4. *Assist with / perform mouth care activities*

   The PCA should wash their hands before and after this activity. Gloving and facial protection is required for this activity. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

5. *Assist with / perform grooming activities (face / hand washing, combing hair, shaving, and ordinary care of nails)*

   The PCA should wash their hands before and after this activity. No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

6. *Assist with / perform bathing / hair washing / skin care activities*

   The PCA should wash their hands before and after this activity. Gloving should be utilized with activity. Facial protection and/or gowning need to occur if PCA should come in contact with high-risk bodily fluids. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

7. *Assist with bowel and bladder care (diapering, bedpan, commode, toilet)*

The PCA should wash their hands before and after this activity. Gloving should be utilized with activity. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

8. *Assist with / perform transfers, turning, and positioning*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids.

9. *Assist with ambulation (walking) activities*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids.

10. *Assist with / perform application / maintenance of prosthetics / orthotics and cleaning of medical equipment*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

11. *Assist with / perform household tasks that relate directly to the client (i.e. make the client's bed, tidy client's room / empty garbage, wash dishes after meal for client, do client's laundry)*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

a. Garbage Handling – all waste generated by the PCA that could have high risk bodily fluid contained within it (diapers, disposable paper doweling, wipes, tissues, gloves, etc.) must be disposed of in a designated waste receptacle that either does not have a lid or that has a touch free opening device. The PCA is to empty this designated waste receptacle at the end of each shift. This waste must be double-bagged and removed with gloved hands. If there is any leakage of the waste into the waste receptacle, the PCA must wash the waste receptacle while wearing gloves and facial protection with normal soap and water and spray on the anti-viral solution, allowing it to air-dry.

b. Laundry Handling – all laundry that could contain a high risk bodily fluid (underwear, clothing soaked with urine, feces or vomit, linens, towels, etc.) must be placed in a closed container such as a laundry hamper / basket lined with a plastic bag or a plastic bag alone. If the PCA transports the laundry to the laundry room, it must be in this closed container while the PCA is wearing gloves. The laundry is transferred directly to the washer with minimal handling (gloves should be worn throughout the process and removed once the laundry is in the washer and the bag is in the designated waste receptacle). Regular laundry procedures are adequate for cleansing the clothing. Each time the PCA handles

the laundry hamper/basket and removes the bagging, it must be sprayed with the anti-viral solution and allowed to air-dry.

12. *Assist the primary care giver with medication(s)*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids.

13. *Respiratory assistance*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids, such as spattering or spraying from coughing or oral/pharyngeal suctioning. In that instance, facial protection should be utilized. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

14. *Redirect, monitor, observe, and / or intervene with problematic behaviors and seizures*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids through vomiting or biting of tongue / lip during a seizure, in which case the PCA should wear gloves and possibly facial protection and gowning as indicated. All non-porous surfaces need to be sprayed with the anti-viral solution if any high-risk bodily fluid contacts these surfaces during these activities.

15. *Accompany client to medical appointments (not including transportation by PCA; AccuKare, Inc.* ***does not*** *permit PCA's to transport clients at any time)*

No personal protective equipment is required for this activity unless the PCA is coming in contact with open / non-intact skin or potentially high-risk bodily fluids.

AccuKare

Annual Training

Section 2

Personal Protective Equipment

Enclosed is a fabric mask. It was made for you by one of many good samaritans in the community. It was donated to AccuKare to generously distribute to all its staff and clients. The recommendation from the Minnesota Department of Health and the CDC is that any staff entering into a care setting should have a covering for their face as should anyone going out into the community.

THIS MASK IS NOT PREWASHED. We did not want people to have reactions to particular soaps, etc. Please wash it as recommended by the CDC.

We recommend making or obtaining more for your general day to day use and not using your work ones anywhere else.

The mask you receive may have a "pocket" or not. We welcomed all that were donated. If it has a pocket, there are options for inserts as you desire on line.

We will distribute as many as we can obtain with first priority going to individuals who have no fabric masks. Once all staff and clients have a mask we will make available more as we are able.

This is NOT to be used in place of a face shield for Blood Borne Pathogens!!!!! It MAY be used in conjunction with a face shield.

AccuKare does not designate any particular style or pattern as a superior or inferior option. Many patterns are out there and many sewers are out there. We are passing on what we have received.

Please do not hesitate to reach out to us at 763-862-3971.

This handout is also available on our website Resources page at http://www.accukare.com/resources/

Use of Cloth Face Coverings to Help Slow the Spread of COVID-19

How to Wear Cloth Face Coverings

Cloth face coverings should—

- fit snugly but comfortably against the side of the face
- be secured with ties or ear loops
- include multiple layers of fabric
- allow for breathing without restriction
- be able to be laundered and machine dried without damage or change to shape

CDC on Homemade Cloth Face Coverings

CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain (e.g., grocery stores and pharmacies), **especially** in areas of significant community-based transmission.

CDC also advises the use of simple cloth face coverings to slow the spread of the virus and help people who may have the virus and do not know it from transmitting it to others. Cloth face coverings fashioned from household items or made at home from common materials at low cost can be used as an additional, voluntary public health measure.

Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the cloth face covering without assistance.

The cloth face coverings recommended are not surgical masks or N-95 respirators. Those are critical supplies that must continue to be reserved for healthcare workers and other medical first responders, as recommended by current CDC guidance.

Should cloth face coverings be washed or otherwise cleaned regularly? How regularly?

Yes. They should be routinely washed depending on the frequency of use.

How does one safely sterilize/clean a cloth face covering?

A washing machine should suffice in properly washing a cloth face covering.

How does one safely remove a used cloth face covering?

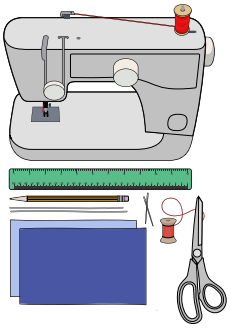
Individuals should be careful not to touch their eyes, nose, and mouth when removing their cloth face covering and wash hands immediately after removing.

cdc.gov/coronavirus

Sewn Cloth Face Covering

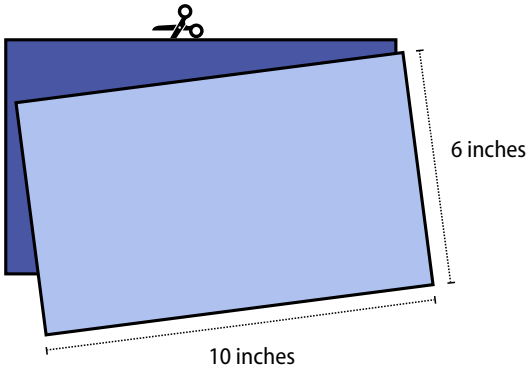
Materials

- Two 10”x6” rectangles of cotton fabric
- Two 6” pieces of elastic (or rubber bands, string, cloth strips, or hair ties)
- Needle and thread (or bobby pin)
- Scissors
- Sewing machine

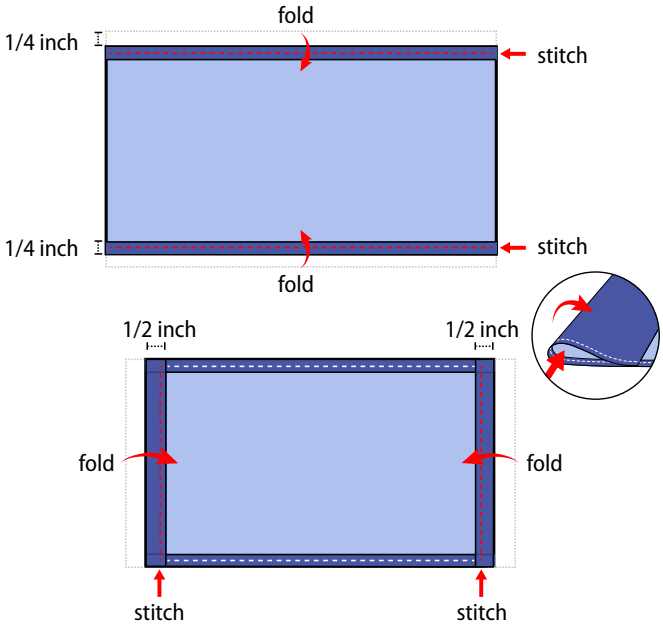


Tutorial

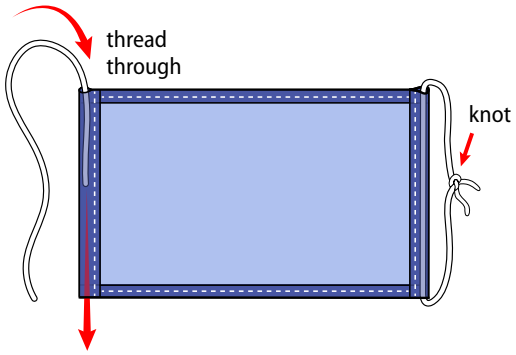
1. Cut out two 10-by-6-inch rectangles of cotton fabric. Use tightly woven cotton, such as quilting fabric or cotton sheets. T-shirt fabric will work in a pinch. Stack the two rectangles; you will sew the cloth face covering as if it was a single piece of fabric.



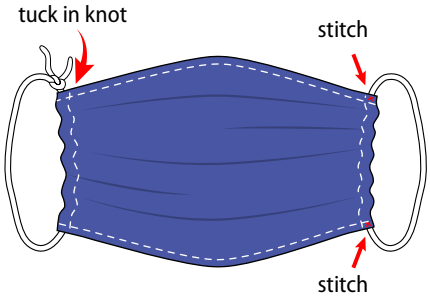
2. Fold over the long sides ¼ inch and hem. Then fold the double layer of fabric over ½ inch along the short sides and stitch down.



3. Run a 6-inch length of 1/8-inch wide elastic through the wider hem on each side of the cloth face covering. These will be the ear loops. Use a large needle or a bobby pin to thread it through. Tie the ends tight.
Don’t have elastic? Use hair ties or elastic head bands. If you only have string, you can make the ties longer and tie the cloth face covering behind your head.



4. Gently pull on the elastic so that the knots are tucked inside the hem.
Gather the sides of the cloth face covering on the elastic and adjust so the cloth face covering fits your face. Then securely stitch the elastic in place to keep it from slipping.



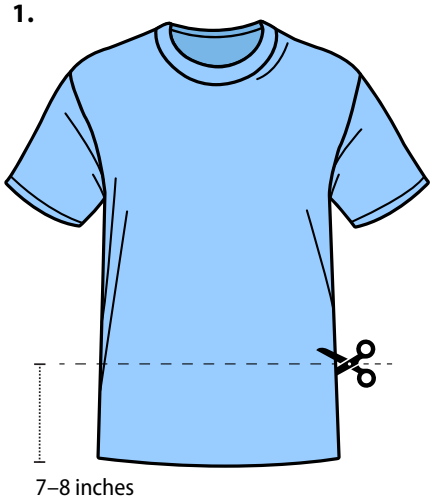
Quick Cut T-shirt Cloth Face Covering (no sew method)

Materials

- T-shirt
- Scissors

Tutorial

1.



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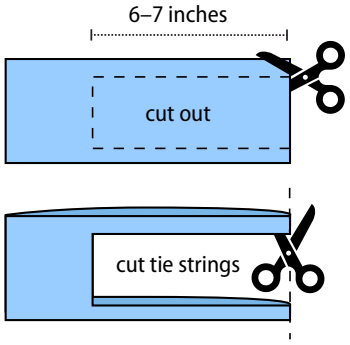

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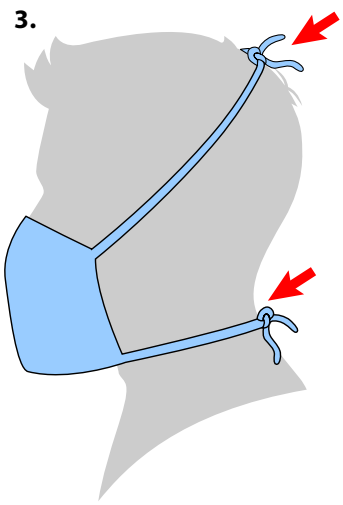


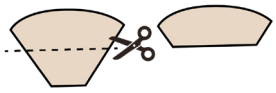
Bandana Cloth Face Covering (no sew method)

Materials

- Bandana (or square cotton cloth approximately 20”x20”)
- Coffee filter
- Rubber bands (or hair ties)
- Scissors (if you are cutting your own cloth)

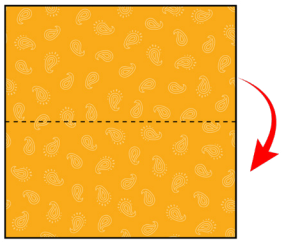
Tutorial

1.



cut coffee filter

2.



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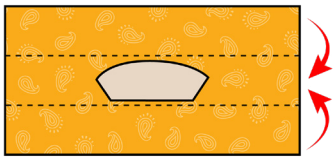


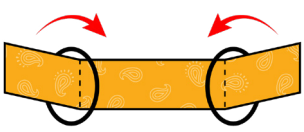
Fold filter in center of folded bandana.

Fold top down. Fold bottom up.

4.

Place rubber bands or hair ties about 6 inches apart.

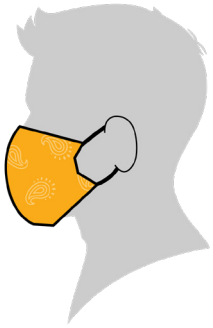
5.



Fold side to the middle and tuck.

6.

7.



PCA & Homemaker Safety Definitions and Work Practices

I. Definitions and Descriptions

A. **Contaminated Waste -** objects that are contaminated with any high-risk bodily fluid to be disposed of, such as:
1. liquid or semi-liquid high-risk bodily fluid
2. contaminated items that would release a high-risk bodily fluid
3. items caked with any dried high-risk bodily fluid

B. **High Risk Bodily Fluids -** body fluids that are known to always contain blood, such as: visible blood (fresh and dried), saliva during hygiene procedures, penile discharges, vaginal secretions, and any other fluid that has visible blood.

C. **Personal Protective Equipment** – various pieces of equipment that act as a barrier between the employee and any potential high-risk bodily fluid.

D. **Sharps** – any item that may puncture skin.

E. **Universal Precautions** – a system whereas bodily fluids are considered infectious whether the status is known or not.

II. Work Practices

A. **Hand Washing** – a procedure by which the employee cleanses the hands
1. Use soap, water, and single use towels, available at the designated hand washing area.
2. Paper towels to be placed in designated waste receptacle.
3. Use waterless hand cleaner, if needed, on outings.
4. Use hand lotion to prevent drying of the skin.
5. May use a waterless hand cleaner, but must wash after 8-10 applications.

Application: To be performed at the start of and end of each work time, when hands come in contact with any high risk bodily fluid, after glove removal, before and after using the restroom, and before and after handling food.

B. **Personal Protective Equipment** – items used by the employee to act as barriers between them and any potentially high risk bodily fluid.

1. GLOVES – vinyl or latex hand coverings that fit without tearing, to be worn only for the task being performed, to be removed promptly after task or if they tear.

Application: To be utilized any time the hands might come in contact with any high risk bodily fluid, such as tooth brushing, oral program, bathing, grooming, toileting, diaper changes, lotion application, laundry handling, and garbage handling.

2. FACIAL PROTECTION – a barrier for the face to prevent the splashing and splattering of any high risk bodily fluid, to be cleaned with soap and water and sprayed with anti-viral solution and left to air-dry after each use.

   Application: To be utilized any time there is splashing as splattering of any high risk bodily fluid such as tooth brushing, oral programs, projectile vomiting, vomit clean-up, blood or large spill of high risk bodily fluid, during feeding if there are large amounts of spitting.

   Note: There will be one face shield in each home for the PCA to use. It is to remain in the home.

3. FLUID RESISTANT GOWN – a barrier for the body to prevent splashing and splattering of any high risk bodily fluid, such as a shower where the client has a rash or open area, handling of large amounts of vomit, feces, or other high risk bodily fluid or transferring a client who has a large amount of high risk bodily fluid on them that would contact the PCA's body.

<u>NOTE</u>: THE PCA MAY UTILIZE ANY OF THE PERSONNEL PROTECTIVE EQUIPMENT AT ANY TIME IN ADDITION TO THESE REQUIREMENTS IF SHE/HE HAS NON-INTACT SKIN OR UPON DIRECTION OF THE SUPERVISOR.

C. **Cleaning** – procedures by which the employee cleanses the client area and any area that could have been exposed to a high risk bodily fluid during the employee work time.
   1. Anytime anything is soiled, it is to be cleaned/changed.
   2. OSHA requires that disinfecting is to be done EACH TIME there is any contact with any high risk bodily fluid
   3. Procedures for cleaning and use of chemicals are available to all employees.

   Application: All areas soiled by tasks involving the employee are to be cleaned by the employee, such as the counter tops, floor area where client is doing exercise or play, etc. If the area comes in contact with a high risk bodily fluid, it is to be cleaned with normal cleaning procedures and then sprayed with an anti-viral solution and allowed to air dry (such as the bathtub, laundry basket, waste receptacle, bathroom sink after oral care, etc.).

D. **Environmental Controls** – procedures for handling duties of the work shift that involve exposure to high-risk bodily fluids.

1. Trash/Garbage Handling
   a. Garbage and wastebaskets used by the employee must have a plastic liner bag.
   b. Gloves must always be worn when closing the plastic liner bag.
   c. Baskets must be disinfected each time there is contact with objects possibly containing high-risk bodily fluids and when no liner bag is used.
   d. All garbage from the designated waste receptacle must be double bagged and sealed by the employee at the end of the work time.
2. Laundry Processing
   a. collected at the point that it occurs.
   b. transported in a closed container or bag.
   c. gloves worn when handling.
   d. NO special washing procedures.
   e. if going to a commercial cleaner, it must be in a red colored plastic bag and labeled.
   f. if not going to be washed right away, it must be sealed in a double bag.
3. Handling of Sharps
   a. Needles – transported through a State approved plan of licensed handlers or as an individual would in their home setting in an approved sharps container and brought to the pharmacy for disposal.
   b. Household sharps – (i.e. broken glass) thrown in the garbage in a non-permeable sealed container (i.e. a coffee can or plastic container) with gloved hands and a scooping technique with a dust pan and broom or a grabbing tool such as pliers or tongs.

Enclosed please find reusable headbands for face shields and multiuse, with proper sanitation, face shields.

They are to be used for any close contact (within 6 feet) between clients and staff**. Concurrent client and staff usage is advised.**

Face shields are to be used in conjunction with any mask to decrease the transmission of pathogens.

The putting on and taking off of the face shield and mask should be done before any contact with any client or staff happens (Locate an area within the client setting that is designated as the area to don and doff PPE.)

A staff may assist the client with the applying and removal of the shield/mask if client/RP requests.

The shields are multiuse with proper sanitation.

Please request more shields **before** your personal supply runs out. More will be either delivered or mailed to you.

Remember to wash your hands thoroughly before putting on any personal protective items and after removal.

Instructions for Re-usable Face Shield Usage

The re-usable face shield is to be used while in close proximity (closer than 6 feet) to any individual who receives services as well as the standard of anytime there is a risk of splashing and splattering of blood or Other Potentially Infectious Material (OPIM) onto the face (eyes, nose, and/or mouth) .

Examples of times a re-usable face shield (this is not an all-inclusive list):

Being within a proximity of 6 feet of client/employee

Oral Care while in front of the client

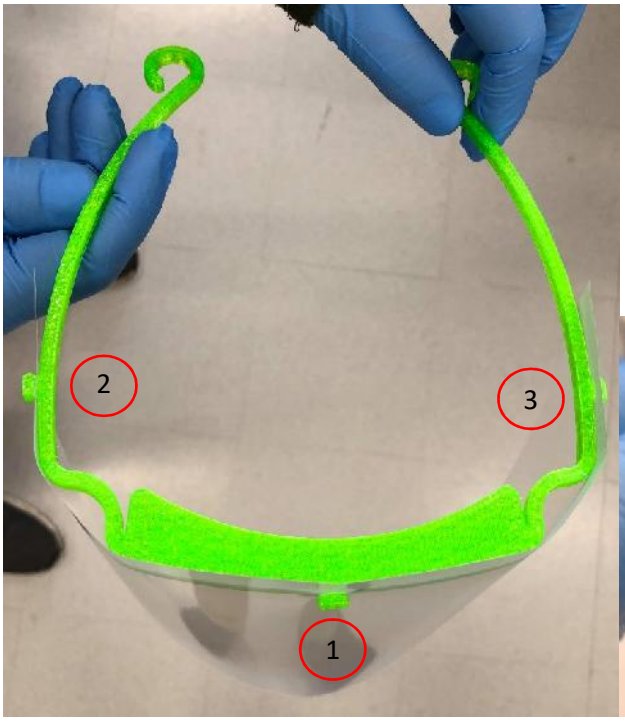
Showering or bathing an individual who has sores or open wounds

Assisting with an irrigation of a wound

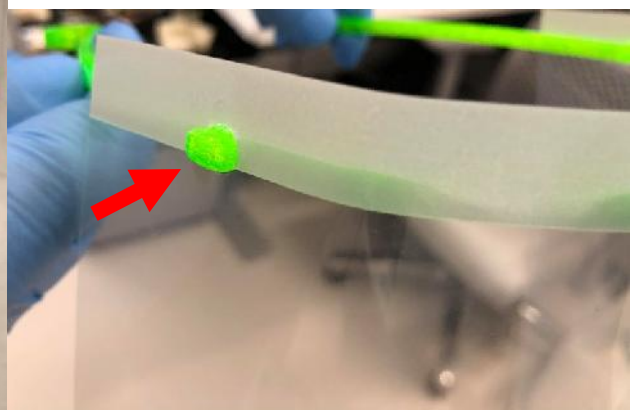
While coming in contact with large amounts of blood or OPIM

Re-usable Face Shield Application and Removal

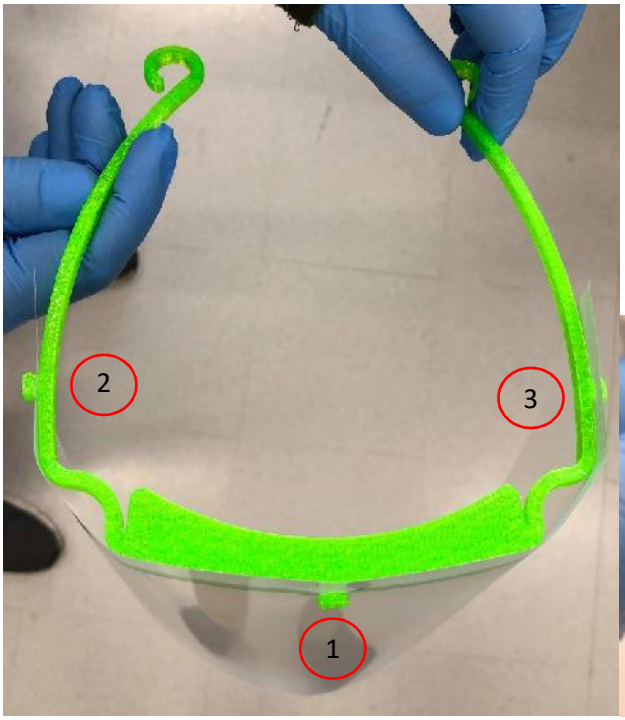
1. Remove it from package/ envelope
2. Place the shield onto the band (see visual)
3. Secure the band onto the head with the shield in front of the face (a mask should be in place already to cover the nose and mouth
4. Perform the tasks needing face shield
5. While minimizing agitation of the shield, remove it with gloved hands and set it aside
6. Remove gloves using proper technique and dispose properly
7. If wearing a gown, remove the gown first, and then the shield
8. Put on the cleaning gloves
9. Wash the shield and headband with soap and water
10. Spray the shield with sanitizer
11. Set aside to dry
12. Spray the cleaning gloves as well and allow to air dry
13. Wash hands immediately



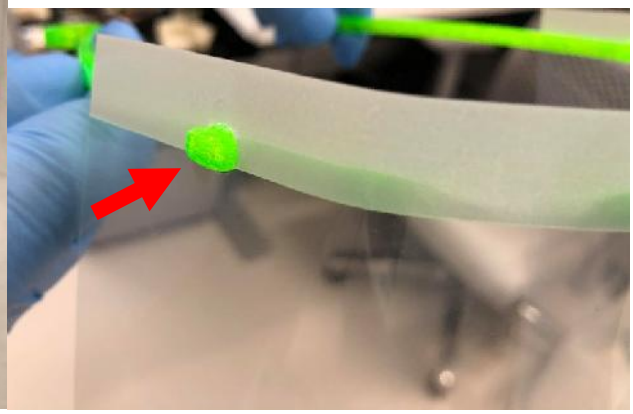
Assemble the face shield by pressing the punched holes on the transparency sheet onto the pegs on the shield head mount (starting with the center hole)



Note: Headband design may vary in size, shape, and color, however assembly instructions apply to all.



Assemble the face shield by pressing the punched holes on the transparency sheet onto the pegs on the shield head mount (starting with the center hole)



AccuKare

Annual Training

Section 3

MSDS/ERTK

osha
DEPARTMENT OF LABOR AND INDUSTRY

MNOSHA heat-stress guide

I. Introduction

Heat stress may occur year-round in foundries, kitchens, or laundries, or only a few days during the summer in almost any work setting.

Heat stress can be as much of a problem in Minnesota as in other regions of the country where high temperatures are common during the summer. This is because people usually do not have the opportunity to become acclimatized and stay acclimatized in climates such as Minnesota's where daily high temperatures can vary up to 30 degrees from one day to the next during the summer.

Heat stress can result in several illnesses as well as decreased productivity and increased likelihood of injuries. Minnesota's heat stress standard is designed to protect employees against the risk of heat-induced illnesses and unsafe acts.

Heat stress results from a combination of internal (body) heat production from doing work and external heat exposure from the environment. Both aspects need to be addressed to properly control heat stress.

Minnesota Rules 5205.0110, subpart 2a, which was revised in July, 1997 and can be found in Appendix A, is the Minnesota OSHA standard for heat exposure. The standard is based on the wet bulb globe temperature (WBGT) and level of work activity. Typically, one will determine the WBGT by using a heat stress monitor, or by using a sling psychrometer and the nomogram in Appendix B to obtain effective temperature, then converting effective temperature to WBGT. Appendix C contains some examples of conditions that approximate the limits under the standard. If the heat stress limit is approached or exceeded, Employee Right-to-Know requirements specified in Minnesota Rules 5206.0700, subparts 1 and 3, "Training Program for Harmful Physical Agents" and Minnesota Rules 5206.1100 "Labeling Harmful Physical Agents; Label Content" also apply.

The following pages contain a discussion of heat disorders, prevention of disorders, methods for evaluating heat stress, and methods of control.

II. Heat disorders

Heat stroke

Symptoms: Usually hot, dry skin; red, mottled or bluish. Sweating may still be present. Confusion, lose of consciousness, convulsions. Rapid pulse. Rectal temperature greater than 104ºF. When in doubt, treat as heat stroke. Can be fatal.

Treatment: ***Medical emergency***. Call paramedics and start cooling victim immediately. Remove victim to a cool area. Soak clothing and skin with cool water, and use a fan to create air movement. Shock may occur. Medical treatment is imperative.

Cause: Partial or complete failure of sweating mechanism. The body cannot get rid of excess heat.

Prevention: Acclimatization. Close monitoring of workers for signs of heat illness. Medical screening. Drink plenty of water.

Heat exhaustion

Symptoms: Fatigue, weakness, dizziness, faintness. Nausea, headache. Moist, clammy skin; pale or flushed. Rapid pulse. Normal or slightly elevated temperature.

Treatment: Have victim rest in a cool area and drink fluids.

Cause: Dehydration causes blood volume to decrease.

Prevention: Acclimatization. Drink plenty of water.

Heat syncope

Symptoms: Fainting while standing erect and immobile. A variant of heat exhaustion. Symptoms of heat exhaustion may precede fainting.

Treatment: Move victim to a cool area. Have victim rest and drink fluids.

Cause: Dehydration causes blood volume to decrease. Blood pools in dilated blood vessels of the skin and lower body, making less blood available to the brain.

Prevention: Acclimatization. Drink plenty of water. Avoid standing in one place. Intermittent activity to avoid blood pooling.

Heat cramps

Symptoms: Painful muscle spasms in the arms, legs or abdomen during or after hard physical work.

Treatment: Rest. Drink water and eat more salty foods.

Cause: Not well understood. May be due to a lose of salt from sweating. Dehydration is a factor.

Prevention: Adequate water intake and adequate salt intake at meals. Do not use salt tablets.

Heat rash

Symptoms: "Prickly heat"; tiny, raised, blister-like rash.

Treatment: Keep skin clean and dry.

Cause: Skin is constantly wet from sweat. Sweat gland ducts become plugged, leading to inflammation.

Prevention: Shower after working in hot environment. Keep skin dry.

Transient heat fatigue

Symptoms: Decline in performance, particularly in skilled physical work, mental tasks, and those requiring concentration.

Treatment: No treatment necessary unless other signs of heat illness are present.

Cause: Discomfort. Stress from the heat less than what would result in other heat illnesses.

Prevention: Acclimatization and training.

Note: Alcohol, prescription drugs and other drugs can increase the possibility of heat disorders occurring even if used the previous day.

III. Prevention

The two most important methods of preventing heat disorders are hydration and acclimatization because they increase the ability of the body to tolerate heat stress. Engineering and administrative controls are important in reducing heat exposure, and are discussed in Section V.

Hydration

The most important factor in preventing heat illnesses is adequate water intake.

1. Thirst is not an adequate indicator. Relying on thirst will result in dehydration.

2. Once the body becomes dehydrated, it is more difficult to rehydrate because the gut does not absorb water as well. Adequate water intake throughout the day is necessary.

3. Workers should drink at least five to seven ounces of cool water every 15-20 minutes.

4. Under conditions of profuse sweating, a commercial electrolyte replacement drink may be appropriate. Some drinks are too concentrated and need to be diluted or consumed along with water.

5. Salt tablets are to be avoided. Salt tablets irritate the stomach and can lead to vomiting, which results in further dehydration.

Acclimatization

A physiological adaptation will occur with repeated exposure to hot environments. The heart rate will decrease, sweating will increase, sweat will become more dilute, and body temperature will be lower. The ability to acclimatize varies among workers. Generally, individuals in good physical condition acclimatize more rapidly than those in poor condition.

Approximately one week of gradually increasing the workload and time spent in the hot environment will usually lead to full acclimatization. On the first day the individual performs 50 percent of the normal workload and spends 50 percent of the time in the hot environment. Each

day an additional 10 percent of the normal workload and time is added, so that by day six, the worker is performing the full workload for an entire day. The exposure time should be at least two hours per day for acclimatization to occur.

Acclimatization is lost when exposure to hot environments does not occur for several days. After a one week absence, a worker needs to reacclimatize by following a schedule similar to that for initial acclimatization. The acclimatization will occur more rapidly, so increases in workload and time can increase by approximately 20 percent each day after the first day, reaching normal work conditions by day four.

Minnesota Employee Right-to-Know Program for AccuKare, Inc.

General Company Policy:

The purpose of this policy is to inform the employee that our company is complying with the Minnesota OSHA Employee Right-to-Know (ERTK) Standard by compiling a hazardous chemicals list, by using material safety data sheets (MSDS), by ensuring that containers are labeled, and by providing the employee with training. Information on harmful physical agents and infectious agents is included in this training. The MN OSHA ERTK Standard/Act's intent is to ensure that employees are aware of the dangers associated with hazards that they may be exposed to in their workplaces.

This program applies to all work operations in our company where employees may be exposed to hazardous substances, harmful physical agents, or infectious agents under normal working conditions or during an emergency.

The President of AccuKare, Inc., Karla R. Adams, RN, in conjunction with the supervising RN's, is the program coordinator and has overall responsibility for the program. Karla R. Adams, RN will review and update the program, as necessary. Employees may obtain copies of the written program from Karla R. Adams, RN.

Under this program, employees will be informed of the content of the MN OSHA ERTK Standard, the hazardous properties of the chemicals with which they work, safe handling procedures, and measures to take to protect themselves from these chemicals. They will also be informed of the hazards associated with non-routine tasks.

I. Hazardous Chemicals

A. A hazardous substance is defined as a chemical or substance, or mixture of substances which:

1. Is regulated by federal OSHA under 29 CFR 1910, subpart Z.

2. May cause substantial acute (short term) or chronic (long-term) personal injury or illness during or as a direct result of any customary or reasonably foreseeable accidental or intentional exposure (according to generally accepted documented medical or scientific evidence).

3. Is determined by the commissioner in the standard to present a significant risk to worker health and safety or imminent danger of death or serious physical harm as a result of foreseeable use, handling, accidental spill, exposure, or contamination.

B. Karla R. Adams, RN will make a list of known hazardous substances and related work practices in the work setting and will update the list as necessary.

1. The list of chemicals identifies all of the chemicals used in work settings. A separate list is available for each individual work setting.

2. Each list also identifies the corresponding MSDS for each chemical. The list and the MSDS are located in the client book in each home.

3. AccuKare, Inc. maintains a master list of the chemicals that are used in work settings. This list is available at the main office.

4. Substances exempt from this list include:

   a. Items that are intended for personal consumption by the employees in the workplace.
   b. Consumer products packaged for distribution to, and used by, the public, if used by employees in the workplace in the same form, concentration, frequency, and manner as would the public.
   c. Any article, including equipment or hardware, which contains a hazardous substance in solid form which does not create a health hazard as a result of being handled by the employee.
   d. Any substance that is bound and not released under normal conditions or work in reasonably foreseeable occurrence resulting form workplace operations.
   e. Any substance received by the employer in a sealed package and subsequently sold or transferred in that package, if the seal remains intact while in the employer's workplace.
   f. "Liquor" as defined in MN Statues.
   g. Foods as defined in the federal Food, Drug, and Cosmetic Act.

C. Examples of hazardous substances include, but are not limited to: cleaning chemicals, gasoline and other petroleum products, gases, vehicle exhaust, and any processing chemicals.

D. MSDS's provide you with specific information on the chemicals you use. Karla R. Adams, RN will maintain a binder in the main office with a MSDS on every substance on the list of hazardous chemical identified in the agency and not on the exempt list. The MSDS will be a fully completed OSHA Form 174 or equivalent. There will be MSDS's specific to each site in the "Client Book" at that site. Karla R. Adams, RN is responsible for acquiring and updating MSDS's. She will contact the chemical manufacturer or vendor if additional research is necessary or if any MSDS has not been supplied with an initial shipment. Karla R. Adams, RN, must clear all new procurements for the company.

II. Harmful Physical Agents

A. There are four harmful physical agents subject to coverage under the MN OSHSA ERTK Act, and they are as follows: NOTE: not all four of these are present in AccuKare, Inc.

1. Noise- ERTK requirements apply where employee exposure is general industry approximates or exceeds the OSHA "Action Level " of 85 Decibels as an average over an 8 hour work shift as set forth in 29 CFR 1910.95. This is not present at AccuKare, Inc.

2. Heat – ERTK requirements apply where employee exposure in general industry approximates or exceeds the WBGT limit set forth in MN Rules 5205.0110. *This is not intended to be present at AccuKare, Inc., but an employee may be outside or in a warm home with a client, hence training on heat stress will be provided.*

3. Ionizing Radiation – ERTK requirement supply where employee exposure in general industry approximates or exceeds the limit set forth in 29 CFR 1910.1096. *This is not present at AccuKare, Inc.*

4. Non-Ionizing Radiation – ERTK requirements apply where employee exposure in general industry approximates or exceeds the limit set forth in 29 CFR 1910.97. *This is not present at AccuKare, Inc.*

B. Karla R. Adams, RN will make a list of harmful physical agents when present in the workplace and where workers may be exposed to the agent through equipment use, product handling, or otherwise.

C. Karla R. Adams, RN is responsible for acquiring a physical agent fact sheet (PAFS) or comparable written information on the identified harmful physical agents to which employees may be exposed in the course of assigned work. The PAFS or other written information will be maintained in a binder in the main office of AccuKare, Inc. and in the "Client Book" at the client home. Karla R. Adams, RN is responsible for acquiring and updating PAFSs.

III. Infectious Agents

A. The MN OSHA ERTK Act covers certain infectious agents, including various bacterial, viral, fungal, parasitic, and rickettsial agents.

B. Karla R. Adams, RN will conduct a survey and make a list of infectious agents that workers may encounter in the course of assigned work. For further information, see the written Exposure Control Plan for the agency, which meets the requirements set forth in 29 CFR 1910.1030 and covers all infectious agents, both blood borne transmitted and those transmitted by other routes. The book "Control of Communicable Diseases Manual" will be available to any employee through the main office of AccuKare, Inc. during business hours.

C. The Exposure Control Plan relating to the control of infectious disease hazards is part of the ERTK requirements and is available in the clients' homes and in the main office of AccuKare, Inc.

IV. Labels and other Forms of Warning

A. Karla R. Adams, RN along with the supervising RNs will ensure that all hazardous chemicals in the client's home that the agency is aware of are properly labeled and updated as necessary.

B. Manufacturer's container labels should list at least the chemical identity, the appropriate hazard warning and the name and address of the manufacturer, importer of other responsible party. The main bottle of concentrated sanitizer/cleaner will remain at AccuKare, Inc. that has this information on it. *The hand sanitizer is in the manufacturer's bottle and will have this information on it.*

C. It the chemical is transferred from a manufacturer's container to another container, the "other" container must have a label which at least identifies the chemical identity and any appropriate hazard warning if, the container will be under the control of more than one employee or, if the

contents will remain in the 'other' container for more than one shift. *This ruling applies to the sanitizer that Karla R. Adams, RN will place in spray bottles at the main office of AccuKare, Inc and then place in the clients' homes.*

D. Immediate use containers, which are containers of hazardous substances which will remain under the control of one employee and which will not remain for more than one shift, need not be labeled. *This does not apply to anything at AccuKare, Inc.*

E. Pipes or piping systems do not have to be labeled but their contents will be described in the training session. *This does not apply to anything at AccuKare, Inc.*

F. Karla R. Adams, RN will ensure that equipment or work areas that specifically generate harmful physical agents at a level which may be expected to approximate or exceed the permissible exposure limit or applicable action level, be labeled with the name of the physical agent and the appropriate hazard warning. *This does not apply to anything at AccuKare, Inc.*

G. The Exposure Control Plan for the agency addresses the labeling procedures or color-coding for receptacles or bags containing potentially infectious material (i.e. laundry bags and garbage bags). *A sample label is on the last page of this document for review.*

V. Training

A. Once the employer has identified the hazardous substances, harmful physical agents, and infectious agents in the survey and has acquired the hazard information on the individually identified items, the employer must use the acquired information to train employees per Right-to-Know Act requirements.

B. Everyone who works with or is potentially exposed to hazardous chemical, harmful physical agents or infectious agents will receive initial training on the Employee Right to Know Standard and the safe use of those chemicals or agents. This program has been prepared for this purpose.

C. Karla R. Adams, RN is responsible for ensuring that this training is provided and that it is provided verbally as well as with written material.

D. Training must be conducted:

1. Before an employee's initial assignments where they may be routinely exposed.

2. When new or additional hazardous substances or agents are introduced into the workplace. Affected employees must be trained before their working with or in the presence of them.

E. Training must be updated annually. Annual update training may be brief summaries of information included in initial and /or previous sessions.

F. Training must be made available by, and at the cost of, the employer. If employees are required to attend training at times other than their normal working schedule, they must be compensated for working that time (either via overtime, equivalent time off, etc.).

G. Training must be in English or a language understood by employees.

H. Training must be provided to affected temporary and seasonal employees.

I. For hazardous substances, the following must be included in the employee training program:

1. A summary of the MN OSHA ERTK standard and AccuKare, Inc.'s written Right-to-Know plan (this document).

2. Specific information from the MSDS of each of the hazardous substances the employee may be exposed to including:

a. The name or names of hazardous substances, including any generic or chemical name, trade name, and commonly used name (see MSDS Sec. I and II).

b. The Permissible Exposure Limit set by OSHA or recommended limit where no OSHA limit exists (see MSDS Sec. III).

c. Primary routes of entry into the body, and acute and chronic effects of exposure at hazardous levels (see MSDS Sec. IV).

d. Known symptoms (see MSDS Sec. VI).

e. A potential for flammability, explosion or reactivity of the hazardous substance (see MSDS Sec. IV and V).

f. Appropriate emergency treatment (see MSDS Sec. VI).

g. Know proper condition of use and exposure to the hazardous substance (See MSDS Sec. VIII).

h. Procedures for cleanup of leaks and spills (see MSDS Sec. VII).

i. The name, phone number, and address of the manufacturer of the hazardous substance (see MSDS Sec. I).

j. Where the MSDS, or comparable written information, is located in the work setting. *MSDS are located in the client homes in the "Client Book" and in the main office of AccuKare, Inc.*

J. For Harmful Physical Agents (if applicable), the following must be included in the employee-training program. *Note: AccuKare, Inc. does not have any known Harmful Physical Agents, but will provide training on heat stress due to the nature of the work employees must occasionally perform outside if a client chooses to go outside.*

1. The name or names of the harmful physical agent, including any commonly used synonym.

2. The level at which exposure to the physical agent has been restricted.

3. Known acute and chronic effects of exposure at hazardous levels.

4. Known symptoms.

5. Appropriate emergency treatments.

6. Known proper conditions for exposure to the physical agent

7. The name, phone number, and address of the manufacturer of the equipment that produces the physical agent, if applicable.

8. Where the PAFS, or comparable written information is in the work setting. *PAFS for Heat Stress is located in the Client Book in the client homes and in the main office of AccuKare, Inc.*

K. Infectious Agents—Where employees have been identified as being at risk of encountering infectious agents in their work assignment, the employer must provide training on each of the infectious agents. A recent change in the Right-to-Know Act states that if the training program covers all infectious agents and includes the training topics required in the OSHA Bloodborne Pathogen standard 29 CFR 1910.1030, then the employer will have met the Right-to-Know training requirements for infectious agents. *Therefore, the training for this piece has been met by the employee's completion of the Bloodborne Pathogens training.*

M. Records of training. The records of training will be maintained for three (3) years at the main office of AccuKare, Inc. and will include:

1. Dates of Training.

2. Name, title, and qualifications of person who conducted the training.

3. Names and job titles of employees who completed the training.

4. A brief summary or outline of the information that was included in the training session.

VI. Non-Routine Tasks

A. When an employee is required to perform hazardous non-routine tasks (as determined by Karla R. Adams, RN in conjunction with the supervising RN), a special training session will be conducted by either Karla R. Adams, RN or the supervising RN regarding the hazard to which the employee might be exposed and the proper precautions to take to reduce or avoid exposure. MSDS's will be available on the hazardous chemical utilized. Karla R. Adams, RN is responsible for ensuring that this training is provided.

B. All employees need to report to AccuKare, Inc. if they encounter something that they have a concern about in order that it may be evaluated and acted upon appropriately.

Conforms to USDOL OSHA 29CFR 1910.1200 HAZCOM

SAFETY DATA SHEET

Lysol Brand IC Quaternary Disinfectant Cleaner

HEALTH • HYGIENE • HOME

1. Product and company identification

Product name : Lysol Brand IC Quaternary Disinfectant Cleaner

Distributed by : Reckitt Benckiser LLC.
Morris Corporate Center IV
399 Interpace Parkway (P.O. Box 225)
Parsippany, New Jersey 07054-0225
+1 973 404 2600

Emergency telephone number (Medical) : 1-800-338-6167

Emergency telephone number (Transport) : 1-800-424-9300 (U.S. & Canada) CHEMTREC
Outside U.S. and Canada (North America), call Chemtrec:703-527-3887

Website: : **http://www.rbnainfo.com**

Product use : Professional use Disinfectant.

This SDS is designed for workplace employees, emergency personnel and for other conditions and situations where there is greater potential for large-scale or prolonged exposure, in accordance with the requirements of USDOL Occupational Safety and Health Administration.

This SDS is not applicable for consumer use of our products. For consumer use, all precautionary and first aid language is provided on the product label in accordance with the applicable government regulations, and shown in Section 15 of this SDS.

SDS # : 366519PSDS v3.0

Formulation #: : 1990-019 (366519 v4.0)

EPA ID No. : 47371-129-675

UPC Code / Sizes : 36241-74983-01 (128 Fl. oz. / 1 Gallon / 3.79 L.) HDPE Container

2. Hazards identification

Classification of the substance or mixture : FLAMMABLE LIQUIDS - Category 4
ACUTE TOXICITY (oral) - Category 4
ACUTE TOXICITY (inhalation) - Category 4
SKIN CORROSION/IRRITATION - Category 1C
SERIOUS EYE DAMAGE/ EYE IRRITATION - Category 1
SKIN SENSITIZATION - Category 1

GHS label elements

Hazard pictograms :

Signal word : Danger

2. Hazards identification

Hazard statements : Combustible liquid.
Harmful if swallowed or if inhaled.
Causes severe skin burns and eye damage.
May cause an allergic skin reaction.

Precautionary statements

General : Read label before use. Keep out of reach of children. If medical advice is needed, have product container or label at hand.

Prevention : Wear protective gloves. Wear eye or face protection. Wear protective clothing. Keep away from flames and hot surfaces. - No smoking. Use only outdoors or in a well-ventilated area. Avoid breathing vapor. Do not eat, drink or smoke when using this product. Wash hands thoroughly after handling. Contaminated work clothing should not be allowed out of the workplace.

Response : IF INHALED: Remove victim to fresh air and keep at rest in a position comfortable for breathing. Immediately call a POISON CENTER or physician. IF SWALLOWED: Immediately call a POISON CENTER or physician. Rinse mouth. Do NOT induce vomiting. IF ON SKIN (or hair): Take off immediately all contaminated clothing. Rinse skin with water or shower. Wash contaminated clothing before reuse. Immediately call a POISON CENTER or physician. IF ON SKIN: Wash with plenty of soap and water. If skin irritation or rash occurs: Get medical attention. IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Immediately call a POISON CENTER or physician.

Storage : Store locked up. Store in a well-ventilated place. Keep cool.

Disposal : Dispose of contents and container in accordance with all local, regional, national and international regulations.

Supplemental label elements : None known.

Hazards not otherwise classified : None known.

3. Composition/information on ingredients

Substance/mixture : Mixture

Ingredient name	%	CAS number
didecyldimethylammonium chloride	10 - 15	7173-51-5
Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides	5 - 10	8001-54-5
Ethyl alcohol	2.5 - 5	64-17-5
sodium hydroxide	1 - 2.5	1310-73-2
d-Limonene	0.1 - 1	5989-27-5

Any concentration shown as a range is to protect confidentiality or is due to batch variation.

There are no additional ingredients present which, within the current knowledge of the supplier and in the concentrations applicable, are classified as hazardous to health or the environment and hence require reporting in this section.

4. First aid measures

Description of necessary first aid measures

Eye contact : Get medical attention immediately. Call a poison center or physician. Immediately flush eyes with plenty of water, occasionally lifting the upper and lower eyelids. Check for and remove any contact lenses. Continue to rinse for at least 10 minutes. Chemical burns must be treated promptly by a physician.

Inhalation : Get medical attention immediately. Call a poison center or physician. Remove victim to fresh air and keep at rest in a position comfortable for breathing. If it is suspected that fumes are still present, the rescuer should wear an appropriate mask or self-contained breathing apparatus. If not breathing, if breathing is irregular or if respiratory arrest occurs, provide artificial respiration or oxygen by trained personnel. It may be dangerous to the person providing aid to give mouth-to-mouth resuscitation. If unconscious, place in recovery position and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as a collar, tie, belt or waistband. In case of inhalation of decomposition products in a fire, symptoms may be delayed. The exposed person may need to be kept under medical surveillance for 48 hours.

Skin contact : Get medical attention immediately. Call a poison center or physician. Wash with plenty of soap and water. Remove contaminated clothing and shoes. Wash contaminated clothing thoroughly with water before removing it, or wear gloves. Continue to rinse for at least 10 minutes. Chemical burns must be treated promptly by a physician. In the event of any complaints or symptoms, avoid further exposure. Wash clothing before reuse. Clean shoes thoroughly before reuse.

Ingestion : Get medical attention immediately. Call a poison center or physician. Wash out mouth with water. Remove dentures if any. Remove victim to fresh air and keep at rest in a position comfortable for breathing. If material has been swallowed and the exposed person is conscious, give small quantities of water to drink. Stop if the exposed person feels sick as vomiting may be dangerous. Do not induce vomiting unless directed to do so by medical personnel. If vomiting occurs, the head should be kept low so that vomit does not enter the lungs. Chemical burns must be treated promptly by a physician. Never give anything by mouth to an unconscious person. If unconscious, place in recovery position and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as a collar, tie, belt or waistband.

Most important symptoms/effects, acute and delayed

Potential acute health effects

Eye contact : Causes serious eye damage.

Inhalation : Harmful if inhaled. May give off gas, vapor or dust that is very irritating or corrosive to the respiratory system. Exposure to decomposition products may cause a health hazard. Serious effects may be delayed following exposure.

Skin contact : Causes severe burns. May cause an allergic skin reaction.

Ingestion : Harmful if swallowed. May cause burns to mouth, throat and stomach.

Over-exposure signs/symptoms

Eye contact : Adverse symptoms may include the following:
pain
watering
redness

Inhalation : No specific data.

Skin contact : Adverse symptoms may include the following:
pain or irritation
redness
blistering may occur

4. First aid measures

Ingestion : Adverse symptoms may include the following:
stomach pains

Indication of immediate medical attention and special treatment needed, if necessary

Notes to physician : In case of inhalation of decomposition products in a fire, symptoms may be delayed. The exposed person may need to be kept under medical surveillance for 48 hours.

Specific treatments : No specific treatment.

Protection of first-aiders : No action shall be taken involving any personal risk or without suitable training. If it is suspected that fumes are still present, the rescuer should wear an appropriate mask or self-contained breathing apparatus. It may be dangerous to the person providing aid to give mouth-to-mouth resuscitation. Wash contaminated clothing thoroughly with water before removing it, or wear gloves.

See toxicological information (Section 11)

5. Fire-fighting measures

Extinguishing media

Suitable extinguishing media : Use dry chemical, CO_2, water spray (fog) or foam.

Unsuitable extinguishing media : Do not use water jet.

Specific hazards arising from the chemical : Combustible liquid. In a fire or if heated, a pressure increase will occur and the container may burst, with the risk of a subsequent explosion. Runoff to sewer may create fire or explosion hazard.

Hazardous thermal decomposition products : Decomposition products may include the following materials:
carbon dioxide
carbon monoxide
nitrogen oxides
halogenated compounds
metal oxide/oxides

Special protective actions for fire-fighters : Promptly isolate the scene by removing all persons from the vicinity of the incident if there is a fire. No action shall be taken involving any personal risk or without suitable training. Move containers from fire area if this can be done without risk. Use water spray to keep fire-exposed containers cool.

Special protective equipment for fire-fighters : Fire-fighters should wear appropriate protective equipment and self-contained breathing apparatus (SCBA) with a full face-piece operated in positive pressure mode.

6. Accidental release measures

Personal precautions, protective equipment and emergency procedures

For non-emergency personnel : No action shall be taken involving any personal risk or without suitable training. Evacuate surrounding areas. Keep unnecessary and unprotected personnel from entering. Do not touch or walk through spilled material. Shut off all ignition sources. No flares, smoking or flames in hazard area. Do not breathe vapor or mist. Provide adequate ventilation. Wear appropriate respirator when ventilation is inadequate. Put on appropriate personal protective equipment.

6. Accidental release measures

For emergency responders : If specialised clothing is required to deal with the spillage, take note of any information in Section 8 on suitable and unsuitable materials. See also the information in "For non-emergency personnel".

Environmental precautions : Avoid dispersal of spilled material and runoff and contact with soil, waterways, drains and sewers. Inform the relevant authorities if the product has caused environmental pollution (sewers, waterways, soil or air).

Methods and materials for containment and cleaning up

Small spill : Stop leak if without risk. Move containers from spill area. Use spark-proof tools and explosion-proof equipment. Dilute with water and mop up if water-soluble. Alternatively, or if water-insoluble, absorb with an inert dry material and place in an appropriate waste disposal container. Dispose of via a licensed waste disposal contractor.

Large spill : Stop leak if without risk. Move containers from spill area. Use spark-proof tools and explosion-proof equipment. Approach release from upwind. Prevent entry into sewers, water courses, basements or confined areas. Wash spillages into an effluent treatment plant or proceed as follows. Contain and collect spillage with non-combustible, absorbent material e.g. sand, earth, vermiculite or diatomaceous earth and place in container for disposal according to local regulations (see Section 13). Dispose of via a licensed waste disposal contractor. Contaminated absorbent material may pose the same hazard as the spilled product. Note: see Section 1 for emergency contact information and Section 13 for waste disposal.

7. Handling and storage

Precautions for safe handling

Protective measures : Put on appropriate personal protective equipment (see Section 8). Persons with a history of skin sensitization problems should not be employed in any process in which this product is used. Do not get in eyes or on skin or clothing. Do not breathe vapor or mist. Do not ingest. Use only with adequate ventilation. Wear appropriate respirator when ventilation is inadequate. Do not enter storage areas and confined spaces unless adequately ventilated. Keep in the original container or an approved alternative made from a compatible material, kept tightly closed when not in use. Store and use away from heat, sparks, open flame or any other ignition source. Use explosion-proof electrical (ventilating, lighting and material handling) equipment. Use only non-sparking tools. Empty containers retain product residue and can be hazardous. Do not reuse container.

Conditions for safe storage, including any incompatibilities : Store in accordance with local regulations. Store in a segregated and approved area. Store in original container protected from direct sunlight in a dry, cool and well-ventilated area, away from incompatible materials (see Section 10) and food and drink. Store locked up. Eliminate all ignition sources. Separate from oxidizing materials. Keep container tightly closed and sealed until ready for use. Containers that have been opened must be carefully resealed and kept upright to prevent leakage. Do not store in unlabeled containers. Use appropriate containment to avoid environmental contamination.

8. Exposure controls/personal protection

Control

Occupational exposure limits

Ingredient name	Exposure limits
Ethyl alcohol	**ACGIH TLV (United States, 6/2013).** STEL: 1000 ppm 15 minutes. **OSHA PEL 1989 (United States, 3/1989).** TWA: 1000 ppm 8 hours. TWA: 1900 mg/m³ 8 hours. **NIOSH REL (United States, 10/2013).** TWA: 1000 ppm 10 hours. TWA: 1900 mg/m³ 10 hours. **OSHA PEL (United States, 2/2013).** TWA: 1000 ppm 8 hours. TWA: 1900 mg/m³ 8 hours.
sodium hydroxide	**ACGIH TLV (United States, 6/2013).** C: 2 mg/m³ **OSHA PEL 1989 (United States, 3/1989).** CEIL: 2 mg/m³ **NIOSH REL (United States, 10/2013).** CEIL: 2 mg/m³ **OSHA PEL (United States, 2/2013).** TWA: 2 mg/m³ 8 hours.

Appropriate engineering controls : Use only with adequate ventilation. Use process enclosures, local exhaust ventilation or other engineering controls to keep worker exposure to airborne contaminants below any recommended or statutory limits. The engineering controls also need to keep gas, vapor or dust concentrations below any lower explosive limits. Use explosion-proof ventilation equipment.

Environmental exposure controls : Emissions from ventilation or work process equipment should be checked to ensure they comply with the requirements of environmental protection legislation. In some cases, fume scrubbers, filters or engineering modifications to the process equipment will be necessary to reduce emissions to acceptable levels.

Individual protection measures

Hygiene measures : Wash hands, forearms and face thoroughly after handling chemical products, before eating, smoking and using the lavatory and at the end of the working period. Appropriate techniques should be used to remove potentially contaminated clothing. Contaminated work clothing should not be allowed out of the workplace. Wash contaminated clothing before reusing. Ensure that eyewash stations and safety showers are close to the workstation location.

Eye/face protection : Safety eyewear complying with an approved standard should be used when a risk assessment indicates this is necessary to avoid exposure to liquid splashes, mists, gases or dusts. If contact is possible, the following protection should be worn, unless the assessment indicates a higher degree of protection: chemical splash goggles and/or face shield. If inhalation hazards exist, a full-face respirator may be required instead.

Skin protection

8. Exposure controls/personal protection

Hand protection : Chemical-resistant, impervious gloves complying with an approved standard should be worn at all times when handling chemical products if a risk assessment indicates this is necessary. Considering the parameters specified by the glove manufacturer, check during use that the gloves are still retaining their protective properties. It should be noted that the time to breakthrough for any glove material may be different for different glove manufacturers. In the case of mixtures, consisting of several substances, the protection time of the gloves cannot be accurately estimated.

Body protection : Personal protective equipment for the body should be selected based on the task being performed and the risks involved and should be approved by a specialist before handling this product.

Other skin protection : Appropriate footwear and any additional skin protection measures should be selected based on the task being performed and the risks involved and should be approved by a specialist before handling this product.

Respiratory protection : Use a properly fitted, air-purifying or air-fed respirator complying with an approved standard if a risk assessment indicates this is necessary. Respirator selection must be based on known or anticipated exposure levels, the hazards of the product and the safe working limits of the selected respirator.

9. Physical and chemical properties

Appearance

Physical state : Liquid. [Clear.]

Color : Amber.

Odor : Mild.

Odor threshold : Not available.

pH : 7.2 to 8.2 [Conc. (% w/w): 100%]

Melting point : Not available.

Boiling point : Not available.

Flash point : Closed cup: 71.111°C (160°F) [Tagliabue.]

Evaporation rate : Not available.

Flammability (solid, gas) : Not available.

Lower and upper explosive (flammable) limits : Not available.

Vapor pressure : Not available.

Vapor density : Not available.

Relative density : 0.99 to 1.01

Solubility : Easily soluble in the following materials: cold water and hot water.

Partition coefficient: n-octanol/water : Not available.

Auto-ignition temperature : Not available.

Decomposition temperature : Not available.

Viscosity : Not available.

10. Stability and reactivity

Reactivity : No specific test data related to reactivity available for this product or its ingredients.

Chemical stability : The product is stable.

Possibility of hazardous reactions : Under normal conditions of storage and use, hazardous reactions will not occur.

Conditions to avoid : Avoid all possible sources of ignition (spark or flame). Do not pressurize, cut, weld, braze, solder, drill, grind or expose containers to heat or sources of ignition.

Incompatible materials : Reactive or incompatible with the following materials:
oxidizing materials
Do not mix with household chemicals.

Hazardous decomposition products : Under normal conditions of storage and use, hazardous decomposition products should not be produced.

11. Toxicological information

Information on toxicological effects

Acute toxicity

Product/ingredient name	Result	Species	Dose	Exposure
didecyldimethylammonium chloride	LD50 Oral	Rat	84 mg/kg	-
Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides	LD50 Oral	Rat	240 mg/kg	-
Ethyl alcohol	LC50 Inhalation Vapor	Rat	124700 mg/m³	4 hours
	LD50 Oral	Rat	7 g/kg	-
d-Limonene	LD50 Dermal	Rabbit	>5000 mg/kg	-
	LD50 Oral	Rat	4400 mg/kg	-

Conclusion/Summary : Harmful if swallowed.

Irritation/Corrosion

Product/ingredient name	Result	Species	Score	Exposure	Observation
didecyldimethylammonium chloride	Skin - Severe irritant	Rabbit	-	500 milligrams	-
Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides	Eyes - Severe irritant	Human	-	50 Micrograms	-
	Eyes - Severe irritant	Monkey	-	24 hours 2 milligrams	-
	Eyes - Mild irritant	Rabbit	-	10 milligrams	-
	Eyes - Severe irritant	Rabbit	-	24 hours 1 milligrams	-
	Skin - Mild irritant	Human	-	72 hours 150 Micrograms Intermittent	-
	Skin - Mild irritant	Human	-	24 hours 3 Percent	-
	Skin - Moderate irritant	Human	-	48 hours 1 Percent	-
	Skin - Moderate irritant	Rabbit	-	24 hours 50 milligrams	-
	Skin - Moderate irritant	Woman	-	0.1 Percent	-

11. Toxicological information

Ethyl alcohol	Eyes - Moderate irritant	Rabbit	-	0.066666667 minutes 100 milligrams	-
	Eyes - Mild irritant	Rabbit	-	24 hours 500 milligrams	-
	Eyes - Moderate irritant	Rabbit	-	100 microliters	-
	Eyes - Severe irritant	Rabbit	-	500 milligrams	-
	Skin - Mild irritant	Rabbit	-	400 milligrams	-
	Skin - Moderate irritant	Rabbit	-	24 hours 20 milligrams	-
sodium hydroxide	Eyes - Severe irritant	Monkey	-	24 hours 1 Percent	-
	Eyes - Mild irritant	Rabbit	-	400 Micrograms	-
	Eyes - Severe irritant	Rabbit	-	24 hours 50 Micrograms	-
	Eyes - Severe irritant	Rabbit	-	1 Percent	-
	Eyes - Severe irritant	Rabbit	-	0.5 minutes 1 milligrams	-
	Skin - Mild irritant	Human	-	24 hours 2 Percent	-
	Skin - Severe irritant	Rabbit	-	24 hours 500 milligrams	-
d-Limonene	Skin - Mild irritant	Rabbit	-	24 hours 10 Percent	-

Conclusion/Summary

Skin : Corrosive to the skin. Causes burns.

Eyes : Corrosive to eyes. Direct contact with the eyes can cause irreversible damage, including blindness.

Respiratory : Harmful if inhaled.

Sensitization

Not available.

Mutagenicity

Not available.

Carcinogenicity

Not available.

Classification

Product/ingredient name	OSHA	IARC	NTP
Ethyl alcohol	-	1	-
d-Limonene	-	3	-

Reproductive toxicity

Not available.

Teratogenicity

Not available.

Specific target organ toxicity (single exposure)

11. Toxicological information

Not available.

Specific target organ toxicity (repeated exposure)

Not available.

Aspiration hazard

Name	Result
d-Limonene	ASPIRATION HAZARD - Category 1

Information on the likely routes of exposure : Not available.

Potential acute health effects

Eye contact : Causes serious eye damage.

Inhalation : Harmful if inhaled. May give off gas, vapor or dust that is very irritating or corrosive to the respiratory system. Exposure to decomposition products may cause a health hazard. Serious effects may be delayed following exposure.

Skin contact : Causes severe burns. May cause an allergic skin reaction.

Ingestion : Harmful if swallowed. May cause burns to mouth, throat and stomach.

Symptoms related to the physical, chemical and toxicological characteristics

Eye contact : Adverse symptoms may include the following:
pain
watering
redness

Inhalation : No specific data.

Skin contact : Adverse symptoms may include the following:
pain or irritation
redness
blistering may occur

Ingestion : Adverse symptoms may include the following:
stomach pains

Delayed and immediate effects and also chronic effects from short and long term exposure

Short term exposure

Potential immediate effects : Not available.

Potential delayed effects : Not available.

Long term exposure

Potential immediate effects : Not available.

Potential delayed effects : Not available.

Potential chronic health effects

Not available.

General : Once sensitized, a severe allergic reaction may occur when subsequently exposed to very low levels.

Carcinogenicity : No known significant effects or critical hazards.

11. Toxicological information

Mutagenicity : No known significant effects or critical hazards.

Teratogenicity : No known significant effects or critical hazards.

Developmental effects : No known significant effects or critical hazards.

Fertility effects : No known significant effects or critical hazards.

Numerical measures of toxicity

Acute toxicity estimates

Route	ATE value
Oral	671.8 mg/kg

12. Ecological information

Toxicity

Product/ingredient name	Result	Species	Exposure
didecyldimethylammonium chloride	Acute EC50 110 µg/l Fresh water	Algae - Chlorella pyrenoidosa - Exponential growth phase	72 hours
	Acute EC50 14.22 ppb Fresh water	Algae - Pseudokirchneriella subcapitata	96 hours
	Acute EC50 18 ppb Fresh water	Daphnia - Daphnia magna	48 hours
	Acute LC50 39 µg/l Marine water	Crustaceans - Americamysis bahia - Juvenile (Fledgling, Hatchling, Weanling)	48 hours
	Acute LC50 0.01 µg/l Fresh water	Fish - Acipenser transmontanus - Larvae	96 hours
	Chronic NOEC 25 µg/l Fresh water	Algae - Pseudokirchneriella subcapitata - Exponential growth phase	72 hours
	Chronic NOEC 125 µg/l Fresh water	Daphnia - Daphnia magna	21 days
Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides	Acute EC50 56 µg/l Fresh water	Algae - Chlorella pyrenoidosa - Exponential growth phase	72 hours
	Acute EC50 56 µg/l Fresh water	Algae - Chlorella pyrenoidosa - Exponential growth phase	96 hours
	Acute EC50 18 µg/l Fresh water	Daphnia - Daphnia magna	48 hours
	Acute EC50 750 µg/l Fresh water	Fish - Oryzias latipes	96 hours
Ethyl alcohol	Acute EC50 17.921 mg/l Marine water	Algae - Ulva pertusa	96 hours
	Acute EC50 2000 µg/l Fresh water	Daphnia - Daphnia magna	48 hours
	Acute LC50 25500 µg/l Marine water	Crustaceans - Artemia franciscana - Larvae	48 hours
	Acute LC50 42000 µg/l Fresh water	Fish - Oncorhynchus mykiss	4 days
	Chronic NOEC 4.995 mg/l Marine water	Algae - Ulva pertusa	96 hours
	Chronic NOEC 0.375 ul/L Fresh water	Fish - Gambusia holbrooki - Larvae	12 weeks
d-Limonene	Acute EC50 421 µg/l Fresh water	Daphnia - Daphnia magna	48 hours
	Acute EC50 688 µg/l Fresh water	Fish - Pimephales promelas - Juvenile (Fledgling, Hatchling, Weanling)	96 hours

12. Ecological information

Persistence and degradability

Not available.

Bioaccumulative potential

Product/ingredient name	$LogP_{ow}$	BCF	Potential
Ethyl alcohol	-0.35	-	low
d-Limonene	4.38	1022	high

Mobility in soil

Soil/water partition coefficient (K_{OC}) : Not available.

Other adverse effects : No known significant effects or critical hazards.

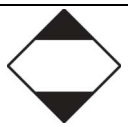
13. Disposal considerations

Disposal methods : The generation of waste should be avoided or minimized wherever possible. Disposal of this product, solutions and any by-products should at all times comply with the requirements of environmental protection and waste disposal legislation and any regional local authority requirements. Dispose of surplus and non-recyclable products via a licensed waste disposal contractor. Waste should not be disposed of untreated to the sewer unless fully compliant with the requirements of all authorities with jurisdiction. Waste packaging should be recycled. Incineration or landfill should only be considered when recycling is not feasible. This material and its container must be disposed of in a safe way. Care should be taken when handling emptied containers that have not been cleaned or rinsed out. Empty containers or liners may retain some product residues. Vapor from product residues may create a highly flammable or explosive atmosphere inside the container. Do not cut, weld or grind used containers unless they have been cleaned thoroughly internally. Avoid dispersal of spilled material and runoff and contact with soil, waterways, drains and sewers.

14. Transport information

Regulatory information	UN number	Proper shipping name	Classes	PG*	Label	Additional information
DOT Classification	UN1903	Disinfectants, liquid, corrosive n.o.s. (didecyldimethylammonium chloride, Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides)	8	III		Limited quantity

14. Transport information

TDG Classification	UN1903	DISINFECTANT, LIQUID, CORROSIVE, N.O.S. (didecyldimethylammonium chloride, Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides)	8	III		**Limited quantity**
Mexico Classification	UN1903	DESINFECTANTE LIQUIDO CORROSIVO, N.E.P. (didecyldimethylammonium chloride, Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides)	8	III		**Limited quantity**
IMDG Class	UN1903	DISINFECTANT, LIQUID, CORROSIVE, N.O.S. (didecyldimethylammonium chloride, Ammonium, alkyldimethylbenzyl-, chloride)	8	III		**Limited quantity**
IATA-DGR Class	UN1903	Disinfectant, liquid, corrosive, n.o.s. (didecyldimethylammonium chloride, Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides)	8	III		**See DG List**

PG* : Packing group

15. Regulatory information

U.S. Federal regulations : **TSCA 8(a) PAIR**: 2-methylundecanal; 3-p-cumenyl-2-methylpropionaldehyde

TSCA 8(a) CDR Exempt/Partial exemption: Not determined

United States inventory (TSCA 8b): Not determined.

Clean Water Act (CWA) 311: sodium hydroxide; edetic acid

Clean Air Act Section 112 (b) Hazardous Air Pollutants (HAPs) : Not listed

Clean Air Act Section 602 Class I Substances : Not listed

Clean Air Act Section 602 Class II Substances : Not listed

15. Regulatory information

DEA List I Chemicals (Precursor Chemicals) : Not listed

DEA List II Chemicals (Essential Chemicals) : Not listed

SARA 302/304

Composition/information on ingredients

Name	%	EHS	SARA 302 TPQ		SARA 304 RQ	
			(lbs)	(gallons)	(lbs)	(gallons)
hydrogen peroxide	< 0.1	Yes.	1000	106.1	1000	106.1

SARA 304 RQ : 6250000 lbs / 2837500 kg [749588.2 gal / 2837500 L]

SARA 311/312

Classification : Fire hazard
Immediate (acute) health hazard

Composition/information on ingredients

Name	%	Fire hazard	Sudden release of pressure	Reactive	Immediate (acute) health hazard	Delayed (chronic) health hazard
didecyldimethylammonium chloride	10 -15	No.	No.	No.	Yes.	No.
Quaternary ammonium compounds, alkylbenzyldimethyl, chlorides	5 - 10	No.	No.	No.	Yes.	No.
Ethyl alcohol	2.5 - 5	Yes.	No.	No.	Yes.	No.
sodium hydroxide	1 - 2.5	No.	No.	No.	Yes.	No.
d-Limonene	0.1 - 1	Yes.	No.	No.	Yes.	No.

State regulations

Massachusetts : The following components are listed: ETHYL ALCOHOL; SODIUM HYDROXIDE; ETHYLENEDIAMINE TETRAACETIC ACID (EDTA)

New York : The following components are listed: Sodium hydroxide; Ethylenediamine tetraacetic acid

New Jersey : The following components are listed: ETHYL ALCOHOL; ALCOHOL; SODIUM HYDROXIDE; CAUSTIC SODA; ETHYLENEDIAMINETETRAACETIC ACID; GLYCINE, N,N'-1,2-ETHANEDIYLBIS[N-(CARBOXYMETHYL)-; EDTA

Pennsylvania : The following components are listed: DENATURED ALCOHOL; SODIUM HYDROXIDE (NA(OH)); GLYCINE, N,N'-1,2-ETHANEDIYLBIS[N-(CARBOXYMETHYL)-

Label elements

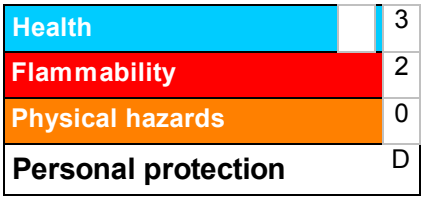
Signal word: : Danger

Hazard statements : Harmful if swallowed.
Harmful if inhaled.
Corrosive Causes irreversible eye damage
Corrosive CAUSES SKIN BURNS.

Precautionary measures : Wear protective gloves/protective clothing/eye protection/face protection. Wash thoroughly after handling. Wash with soap and water. Remove contaminated clothing and wash it before reuse. Keep out of reach of children.

16. Other information

Hazardous Material Information System (U.S.A.) :



Caution: HMIS® ratings are based on a 0-4 rating scale, with 0 representing minimal hazards or risks, and 4 representing significant hazards or risks Although HMIS® ratings are not required on MSDSs under 29 CFR 1910. 1200, the preparer may choose to provide them. HMIS® ratings are to be used with a fully implemented HMIS® program. HMIS® is a registered mark of the National Paint & Coatings Association (NPCA). HMIS® materials may be purchased exclusively from J. J. Keller (800) 327-6868.

The customer is responsible for determining the PPE code for this material.

National Fire Protection Association (U.S.A.) :

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Copyright ©2001, National Fire Protection Association, Quincy, MA 02269. This warning system is intended to be interpreted and applied only by properly trained individuals to identify fire, health and reactivity hazards of chemicals. The user is referred to certain limited number of chemicals with recommended classifications in NFPA 49 and NFPA 325, which would be used as a guideline only. Whether the chemicals are classified by NFPA or not, anyone using the 704 systems to classify chemicals does so at their own risk.

Key to abbreviations : ATE = Acute Toxicity Estimate
BCF = Bioconcentration Factor
GHS = Globally Harmonized System of Classification and Labelling of Chemicals
IATA = International Air Transport Association
IBC = Intermediate Bulk Container
IMDG = International Maritime Dangerous Goods
LogPow = logarithm of the octanol/water partition coefficient
MARPOL 73/78 = International Convention for the Prevention of Pollution From Ships, 1973 as modified by the Protocol of 1978. ("Marpol" = marine pollution)
UN = United Nations

Date of issue : 30/03/2015.

Date of previous issue : 18/01/2012.

Version : 3

16. Other information

Prepared by : Reckitt Benckiser LLC.
Product Safety Department
1 Philips Parkway
Montvale, New Jersey 07646-1810 USA.
FAX: 201-476-7770

Revision comments : Update as per US GHS.

Indicates information that has changed from previously issued version.

Notice to reader

To the best of our knowledge, the information contained herein is accurate. However, neither the above-named supplier, nor any of its subsidiaries, assumes any liability whatsoever for the accuracy or completeness of the information contained herein.
Final determination of suitability of any material is the sole responsibility of the user. All materials may present unknown hazards and should be used with caution. Although certain hazards are described herein, we cannot guarantee that these are the only hazards that exist.

RB is a member of the CSPA Product Care Product Stewardship Program.

Date: 3 June 2014
Supercedes: 26 October 2011

MATERIAL SAFETY DATA SHEET

IN CASE OF EMERGENCY CALL CHEMTREC AT 1-800-424-9300

1. PRODUCT IDENTIFICATION AND COMPANY IDENTIFICATION:

Product Name: **PURELL® Advanced Hand Sanitizer Refreshing Gel**

Company Name & Address: GOJO Industries, Inc.
One GOJO Plaza, Suite 500
Akron, OH 44311

Emergency Phone: **1-800-424-9300 CHEMTREC**
Non-Emergency Phone: (330) 255-6000
MSDS Request Phone: (330) 255-6000 x8804

2. INFORMATION ON INGREDIENTS:

HAZARDOUS INGREDIENTS	CAS NUMBER	OSHA PEL	ACGIH TLV	% RANGE
Ethyl Alcohol	64-17-5	1000 ppm	1000 ppm	70% v/v
Isopropanol	67-63-0	400 ppm	200 ppm	< 5

Other ingredient(s) with notification requirements:	CAS NUMBER	List
Ethyl Alcohol	64-17-5	MA 1; NJ 1S; PA 1; CN 2
Isopropanol	67-63-0	MA 1; NJ 1S; PA; CN

3. HAZARDS IDENTIFICATION:

EMERGENCY OVERVIEW

When used according to instructions, the product applicable to this MSDS is safe and presents no immediate or long-term health hazard. However, abnormal entry routes, such as gross ingestion, may require immediate medical attention.

Potential Health Effects:

HMIS: Health 2 Flammability 3 Reactivity 0 Personal Protection None

Eye Contact: May cause eye irritation.
Skin Contact: No irritation or reaction expected.
Inhalation: Abnormal entry route
Ingestion: May cause upset stomach, nausea (Abnormal entry route).
Carcinogenicity: Not listed as a carcinogen by NTP, IARC, OSHA or ACGIH.

4. FIRST AID MEASURES:

Eye Contact: Do not rub eyes. Flush eyes thoroughly with water for 15 minutes. If condition worsens or irritation persists, contact physician.
Skin Contact: In the case of allergic reactions see a physician
Inhalation: Move to fresh air
Ingestion: Do not induce vomiting. Contact a physician or Poison Control Center.

5. FIRE FIGHTING MEASURES:

NFPA: Health 2 Fire 3 Reactivity 0

Flashpoint °F/°C (PMCC method): 77°F/ 25°C
Unusual Fire and Explosion Hazards: Product is flammable due to alcohol content.
Special Fire Fighting Procedures: None known.

Extinguishing Media: X Water Fog X Alcohol Foam X CO_2 X Dry Chemical ____ Other

6. ACCIDENTAL RELEASE MEASURES:

Avoid contact with ignition sources since product is flammable. Absorb onto inert material and dispose in appropriate manner. Water clean up and rinse. CAUTION – WILL CAUSE SLIPPERY SURFACES.

7. HANDLING AND STORAGE:

Keep away from fire or flame. Store at normal room temperature away from reach of small children. Keep containers sealed. Use older containers first. Avoid freezing conditions.

8. EXPOSURE CONTROLS/PERSONAL PROTECTION:

Eye Protection:	None required under normal conditions.
Skin Protection:	None required under normal conditions.
Respiratory Protection:	None required under normal conditions.
Ventilation:	None required under normal conditions.
Protective Equipment or Clothing:	None required under normal conditions.

9. PHYSICAL AND CHEMICAL PROPERTIES:

Appearance and Odor	Clear liquid, citrus fragrance
pH (undiluted):	6.5 – 8.5
VOC , %:	< 70%

10. STABILITY AND REACTIVITY:

Stable/Non reactive product. Avoid ignition sources.

11. TOXICOLOGICAL INFORMATION:

No acute or chronic toxic effects expected when used according to directions.

12. ECOLOGICAL CONSIDERATIONS:

No ecological or special considerations when used according to directions. Not considered environmentally harmful from normal dilution, expected usage and typical drainage to sewers, septic systems and treatment plants.

13. DISPOSAL CONSIDERATIONS:

Characteristic hazardous waste-flammable liquid. Dispose according to local, state and Federal regulations.

14. TRANSPORT INFORMATION:

Hazardous by transport regulations. When transported by ground modes in the U.S., this product is typically shipped as Consumer Commodity ORM-D. When transported by water, this product is typically shipped as a UN1170 in Limited Quantities. Refer to all current transport regulations for exact requirements.

15. REGULATORY AND OTHER INFORMATION:

TSCA: All ingredients are listed or exempt per reference 15 USC 2602 (2)(B)(vi).

Complies with current FDA regulations for cosmetic and/or over-the-counter drug products.

WHMIS: Exempt under the Food and Drug Act

TB Elimination
Tuberculosis: General Information

What is TB?

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

What are the Symptoms of TB?

The general symptoms of TB disease include feelings of sickness or weakness, weight loss, fever, and night sweats. The symptoms of TB disease of the lungs also include coughing, chest pain, and the coughing up of blood. Symptoms of TB disease in other parts of the body depend on the area affected.

How is TB Spread?

TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

What is the Difference Between Latent TB Infection and TB Disease?

People with latent TB infection have TB germs in their bodies, but they are not sick because the germs are not active. These people do not have symptoms of TB disease, and they cannot spread the germs to others. However, they may develop TB disease in the future. They are often prescribed treatment to prevent them from developing TB disease.

People with TB disease are sick from TB germs that are active, meaning that they are multiplying and destroying tissue in their body. They usually have symptoms of TB disease. People with TB disease of the lungs or throat are capable of spreading germs to others. They are prescribed drugs that can treat TB disease.

What Should I Do If I Have Spent Time with Someone with Latent TB Infection?

A person with latent TB infection cannot spread germs to other people. You do not need to be tested if you have spent time with someone with latent TB infection. However, if you have spent time with someone with TB disease or someone with symptoms of TB, you should be tested.

What Should I Do if I Have Been Exposed to Someone with TB Disease?

People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or coworkers. If you have been around someone who has TB disease, you should go to your doctor or your local health department for tests.

How Do You Get Tested for TB?

There are tests that can be used to help detect TB infection: a skin test or TB blood tests. The Mantoux tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm. The TB blood tests measures how the patient's immune system reacts to the germs that cause TB.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of Tuberculosis Elimination

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What Does a Positive Test for TB Infection Mean?

A positive test for TB infection only tells that a person has been infected with TB germs. It does not tell whether or not the person has progressed to TB disease. Other tests, such as a chest x-ray and a sample of sputum, are needed to see whether the person has TB disease.

What is Bacille Calmette–Guèrin (BCG)?

BCG is a vaccine for TB disease. BCG is used in many countries, but it is not generally recommended in the United States. BCG vaccination does not completely prevent people from getting TB. It may also cause a false positive tuberculin skin test. However, persons who have been vaccinated with BCG can be given a tuberculin skin test or TB blood test.

Why is Latent TB Infection Treated?

If you have latent TB infection but not TB disease, your doctor may want you to take a drug to kill the TB germs and prevent you from developing TB disease. The decision about taking treatment for latent infection will be based on your chances of developing TB disease. Some people are more likely than others to develop TB disease once they have TB infection. This includes people with HIV infection, people who were recently exposed to someone with TB disease, and people with certain medical conditions.

How is TB Disease Treated?

TB disease can be treated by taking several drugs for 6 to 12 months. It is very important that people who have TB disease finish the medicine, and take the drugs exactly as prescribed. If they stop taking the drugs too soon, they can become sick again; if they do not take the drugs correctly, the germs that are still alive may become resistant to those drugs. TB that is resistant to drugs is harder and more expensive to treat. In some situations, staff of the local health department meet regularly with patients who have TB to watch them take their medications. This is called directly observed therapy (DOT). DOT helps the patient complete treatment in the least amount of time.

Additional Information

CDC. Questions and Answers About TB
http://www.cdc.gov/tb/publications/faqs/default.htm

http://www.cdc.gov/tb

AccuKare

Annual Training

Section 4

Basic First Aid

Emergencies: Be Prepared

Introduction

Emergencies are not everyday occurrences, but they can occur. The best way to face an emergency is to be prepared with a plan of action.

This module discusses recommendations of what to do during medical and non-medical emergencies. However if your agency has a specific policy, always follow the agency specific policy, or the persons care plan.

The Basics

Emergencies are usually sudden and call for action right away. An example of an emergency is an injury that occurs in a fall or a severe weather event. Your agency is required to have safety policies and procedures in place, and offer any training they provide on emergency measures before you begin work.

Discuss emergency preparedness with the person receiving PCA services or the responsible party and the qualified professional (QP). The discussion makes sure everyone knows the general chain of events and what to expect during an emergency. Knowing what to expect may keep you and others calm and focused during the crisis. After all, you will know how to handle a situation and what to do!

Emergencies: Be Prepared

The Basics

In the event of an emergency, the PCA care plan will contain much of the information you need, such as:

- Person's name, location and phone number
- Emergency contact information
- Specific plan that addresses identified safety and vulnerability issues
- Back-up staffing plan that should be followed if you are unavailable due to a weather emergency or situation beyond your control

Not all emergencies require you to call 911. For a situation that is non-life threatening, the QP or PCA agency is your first call for help. The responsible party or a person whose care is self- directed may choose to call the doctor's office for advice first rather than calling 911. You must report any emergency to the QP, PCA agency and responsible party. The order of contact depends on the type of emergency.

During any situation, you should always adhere to the agency specific policies and or the person's plan of care.

911 Procedure

You determine you have an emergency and need to call 911. You know time is critical. Your heart is beating fast! You are scared! The emergency operator will ask you lots of questions! Take a deep breath and calm down. Be prepared and expect the questions. Get the help you need.

Follow these steps:

1. Place the 911 call.
2. Stay calm.
3. Provide the information needed by the operator,
    - which can include: Location of the emergency
    - Phone number from where you are calling
    - Address
    - Your name
    - What happened
    - Number of people injured and their condition
    - What you have already done to provide help
4. Respond to any additional questions the operator asks. Be sure to respond calmly.
5. DO NOT HANG UP – You may be given additional information and instructions on how to proceed until assistance arrives. Let the 911 operator hang up first.

Medical Emergencies

Some emergencies are obvious and some emergencies are not. How do you know when to call 911? Call if you think the emergency is life-threatening. You can ask yourself the following questions to help make a decision:

1. Is the brain being affected? These are some things to look for:

Sudden problems with vision loss, weakness, confusion, severe headache, loss of consciousness, seizure, numbness, difficulty speaking and weakness. These may be signs of a serious problem in the brain such as a stroke or aneurysm.

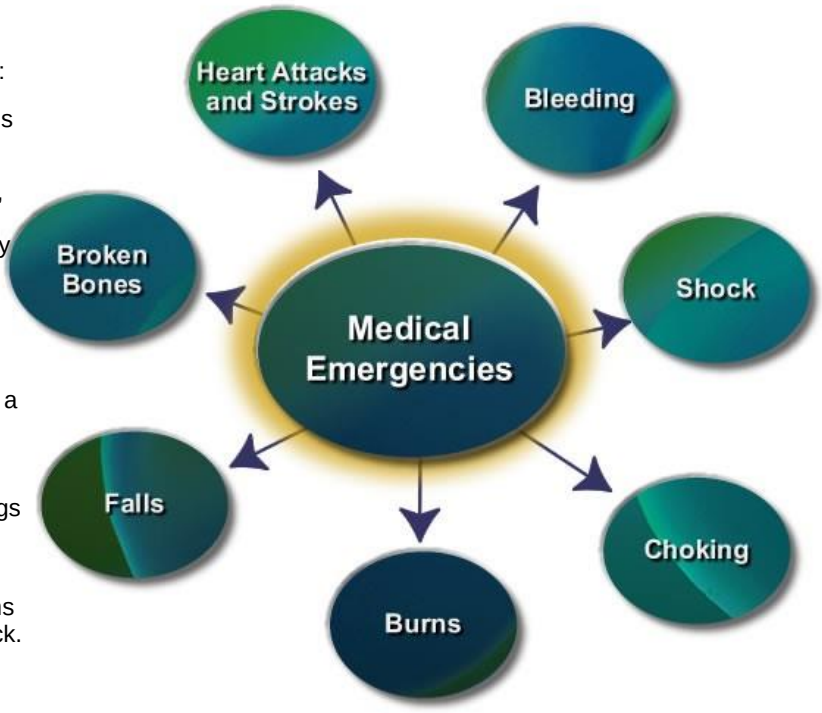
2. Are there problems with breathing? Severe limitation of breathing is a sign of a breathing emergency. Examples include an allergic reaction, a choking episode where the person becomes unconscious.

3. Are there problems with the heart? These are things to look for:

Sudden shortness of breath along with pain in the chest and being unable to relieve the pain. These may be signs of a serious problem with the heart such as a heart attack.

4. Is there bleeding that cannot be controlled?

Bleeding that cannot be stopped with pressure alone is a sign that follow-up is needed.



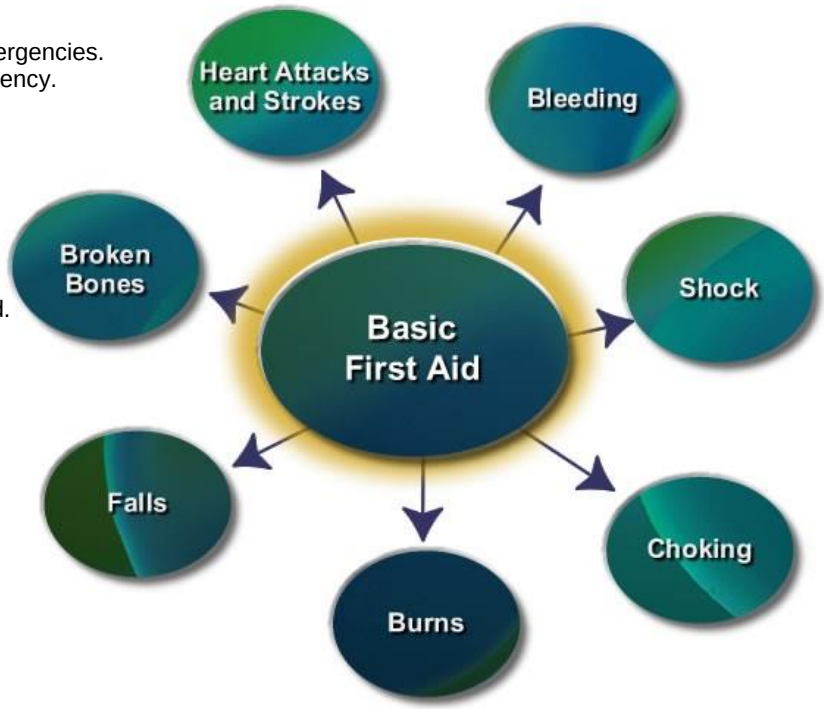
Basic first aid may be the best response to some medical emergencies. Knowing first aid will help you respond effectively in an emergency.

When you call 911, the operator can:

- Dispatch emergency vehicles and staff
- Assist with first aid instructions until help arrives
- Provide you with reassurance during an emergency

You should also know how to respond effectively in an emergency. Learning basic first aid is one way to be prepared. Knowing what to do when the person for whom you are providing PCA services has one or more of the following symptoms:

- Bleeding
- Broken
- bones
  Burns
- Chest
- pain
- Choking
  Falls
- General weakness or loss of coordination
- Heart Attacks and
- Strokes Problems with
- vision Seizures
- Shock
- Trouble breathing

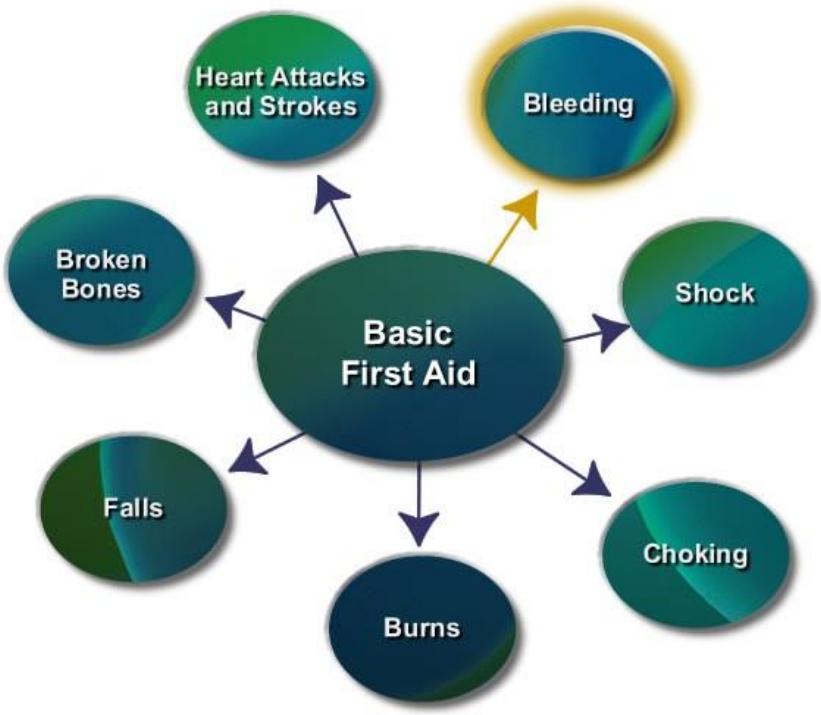


Medical Emergencies

Bleeding

Bleeding may be internal or external. If you suspect internal bleeding, call 911 right away. Signs of internal bleeding may include:

- Bleeding from the ear, nose, or other places
- Bruising on neck, chest, abdomen or side between the ribs and hip
- Coughing or vomiting up blood
- Shock with signs of weakness, anxiety, thirst or skin that is cool to the touch
- Wounds that penetrate the skull, chest or abdomen

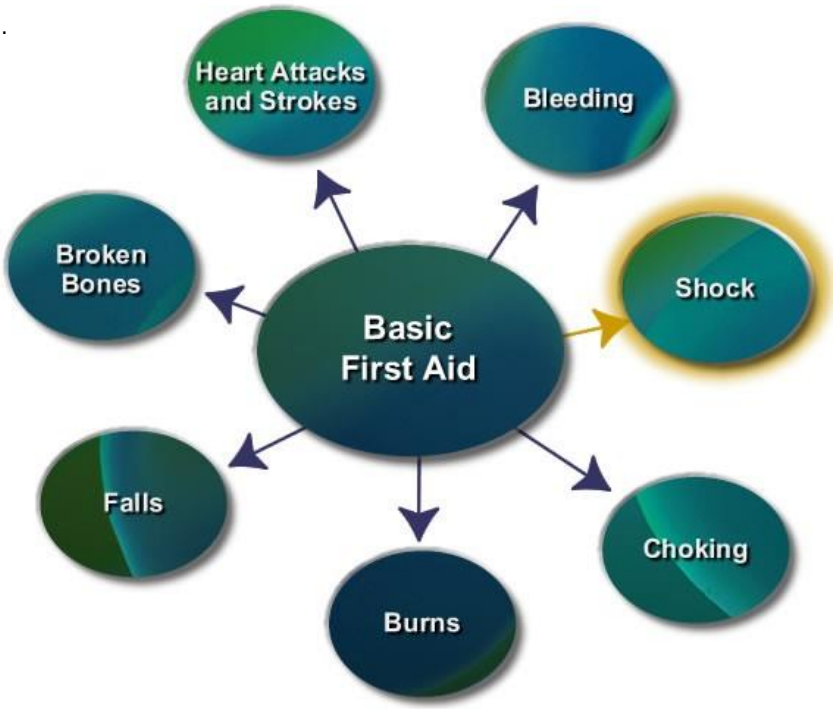


An injury that causes severe bleeding from some type of a wound can be frightening. However, there are steps to follow to help control blood loss while waiting for the ambulance to arrive.

1. Have the injured person lie down and cover the person to prevent the loss of body heat.
2. Put pressure directly on the bleeding area until the bleeding stops.
3. Call 911, if the bleeding is severe.
4. Leave the bandage in place until help comes. If the bleeding leaks through the gauze or other material used to apply pressure, **do not** remove the gauze or bandage. Instead, place more gauze/material on top of the original material or gauze covering the bleeding area.

Shock

Shock can result from severe trauma, bleeding, heatstroke, allergic reactions, poisoning and other causes. Shock
occurs when there is a decrease in blood flow to the brain or other major organs.



If left untreated, shock can be fatal. When a person is in shock, the skin is cool, clammy and appears pale or gray. The eyes may seem to stare and the person may be conscious or unconscious

When working with a shock victim:

1. Dial 911 and stay on the line with the 911 operator, follow the 911 operator's instructions until help arrives.
2. Have the person lie down on their back with their feet higher than the head unless raising the legs will cause pain or more injury.
3. Check for signs of circulation, breathing, coughing or movement.
4. Keep the person warm and comfortable. Loosen clothing. Cover the person with a blanket.
5. Do not give the person anything to eat or drink even if the person complains of thirst.
6. Turn the person on their side to prevent choking if they begin to throw up or bleed from the mouth.
7. If the shock is caused by bleeding, put pressure on the wound to stop the bleeding. Follow the bleeding instructions in the previous section.

Medical Emergencies

Choking

Choking occurs when air flow is being blocked, which will cut off the flow of oxygen to the brain. In adults, food is usually the cause of choking. In children, swallowing a small object is often the cause. Because choking cuts off oxygen to the brain, begin first aid as quickly as possible.

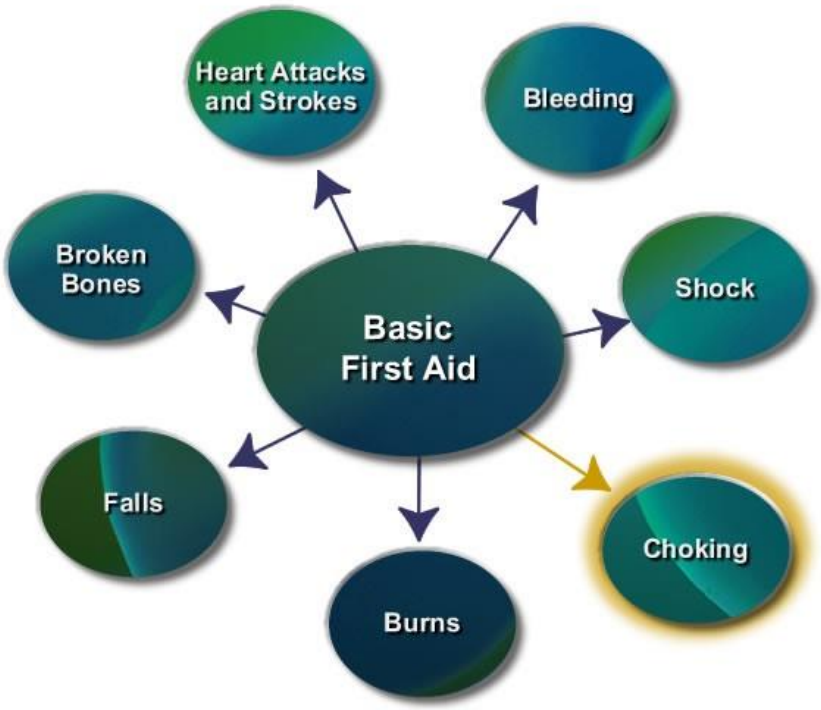
The universal sign for choking is hands gripped around the neck. Other signs include:

- Difficulty breathing or noisy breathing
- Loss of consciousness
- Skin, lips and nails turn blue
- Unable to cough forcefully
- Unable to talk

To help a person choking, a few different methods and techniques may be used. You should use the technique that you learned through your agency.

One method that you could use is the Heimlich maneuver to dislodge the object that is causing the choking. The Heimlich maneuver is a combination of back blows and abdominal thrusts. The techniques are different depending on many factors such as:

- Whether the person is an adult or child
- Consciousness
- Pregnancy
- Obesity



Burns

Burns may be simple like that resulting from touching a stove or more serious if someone's clothes catch on fire. The amount of damage to body tissues determines a simple or minor burn from a serious or major burn. There are three classifications of burns:

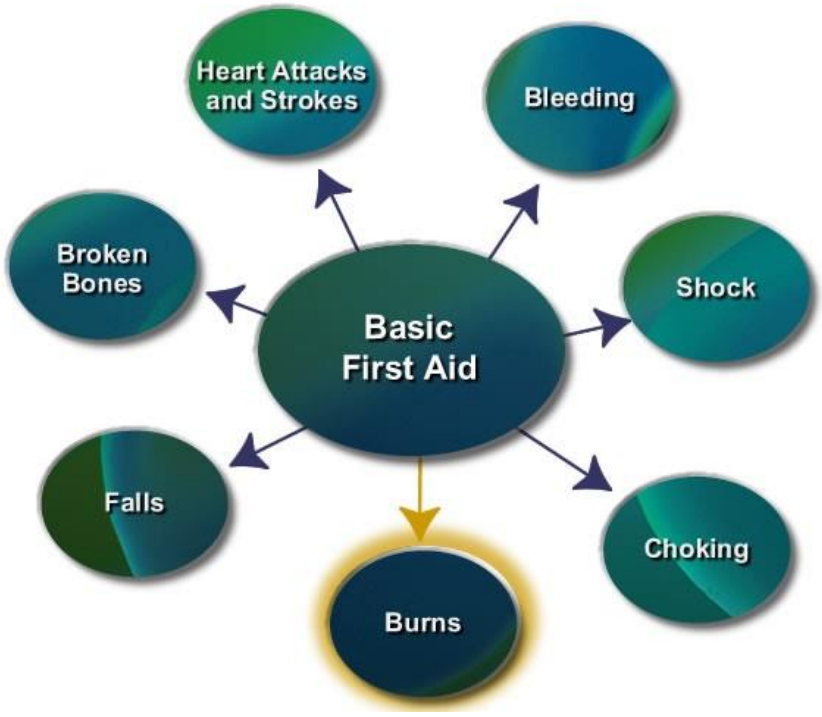
- First-degree burn- First degree burns damage the outer layer of skin (epidermis) and cause pain, redness and swelling (erythema).
- Second-degree burn- Second degree burns damage the epidermis and the inner layer, the dermis, causing erythema and blistering.
- Third-degree burn– Damage from third degree burns extend into the hypodermis, causing destruction of the full thickness of skin with its nerve supply (numbness). Third degree burns leave scars and may cause loss of function and/or sensation.

For minor burns:

1. Run the area under cool water.
2. Do not use ice.
3. Do not apply butter or ointments to the burn.
4. Do not break the blisters.

For major burns:

1. Check for signs of circulation (breathing, coughing or movement).
2. Loosely cover the area of the burn.
3. Do not remove burnt clothing.
4. Do not immerse large severe burns in cold water or use ice.



Emergencies: Be Prepared

Medical Emergencies

Burns

Call 911 for more severe burns, if skin is missing, or if the burn covers an area the size of your palm or larger, and when burns are caused by chemicals or electricity.

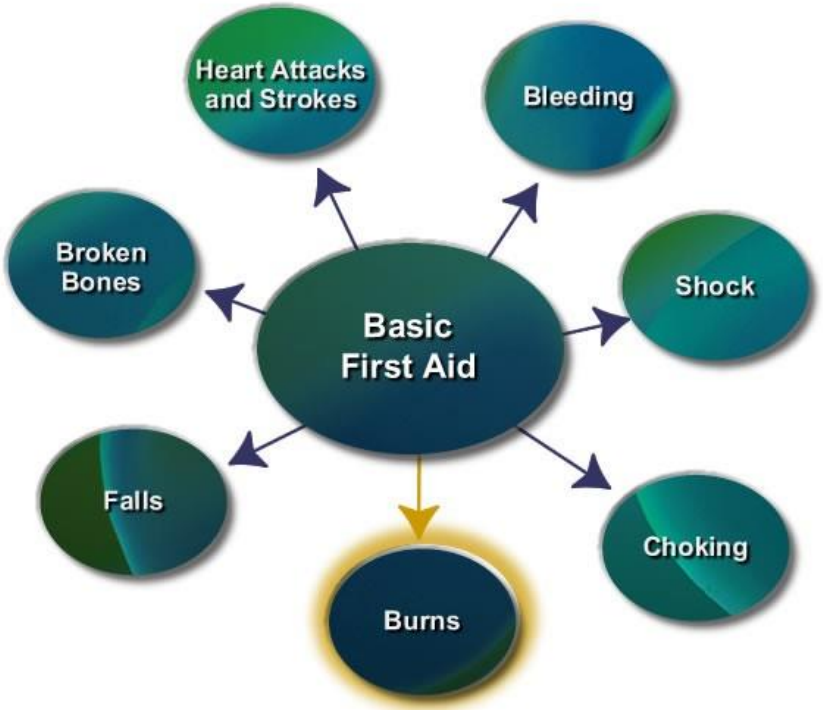
Burns can be very painful and cause much damage if not treated properly. Damage from burns may include:

- Dehydration
- Destruction of skin tissue
- Infection
- Loss of bodily heat

Ointments, sprays and over the counter pain medications can be used to help treat the pain. However, the decision to use these products is NOT a PCA level of care decision. The person or responsible party can make these decisions. The person or responsible party should contact the doctor if the burn is serious or if there are questions. The PCA needs to contact the QP or PCA agency.

Call 911 right away if the burn causes:

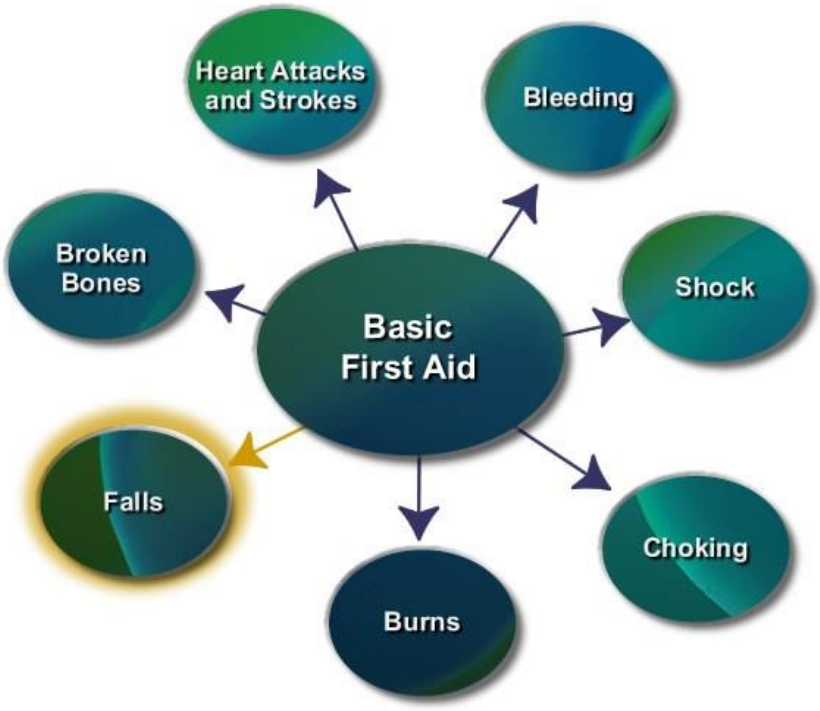
- Difficulty breathing
- Dizziness
- Fever
- Weakness



Falls

When a person falls, it can be an alarming event. Stay calm and act wisely. The first thing to do is make sure the person is safe.

Remove any items that may have fallen on the person. Ask if the person has any pain. If the person is willing and able, move to a comfortable location. If there is severe pain or possible broken bones, call 911.

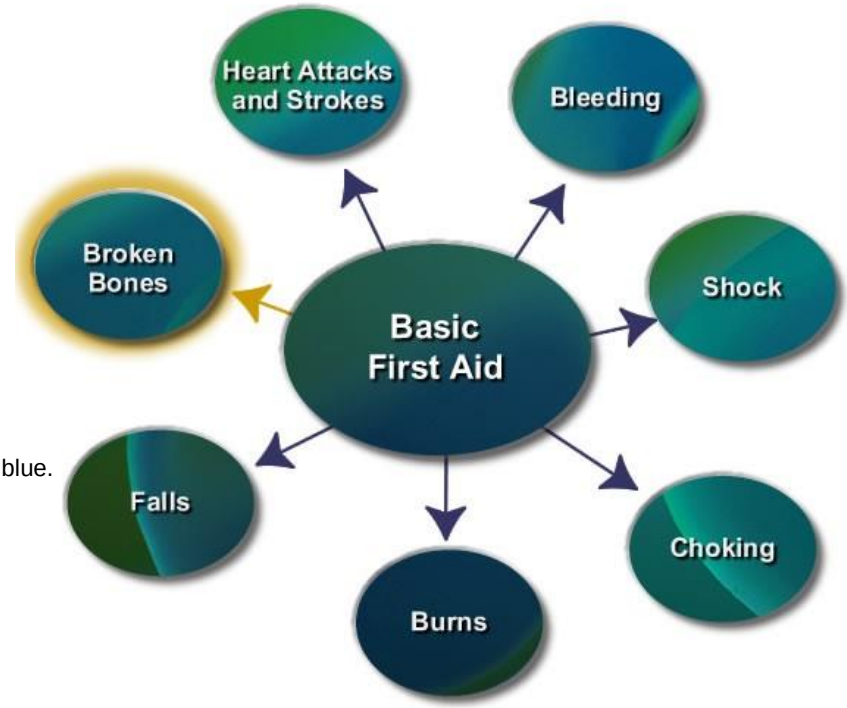


Medical Emergencies

Broken Bones

A broken bone is a fracture and always requires medical attention. If you suspect a bone is broken:

1. Assist the person by stabilizing the body part you suspect is broken. Try to keep it immobile and do not try to move it or straighten it.
2. Ice the extremity every 20 minutes. This could help with swelling while you wait for assistance.
3. Contact the QP, PCA agency, and responsible party to report the injury.
4. Take steps so a medical provider can evaluate the injury further.
5. Call 911 if the injured body part is cold and turns blue.



Heart Attacks and Strokes

Heart attacks and strokes can come on suddenly or slowly. There are common signs for either and a fast response time is critical. Typical signs of heart attack include:

- Chest discomfort or pain in other areas of the upper body
- Cold sweats
- Lightheadedness
- Nausea
- Shortness of breath

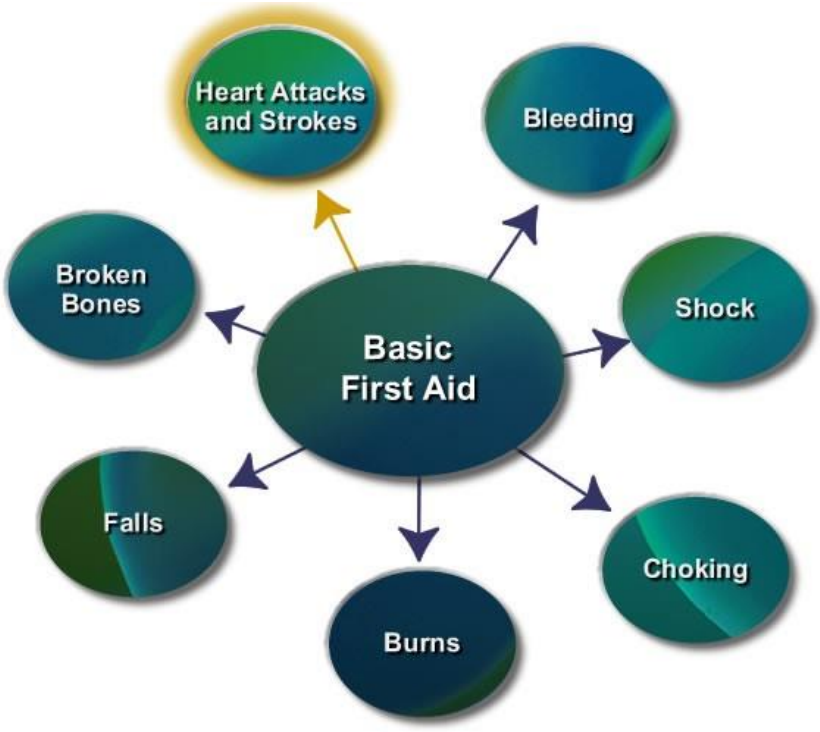
Common stroke signs involve:

- Loss of coordination
- Numbness in the face or extremities
- Sudden headache
- Sudden inability to speak or think clearly
- Trouble with vision

Stroke signs tend to appear more suddenly. Heart attack signs are usually more gradual although signs may be sudden as well. In either case, call 911 right away. Keep the person as comfortable as possible until help arrives.

Emergencies are never easy to handle. To get through any medical emergency:

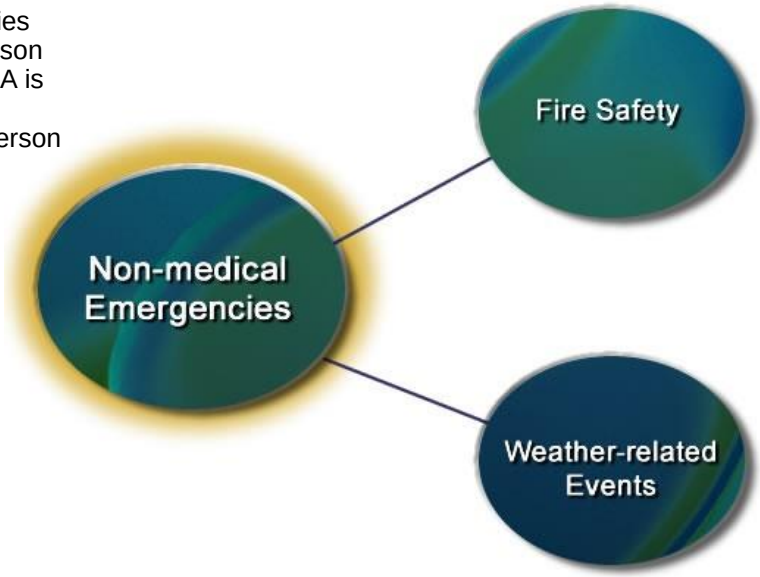
- Remain calm
- Know and follow first aid techniques
- Follow your agency's policies and procedures



Emergencies: Be Prepared

Non-medical Emergencies

Non-medical emergencies deal with emergencies such as fire or weather-related events. The person should have a plan for what to do when the PCA is present as well as what to do if the PCA is not working. The qualified professional (QP) and person should be able to plan for both types of events.



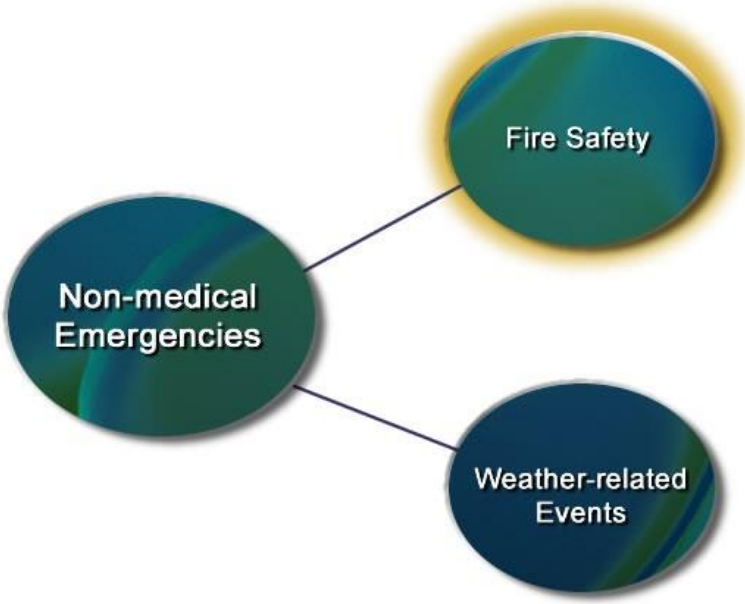
Fire Safety

A good fire safety plan should note where the smoke alarms are in the home where you will be providing PCA services. The plan should also say if there are fire extinguishers in the home. Check these items for working order.

The QP should meet with the person or responsible party and the PCA to work out the best plan. Items that need to be covered in the plan include:

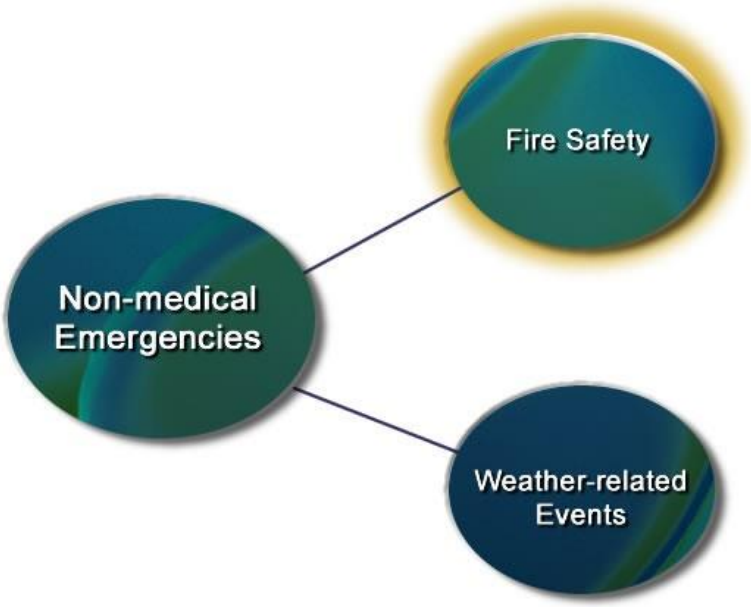
- Time needed to remove the person from the home
- Special equipment needed to remove the person from the home
- Number of people needed to remove the person from the home

The fire safety plan becomes the steps the PCA will follow if there is a fire in the home. The primary concern should always be for the safety of the person and the PCA.



Emergencies: Be Prepared

Non-medical Emergencies



Fire Safety

The acronym, RACE (R-A-C-E) will help you remember the steps to take when there is a fire.

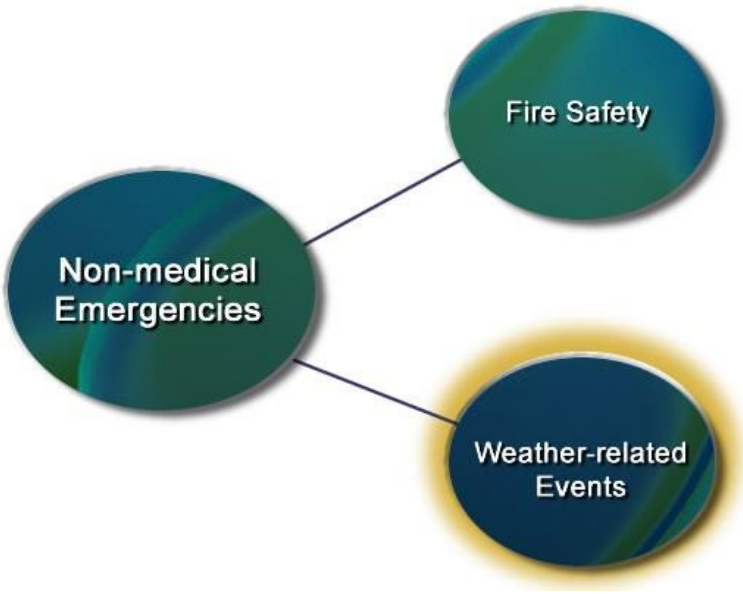
R – RESCUE. Follow the plan to remove the person from danger.
A – ALARM/ALERT. Call 911 to report the fire.
C – CONTAIN. Take what steps are possible to contain the fire without risking yourself or the person.
E – EXTINGUISH or **E**VACUATE. Put the fire out if it is safe to do so, or **E**VACUATE and wait for the fire department to arrive.

If a fire extinguisher is available and the fire is small, use the PASS method to put out the fire. PASS stand for:

P - Pull the pin on the extinguisher.
A - Aim the nozzle at the base of the fire.
S - Squeeze the trigger to allow the water or carbon dioxide out of the extinguisher. (Remember, fire extinguishers can be noisy!)
S - Sweep from side to side until the flames are extinguished.

Do not turn your back on a fire because it can flare up. Close doors to prevent the spread of smoke and fire. But, leave the doors unlocked. Always have the fire department check the area to make sure the fire is completely out. Most importantly, be aware that smoke is more dangerous than the flames. Always play it safe with your security and the safety of the person receiving PCA services.

Weather-related Events



You cannot control the weather. However, you can control how to react when there is a weather emergency.

We think of a tornado or blizzard as the main type of weather emergency in Minnesota. The loss of power or heat due to a thunder storm, ice storm or flooding may also create a weather emergency for a person with special health needs.

Everyone should have a plan for emergencies. Visit the Minnesota State Council on Disability Web site to learn how to plan for emergencies:

- How to create a home plan
- A plan for each type of emergency
- Checklists
- Determining if evacuation is possible and deciding on a location
- Supply kit
- Transportation needs
- Who will be notified and how

Click on Everybody Needs a Plan:

A checklist can guide you through an emergency. Items to include on the checklist are:

- Names and telephone numbers of emergency contacts
- Location of a supply kit, flashlight, radio and first aid kit

A supply kit should contain the following:

- An extra set of eye glasses
- Blanket or sleeping bag
- Change of clothing
- Copy of pertinent medical records
- One week's worth of medication and medical supplies
- Some water and non-perishable food items

AccuKare

Annual Training

Section 5

HIPPA/Data Privacy

Notice of Privacy Practices

Effective Date: December 11, 2003

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

"Protected Health Information" is information that identifies you and relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present, or future payment for health care furnished to you. In this notice, we call Protected Health Information "health information." If you have any questions about this notice, please call us at 763-862-3971.

Our pledge regarding health information

We understand that health information about you is personal. We are committed to protecting the privacy of your health information by following all applicable federal and state privacy and confidentiality requirements. As a result, we have developed policies, improved the controls over our computers and other systems which access and store health data, and educated our employees about protecting your health information. We are required by law to keep your health information private and to give you this notice of our legal duties and privacy practices. When required by Minnesota, federal or any other law, we will get your consent before using or disclosing your health information.

AccuKare, Inc. obtains health information about and from our clients. When we get this information, we make a record of the care and services you receive from AccuKare, Inc. We need this record to give you quality care and to comply with certain legal requirements. This notice tells you how we use and disclose health information about you. It also describes the rights you have to access your information, certain obligations we have regarding the use and disclosure of your health information and how we make sure it is kept private.

This notice applies to all of the records of your care provided by AccuKare, Inc., created by us, your physician(s), other health care providers or an employee of a company we have contracted with to help us provide services. All of our employees will follow this notice.

Protecting the security of your health information

AccuKare, Inc. works hard to protect the privacy and security of your health information while you are cared for and after your care has ended. AccuKare, Inc. uses electronic record systems and believes that they are an important part of improving the quality and safety of the care we give. Authorized members of our workforce use these systems so that they have the information needed to care for you. AccuKare, Inc. has policies, processes and technical protections in place to keep your information from being seen by anyone who should not see it.

While our internal information systems are secure from access by unauthorized people, e-mail communication between you and AccuKare, Inc. is not secure because it is sent through public communication lines (the internet). There is a possibility that e-mail sent using the Internet could be received by an unauthorized person. Nurses and staff will not communicate with you using e-mail unless you want us to do so.

How we may use and disclose health information about you:

The following sections list different ways that we use and disclose health information. Not every use or disclosure will be listed; however, all the ways we use and disclose information will fall into one of the categories.

For treatment. We use health information about you to provide your health care. We may disclose health information about you to physicians, nurses, technicians, medical students, PCA's or other staff who are involved in taking care of you.

For payment. We used and disclosed health information about you so that we can bill you, the responsible party (guarantor), Medicare or other governmental programs, insurance companies or a third party for the services provided. We may tell your health plan about a treatment you are going to have to determine whether your plan will pay for the treatment.

For health care operations. We may use and disclose health information about you for health care operations. These uses and disclosures are necessary to run our facility and make sure that all of our clients get quality care. For example, we may use heath information to review our services and the staff caring for you. Sometimes we need to hire other companies such as consultants and accountants to help us with some health care operations. If we do, we only provide them with health information when it is needed and only after they have signed an agreement to follow our Notice of Privacy Practices and the law.

Health-related benefits and services. We may use and disclosed health information to tell you about health-related benefits or services that you may be interested.

Individuals involved in your care or payment for your care. When you allow us to, we may release health information about you to a family member or friend who is involved in your health care while you are a client of AccuKare, Inc. We may also give a limited amount of information to someone who helps pay for your care so they can help with the payment of a claim. In the event of a natural disaster or other disaster, we may disclose health information about you to an entity helping with a disaster relief effort so that your family can be notified about your condition and location.

As required by law. We will disclose health information about you when required to do so by federal, state or local law.

Special situations

To avert a serious threat to health or safety. We may use and disclosed health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat.

Workers Compensation. If you are being treated for a work-related injury or condition, we may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public health risks. We may disclose health information about you to public health authorities for certain public health activities. These include:

- to prevent or control disease, injury or disability;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls or products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for getting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence.

Health oversight activities. We may disclose health information to a health oversight agency for activities authorized by law. Examples of oversight activities include audits, investigations, inspections and licensing. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you if we get a court or administrative order. WE may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but generally only if your consent is obtained.

Law enforcement. We may release health information if asked to do so by a law enforcement official:

- in response to a court order, grand jury subpoena, warrant, summons or similar process;
- to identify a deceased person, or locate a missing child under age 18;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.

We may also disclose the health information to a law enforcement official:

- about a death we believe may be the result of criminal conduct;
- about criminal conduct in a client home;
- in emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime;
- in other situations as required by law.

National security and intelligence activities. We may release health information about you to authorized federal officials for activities authorized by law. We may disclose health information about you to authorized federal officials so they may provided protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Your rights regarding health information about you

You have the following rights regarding health information we maintain about you.

Right to inspect and copy. You have the right to inspect and copy your health information. You must submit your request in writing to the address on the bottom of this privacy notice. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conduction the review will not be the person who denied your request. We will comply with the decision of the reviewer.

Right to amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, submit a written request to the address on the bottom of this privacy notice. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for us;
- is not part of the information which you would be permitted to inspect and copy;
- is accurate and complete.

We will notify you in writing if we deny your request. If the request is denied, you have the right to submit a written statement disagreeing with the denial, which will be added or linked to the health information in question.

Right to an accounting of disclosures. You have the right to request a list of the disclosures of your health information, if any, we have made without our written authorization to third parties for purposes other than for

treatment, payment, health care operations and certain other limited purposes. To request this list, you must send your request in writing to the address on the bottom of this privacy notice. Your request must give a time period that you want the list to include, which may not be longer than six years.

Right to request restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. Federal law states that we are not required to agree to your request. If we agree to the restriction, we will restrict the information unless the information is needed to provide you with emergency care. To request restrictions, make your request in writing to the address on the bottom of this privacy notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

Right to request confidential communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the address at the bottom of this privacy notice. We will not ask you the reason for your request. We will allow all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a paper copy of this notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may request a paper copy by writing to the address at the bottom of this privacy notice or calling the number at the bottom of this privacy notice.

Changes to this notice

We must follow the terms of this Notice of Privacy Practices. WE can change this Notice of Privacy Practices, however, and reserve the right to make the new notice effective for health information we already have about you as well as any information we receive in the future. WE will post a copy of the current notice in this facility. The effective date of this notice is listed on the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may call AccuKare, Inc. at 763-862-3971 to discuss your complaint, ask questions or to get the contact information for the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other uses of health information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you have given us written permission to use or disclose health information about you, you may take back that permission, in writing, at any time. If you take back your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to keep our records of the care that we provided to you.

Please submit all written requests to: AccuKare, Inc.
13750 Crosstown Drive NW, Suite L100
Andover, MN 55304

If you have any questions, please call us: 763-862-3971

Nondisclosure Agreement

Confidential Information

(1) The Employee/Consultant acknowledges that he/she will receive and have access during the term of his employment to Confidential Information. Confidential Information shall not include any information which:

- was in the public domain prior to the date of receipt by the Employee/Consultant;
- was in the Employee's/Consultant's lawful possession prior to the date of communication by the AccuKare, Inc. ("the Employer");
- becomes part of the public domain by publication or otherwise not due to any unauthorized act or omission of the Employee/Consultant;
- was supplied to the Employee/Consultant by a third party having the lawful right to do so;
- was independently developed by the Employee/Consultant without use of the Confidential Information; or
- the Employee/Consultant is required by law to disclose, provided that the Employee/Consultant first notifies the Employer that it is required to disclose such Confidential Information and he allows the Employer a reasonable period of time to contest the disclosure of such Confidential Information.

(2) All right, title, and interest in and to the Confidential Information shall remain the exclusive property of the Employer and the Confidential Information shall be held in trust by the Employee/Consultant for the benefit of the Employer. The Employee/Consultant shall not, directly or indirectly, use or exploit the Confidential Information for any operational, commercial or other purpose whatsoever or in any manner detrimental to the Employer or disclose, disseminate, impart or grant access to the Confidential Information to any person for any purpose.

(3) The Employee/Consultant shall not copy, reproduce in any form or store in any retrieval system or database the Confidential Information without the prior written consent of the Employer, except for such copies, reproductions and storage as may be reasonably required internally by the Employee/Consultant for the purpose for which the Employee/Consultant receives the Confidential Information.

Employer Property

All materials relating to the business and affairs of the Employer, including, without limitation, all manuals, documents, reports, equipment, working materials, and lists of customers or suppliers prepared by the Employer or by the Employee/Consultant in the course of the Employee's/Consultant's employment are for the benefit of the Employer and are and shall remain the property of the Employer.

Equitable Remedies

The parties hereto agree that any breach by the Employee/Consultant of this agreement shall be deemed to cause the Employer irreparable harm which cannot be adequately compensated in damages and the Employer, in addition to all other remedies, shall be entitled to injunctive or other equitable relief to restrain such breach.

Entire Agreement

This Agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous agreements, understandings, negotiations and discussions, whether oral or written, of the parties hereto and there are no warranties, representations or other agreements between the parties in connection with the subject matter hereof except as specifically set forth herein.

Severability

If any provision in this Agreement is determined to be invalid, void, or unenforceable by the decision of any court of competent jurisdiction, which determination is not appealed or appealable for any reason whatsoever, the provision in question shall not be deemed to affect or impair the validity or enforceability of any other provision of this Agreement and such invalid or unenforceable provision or portion thereof shall be severed from the remainder of this Agreement.

Successors and Assigns

This Agreement shall enure to the benefit of and be binding upon the parties and their respective heirs, executors and administrators or successors and permitted assigns, as the case may be.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Print Name – Witness	Signature – Witness	Date

AccuKare

Annual Training

Section 6

Staff/Recipient Boundaries

Boundaries Policy

Professional boundaries are important and this policy is for your safety as well as the safety of your client.

You may not:

- Accept gifts or money from the person receiving services or from family members
- Borrow money, cars, equipment or anything else from the person receiving services or from family members
- Buy any possessions from the person receiving services or from their family members
- Have a romantic or sexual relationship with the person receiving services or with immediate family members
- Loan money to the person receiving services or their family members
- Sell items of any kind to the person receiving services or to family members
- Sexually harass the person receiving services or family members
- Verbally, physically, financially or sexually abuse the person receiving services or their family members
- Contact a previous client, client family member or client representative once you are no longer employed as a staff for that client. Any attempt to do so could be viewed as harassment by the individual and handled accordingly.

Signs of boundary issues in the working relationship include:

- Offers of gifts
- Person receiving services makes unreasonable requests and/or requests tasks not in the care plan
- Speaking negatively about other workers with client or fellow workers
- When an employee that is not a family member functions in the role of an informal family member/friend
- Communications with client/responsible party outside of scheduled shift

Boundaries for family members and friends:

You must be careful to guard the client's privacy. You must have a professional manner while carrying out PCA/Homemaker/Respite services.

The tasks you do for a person as a PCA/Homemaker/Respite must remain between you, your agency and the client. Be cautious when talking about anyone else who provides PCA/Homemaker/Respite services.

Friends and family often do many small tasks for each other on a daily basis. You may count time only for activities that are in the care plan during scheduled work time.

PHR-109 Policy Date: 07-07-2017

AccuKare

Annual Training

Section 7

Emergency Use of Manual Restraints

Emergency Use of Manual Restraints Policy

Program Name: AccuKare, Inc

I. Policy

It is the policy of this DHS licensed provider, AccuKare (program), to promote the rights of persons served by this program and to protect their health and safety during the emergency use of manual restraints.

"Emergency use of manual restraint" means using a manual restraint when a person poses an imminent risk of physical harm to self or others and it is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own, do not constitute an emergency.

AccuKare DOES NOT use Manual restraints; however, if an emergency occurs, please follow this criteria. If your client is escalating in behavior, attempt the following to redirect the behavior.

II. Positive support strategies and techniques required

A. The following positive support strategies and techniques must be used to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others:

- Follow individualized strategies in a person's coordinated service and support plan and coordinated service and support plan addendum;
- Shift the focus by verbally redirect the person to a desired alternative activity;
- Model desired behavior;
- Reinforce appropriate behavior
- Offer choices, including activities that are relaxing and enjoyable to the person;
- Use positive verbal guidance and feedback;
- Actively listen to a person and validate their feelings;
- Create a calm environment by reducing sound, lights, and other factors that may agitate a person;
- Speak calmly with reassuring words, consider volume, tone, and non-verbal communication;
- Simplify a task or routine or discontinue until the person is calm and agrees to participate; or
- Respect the person's need for physical space and/or privacy.

B. The program will develop a positive support transition plan on the forms and in manner prescribed by the Commissioner and within the required timelines for each person served when required in order to:
   1. eliminate the use of prohibited procedures as identified in section III of this policy;
   2. avoid the emergency use of manual restraint as identified in section I of this policy;
   3. prevent the person from physically harming self or others; or
   4. phase out any existing plans for the emergency or programmatic use of restrictive interventions prohibited.

III. Permitted actions and procedures

Use of the following instructional techniques and intervention procedures used on an intermittent or continuous basis are permitted by this program. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum.

A. Physical contact or instructional techniques must be use the least restrictive alternative possible to meet the needs of the person and may be used to:

i. calm or comfort a person by holding that persons with no resistance from that person;
ii. protect a person known to be at risk of injury due to frequent falls as a result of a medical condition;
iii. facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; or
iv. block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others, with less than 60 seconds of physical contact by staff; or
v. to redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

B. Restraint may be used as an intervention procedure to:
1. allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition; or
2. assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm; or
3. position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.
Any use of manual restraint as allowed in this paragraph [Section B] must comply with the restrictions identified in [Section A].

C. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

IV. Prohibited Procedures

Use of the following procedures as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience, is prohibited by this program:

1. chemical restraint;
2. mechanical restraint;
3. manual restraint;
4. time out;
5. seclusion; or
6. any aversive or deprivation procedure.

V. Manual Restraints Not Allowed in Emergencies

A. This program does not allow the emergency use of manual restraint. The following alternative measures must be used by staff to achieve safety when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety:

- Continue to utilize the positive support strategies;
- Continue to follow individualized strategies in a person's coordinated service and support plan and coordinated service and support plan addendum;
- Ask the person and/or others if they would like to move to another area where they may feel safer or calmer;
- Remove objects from the person's immediate environment that they may use to harm self or others
- Call 911 for law enforcement assistance if the alternative measures listed above are

ineffective in order to achieve safety for the person and/or others. While waiting for law enforcement to arrive staff will continue to offer the alternative measures listed above if doing so does not pose a risk of harm to the person and/or others.

- Refer to the attached list of alternative measures that includes a description of each of the alternative measures trained staff are allowed to use and instructions for the safe and correct implementation of those alternative measures.

B. The program will not allow the use of an alternative safety procedure with a person when it has been determined by the person's physician or mental health provider to be medically or psychologically contraindicated for a person. This program will complete an assessment of whether the allowed procedures are contraindicated for each person receiving services as part of the required service planning required under the 245D Home and Community-based Services (HCBS) Standards (section 245D.07, subdivision 2, for recipients of basic support services; or section 245D.071, subdivision 3, for recipients of intensive support services).

VI. Conditions for Emergency Use of Manual Restraint

A. Emergency use of manual restraint must meet the following conditions:
   1. immediate intervention must be needed to protect the person or others from imminent risk of physical harm;
   2. the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety; and
   3. the manual restraint must end when the threat of harm ends.

B. The following conditions, on their own, are not conditions for emergency use of manual restraint:
   1. the person is engaging in property destruction that does not cause imminent risk of physical harm;
   2. the person is engaging in verbal aggression with staff or others; or
   3. a person's refusal to receive or participate in treatment or programming.

VII. Restrictions When Implementing Emergency Use of Manual Restraint

Emergency use of manual restraint must not:
   1. be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury;
   2. be implemented with an adult in a manner that constitutes abuse or neglect;
   3. be implemented in a manner that violates a person's rights and protection;
   4. be implemented in a manner that is medically or psychologically contraindicated for a person;
   5. restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing;
   6. restrict a person's normal access to any protection required by state licensing standards and federal regulations governing this program;
   7. deny a person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;
   8. be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by this program;
   9. use prone restraint. "Prone restraint" means use of manual restraint that places a person in a face-down position. It does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible; or

10. apply back or chest pressure while a person is in a prone position, supine (meaning a face-up) position, or side-lying position,
11. be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

VIII. Monitoring Emergency Use of Manual Restraint

A. The program must monitor a person's health and safety during an emergency use of a manual restraint. The purpose of the monitoring is to ensure the following:
   1. only manual restraints allowed in this policy are implemented;
   2. manual restraints that have been determined to be contraindicated for a person are not implemented with that person;
   3. allowed manual restraints are implemented only by staff trained in their use;
   4. the restraint is being implemented properly as required; and
   5. the mental, physical, and emotional condition of the person who is being manually restrained is being assessed and intervention is provided when necessary to maintain the person's health and safety and prevent injury to the person, staff involved, or others involved.

B. When possible, a staff person who is not implementing the emergency use of a manual restraint must monitor the procedure.

C. A monitoring form, as approved by the Department of Human Services, must be completed for each incident involving the emergency use of a manual restraint.

IX. Reporting Emergency Use of Manual Restraint

A. Within 24 hours of an emergency use of manual restraint, the legal representative, the responsible party and the case manager must receive verbal notification of the occurrence as required under the incident response and reporting requirements in the 245D HCBS Standards, section 245D.06, subdivision 1.
   When the emergency use of manual restraint involves more than one person receiving services, the incident report made to the legal representative, the responsible party and the case manager must not disclose personally identifiable information about any other person unless the program has the consent of the person.

B. Within 3 calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the program's designated coordinator, AccuKare Manager, the following information about the emergency use:
   1. who was involved in the incident leading up to the emergency use of a manual restraint; including the names of staff and persons receiving services who were involved;
   2. a description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of a manual restraint;
   3. a description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the emergency use of a manual restraint was implement. This description must identify when, how, and how long the alternative measures were attempted before the manual restraint was implemented;
   4. a description of the mental, physical, and emotional condition of the person who was manually restrained, leading up to, during, and following the manual restraint;
   5. a description of the mental, physical, and emotional condition of the other persons involved leading up to, during, and following the manual restraint;
   6. whether there was any injury to the person who was restrained before or as a result of the use of a manual restraint;
   7. whether there was any injury to other persons, including staff, before or as a result of the use of a manual restraint; and

8. whether there was a debriefing with the staff and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident. Include the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned.

C. A copy of this report must be maintained in the person's service recipient record. The record must be uniform and legible.

D. Each single incident of emergency use of manual restraint must be reported separately. A single incident is when the following conditions have been met:
   1. after implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety;
   2. upon the attempt to release the restraint, the person's behavior immediately re-escalates; and
   3 staff must immediately re-implement the manual restraint in order to maintain safety.

X. Internal Review of Emergency Use of Manual Restraint

A. Within 5 business days after the date of the emergency use of a manual restraint, the program must complete and document an internal review of the report prepared by the staff member who implemented the emergency procedure.

B. The internal review must include an evaluation of whether:
   1. the person's service and support strategies need to be revised;
   2. related policies and procedures were followed;
   3. the policies and procedures were adequate;
   4. there is need for additional staff training;
   5. the reported event is similar to past events with the persons, staff, or the services involved; and
   6. there is a need for corrective action by the program to protect the health and safety of persons.

C. Based on the results of the internal review, the program must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the program.

D. The corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

E. The program has identified the following person or position responsible for conducting the internal review and for ensuring that corrective action is taken, when determined necessary:

AccuKare Manager

XI. Expanded Support Team Review of Emergency Use of Manual Restraint

A. Within 5 working days after the completion of the internal review, the program must consult with the expanded support team to:
   1. Discuss the incident to:
      a. define the antecedent or event that gave rise to the behavior resulting in the manual restraint; and
      b. identify the perceived function the behavior served.
   2. Determine whether the person's coordinated service and support plan addendum needs to be revised to:
      a. positively and effectively help the person maintain stability; and
      b. reduce or eliminate future occurrences of manual restraint.

B. The program must maintain a written summary of the expanded support team's discussion and decisions in the person's service recipient record.
C. The program has identified the following person or position responsible for conducting the expanded support team review and for ensuring that the person's coordinated service and support plan addendum is revised, when determined necessary.

Karla R Adams, President

XII. External Review and Reporting of Emergency Use of Manual Restraint

Within 5 working days after the completion of the expanded support team review, the program must submit the following to the Department of Human Services using the online behavior intervention reporting form which automatically routes the report to the Office of the Ombudsman for Mental Health and Developmental Disabilities:

1. report of the emergency use of a manual restraint;
2. the internal review and corrective action plan; and
3. the expanded support team review written summary.

XIII. Staff Training

Before staff may implement manual restraints on an emergency basis the program must provide the training required in this section.

A. The program must provide staff with orientation and annual training as required in Minnesota Statutes, section 245D.09.
    1. Before having unsupervised direct contact with persons served by the program, the program must provide instruction on prohibited procedures that address the following:
        a. what constitutes the use of restraint, time out, seclusion, and chemical restraint;
        b. staff responsibilities related to ensuring prohibited procedures are not used;
        c. why such prohibited procedures are not effective for reducing or eliminating symptoms or undesired behavior;
        d. why prohibited procedures are not safe; and
        e. the safe and correct use of manual restraint on an emergency basis according to the requirements in the 245D HCBS Standards, section 245D.061 and this policy.
    2. Within 60 days of hire the program must provide instruction on the following topics:
        a. alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others;
        b. de-escalation methods, positive support strategies, and how to avoid power struggles;
        c. simulated experiences of administering and receiving manual restraint procedures allowed by the program on an emergency basis;
        d. how to properly identify thresholds for implementing and ceasing restrictive procedures;
        e. how to recognize, monitor, and respond to the person's physical signs of distress, including positional asphyxia;
        f. the physiological and psychological impact on the person and the staff when restrictive procedures are used;
        g. the communicative intent of behaviors; and
        h. relationship building.
B. Training on these topics received from other sources may count toward these requirements if received in the 12-month period before the staff person's date of hire or in the 12-month period before this program's 245D-HCBS license became effective on Jan. 1, 2014.
C. The program must maintain documentation of the training received and of each staff person's competency in each staff person's personnel record.

Policy reviewed and authorized by:

Karla R Adams, President	Signature on File
Print name & title	Signature

Date of last policy review: 7/20/2015 Date of last policy revision: 7/20/2015
Legal Authority: MS §§ 245D.06, subd. 5 to subd, 8; 245D.061

C-24 & PHR-82 Policy Date: 09-09-2013
Revision Date:06-20-2015
Revision Date:07-20-2015

AccuKare

Annual Training

Section 8

Duties Integral to Job/Job Description

Job Description for PCA

Title: Personal Care Assistant (PCA)
Supervisor: Qualified Professional

Job Responsibilities: Providing personal cares as per the care plan in place in accordance with all Department of Human Services (DHS) and agency standards.

Qualifications:
You must have clearance from the Office of Inspector General of the United States Department of Health and Human Services per AccuKare, Inc review of online documentation.

- Must be at least age 18 (applicants ages 16-17 meeting DHS criteria)
- Have the ability to commute to the client home.
- Pass a criminal background check required by the Department of Human Services.
- Complete required initial and ongoing training.
- Be able to lift 50 lbs. (or more if necessary for specific client assignment) and tolerate periods of repeated bending, stooping, etc. as necessary to meet the needs of individual clients.
- May not be a consumer of Personal Care Assistant services.
- May not be the client's spouse, parent or stepparent (if under age 18), paid legal guardian of adult, legal guardian (if under age 18), or licensed foster provider.
- Successfully complete the following: "Individualized Personal Care Assistant Training"

The PCA *MAY* do the following:

- Bowel and bladder care
- Bathing, grooming, hair washing, dressing, skin care
- Transfers, positioning, turning, mobility, ambulation
- Range of motion and strengthening exercises to maintain the optimal level of functioning.
- Respiratory assistance, tracheotomy suctioning using a clean procedure (determined by RN) and only after training by an RN. Application and maintenance of prosthetics and orthotics.
- Assistance with food, nutrition, and diet activities, as deemed necessary by Assessment.
- Assistance with medication, per DHS PCA manual (NOT DISPENSING FROM THE BOTTLE).
- Cleaning medical equipment, cleaning in relationship to cares provided, assisting with instrumental activities of daily living as listed on the Assessment/Service Plan.
- Redirection, monitoring, assisting, and observing/prompting that are integral to the cares listed above for client completion and PCA insuring completed.
- Redirection and intervention for behaviors, including observation and monitoring.
- Interventions for seizure disorders as instructed by the Qualified Professional and Responsible Party, where applicable.
- Must maintain appropriate boundaries with the client by not becoming involved in personal life issues, utilizing the QP for collaboration in this area
  NOTE: A PCA MAY ACCOMPANY A CLIENT OUTSIDE OF THEIR HOME TO PERFORM THE ABOVE SERVICES IF THE CLIENT'S HEALTH OR SAFETY WOULD BE JEOPARDIZED WITHOUT THE SERVICES.

PCA Initials_____

The PCA may *NOT* do the following:

- May not dispense medication (dose measuring) nor inject any fluids/medications into veins, muscles or skin.
- May not perform any sterile procedures including sterile dressing changes.
- May not perform any cares not listed in the Care Plan or Assessment/Service Plan or for which the PCA has not been trained.
- May not claim any time that was not actually spent performing the cares as per the Care Plan.
- May not bring their children to work.
- May not care for anyone other than the client while claiming time for working with the client. A PCA may NOT be responsible for or baby-sit for ANYONE while working as a PCA for the client.
- May not borrow, lend or exchange money, goods or services between employee and client
- May not eat the client's food
- May not submit a fraudulent time card.
- May not provide services in the PCA's home, unless PCA lives with client.
- May not use the client's bank card, credit card, or EBT card.
- May not have in possession a key to client's home.

It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092 and 256B.49.

I have received a copy of this job description, understand its contents and will adhere to them.

Signature Title Date

Job Description for Homemaker

Title: Homemaker (HM)
Supervisor: Qualified Professional (Agency Social Worker or Nurse)

Job Responsibilities: Providing homemaking services as per the care plan in place in accordance with all Department of Human Services (DHS) and agency standards.

Qualifications:
You must have clearance from the Office of Inspector General of the United States Department of Health and Human Services per AccuKare, Inc. review of online documentation

- Must be at least 16 years of age.
- Must have the ability to commute to the client home.
- Must be able to lift 50 lbs and be able to sustain long periods of bending, stooping, squatting, kneeling, or standing.
- Must be able to pass a criminal background check.
- Must be able to complete initial and ongoing training.

The Home maker *MUST* do the following:

- Provide the homemaking duties as instructed by the supervisor.
- Maintain, minimally, every other week contact with the administration of AccuKare, Inc.
- Utilize supplies provided by the client or the agency only for the purpose of performing the job of Homemaker for that client.
- Utilize company standards regarding documentation.
- Only maintain the role of homemaker while being paid as a homemaker.
- Maintain appropriate boundaries with the clients/PCA by not becoming involved in personal life issues, utilizing the QP for collaboration in this area.
- Must also complete 24 hours of training within the first year of employment, and 6 hours annually thereafter
- Maintain current Driver's License & Car Insurance on file with AccuKare
- Comply with AccuKare cell phone policy

The Homemaker may *NOT* do the following:

- May not perform any cares not listed in the Service Plan or County Case Manager's assessment or for which the Homemaker has not been trained
- May not bring their children to work.
- May not care for or do homemaking duties for anyone other than the client while claiming time for assisting that client with their homemaking duties.
- May not be responsible for or baby-sit anyone while working for the client as a homemaker.
- May not borrow, lend or exchange money, goods or services between employee and client.
- May not eat the client's food.

Homemaker Initials_____

The Homemaker may *NOT* do the following continued:

- May not claim time for having performed duties that were not actually performed at the time claimed.
- May not perform any personal cares.
- May not submit a fraudulent time card.
- May not use the client's bank card, credit card, or EBT card.
- May not have in possession a key to client's home.

It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092 and 256B.49.

I have received a copy of this job description, understand its contents and will adhere to them.

Signature Title Date

AccuKare

Annual Training

Section 9

Exposure Control Plan

AWAIR

AWAIR Hazards List

Date: 06-06-02

Hazards Identified by: Karla R. Adams, RN

Hazardous Chemicals

Within the Purell Instant Hand Sanitizer (see MSDS sheet for this product which is available online at www.accukare.com and in the Home Kit Contents packet in the box at the client home)
Ethyl Alcohol
Isopropanol

Within the Lysol Brand Quaternary Disinfectant Cleaner (see MSDS sheet for this product which is available online at www.accukare.com and in the Home Kit Contents packet in the box at the client home)
Didecyl Dimethyl Ammonium Chloride
Alkyl Dimethyl Benzyl Ammonium Chlorides
Sodium Hydroxide
Ethanol

Within the Copier Drum (see MSDS sheet for this product available in the AccuKare office)
Arsenic Triselenide

Harmful Physical Agents

There are no known harmful physical agents, but refer to the Heat Stress Guide on the AccuKare website at www.accukare.com. Employees are trained on this upon hire and annually. A full PAFS is available for review in the main office.

Infectious Agents

- A full list of possible infectious agents is attached.
- Due to the attention to client data privacy and agency unaware of all of the client's potential infectious agents, all patients are to be handled with full Universal Precautions.
- No know active TB is present within the agency.
- No known infectious agents are present in the current caseload, but no assumptions will be made as to the lack of awareness of a possible presence of an infectious agent.

Other Hazards

Repetitive lifting, bending, turning

Exposure Control Plan for AccuKare, Inc.

Purpose: To provide a guide for maintaining a safe and healthful work environment for all employees.

In pursuit of this endeavor, the following Exposure Control Plan (ECP) is provided to eliminate or minimize occupational exposure to blood borne pathogens (BBP) in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens."

The ECP is a key document in assisting our agency in implementing and ensuring compliance with the standard, thereby protecting our employees. This ECP includes:

- Determination of employee exposure
- Implementation of various methods of exposure control, including:
  - Universal Precautions (UP)
  - Engineering and work practice controls
  - Personal protective equipment (PPE)
  - Housekeeping
- Hepatitis B vaccination program
- Post-exposure evaluation and follow-up
- Record keeping
- Procedures for evaluation circumstances surrounding an exposure incident

The methods of implementation of these elements of the standard are discussed in the subsequent pages of this ECP.

Karla R. Adams, RN is responsible for the implementation of the ECP. Karla R. Adams, RN will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures. Contact location/phone number is 763-862-3971/ main office of AccuKare Inc.

Those employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with procedures and work practices outlined in this ECP.

Karla R. Adams, RN along with the supervising RN will maintain and provide all necessary PPE, engineering controls, labels (if needed), and or bags (if needed). Karla R. Adams, RN along with the supervising RN will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes. Contact location/phone number is 763-862-3971/ main office of AccuKare Inc.

Karla R. Adams, RN will be responsible for ensuring that all medical actions required are performed and that appropriate medical records are maintained. Contact location/phone number is 763-862-3971/ main office of AccuKare Inc.

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Karla R. Adams will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, and NIOSH representatives. Contact location/phone number is 763-862-3971/ main office of AccuKare Inc.

I. Employee Exposure Determination

A. As part of the exposure determination section of our ECP, the following is a list of all job classifications at our establishment in which all employees have occupational exposure:

JOB TITLE	DEPARTMENT/LOCATION
Supervising Registered Nurse	Nursing/In client homes
Personal Care Assistant	Nursing/ In client homes
Homemaker	Nursing/In client homes

B. The following is a list of job classifications in which some employees at our establishment have occupational exposure. Included is a list of tasks and procedures, or groups of closely related.

1. NONE

II. Methods of Implementation and Control

A. Universal Precautions (UP)

All employees will utilize UP. Universal Precautions is an infection control method that requires employees to assume that all human blood and specified human body fluids (such as OPIM) are infectious for HIV, HBV, HCV, and other bloodborne pathogens, and must be handled accordingly.

B. Exposure Control Plan (ECP)

1. Employees covered by the bloodborne pathogens standard will receive an explanation of this ECP during their initial training session. It will also be reviewed in their annual refresher training. All employees will have a copy of this plan given to them upon hire. The plan is available in each client home and in the main office and may be reviewed at any time. If an employee or client requests another copy, it will be provided free of charge within 15 days.
2. Karla R. Adams, RN will be responsible for reviewing and updating the ECP annually or more frequently if necessary to reflect any new or modified tasks and procedures, which affect occupational exposure, and to reflect new or revised employee positions with occupational exposure.

C. Engineering Controls and Work Practices

1. Engineering controls and work practice controls will be used to prevent or minimize exposure to bloodborne pathogens. The specific engineering controls and work practice controls which we will use, and where they will be used, are listed below.
    a. Sharps- there is no sharps that the employee will routinely be in contact with or generating. In the event that the employee needs to handle broken glass or an item that is sharp that may contain blood or OPIM, they are to handle it with the pliers provided in the "Home Kit" provided in each client home. Small shards or granules are to be swept up with the broom and dustpan provided. The employee is to have gloved hands for the duration of the process. The sharp items are to be placed in a PUNCTURE RESISTANT container such as a plastic lidded bowl or a laundry soap bottle and then disposed of per the method the client instructs them. All reusable items from the "Home Kit" need to be sanitized per the method listed in the kit and the ECP.
    b. Sanitization - Only non-porous and nondisposable items may be sanitized. An item is sanitized if it has or potentially has come in contact with blood or OPIM. Sanitization is performed by washing the item (using the cleaning gloves in the "Home Kit") in warm soap and water or cleanser and then spraying with the sanitizer and allowed to air-dry. The gloves are sprayed and allowed to air dry as well.

c. Employees are strictly forbidden from eating, drinking, smoking, applying cosmetics or lip balm, or handling contact lenses in areas where there is a reasonable likelihood of exposure to blood or OPIM.
d. Food and drink shall not be kept in refrigerators, freezers, shelve, cabinets or on countertops or bench tops where blood or OPIM are present or may be present.
e. Hand washing – hands are to be washed, at least, at the following times: upon arrival to work, when removing gloves of any kind (cleaning gloves or care gloves), after any toileting activity (commode, catheter, bowel program, diapering) of self or client, before food preparation, before any eating event for self or client, after any nose blowing or wiping, after coughing or sneezing of self or client, before and after cosmetic application, and any other time that the hands may have come in contact with blood or OPIM.
    1. The technique for handwashing is:
        a. Stand away from the sink; clothes and hands may not touch the sink.
        b. Turn on the water.
        c. Remove all jewelry
        d. Wet hands and wrists
        e. Apply soap over hands and wrists-work into a lather
        f. Use friction for at least 2 minutes at your initial scrub upon arrival and at least 30 seconds for subsequent scrubs.
        g. Rinse hands ands wrists under running water.
        h. Dry hands and wrists on a new clean towel (may be a new clean cloth towel or disposable paper toweling).
        i. Turn off the water using a towel.

        NOTE: The alternative for handwashing if there is no handwashing station available or the supplies needed are not immediately available is to utilize the hand sanitizer provided in the "Home Kit."

        The process for utilizing the hand sanitizer is as follows:
            1. Remove any jewelry
            2. Squeeze a dime-sized amount into the hands
            3. Rub hands and wrists vigorously until all of the sanitizer is dissipated.
f. Minimizing all procedures that cause splashing and spattering – Employees are to perform tasks such as toothbrushing, toothbrush washing, showering a client, etc. in a manner that does not cause splashing and spattering onto the employees face (eyes, nose, or mouth), clothes, or the room. The employee is to stand out of the path of any splashing and spattering as able in addition to utilizing the needed Personal Protective Equipment (PPE). If any spattering occurs, the employee is to use PPE for protection during the task, and then sanitize any area splashed and spattered upon.

D. Personal Protective Equipment (PPE)
    1. PPE will be provided at no cost to employees. Karla R. Adams, RN, in conjunction with the supervising RN, will provide training in the use of the appropriate PPE for the tasks or procedures employees will perform.

2. The types of PPE a available to employees are as follows:
    a. Gloves
    b. Gowns
    c. Face Shields
    d. Utility/Cleaning gloves
3. Refer to written procedures (i.e. the agency's policy and procedure manual) for instruction on the use of PPE for specific tasks that may expose workers to blood or OPIM.
4. The employee is to remove all PPE after it has become contaminated and before leaving the work area.
5. PPE is located in the client homes with replacements being obtained through the main office of AccuKare Inc. (the agency will ensure it is delivered to the client home). The employee is to call the main office or notify their supervising RN if they need additional supplies. Karla R. Adams, RN, in conjunction with the supervising RN, will ensure the need is met.
6. All employees using PPE must observe the following precautions:
    a. Wash hands or use waterless hand sanitizer immediately or as soon as feasible after removal of gloves or other PPE.
    b. Used PPE may be disposed of in the client's home.
    c. Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or OPIM, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised.
    d. Utility/cleaning gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.
    e. Never wash or decontaminate disposable gloves for reuse.
    f. Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to the eye, nose, or mouth.
    g. Remove, immediately or as soon as feasible, any garment contaminated by blood or OPIM, in such a way as to avoid contact with the outer surface.
7. The procedure for handling contaminated PPE is as follows: Sanitization - Only non-porous and nondisposable items may be sanitized. An item is sanitized if it has or potentially has come in contact with blood or OPIM.
    a. Wash the item (using the cleaning gloves in the "Home Kit") in warm soap and water or cleanser.
    b. Spray with the sanitizer and allow to air dry.
    c. The utility gloves used to do this task are sprayed and allowed to air dry as well.

    NOTE: Do not wipe the sanitizer off of the item. It MUST be allowed to air-dry.

E. Housekeeping

1. The procedure for handling sharps. There are no sharps that the employee will routinely be in contact with or generating. In the event that the employee needs to handle broken glass or an item that is sharp that may contain blood or OPIM, they are to handle it with the pliers provided in the "Home Kit" provided in each client home. Large pieces are to be picked up using the pliers provided in the "Home Kit" along with wearing the utility gloves. Small shards or grannuals are to be swept up with the broom and dustpan provided. The employee is to have gloved hands (utility gloves) for the duration of the process. The sharp items are to be placed in a PUNCTURE RESISTANT container such as a plastic lidded bowl or a laundry

soap bottle and then disposed of per the method the client instructs them. All reusable items from the "Home Kit" need to be sanitized per the method listed in the kit and the ECP. If there is a need for a sharps container, it will have been predetermined and have been prepared for by the agency. The sharps containers would be easily accessible and as close as feasible to the immediate area where sharps are used.

2. The procedure for handling waste such as menstrual pads, diapers with blood in them, any band aid or blood item, etc. is to double bag it, label it as infectious waste using the labels provided in the "Home Kit", and place it in the client's outside garbage receptacle utilizing gloved hands.
3. Bins and pails (wash basins, emesis pans, toilet pails) must be cleaned and sanitized via the means listed above as soon as feasible after visible contamination.
4. Handling of garbage. Garbage is to never be placed in an unlined receptacle. It must always have a plastic liner. The garbage is to never be compressed. The top of the plastic liner is to be gathered and closed. If the bag leaks, it is to remain in the receptacle, carried to the final garbage destination, and double bagged at that point. It is to be sealed either by tying a knot or placing on a fastener. The employee is to utilize gloved hands for this process. The garbage receptacle is to then be sanitized per the protocol as listed above.

F. Laundry
   1. The following contaminated articles will be laundered by the employees of this company:
      a. Any normal household linen that is soiled with blood or OPIM
      b. Any clothing item of a client that is soiled with blood or OPIM
      c. Any other item utilized for normal ADL's that may be soiled with blood or OPIM
   2. The PCA or Homemaker will perform laundering at any time, depending on who is scheduled in the client home.
   3. The following laundering requirements must be met:
      a. Handle contaminated laundry as little as possible, with minimal agitation.
      b. Place wet contaminated laundry in leak-proof, labeled, or color-coded containers before transporting if transporting needs to happen. (double-bagging in a labeled container within the laundry basket may occur)
      c. Use bags marked with the biohazard symbol if laundering is not going to be done with Universal Precautions and the wearing of PPE.
      d. Appropriate PPE for Universal Precaution laundry handling is facial, body, and hand protection from any splashing or spattering of blood or OPIM.
      e. Appropriate PPE for non-contaminated laundry is gloved hands.
      f. Normal laundry cycles should be used according to the washer and detergent manufacturer's recommendations, as per CDC "Guidelines for Prevention of transmission of HIV and HBV," MNWR 6/23/89, 38, No. S-6.

G. Labels
   1. The following labeling methods will be used:
      a. Laundry bags of contaminated laundry will be labeled with a Biohazard sticker after having 2 bags placed around the items.
   2. Employees are not to transport any contaminated items.
   3. Employees are to notify Karla R. Adams, RN if they discover any regulated waste or laundry (items that contain blood or OPIM) that is not properly bagged, labeled, or disposed.

III. Hepatitis B Vaccination

A. Karla R. Adams, RN, in conjunction with the Supervising RN, will provide training to employees on the hepatitis B vaccinations, addressing the safety, benefits, efficacy, method of administration, and availability. The hepatitis B vaccination series will be made available at no cost after training and within 10 days of initial assignment to employees who have occupational exposure to blood or OPIM unless one of the following is present:

1. Documentation exists that the employee has previously received the series
2. Antibody testing reveals that the employee is immune
3. Medical evaluation shows that vaccination is contraindicated.

B. All employees are strongly encouraged to receive the Hepatitis B vaccination series. However, if an employee chooses to decline vaccination, the employee must sign a declination form. Employees who decline may request and obtain the vaccination at a later date at no cost. Documentation of refusal of the vaccination will be kept in the main office, locked, with the other medical records, separated from the rest of the personnel file. The only individuals who will have access to the medical records is the President, Karla R. Adams, RN, the Human Resources administrator, the employee, and the employee's MD in the event of need arising due to injury or exposure.

C. The vaccination will be provided by Allina Health Coon Rapids Clinic 9055 Springbrook Dr., Coon Rapids, MN 55433-5841, 763-236-1210, in accordance with OSHA standards as written.

D. For Hepatitis B vaccinations, the health care professional's written opinion will be limited to whether the employee requires the Hepatitis vaccine, and whether the vaccine was administered.

IV. Post Exposure Evaluation and Follow-up

A. Should an exposure incident occur, contact Karla R. Adams, RN at (763) 862-3971 first, if she is unavailable then contact the supervising RN on the case at the number listed in the client home.

B. An exposure incident is considered to be any incident where one of the following has occurred:

1. Blood or OPIM has come in contact with the employees eyes, nose, mouth, or unprotected open skin that results from the performance of an employee's duties.
2. A puncture or abrasion of the skin (parenteral contact) has occurred by an item that had been in contact with blood or OPIM being punctured or abraded that results from the performance of an employee's duties.

H. Following an exposure incident, prompt evaluation and prophylaxis is imperative.

1. Wound care /First Aid
   a. Clean wound with soap and water.
   b. Flush mucous membranes with water or normal saline solution
   c. Any other wound care as indicated such as bandaging.
2. Notification of Designated Parties
   a. Notify Karla R. Adams, RN or the Supervising RN at the main office or the Emergency number for AccuKare Inc. posted in the Client Book, in the client's home.

I. An immediately available confidential medical evaluation and follow-up will be conducted by Allina Health Coon Rapids Clinic. The following elements will be performed.

1. Document the routes of exposure and how the exposure occurred.
2. Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law).

3. Obtain and retain consent and make arrangements to have the source individual tested as soon as possible to determine HIV and HBV infectivity; document and retain that the source individual's test results were conveyed to the employee's health care provider.
4. If the source individual is already known to be HIV and/or HBV positive, new testing need not be performed.
5. Ensure that the exposed employee is provided with the source individual's test result and with information about applicable discloser laws and regulations concerning the identity and infectious status of the source individual (See the Confidentiality Policy in the Policy and Procedure manual).
6. After consent is obtained to be tested, the employee is to be sent to be tested in accordance with OSHA and CDC standards, as soon as feasible for testing of the blood for HBV and HIV serological status. The clinic will handle the matter per guidelines if the employee does not give consent.

J. Health Care Professional's Follow-up
   1. Karla R. Adams, RN or the Human Resources Director or the Supervising RN will ensure that health care professionals responsible for employee's hepatitis B vaccination and post-exposure evaluation and follow-up be given a copy of OSHA's bloodborne pathogens standard.
   2. Karla R. Adams, RN or the Human Resources Director or the Supervising RN will ensure that the health care professional evaluating an employee after an exposure incident receives the following:
      a. A description of the employee's job duties relevant to the exposure incident
      b. Routes of exposure
      c. Circumstances of exposure
      d. If possible, results of the source individual's blood test
      e. Relevant employee medical records, including vaccination status
   3. Karla R. Adams, RN or the Human Resources Director or the Supervising RN will provide the employee with a copy of the evaluation health care professional's written opinion 15 days after completion of the evaluation.
   4. The written opinion for post-exposure evaluation and follow-up will be limited to whether or not the employee has been informed of the results of the health evaluation and of any health conditions which may require further evaluation and treatment.
   5. All other diagnoses must remain confidential and are not to be included in the written report to AccuKare Inc.

K. The incident is to be documented on the appropriate forms by the employee and Karla R. Adams, RN, the supervising RN, or the Human Resources Director.
   1. An Exposure Form
   2. An Incident Report
   3. The OSHA 300 log

L. This procedure for reporting an exposure should be given to each employee upon hire and placed in the Client Book for access availability at all working times.

M. Post exposure counseling is mandatory under the standard. The following are the recommendations for counseling as per the American Nurses' Association
   1. Counseling should be provided by skilled personnel through previously established agency protocol of utilizing the Allina Health Coon Rapids Clinic for referrals in conjunction with Karla R. Adams, RN at AccuKare Inc., or the Supervising RN, or the Human Resources Director.
   2. Counseling should include the following:
      a. Meaning of test results
      b. Discussion of personal life factors such as safer sex practices
      c. Conception and contraception
      d. Informing sexual partners
      e. Discussion regarding avoidance of blood, semen, and tissue donation
   3. Counseling should include a validation of the employee's concerns and fears, and the implications of disclosure to other persons in their support system.
   4. The employee should be encouraged to monitor for signs and symptoms of acute sero-conversion illness (fevers, myalgias, rash, etc.) and to report these symptoms to designated personnel immediately (Karla R. Adams, RN, or the Supervising RN, or the Human Resources Director).
   5. Information regarding workers' compensation, disability, and other benefits should be provided.

      NOTE: Any information regarding an exposure incident will remain in the highest level of confidentiality.

V. Procedures for Evaluation the Circumstances Surrounding an Exposure Incident
   A. Karla R. Adams, RN or the Supervising RN along with the Safety Committee will review the circumstances of all exposure incidents while maintaining confidentiality of all involved to determine:
      1. Why the exposure incident occurred.
      2. If procedures were being followed.
      3. If procedure, protocols, and/or training need to be revised.
      4. Engineering controls in use at the time of the incident.
      5. What work practices were being followed at the time of the incident.
      6. A description of any devices being used at the time of the incident.
      7. What PPE was being used at the time of the incident.
      8. Where the incident occurred.
      9. Procedure/care being performed at the time of the incident.
      10. The involved employee's training.
   B. If it is determined that revisions need to be made, Karla R. Adams, RN will ensure that appropriate changes are made to this ECP. (Changes may include an evaluation of new systems, adding employees to the exposure determination list, etc.)
   C. Documentation of this evaluation should accompany the exposure report.

VI. Employee Training
   A. All employees who have occupational exposure to bloodborne pathogens will receive training conducted by Karla R. Adams, RN-President of AccuKare Inc. or the Supervising RN on the case.

B. Training shall be provided:
   1. At initial assignment to tasks where occupational exposure may take place.
   2. When new exposure is created by a change in tasks or procedures.
   3. At least annually after training.
   4. At no cost to the employee, during working hours.
   5. With material appropriate to educational level, literacy, and language of employees.
   6. By a person knowledgeable in the subject matter being presented, as it related to home care.

C. All employees who have occupation exposure to bloodborne pathogens will receive training on the epidemiology, symptoms, and transmission of bloodbone pathogen diseases. In addition, the training program will cover, at a minimum, the following elements.
   1. A copy and explanation of the standard
   2. An explanation of our ECP and how to obtain a copy
   3. An explanation of methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident
   4. An explanation of the use and limitations of engineering controls, work practices, and PPE.
   5. An explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
   6. An explanation of the basis for PPE selection
   7. Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, and the benefits of being vaccinated. The vaccine along with the titre and re-vaccination will be offered free of charge.
   8. Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM
   9. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident an the medical follow-up that will be made available
   10. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident
   11. An explanation of the signs and labels and/or color coding required by the standard and used at this facility
   12. An opportunity for interactive question and answers with the person conduction the training session.

D. Training Records
   1. Training records will be completed for each employee upon completion of training. Theses documents will be kept the employee's records at the main office of AccuKare Inc. in the personnel cabinet.
   2. Karla R. Adams, RN or the Human Resources Director will maintain training records.

3. The training records shall include
    a. The dates of the training sessions.
    b. The contents or a summary of the training sessions.
    c. The names and qualifications of the people conducting the training.
    d. The names and job titles of all persons attending the training sessions.
4. Train records will be maintained for a minimum of three (3) years from the date on which the training occurred.
5. Employee training records will be provided upon request to the employee or the employee's authorized representative within fifteen (15) working days.

VII. Medical Records

A. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.1020 "Access to Employee Exposure and Medical Records."

B. Karla R. Adams, RN and/or the Human Resources Director are responsible for maintenance of the required medical records. They are kept at the main office for AccuKare Inc. in the locked file cabinet, with the other medical records, separated from the rest of the personnel file. The only individuals who will have access to the medical records are the President, Karla R. Adams, RN, the Human Resources administrator, the employee, and the employee's MD in the event of need arising due to injury or exposure.

C. In addition to the requirement of 29 CFR 1910.1020, the medical record will include:
    1. The name and social security number of employee
    2. A copy of the employee's hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination
    3. A copy of all results of examinations, medical testing, and follow-up procedures as required by the bloodborne pathogens standard
    4. A copy of all health care profession's written opinion(s) as required by the bloodbone pathogens standard.

D. All employee medical records will be kept confidential and will not be disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by the standard or other legal provisions.

E. Employee medical records shall be maintained for at lest the duration of employment plus thirty (30) years in accordance with 29 CFR 1910.1020.

F. Employee medical records shall be provided upon request of the employee or to anyone having written consent of the employee within fifteen (15) working days.

G. The medical records of employees who have worked for less than one year for the employer need not be retained beyond the term of the employment if they are provided to the employee upon the termination of employment.

H.

VIII. OSHA Recordkeeping

A. An exposure incident is recordable on the OSHA 300 Log if the case meets OSHA's Recordkeeping Requirements (29 CFR Part 1904). This determination and the recordkeeping activities are done by Karla R. Adams, RN-President or the Human Resources Director.

A Workplace Accident and Injury Reduction Plan for AccuKare, Inc.

I. The purpose of this plan is to set forth guidelines that will help AccuKare, Inc. to identify hazards and train employees accordingly.

A. Karla R. Adams, RN, in conjunction with the Safety and Health Committee, will be responsible for identifying hazards and reporting them for appropriate action to take place. The form utilized for this is the "Hazard Report Form" (see S-10).

B. Karla R. Adams, RN, in conjunction with the Safety Committee, will formulate the training plan and factors that can assist an employee in having a safer working environment.

II. Program Implementation.

A. Each employee will be trained in the identified hazards at the time of hire and annually thereafter, in conjunction with their OSHA BBP and ERTK training. Once a new hazard is identified, all employees will be trained by Karla R. Adams, RN or the supervising RN, with written documentation of this being placed in their training file.

B. The identified hazards are listed on the "AWAIR Hazards List," (See S-06) with this list being located:

1. In the "Client Book" in client homes.

2. In the hiring packet.

C. Each employee will be trained to inform Karla R. Adams, RN, a member of the Safety and Health Committee, or their Supervising RN if there is anything in their work environment that they question regarding safety. Karla R. Adams, RN, will ensure that this issue will be investigated and policy set forth as needed along with training.

D. There will be a review at the Safety and Health Committee meetings of agency standards for hazards. (See Safety Committee Policy S-1 for meeting requirements)

E. The Supervising RN will ongoingly assess the work environment for potential hazards and employee compliance with safety measures in place and instruct as needed, documenting the result of assessment and instruction.

F. AccuKare, Inc. will enforce a "no tolerance" policy for not complying with safety measures; employees will be trained of upon hire.

G. The Quality Assurance Committee will annually review the work of the Safety Committee for recommendations and guidance as needed.

III. Methods of Implementation and Communication to Employees

A. Karla R. Adams, RN, the Safety Committee members, or the Supervising RN will identify hazards. Employees may bring concerns to any of these individuals.

B. Karla R. Adams, RN will immediately analyze hazards upon awareness of a concern.

C. New and existing hazards, conditions, and operations will be controlled through necessary training by either Karla R. Adams, RN or the Supervising RN and ongoing monitoring during supervisory visits.

D. Employees will be trained:

1. Upon hire.

2. As a new hazard is identified.

3. Annually as part of their OSHA BBP and ERTK training of the workplace hazards and protections in place.

E. Documentation of training in the form of the "Safety Training Certificate" (See S-12/PHR-18) will be placed in their training file.

F. The "Employee Orientation Checklist" (See PHR-6) will be used to assist in ensuring all training needs will be met.

G. Karla R. Adams, RN will inform Supervising RN's of any new hazard and training method/plan in place and annually as a review of their role in monitoring and training.

H. Karla R. Adams, RN will randomly and periodically interview employees regarding their training to verify the effectiveness of the training

IV. Investigation and Correction

A. Workplace accidents and reported "near misses" of an accident will be investigated by Karla R. Adams, RN and the Supervising RN upon AccuKare, Inc. becoming aware of the accident via the Incident Report (See PHR-13/C-2), through utilization of the "Supervisor's Accident Investigation Report"(See S-14), and the OSHA rules for guidance.

B. Any corrections that need to occur to the plan will occur at that time and employees will be trained immediately via a written training with their pay checks and in the "Client Books" in the homes along with verbal training by the Supervising RN's during supervisory visits or phone calls.

C. Policies will be changed and supplies procured/delivered as needed due to investigative results.

V. Inspections

A. Inspections need to occur to ensure that the training is effective and employees are utilizing the proper safety protocols utilizing the "Inspection Form" (See S-15).

B. Due to the nature of the business, inspections need to occur on an employee-by-employee basis and will not occur within the agency all at one time.

C. Inspections will be conducted by primarily the Supervising RN as part of supervisory visits, as listed above, but may be performed by Karla R. Adams, RN or a member of the Safety and Health Committee.

D. There will be three (3) types for inspections:

1. Initial inspection – conducted when a new program is first implemented, an employee is new to the agency, or an employee is made aware of a previously unrecognized hazard.

2. Scheduled inspections – conducted periodically as part of the ongoing monitoring of adherence to safety requirements.

3. Changes in the workplace – inspections will be conducted whenever new substances, process, procedures, equipment, or employees are introduced into the workplace.

VI. Hazard Control

A. This system will be used to correct identified hazards before they result in an accident or illness.

B. There are four (4) prioritized methods to correct the hazard.

1. Eliminate the hazard.

2. Engineering Controls (See ECP S-02).

3. Administrative Controls – through limiting the amount of time that an employee is exposed to the hazard

4. PPE (see ECP S-02).

VII. Enforcement

A. Safe work practices will be enforced through Supervisory RN monitoring, unannounced and announced supervisory visits, consultation with the clients (responsible parities), and employee interview.

B. Infractions of utilizing safe work practices will not be tolerated and will be dealt with in a manner of first, retraining the employee, and then through the discipline measures set forth in the policy and procedure manual.

Safe Lifting Checklist

Follow safe lifting principles to avoid back strain.

- Let your legs, not your back, do the work.
- Try to avoid leaning, bending, reaching, and stooping.
- Stand at bedside with one knee bent or resting on a stool.
- Don't twist to reach or change position. Turn your feet or swivel your hips, keeping your back straight.
- Wear sturdy shoes with nonskid soles.
- Keep feet spread a bit to provide support.
- Work at a height that doesn't require much bending.
- Change positions frequently.
- Take short breaks to stretch or move around.
- Don't overexert yourself. Learn your own limits.

Plan before you lift or move a patient.

- Decide if you need help from another person or mechanical aid.
- Assemble the equipment or help you need.
- Check that you have a clear route; remove any obstacles.
- Explain the procedure to the patient.

Plan and coordinate two person lifts.

- Have one person in charge, giving the count.

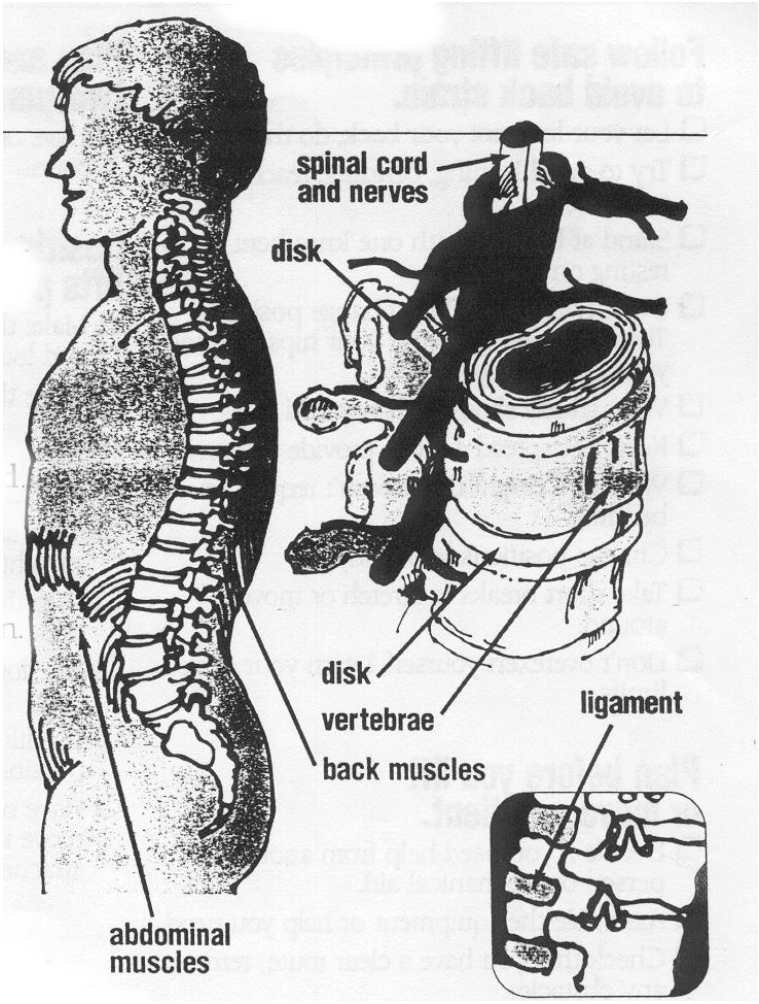
Position and complete lifts properly.

- Make the bed and other surface level, close, and lock in place.
- Move the patient to the transfer side of the bed.
- Stand close to the patient, with your feet shoulder-width apart.
- Bend at the hips and knees with your back straight.
- Grip the patient firmly and hold him or her close to your body.
- Lift slowly with your legs, keeping knees bent.
- Use lifting boards or mechanical lifts when possible.
- Have two or more persons help on the move if the patient is heavy, immobile or attached to tubes and wires.

Your back is your foundation...

it supports your entire body.

Your spinal column is made up of **vertebrae** (bones) and **disks** (cushioning pads between the vertebrae).



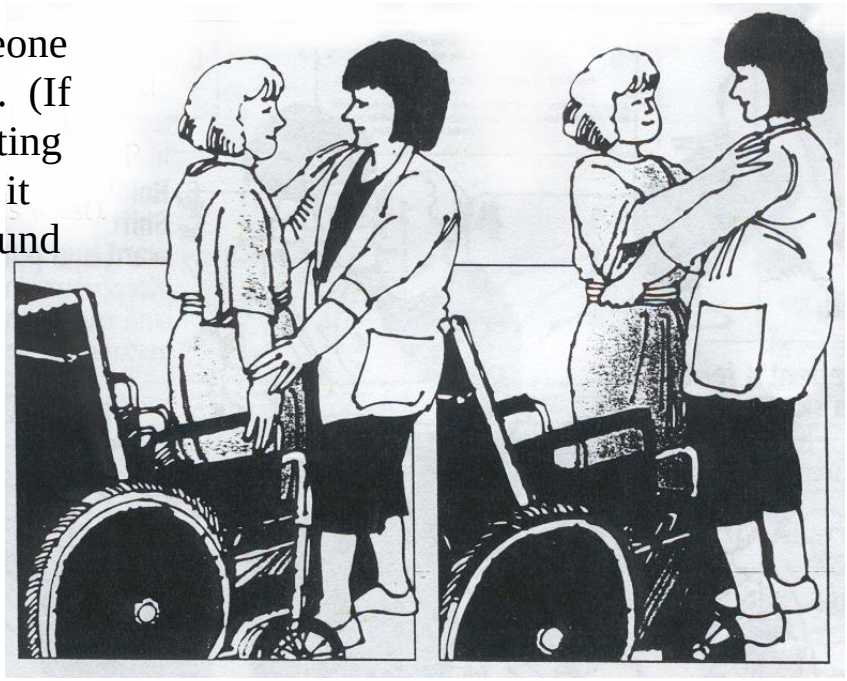
Ligaments connect your vertebrae. At the center of the spinal column is the **spinal cord. Nerves** run from the **spinal cord** to other parts of the body. **Muscles** are also attached to the bones in your spinal column. Working with the muscles in your stomach, they keep the spinal column in place.

If you Slouch...

the ligaments, not the muscles, do all the work – work they're not designed to do. They stretch – and hurt – and put pressure on the vertebrae. Your lower back takes most of the strain when you're sitting, so you have to be particularly careful with it.

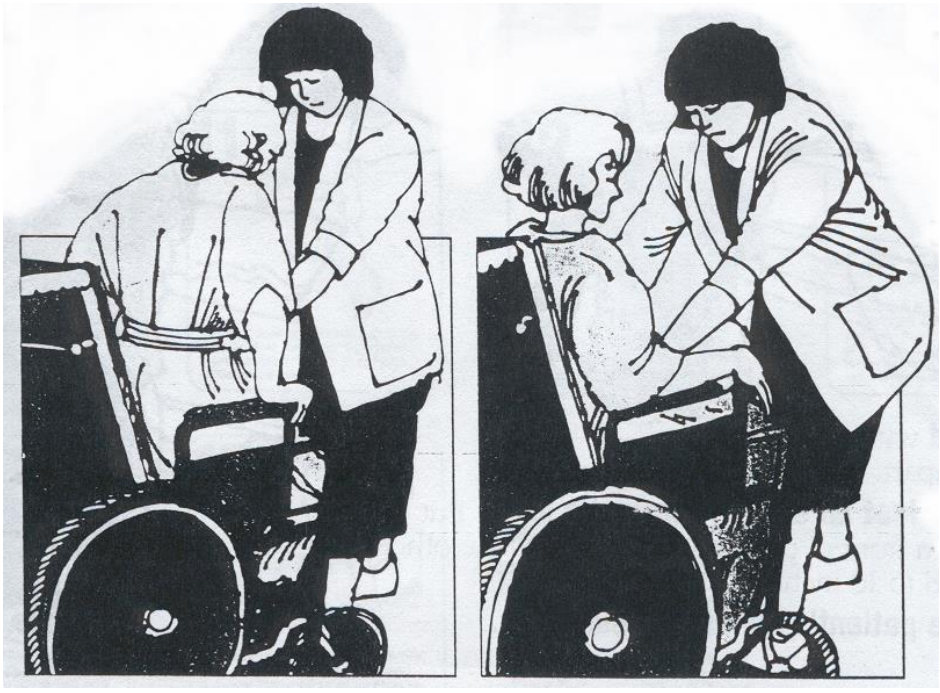
Helping Patients Sit Down

1. **Lock** chair wheels or have someone hold chair. (If using a lifting belt, wrap it firmly around patient's waist).



2. **Place patient's hands on your arms.**

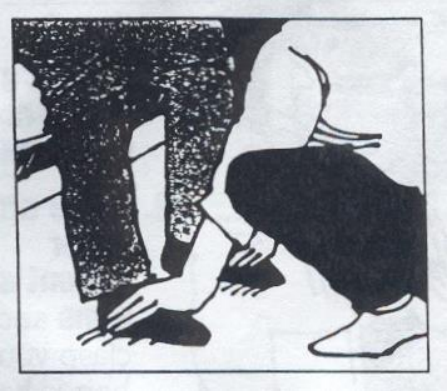
3. **Place arms under patient's arms** and clasp your hands behind patient's back or grab back of lifting belt.



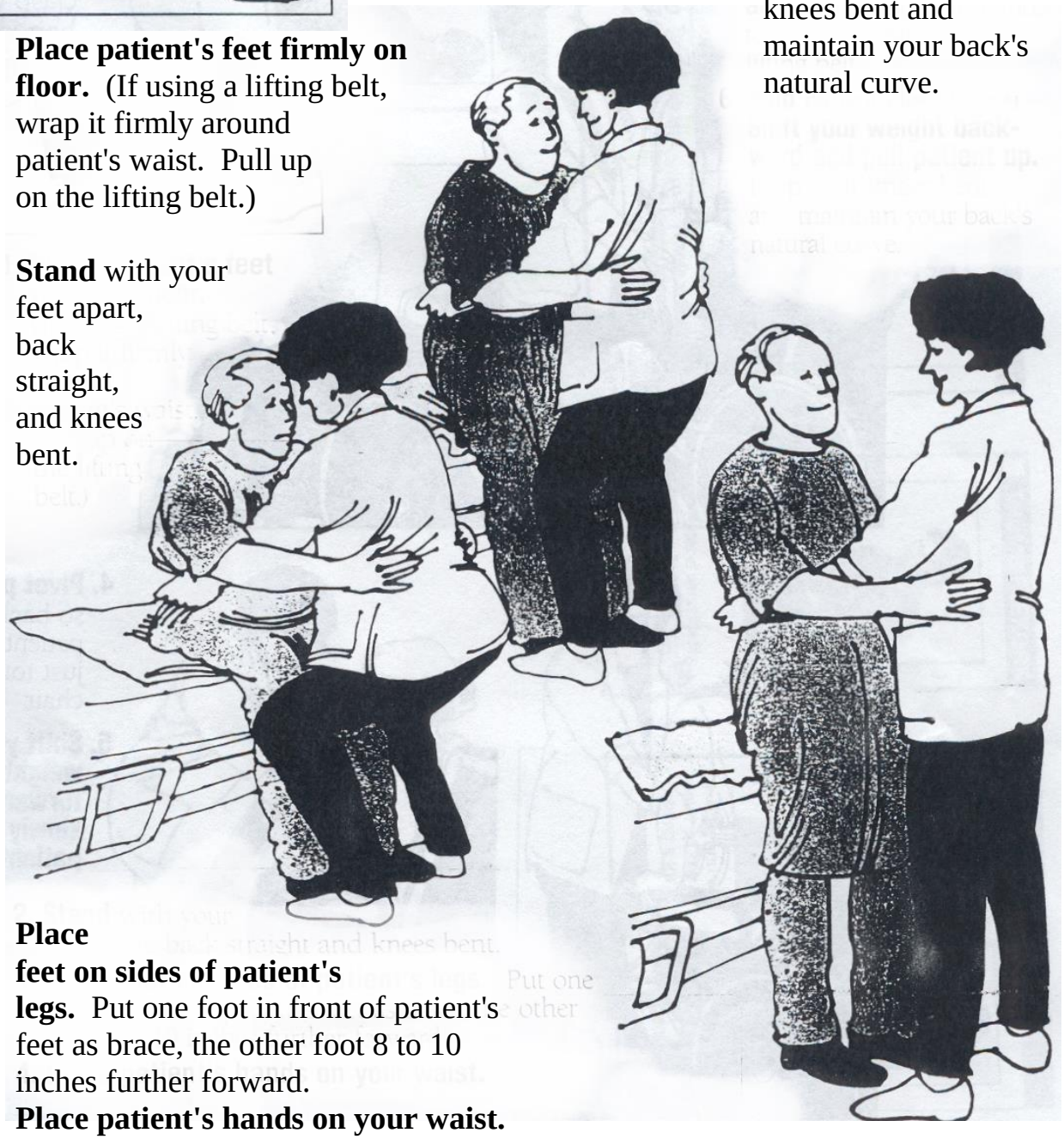
4. **Pivot patient** so back of patient's legs just touch chair.

5. **Shift your weight forward and slowly lower patient** into chair. As you shift weight, slide one foot beside the chair so one foot is well ahead of the other.

Helping Patients Stand Up



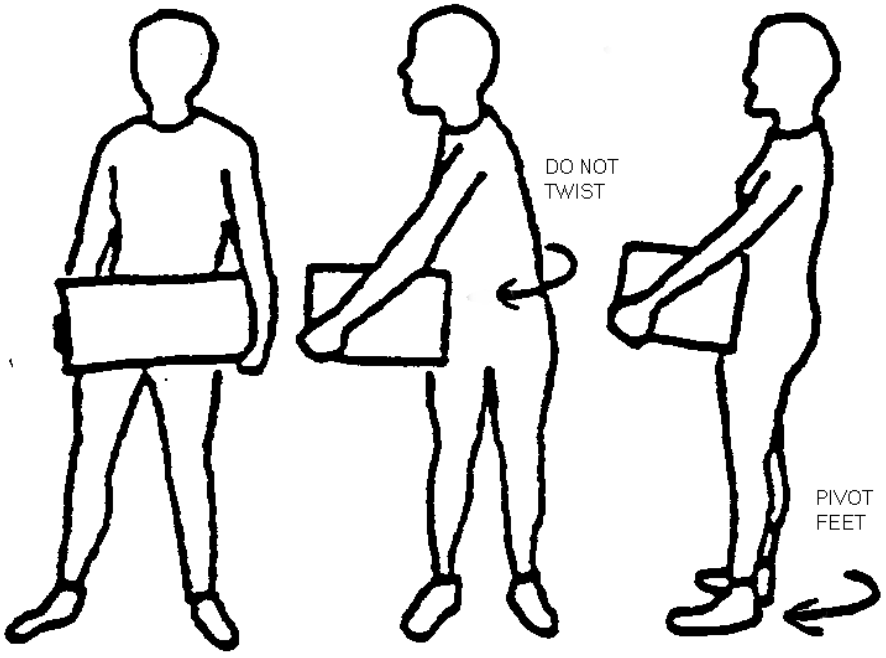
1. **Place patient's feet firmly on floor.** (If using a lifting belt, wrap it firmly around patient's waist. Pull up on the lifting belt.)
2. **Stand** with your feet apart, back straight, and knees bent.
3. **Place feet on sides of patient's legs.** Put one foot in front of patient's feet as brace, the other foot 8 to 10 inches further forward.
4. **Place patient's hands on your waist.**
5. **Put arms under patients arms** and clasp your hands together or grab back of lifting belt.
6. **Hold** patient close to you. **Shift your weight backward and pull patient up.** Keep your knees bent and maintain your back's natural curve.



Body Mechanics

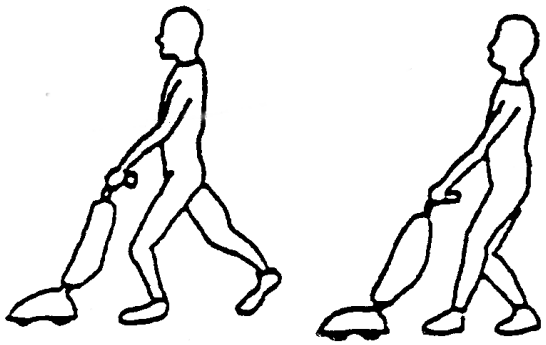
Most people are not aware of the excessive amount of bending and twisting they do throughout the day. This repeated bending and twisting can contribute to back pain. Here are some tips to help reduce twisting of your low back.

1. Do pivot your feet. Do not twist at the waist.

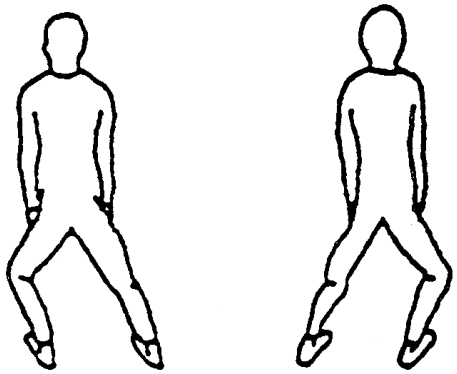


2. Shifting your weight: use this when vacuuming or mopping floors.

Forward and Backward



Side to Side

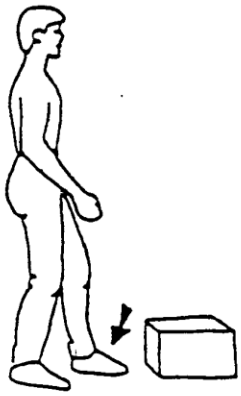


Lifting and Moving Objects

It is extremely important that when lifting objects you maintain proper body positioning. The most important part of lifting is planning.

How to lift properly:

1. Size up the load: If the load is too bulky or heavy, find someone to help you or use available equipment, such as a pull cart or dolly.
2. Maintain a firm footing: Keep your feet apart, toes pointed outward.
3. Bend at your knees, keep back straight.
4. Tighten your stomach muscles.
5. Lift with your legs.
6. Keep your load close.
7. Don't twist: twisting increases the stress on your spine. Pivot with your feet or take small steps.



Bending:

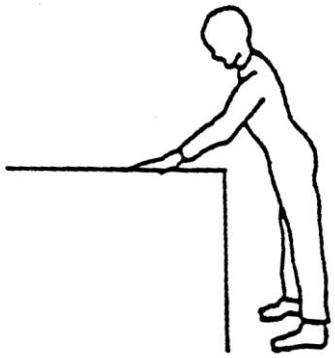
Sometimes bending forward cannot be avoided. Here are some tips to help you bend correctly.

1. **Bend at the hips** rather than the waist. Keep abdominals pulled in, keep knees slightly bent.

Correct

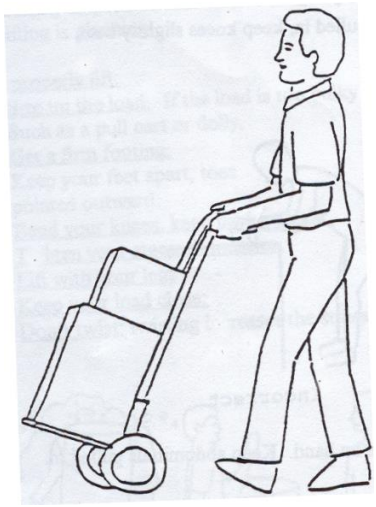
Incorrect

2. Put hand forward on table or counter top and lean on it. Keep abdominals pulled in.



3. Extend one leg behind.

Pushing and Pulling Objects:



Pushing and pulling may cause excessive strain on your spine. Improper pushing and pulling can cause a major change in your three natural spinal curves, and it may also over stretch the muscles and ligaments in your back. It is better for your back to push or pull an object than it is to lift it. If you have the option, push rather than pull.

The following guidelines are for pushing and pulling techniques:

1. Keep your back straight. Maintain all three spinal curves. Keep your chest high.

2. Place one leg behind you for better leverage. Your toes should point straight ahead.

3. Bend at the knees and hips. Use your leg muscles to push. Your arms and back are for stabilizing only.

4. Your force should be applied in the direction the object is moving.

LOW BACK EXERCISE PROGRAM

The following exercises are designed to increase gradually strength and flexibility in the low back and surrounding musculature. Continue to do the exercises after your back injury has healed. This will decrease the chance of re-injury and future back problems.

THIS PROGRAM SHOULD BE DONE ONLY WITH THE APPROVAL OF YOUR DOCTOR.

DIRECTIONS FOR EXERCISES

1. Study the position of each figure carefully before performing each exercise.
2. Complete all exercises in the order shown unless otherwise instructed by your doctor.
3. Do this routine at least 3 - 5 times a week, daily is preferable.
4. Discontinue any exercise which causes pain, until you can add it to the program without discomfort.
5. Begin by completing 5 repetitions of each exercise, except those which state **ONLY ONCE** in the caption.
6. Add additional repetitions as you can tolerate comfortably. Work to 15 repetitions of each. Continue to do only 1 repetition where instructed.
7. Peform all exercises smoothly, **never jerk or bounce** from one position to another.
8. Unless the caption says otherwise, when an exercise is done to both sides of the body, complete the repetitions to one side and then repeat to the other side.

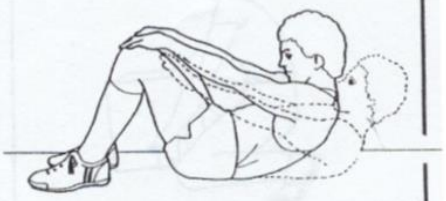
1

Keeping low back flat, bring each knee to chest for 30 seconds. Alternate legs. **DO ONCE.**

2

Keeping low back flat, bring knees to chest for one minute. **DO ONCE**

3

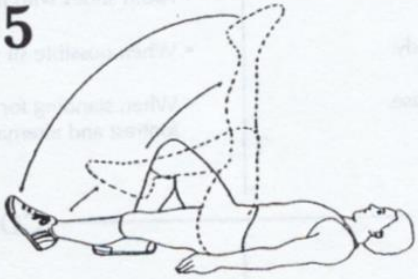


Keeping low back flat on floor, curl upper body toward pelvis until hands cup kneecaps. Hold 2-3 seconds.

4

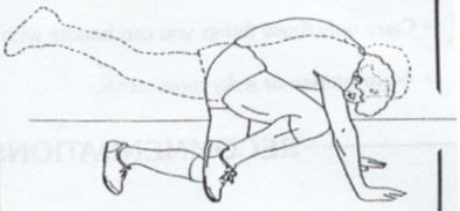
Tilt hips toward head, pressing low back firmly to floor and tightening abdominals. Hold 2-3 seconds.

5



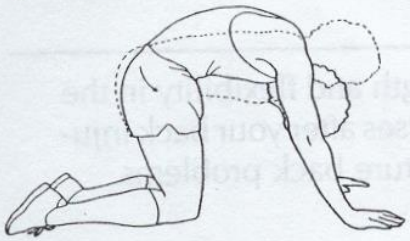
Pull leg to bent position then follow motion shown. Complete all repetitions to one side.

6



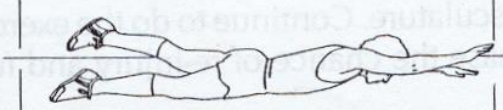
Tuck leg to chest, then drive leg back and up until it is straight and level with body.

7



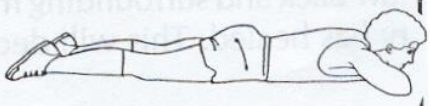
Arch entire back. Bring pelvis forward and chin to chest while tightening abdominals. Hold 2-3 seconds.

8



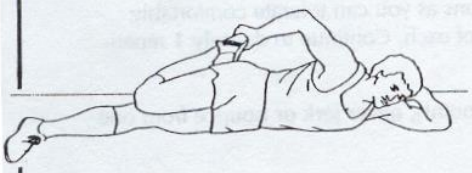
Raise one hand and opposite leg six inches off floor for three seconds. Alternate sides.

9



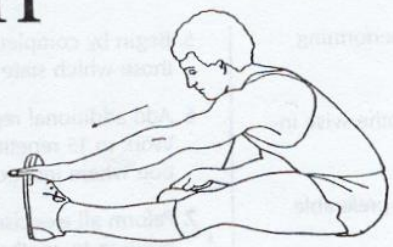
Tighten buttocks while pressing pelvis to floor. Hold 2-3 seconds.

10



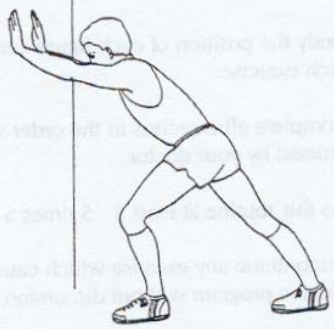
Pull heel to buttocks while contracting abdominals. Hold 30 seconds. Stretches thigh. **DO ONCE.**

11



Keep back of leg on floor. Bend only from the waist. Hold 30 seconds. Stretches back of leg.

12



From position shown, lower body toward wall by bending elbows. Keep rear heel on floor. Hold 30 seconds.

LIFTING TECHNIQUE

- Keep head up.
- Bend at hips and knees.
- Do not bend at waist.
- Keep back straight.
- Grip object firmly.
- Get down to level of object.
- When turning, move the whole body not just the upper body.

BACK CARE TIPS

- Do not lift heavy objects above your waist.
- Heavy objects should be held close to your body.
- Carry only those things you can handle with ease.
- Avoid sudden or jerky movements.
- Avoid shoes with high heels.
- When possible sit with knees higher than hips.
- When standing for long periods of time use an elevated footrest and alternate feet.

CERVICAL SPINE MOBILITY

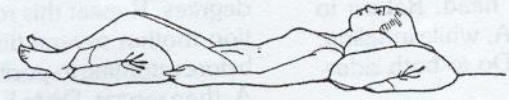
EXERCISE GUIDELINES

These exercises are designed to help develop correct cervical posture, achieve normal muscle tone/joint mobility, and reduce musculoskeletal stress.

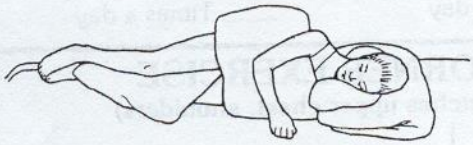
- **Do these exercises only under the supervision of a physical therapist and/or doctor.**
- Pulling, aching, and throbbing feelings are to be expected, while doing the exercises.
- Feeling tired, weak, or sore for the first week of exercises is possible.
- **Stop** exercising if you experience:
  - sharp or stabbing pain, and/or radiating pains into the head/arms/facial areas.
  - nausea or dizziness.

SLEEPING

- **DO NOT** sleep on the stomach.
- Support the curve in the neck when sleeping on back or side.
- Your physical therapist will discuss the use of an appropriate neck pillow.

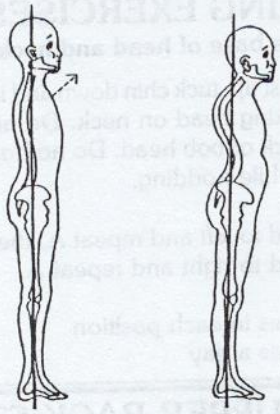


Pillow under knees places low back in rest position.
Use appropriate neck support.



Use pillow under arm and between knees.
Use appropriate neck support.

CHEST UP (Posture Exercise)



Good head/neck posture during sitting, standing, walking, etc is accomplished by holding your chest up and forward. This head/neck posture may be strenuous at first. **Do not force.**

SITTING - RISING

Chairs should have:
- wheels (if possible)
- unyielding straight back
- up/down adjustment of seat (if possible)
- low back support (Discuss with physical therapist.)
- armrests which do not prevent you from getting close to your work area.

- Reading material should be at eyelevel (if possible)
- **Do not look** down at your work by moving your head, neck, and shoulders forward. Look down by moving your head on your neck only.
- Keep chest up always.

Correct position - solid; incorrect - dotted. Do not sit with head, neck, and shoulders forward.

Reading position: Pillow under arms removes stress from neck, shoulders and low back.

Rising from a chair is done by keeping the chest up (solid), and **NOT** with chest down (dotted).

NODDING EXERCISES

(Stretches base of head and neck)

A. With chest up, tuck chin down and in, as if rocking head on neck. **Do not** bend neck or bob head. Do no hold breath while nodding.

B. Turn head to left and repeat A, then turn head to right and repeat A.

_____ Times in each position
_____ Times a day

DIAGONAL EXERCISES

(Stretches neck, shoulders, and upper back)

A. This is the starting/ending position. Can be done sitting or standing.

B. While exhaling, turn head slightly and pull head/neck down in a diagonal direction. Release pressure from hand on head. Return to position A, while inhaling. Repeat. Do to both sides.

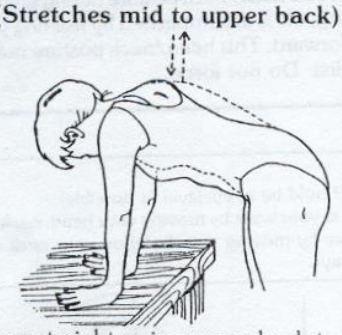
____ Times in each position
____ Times a day

C. When head reaches the end point in B, maintain pressure, and rotate head away from arm about 40 degrees. Repeat this rotation motion several times before returning to position A, then repeat. Do to both sides.

____ Times
____ Times a day

UPPER BACK STRETCH

(Stretches mid to upper back)



With chin in, arms straight, raise upper back toward ceiling, inhale. Relax, exhale, and lower spine letting shoulder blades come close to each other.

____ Times ____ Times a day

CORNER EXERCISE

(Stretches upper chest, shoulders)

With hands at prescribed level, lean in toward corner keeping chest up and exhaling.

____ Times, hands chest level
____ Times, hands head level
____ Times, hands above head level
____ Times a day

ARM RAISE

(Stretches/strengthens shoulder & mid back)

Interlock fingers and raise arms as high as possible while exhaling. **Keep chest up, chin in.**

____ Times
____ Times a day

SHOULDER ROTATION

(Stretches/strengthens shoulder girdle)

Holding rubber tubing, move hands apart while exhaling and pinching shoulder blades together slightly. Keep elbows bent to 90 degrees and at sides, chest up.

____ Times
____ Times a day

ACTIVE RELEASE TECHNIQUES® ARM, WRIST, AND HAND STRETCHES

WRIST PRONATORS

1. Flex arm and stretch fingers down and back with opposite hand.

2. Straighten arm while keeping tension on fingers.

3. Rotate arm by twisting fingers inward.

THUMB FLEXORS

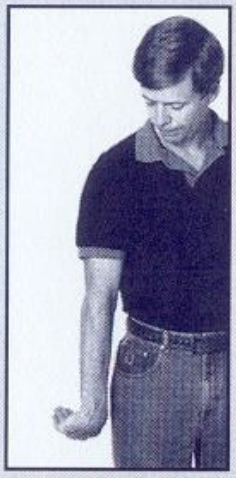
1. Flex arm.
2. Extend wrist back, allowing fingers to curl in.
3. Stretch thumb back toward arm.

WRIST FLEXORS

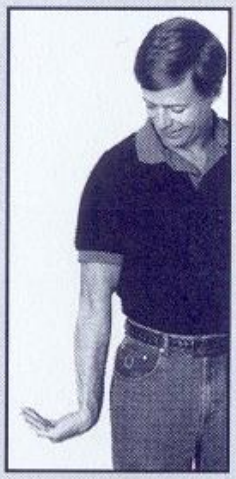
1. Flex arm with palm up like holding a tray.

2. Reach through with opposite hand and stretch last two fingers down.

WRIST EXTENSORS



1. Place arm straight down at side with plam facing back.
2. Stretch hand back, allowing fingers to cup.



3. Rotate hand outward.
4. Make a loose fist for more stretch.

Stop Germs! Wash Your Hands.

When?

- After using the bathroom
- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone at home who is sick with vomiting or diarrhea
- After changing diapers or cleaning up a child who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal feed, or animal waste
- After handling pet food or pet treats
- After touching garbage

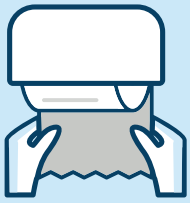
How?

Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.

Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.

Scrub your hands for at least 20 seconds. Need a timer? Hum the “Happy Birthday” song from beginning to end twice.

Rinse hands well under clean, running water.



Dry hands using a clean towel or air dry them.

Keeping hands clean is one of the most important things we can do to stop the spread of germs and stay healthy.

LIFE IS BETTER WITH CLEAN HANDS

www.cdc.gov/handwashing

This material was developed by CDC. The Life is Better with Clean Hands Campaign is made possible by a partnership between the CDC Foundation, GOJO, and Staples. HHS/CDC does not endorse commercial products, services, or companies.

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AccuKare

Annual Training

Section 10

HIV and Hepatitis B

OSHA-BLOODBORNE PATHOGENS

HEPATITIS B VACCINATION DECISION REPORT

I understand that I have been offered the series of three (3) vaccinations for the immunization against Hepatitis B with a follow up test for antibodies surface antigen one to two months after the completed series. I understand that if I do not respond to the primary vaccination series, AccuKare must provide me with a second series of three (3) vaccinations and retesting. If I still do not respond, I must be medically evaluated. My decision is reflected below. I understand that I may, at any time, change my decision. If I decide to receive the Hepatitis B Series of injections, I am to contact AccuKare Inc. for further instruction. I understand that if I begin the series of injections, that it is my responsibility to commit to attend the appointments for the injections or be responsible for the missed appointment fee.

____ I have received the Hepatitis B series previously

____ I do not wish to receive the Hepatitis B series.
I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

____ I wish to receive the Hepatitis B series.

Signature_____Date_____

All above information is to be considered confidential and is to be treated in accordance with agency policy.

HEPATITIS B

KNOW HEPATITIS B™

Are You At Risk?

What is Hepatitis B?

Hepatitis B is a liver disease. It is caused by the Hepatitis B virus. For some people who get Hepatitis B, the virus stays in the body, causing a lifelong illness. Hepatitis B can cause serious health problems over time. These problems can include liver cancer and liver failure.

How is Hepatitis B spread?

Hepatitis B is spread when someone comes in contact with blood from a person who has the disease. Most people born in China and other Asian countries who have Hepatitis B were infected as infants or young children. Hepatitis B can be passed from an infected mother to her baby at birth or from a family member to young children.

Hepatitis B is not a genetic disease. People also do not get Hepatitis B from sharing meals, bowls or utensils with someone who has the disease. Hepatitis B is not spread through breastfeeding, hugging, kissing, holding hands, coughing, or sneezing.

How common is Hepatitis B?

Hepatitis B is very common in China and other Asian countries. Approximately 1 in 12 Asians are living with Hepatitis B, but most people do not know it.

What are the symptoms of Hepatitis B?

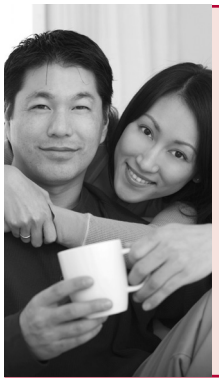
Most people who have Hepatitis B do not know they have it. The disease does not always cause symptoms. Hepatitis B can stay hidden in the body. Many people can live with Hepatitis B for 20 years without feeling sick. Still, liver damage from the disease can take place during this time.

How serious is Hepatitis B?

Hepatitis B can become very serious. For some people, this disease leads to liver damage, like liver failure or cancer.

How do people know if they have Hepatitis B?

A Hepatitis B test lets people know if they have it. This is a simple blood test that takes only a little bit of blood from a person's arm. Doctors do not always do this test, so it is important to ask to be tested.



Who should be tested for Hepatitis B?

Hepatitis B testing is recommended for:

- People born in China and other Asian countries
- People whose parents were born in China and other Asian countries
- People who live with someone who has Hepatitis B

Why should people be tested for Hepatitis B?

Getting tested lets a person know if he or she has Hepatitis B. There are treatments available for Hepatitis B that can help prevent serious liver damage. People who find out they have Hepatitis B can also keep other family members healthy. This is why women are always tested for Hepatitis B when they are pregnant. Family members who have never had Hepatitis B can get a vaccine to protect them from getting it.

Hepatitis B test results will be kept confidential. People with Hepatitis B cannot be forced to leave the United States. They also cannot be fired from a job, or forced to leave school.

How is Hepatitis B treated?

People who have hepatitis B should see a doctor who is very knowledgeable about the disease. The doctor can give medicines that will slow down liver damage. It is important to ask the doctor before taking any Eastern liver remedies because they might hurt the liver or cause problems with some of the medicines prescribed by your doctor.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Hep B United™
hepbunited.org

cdc.gov/knowhepatitisB

June 2013

Publication No. 220383
HMKR TR-42

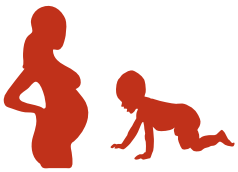
HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

HIV CAN BE TRANSMITTED BY

Sexual Contact

Sharing Needles to Inject Drugs



Mother to Baby During Pregnancy, Birth, or Breastfeeding

HIV IS NOT TRANSMITTED BY

Air or Water

Saliva, Sweat, Tears, or Closed-Mouth Kissing

Insects or Pets

Sharing Toilets, Food, or Drinks

Protect Yourself From HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Limit your number of sex partners.
- Don't inject drugs, or if you do, don't share needles, syringes, or other drug injection equipment.

- If you are at very high risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.

Keep Yourself Healthy And Protect Others If You Have HIV

- Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
- Take your HIV medicine as prescribed.
- Stay in HIV care.

- Tell your sex or drug-using partners that you have HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.

For more information please visit www.cdc.gov/hiv

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

AccuKare

Annual Training

Section 11

Care Plan Utilization

AccuKare Inc.
13750 Crosstown Drive NW, Suite L100
Andover, MN 55304
Ph. (763) 862-3971 Fax (763) 862-2135

Behavior Incident Report

Name of client:_____

Employee who observed incident:_____

Date of Incident:_____Time of Incident:_____AM/PM

Behavior: ___ Verbal Confrontation ___ Injury to Others

___ Injury to Property ___ Injury to Self

Describe the Incident (Please print)_____

_____

_____

_____

_____

Responsible Person notified (Parent, Spouse, etc):_____
(Leave message if needed)

Name

Supervisor Notified of incident:_____

Name

AccuKare, Inc. Mgmt. notified of incident:_____
(Leave message if after hours)

Name

Name of person completing form:_____

Signature of Person completing form:_____

This form is to be turned in to AccuKare Inc. Immediately!!!!

All above information is to be considered confidential and is to be treated in accordance with agency policy.

AccuKare

Annual Training

Section 12

Vulnerable Adult

Child Protection

Maltreatment

Reporting

AccuKare Inc.
13750 Crosstown Drive NW, Suite L100
Andover, MN 55304
Ph. (763) 862-3971 Fax (763) 862-2135

Incident Report

Name of person affected by the incident:_____

Date of Incident:_____Time of Incident:_____AM/PM

Type of Incident: ___Client Fall ___Client Property Damage

___Client Injury

___Employee Injury ___Employee Property Damage

Describe the Incident (Please print)_____

_____

_____

_____

_____

Responsible Person notified (Parent, Spouse, etc):_____
Name

Supervising RN Notified if client incident:_____
Name

AccuKare, Inc. Mgmt. notified if employee incident:_____
Name

Name of person completing form:_____

Signature of Person completing form:_____

This form is to be turned in to AccuKare Inc. Immediately!!!!

All above information is to be considered confidential and is to be treated in accordance with agency policy.

DHS-2917-ENG 5-18

Resource Guide for Mandated Reporters of Child Maltreatment Concerns

Child Safety and Permanency Division
Minnesota Department of Human Services, May 2018

Contents

Introduction

A safe community where children can live and grow among caring adults does not just happen. It is created by individuals who are committed and determined to help shape that safe community. Abused or neglected children are especially in need of a caring community. Minnesota policy is protection of children whose health or welfare may be jeopardized through child maltreatment. "While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so. When this occurs, the health and safety of children must be of paramount concern. Intervention and prevention efforts must address immediate concerns for child safety and the ongoing risk of abuse or neglect and should engage the protective capacities of families." [Minn. Stat. 626.556, subd. 1]

Strengthening families is effective in preventing child abuse and neglect.

Anyone may voluntarily report suspected child abuse or neglect to the local child protection or law enforcement agency. If you work with children or families, you are **legally required** to report suspected child abuse or neglect. This guide is designed to help you better understand the mandated reporter statute and to outline appropriate actions you should take if you know or suspect a child is being abused or neglected.

This guide includes information on:

- The process for reporting suspected child maltreatment
- The partnership among law enforcement, child protection and licensing agencies
- Conditions of neglect and abuse that should be reported
- Some behaviors and characteristics of children and families who may need help
- Relevant state statutes.

Who should report suspected child abuse or neglect?

If you are a professional who works with children and families, you are in a key position to help protect children from harm. Minnesota law requires professionals and their delegates who work with children to make a child protection report if they know of or have reason to believe a child:

- Is being neglected or abused, or
- Has been neglected or abused within the preceding three years.

Mandated reporters include professionals and their delegates in the following fields:

Health care

- Hospital administrators
- Medical personnel and professionals
- Dental professionals.

Social services

- Caseworkers
- Group home staff
- Foster parents.

Mental health professionals

- Psychiatrists
- Psychologists
- Therapists.

Child care

- Family child care providers
- Child care center staff.

Education

- Teachers and assistants
- School administrators
- School support staff.

Law enforcement

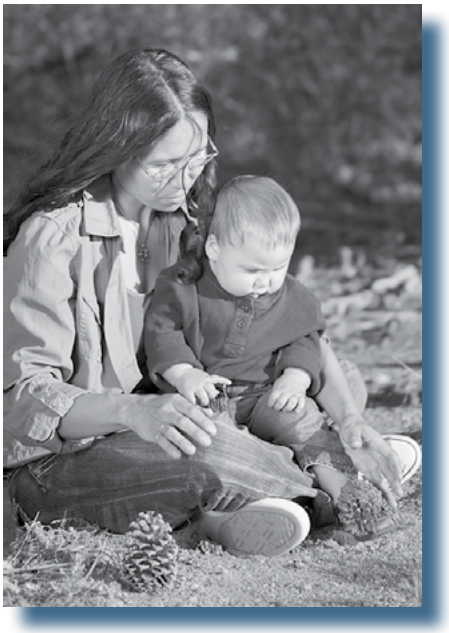
Guardians ad litem

Clergy*

Probation and correctional services.

*Members of the clergy are required to report suspected child abuse or neglect unless that information is received under certain privileged circumstances. See Minn. Stat., section 626.556, subd. 3(a)(2), and Minn. Stat., section 595.02, subd. 1(c).

Minnesota laws obligate mandated reporters to take action.



There are specific state and federal laws that govern child protection involvement with an Indian child.

If you suspect a child is being abused or neglected, you cannot shift the responsibility of reporting to a supervisor, or to someone else in the office, school, clinic or licensed facility. You alone are required to make the report to the responsible agency.

Anyone who reports child abuse or neglect in good faith is immune from civil liability. A reporter's name is confidential. It is accessible only if a reporter consents, by court order, or by court procedure.

If you are required to report known or suspected abuse or neglect and fail to do so, you are guilty of a misdemeanor.

Reporting suspected abuse or neglect is a serious matter that must not be taken lightly. The child protection worker, law enforcement agent, or licensing agency worker to whom you report may ask you to provide as many facts as possible so they can assess a child's situation and determine the need for intervention. If a child protection report results in a court hearing, you may be asked to testify. Any inconvenience of reporting is offset by a simple fact: The action you take may save the life and spirit of a child and provide a family with needed support.

When to report suspected abuse or neglect

The law requires mandated reporters to make a report if they know of or have reason to believe a child is being neglected or abused, or has been neglected or abused within the preceding three years. Verbal reports must be made immediately (no longer than 24 hours). A written report must be submitted within 72 hours (weekends and holidays are excluded).

Reports should be made to the local child welfare agency. For a complete listing of local child welfare agencies, refer to Minnesota's county and tribal child protection agencies.

Where to report suspected abuse or neglect

Immediate danger – If you know or suspect that a child is in immediate danger (such as a recent sexual assault or a serious physical assault) or a child is abandoned, contact your local law enforcement agency right away. Law enforcement officers can remove a child from a threatening environment to protect them.

No immediate danger – If a child is not in immediate danger, as soon as you have reason to believe a child has been maltreated you should contact:

- The local child welfare agency if an alleged perpetrator is a parent, guardian, family child care provider, family foster care provider, an unlicensed personal care provider.
- The **Minnesota Department of Human Services, Licensing Division,** 651-431-6500, if alleged maltreatment was committed by a staff person at a child care center, residential treatment center (children's mental health), group home for children, minor parent program, shelter for children, chemical dependency treatment program for adolescents, waivered services program for children, crisis respite program for children, or residential program for children with developmental disabilities.

- The **Minnesota Department of Health, Office of Health Facility Complaints,** 651-201-4200 or 800-369-7994,if alleged maltreatment occurred in a home health care setting, hospital, regional treatment center, nursing home, intermediate care facility for the developmentally disabled, or licensed and unlicensed care attendants.
- The **Minnesota Department of Education,** 651-582-8546, or fax, 651-634-2277, if an alleged perpetrator is employed by a public pre-school, elementary school, middle school, secondary school, or charter school when a child is a student in the school. Reports received regarding staff working in private or parochial schools are sent directly to law enforcement.
- **Local law enforcement agency** if alleged offender is staff working in a private or parochial school, someone outside the family and not a staff person at a regulated facility. Examples of non-family, non-facility caretakers include athletic club staff and babysitters.

If you are unsure whether to make a report, call your local child welfare agency and report your concern. The child welfare agency will consult with you about a concern. Consultation is an important function of local agency screeners and can aid mandated and voluntary reporters to ensure a report gets to the right agency. Screeners can also consult with reporters regarding concerns that are not specific to an identifiable child.

When a report is made

When receiving a report of child maltreatment, the local child welfare agency staff must first determine whether a report meets the legal definition of child maltreatment. A screened in report of alleged child maltreatment must include the following three elements:

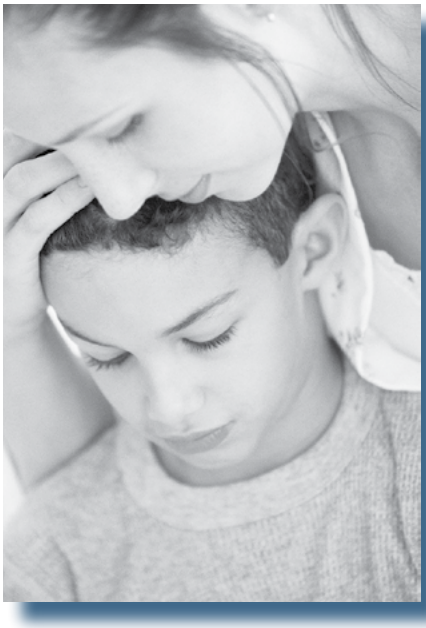
- The allegation meets the statutory definition of child maltreatment according to Minn. Stat. 626.556
- There is sufficient identifying information to attempt to locate the child, or at least one member of the family
- The report contains maltreatment allegations that have not been previously assessed or investigated by the local child welfare agency or another child welfare agency.

To determine if a report meets the statutory definition, child protection staff may contact other people with knowledge of the child and/or family for additional information. Past reports and history of social services involvement are considered.

For more information regarding screening guidelines see: Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines

At times, there may be inadequate information to begin an assessment or investigation. In these cases an offer of services may be made to the family. Law enforcement and child protection agencies, and other responsible agencies, cooperatively assess and investigate accepted reports that meet the statutory criteria of child maltreatment. These agencies are best prepared to help a child and family in need of support, and will assess or investigate reports of maltreatment. The local child welfare agency will offer services to safeguard the welfare of an abused or neglected child. Whether initially reported to local law enforcement, child welfare, or other responsible agency, it is possible that other agencies may contact you as they coordinate investigation or assessment activities.

If you are unsure whether to make a report call your local child welfare agency and they will consult with you about the concern.



While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so.

What will be asked?

Information gained from reporters is essential for the best screening decisions possible. Reporters can provide valuable information to an agency. If you contact a local child welfare agency, the child protection screener may request the following information:

- Your name, phone number, relationship to family or child, and source of information (witnessed, heard, etc.)
- Name, address, age, and other identifying information regarding alleged victim, siblings, alleged offender, other household members, or any additional witnesses.
- Specific description of allegations. When and where alleged incident occurred and if a child is in immediate danger.
- Description of a child's injuries or present conditions, and reporter's understanding of the impact of alleged maltreatment to the child.
- Presence of domestic violence, criminal activity, including sex trafficking of children, weapons, or other dangerous activities in the home.
- Description of any action a school and/or other facility or agency has taken specifically in response to an incident.
- Family's awareness of reporter's contact with the agency.
- Reporter's awareness or knowledge of any immediate family/ relative/community resources willing to offer protection or support. What reporter is willing to do (or has done) to help the family.
- Reporter's awareness of a child's lineage to Indian tribes, and if so, which tribes, if known.
- Additional information regarding a child and/or family which may be helpful.
- Whether reporter would like to be notified of the initial disposition.

Although you may not have knowledge or answers to all questions asked, respond to the best of your ability.

Collateral contacts

A child protection screener may contact other persons regarding a child. Contacting an individual or professional other than a reporter to assist in making a screening decision is permissible by law. A collateral contact is not required to provide the requested information. A collateral contact may include:

- Individuals who can provide first-hand information necessary to provide a fuller picture of alleged child maltreatment
- Mandated reporters who have recent and/or regular contact with child
- Individuals who can judge the quality and nature of parents' or caregiver's behavior
- Relevant law enforcement agencies.

The name of initial reporter remains confidential and may only be released by consent or a court order.

Use of past history in screening reports

When determining whether a report will be screened in or screened out, prior accepted and screened out reports of child maltreatment are considered in screening a current child maltreatment report. This includes case histories of all participants involved in current reports.

When prior records or contact with child protection exist in another Minnesota child welfare agency, or another state, every effort is made to obtain relevant information to screen a current report.

Non-discrimination in screening

A child's family's race; religion; age; socioeconomic; cultural history; ethnicity; political, immigrant, refugee, citizenship status; gender or sexual orientation; is not a factor when making a screening decision on a report of alleged child maltreatment. Child safety issues alone guide this decision.

Local child welfare agency workers will remain aware of the impact that historical trauma and current war-trauma has for families of color and American Indian families who become involved with the child protection system.

When a maltreatment assessment or investigation is conducted, accepted child-rearing practices of the culture in which a child participates, and accepted discipline practices which are not injurious to a child's health, welfare and safety are taken into account.

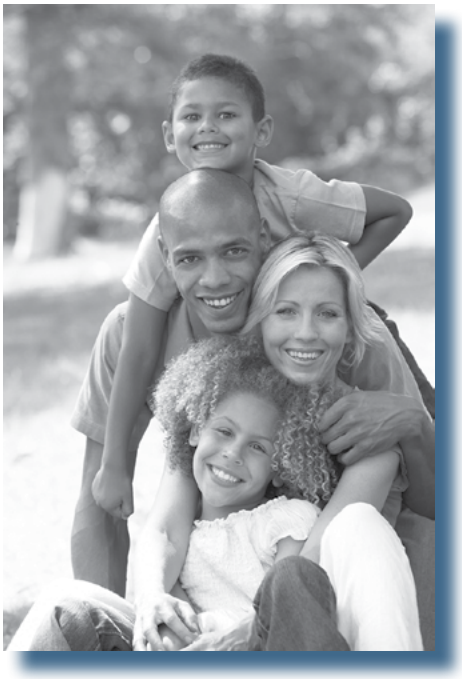
Child protection's responsibility

Local child welfare agency programs perform three essential functions:

- Receiving and screening reports of child maltreatment
- Assessing or investigating accepted reports of child maltreatment where the alleged offender is a parent, guardian, family child care or foster care provider
- Providing child protective and family support services, as needed.

Local child welfare agency staff do not have the authority to assess or investigate every complaint or concern expressed. Authority only exists for local child welfare agency services to respond to reports that meet the statutory definition of child maltreatment. Minnesota Statutes have criteria for determining how to evaluate and appropriately respond to child protection reports.

Reports made to child welfare agencies are first screened to determine whether a report meets criteria to be assigned for a child protection response. This screening decision is reviewed and confirmed by a screening team, or in the absence of a team, the child protection supervisor or designee. The screening team may consist of child protection staff, as well as other professionals such as law enforcement, county attorneys, mental health professionals and physicians. If maltreatment occurred in a family and meets the statutory definition, it is assigned for an Investigative response or a Family Assessment response. All reports of sex trafficking receive an Investigation response, and an alleged offender does not have to be in a caregiving role. Both statutory and discretionary reasons are involved in selecting the child protection response used for screened in reports of child maltreatment. Family Assessment and Family Investigation are not voluntary responses. They are both involuntary, serious child protective service responses focused on child safety as the paramount concern.



Children belong with their families unless they are not safe.

It is not child protection's role to investigate every complaint or concern expressed.

Screened in reports and response paths

Screened in reports must be assigned one of the following response paths, depending on reported concerns:

- Family Investigation
- Family Assessment
- Facility Investigation

All three child protection responses are required under Minnesota Statute. All three focus on child safety as the priority. A Family Investigation, Family Assessment or Facility Investigation must be completed within 45 days of the date of receipt of a report. [Minn. Stat. 626.556, subd. 10e]

The goals of child protection are to help achieve positive outcomes for families, their children, and:

- Make child safety paramount and at the forefront of decision making
- Assess and ensure the safety of a child initially and ongoing during involvement
- Gather facts to help decide if a child has experienced harm and provide needed services
- Identify family strengths to help address risks and ensure child safety
- Affirm a family's cultural beliefs
- Coordinate and monitor services to families, including the use of trauma-informed interventions
- Promote children's well-being and permanency.

Working with families

Both statutory and discretionary reasons are involved in selecting the child protection response used for screened in reports of child maltreatment. By law, child protection has a specialized role in working with a child and family. Child protection's responsibilities are to:

- Respond promptly to reports of alleged abuse, neglect or exploitation of a child
- Assess and assure the safety of a child
- Determine if a child was harmed by their exposure to maltreatment and provide corrective interventions
- Identify family problems that contributed to child safety concerns, and when possible, assist family to locate supports to help keep their child safe
- Evaluate family's ability to benefit from services
- Develop a treatment and service plan with family to meet their needs
- Implement a treatment plan and involve community resources to meet identified needs
- Seek authority of juvenile or family court in situations where there is a determined need for protective services and a family refuses services, or continues to pose a threat to the safety of a child.

Family Investigation response overview

Family Investigations respond to the most serious reports of maltreatment to children, including those situations in which there is not a serious report of harm or neglect, but there are additional considerations or vulnerabilities that indicate a need for an Investigation response. Reports of child maltreatment that allege substantial child endangerment or sexual abuse must receive an Investigation. Reports involving sex trafficking also must have an Investigation response. Minnesota Statutes define substantial child endangerment to include categories of egregious harm, physical and sexual abuse, and reports of high risk neglect. [Minn. Stat. 626.556, subd. 2 (c) (1) – (13)]

Investigations are sometimes conducted with law enforcement as part of a police investigation. Depending on the circumstances of a report, a local child welfare agency may decide to assign a report not involving substantial child endangerment for an Investigation. When this occurs, it is called Discretionary Family Investigation because it is at the discretion of a child welfare agency as to when it will provide an Investigation response, even though the situation is not related to substantial child endangerment or sexual abuse.

The focus of a Family Investigation response centers on gathering facts, assessing/evaluating risk for subsequent child maltreatment, and assessing family protective capacities related to child safety.

In situations where serious harm has occurred, or where there is risk of serious and imminent harm, the local police or sheriff's department has authority to immediately remove a child from the family home for 72 hours. The child welfare agency may seek emergency protective care of a child by petitioning the local juvenile court. Emergency protective care grants authority to the child welfare agency to continue a child in placement, providing for their safety while a thorough investigation is completed.

Reports alleging substantial child endangerment, sexual abuse or other reports assigned for an Investigation, must begin immediately and include face-to-face contact with child and their caretaker. All reports assigned for Investigation must be concluded within 45 days.

Two decisions are made at the conclusion of a Family Investigation:

- A determination of whether child maltreatment occurred
- Whether child protective services are needed.

Family Assessment response overview

Reports not involving substantial child endangerment, sexual abuse, or situations of serious danger, may be assigned for a Family Assessment. Reports that provide information indicating less serious safety concerns for children may be appropriate for a Family Assessment response. The focus is child safety and is not a voluntary response.

Family Assessment involves gathering facts to thoroughly evaluate child safety, the risk for subsequent child maltreatment, and a family's strengths that demonstrate protection of a child over time. The focus of Family Assessment is to engage a family's protective capacities and offer services that address immediate and ongoing safety concerns of a child. Family Assessment uses strength-based interventions and involves families in planning for and selecting services. If a family does not complete a Family Assessment, does not follow through with recommended services, or when an agency has not been successful in engaging a family in discussion around child safety, the response track may be changed to an Investigation response.

Investigations are designed to respond to the most serious reports of harm to children.

Physical abuse does not include reasonable and moderate physical discipline of a child administered by a parent or guardian that does not result in injury.

In Family Assessment response, child protection agency staff must have face-to-face contact with child and their primary caretaker within five calendar days. A Family Assessment must be completed within 45 days of an agency accepting a report.

No determinations of maltreatment are made in Family Assessment response. Two decisions are made at the conclusion of a Family Assessment, whether:

- Child protective services are needed
- Family support services are jointly agreed upon by the agency and parents.

Facility Investigation overview

Facility Investigations are completed when allegations of maltreatment involve children being served by licensed and unlicensed child care providers, foster care providers and unlicensed personal care providers. Legally unlicensed child care includes a caregiver, relative or non-relative, caring for a child as part of an ongoing arrangement, whether paid or unpaid, regardless of location. Other types of facilities are investigated by other entities, including the Minnesota Departments of Human Services, Education and Health. Facilities are held to a higher standard, as they are responsible for the care of children that are not their own.

Decisions made at the conclusion of a Facility Investigation include whether:

- Child maltreatment occurred
- A staff person was responsible
- A facility was responsible
- Child protective services are needed.

The Minnesota Departments of Human Services, Education and Health are responsible for investigating reports of child maltreatment occurring in a school or various licensed facilities. When these agencies receive a maltreatment report, they screen the report and determine whether it will be investigated, and if so, what priority an investigation will receive. After an investigation, the investigating agency determines whether maltreatment occurred, and what corrective or protective actions are needed. When maltreatment is determined in an investigation involving a facility, the investigating agency also determines whether the facility, or individual, was responsible for the maltreatment, or whether both were responsible.

Facility operators are required to inform mandated reporters employed by a facility of the mandated reporter requirements, and of the prohibition against retaliation for reports made in good faith. Minn. Stat., section 626.556, subd. 10d. (a), (b), (c), include additional requirements concerning facility and school investigations and notification of parents.

Learning the outcome

Privacy laws limit the information that child protection and licensing agencies can discuss. A mandated reporter can find out if a report has been accepted for investigation. If accepted, the reporter will receive a summary of a disposition of the report, unless such a release of information would be detrimental to the best interests of a child. The summary that a mandated reporter receives includes the following information:

- The agency's assigned response path under Minn. Administrative Rules, part 9560.0230, subp. 5
- The name of the child protection worker or investigator who conducted the Family Assessment or Family Investigation
- The nature of the maltreatment, if an agency determined that maltreatment occurred
- If a case has been opened for child protection or other services
- If a referral has been made to a community organization.

A voluntary reporter will receive a summary, if requested. The summary is limited to the following information:

- The agency's assigned response path under Minn. Administrative Rules, part 9560.0230, and
- A statement regarding whether child protective services are being provided.

Under Minn. Stat., section 626.556, subd. 10(j), local child welfare agencies are required to provide data to a mandated reporter making a report who has ongoing responsibility for the health, education or welfare of a child affected by the data, unless providing the data would not be in a child's best interest; data may be provided to other mandated reporters with ongoing responsibility for the health, education or welfare of a child. Data provided under this section must be limited to data pertinent to the individual's responsibility of caring for a child.

Maltreatment determinations

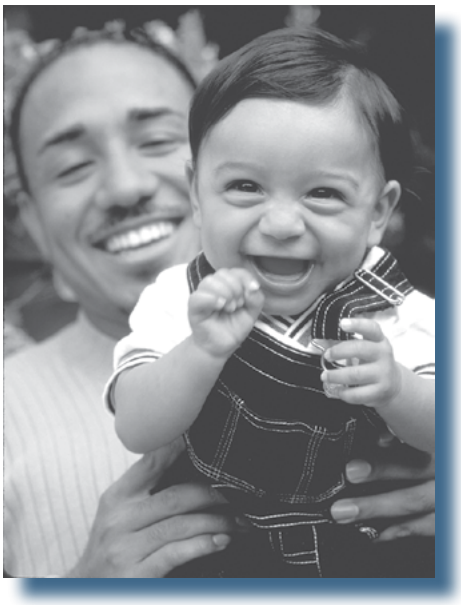
In Family Investigations, a determination of whether maltreatment occurred is made, and if child protective services are needed.

Determinations are made based on a preponderance of evidence of the facts, which may include information from interviews, physical evidence, records and other documentation.

In Family Assessment, no determinations of maltreatment are made. Two decisions are made at the conclusion of a Family Assessment, including whether:

- Child protective services are needed
- Family support services are jointly agreed upon by the agency and parents.

In both Family Investigations and Family Assessments, a determination of whether child protective services are needed is made. According to Minn. Stat. 626.556, subd. 10e (g): "a determination that child protective services are needed means that the local welfare agency has documented conditions during the assessment or investigation sufficient to cause a child protection worker to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment."



Historical trauma may have an impact for families of color and American Indian families.

Child protection responses are focused on child safety as the priority.

Reconsideration of maltreatment determinations

An individual or facility acting on behalf of a child may request that the investigating agency reconsider its final decision regarding maltreatment.

Maltreatment types

The following explanations of maltreatment types, pages 9-13, are offered to help better understand what law enforcement, child protection, and other responsible agencies are required to assess. Further details are included in relevant statutes and in the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines.

- Neglect
- Physical abuse
- Threatened injury
- Sexual abuse
- Threatened sexual abuse
- Domestic violence
- Predatory offenders
- Sexually exploited youth

Neglect

Neglect, according to Minn. Stat. 626.556, subd. 2(g), is the failure by parents or caretakers to provide a child with necessary food, shelter, clothing or medical care. Neglect also includes failure to ensure that a child is educated, although this does not include parents' refusal to provide a child with nervous system stimulant medications. Neglect also may occur when a person responsible for a child's care fails to protect them from conditions or actions that seriously endanger their physical or mental health when reasonably able to do so. In addition, neglect includes failure to provide for appropriate supervision or child care arrangements after considering a child's age, mental ability, and physical condition, length of absence or environment.

Child neglect differs from child abuse, though the results of abuse and neglect may be similar. Both can lead to physical injury, emotional harm and even death. Neglect is the failure of a parent or other caretaker to do what they are legally obligated to do rather than what s/he does. The following are conditions of neglect that must be reported:

- Inadequate food, clothing, shelter or medical care
- Abandonment
- Exposure to threatening or endangering conditions
- Failure to ensure education
- Prenatal exposure to certain controlled substances
- Failure to provide necessary supervision or child care arrangements
- Environmental hazardous conditions that pose a significant health or safety hazard to a child and not corrected by the parent or guardian
- Failure to provide for a child's special needs
- Exposure to, or involvement in, criminal activities
- Failure to protect a child from conditions or actions that present serious endangerment
- Chronic and severe use of alcohol or a controlled substance by a parent or person responsible for a child's care that adversely affects the child's basic needs and safety.

There are times when poverty generates circumstances that may be perceived as neglect and parents are unable to provide care for their child due to lack of adequate financial resources. Under these circumstances, the local child welfare agency will work to assist the parent(s) in providing the necessary care for a child, and not define the parental behavior as neglectful.

Physical abuse

Physical abuse, according to Minn. Stat. 626.556, subd. 2k, is defined as any:

- Physical injury, mental injury or threatened injury, inflicted by a person responsible for a child's care, to a child other than by accidental means
- Physical or mental injury that cannot reasonably be explained by a child's history of injuries
- Aversive or deprivation procedures, or regulated interventions, that have not been authorized under law for use in facilities serving persons who have developmental disabilities or related conditions.

Children who are physically abused sometimes have bruises, welts, burns, bite mark, cuts, fractures, swelling, or lost teeth. While internal injuries are seldom detectable without a medical exam, anyone in close contact with children should be alert to multiple injuries, a history of repeated injuries, new injuries added to old injuries and untreated injuries.

Other indicators of physical abuse that should be reported include:

- An injury that appears to be non-accidental in nature
- Physical injury resulting from hazardous conditions not corrected by a parent or guardian
- Significant threats indicating there is substantial risk of physical abuse or mental injury
- A visible injury at the time of making a report is not necessary to report physical abuse.

Physical abuse does not include reasonable and moderate physical discipline of a child administered by a parent or guardian that does not result in injury. Minn. Stat. section 626.556, subd. 2(k), 1-11, lists actions that are not reasonable and moderate and should be reported as physical abuse.

Threatened injury

Threatened injury, according to Minn. Stat. 626.556, subd. 2 (p), is a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury to a child by someone who is responsible for their care, unless it involves sex trafficking. In sex trafficking reports, an alleged offender does not have to be in a caregiving role. Threatened injury includes a person who has:

- Subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm as defined in Minn. Stat. 260C.007, subd. 14, or a similar law of another jurisdiction
- Been found to be palpably unfit under Minn. Stat. 260C. 301, subd. 1 (b) (4)
- Committed an act that resulted in an involuntary termination of parental rights
- Committed an act that resulted in the involuntary transfer of permanent physical and legal custody of a child to a relative.

Child protection staff must make reasonable efforts and active efforts for an Indian child to prevent a child being placed out of the home.

The health and safety of children is the paramount concern for child protection intervention.

Mental injury

Mental injury, according to Minn. Stat. 626.556, subd. 2(f), is an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in their ability to function within a normal range of performance and behavior, with due regard to a child's culture. Possible behavioral indicators of mental injury may include:

- Excessive sucking or rocking
- Destructive or antisocial behavior
- Sleep disorders
- Inhibition of play
- Behavioral extremes (passive or aggressive)
- Some types of developmental delays
- Substance abuse
- Obsessive and/or compulsive behaviors and phobias.

The presence of the behaviors described above are often evaluated by a mental health practitioner to determine the cause of the behaviors, since there may be factors other than mental injury that contribute to development of a particular disorder.

Sexual abuse

Sexual abuse, according to Minn. Stat. 626.556, subd. 2(n), means the subjection of a child to sexual contact by a person responsible for a child's care, person with a significant relationship to the child, or in a position of authority. In a report of sex trafficking, an alleged offender does not have to be in a caregiving role. Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under Minn. Stat. 609.321 to 609.234 or 617.247.

Sexual contact includes fondling, touching intimate parts and sexual intercourse. Sexual abuse also includes the use of a child in prostitution or in the production of sexually explicit works, or knowingly allowing a child to engage in the activities described in this paragraph. Sexual abuse also includes threatened sexual abuse. Since a sexually abused child may lack the outward symptoms of physical abuse, sexual abuse can be difficult to identify. A child often does not know how to express or explain what has happened to them and may be afraid, confused or ashamed. A child may not be developmentally capable of understanding or preventing the contact. Possible indicators of sexual abuse include a sudden change in behavior and signs of emotional disturbance.

Broadly defined, sexual contact includes:

- Touching of a child's intimate parts
- Having a child touch the intimate parts of another person
- Touching clothing, or the clothing covering the immediate area of intimate parts
- Performing an act with sexual or aggressive intent. [Minn. Stat. 609.341, subd. 11]

Warning signs may include:

- Fear of, or unwillingness to be near a particular place or person
- Nightmares
- Regressive behaviors such as crying excessively, sucking, rocking, bed- or pants-wetting

- Withdrawal from social relationships
- Ongoing anger
- Sexually acting out with other children
- Playing out what happened to them with dolls or another person
- Unusual interest in the private body parts of other children
- Inappropriate sexual knowledge for a child's developmental or chronological age.

The local child welfare agency is responsible for investigating allegations of sexual abuse if alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for a child's care, or a person with a significant relationship to a child, if that person resides in a child's household.

Threatened sexual abuse

Threatened sexual abuse, according to Minn. Stat. 626.556, subd. 2 (n), goes beyond the provisions of the criminal sexual conduct statutes and includes the following, but not limited to:

- Anything said or done that poses a significant danger that an alleged offender will perpetrate or attempt to perpetrate sexual abuse, or threaten to have sexual contact with a child.
- An adult soliciting sexual activity with another minor (not a household minor). An adult does not have to be in a caregiving role.
- Parent or other person residing in a household found to be in possession of child pornography.
- A person who has sexually abused a child, based on prior maltreatment determination or current credible statements, is residing with a child or having unsupervised contact with a child.
- Behavior recognized as preparation for initiating sexual contact with a child, such as showering or bathing with sexualized intent, prolonged lip kissing, and/or peeking at a child while they are undressing or dressing.

Domestic violence

There are times when domestic violence and child maltreatment co-occur. In these situations, a report must meet the statutory threshold for physical abuse, mental injury, threatened injury, sexual abuse, or neglect to a child. In most cases, a child must be involved in, a witness to, or otherwise situated in a location that puts them at risk during incidents of domestic violence.

There are other conditions of domestic violence that may meet the definition of threatened injury or mental harm and are included in the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines under Domestic Violence.

Conditions of domestic violence may meet the definition of maltreatment and include but not limited to, any of the following:

- Injuries to a parent, caretaker, or offender are potentially life threatening or permanent, or an injured person receives internal injuries or other serious injuries, such as broken bones, broken teeth, burns or injuries requiring sutures
- Objects are used as weapons in the course of domestic violence
- Sexual assault occurs in the course of domestic violence
- A child intervenes in the course of domestic violence, such as making a 911 call

There are times when poverty generates circumstances that may be perceived as neglect.

Maintaining a child's connection to family and their culture is a priority.

- A child inserts themselves as a shield to protect the parent, is physically restrained from leaving, or is used as a shield in an incidence of violence
- An alleged offender does not allow the protective parent and child access to basic needs, impacting their health and safety
- A child is exhibiting observable behavioral, emotional or psychological effects due to violence
- An alleged offender is making believable threats to anyone in the family, including extended family members and pets
- A child is in fear for their life, or the life of a parent, or the life of a person responsible for their care, or for the life of someone else in relation to the incident
- Violence is increasing in frequency and severity
- When kidnapping, threats of kidnapping, suicide or homicide occur
- When an offender has killed, substantially harmed, or is making believable threats to do so to anyone in the family, including extended family members and pets.

Predatory offenders

A parent or household member who is registered or required to register as a predatory offender needs to be reported. This includes parents who do not reside in a child's primary household. The local county child welfare agency must assess the situation to assure safety of children residing in the home.

Sexually exploited youth

Sexually exploited youth are individuals who are alleged to have engaged in conduct which would, if committed by an adult, constitute a violation of prostitution offenses and/or the use of a minor in a sexual performance. Youth being sexually exploited occurs when anything of value (e.g., money, drugs, food, shelter, rent or higher status in a gang or group, or the promise of anything of value is given by any means in exchange for any type of sexual activity. A third party may or may not be involved. Some circumstances of sexually exploited youth include, but are not limited to:

- A minor solicited to engage in sexual conduct by any means
- Children who have unexplained injuries to their genitals that are suspicious for sexual abuse
- A child intentionally exposed to sexual activity for the purpose of sexual arousal or sexual gratification
- Children who have sexually transmitted diseases.

Youth who are being sexually exploited need to be reported to the local child welfare agency when a parent or person with a significant relationship is involved. When in doubt make a report. The local agency will determine if a report meets criteria for physical abuse, neglect, sexual abuse or threatened sexual abuse. All sexually exploited youth are crime victims and will receive an offer of services.

Sex trafficking

All reports of known or suspected sex trafficking involving a child should be reported to child protection. Sex trafficking is a type of commercial sexual exploitation that involves the prostitution of an individual in which a third person, not the buyer or the victim, facilitates or receives profits. Sex trafficking victims are engaged in commercial sexual activity through the use of force, fraud or coercion by a third person, not the buyer or the victim.

A child who is identified as a victim of sex trafficking is considered a victim of sexual abuse.

When a child is placed in out-of-home care

Children belong with their families unless they are not safe. Child protection staff must make reasonable or active efforts to prevent a child from being placed out of their home, and provide safety for them in the home whenever possible. If it is necessary for a child's safety to separate a child from an abusive or neglectful family member, the child protection agency will try to provide the least restrictive setting possible. Whenever possible, an alleged offender is asked to leave the premises to prevent removal of a child from the home. Placement of child with relatives is often considered. If a suitable relative home is not available, however, other responsible adults who have a significant relationship with a child may be considered for placement. Maintaining a child's connection to family and their culture is a priority. If a relative or kinship placement is not available or not in the best interest of a child, they may be placed in foster care. The goal is to help a family resolve problems that contributed to maltreatment so that it is safe for a child to reunite with their family.

Placement of an Indian child

There are specific state and federal laws that govern placement of an Indian child. The best interests of an Indian child means compliance with the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act to preserve and maintain an Indian child's family, extended family, and a child's tribe. Active efforts must be made to prevent placement of an Indian child. Active efforts include acknowledging traditional helping and healing systems of an Indian child's tribe, and using these systems as the core to help and heal an Indian child and their family. Active efforts set a higher standard than reasonable efforts to preserve a family, prevent breakup of a family, and reunify families.

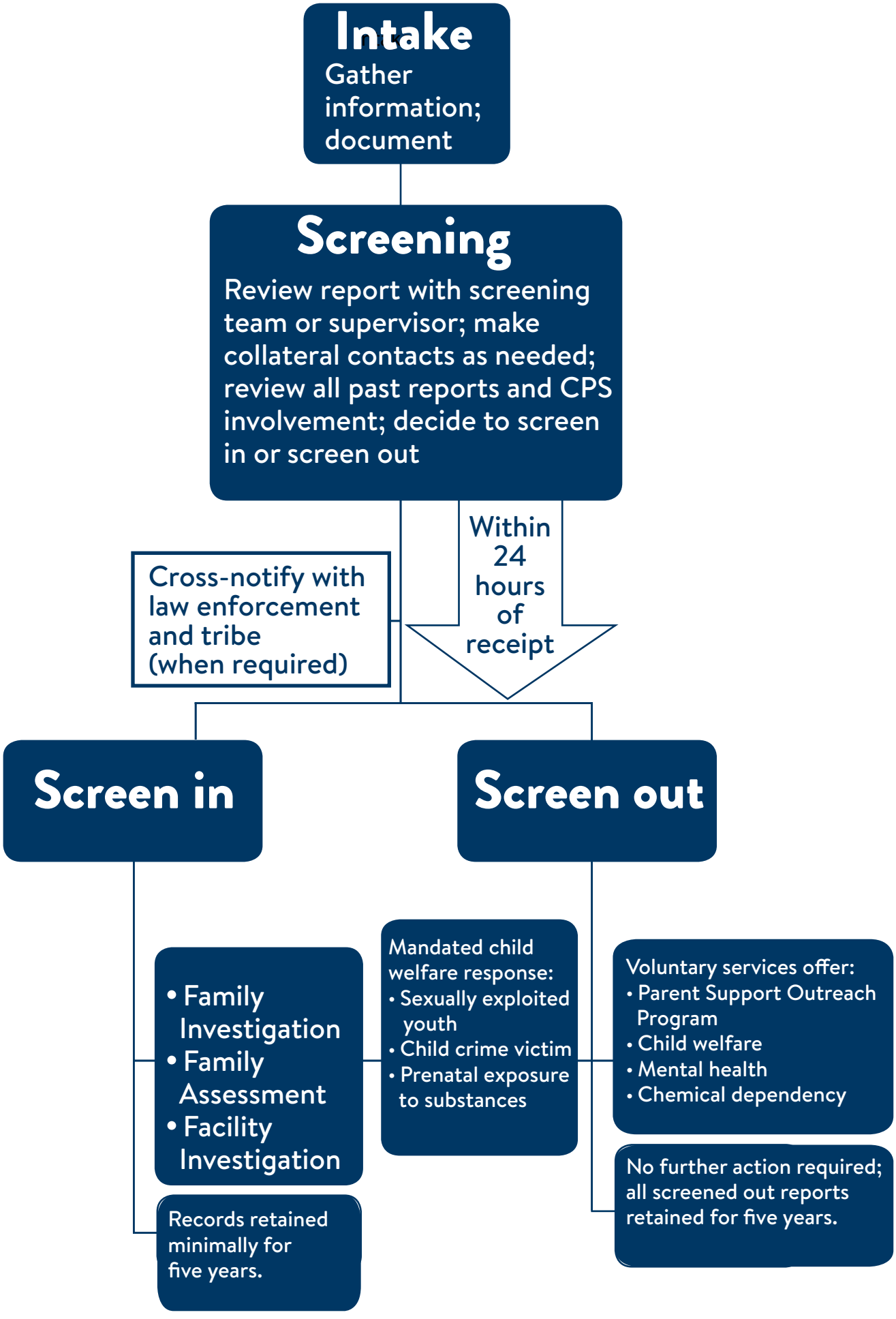
The best interests of an Indian child support the child's sense of belonging to family, extended family and tribe.

Relevant statutes and guidelines

- The Reporting of Maltreatment of Minors Act: Minn. Stat. section 626.556
- The statute governing reporting of prenatal exposure to controlled substances: Minn. Stat. section 626.5561
- The statute regarding the definition of Child in Need of Protection or Services (CHIPS): Minn. Stat. section 260C.007, subd. 6
- The administrative rule governing disclosure of records: Minnesota Administrative Rule 9560.0230
- The federal statute governing Indian children in the child welfare system: Indian Child Welfare Act, (ICWA) 25 USC 1901 ET SEQ
- The state statute governing Indian children in the child welfare system: Minn. Stat. 260.762
- The state statute governing prostitution and sex trafficking: Minn. Stat. 609.321 to 609.324

For more information on all child maltreatment guidelines see:

- Minnesota Child Maltreatment Intake, Screening Response Path and Assessment Guidelines


Intake
Gather information; document
Screening
Review report with screening team or supervisor; make collateral contacts as needed; review all past reports and CPS involvement; decide to screen in or screen out
Within 24 hours of receipt
Cross-notify with law enforcement and tribe (when required)
Screen in
Screen out
• Family Investigation
• Family Assessment
• Facility Investigation
Records retained minimally for five years.
Mandated child welfare response:
• Sexually exploited youth
• Child crime victim
• Prenatal exposure to substances
Voluntary services offer:
• Parent Support Outreach Program
• Child welfare
• Mental health
• Chemical dependency
No further action required; all screened out reports retained for five years.

651-431-4697

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LB2 (8-16)

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-4697, or use your preferred relay service. ADA1 (2-18)

Children and Family Services
P.O. Box 64943
St. Paul, MN 55164-0943
www.mn.gov/dhs

DEPARTMENT OF HUMAN SERVICES

DHS-6778E-ENG 11-17

Report suspected abuse, neglect, self-neglect or financial exploitation of vulnerable adults

CALL THE MINNESOTA ADULT ABUSE REPORTING CENTER: 1-844-880-1574

Maltreatment could include:

- **ABUSE:** Including physical, emotional and sexual abuse; use of restraints; and/or involuntary seclusion or punishment
- **NEGLECT:** Failure by a caregiver to fulfill a caretaking obligation
- **SELF-NEGLECT:** Failure by a vulnerable adult to adequately provide for their own health and safety, including having enough food, shelter, clothing, health care and/or supervision
- **FINANCIAL EXPLOITATION:** Unauthorized use of a vulnerable adult's funds or property, including theft or withholding of money or property and/or use of money or property not for the vulnerable adult's benefit

MALTREATMENT COULD HAPPEN... Anywhere, by Anyone

- Abuse, neglect and financial exploitation of a vulnerable adult could occur anywhere – from one's own home to a nursing home; from an assisted living facility to an adult day program. Abusers include spouses, children, staff and caregivers. A vulnerable adult who is no longer able to care for themselves could also be in danger of "self-neglect."

Vulnerable Adults in Minnesota NEED YOUR HELP

A vulnerable adult is anyone over age 18 who:

- **COULD HAVE** a physical, mental or emotional need that makes it hard for them to care for themselves without assistance
- **COULD BE** in a hospital, nursing home, transitional care unit, assisted living, housing with services, board and care, foster care or other licensed care facility
- **COULD RECEIVE** services such as home care, day services, licensed services, or other personal care

Maltreatment of vulnerable adults is a real and serious issue in Minnesota. It's under-reported because people don't know what to look for, don't know how to help, or just don't want to get involved.

You doing something COULD BE all the difference.

THAT'S THE POWER OF COULD

Call: 1-844-880-1574
or visit: mn.gov/dhs/adult-protection

What You Do Could Be the Difference

Report suspected maltreatment of a vulnerable adult by calling the Minnesota Adult Abuse Reporting Center at 1-844-880-1574.

The toll-free phone line is available 24 hours a day, seven days a week. Your identity will remain confidential and the appropriate investigative agencies will follow up on your report.

For serious or immediate danger, **CALL 9-1-1.**

YOU COULD MAKE A DIFFERENCE

Signs of Maltreatment COULD BE

These are some signs that could be maltreatment and should alert you that a report should be made:

PHYSICAL SIGNS

- Bruises and skin tears
- Black eyes, sunken eyes or cheeks, or poor coloration
- Broken bones, burns, cuts or infections
- Incontinence
- Dehydration
- Lack of necessities such as food, water, or utilities
- Repeated falls

BEHAVIORAL SIGNS

- Increased agitation, combativeness or confusion
- Fear or anxiety
- Depression or non-responsiveness
- Isolation or withdrawal
- Conflicting statements
- Hesitation to talk openly

FINANCIAL SIGNS

- Unpaid bills
- Lack of access to their own money
- Sudden changes made to will or banking practices
- Unexplained missing funds or valuables
- Forged signatures or financial transactions
- Assets being transferred or sold
- Individual is taken to bank to make account withdrawals

651-431-2600

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Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA Advisory

For accessible formats of this publication or assistance with additional equal access to human services, write to dhs.info@state.mn.us, call 651-431-2600, or use your preferred relay service. ADA1 (9-15)

AccuKare

Annual Training

Section 13

Timecard Usage

Fraud

Time Sheet

(PLEASE PRINT)

HOMEMAKER NAME:_____ **CLIENT NAME:**_____

MHCP (PCA) Provider #: _____ **D.O.B.:** _____

Pay Period: _____ **MHCP (MA) ID #:** _____

This timesheet is to be completed DAILY by each Homemaker. By signing below, the Homemaker and CLIENT verifies that all of the information that has been completed on this form is accurate and truthful. All time and duties listed MUST have been actually worked/performed with/for the client. Listing any time or duties that was not worked/performed with/for the client is considered FRAUD and may result in termination of employment/services Any FRAUD or suspected FRAUD will be reported to the Fraud Investigation Division of the Department of Human Services. This timesheet must be in the AccuKare Inc. office by 5:00pm on the Tuesday after the pay period ends. It is the responsibility of each individual to handle the sending/faxing of his or her time card.

Email to: timecards@accukare.com

Mail to: AccuKare Inc.
13750 Crosstown Dr. NW #L100
Andover, MN 55304
PH. (763) 362-3971

OR

Fax to: (763) 862-2135
(If you fax your time card, call and verify it has been received)

Date	Time In	Time Out	Daily Total Time	Cleaning (Home)	Cleaning (Equipment)	Errands	Shopping (Grocery)	Cooking	Laundry		
	AM PM	AM PM									
	AM PM	AM PM									
	AM PM	AM PM									
	AM PM	AM PM									
	AM PM	AM PM									
	AM PM	AM PM									
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	AM PM	AM PM									
Total Time for Pay Period											

Notes: _____

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****NOTICE: It is a federal crime to falsely bill for MA services****

****The client MUST draw a line through dates and times written down if services were not actually provided at those times****

HOMEMAKER SIGNATURE: _____ **CLIENT SIGNATURE**:_____

Date: _____ **Date:** _____

All above information is to be considered confidential and is to be treated in accordance with agency policy.

Time Sheet

(PLEASE PRINT)

PCA/RN NAME:______________________________ **CLIENT NAME:**______________________________

MHCP (PCA) Provider #: ______________________________ **D.O.B.:** ______________________________ or

Pay Period: ______________________________ **MHCP (MA) ID** #: ______________________________

*** This time sheet is NOT to be used for SHARED CARE ***

This timesheet is to be completed DAILY by each PCA or Supervising RN who has physical presence contact with the client. By signing below, the PCA or Supervising RN and CLIENT verifies that all of the information that has been completed on this form is accurate and truthful. All time and duties listed MUST have been actually worked/performed with/for the client. Listing any time or duties that was not worked/performed with/for the client is considered FRAUD and may result in termination of employment/services. Any FRAUD or suspected FRAUD will be reported to the Fraud Investigation Division of the Department of Human Services. <u>This timesheet must be in the AccuKare Inc. office by Tuesday after the pay period ends.</u> It is the responsibility of each individual to handle the sending/faxing of his or her time card.

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PH. (763) 862-3971

OR

Fax to: (763) 862-2135
(If you fax your time card, call and verify it has been received)

Email to: timecards@accukare.com

Date (Mo/Day/Yr)	Time In (Circle AM or PM)	Time Out	Daily Total Time	Safety	Grooming	Bathing	Skin Care	Dressing	Eating	Resp. Care	Toileting Needs	Transfers	Positioning	Mobility	Exercises	R.O.M.	Behaviors	Seizures	Med. Assist.	Laundry	Cleaning Med. Equip.	Cleaning (Related to Cares)
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	AM PM	AM PM																				
	AM PM	AM PM																				
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Total Time for Pay Period	

*** More than one line may be used per day.**
*** More than one time sheet may be used per pay period, per employee, per client.**

Notes: ____

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****NOTICE: After the PCA has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the PCA. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on PCA billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan. All unused lines are to be crossed out.**

PCA SIGNATURE: ______________________________ **CLIENT SIGNATURE**: ______________________________

Date: ______________________ **Date:** ______________________

All above information is to be considered confidential and is to be treated in accordance with agency policy.

Fraud Policy

An employee hired as a PCA, Homemaker or Qualified Professional is only able to claim hours that they have worked that directly correlate to their job description. As a PCA or Homemaker, no time may be claimed for duties that were not performed as per the Care Plan or Homemaker Care Plan. Any attempt to claim time for duties that were not performed as per the job description, the Care Plan and/or Homemaker Care Plan will be considered attempts towards fraud and will be reported to the Fraud Investigation Department of the Department of Human Services. The employee may be terminated for such attempts.

- As a PCA, the employee must be physically with the client for all of the time claimed in order to claim the time.
- As a PCA, the employee may only claim time when the only person they are responsible for is the client.
- An employee must be actually performing the claimed duties in order to claim the time.
- The employee may not claim the scheduled 'start' and 'end' time of their assignment unless they are actually with the client or doing the Service Plan duties at those claimed times.
- The employee may not 'round' to the nearest half hour on the time card. Rounding to the nearest fifteen (15) minutes is acceptable.
- The employee may not claim time for the entire scheduled time even if the client or Responsible Party sends them home early. If this (being sent home early) is consistently happening, AccuKare, Inc. needs to be notified.
- The employee may not claim time for 'running errands' for the client unless it specifically is stated in the Care Plan or Service Plan in place within the agency.
- The employee may not claim time for providing services in their (the employee's) home unless they live with the client.
- The employee may not claim time for things that are not in the Care Plan or Service Plan even if the client or responsible party 'tells them to do it.'

The above list is a compiling of examples, but is not all-inclusive. The best methods to use to avoid fraudulent time card usage are:

1. As a PCA, only claim time when physically with the client, performing the duties on the Care Plan
2. As a Homemaker, performing duties as listed on the Homemaker Care Plan
3. As a Qualified Professional, performing the duties listed in DHS guidelines (refer to Steps for Success training and Job Description-JD-03

Any infraction of this will not be tolerated.

"It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092 and 256B.49."

PHR-30 Policy Date: 06-10-2002
Revised Date: 10-08-2012
Revised Date: 07-31-2017
Revised Date: 08-08-2019

Respite Time Sheet

(PLEASE PRINT)

PCA/RN NAME: ______________________________ **CLIENT NAME:** ______________________________

MHCP (PCA) Provider #: ______________________________ **D.O.B.:** ______________________________ or

Pay Period: ______________________________ **MHCP (MA) ID** #: ______________________________

*** This time sheet is NOT to be used for SHARED CARE ***

This timesheet is to be completed DAILY by each PCA or Supervising RN who has physical presence contact with the client. By signing below, the PCA or Supervising RN and CLIENT verifies that all of the information that has been completed on this form is accurate and truthful. All time and duties listed MUST have been actually worked/performed with/for the client. Listing any time or duties that was not worked/performed with/for the client is considered FRAUD and may result in termination of employment/services. Any FRAUD or suspected FRAUD will be reported to the Fraud Investigation Division of the Department of Human Services. <u>This timesheet must be in the AccuKare Inc. office by Tuesday after the pay period ends.</u> It is the responsibility of each individual to handle the sending/faxing of his or her time card.

Mail to: AccuKare Inc.
13750 Crosstown Drive, NW #L100
Andover, MN 55304
PH. (763) 862-3971

OR

Fax to: (763) 862-2135
(If you fax your time card, call and verify it has been received)

Email to: timecards@accukare.com

Date (Mo/Day/Yr)	Time In (Circle AM or PM)	Time Out	Daily Total Time	Safety	Grooming	Bathing	Skin Care	Dressing	Eating	Resp. Care	Toileting Needs	Transfers	Positioning	Mobility	Exercises	R.O.M.	Behaviors	Seizures	Med. Assist.	Laundry	Cleaning Med. Equip.	Cleaning (Related to Cares)
	AM PM	AM PM																				
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Total Time for Pay Period																						

*** More than one line may be used per day.**
*** More than one time sheet may be used per pay period, per employee, per client.**

Notes: ____

____

****NOTICE: After the PCA has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the PCA. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on PCA billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan. All unused lines are to be crossed out.**

PCA SIGNATURE: ______________________________ **CLIENT SIGNATURE**: ______________________________

Date: ____________________ **Date:** ____________________

All above information is to be considered confidential and is to be treated in accordance with agency policy.

PHR-17b

AccuKare

Annual Training

Section 14

Person Centered Practices

Minnesota strives to make sure everyone who receives long-term services and supports and mental health services can live, learn, work and enjoy life in the most integrated setting.

Person-centered support systems help people:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life.

Person-centered practices are flexible and adaptable. They encourage informed choice and creativity. We use person-centered practices because they increase people's quality of life.

Person-centered practices are based on the fundamental principle that government and service providers must listen to people about what is important to them to create or maintain a life they enjoy in the community.

When a person-centered approach is used, support and service planning is not driven by professional opinion or limited service options. Instead, planning looks at services and supports in the context of what it takes for a person to have the life they want. The person along with his/her support team identities effective support and services that will help the person live, learn, work, and participate in preferred communities on his/her own terms.

These practices encourage professionals to see people as unique and whole individuals with potential and gifts to share. Using these practices, professionals and informal support people learn what is important to each person and what contributes to each person's quality of life. “Person-centered” services are an alternative to “system-centered” or “professionally-driven” approaches.

Person-centered practices focus on each person's abilities and strengths, including natural supports, so that he or she can maintain or work toward:

- What is important to him or her
- What is important for him or her.

When we use a person-centered approach, the person often is able to achieve much more than those around him/her assumed was possible.

Plans that are person-centered help children and adults develop and use resources to support their goals and preferences. It can require creativity and work to and develop the necessary supports. It may take time and several steps to achieve each person's
goals.

When we use person-centered practices, the people we serve experience a better quality of life. They:

- Grow in relationships
- Contribute to their community
- Make choices and have positive control over their lives
- Are treated with dignity and respect
- Have a valued social role
- Share ordinary places and activities
- Participate in local community life.

The people who deliver services benefit as well. They:

- Witness the people they support achieve goals that are meaningful to them
- Are able to work creatively and collaboratively with others to and successful solutions
- Experience fewer disruptions and crises because plans are successful more often.
- Empower the people they support
- Share the responsibility of resource allocation and decision-making.

The use of person-centered principles and practices is a way of assuring that people with disabilities have the same rights and responsibilities as other people, including having control over their lives, making their own choices, and contributing to the community in a way that makes sense for the person. To be person-centered is to:

- Treat each person with dignity and respect
- Build on his or her strengths and talents
- Help him or her connect with his or her community and develop relationships
- Listen to and act on his or her communication to you
- Make a sincere effort overall to understand him or her as a unique person

Person-centered practices are based on five key areas, and therefore, services for and interactions with people should be judged by their ability to help people:

- Share ordinary places and activities
- Make choices
- Contribute
- Be treated with respect and have a valued social role
- Grow in relationships.

Person-centered service delivery that:

- supports what is important to the person as well as what is important for the person, including preferences for when and how support service is provided within one's job description and client's care plan;
- respects each person's history, dignity, and cultural background;
- opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication;
- affirming and protecting of each person's civil and legal rights;
- inclusion and participation in the person's community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible and supports the person in developing and maintaining a role as a valued community member;
- opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports;
- a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety, or rights.

Agency/QPs to perform:

- Incorporating the principles of person-centeredness into the services provided
- Evaluating with the person, at least every six months, whether the services support the person's preferences, daily needs and activities, and the accomplishment of the person's goals.

AccuKare

Annual Training

Section 15

Client/Recipient

Rights

Minnesota Home Care Bill of Rights

PER MINNESOTA STATUTE, SECTION 144A.44

These rights pertain to consumers receiving home care services from licensed only home care providers.

Statement of Rights

A person who receives home care services has these rights:

1. The right to receive written information about rights before receiving services, including what to do if rights are violated.
2. The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services.
3. The right to be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.
4. The right to be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan.
5. The right to refuse services or treatment.
6. The right to know, before receiving services or during the initial visit, any limits to the services available from a home care provider.
7. The right to be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying.
8. The right to know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.
9. The right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, or other health programs.
10. The right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.
11. The right to access the client's own records and written information from those records in accordance with sections 144.291 to 144.298.
12. The right to be served by people who are properly trained and competent to perform their duties.
13. The right to be treated with courtesy and respect, and to have the client's property treated with respect.
14. The right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.

15. The right to reasonable, advance notice of changes in services or charges.
16. The right to know the provider's reason for termination of services.
17. The right to at least ten days' advance notice of the termination of a service by a provider, except in cases where:
    (i.) The client engages in conduct that significantly alters the terms of the service plan with the home care provider;
    (ii.) The client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or
    (iii.) An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.
18. The right to a coordinated transfer when there will be a change in the provider of services.
19. The right to complain about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property.
20. The right to know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.
21. The right to know the name and address of the state or county agency to contact for additional information or assistance.
22. The right to assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.

If you have a complaint about the provider or person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities.

Office of Health Facility Complaints
Phone: (651) 201-4201 or 1-800-369-7994
Fax: (651) 281-9796
Website: http://www.health.state.mn.us/divs/fpc/ohfcinfo/contohfc.htm
Email: health.ohfc-complaints@state.mn.us
Mailing Address:
Minnesota Department of Health
Office of Health Facility Complaints
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, Minnesota 55164-0970

Ombudsman for Long-Term Care
Phone: (651) 431-2555 or 1-800-657-3591
Fax: (651) 431-7452
Website: http://tinyurl.com/Ombudsman-LTC
Email: mba.ooltc@state.mn.us
Mailing Address:
Home Care Ombudsman
Ombudsman for Long-Term Care
PO Box 64971
St. Paul, MN 55164-0971

Ombudsman for Mental Health and Developmental Disabilities
Phone: 651-757-1800 or 1-800-657-3506
Fax: 651-797-1950 or 651-296-1021
Website: http://mn.gov/omhdd/
Email: ombudsman.mhdd@state.mn.us
Mailing Address:
121 7th Place East Suite 420 Metro Square Building St. Paul, Minnesota 55101-2117

Licensee Name: AccuKare, Inc

Phone: 763-862-3971 **Email:** info@accukare.com

Address: 13750 Crosstown Dr NW #L100, Andover, MN 55304

Name/Title of Person to Whom Problems or Complaints May be directed:
Karla Adams, President

For informational purposes only and is not required in the Home Care Bill of Rights text:

MN Statute, section 144A.44 Subd. 2. **Interpretation and enforcement of rights.**

These rights are established for the benefit of clients who receive home care services. **All home care providers, including those exempted under section 144A.471, must comply with this section.** The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or providers licensed under sections 144A.43 to 144A.482.

Minnesota Department of Health
Health Regulation Division
Home Care and Assisted Living Program
P.O. Box 3879
St. Paul, Minnesota 55101-3879

January 2014

To obtain this information in a different format call 651-201-5273.

AccuKare

Annual Training

Section 16

Covid-19 Plan

Coronavirus disease 2019 (COVID-19) and you

What is coronavirus disease 2019?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can I get COVID-19?

Yes. COVID-19 is spreading from person to person in parts of the world. Risk of infection from the virus that causes COVID-19 is higher for people who are close contacts of someone known to have COVID-19, for example healthcare workers, or household members. Other people at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.

Learn more about places with ongoing spread at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html#geographic.

The current list of global locations with cases of COVID-19 is available on CDC's web page at https://www.cdc.gov/coronavirus/2019-ncov/locations-confirmed-cases.html.

How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but is now spreading from person to person. The virus is thought to spread mainly between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs or sneezes. It also may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.Learn what is known about the spread of newly emerged coronaviruses at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

Patients with COVID-19 have had mild to severe respiratory illness with symptoms of:

- fever
- cough
- shortness of breath

What are severe complications from this virus?

Some patients have pneumonia in both lungs, multi-organ failure and in some cases death.

People can help protect themselves from respiratory illness with everyday preventive actions.

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.

If you are sick, to keep from spreading respiratory illness to others, you should

- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces.

What should I do if I recently traveled from an area with ongoing spread of COVID-19?

If you have traveled from an affected area, there may be restrictions on your movements for up to 2 weeks. If you develop symptoms during that period (fever, cough, trouble breathing), seek medical advice. Call the office of your health care provider before you go, and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While sick, avoid contact with people, don't go out and delay any travel to reduce the possibility of spreading illness to others.

Is there a vaccine?

There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to take everyday preventive actions, like avoiding close contact with people who are sick and washing your hands often.

Is there a treatment?

There is no specific antiviral treatment for COVID-19. People with COVID-19 can seek medical care to help relieve symptoms.

For more information: **www.cdc.gov/COVID19**

CS 314937-H 03/06/2020

AccuKare Inc.
13750 Crosstown Drive
Suite 202
Andover, MN 55304

AccuKare Inc.

March 15, 2020

Dear Families and Employees of AccuKare,

I hope this information finds you all in a place of inquiry and task orientation as we all seek to do our very best to understand all that is before us. So much information is being thrusted at us right now. Much of the information is being presented through the filters of news media, social media, friends and family, and our own past understandings of disease prevention. I have waited to send information to you all in order that AccuKare can be part of the cohesive presentation of data and recommendations that the Department of Human Services (DHS) and the Minnesota Department of Health (MDH) in conjunction with the Center for Disease Control (CDC) have provided. The handouts and resources I have provided here are straight from their webpages. Our research has shown us that most of the care delivery precautions are things that we already cover upon hire and at annual training. We are so glad that our employees have the training, resources, and supplies needed to safely care for our clients. It is how we have conducted business all along for 18 years. We are whole heartedly reminding you of what you know already and echoing the official information that we are all being taught in light of our current COVID-19 outbreak.

AccuKare understands and supports that our clients continue to need the assessed ongoing care that they have been receiving prior to today and will continue to need it. This is regarding all the cares –PCA, Respite, and Homemaking. We intend to continue providing our high standard of care. Our staff will have challenges due to all the adjustments that our entire world is making in light of our COVID-19 pandemic. We will all be patient with each other and flexible. Our population of clients will still need help. We believe that all of our staff will do their very best to continue to provide care and do their job. **DO NOT GO TO YOUR CLIENT'S HOME IF YOU ARE SICK!!** Please give AccuKare (any of the supervisors, the main number, or the emergency number) a call if you think you are ill. Give all our numbers to your family members so we can receive a call if you are unable to call us or direct someone to do that for you. Our clients can not be left wondering if they have care or not. **IF A CLIENT IS ILL WE ASK THAT THE CLIENT, THE CLIENT FAMILY, OR STAFF CONTACT US** at AccuKare (any of the supervisors, the main number, or the emergency number) to inform us so we can help to protect our staff from exposure and help to make arrangements for care and safety for our clients and staff.

Proper handwashing has always been and still is the strongest recommendation for averting illness for the caregiver as well as the one receiving care. The key word in the statement is "proper." Frequent handwashing is mandatory!! We have included in this packet the CDC's proper handwashing information graphic. **MAKE SURE TO WASH YOUR HANDS AS THE FIRST THING YOU DO WHEN YOU ENTER THE CLIENT'S HOME AND YOUR HOME AND AS THE LAST THING YOU DO BEFORE YOU LEAVE.** Hand sanitizer is only to be used if proper handwashing stations/supplies (running water, soap, single use drying towel (paper towels or a clean towel used once and then laundered)) are not available. Since we are in our client homes providing care, the national shortage on hand sanitizer that is affecting us

all should not be of great impact for our delivery of care as handwashing is available to us. Be sure to contact us immediately if you are in need of handwashing supplies for us to assist with the acquisition. Our supervisors have supplies/information as well that reflects this directive.

Our surface sanitizer and hand sanitizer bottles are to be returned to the office/supervisors when used for refill/replacement after our sanitizing them with the same sanitizer we use in the homes. Be sure to return things in a closed container such as a bag. We do **not** have an abundance of hand sanitizer and what was sent to us was expired so we are in a limited stock at current as is the nation. Our surface sanitizer (Lysol Quaternary IC), used as directed, is listed as one of the effective sanitizers to kill COVID-19 among many other things.

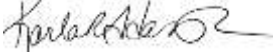
We have included the CDC COVID-19 information handout to give you the official information and for you to have as guidance and reference. The CDC website is on the bottom of the handout as well as here:
www.cdc.gov
Other helpful websites are:
www.health.state.mn.us/
www.mn.gov/dhs/

When you stop by our office you will notice some changes that we have instituted as part of our response to decrease contact. We ask that you call or text that you are coming and request items you may need so we can have it prepared for you. We do understand that you can't always do this, but if we all try we can reduce all of our exposures. We have a basket for you to place your time card in that is labeled and readily available once you enter the AccuKare entrance. Time cards are by the basket ready for you to take what you need for the next pay period. A supply table is placed in front of the reception desk for you to get needed available supplies for the next pay period. **PLEASE DO NOT TAKE MORE THAN YOU NEED FOR THE PAY PERIOD KNOWING THAT YOU CAN REPLENISH YOUR STOCK IN ORDER THAT OUR RESOURCES CAN HELP ALL OF OUR CLIENTS AND STAFF.** If there are additional things you may need please do not hesitate to ask. We will greet you and visit with you but we will also maintain distance. We are trying to do our part to decrease transmission and exposure risk for us all.

This informational letter and handouts are on our website. We have added them to the page you are familiar with accessing - Resources. The Resources and Employee Resources pages have all the hire and annual training handouts, time cards, handbook, care deliver training materials, etc. to assist you in safely receiving/giving care.

Please remember to be patient with yourselves and each other as we are all working to do our parts to support all of our health and wellness. Take a few minutes each day to find joy and laughter in the small things (big ones too!!!). Connect with your family and friends in non-transmission manners frequently as we never know who is feeling isolated and frightened. Comfort each other and know that we are all doing our very best in a unique worldwide experience.

Sincerely,



Karla R. Adams
AccuKare, Inc. President

EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▸ PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

WH1422 REV 03/20

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

How to Protect Yourself

Older adults and people who have severe underlying chronic medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness. Please consult with your health care provider about additional steps you may be able to take to protect yourself.

Know How it Spreads

- There is currently no vaccine to prevent coronavirus disease 2019 (COVID-19).
- **The best way to prevent illness is to avoid being exposed to this virus.**
- The virus is thought to spread mainly from person-to-person.
  - Between people who are in close contact with one another (within about 6 feet).
  - Through respiratory droplets produced when an infected person coughs or sneezes.
- These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

Take steps to protect yourself

Clean your hands often

- **Wash your hands** often with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, **use a hand sanitizer that contains at least 60% alcohol**. Cover all surfaces of your hands and rub them together until they feel dry.
- **Avoid touching your eyes, nose, and mouth** with unwashed hands.

Avoid close contact

- **Avoid close contact** with people who are sick
- Put **distance between yourself and other people** if COVID-19 is spreading in your community. This is especially important for people who are at higher risk of getting very sick.

Take steps to protect others

Stay home if you’re sick

- **Stay home** if you are sick, except to get medical care. Learn what to do if you are sick.

Cover coughs and sneezes

- **Cover your mouth and nose** with a tissue when you cough or sneeze or use the inside of your elbow.
- **Throw used tissues** in the trash.
- Immediately **wash your hands** with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.

Wear a facemask if you are sick

- **If you are sick:** You should wear a facemask when you are around other people (e.g., sharing a room or vehicle) and before you enter a healthcare provider's office. If you are not able to wear a facemask (for example, because it causes trouble breathing), then you should do your best to cover your coughs and sneezes, and people who are caring for you should wear a facemask if they enter your room. Learn what to do if you are sick.

- **If you are NOT sick:** You do not need to wear a facemask unless you are caring for someone who is sick (and they are not able to wear a facemask). Facemasks may be in short supply and they should be saved for caregivers.

Clean and disinfect

- **Clean AND disinfect** frequently touched surfaces **daily**. This includes tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- **If surfaces are dirty, clean them:** Use detergent or soap and water prior to disinfection.

To disinfect:
Most common EPA-registered household disinfectants will work. Use disinfectants appropriate for the surface.

Options include:

- **Diluting your household bleach.**
  To make a bleach solution, mix:
  - 5 tablespoons (1/3rd cup) bleach per gallon of water
    OR
  - 4 teaspoons bleach per quart of water

  Follow manufacturer's instructions for application and proper ventilation. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.
- **Alcohol solutions.**
  Ensure solution has at least 70% alcohol

Ensure solution has at least 70% alcohol.

- **Other common EPA-registered household disinfectants.**
  Products with EPA-approved emerging viral pathogens [7 pages] claims are expected to be effective against COVID-19 based on data for harder to kill viruses. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).

More handwashing tips

Hand Hygiene in Healthcare Settings

More information

Symptoms

What to do if you are sick

If someone in your house gets sick

Frequently asked questions

Travelers

Individuals, schools, events, businesses and more

Healthcare Professionals

Page last reviewed: March 14, 2020

AccuKare
Annual Training
Section 17
Minimizing Risk of Sexual Violence

Preventing Sexual Violence & Intimate Partner Violence

Definition of Sexual Violence: Anything involving the human body that is unwanted or unchosen is considered violence.

In the home care environment, it is the caregiver's responsibility to provide body autonomy for private individual care. Bodily autonomy is the right to make decisions about your own body, life, and future, without coercion or violence. It includes the freedom to decide what happens to your body, whether it's choosing what to wear, making medical decisions, or deciding when, or whether any care event should happen. All practices should be person centered and empowering for recipient of service and actively sets the stage for future interactions. When we have full bodily autonomy, not only are we empowered to make decisions about our health and future – without coercion or control by others – we also have the support and resources needed to meaningfully carry out these decisions.

In the home care environment, we support principals to minimize Sexual Violence (SV) & Intimate Partner Violence (IPV) in the following way:

- **Bodily Autonomy** - Care givers explain every step of every process of every care event. No coercion or fear-based tactics.
- **Empowerment** - Recipients of service should be given the right to make decisions regardless of abilities.
- **Setting the Stage** - We are setting expectations that care will morph and shift to the clients' needs and not the other way around.
- **Privacy/Anonymity/Confidentiality -** We as care givers provide these rights to recipients of care through our words and actions.
- **Maintaining of Boundaries -** Maintaining boundaries means following the limits set to ensure the recipient of care's needs are respected.
- **Maintaining Dignity with Care -** Maintaining care with dignity means treating people with respect, compassion, and empathy, and supporting their independence.
- **Reporting -** If you have concerns about anything that you have observed, heard or done, you must talk to your supervisor.

CDC Preventing Sexual Violence

CDC developed the Sexual Violence Prevention Resource for Action to help communities take advantage of the best available evidence to prevent sexual violence. Many of the prevention strategies focus on reducing the likelihood that a person will engage in sexual violence.

The prevention strategies and their corresponding approaches are listed in the table below.

Strategy	Approach
Promote social norms that protect against violence.	• Bystander approaches. • Mobilizing men and boys as allies.
Teach skills to prevent sexual violence.	• Social-emotional learning. • Teaching healthy, safe dating and intimate relationship skills to adolescents. • Promoting healthy sexuality. • Empowerment-based training.
Provide opportunities to empower and support girls and women.	• Strengthening economic supports for women and families. • Strengthening leadership and opportunities for girls.
Create protective environments.	• Improving safety and monitoring in schools. • Establishing and consistently applying workplace policies. • Addressing community-level risks through environmental approaches.
Support victims/survivors to lessen harms.	• Victim-centered services. • Treatment for victims of sexual violence. • Treatment for at-risk children and families to prevent problem behavior including sex offending.

CDC Preventing Intimate Partner Violence

Prevention efforts should reduce the occurrence of intimate partner violence by promoting healthy, respectful relationships. Healthy relationships can be promoted by addressing risk and protective factors at the individual, relationship, community, and societal levels. CDC developed the Intimate Partner Violence Prevention Resource for Action to help states and communities take advantage of the best available evidence to prevent intimate partner violence.

Prevention strategies and their corresponding approaches are listed in the table below.

Strategy	Approach
Teach safe and healthy relationship skills.	• Social-emotional learning programs for youth. • Healthy relationship programs for couples.
Engage influential adults and peers.	• Men and boys as allies in prevention. • Bystander empowerment and education. • Family-based programs.
Disrupt the developmental pathways toward partner violence.	• Early childhood home visitation. • Preschool enrichment with family engagement. • Parenting skill and family relationship programs. • Treatment for at-risk children, youth and families.
Create protective environments.	• Improve school climate and safety. • Improve organizational policies and workplace climate. • Modify the physical and social environments of neighborhoods.
Strengthen economic supports for families.	• Strengthen household financial security. • Strengthen work-family supports.
Support survivors to increase safety and lessen harms.	• Victim-centered services. • Housing programs. • First responder and civil legal protections. • Patient-centered approaches. • Treatment and support for survivors of intimate partner violence, including teen dating violence.

Preventing Sexual Violence & Intimate Partner Violence Training Guide

Definition of Sexual Violence: Anything involving the human body that is unwanted or unchosen is considered violence.

In the home care environment, we support principals to minimize Sexual Violence (SV) & Intimate Partner Violence (IPV) in the following way:

- **Bodily Autonomy** - Caregivers explain every step of every process of every care event. No coercion or fear-based tactics.
- **Empowerment** - Recipients of service should be given the right to make decisions regardless of abilities.
- **Setting the Stage** - We are setting expectations that care will morph and shift to the clients' needs and not the other way around.
- **Privacy/Anonymity/Confidentiality -** We as caregivers provide these rights to recipients of care through our words and actions.
- **Maintaining of Boundaries -** Maintaining boundaries means following the limits set to ensure the recipient of care's needs are respected.
- **Maintaining Dignity with Care -** Maintaining care with dignity means treating people with respect, compassion, and empathy, and supporting their independence.
- **Reporting -** If you have concerns about anything that you have observed, heard or done, you must talk to your supervisor.

Bodily Autonomy - The right to make decisions about your own body, life, and future, without coercion or violence. It includes the freedom to decide what happens to your body, whether it's choosing what to wear, making medical decisions, or deciding when, or whether any care event should happen.

Before we touch the recipient of service, we need to let them know what we are doing and why, we need to ask their permission, we do this for every step of the process. This gives the recipient of service the opportunity to exercise their right to decline or provide their opinion/wishes for the care event. All people, including non-verbal, should be given the right to make decisions. The right to care = the right to refuse.

Example: If you are going to wash their face, you need to let them know that your intent is to wash their face and that you are going to dampen a cloth with warm water and gently wipe their mouth. As you do each step, you tell them what you are doing and why. This gives them the opportunity to inform you that maybe they want a cold cloth or that they prefer a napkin.

Empowerment - When we have full bodily autonomy, not only are we empowered to make decisions about our health and future – without coercion or control by others – we also have the support and resources needed to meaningfully carry out these decisions.

By asking and explaining the care event and providing the opportunity for the recipient of care to express what they want, or what they don't, we are giving them the freedom to decide what

happens to their body without coercion or fear. We must explain every step of the process of every care event. If the recipient of care chooses not to continue the care event, and if it is not a matter of safety, we as caregivers are to respect this decision and not do the care event. We do not try to coerce them or bribe them. We can try to get to the reason why by asking them or we can ask if they would like the action done differently but if the answer is no, we move on.

Example: Caregiver, Alice, has let the recipient of care, Linda, know that she intend to wash Linda's make-up off of her face. Linda does not want her face washed and gets agitated and pushes the wash cloth away. Alice immediately stops and askes "Why do you not want your face washed". Linda says "I don't want to!". Alice patiently asks again why. Linda says "Because I look pretty". Alice puts the wash cloth down and does not wash Linda's face. Alice can explaining the result of not washing the makeup off and offering to help with makeup in the morning and it may assist Linda's decision, it may not. The final choice is Linda's

In this example washing the face was not a safety issue, a hygiene issue maybe, but did not pose a risk to Linda. Linda expressed bodily autonomy by stating that she did not want her face washed. Alice did not try to bribe or force the washing of the face. Chances are that by responding in this manner, Alice will see less resistance to all other things because Linda will not feel the loss of control that can potentially cause them to dig in and resist everything.

Setting the Stage – All practices should be person centered and empowering for the recipient of service and actively sets the stage for future interactions. We are setting expectations that care will morph and shift to the recipients needs and not the other way around. As a caregiver you are working with a recipient because you care. We are always setting up our recipients to experience respectful care and body autonomy. One day the care might not be from you. The recipient needs to know that they are in control of their body no matter who provides the care. With the caregiver explaining the care events, asking for permission and respecting the persons wishes, we give them the opportunity to embrace the right to express bodily autonomy in all situations. A caregivers role is to providing the recipient of services with the opportunity to have the maximum level of functionality free from other persons beliefs or perceptions.

Privacy/Anonymity/Confidentiality – Privacy is the ability to control when and how your personal information is given. Anonymity is the freedom to act without your actions connecting to your identity. Confidentiality means information shared with one party is still private to all others. We as caregivers provide these rights to recipient of care through our words and actions. Whether we are speaking to the recipient or to others we must be considerate of the words that we are saying and how our actions will protect their choices, privacy and person.

Examples:

- In a public setting, we must honor their desire to be identified or not.
- We should not speak on behalf of the recipient of care.
- We should honor their choices by not giving our input on them. The have the right to choose the movies they watch of the games they play without our opinion or input.
- Keep all records in the recipient's home, not in our personal possession, car, home or otherwise.
- Do not open their mail.
- Shut doors and/or close curtains when recipient of care is in any state of undress.

- Do not take pictures of the recipient of care or have them on your phone.
- Do not stay in the bathroom or in the bedroom with the recipient of care when dressing unless this is in the care or service plan due to listed safety concern.

Maintaining of Boundaries – Maintaining boundaries means following the limits set to ensure the recipient of care's needs are respected. Boundaries can be physical, emotional, time-based, or space-based. It is important to know the role that you are interacting with the recipient of care as. As a paid caregiver you now have two hats, the caregiver and the relation. These hats can not be worn at the same time. As the paid caregiver you must constantly ask yourself who are you being paid to be. It is your responsibility to carry out the care/service plan as written and nothing more. You may clock out at anytime and put your relation hat on but know that those are two very different roles. We also must be aware of how we know something about the recipient, do we know because we are the relation or the caregiver? We cannot let personal experience with the recipient of care dictate our actions when it comes to providing a care event.

Example: Linda has decided that she would like to walk around in her bra today with no shirt. As her caregiver it is your responsibility to honor those wishes, not try to coheres or change her mind and to respect her privacy by shutting the curtains. As her mother you may have an opinion about Alice walking around in her bra but as her caregiver you cannot. Which hat are you wearing?

Maintaining Dignity with Care – Maintaining care with dignity means treating people with respect, compassion, and empathy, and supporting their independence. It's a key factor in quality care and can be applied to both the recipient of care and caregiver. Care with dignity supports the self-respect of the person, recognizing their capacities and ambitions, and does nothing to undermine it. It includes respect for what they can do, who they are, and the life they've lived. It is our responsibility in facilitating them doing what they can do, rather than doing it for them.

Example: While assisting to use the bathroom it may be quicker to wash and dry their hands for them but if this is something that they are capable of doing then we must respect their independence, regardless of the time it takes.

Reporting – If you have concerns about anything that you have observed, heard or done, you must talk to your supervisor. As a paid care taker you are a mandated reporter and are legally required to report suspected or known abuse or neglect to the proper authorities. Do not assume or think that the concern will go away and it is not your responsibility to address this directly to the recipient of care or others involved in the concern. It is your responsibility to report it to your supervisor and let the supervisor do the research. Even if you only think it might be a concern, but you have no solid reason to suspect anything, it is your obligation to report this to your supervisor.

By supporting these 7 principals, we are doing our part as caregivers minimize Sexual Violence (SV) & Intimate Partner Violence (IPV).

STOP SV:

A Technical Package to Prevent Sexual Violence

National Center for Injury Prevention and Control
Division of Violence Prevention

STOP SV: A Technical Package to Prevent Sexual Violence

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2016

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Contents

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Overview of STOP SV

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to reduce sexual violence (SV) and its consequences. These strategies focus on promoting social norms that protect against violence; teaching skills to prevent SV; providing opportunities, both economic and social, to empower and support girls and women; creating protective environments; and supporting victims/survivors to lessen harms. The strategies represented in this package include those with a focus on preventing SV from happening in the first place as well as approaches to lessen the immediate and long-term harms of SV. Though the evidence for SV is still developing and more research is needed, the problem of SV is too large and costly and has too many urgent consequences to wait for perfect answers. There is a compelling need for prevention now and to learn from the efforts that are undertaken. Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business/labor, and government can bring about the successful implementation of this package.

What is a Technical Package?

A technical package is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome.[1] Technical packages help communities and states prioritize prevention activities based on the best available evidence. This technical package has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing SV. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The ***evidence*** for each of the approaches in preventing SV or its associated risk factors is included as the third component. This package is intended as a resource to guide and inform prevention decision-making in communities and states.

Preventing Sexual Violence is a Priority

SV is a serious public health problem that affects millions of people each year. SV involves a range of acts including attempted or completed forced or alcohol/drug facilitated penetration (i.e., rape), being made to penetrate someone else, verbal (non-physical) pressure that results in unwanted penetration (i.e., sexual coercion), unwanted sexual contact (e.g., fondling), and non-contact unwanted sexual experiences (e.g., verbal harassment, voyeurism).[2]

SV is highly prevalent. Approximately 1 in 5 women (19.3%) in the United States have experienced rape or attempted rape in their lifetime and 43.9% have experienced other forms of SV. For instance, 12.5% have experienced sexual coercion, 27.3% have experienced unwanted sexual contact, and 32.1% have experienced non-contact unwanted sexual experiences.[3] Although national prevalence studies indicate that women carry the greatest burden of SV over their lifetimes, men are also impacted by SV. Approximately 1 in 15 men (6.7%) have been made to penetrate someone at some point during their lives, 5.8% have experienced sexual coercion, 10.8% have experienced unwanted sexual contact, and 13.3% have experienced non-contact unwanted sexual experiences.[3]

As with other forms of violence, some racial/ethnic and sexual minority groups are disproportionately impacted by SV. Lifetime estimates of rape or attempted rape of women range from 32.3% among multiracial women, 27.5% among American Indian/Alaska Native women, 21.2% among Black women, 20.5% among non-Hispanic white women, to 13.6% among Hispanic women. Among men, 39.5% of multiracial men, 26.6% of Hispanic men, a quarter of American Indian/Alaska Native (24.5%) and Black men (24.4%), and 22.2% of non-Hispanic white men have also experienced some form of SV in their lifetime.[3] Furthermore, among sexual minorities, 46.1% and 13.1% of bisexual and lesbian women, respectively, have experienced rape at some point in their lives, and 74.9% and 46.4%, respectively, have experienced other forms of SV in their lifetime. Among men, 47.2% bisexual men and 40.2% gay men have experienced some form of SV other than rape in their lifetime.[4]

SV starts early in the lifespan. Among women reporting a history of completed rape, 40% first experienced it before age 18, with more than 28% indicating they were first raped between the ages of 11 and 17; among men who were made to penetrate someone, 71% first experienced this before the age of 25, and 21.3% experienced this before the age of 18.[3] While adolescence seems to be a period of high risk, college may also be a particularly vulnerable time. In a large, cross-sectional survey of campus sexual assault, 20% of the undergraduate women indicated that they had been a victim of SV since beginning college.[5]

SV is associated with several risk and protective factors. Risk for SV perpetration is influenced by a range of factors, including characteristics of the individual and their social and physical environments. These factors interact with one another to increase or decrease risk for SV over time and within specific contexts. Examples of key risk factors for SV perpetration include a history of child physical abuse, exposure to parental violence, involvement in delinquent behavior, acceptance of violence, hyper-masculinity, traditional gender role norms, excessive alcohol use, early sexual initiation and sexual risk-taking behavior (e.g., sex without a condom), and association with sexually-aggressive peer groups.[6] Poverty or low socioeconomic status,[7] gender inequality,[8] exposure to community crime and violence, social norms supportive of SV and male sexual entitlement, and weak laws and policies related to SV are also risk factors for SV perpetration.[6,9] Less is known about protective factors—that is, factors that decrease or buffer the risk for SV. However, the evidence suggests that greater empathy, emotional health and connectedness, academic achievement, and having parents who use reasoning to resolve family conflicts are associated with a lower risk of SV perpetration.[6]

SV is connected to other forms of violence. Research has demonstrated that experiences with SV are related to experiencing other types of violence. For example, girls who have been sexually abused are more likely to suffer physical violence and sexual violence re-victimization, and be a victim of intimate partner violence later in life.[10] In addition, perpetrating bullying in early middle school is associated with subsequent sexual harassment perpetration.[11] Adolescents who have experienced forced intercourse at some point in their life are more likely than those who have not been forced to have intercourse to have thoughts of suicide.[12] The overlap and co-occurrence of SV and other types of violence may reflect the presence of shared risk factors across the multiple violent behaviors and experiences. As such, approaches that address multiple forms of violence and/or risk factors that are shared across the types of violence may be an effective and efficient way to prevent violence.

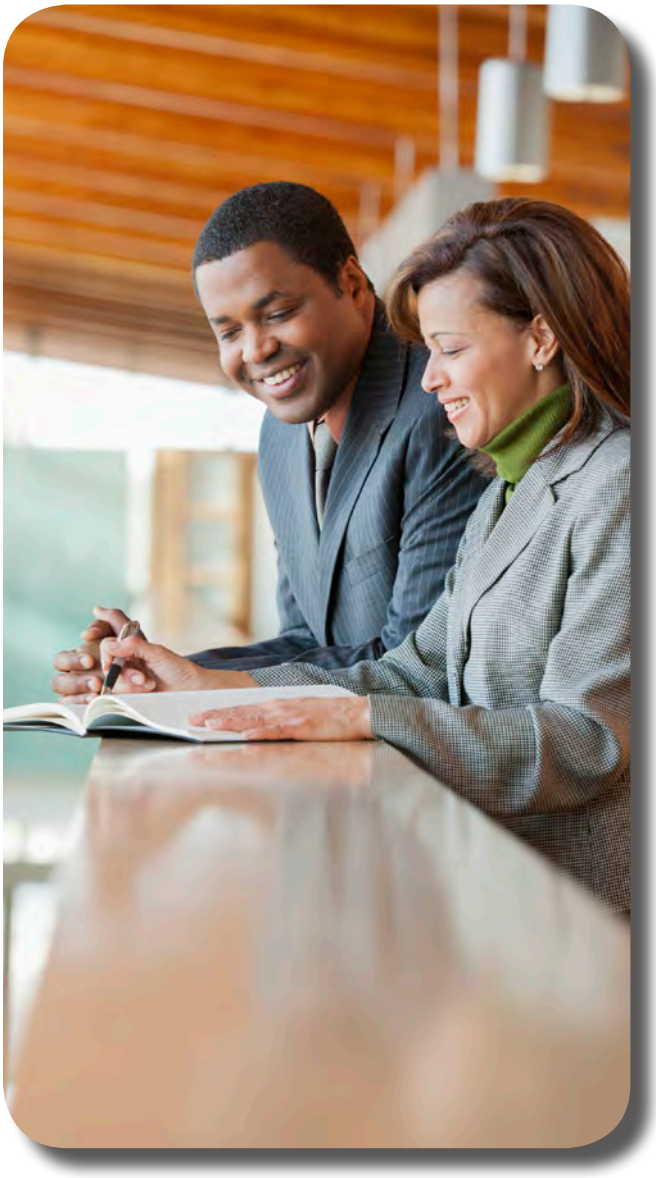
The health and economic consequences of SV are substantial. SV victimization may result in injuries that are physical (e.g., bruising, genital trauma) or psychological (e.g., depression, anxiety, suicidal thoughts).[13] The consequences of SV may also be chronic; some victims experience re-occurring gynecological, gastrointestinal, and sexual health problems.[13] Victims may also suffer from post-traumatic stress disorder.[13] SV is also associated with risk behaviors (e.g., smoking, excessive alcohol use) for chronic disease and medical conditions (e.g., high cholesterol, increased risk of a heart attack).[14] In addition, sexual abuse in childhood and forced sexual initiation in adolescence are associated with increased HIV- and STD-related risk-taking behaviors, including sex with multiple partners, sex with unfamiliar partners, sex with older partners, alcohol-related risky sex, anal sex, and low rates of condom use,[9, 15-17] as well as HIV infection in adult women.[18] Other negative consequences of SV victimization include decreased self-esteem and disruptions to daily routine.[19] Readjustment after victimization can be challenging and influences recovery time. Victims may have difficulty in their personal relationships, in returning to work or school, and in regaining a sense of normalcy.[13]

Society incurs significant costs associated with the long-term physical and mental health consequences of sexual victimization.[20-22] SV victims exceed non-victims in the average number and cost of medical care visits.[23] Beyond medical costs, there are productivity costs and other long-term costs to victims and their families such as pain and suffering, trauma, disability, and risk of death. For example, findings from one state estimated the total cost of SV in 2009 to be $4.7 billion, or about $1,580 per resident.[24] This estimate included quality of life, work loss, medical (including mental health), and criminal justice costs. In a qualitative study of SV survivors, Loya[25] found that SV and the trauma resulting from it can have an impact on the survivor's employment in terms of time off from work, diminished performance, job loss, or being unable to work. These impacts disrupt earning power and have a long-term effect on the economic well-being of SV survivors.

SV can be prevented. Public health underscores the importance of primary prevention, or preventing SV before it occurs.[26,27] A comprehensive approach with preventive interventions at multiple levels of the social ecological model (i.e., individual, relationship, community, and societal) is critical to having a population level impact on SV. Compared to other types of violence (e.g., youth violence) and other public health topics (e.g., HIV prevention), the evidence base for SV prevention is less developed. We must continue to build the evidence base of what works to prevent SV by investing in rigorous evaluation of promising prevention approaches. In the meantime, we must act on the evidence that does exist. There is evidence that some approaches, such as brief, one-session educational programs aimed at raising awareness and knowledge about SV, do not work to prevent SV perpetration.[28] To have the greatest impact on SV prevention, we must take advantage of the best available evidence and focus on the strategies and approaches most likely to impact SV.

Assessing the Evidence

STOP SV includes programs, practices, and policies with evidence of impact on SV victimization, perpetration, or risk factors for SV. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria: a) meta-analyses or systematic reviews showing impact on SV victimization or perpetration; b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on SV victimization or perpetration; c) meta-analyses or systematic reviews showing impact on risk factors for SV victimization or perpetration, or d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk factors for SV victimization or perpetration. Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.



Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of SV victimization or perpetration but instead are supported by evidence indicating impacts on risk factors for SV (e.g., rape-supportive peers, risky sexual behavior). In terms of the strength of the evidence, programs that have demonstrated effects on SV outcomes (reductions in perpetration or victimization) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community and societal level approaches on SV outcomes. Thus, approaches in this package that have effects on risk factors reflect the developmental nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy area in terms of the nature and quality of the available evidence. Not all programs, policies, or practices that utilize the same approach (e.g., bystander training, empowerment-based training) are equally effective, and even those that are effective may not work across all populations. Very few evaluations have looked at diverse populations (e.g., racial/ethnic or sexual minorities). It is also important to note that few programs have been designed for diverse populations, so tailoring programs and more evaluation may be necessary to address different population groups. The examples provided are not intended to be a comprehensive list of evidence-based programs, policies, or practices for each approach, but rather illustrate models that have been shown to impact SV victimization or perpetration or have beneficial effects on risk factors for SV. In practice, the effectiveness of the programs, policies and practices identified in this package will be strongly dependent on the quality of their implementation and the communities in which they are implemented. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

Context and Cross-Cutting Themes

The strategies and approaches in this package represent different levels of the social ecology with efforts not only intended to impact individual behaviors, but also the relationships, families, schools, communities, and social structures that influence risk and protective factors for SV and ultimately SV behaviors (see box below). Strategies and the approaches within them are intended to work in combination and reinforce each other to influence both individual and environmental factors related to SV. While individual skills are important and research has shown some skill-based programs to be useful for reducing SV, approaches addressing relationships, schools, communities and larger social forces are equally important for a comprehensive approach that can have the greatest public health impact.

The example programs, policies, and practices have been implemented within particular contexts. Each community and organization working on SV prevention across the nation brings its own social and cultural context to bear on the selection of strategies and approaches that are most relevant to its populations and settings. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

STOP SV

	Strategy	Approach
S	**Promote Social Norms that Protect Against Violence**	• Bystander approaches • Mobilizing men and boys as allies
T	**Teach Skills to Prevent Sexual Violence**	• Social-emotional learning • Teaching healthy, safe dating and intimate relationship skills to adolescents • Promoting healthy sexuality • Empowerment-based training
O	**Provide Opportunities to Empower and Support Girls and Women**	• Strengthening economic supports for women and families • Strengthening leadership and opportunities for girls
P	**Create Protective Environments**	• Improving safety and monitoring in schools • Establishing and consistently applying workplace policies • Addressing community-level risks through environmental approaches
SV	**Support Victims/Survivors to Lessen Harms**	• Victim-centered services • Treatment for victims of SV • Treatment for at-risk children and families to prevent problem behavior including sex offending

One important feature of the STOP SV package is the complementary, but potentially synergistic impact of the strategies and approaches. The strategies and approaches delineate prevention efforts that impact various SV-related outcomes. The *strategies* are not mutually exclusive categories, but each has an immediate focus. The strategy *Create Protective Environments*, for example, may ultimately impact SV social norms, but the immediate focus of this strategy is to change school, workplace and community environmental factors. Similarly, the *approaches* within any one strategy sometimes have components that cross other strategies. For example, *Mobilizing Men and Boys as Allies*, an approach in the *Promote Social Norms that Protect against Violence* strategy, includes fostering healthy dating relationships which is also found in some of the approaches under the *Teach Skills to Prevent SV* strategy.

The strategies and approaches in this package may impact other forms of violence,[29] which reflects the interconnectedness and overlap between SV risk and protective factors and risk and protective factors for other forms of violence. For example, a program within *Bystander Approaches* has not only been shown to reduce SV, but also dating violence and stalking.[30] In addition, the approach *Teaching Healthy, Safe Dating and Intimate Relationship Skills to Adolescents* includes an example program that has shown reductions in SV and also peer victimization and weapon carrying behavior.[31] Further, some of the approaches in this package address early exposures to violence which is a risk factor for later SV perpetration. For example, *Treatment for at-Risk Children and Families to Prevent Problem Behavior* reflects the strong connection between early witnessing or experiences of violence (e.g., child abuse and neglect) and SV.[6] Programs described under this approach are intended to promote training, therapy, and other supports early in life that can impact risk for SV in adolescence and adulthood.

SV prevention has always centered on issues related to gender, and gender equality is central to SV prevention. In the context of health and SV prevention, gender equality refers to equal rights, responsibilities and opportunities that enable all individuals to achieve their full rights and potential to be healthy, contribute to health development, and benefit from the results.[*,33,34] While most gender-based strategies are defined by male and female identities, it is important to recognize and affirm identities that do not necessarily fit into binary male or female sex categories.[33] Many in the field, particularly in the global context, refer to SV as a form of *gender-based violence* (GBV). In this technical package, the strategy *Provide Opportunities to Empower and Support Girls and Women* directly addresses gender equality through specific approaches intended to, for example, improve the social and economic status of girls and women. Gender, however, cuts across all strategies included in the technical package and is represented by approaches that influence both male and female gender norms, and other risk and protective factors. For example, the approach *Mobilizing Men and Boys as Allies* in preventing SV perpetration is intended to foster healthy, positive norms about masculinity, gender and violence. In addition, approaches included under other strategies focus on environmental factors that influence social norms related to violence, including gender norms.

The strategies and approaches in this technical package address prevention across the lifespan. Addressing SV over the lifespan requires particular attention to children's critical developmental years and the connections between childhood victimization experiences and health and well-being later in life. The experience of violence early in life is not only traumatic in childhood, but manifests in poor mental and physical health outcomes, as well as increased risk for SV victimization or perpetration later in life. Approaches that promote safe, stable and nurturing relationships and environments for children and their families[35] are important foundational steps in a comprehensive SV prevention effort. Indeed, many of the strategies and approaches in this technical package are focused on children and youth given that SV tends to happen early in life for victims.

* Some gender-based initiatives use the term *gender equity*, which is related to, but not necessarily a synonym for gender equality. *Gender equity* refers to "fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but which is considered equivalent in terms of rights, benefits, obligations and opportunities."[32] We use the term *gender equality* in the package to be consistent with the literature we are citing.

Several approaches in the technical package focus on preventing SV perpetration. This is in keeping with CDC's emphasis on promoting prosocial behavior and creating the context for non-violent behavior, relationships, and norms to prevent SV. Preventing behavioral patterns of aggression and violence, particularly from taking shape in the first place, is an important step toward achieving population-level reductions in rates of SV. Other approaches in STOP SV focus on treatment or risk reduction for SV victimization. For example, *Treatment for Victims of SV*, an approach in the *Support Victims/Survivors to Lessen Harms* strategy, is exclusively focused on helping victims after victimization occurs. *Empowerment Based Training* is one approach under the *Teach Skills to Prevent SV* strategy that focuses on reduction of risk for SV victimization. Similarly, approaches within the *Provide Opportunities to Empower and Support Girls and Women* strategy aim to strengthen economic supports, leadership, and opportunities for girls and women to reduce risk for SV victimization. These approaches can serve as a useful and effective complement to efforts focused on the prevention of perpetration, particularly when implemented as part of a comprehensive, multifaceted prevention effort. It is critical that any program, practice, or policy focused specifically on reducing risk for victimization avoid placing any responsibility, implied or explicit, for potential victimization on participants.

Implementing STOP SV will require the engagement and investment of multiple sectors. STOP SV includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business/labor is critical to implement a particular policy or program (e.g., workplace policies). The role of various sectors in the implementation of a strategy or approach in STOP SV is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing SV are described.

Promote Social Norms that Protect Against Violence

Rationale

Changing social norms that accept or allow indifference to violence is necessary to prevent SV. Norms are group-level beliefs and expectations about how members of the group should behave. The group can be large or small, ranging from the cultural norms of an entire country to those of a small sub-population. Gender norms define appropriate behaviors for men and women, and girls and boys, in terms of roles, behavior, and how to relate to one another. Restrictive gender norms (i.e., rigid ideas about the appropriate roles and behavior of men and women) can serve to support or condone violent behavior in intimate and other relationships. Studies show that individuals and communities adhering to restrictive and harmful social norms are more likely to perpetrate physical, sexual, and emotional violence against women.[6,9]

Approaches

The following approaches seek to change social norms in ways that protect against SV.

Bystander Approaches. These types of approaches engage individuals to change social norms and provide leadership around preventing SV. These types of approaches engage people, often youth, with the purpose of promoting social norms that protect against violence. They are also used to motivate people to promote protective norms through providing peer leadership around preventing SV and to help when they see behavior that puts others at risk and take appropriate steps to safely and effectively intervene. Bystander approaches have typically been evaluated in high school and college settings.

Mobilizing Men and Boys as Allies. These approaches provide an opportunity to encourage men and boys to be allies in preventing sexual and relationship violence by demonstrating their role in preventing violence and supporting victims while also teaching skills and reinforcing norms that reduce their own risk for future perpetration. Such approaches work by fostering healthy, positive norms about masculinity, gender, and violence among individuals with potential for these social norms to spread through their social networks. Approaches focused on male audiences can be implemented in targeted peer groups, such as sports teams or fraternities, or can recruit men from high schools, colleges, or community-based organizations for participation. Some programs for youth utilize adult male implementers who can serve as strong role models for healthy, positive definitions of masculinity.

Potential Outcomes

- Reductions in acceptability of SV
- Increases in favorable beliefs towards safe communities
- Increases in favorable attitudes towards women and girls
- Increases in recognition of abusive behavior towards men, women, and children
- Increases in bystander behavior to prevent violence against men, women, and children
- Reductions in negative bystander behavior
- Reductions in the perpetration of SV
- Reductions in the perpetration of related forms of violence (e.g., stalking, dating violence, intimate partner violence)
- Reductions in peer support for violence

Evidence

There is some evidence suggesting that bystander approaches and approaches that mobilize men and boys as allies can prevent SV perpetration.

Bystander Approaches. Experimental evaluations show that programs such as *Bringing in the Bystander* and *Green Dot* can empower young people to intervene in their peer groups by speaking up against sexist language or behaviors that promote violence, reinforcing positive social norms, and offering help or support in situations where violence may occur or has occurred.[36-38] Evidence suggests that these programs can increase positive bystander intervention behaviors (e.g., stepping in to help or speaking up) and increase participants' confidence in their own ability to intervene to prevent violence. Evaluations of *Bringing in the Bystander* show increases in self-efficacy and intentions to engage in bystanding among college students[36] and bystander behaviors that involve helping friends.[39]

An evaluation of *Green Dot* implemented with college students found the intervention campus had an 11% lower rate of sexual harassment and stalking victimization and a 19% lower rate of sexual harassment and stalking perpetration when compared to two non-intervention campuses.[38] Another evaluation found that *Green Dot* substantially decreased SV, including sexual harassment, dating violence, and stalking in high schools, including a decrease in SV perpetration.[30]

Mobilizing Men and Boys as Allies. Several programs have been developed and implemented across the country and internationally that focus on engaging men and boys as allies, modeling positive masculinity, and changing social and peer-group norms related to relationships, violence, and sexuality, but few have yet been evaluated and more evidence is needed to understand the effectiveness of these approaches.[40] *Coaching Boys into Men* is an example of a program with rigorous evaluation evidence that engages boys through high school athletics by providing coaches with training tools to model and promote respectful, non-violent, healthy relationships with their male athletes. *Coaching Boys into Men* has been shown to decrease negative bystander behavior (e.g., laughing at sexist jokes) and decrease dating violence perpetration, including physical, sexual, and emotional abuse, among male high school athletes.[41, 42]

Several programs have been developed and implemented that focus on engaging men and boys as allies, modeling positive masculinity, and changing social and peer-group norms related to relationships, violence, and sexuality.

Teach Skills to Prevent Sexual Violence

Rationale

Individual skill-based learning is an important component of a comprehensive approach to SV prevention. Several individual skills are associated with preventing SV, including social-emotional learning skills (e.g., empathy, conflict management, and communication), healthy dating and intimate relationship skills, skills related to healthy sexuality, and empowerment skills. Building individual skills in these areas can help reduce both perpetration of and victimization from SV including sexual harassment, as well as bullying, dating violence, and other factors associated with SV (e.g., empathy, increased communication about sex).

Approaches

There are a number of approaches that utilize skills-building training to address SV perpetration, victimization or risk factors for SV. These include:

Social-emotional learning approaches. These approaches work in childhood and adolescence to enhance a core set of social and emotional skills including communication and problem-solving, empathy, emotional regulation, conflict management, and bystanding skills. In addition to providing information about violence, these approaches focus on changing the way children and adolescents think and feel about violence and provide opportunities to practice and reinforce skills. These approaches have typically been used in middle and high school settings.

Teaching healthy, safe dating and intimate relationship skills to adolescents. These programs strive to reduce SV that occurs in the context of dating and intimate partner relationships. Such approaches can work to build communication and conflict resolution skills as well as expectations for caring, respectful, and non-violent behavior. Opportunities to practice and reinforce these skills are an important part of prevention programs that work. Although typically implemented with adolescent populations in school-based settings, these approaches and skills may also be useful with young adults.

Promoting healthy sexuality. These approaches focus on comprehensive sex education that addresses sexual communication, sexual respect, and consent. These approaches protect against SV by increasing awareness of risks and improving communication between parents and youth. They are also cross-cutting in that they often focus on sexual health (e.g., risk for HIV or STDs, pregnancy prevention) as well as empowering youth to reduce risk for SV and dating violence by encouraging sexual communication and healthy sexual behavior. Although these approaches focus on sexual health outcomes, they may also result in decreased risk for SV due to impacts on shared risk factors. Specifically these approaches focus on such things as delaying sexual initiation as well as reducing sexual risk-taking (e.g., sex without a condom, multiple sexual partners, and preference for impersonal sex) which are all risk factors for SV perpetration as well as for STDs and other negative sexual health outcomes.[6]

Empowerment-based training for women to reduce risk for victimization. These approaches focus on strengthening the ability of women to assess risk for violence in relationships and situations and empowering them to act. They address potential emotional and physical barriers that may inhibit actions to reduce risk for sexual victimization, such as fear, internalized sex role norms, or physical size and strength. Empowerment-based approaches that focus on increasing participants' self-efficacy to identify and reduce exposure to risky situations and people through intensive skills training have greater research and theoretical support than approaches focused primarily on physical self-defense training. Empowerment-based training approaches have typically been implemented and evaluated with college populations.

Potential Outcomes

- Reductions in SV victimization and perpetration
- Reductions in sexual harassment perpetration
- Reductions in teen dating violence victimization and perpetration
- Reductions in stalking victimization and perpetration
- Reductions in homophobic teasing victimization
- Increases in self-efficacy and intentions to engage in active bystanding behavior
- Reductions in peer victimization
- Reductions in weapon carrying
- Reductions in sexual risk behaviors (e.g., sex without a condom, number of sexual partners)

Evidence

The current evidence suggests several approaches to teach skills that can lead to reductions in SV perpetration and victimization or their risk factors.

Social-emotional learning approaches. These types of approaches have demonstrated reductions in peer violence[43] and may also prevent SV. One example is the *Second Step: Student Success through Prevention* program, which is a social-emotional skills based program for middle school students aimed at reducing bullying and SV perpetration. The program is delivered over 15 weeks by teachers and includes content related to bullying, problem-solving skills, emotion management, and empathy. Lessons are highly interactive and incorporate small-group and classroom discussions, activities, dyadic exercises, and individual work. A rigorous multi-site evaluation found that *Second Step* was associated with a 39% reduction in SV perpetration and a 56% reduction in homophobic teasing victimization in one of the two states where it was implemented; implementation differences between sites may account for the variation in effectiveness.[44]

Teaching healthy, safe dating and intimate relationship skills to adolescents. These approaches, often delivered in school settings, build the skills needed to support healthy, safe relationships. One example is the *Safe Dates* program, which focuses on teaching healthy relationship skills to adolescents, including positive communication, anger management, and conflict resolution. *Safe Dates* includes a 10-session curriculum focused on attitudes and behaviors associated with dating abuse and violence, as well as a play to set the stage for the program, a poster contest to reinforce concepts learned in the curriculum, and parenting materials. Results of a rigorous evaluation found that *Safe Dates* reduces physical and sexual violence perpetration and victimization within the dating context among 8th and 9th graders. Youth exposed to *Safe Dates* reported from 56% to 92% less dating violence victimization and perpetration compared to controls at follow-up. The effects of the *Safe Dates* program were sustained for four years after implementation.[45] Additional research found that *Safe Dates* also reduced peer victimization and weapon carrying behavior among youth receiving the intervention one year after the intervention.[31] The program has also been found to have similar effects for males and females and for racial minority and non-minority adolescents.[45]

Promoting healthy sexuality. Comprehensive sex education programs have been shown to reduce high risk sexual behavior,[46] a clear risk factor for SV victimization and perpetration.[6,47]

Strong African American Families (SAAF) is a prevention program developed for rural African American parents and their preadolescent children. The program seeks to prevent adolescent problem behaviors, including early sexual involvement and risky sexual behavior, by focusing on protective parenting practices (e.g., parental involvement, limit setting, consistent discipline, monitoring, adaptive racial socialization, general communication, and specific parent-child communication and expectations around sexual behavior, alcohol, and substance abuse). A rigorous evaluation of *SAAF* found improvements in parenting practices among parents in the intervention group relative to those in the control group.[48] Long-term follow up assessments when youth were 17 years old (65 months from pre-test) demonstrated that changes in parenting practices mediated changes in sexual behavior among the youth. Intervention youth (vs. controls) had higher levels of self-pride and protective sexual norms, which in turn resulted in later onset of sexual behavior and engagement in fewer high-risk sexual behaviors.

Another example is the *Safer Choices* program which is a multi-component educational program focused on HIV, other STDs, and pregnancy prevention and designed to reduce sexual risk behaviors and increase protective behaviors among high school students.[49] *Safer Choices* includes student, school staff and parental components. A rigorous evaluation of *Safer Choices* involving 3,869 ninth-grade students revealed that students in schools that received *Safer Choices* (compared to students in comparison group schools that received a standard HIV knowledge-based curriculum) showed reductions at 31 month follow up in several high-risk sexual behaviors (e.g., frequency of intercourse without a condom, number of sexual partners with whom students had intercourse without a condom).

Empowerment-based training for women to reduce risk for victimization. The *Enhanced Assess, Acknowledge, Act* program is a 12-hour victimization prevention program for college-aged women that provides education and skills training with the goal of being able to assess risk from acquaintances, overcome emotional barriers in acknowledging danger, and use verbal and physical strategies to reduce risk for violence. In a rigorous study of Canadian college women, participants were 50.4% less likely to have experienced a rape and/or attempted rape at one year follow-up than a control group. Risk of sexual coercion and other non-consensual sexual contact was also significantly lower in the intervention group.[50]

Provide Opportunities to Empower and Support Girls and Women

Rationale

Empowering and supporting girls and women through education, employment, income supports and providing other opportunities (e.g., for leadership, civic participation) is important for reducing women and girls' risk for SV. Studies show that gender inequality in education, employment, and income results in increased risk for SV.[8,51] Poverty and low income status have been directly linked to SV and sexual trafficking[7,52] and are conceptually linked to vulnerability for abuse in that they force women and their children into situations that may put them at increased risk for SV, such as walking home alone, living in unstable and unsafe housing, limiting the time and opportunities parents have to supervise their children, or engaging in sex work out of financial necessity.[53] Cross-national evidence indicates that rates of SV are lower in countries where women have higher educational and occupational status.[54] Policies and programs that improve economic security and stability for women and provide women and girls with opportunities to strengthen their education, employment, and income outcomes can reduce the risk for SV victimization.

Approaches

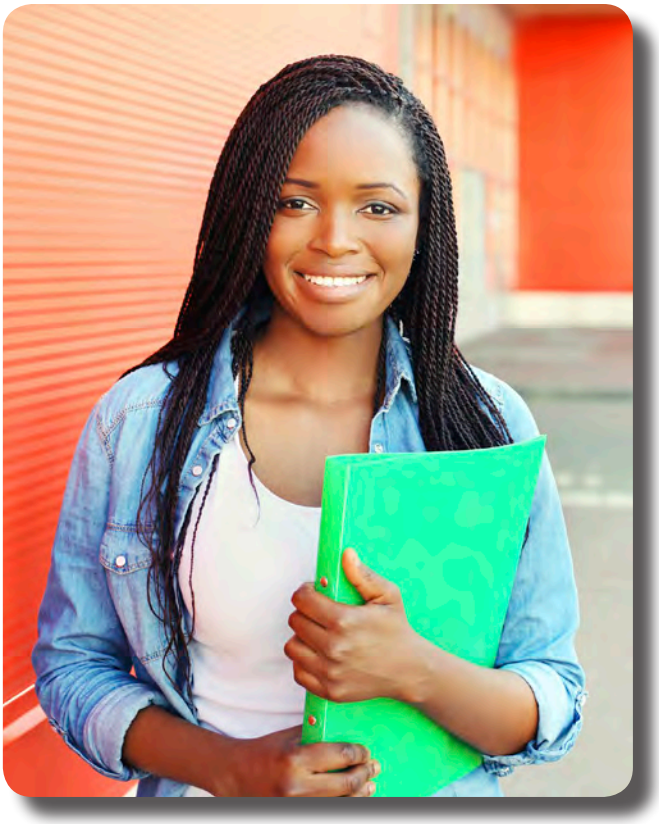
Two approaches to empower and support girls and women in ways that can reduce their risk for SV include strengthening economic supports and increasing leadership opportunities.

Strengthening economic supports for women and families. This approach addresses poverty, economic security, and power imbalances between women and men. The economic security of families depends on women's access to full and equal labor force participation, including having comparable salaries to men, income generating options, and work supports such as affordable quality child care through vouchers, lower cost child care, or cash-transfers to off-set the cost of quality, full-time child care. Provision of these types of supports to ensure women can remain in and contribute substantially to the workforce not only improves their economic conditions and promotes family stability, but also decreases gender inequality, which has been linked to risk for SV.[8,54] Paid family and medical leave is also critical because it provides income replacement to workers for life events such as the birth of a child or a short- or long-term illness. When these life events arise, women and children can become vulnerable to financial, employment, and housing instability, increasing their risk for SV victimization.[7,55]

Strengthening leadership and opportunities for adolescent girls. Programs that build confidence, knowledge, and leadership skills in young women can lead to greater outcomes in education, employment, and community engagement, including political participation. Such programming ideally involves girls as leaders in planning, development, and implementation. Effective programs also support family involvement and provide opportunities for girls to connect with their cultural and community identities. Effective girls' programming provides a safe space for girls to grow and connect while developing leadership skills and abilities.[56] Such approaches may improve girls' educational and occupational opportunities and contribute to the status and influence of women in society, potentially reducing risk for SV, given the links between gender inequality, low SES, educational and occupational status of women, and risk for SV.[7,8,54]

Potential Outcomes

- Increases in economic stability for women
- Increases in equitable education opportunities
- Increases in gender equality and economic and occupational status of women
- Decreases in poverty of women and children
- Decreases in pay differentials between women and men
- Increases in employment stability for women
- Reductions in sexual violence victimization
- Reductions in sexual harassment
- Reductions in sexual trafficking
- Increases in knowledge of gender norms and health
- Increases in knowledge and skills for girls on healthy relationships, education and employment, and civic engagement
- Increased leadership skills for girls and young women



Evidence

There are a number of policies and programs with evidence of impact on gender inequality and related risk factors for SV.

Strengthening economic supports for women and families. The majority of states have equal pay laws, although the laws themselves vary in terms of the populations covered, remedies available to employees, and the nature and extent to which comparable worth provisions are included.[57,58] *Comparable worth*—which means equal pay for women and men for *equivalent work*—is determined by measuring the skill, working conditions, effort, and responsibility of positions, and determining pay rates based on these factors.[59] Studies of the potential impact of a national comparable worth policy on earnings inequality show decreases in overall earnings inequality, inequality between women and men, and inequality among women.[60,61] More recent findings from an analysis of the 2010-2012 Current Population Survey Annual Social and Economic supplement show potential impacts on women's annual earnings, annual family income, and poverty rates even after controlling for labor supply, human capital, and labor market characteristics.[62] These policies could have an impact on reducing SV by increasing economic stability of women and their families, given that economic inequality is a known risk factor for SV victimization.[7]

Adequate work supports such as affordable and good quality child care are essential to working parents, particularly single mothers. The evidence indicates that child care prices can significantly impede married mothers' labor force participation.[63] Family-friendly policies such as maternity benefits and paid family and medical leave can also contribute to economic security. Women with maternity benefits are more likely to return to their original employers.[64] A related benefit is that mothers who are employed prior to child birth and who delay returning to work after giving birth experience fewer depressive symptoms than those who return to work earlier,[65] which suggests the importance of maternity leave on the psychological well-being of mothers. While affordable child care and paid family leave policies have not been directly linked to reductions in SV, the literature suggests they are linked to mothers staying employed, which may be protective against SV victimization given the links in the literature between unemployment and SV.[7]

Income generating options such as *Microfinance* provide loans and savings opportunities to low-income households to improve the financial and social status of women and families.[66] Microfinance typically includes incentives for repayment (e.g., access to future loans), and social supports such as borrower groups in which members collectively guarantee loans for each other. Loan and savings programs are sometimes combined with participatory multi-session training on topics that promote empowerment and influence women's social status and health including domestic violence, gender norms, sexuality and HIV. Microfinance is supported by theories of sustainable living that hypothesize that individuals and families draw from multiple types of capital—including financial, social, human, natural and physical resources—to make a living and survive.[53] Kim et al.[67] and Pronyk et al.[68] found that microfinance in combination with training on gender norms and health topics reduced participants experience with past-year physical and sexual intimate partner violence by half after two years in the program. Although microfinance has been mostly studied in low income countries, the application of sustainable living is relevant to the experiences of poor women living in the United States, and microfinance opportunities are viable options for increasing women's household income. This is likely to protect against SV victimization given low income puts women at risk for SV.[7] There are organizations providing this type of lending in the United States.

Strengthening leadership and opportunities for adolescent girls. These programs work by building confidence and leadership skills in young women as a way to influence their potential in education, employment, and community engagement. One example is *Powerful Voices*, a Seattle, Washington-based organization that provides opportunities for adolescent girls to develop individual leadership skills, while also seeking to address root issues for gender inequity through social justice. *Powerful Voices* offers several programs, including: *Powerful Choices*, a middle school curriculum for girls; girl justice training; *Girlvolution* Conference; community coalitions led by girls; and the *Youth Employment Program* for adolescent girls to build their marketability and job readiness. Evaluation results show that after participating in the program, the majority of girls had increased connection to their cultural identity and values, increased their ability to develop healthy relationships with peers and adults, received performance evaluations indicating "good" or "excellent" job skills, and had increased motivation to excel at school.[69] While there is not empirical evidence linking this program to reductions in SV, it is expected that school success and improved job skills in adolescence will lead to reduced risk of poverty and low educational attainment which are known risk factors for SV victimization.[7]

Policies and programs that improve economic security and stability for women and provide women and girls with opportunities to strengthen their education, employment, and income outcomes can reduce the risk for SV victimization.

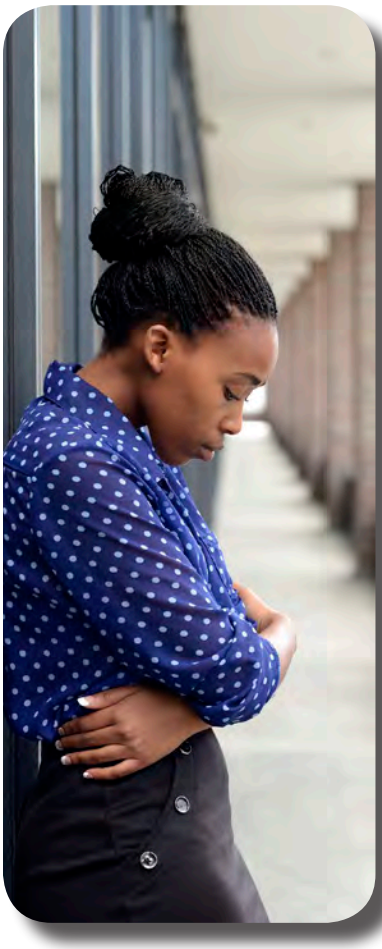
Create Protective Environments

Rationale

Creating protective community environments is a necessary step towards achieving population-level reductions in SV. Communities can include any defined population with shared characteristics and environments, including schools, neighborhoods, cities, organizations (e.g., workplaces), or institutions. Approaches that operate by modifying characteristics of the community, rather than individuals within the community, are considered community-level approaches. Such approaches can involve, for example, changes to policies, institutional structures, or the social and physical environment in an effort to reduce risk characteristics and increase protective factors that affect the entire community. Characteristics of the social and physical environment can have a significant influence on individual behavior creating a context that can promote positive behavior or facilitate harmful behavior. Although the evidence base supporting community-level approaches to prevent SV is less developed than the individual- or relationship-level evidence base, it is growing.

Approaches

The current evidence suggests three approaches with promise for modifying community-level characteristics associated with SV to create protective environments. These include:



Improving safety and monitoring in schools. These approaches monitor and modify physical and social characteristics of the school environment to reduce SV by addressing areas where students feel less safe, to identify safe spaces and staff support for students, and to create an atmosphere of intolerance for harassment and violence. Although these approaches can have an impact on their own, they can be implemented in conjunction with other efforts to educate, teach skills, and change social norms related to sexual and relationship violence in schools. Such approaches have typically been used in middle and high school environments, but could be adapted for use on college campuses or other settings.

Establishing and consistently applying workplace policies. Workplace policies address risk factors for SV and create healthy organizational climates. These policies are designed to help employees and managers know what is expected of them with respect to standards of behavior and can prevent workplace bullying and sexual harassment. Research indicates that individual characteristics and organizational characteristics interact to create an environment in which sexual harassment is tolerated.[70] Sexual harassment is a form of SV[2] and it also creates conditions that are conducive to other forms of SV.[71,72] Individual characteristics can be mitigated by changing the organizational culture and tolerance of sexual harassment.

Addressing community-level risks through environmental approaches. These approaches address aspects of neighborhood and other community settings to make SV less likely. Such approaches address community-level risk factors by changing, enacting, or enforcing laws, regulations, or organizational policies (e.g., alcohol policies) or by changing the physical environment, economic or social incentives (or consequences) for behavior, or other characteristics of the community (e.g., ability to monitor and respond to problem behavior, increased social controls). Community-level environmental approaches have potential for population-level impact on SV outcomes, often at low cost for implementation.

Potential Outcomes

- Reductions in perceived tolerance of sexual harassment and violence in communities
- Reductions in sexual harassment
- Reductions in excessive alcohol use at the community level
- Increases in indicators of community connectedness
- Increases in feelings of safety in one's school, workplace, or neighborhood
- Reductions in rates of SV at the community level
- Reductions in bullying and other youth violence
- Reductions in teen dating violence

Evidence

Current evidence provides some support for these types of approaches in reducing risk for SV.

Improving safety and monitoring in schools. Research has found that modifying the physical environment of schools to increase monitoring in areas perceived as unsafe can have a beneficial impact on rates of sexual harassment, other SV, and dating violence among students. *Shifting Boundaries* building-level intervention is an example of a school-based intervention that involves (a) revising school protocols for identifying and responding to dating violence and sexual harassment, (b) the use of temporary building-based restraining orders to reinforce respectful boundaries between victims and perpetrators, (c) a poster campaign, and (d) increasing staff monitoring based on "hotspot" mapping that students complete. *Shifting Boundaries* building-level intervention was found to reduce peer SV perpetration by 40% and sexual harassment perpetration by 34% among middle school students in New York City in a rigorous evaluation.[73] Reductions were also found for peer SV victimization and SV victimization by a dating partner.

Establishing and consistently applying workplace policies. *Proactive Sexual Harassment Prevention Policies and Procedures* that include commitment from top management, zero tolerance, notification to applicants and new hires of harassment-free environments, regular organizational assessments, and consistent, specific training can reduce workplace SV behaviors. A national study of Canadian women[74] found that proactive versus information-only policies were associated with fewer incidents of sexual harassment in the past 12 months. Women in workplaces with proactive sexual harassment policies were less likely to be physically threatened or to be the targets of unwanted sexual behavior or comments. Women also responded more assertively to unwanted sexual behavior when the workplace implemented policy, complaint procedures, and training to prevent sexual harassment. A more recent review of previously published workplace ethnographies found that having formal, written grievance procedures protected women from predatory harassment—the most threatening and well-defined form of sexual harassment.[71]

Addressing community-level risks through environmental approaches. Research suggests that changes to *alcohol-related policies* can reduce risk for SV at the community level.[75] Excessive alcohol use interacts with other individual and community-level risk factors to increase the risk for SV perpetration. Also, the location and concentration of alcohol outlets in a community can have a negative impact on characteristics of the community, including perceived safety and social connections between individuals, which can in turn influence rates of violence. Alcohol policy approaches with the strongest evidence related to SV are those which work to reduce excessive alcohol use by increasing prices or reducing the density of outlets in a community. Research has found that higher alcohol prices are associated with lower rates of SV victimization in communities, while greater outlet density is linked to higher rates of SV.[75]

Support Victims/Survivors to Lessen Harms

Rationale

Violence victimization in childhood, adolescence, or adulthood can have long-term effects on the psychological well-being and functioning of survivors.[12,13,76] Exposure to violence and other trauma in childhood can also increase risk for later SV perpetration and other problem behaviors in adolescence and adulthood.[6] To lessen these harms, this strategy employs the use of evidence-based therapeutic and victim centered approaches that address the needs of survivors to improve their outcomes and reduce long-term risks for negative psychological and behavioral consequences. Approaches for youth, including those at risk for or who have engaged in sexual offending behaviors, often address the needs of the family as well to improve parent-child relationships and increase the supports available to youth and their parents in their homes and communities.

Approaches

The current evidence suggests the following three approaches:

Victim-centered services. These approaches include an array of formal services such as support groups, crisis intervention, medical and legal advocacy, and access to community resources to help improve outcomes for survivors and mitigate long-term negative health consequences. Services are based on the unique needs and circumstances of victims and survivors and coordinated among community agencies and victim-advocates.

Treatment for victims of SV. These approaches include a range of evidence-based psychological interventions that are conducted in therapeutic settings by licensed providers. Psychosocial interventions help address depression, fear and anxiety, problems adjusting to school, work or daily life and other symptoms of distress associated with experiencing SV. These types of interventions are associated with improved psychological health and long-term positive impact for victims/survivors of SV.[77,78] Some programs are designed for specific populations of SV victims (i.e., child vs. adult).

Treatment for at-risk children and families to prevent problem behavior, including sex-offending. Many youth at risk for violence perpetration and other serious behavioral problems in childhood and adolescence have been exposed to violence in their homes or communities as witnesses or victims.[79] These intensive therapeutic approaches address the individual, family, school and community factors associated with violence perpetration, including sexual offending among these high-risk and high-need youth. Importantly, these approaches also focus on strengthening parent-child relationships and parental outcomes, such as stress and depression, which influence parenting behaviors that may impact children's risk for SV perpetration.

Potential Outcomes

- Reductions in short- and long-term negative effects of SV victimization
- Reductions in risk for later SV perpetration among victimized youth
- Reductions in parental stress and depression and improvements in parenting outcomes for parents of youth with behavioral problems
- Improvements in parental limit setting, parent-child communication, and youth's prosocial behavior
- Reductions in problematic sexual behavior reoffending
- Reductions in arrests for sexual crimes
- Improvements in family cohesion and adaptability
- Improvements in peer relations, including aggression
- Improvements in academic performance
- Improvements in access to services for SV survivors

Evidence

There is strong support for the value of victim-centered services and therapeutic approaches in reducing the short- and long-term impacts of SV. Examples of specific approaches with evidence include:

Victim-centered services. Rape Crisis Centers provide a safe, healing environment in which survivors can access resources and victim advocacy, and studies show that survivors consider the services received as healing and helpful.[80] A study conducted in one state found that most victims accessing advocacy services reported high levels of information (62%), support provision (79%), and help in making decisions (54%).[81] Victims who work with advocates had more positive experiences with both the medical and legal systems, including increased reporting and receipt of medical care, and decreased feelings of distress.[82] Other types of services include Sexual Assault Response Teams and Sexual Assault Nurse Examiner programs. These are valuable and widely-used practices but currently have not been rigorously evaluated.

Treatment for victims of SV. There are a number of evidence-based treatments for victims of SV. One example is *Trauma-focused Cognitive Behavioral Therapy (TF–CBT)* which is a widely-used, evidence-based treatment for children, adolescents, and their non-offending parents/caregivers. The goals of *TF–CBT* are to address the negative effects of sexual abuse (e.g., post-traumatic stress disorder [PTSD], depression, anxiety, and emotional and behavioral problems). *TF–CBT* also enhances parents' skills to respond to and support their children who have been victims.[83] Multi-site randomized controlled trials have shown that *TF–CBT* can reduce symptoms of PTSD, depression, and behavioral problems in child victims of sexual abuse. Research also indicates that improvements are sustained for 6–12 months after treatment has concluded.[84,85] Several psychological interventions, including exposure interventions and eye movement desensitization and reprocessing interventions, have also been shown to reduce psychological symptoms and improve functioning for survivors of SV.[78] Two specific therapeutic modalities show particular promise given evidence of continued effects at long-term follow-up. *Cognitive Processing Therapy (CPT)* is an evidence-based psychological treatment that addresses PTSD symptoms among victims of trauma, including rape, using a trauma-specific adaptation of cognitive behavioral therapy. *Prolonged Exposure Therapy (PET)* is an evidence-based psychological treatment that addresses PTSD symptoms through the use of exposure therapy. *PET* has been used to treat victims of rape and other trauma, such as war veterans. Both *CPT* and *PET* were associated with sustained improvements in PTSD and depression symptoms at 6-year follow-up among adult rape victims in an RCT.[86]

Treatment for at-risk children and families to prevent problem behavior, including sex-offending. The evidence is also strong for therapeutic approaches that focus on high-risk children who may have been exposed to violence in their homes and communities and are at risk for violence perpetration and other serious behavioral problems. One example is the *Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-Age Program (PSB–CBT)*. *PSB–CBT* is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems. The program is an outpatient group treatment program for children ages 6 to 12 years and their parents or other caregivers. Treatment for the child focuses on acknowledging and identifying inappropriate sexual behavior, learning sexual behavior rules and self-control techniques, and sex education. Parents and caregivers receive information on developmentally normal and atypical childhood sexual behavior and are taught skills for preventing and responding to the child's problematic sexual behavior. In a 10-year prospective study of children aged 5–12 with sexual behavior problems, significant reductions in re-offending were noted for the *PSB–CBT* treatment group when compared to a play therapy group (2% vs 10%), and the *PSB–CBT* group was reduced to baseline, general-clinic population levels that are very low.[87] In other research, *PSB–CBT* has demonstrated improvements in child sexual behavior problems at post-treatment and/or follow-up.[88,89]

Multisystemic Therapy—Problem Sexual Behavior (MST–PSB) focuses on aspects of a youth's ecology that are functionally related to problem sexual behavior and includes reduction of parent and youth denial about the sexual offenses and their consequences; promotion of the development of friendships and age-appropriate sexual experiences; and modification of the individual's social perspective-taking skills, belief system, or attitudes that contributed to sexual offending. Families are provided family therapy; youth are provided individual therapy. Bourduin and colleagues[90] found *MST–PSB* participants had fewer rearrests for sexual crimes compared with the control group, and 83% fewer arrests for sexual crimes at eight-year follow-up.[91] In the same study they also found improvements in family relations, peer relations, and academic performance. In a randomized clinical trial with juvenile sex offenders, Letourneau and colleagues[92] found *MST–PBS* participants had decreased sexual behavior problems, delinquency, substance use, externalizing symptoms, and out-of-home placements compared to juveniles in the usual sex offender specific treatment.

Sector Involvement

Public health can play an important and unique role in addressing SV. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate SV prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing SV, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone.

Other sectors vital to implementing STOP SV include, but are not limited to, education, government (local, state, and federal), social services, health services, business/labor, justice, housing, media, and organizations that comprise the civil society sector such as rape crisis centers, SV coalitions, faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing SV by impacting the various contexts and underlying risks that contribute to SV.

The strategies and approaches described in the STOP SV technical package are summarized in Appendix A along with the relevant sectors that are well positioned to lead implementation efforts. For example, the approaches and programs for the first two strategies (*Promoting Social Norms that Protect against Violence* and *Teach Skills to Prevent SV*) are often delivered in educational settings, making education an important sector for implementation. Health departments across the country often work in partnership with school districts and community-based organizations to implement and evaluate prevention programs in school settings. Some of these programs may also be suitable for delivery in community settings. Through their work with community-based organizations, local and state health departments can also play a leadership role in implementing and evaluating these programs in other settings.

The business, education, and labor sectors, as well as government entities, are in the best position to establish and implement policies to advance strategies in the STOP SV technical package such as those focusing on *Empowering and Supporting Girls and Women* through education, employment, and income supports or *Creating Protective Environments* in workplaces and community settings. These strategies go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that make SV more likely to occur. Public health entities can play an important role by gathering and synthesizing information, working with other agencies within the executive branch of their state or local governments in support of policy and other approaches, and evaluating the effectiveness of measures taken.

Finally, the STOP SV technical package includes victim-centered services and a number of therapeutic approaches to *Support Victims/Survivors* of SV. Rape crisis centers, SV coalitions, and other professionals who work with victims and survivors, in collaboration with justice, housing, social services, and the health care sector, are uniquely positioned to identify and deliver critical intervention support and victim-centered services in a manner that best meets the needs and circumstances of victims and survivors. The health care sector, working with victim advocates and in collaboration with justice and social services, is also uniquely positioned to address trauma and the long-term consequences of SV. In addition to having licensed providers trained to recognize and address trauma, the health care sector can also coordinate wrap-around behavioral health and social services to address the health consequences of SV and also the conditions that may put the patient at risk of repeated violence or perpetration (e.g., among children or adolescents with behavioral problems, including sexual offending).

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in helping accomplish the work to STOP SV.

Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are necessary for program implementation; planning, implementation, and assessment all rely on accurate measurement of the problem.

Surveillance data helps researchers and practitioners track changes in the burden of SV. Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. At the federal and state level, the National Intimate Partner and Sexual Violence Survey (NISVS) and the Youth Risk Behavior Surveillance System (YRBSS) are examples of surveillance systems that provide data for SV. NISVS collects information on intimate partner violence, SV, and stalking victimization at both the state and national level, including data on characteristics of the victimization, demographic information on victims and perpetrators, impacts of the violence, first experiences of these types of violence, and health outcomes associated with the violence.[93] YRBSS collects information on teen dating violence victimization (including physical and sexual), SV victimization, youth violence victimization (including bullying) and suicidal behavior among high-school aged youth. This information is available at the local, state, and national levels.[94] In addition, there are data at the local level including school surveys, women's health surveys, criminal justice data and other data that are important in local efforts to monitor the problem of SV.

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of STOP SV. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce SV rates and risk and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

Much progress has been made in recent years to build the evidence-base for SV prevention through research. However, additional research is needed to expand the inventory of SV prevention strategies with known effectiveness. Prevention practitioners play a large role in building the evidence-base by evaluating programs for impact on SV rates and risk and protective factors. The field will advance if research continues to evaluate the effectiveness of programs developed in the practice field, and identifies and tests new programs for high-need populations. Additionally, research is needed on the impact of community- and societal-level strategies, including policies, the application of social media, and community environmental change, to reduce rates of SV. Lastly, it will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in the STOP SV package. Most existing evaluations focus on approaches implemented in isolation. However, there is potential to understand the synergistic effects within a comprehensive prevention approach. Additional research is needed to understand the extent to which combinations of strategies and approaches result in greater reductions in SV than individual programs, practices, or policies.

Conclusion

SV is a significant public health problem but it can be prevented. STOP SV represents the best available evidence to address the problem of SV. This technical package includes a range of complementary strategies and approaches that ideally would be used in combination in a multi-level, multi-sector approach to prevent SV. It includes strategies and approaches that are in keeping with CDC's emphasis on the primary prevention of perpetration, or stopping SV perpetration before it starts, as well as approaches to reduce risk for victimization and to lessen the short- and long-term harms of SV. The hope is that multiple sectors, such as public health, health care, education, justice, and social services will use this technical package to prevent SV and its consequences.

Collectively, the strategies and approaches found in this technical package represent CDC's understanding of the best ways to prevent SV based on the current state of the evidence. As previously noted, the current state of the evidence is limited and must continuously be built through rigorous evaluation. Decisions on specific programs should be based on a thorough understanding of the evidence for a particular program, its applicability to the intended population and setting, and best practices for effective prevention.[95,96] By continuing to invest in the evaluation of practice-based prevention programs and promising practices, researchers and funders can also help to expand our understanding of what works to prevent SV. Several innovative studies are currently in progress to uncover promising future directions for SV prevention work. As new programs, policies or practices are identified, evaluated, and shown to be effective, they will be added to this technical package.

For more information

To learn more about sexual violence prevention, call 1-800-CDC-INFO or visit CDC's violence prevention pages at www.cdc.gov/violenceprevention.

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Division of Violence Prevention

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