

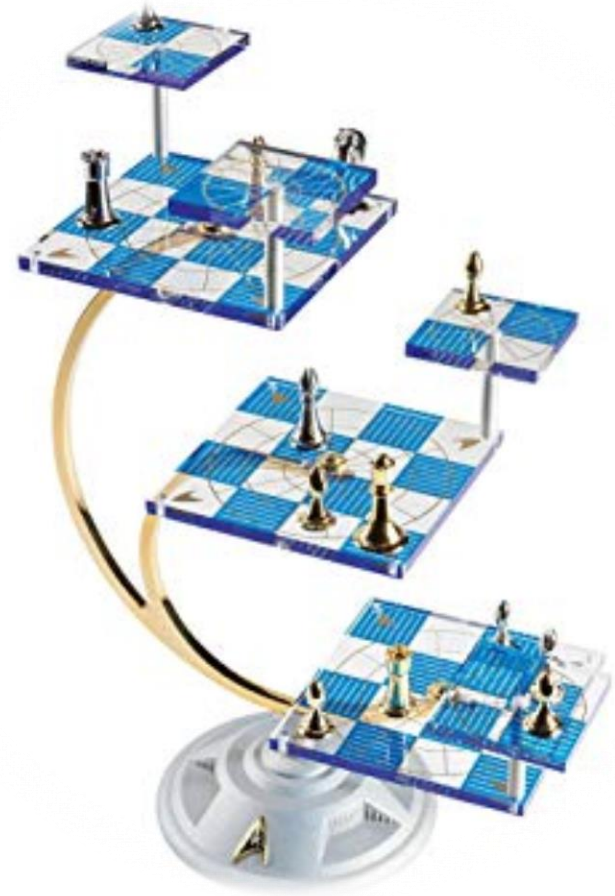


In-Service May 2019



Client Services and Staffing

Doc Cowher



Dave “Doc” Cowher - Scheduler

- USAF veteran
- Was trained as a PA, 45 years ago
- 43 years in the oilfields
- Facilitator
- Married, 3 kids, 5 grandkids, live in Conroe

Information

- Doc's Office Hours - Monday through Friday
 - 7am - 4pm
 - *Go through On-Call after hours and weekends, however, don't hesitate to call me if necessary.*
 - *I try to maintain a work/life balance*
- Doc's Cell Phone - 832-938-9620
- After Hours - 832-930-9500
- Email - dcowher@iconhealthservice.com

Celest Lake

- Assistant Scheduler – North Route Courier
- Patient/Family/Nurse Communications
 - *Follow-up*
 - *Meet & Greets*
 - *Orientations*
 - *Call Outs*
- Cell Phone – Pending
- Email – clake@iconhealthservice.com

Scheduling Flow

- Meet & Greet
 - *Nurses need to show a sincere interest in the patient.*
 - *Ask good questions and write things down.*
- Patient Orientation
 - *With an on duty nurse*
 - *Sometimes Mom*
 - *Sometimes Case Manager*
 - *Train/orient as long as needed as many shifts as needed.*
- Get placed on the Schedule

Availability Form



ICON HEALTH SERVICES NURSE SHIFT AVAILABILITY AND REQUEST FORM

NAME	LICENSE	TRACH QUALIFIED	VENT QUALIFIED	GBUTTON QUALIFIED	ABLE TO LIFT PATIENTS	ANY RESTRICTIONS	DAYS AVAILABLE	HOURS AVAILABLE	HOURS AVAILABLE	AREA OF TOWN DESIRED	AREA OF TOWN WILLING TO WORK
ENTER YOUR NAME	CHECK ONE	CHECK ONE	CHECK ALL THAT APPLY	CIRCLE ONE	CIRCLE ONE	ARE THERE ANY RESTRICTIONS TO YOUR ABILITIES? EXAMPLE-LIFTING RESTRICTION, ALLERGIES, ETC.	CHECK ALL THAT APPLY	HOURS DESIRED FIRST CHOICE	HOURS DESIRED SECOND CHOICE	WHAT AREAS WILL YOU COMMUTE TO?	HOW FAR WILL YOU GO?
	RN <input type="checkbox"/> LVN <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> LTV? <input type="checkbox"/> TRILOGY? <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY <input type="checkbox"/>				

COMMENTS

Behavior At Work

Are we Professionals
100% of the time?



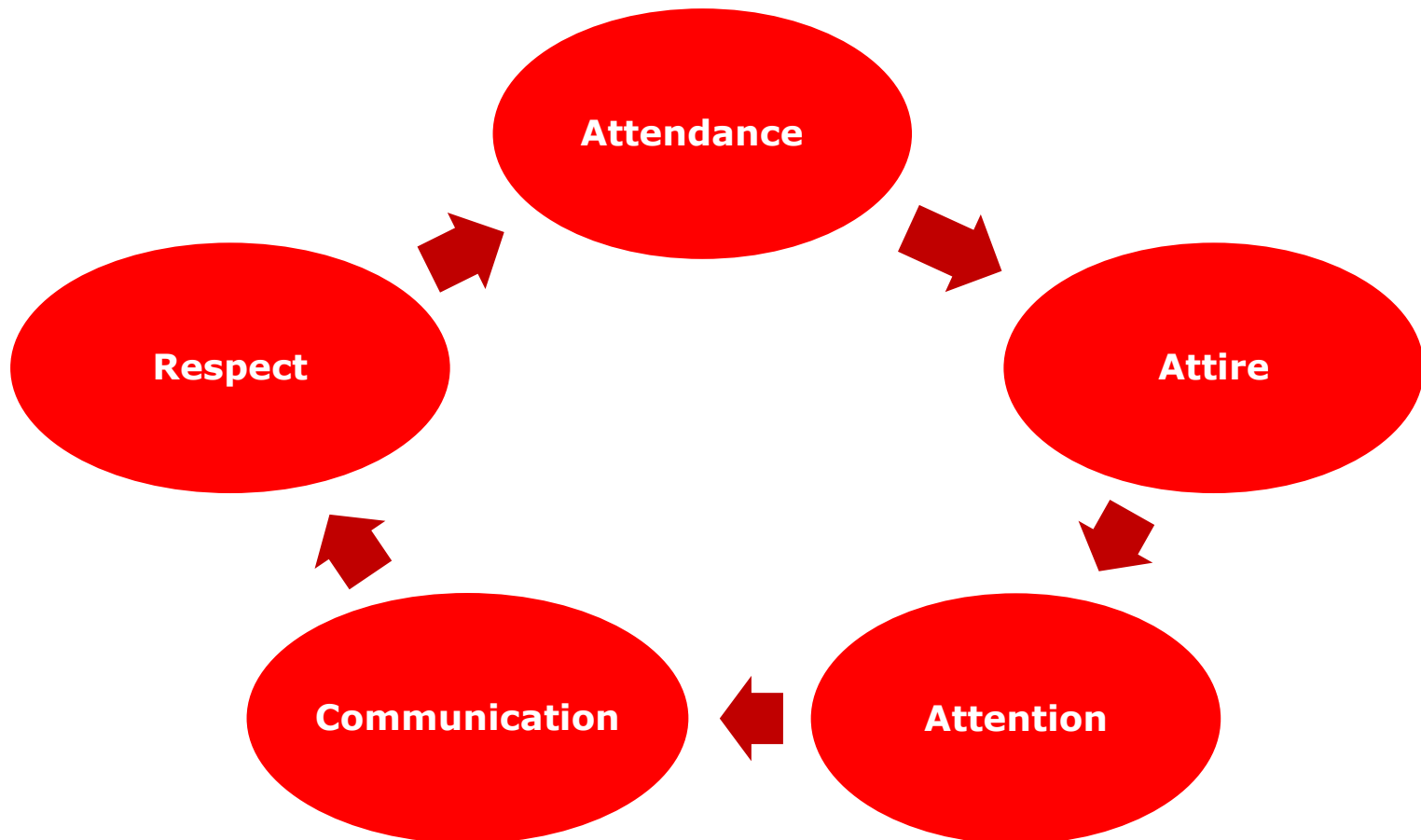
Behavior At Work

First of All... We are proud of you!

- Our Icon nurses make us proud on a day to day basis.
- Occasionally, situations occur that require assessment, intervention and sometimes action by the office staff.
- **THIS IS A REMINDER TO EVERYONE!**
- Your professionalism and behavior are being evaluated by those around you every day.
- The standard you are being held to is simple
 - *If you cannot do it in the hospital, you cannot do it for ICON.*

Behavior At Work

**Our behavior reflects who we are:
From start to finish!**



ATTENDANCE

- Just as in a hospital setting, when you accept a shift, you must work that shift.
- *OCCASIONALLY*, things happen and people must call in. **YOU MUST COORDINATE WITH THE OFFICE AND THE FAMILY WHEN YOU CALL IN.**

PROCEDURE

1. Tell the family first. Try to get a co-worker to fill the shift if possible.
 2. Call the office (*automatically rolls over to the on-call after hours*) OR if no answer – Call the Scheduler
- *However*, calling the scheduler after hours needs to be the exception and **not** the normal.

ATTENDANCE

- From the beginning of ICON, we put into place a monthly monetary “thank you” for those that simply did what they promised to do....WORK THE SHIFTS THAT THEY CONFIRMED.
- While current monetary restraints on the company forced a reduction of this amount, the owners still want to thank those hard working professional nurses that accept shifts and actually work them so there is a small stipend placed into your check after one month of full time work with no missed shifts.

ATTENDANCE

- Just as in the hospital setting, you are expected to be on the floor, in enough time prior to your scheduled shift, to take report and then be able to start your shift on time.
- This is no different in home health. You must arrive in enough time to park, enter the home, settle your belongings, get a report from the off-going nurse or the caregiver and **START your shift ON TIME.**
- You may not clock in until your scheduled shift starts. If you are scheduled at 0700, you may not put 0650 even if you arrived at that time.
- If you are late, you may not make up the time at the end of your shift unless you have received permission from the parents and there is no other nurse relieving you.
- Your first entry time and your last entry time on your progress notes, must match your clock in and out times from your assessment page.

Scheduled Shifts

- Parents reserve the right to cancel or modify your shifts at any time for any reason.
- They may also ask you to leave early without explanation.
- The Case Managers will talk with families if this becomes frequent as we want to establish as much consistency in the schedule as possible for your benefit.
- Be open with the Scheduler on issues that arise with the schedule and work with the office on resolving them.
- YOU **MUST** CALL THE OFFICE TO NOTIFY US OF **ALL** CHANGES TO THE SCHEDULE. YOU ALONE ARE RESPONSIBLE FOR THE COORDINATION OF YOUR SCHEDULE WITH THE OFFICE.
- This means calls off for illness, car trouble, vacation, personal problems etc. THE OFFICE **MUST BE NOTIFIED EVERY SINGLE TIME!** You may not finalize your schedule or any changes with only the parents.

Attire

- You must dress appropriately.
- Each home is different and they may dictate what type of dress code they prefer.
- Wear clean clothing or scrubs with no tears or stains.
- Do not wear tank tops, short shorts or flip flops.
- Do not wear t-shirts with inappropriate sayings.
- **Bottom line is you represent yourself and ICON when you are out in public and meeting other health care professionals.**

Paying Attention to the Patient

- While phones, computers and tablets are allowed at work, their use must be kept at a minimum as in a hospital setting.
- We receive a lot of complaints from parents that nurses are spending a lot of time “playing” or texting on their phones. This would not be tolerated in the hospital and is not tolerated at ICON.
- You have one patient and one patient only.
- Your entire focus, care and documentation must be done in a timely, accurate and professional manner during your shift. Nurses in the ICU get their care and documenting done. You can do the same. In both cases, the job is hectic and chaotic but it is a reasonable expectation.

Interacting With Your Patient

- You must engage and interact with your patients your entire shift.
- Your patient should never just lay in bed or sit in his/her wheelchair in front of a TV while you play on your phone.
- Provide supplemental therapies (PROM, stretching, standers and gait trainers etc.)
- Assist with supplemental school activities as appropriate.
- Read to your patients. Sing to them.
- Take them to the park or for a walk outside.
- Watch TV with them, but do not change the channel for your sake, even if the patient is non-verbal.

Communication with Patients, Families and Others

- As previously stated, everything about you on a given day, communicates who and what you are to the world.
- This is a direct reflection of you and in turn a reflection of ICON while you perform your duties as a staff nurse.
- The home setting is a more relaxed environment.
- With this environment, comes comfortableness and complacency.
- We often lower our standards as we become more familiar and close to the families and patients.
- Professional boundaries must be established and maintained at all times.
- Because of the close relationship with the family, it is easy to forget the coordination with the office with schedules, issues, etc. **YOU ARE RESPONSIBLE** for this coordination and you must always remember that while you work with the family, **YOU ARE AN EMPLOYEE OF ICON.**

Expected Behavior

- We must speak and conduct yourselves with high standards.
- It should go without saying, that independent of how we are treated or spoken to, we must rise above any confrontation.
- You must work to decrease the tension and resolve conflict rather than escalate and exacerbate the situation.
- **INTERACT.....DON'T REACT!!!!!!**
(**Interact**=you control the situation, **React**=they control the situation)
- If a patient or family member is upset, raises their voice or is confrontational, then you as the nurse, are expected not to react to the situation, remain calm and do not raise your voice in return.
- If you need to contact your case manager to try to calm the situation, please do so as soon as possible.
- Under NO CIRCUMSTANCE, may you use any form of profanity

RESPECT

Words of Wisdom

- **“Respect is earned - Honesty is appreciated - Trust is gained - Loyalty is returned”**
- **“They may forget what you said, but they will not forget how you made them feel”**
- **“You are free to choose, but you are not free from the consequence of your choice”**
- **“Your attitude determines your direction”**
- **“Be kinder than you feel”**
- **“How beautiful it is to stay silent when someone expects you to be enraged”**

Responsibilities

- It is your job to stock, restock and restock again.
- Monitor supplies and medications. When items become low, inform the parents and reorder for them if they request for you to.
- You are responsible for opening supply boxes and putting them away if they arrive on your shift. **DO NOT LEAVE THEM FOR THE PARENTS TO DO!!**
- Remember to rotate stock. Oldest in the front. Everything has an expiration date.
- **DON'T BE COMPLACENT OR LAZY!!** This leaves a bad impression on the parents. It never hurts anyone to be helpful, engaging and proactive.
- Leave your environment better than you found it!

Documentation



Approval Process for PDN hours

- The authorizing agencies continue to look for ways to decrease services. Accurate and concise patient specific documentation is the primary focus for PDN authorized hours.
- We must submit 10-14 days of consecutive nurse notes, MARS, suction logs, apnea logs and seizure logs with EVERY PDN renewal. This means that your notes no longer MIGHT be sent, THEY WILL BE SENT.
- Your documentation notes are being looked at by many professionals at the insurance health plans. So make sure your charting is on POINT!!

Your Documentation Requirements

- YOU ARE DOCUMENTING TO KEEP YOUR JOB!!!
- If hours are cut for these children, make sure it was not because you did not do your job!
- It is MANDATORY that you chart fully and completely for your entire shift and do it well. **THIS MUST BE IN BLACK OR BLUE INK ONLY.**
- Write legibly and on one single line at a time. Do not scrunch an extra line into the space to save paper. Remember. We are now having to fax your notes to the state and that can make them very blurry.
- Your name and credentials must be at the top of the first page of the Nurse's note and on the top of each page of your progress note.

Your Documentation Requirements

- Your time in and out and your total time must be completed every single shift and must be the same as your initial time and your final time on the progress notes.
- Your time in and out should also be correct. So many unnecessary phone calls, both to you and the parents, about confirming times every week can be avoided this way.
- The correct date is a must too. I know most of us have cell phones. If you don't know the date, look it up. It is a nightmare putting notes in order when the dates are wrong.
- Caregivers must sign your notes before they are turned into the office. This confirms to the office and ultimately the state that you truly worked the hours you charted.

Vital Signs and Narratives

- Vital signs must be completed within 30 minutes of the start and 30 minutes of the end of your shift with Q4 vitals completed in between.
- The Input and Output section must be totaled at the end of your shift.

YOUR NARRATIVE - PLEASE REMEMBER THE FOLLOWING!

- Document the exact time you took over care.
- All of your times for your entries must be at the left side of the page under the section that says "TIME". Please do not put times in the body of the narrative. This becomes messy.
- Document who you received a full report from and what condition the child was in when you received him/her.

Vital Signs and Narratives

- At both the beginning and end of your notes, state that you completed a full assessment and hit on some key elements about your assessment that reflect the medical care that the child requires. (Respiratory, GB, Neuro-seizures etc).
- With every treatment, medication, feeding, activity and anything else that you do with your patient, state how he/she tolerated it.
- Give small details about what you do with the child all day. What stimulation you provide, activities you engage in etc.
- Charting must be minimally Q2 hours. You may chart more often, but there should NEVER be longer than a 2 hour span between entries.
- EACH 2 HOUR ENTRY MUST HAVE A MINIMUM OF ONE NURSING ASSESSMENT DETAILED!
- According to the state, the only things that differentiate a nurse from a caregiver are assessments and documentation of those assessments.

Patient Specific Documentation Guidelines

- In an effort to make documentation more patient specific, the Case Managers will be providing specific guidelines for each of your patients that will be sent to each home.
- If the bullet points provided do not cover all of your patient's care needs as your assessments are most current, make the necessary changes on the guideline forms and contact your CM to make the corrections on our paperwork.
- Staff nurses and Case Managers will coordinate together to identify changes and update the patient specific guidelines.

TEACHING

- Teaching to the parent, caregiver, patient etc. **MUST** happen **EVERY SINGLE** shift and **BE DOCUMENTED** on the **TEACHING** section that has been added to the assessment page of the nurse notes. If you need additional space, detail in the progress narrative section of the nurse notes.
- This is a DADS and MEDICAID requirement.

TEACHING

Examples:

- Reviewing AVS reports with the families to see if any clarification is needed.
- Review all medications with family, discuss potential side effects (especially new medications or “short term” medications like antibiotics or steroids)
- Safety concerns and infection control.
- Coordination with school and therapists.
- Age appropriate developmental stimulation.

Examples for Better Charting

1. Infection control completed, wiped equipment, wiped bed and floor with antibacterial/antiviral agent, patient currently stable with no s/s infection.
2. Incontinence Care administered. Dermal assessment completed. No s/s of infection or dermal irritation.
3. Patient has decreased attention span. Patient watching age appropriate developmental stimulation for approximately 15 minutes. This is approximately 5 minutes more than observed on 5/5/19.
4. Respiratory assessment completed. POX reading. POX probe rotated to left great toe. Vitals stable. No s/s of respiratory distress.

Examples for Better Charting

5. GB feeding administered. No abdominal distention. Feeding tolerated well.
6. Scheduled medication administered via GB. Patient tolerated well.
7. PRN Nebulizer treatment administered as ordered for increased congestion and coarse rhonchi. CPT performed for approximately 5 minutes. Trach and oral suction performed and pt. tolerated well. Patient's breath sounds improved in all lobes. Remain improved when reevaluated 30 minutes post treatment.

Examples for Better Charting

8. Patient at risk for safety secondary to medical condition. Evaluated patient's environment and no changes needed at this time.
9. Patient unable to reposition. Repositioned from left side to right side and utilized pillow between knees and low lumbar to facilitate comfortable positioning. Dermal assessment of potential pressure areas completed. No s/s of irritation or dermal complications.

More details about charting

- Each entry must have a line drawn to the end of the space and your initials as well as your credentials written at the end of your entry. There may not be any “open” spaces in your note where someone could document/change your note after you have finished.
- Indicate who you gave report to at the end of your shift as well as the condition of the child after you completed your last full assessment and vitals.
- Your entire first and last name plus credentials must be written at the very end of you documentation to close out your note.
- Do not document incorrect times to try to gain an extra few minutes. If you are not working, you are not charting. If caught, this can be considered Medicaid fraud and may be grounds for disciplinary action.

Suction, Seizure and Vent Logs

I know...we don't like them either, but guess what?... The state does...

- **Suction logs** are crucial for hour approval. Be clear, accurate and thorough. Many of you do a great job with this. KEEP IT UP! 😊
- **Seizure logs.** Icon nurses are not so great at this one. They are a pain, but they are important. Please complete them and send them in with your notes each week.
- **Vent logs.** There is a date section at the top of the page. COMPLETE IT PLEASE. Overall, Icon nurses do a great job with these logs. Please keep it up!
- Nurses often voice that they do not have time to properly document. You have only one patient. Garry's popular saying is, *"If you cannot do it in the hospital, then you cannot do it for me."* ICU nurses, Life Flight Nurses and Floor Nurses with multiple patients, get their jobs done and chart properly. You can too. If you do not, there is a really good chance that the patient's lost hours will come back on you.

Medication Administration Records (MARS)

- On the first signature page, make sure that your shift times are the exact times that you clocked in and out on your nurses' note. They must match!
- Medications must be administered within the hour (30 minutes before and 30 minutes after) they are scheduled. If they are consistently not given on time, we need to revisit the timing of the medications with the parents.
- Every box must have the time that you administered the medication, the units that you gave (ml, tabs, caps, ampules etc) as well as your initials. **YOU ARE RESPONSIBLE** for every medication, feeding, treatment, etc ordered by the physician during your shift. **IF YOU DO NOT ADMINISTER**, then who did? This section cannot be left blank. "Mom" and your initial if the mother administered is a good example of what should be in there if you did not give the medication.

Weekly Updates and Communication Book

- Coordination of care is mandatory per DADS requirements.
- Weekly updates are mandatory. One Weekly update per patient is required and multiple nurses can document and sign on the same form. Changes in condition, MD appointments, future MD appointments, etc. must be documented. It is just as important to check “no change” and sign. A reduction in hours is not supposed to be allowed without a change in patient condition. Your documentation of “no change” makes it more difficult for them to reduce hours on a stable child. If this is not done during the course of the week, the nurse working the last shift of the week is responsible for completion. This should be a team effort and the more nurses utilizing this form, the better.

Weekly Updates and Communication Book

- The Communication book in the home is important as well. This is how nurses coordinate and communicate with each other. PLEASE INITIAL THE ENTRY/ENTRIES of the other nurses. This simple act goes a long way in confirmation of communication while ensuring coordination and continuity of care.
- It is a great way to reference status of the patient during previous shifts without referencing the previous nurse's notes and trying to remember every single detail you received in your report.

Assuring We Keep Working

- If the hours are cut, your hours will be reduced or eliminated. You may be out of a job.
- Be the professional nurse that you are and document well.
- NO EXCUSES, take responsibility for your actions.
- As an agency, we are only as good as each and every one of you. Be the best you can be!!
- We are withholding a great reputation in the industry. Let's keep it going team!!

Assuring We Keep Working

- Lastly, the managed care agencies are requiring that we submit the latest AVS (After Visit Summaries) from each of their MD visits (PCP as well as Specialists) with each PDN renewal process. Please get a copy of those to the office ASAP. (You may also send in the original with a note to copy one for the home and we will send it back to the home with the following week's MAR).
- If we do not submit one of the requested items that the Managed Care agencies ask for within the 12 to 24 hour window they provide us, the hours will immediately be denied forcing the Fair Hearing Request and Appeal by the Parents.

Assuring You Get Paid On Time

- You must have your notes completed and ready for pickup by Monday morning each week. THIS HAS BEEN A MAJOR ISSUE.
- If you are mailing them in, get them in the mail Monday please.
- For those mailing them in, please email a photo of the 1st page of the nurse note as well as the first and last page of your progress notes. This helps us to verify that the time you charted in and out are correct.
- If your notes are received in the office after 4:00 on Tuesday, you will not be paid for those hours until the following paycheck.

WARNING!!

- DO NOT PRE-CHART any part of your nursing assessment, your narrative, your MAR or your logs.
- If for any reason, you must leave your shift abruptly, you gave proper report and assured adequate care for the child then had to leave without finishing your charting, it must not be noted that you completed your documentation ahead of time. If so, this will be considered MEDICAID FRAUD and will be grounds for disciplinary action.

Top 2 ways to help control infection

According to the CDC, the 2 most effective ways to protect a patient from contamination is to:

1. WASH YOUR HANDS!! (Single most important measure for preventing the spread of infection)
2. CLEAN THE PATIENT'S ENVIRONMENT EVERY SINGLE SHIFT

Importance of Infection Control

1. The patient (and their families) do not need the physical or mental stress an infection can cause.
 - a) Their medical conditions often predispose them to added risks.
 - b) Too often, patient infections can result in hospitalizations or worse.

2. Patient infections affect the nurse in several ways.
 - a) The question arises in whether or not the nurse did everything he/she could to prevent the infection.
 - b) The nurse is now without work while the patient is in the hospital and that affects his/her own person financial situations.

Practical Steps to Prevent Infection

- Always practice universal precautions with all patients.
- Wear gloves when handling blood or body fluids.
- Hold contaminated linens away from your body when carrying them.
- Dispose of sharp instruments in puncture proof container. Do not recap needles.
- Immunize yourself to protect against infections.

Tracheostomy RISKS

- Open pathway for bacteria and virus to the lungs.
- The nose and mouth “filters” are removed.
- “Artificial filters” are a must (HME or PMV) for trachs without vent use.
- Sterile vent circuits are to be used (standard and travel circuits) as well as sterile humidification for those patients that are on a vent.

Tracheal Suctioning

- Tracheal suctioning must be sterile.
- Suction catheters are either one time use or they are sleeved for re-use.
- The clearing of the suction catheter for secretions must be done with sterile saline or sterile water.
- (If you open a large sterile bottle of water, it is no longer sterile)
- **NEVER USE TAP WATER OR DISTILLED WATER TO CLEAR A SLEEVED CATHETER THAT YOU WILL USE AGAIN.**

TRACH CARE

- Completed per MD instruction
- MUST ALWAYS BE DONE IN A STERILE MANNER.
- Sterile cotton swabs or sterile gauze must be used.
- Document this care well
- Contamination is the #1 cause of tracheitis and often other respiratory infections.

ORAL/NASAL SUCTIONING

- The “little sucker” or similar device must be as clean as possible.
- Multiple use oral/nasal suction devices must be cleaned after each use.
- Use of diluted white vinegar solution or mouthwash is recommended.
- DOCUMENT THIS CARE.

DAILY CARE and WEEKLY CHANGE OF SUCTION CANISTER AND TUBING

- Thorough cleaning of the suction tubing and canister must be done each shift
- Use of diluted vinegar/water solution 1:4 or mouthwash is recommended.
- The entire canister and tubing must be thrown out and replaced with a new set once per week. Initial and date on the canister as well as the tubing when they were changed.
- Do NOT leave this responsibility for the next shift nurse or the parents.

GI and Respiratory Equipment

- Syringes, extension tubing, nebulizer units etc. must be cleaned and put in disinfectant between each use.
- Use separate containers for GI and Respiratory equipment to prevent cross contamination.
- Use commercial disinfectant or Vinegar/Water (1:4) Solution.
- Equipment should be submerged for a minimum of 30 minutes (longer the better) and then rinsed and dried.
- Change feeding bags every 24 hours. (Initial and date the bag)
- Document this care

GENERAL INFECTION CONTROL

- Equipment and patient environment (bed, wheelchair, feeding pump and stand, suction machine, ventilator, cough assist, IPV etc. should be wiped down thoroughly EVERY SHIFT and documented.
- Changing linens, towels etc. on a regular basis is like washing your hands. It helps more than you know to prevent infections.
- Sweeping and mopping the patient's environment is also required (their entire bedroom floor and any other floor they lie on).
- THIS IS THE NURSE'S DUTY UNDER INFECTION CONTROL REGULATIONS

CATHETERIZATIONS

- As taught in nursing school and per policy, this must be done in a sterile manner.
- Document this care.

TUBERCULOSIS

- Our policies indicate on hire and annually, that all staff who have direct contact with patients will be screened for TB by submitting the results of a RECENT TB test, blood spot test or x-ray.
- Also upon hire and annually, staff must complete a TB Fact Sheet/Symptom Screening Form.
- The form provides information about TB as well as documentation of the employee's risk factors and potential symptoms of TB.
- Employees who indicate having symptoms on the TB Fact Sheet/Symptom Screen or who exhibit symptoms of TB will be referred to their primary care provider or the local or state health department for evaluation.
- A work release will be required prior to the employee's return to work.
- The agency will coordinate the home management of patients/clients with suspected or confirmed tuberculin infection through engineering and work practice oversight.

Home Fire Safety Tips – Prevention

- Do not use overloaded electrical systems
- Do not use frayed electrical wires
- Smoke detectors – check batteries monthly – replace batteries yearly
- Never leave home with clothes dryer running.
- Kitchen fires – never put anything on the stove you don't want to heat.
- Extinguish a grease fire with baking soda.
- Keep a fire extinguisher mounted nearby.
- Learn how to use your fire extinguisher before there is an emergency.
- Establish a fire escape plan – every room should have 2 means of escape.
- To report a fire call 911.

How to Escape a Fire

In case of a fire do the following:

GET THE PATIENT AND YOURSELF OUT, then call for help – 911.

- Remember you have 2 minutes to escape a home fire. Most people die in the first 5 minutes of a fire. If a patient receives oxygen but is not on life support, the nurse should disconnect the oxygen and get the patient out immediately. After you are out, call 911.
- If the patient is on life support, the nurse needs to maintain the client's respiratory status manually with an ambu-bag and move the patient out immediately. After you are out, call 911.

Fire Facts

- A fire burning in a house for 1 minute grows to 3 times its original size. In 4 minutes it grows 11 times its size, and in 6 minutes, it reaches 50 times its original size.
- Purchase an ABC type extinguisher – they extinguish all types of fires.
- The fire department estimated that as many as half of the smoke detectors installed in homes don't work because the batteries are dead or missing.

Child Abuse

- Unexplained or questionable scars, burns, welts, bruises or fractures.
- Unnecessary confinement.
- Witnessed beatings.
- Sexual abuse
- Emotional abuse
- Withdrawn, angry, or unusual behavior exhibited by the child.

Child Neglect

- Malnourishment, failure to thrive and grow.
- Lack of medical care.
- Filthy or unsafe environment.
- Poor hygiene and personal care.
- Absence of parents and/or appropriate supervision.
- Irregular school attendance.

SIDE NOTE:

Nurses sleeping on duty will be reported to the board. This considered a form of NEGLECT!!

Cameras in the Home

- Families have the right to have cameras in the home and they do not have to disclose that they are present.
- I am sure that many of you have cameras in your own homes.
- It is not that they are spying on you. It is a type of family “peace of mind”.
- Cameras also have the ability to reinforce the excellent care you are providing as nurses for your patient.

Adjourn





Pediatric Home Healthcare

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Home Healthcare is our Service

Your Families Home Healthcare is our Priority