



## **Welcome to the Aveanna Family!**

We are excited you joined our Home Health team here at Aveanna. We know it is a big decision to join a new organization. We want to make sure you are well equipped to be successful upon starting your journey with us.

With that as our backdrop, it is important you have all the information you need to confidently perform your job. Please feel free to ask any questions during this orientation period. The leadership team has developed a thorough orientation program that will provide you the foundational information necessary to be successful as a clinician at Aveanna.

To get the most out of this time, the orientation training log in this folder will be your roadmap, and you will be responsible for completing all items timely. It is important to thoroughly complete all items even if you are an experienced clinician in home health as there are always nuances at organizations that may be different. You may also learn new information. This training log will need to be turned in to office leadership at the end of your orientation, please keep track of it.

Knowledge Base is our education platform that you will be introduced to as you complete your orientation. Knowledge Base is your source for educational materials in addition to content and resources such as educational handouts that you can print for patients. Don't forget to take advantage of this resource after orientation. You can access this on the tablet you have received so it is always available to you.

Home Care Home Base is our EMR platform for all clinical documentation. You will have a preceptor/mentor/clinical leadership, along with access to Knowledge Base processes to help guide you through using the system.

The branch you are assigned to will be your local contact during this orientation period and throughout your employment. Please contact them with any questions.

Thank you again for choosing Aveanna, our patients and your team members are excited to meet you!

Sincerely,

Janet Fehler, RN - VP Clinical Systems & Applications  
Adam Marconi, PT - AVP Therapy Services



To revolutionize the way home care is delivered, one patient at a time.

## Our Core Values

Compassion

Team Integrity

Inclusion

Trust

Innovation

Compliance

Fun

## My Contacts and Notes

1. Executive Director: \_\_\_\_\_
  - a. Contact Number: \_\_\_\_\_
2. Clinical Manager: \_\_\_\_\_
  - a. Contact Number: \_\_\_\_\_
3. Branch Office Phone Number: \_\_\_\_\_
4. Branch Office Fax Number: \_\_\_\_\_
5. Preceptor Name: \_\_\_\_\_
  - a. Contact Number: \_\_\_\_\_
6. Corporate office address/Number:
  - a. 400 Interstate North Parkway, SE
  - b. Suite 1600 Atlanta, GA 30339
  - c. (770) 441-1580

[illegible]



# Integrated Tuberculosis (TB) Screening and Risk Assessment Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Persons should be considered at increased risk for TB if they answer "yes" to any question(s)*

1. What position will you hold? \_\_\_\_\_
2. Have you had temporary or permanent residence of >1 month in a country with a high TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.  
☐ Yes ☐ No
3. Have you had close contact with anyone who has had infectious TB disease since the last TB Test?  
☐ Yes ☐ No
4. Do you currently have any of the following symptoms?
  - a. ☐ Yes ☐ No unexplained fever for more than 3 weeks
  - b. ☐ Yes ☐ No cough for more than 3 weeks with sputum production
  - c. ☐ Yes ☐ No bloody sputum
  - d. ☐ Yes ☐ No unintended weight loss >10 pounds
  - e. ☐ Yes ☐ No drenching night sweats
  - f. ☐ Yes ☐ No unexplained fatigue for more than 3 weeks
5. Have you ever been diagnosed with active TB disease?  
☐ Yes ☐ No
6. Have you ever been diagnosed with latent TB infection or had a positive skin test or a positive blood test for TB?  
☐ Yes ☐ No
7. Have you been treated with medication for TB or for a positive TB test (eg, taken "INH")?  
☐ Yes ☐ No

If yes, what year, with which medication, for how long, and did you complete the treatment course?

\_\_\_\_\_

8. Do you have any current or planned immunosuppression?  
Including HIV infection organ transplant recipient, treatment with a TNF-alpha antagonist (eg., infliximab, etanercept, or other) chronic steroids (equivalent of prednisone > 15 mg/day for > 1 month) or other immunosuppressive medication?  
☐ Yes ☐ No

\_\_\_\_\_  
Clinician Reviewer Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Job Title: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

**PART A SECTION 1 (MANDATORY) - The following information must be provided by every employee who has been selected to use any type of respirator (please print).**

Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Your weight: \_\_\_\_\_

Check the type of respirator you will use (you can check more than one category):

- a. ☐ N (N series masks such as N95, N100)  
b. ☐ Other type (for example, half – or full-facepiece type, powered – air purifying, supplied air, self-contained breathing apparatus).

Have you worn a respirator (check one): ☐ Yes ☐ No \_\_\_\_\_ If “Yes”, what type(s): \_\_\_\_\_

**PART A SECTION 2 (MANDATORY) - Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (Check “Yes” or “No”)**

<b>1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2. Have you ever had any of the following conditions?</b>	
Seizures (fits)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes (sugar disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergic reactions that interfere with your breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Claustrophobia (fear of closed-in places)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble smelling odors	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. Have you ever had any of the following pulmonary or lung problems?</b>	
Asbestosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Silicosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumothorax (collapsed lung)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Broken ribs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any chest injuries or surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other lung problem that you’ve been told about	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4. Do you currently have any of the following symptoms of pulmonary or lung disease?</b>	
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath when walking on level ground or walking up a slight hill or incline	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have to stop for breath when walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath when washing or dressing yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing that produces phlegm (thick sputum)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing that wakes you early in the morning	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing that mostly occurs when you are lying down	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing up blood in the last month	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain when you breathe deeply	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other symptoms that you think may be related to lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5. Have you ever had any of the following cardiovascular or heart problems?</b>	
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart arrhythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other heart problems that you've been told about	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6. Have you ever had any of the following cardiovascular or heart symptoms?</b>	
Frequent pain or tightness in your chest	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or tightness in your chest during physical activity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or tightness in your chest that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past two years, have you noticed your heart skipping or missing a beat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn or indigestion that is not related to eating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other symptoms that you think might be related to heart or circulation problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>7. Do you currently take any medications for any of the following problems?</b>	
Breathing or lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures (fits)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>8. If you've ever used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following box <input type="checkbox"/> and go to question 9.)</b>	
Eye irritation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin allergies or rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
General weakness or fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other problem that interferes with your use of a respirator	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>9. Would you like to talk to a health care professional who will review this questionnaire about your answers to these questions?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>This Section Generally Not Applicable:</b> Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.	
<b>10. Have you ever lost vision in either eye (temporarily or permanently)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>11. Do you currently have any of the following vision problems?</b>	
Wear contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wear glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other eye or vision problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>12. Have you ever had an injury to your ears, including a broken ear drum?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>13. Do you currently have any of the following hearing problems?</b>	
Difficulty hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wear a hearing aide	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other hearing or ear problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>14. Have you ever had a back injury?</b>	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>15. Do you currently have any of the following musculoskeletal problems?</b>	
Weakness in any of your arms, hands, legs, or feet	
Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty fully moving your arms or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or stiffness when you lean forward or backward at the waist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty fully moving your head up and down	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty fully moving your head side to side	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty bending at your knees	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty squatting to the ground	<input type="checkbox"/> Yes <input type="checkbox"/> No
Climbing a flight of stairs or a ladder carrying more than 25 pounds	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/> Yes <input type="checkbox"/> No

## TO THE PLHCP - Physician or Licensed Healthcare Professional

### Check the ONE that applies:

- ☐ I have reviewed Part A Section 2 of this questionnaire **with** the employee and **I do not recommend** that a physical examination be performed.
- ☐ I have reviewed Part A Section 2 of this questionnaire **with** the employee and **I am recommending** that a physical examination be performed.
- ☐ I have reviewed Part A section 2 of this questionnaire **without** the employee and **I do not recommend** that a physical examination be performed.
- ☐ I have reviewed Part A Section 2 of this question **without** the employee and **I am recommending** that a physical examination be performed.

PLHCP Signature

Printed Name

Date

Employee Signature

Printed Name

Date

## Information for Employees Using Respirators when Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not represent a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator packaging. It will tell you what the respirator is designated for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designated to filter dust particles will not protect you against gases, fumes, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.





## Employee Fit Test/Personal Protective Equipment (PPE)

Employee Name: \_\_\_\_\_ Job Title: \_\_\_\_\_ Date: \_\_\_\_\_

☐ Medical questionnaire reviewed by: Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I have received and understood training on each of the following:**

Attestation	Initials
Review of written Respiratory Protection Program	
Description of the activities and circumstances for which respirator use is required	
Importance of proper fit and the consequences of improper fit	
Importance of proper use, storage, or inspection and when to discard or reuse	
Limitations of this type of respirator	
Appropriate action if respirator becomes damaged, a leak is detected or breathing becomes difficult	
Review of manufacturer instruction sheet: proper donning, performing user seal check, and removing respirator	
Appropriate use of a respirator when necessary to protect against infectious disease when providing patient care	

☐ Initial fit test   ☐ Annual fit test   ☐ Re-test fit test (if reason for Re-test is due to an employee's condition change, then the medical questionnaire must be completed prior to fit testing).

☐ **Employee reports no change in health condition**

Sensitivity Test		
<input type="checkbox"/> Bitrix <input type="checkbox"/> Saccharin	<input type="checkbox"/> Bitrix <input type="checkbox"/> Saccharin	<input type="checkbox"/> Bitrix <input type="checkbox"/> Saccharin
# of squeezes _____ *if not detected after 30 squeezes, repeat with another solution	# of squeezes _____ *	# of squeezes _____

☐ Seal check/proper fit assessed by participant   ☐ Respirator worn for 5 minutes prior to fit test

Qualitative Fit Test		
Test Solution	<input type="checkbox"/> Bitrix <input type="checkbox"/> Saccharin	<input type="checkbox"/> Bitrix <input type="checkbox"/> Saccharin
Breathe normally (60 seconds)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Breathe deeply (60 seconds)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Turn head side to side (60 seconds)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Talking (60 seconds)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Move head up and down (60 seconds)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Bend over at waist (60 seconds)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Breathe normally (60 seconds)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

☐ Unable to complete test: Reason \_\_\_\_\_

☐ Failed Fit test: Manufacturer \_\_\_\_\_ Model Type \_\_\_\_\_ Size \_\_\_\_\_

☐ Successfully completed fit test: Manufacturer \_\_\_\_\_ Model Type \_\_\_\_\_ Size \_\_\_\_\_

**Back Brace - The use of back braces is optional. If you choose to wear one Aveanna will provide one for your use.**

☐ Yes, I want a back brace   ☐ No, I do not want a back brace. I understand I can change my mind in the future.

Back Brace Size: \_\_\_\_\_ ☐ Available in Patient Care Area   ☐ Distributed to employee

**PPE:** Available in Patient Care Area (PCA) Distributed to employee (E) (Check appropriate box and circle location)

<input type="checkbox"/> N95 Respirator	PCA	E	N/A	<input type="checkbox"/> Apron	PCA	E	N/A	<input type="checkbox"/> Hair Covering	PCA	E	N/A
<input type="checkbox"/> KN95	PCA	E	N/A	<input type="checkbox"/> Gown	PCA	E	N/A	<input type="checkbox"/> Biohazard Bag	PCA	E	N/A
<input type="checkbox"/> Surgical Mask	PCA	E	N/A	<input type="checkbox"/> Sterile Gloves	PCA	E	N/A	<input type="checkbox"/> Sharps Container	PCA	E	N/A
<input type="checkbox"/> Eye Protection	PCA	E	N/A	<input type="checkbox"/> Non-Sterile Gloves	PCA	E	N/A	<input type="checkbox"/> Shoe Covers	PCA	E	N/A
<input type="checkbox"/> Face Protection	PCA	E	N/A	<input type="checkbox"/> Utility Gloves	PCA	E	N/A	<input type="checkbox"/> Other _____	PCA	E	N/A

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Company Representative Signature \_\_\_\_\_

Date \_\_\_\_\_

**3M™ FT-10 (sweet) and 3M™ FT-30 (bitter) fit test kits are suitable for disposable respirators, half facepiece fitted with particulate filters, and full facepieces fitted with particulate filters.<sup>1</sup>**

**!** Wearers must be clean-shaven to get a proper fit with a respirator.

**!** Please note, in order to carry out a full fit test, all the steps detailed below must be followed (Parts 1 & 2).



### Part 1 - Sensitivity Testing (The “Taste Test”)

1. Add 1/2 teaspoon of sensitivity solution (in red labeled bottle) into the sensitivity nebulizer (marked in red). Visually confirm that the nebulizer produces a cloud of aerosol when the bulb is squeezed.
2. Place test hood on participant. A respirator should not be worn during the sensitivity test.
3. Ask the participant to breathe through their mouth with their tongue slightly extended and ask them to indicate immediately when they taste the solution.
4. Squeezing the bulb completely and aiming the nebulizer to the side rather than directly at the subject, squeeze solution into the hood and count the number of squeezes it takes for the solution to be tasted.
5. If desired, participant may drink some water.



**!** Stop the test if solution is not tasted after 30 squeezes. Try an alternative solution from below.

**Sweet taste** 3M-FT11 (sensitivity solution)  
3M-FT12 (test solution)

**Bitter taste** 3M-FT31 (sensitivity solution)  
3M-FT32 (test solution)

### Part 2 - Fit Testing

1. Add 1/2 teaspoon of test solution (in black labeled bottle) into the test nebulizer (marked in black). Visually confirm that the nebulizer produces a cloud of aerosol when the bulb is squeezed.
2. Don the respirator and make sure respirator is fitted correctly. Refer to the 3M fitting instructions or poster for correct procedure. After the respirator is correctly donned, wait five minutes before beginning the next step.
3. Place test hood on participant.

Number of Squeezes Needed in Part 1	Number of Squeezes for Initial Dose	Number of Squeezes for a Replenishing Dose Every 30 Seconds
1-10	10	5
11-20	20	10
21-30	30	15

4. Introduce solution in an initial dose and start the exercises. Add a replenishing dose after every 30 second per the table below.
5. After the initial dose, ask the participant to carry out the 7 exercises shown in turn for 1 minute each and indicate immediately if solution is tasted. Remember to add a replenishing dose every 30 seconds. **Throughout the test, remind the participant to breathe through their mouth and visually confirm that the nebulizer is not clogged.**
6. Record all results.  
If solution is not tasted after all 7 exercises, they have passed the test with that specific respirator. If solution is tasted, stop the test, rinse mouth, face, and hands, refit respirator and restart at Part 1 - Sensitivity Testing.  
If solution is still tasted on the second attempt, stop the test, rinse hands, mouth, and face, and consider trying an alternative 3M respirator.
7. Discard all unused solution.

### 7 Exercises



This product is part of a system that helps reduce exposures to certain airborne contaminants. Before use, the wearer must read and understand these User Instructions. Follow all local regulations. In the U.S., a written respiratory protection program must be implemented meeting all the requirements of 29 CFR 1910.134, including training, fit testing and medical evaluation. In Canada, CSA standard Z94.4 requirements must be met and/or requirements of the applicable jurisdiction, as appropriate. Misuse may result in injury, sickness or death. For correct use, consult supervisor and User Instructions, or call 3M Technical Service in USA at 1-800-243-4630 and in Canada at 1-800-267-4414.

<sup>1</sup>Quantitative fit testing must be used when an assigned protection factor higher than 10 is needed for a full facepiece used in negative pressure mode, per 29 CFR 1910.134

#### Personal Safety Division

3M Center, Building 235-2W-70  
St. Paul, MN 55144-1000

#### In United States of America

Technical Service: 1-800-243-4630  
Customer Service: 1-800-328-1667

3M.com/workersafety

#### In Canada

Technical Service: 1-800-267-4414  
Customer Service: 1-800-364-3577

3M.ca/Safety

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Please recycle. February 2019



For a demonstration  
video, visit the link below.

[go.3M.com/Fit](https://go.3M.com/Fit)

# Seven Steps to Correctly Wear a Respirator at Work

Following these simple steps will help you properly put on and take off your respirator, and keep you and everyone else safe.

## 1 Wash Your Hands



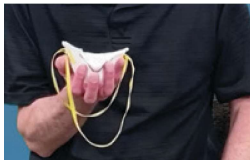
Wash your hands with soap and water or alcohol-based hand rubs containing at least 60% alcohol.

## 2 Inspect the Respirator



Inspect the respirator for damage. If it appears damaged or damp, do not use it.

## 3 Put on the Respirator



Cup the respirator in your hand with the nosepiece at your fingertips and the straps hanging below your hand.



Cover your mouth and nose with the respirator and make sure there are no gaps (e.g., facial hair, hair, and glasses) between your face and the respirator.



Place the strap over your head and rest at the top back of your head. If you have a second strap, place the bottom strap around your neck and below your ears. Do not crisscross straps.



If your respirator has a metal nose clip, use your fingertips from both hands to mold the nose area to the shape of your nose.

## 4 Adjust the Respirator



Place both hands over the respirator. Inhale quickly and then exhale. If you feel leakage from the nose, readjust the nosepiece; if leakage from the respirator edges, readjust the straps.



Repeat until you get a proper seal. If you can't get a proper seal, try another respirator.

## 5 Wear the Respirator



Avoid touching the respirator while using it. **If you do, wash your hands.**

*Note: If you reuse your respirator, wear gloves when inspecting and putting on the respirator. Avoid touching your face (including your eyes, nose, and mouth) during the process.*

## 6 Remove the Respirator



Wash your hands.



Remove the respirator from behind. Do not touch the front.

## 7 Dispose of the Respirator



If the respirator does not need to be reused because of supply shortages, discard it in a closed-bin waste receptacle. Wash your hands.

For more information, see the quick video, "Putting On and Taking Off a Mask". ▶



## Respiratory Protection Program Employee Education

Aveanna Healthcare's Respiratory Protection Program applies to all home health and Aveanna employees who may at times require respiratory protection for infection control purposes. This program is intended to provide each employee with a respirator where applicable to protect the health of such employee.

A respirator may be used to provide protection from infectious diseases such as measles, varicella, smallpox, tuberculosis, SARS, pandemic influenza or COVID. It is important to ensure a proper fit. An improper fit, improper use, failure to store properly or failure to inspect prior to each use can compromise protective equipment. For questions related to respirator use, contact your supervisor.

### Limitations of a respirator:

- Respirators are intended for biologic agents.
- Respirators limit but do not provide a 100% guarantee to eliminate risk.
- Respirators do not protect against gasses, vapors, oil, aerosol, asbestos, arsenic, cadmium, lead or sandblasting.
- Respirators do not provide oxygen.
- Respirators should not be used with beards or facial hair that can obstruct a good seal.

### Respirator malfunction:

- If the respirator becomes damaged or soiled, a leak is detected, or breathing becomes difficult, leave the contaminated area immediately and replace the respirator.

### Donning and Removing the Respirator:

- Review the 'Helping You Wear It Right' manufacturer instruction sheet for proper donning, user seal check, and removal of the respirator.
- You must perform a user seal check to ensure that an adequate seal is achieved each time the respirator is put on using the respirator manufacturer's recommended user seal check method.

### Storage, Cleaning and Reuse of the Respirator:

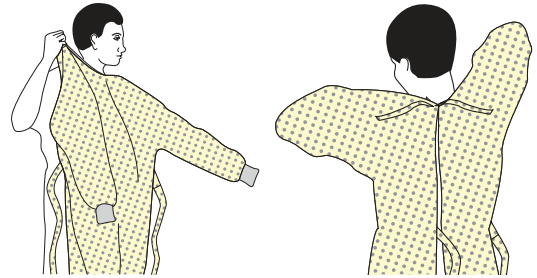
- Store in a clean, dry area with no exposure to direct sunlight or temperature extremes.
- The respirator can be stored in a paper bag.
- Do not crush the respirator.
- Respirators cannot be cleaned or disinfected.
- There are no manufacturer recommendations on time use limit.
- If the medical condition requires only airborne precautions (e.g., TB):
  - Discard the respirator if it is soiled, if breathing becomes labored, or if structural integrity is compromised.
- If the condition also requires contact and/or droplet precautions:
  - The respirator must be discarded after a single use. However, in times of shortage, users may be instructed to cover the respirator with a surgical mask and discard the mask after use but reuse the respirator. This decision will be made by the Respiratory Protection Program Administrator based on supply and available epidemiological data. Decisions will be clearly communicated to the staff.

# SEQUENCE FOR **PUTTING ON** PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

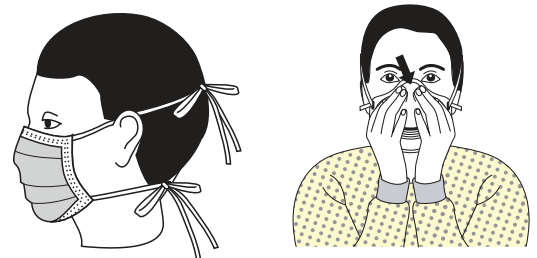
## 1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



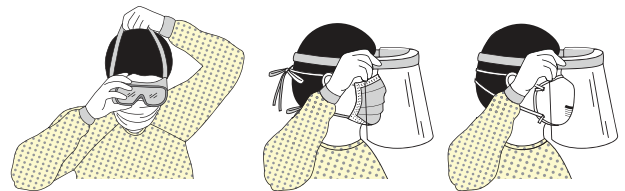
## 2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



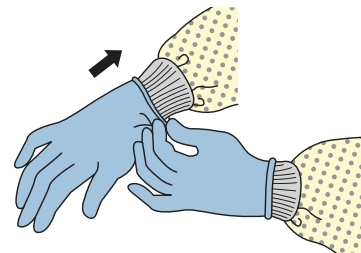
## 3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



## 4. GLOVES

- Extend to cover wrist of isolation gown



## USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene





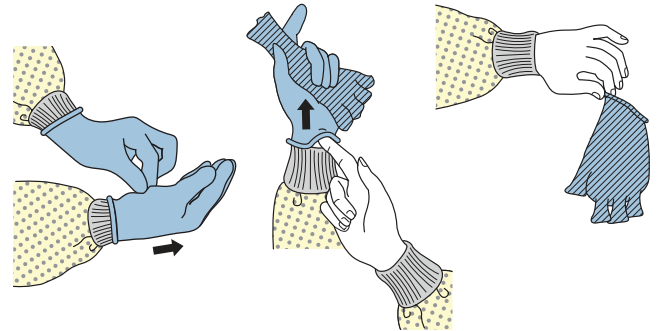
# HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)

## EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

### 1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



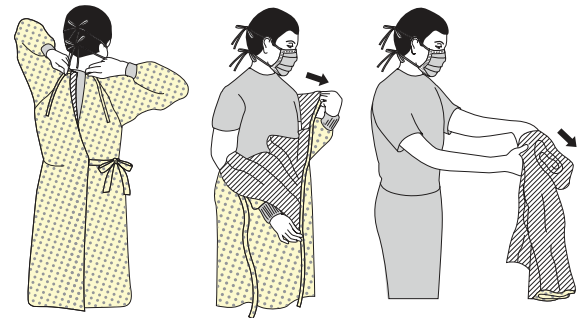
### 2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container



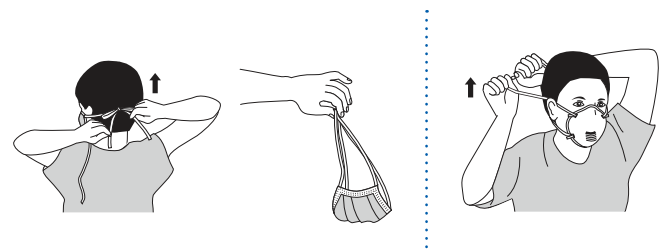
### 3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

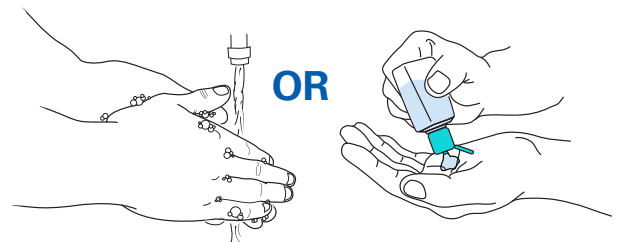


### 4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



### 5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE**



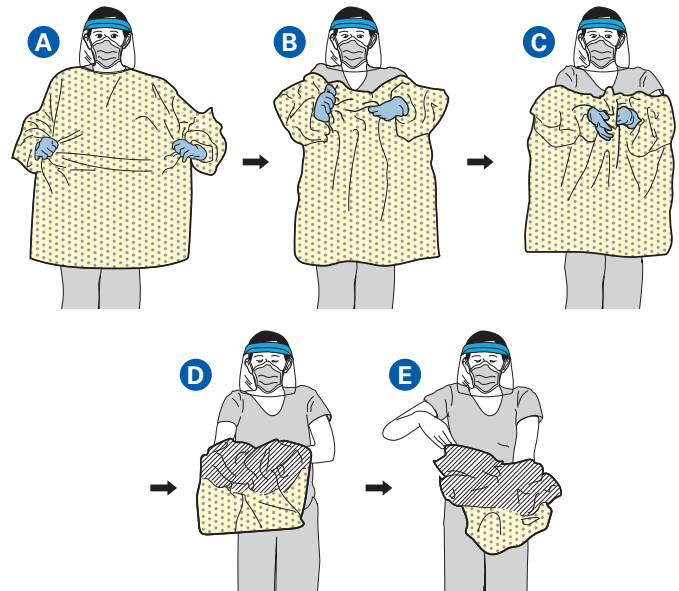
# HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)

## EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

### 1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



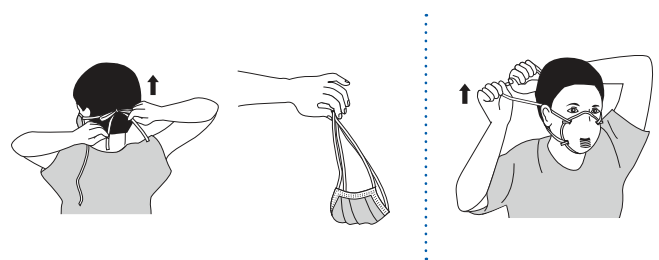
### 2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

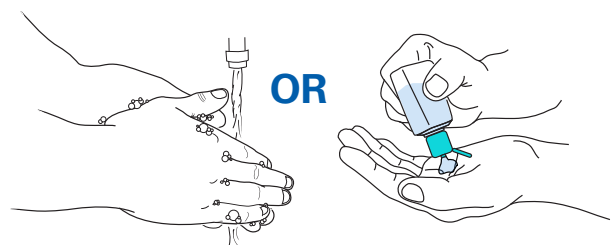


### 3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



### 4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE**



When using an EMR where only capital letters are used, the capitalized version of these abbreviations are also approved. *Industry Standard abbreviations (i.e. Diagnoses) are acceptable to use.*

**&** = and

**2ww** = two wheeled walker

**4ww** = four wheeled walker

## A

**a.m.** = before noon (*latin: ante meridiem*)

**ā** = before (*latin: ante*)

**A** = absent (PDHC MAR)

**AAROM** = active assisted range of motion

**ABX** = antibiotics

**ABD** = abdomen

**ac** = before meals (*latin: ante cibum*)

**AD** = assistive devices

**ad lib** = at liberty, freely

**ADL** = activities of daily living

**AFO** = ankle foot orthosis

**AFib** = atrial fibrillation

**AKA** = above knee amputation

**ALF** = assisted living facility

**AMP** = amputation

**AMS** = altered mental status

**Appt** = appointment

**AROM** = active range of motion

**ASAP** = as soon as possible

**Auth** = authorization

**ax.** = axillary, axis

## B

**b.i.d.** = twice a day (*latin: bis in die*)

**B or B/L** = bilateral

**BBS** = bilateral breath sounds

**BG** = blood glucose

**BIPAP** = bilevel positive airway pressure

**BJA** = below knee amputation

**BLE** = bilateral lower extremities

**BLS** = basic life support

**BM** = bowel movement

**BOS** = base of support

**BP** = blood pressure

**BS** = breath sounds or bowel sounds

**BSC** = bedside commode

**BST** = bedside table

**BUE** = bilateral upper extremities

## C

**c̄** = with (*latin: cum*)

**C/B or CB** = characterized by

**C/D/I** = clean, dry & intact

**c/o** = complains of

**C** = centigrade

**CABG** = coronary artery bypass graft

**cal** = calorie

**cath** = catheter

**CG** = contact guard

**CGA** = contact guard assistance

**cg** = caregiver

**CHF** = congestive heart failure

**CLOF** = current level of function

**cm** = centimeter

**CN** = cranial nerve

**CNA** = certified nursing assistant

**CNS** = central nervous system

**CO<sub>2</sub>** = carbon dioxide

**Cont.** = continued

**COPD** = chronic obstructive pulmonary disease

**CoPs** = conditions of participation

**COTA** = Certified Occupational Assistant

**CP** = cerebral palsy

**CPAP** = constant positive airway pressure

**CPR** = cardiopulmonary resuscitation

**CPT** = chest percussion therapy

**CSO** = case specific orientation

**CTA** = clear to auscultation



**CTI** = certification of terminal illness

**CVAD** = central venous access device

**CVC** = central venous catheter

**CVL** = central venous line

**CXR** = chest x-ray

## D

**d/t** = due to

**D/C or DC** = discharge; discontinue

**DD** = discipline discharge

**Demo** = demonstrate/demonstration

**DM** = diabetes mellitus

**DME** = durable medical equipment

**DNR** = do not resuscitate

**DOB** = date of birth

**DOE** = dyspnea on exertion

**DOS** = date of service

**DSD** = dry sterile dressing

**DTR** = daughter

**Dx** = diagnosis

## E

**ECOC** = estimated cost of care

**ED** = Emergency Department

**EENT** = eye, ear, nose & throat

**EMT** = Emergency Medical Technician

**ENT** = ear, nose & throat

**EOB** = end of bed

**EOL** = end of life

**EPAP** = expiratory positive airway pressure

**ER** = Emergency Room, external rotation

**ETCO<sub>2</sub> or ETCO<sub>2</sub>** = end tidal carbon dioxide

**ETT** = endotracheal tube

**Exam** = examination

**EXT** = external

## F

**F** = fahrenheit

**F/U** = follow up

**F2F** = face to face

**FFOC** = foster father of child

**FM** = fine motor

**FMOC** = foster mother of child

**FOC** = focus of care, father of child

**Fr** = French

**FSBS** = finger stick blood sugar

**FWB** = full weight bearing

**FWW** = front wheeled walker

**FX** = fracture

## G

**GAH** = given at home (PDHC MAR)

**GCS** = Glasgow Coma Scale

**GERD** = gastro esophageal reflux disease

**GFOC** = grandfather of child

**GI** = gastrointestinal

**GJ** = gastrostomy-jejunostomy tube

**gm.** = gram

**GM** = gross motor

**GMOC** = grandmother of child

**Gt. Tr. or GT. TR.** = gait training

**GT or Gtube** = gastrostomy tube

**gtt** = drops (*latin: guttae*)

**GU** = genitourinary

## H

**H/A** = headache

**h.s.** = bedtime (*latin: hora somni*)

**H/O** = history of

**H<sub>2</sub>O or H<sub>2</sub>O** = water

**HCS** = healthcare surrogate

**HEP** = home exercise program

**HH** = Home Health

**HHH** = Home Health Hospice

**HHA** = Home Health Aide

**hha** = hand hold assist

**HI** = homicidal ideation

**HLD** = hyperlipidemia

**HME** = heat moisture exchanger

**HOB** = head of bed

**HoH** = hard of hearing

**HOH** = hand over hand

**HOHA** = hand over hand assistance

**hr.** = hour

**HR** = heart rate

**HRRR** = heart rate and rhythm regular

**HTN** = hypertension

**HUH** = hand under hand

**HX** = history

**hz** = hertz

## I

**I** = independent

**I/O or I&O** = intake/output

**IADLs** = instrumental activities of daily living

**IBS** = irritable bowel syndrome

**ICP** = intracranial pressure

**ICU** = Intensive Care Unit

**IE** = initial evaluation

**IHSS** = In Home Support Services

**ILF** = Independent Living Facility

**IM** = intramuscular

**IMV** = intermittent mandatory ventilation

**IND** = independently

**IPAP** = inspiratory positive airway pressure

**IPPB** = intermittent positive pressure breathing

**IR** = internal rotation

**Irreg. or IRREG.** = irregular

**IV** = intravenous; intraventricular

## J

**JTube** = jejunostomy tube

## K

**KAFO** = knee ankle foot orthosis

**kg** = kilogram

## L

**L** = left

**lb** = pound

**LBQC** = long based quad cane

**LCTA** = lungs clear to auscultation

**LE** = lower extremity

**LHA** = Licensed Health Aide

**LLE** = left lower extremity

**LMN** = letter of medical necessity

**LOB** = loss of balance

**LOC** = level of consciousness

**LOS** = length of stay

**LPM** = liters per minute

**LPN** = Licensed Practical Nurse

**LVN** = Licensed Vocational Nurse

**LUE** = left upper extremity

## M

**MAEW** = moves all extremities well

**Maint** = maintain

**MAR** = medication administration record

**Max. or Mas** = maximum or maximal, maxillary

**MaxA** = maximal assistance

**MBSS** = modified barium swallow study

**mcg** = micrograms

**MD** = Medical Doctor

**MDI** = metered dose inhaler

**med** = medication

**Med Dir** = Medical Director

**mEq** = milliequivalent

**Min** = minimal

**mg** = milligram

**MinA** = minimal assistance

**mL** = milliliter

**mm** = millimeter

**MMT** = manual muscle test

**MNS** = medication not sent (PDHC MAR)

**MOC** = mother of child

**Mod** = moderate

**ModA** = moderate assistance

**ModI** = modified independent

**MR#** = medical record number

**MRI** = magnetic resonance imaging

**MSW** = Medical Social Worker

**MVA** = motor vehicle accident

## N

**n/a** = not applicable

**NAD** = no abnormality detected, no apparent distress

**NB** = non-billable

**NC** = nasal cannula

**ND** = not done

**Neg** = negative

**NG** = nasogastric

**NICU** = Neonatal Intensive Care Unit

**NJ** = nasojejunal

**NKA** = no known allergies

**NKDA** = no known drug allergies

**NMES** = neuro muscular electrical stimulation

**NOE** = notice of election

**NPO** = nothing by mouth (*latin: nil per os*)

**NP** = Nurse Practitioner

**NS** = normal saline

**N&V, NV, or N/V** = nausea and vomiting

**NWB** = non-weight bearing

## O

**O<sub>2</sub> or O2** = oxygen

**O2 Sat** = oxygen saturation

**OBT** = over bed table

**OG** = oral glucose or orogastric

**Oint.** = ointment

**OJ** = orojejunal

**OOB** = out of bed

**Opth** = ophthalmology

**OSA** = obstructive sleep apnea

**Ost.** = ostomy

**OT** = Occupational Therapist/Therapy

**OTA** = Occupational Therapy Assistant,  
open to air

**OTC** = over the counter

**oz** = ounce

## P

**p** = post, after

**PALP** = palpate, palpated, palpation

**pc** = after meals (*latin: post cibum*)

**PC** = pressure control

**PCG** = patient caregiver

**PCO<sub>2</sub>** = partial pressure of carbon dioxide

**PCP** = primary care physician

**PDHC** = Pediatric Day Health Center

**PDN** = Private Duty Nursing

**PDS** = Private Duty Services

**PEEP** = positive end expiratory pressure

**PEG** = percutaneous endoscopic gastrostomy

**PERRL/PERRLA** = pupils equal round and  
reactive to light (accommodate)

**Pharm** = pharmacy

**PICC** = peripheral inserted central catheter

**PICU** = Pediatric Intensive Care Unit

**PIP** = proximal interphalangeal

**PIV** = peripheral inserted venous

**PLOF** = prior level of function

**pm** = afternoon/night (*latin: post meridiem*)

**PMH** = past medical history

**PN** = progress note

**PNA** = pneumonia

**po** = by mouth (*latin: per os*)

**POA** = power of attorney

**POC** = plan of care

**POD** = post operative day  
**POE** = prone on elbows  
**POX** = pulse oximetry  
**PPOT** = physician plan of treatment  
**POT** = plan of treatment  
**PRN** = as often as necessary (*latin: pro re nata*)  
**PROM** = passive range of motion  
**PS** = pressure support  
**PT** = Physical Therapy/Therapist  
**PTA** = Physical Therapy Assistant  
**pt** = patient  
**PVR** = post void residual  
**PWB** = partial weight bearing  
**PX or prog.** = prognosis

## Q

**q.h.** = every hour (*latin: quaque hora*)  
**q/Q** = each; every; line over (*latin: quaque*)  
**QID or q.i.d.** = four times daily (*latin: quater in die*)  
**QIO** = Quality Improvement Organization  
**QUAD** = quadriplegic

## R

**R** = right  
**RA** = room air  
**RE** = re-evaluation, regarding  
**Rehab.** = rehabilitation  
**Req'd** = required  
**Resp** = respiratory  
**RLE** = right lower extremity  
**RN** = registered nurse  
**R/O or RO** = rule out  
**ROM** = range of motion  
**RR** = respiratory rate  
**RUE** = right upper extremity  
**Rx** = prescription, therapy

## S

**Ŝ** = without (*latin: sine*)

**s/p** = status post  
**s/s** = signs & symptoms  
**Sat** = saturated  
**SBA** = stand by assistance  
**SBQC** = small based quad cane  
**SGA** = small for gestational age  
**SI** = suicidal ideation  
**SIL** = son in law  
**SIMV** = synchronized intermittent mechanical ventilation  
**SIDS** = sudden infant death syndrome  
**SL** = sublingual  
**SLP/ST** = Speech Language Pathologist/Therapist  
**SLPA** = Speech Language Pathology Assistant  
**SLS** = single limb stance

**sm or SM** = small

**SMAFO** = supramalleolar ankle foot orthosis  
**SMO** = supra-malleolar orthosis  
**SN** = skilled nurse  
**SNF** = Skilled Nursing Facility  
**SNV** = skilled nursing visit  
**SOAP** = subjective, objective, assessment, plan  
**SOB** = shortness of breath  
**SOS** = step over step  
**SP or S/P** = status post  
**SpO<sub>2</sub> or SPO2** = pulse oximetry  
**SPON or spont.** = spontaneously  
**SQ or subcut.** = subcutaneous  
**STAT** = immediately (*latin: statim*)  
**SUP** = supervision  
**SX** = symptoms  
**SZ or sz** = seizure  
**sxn** = suction

## T

**T&A** = tonsils and adenoids, tonsillectomy and adenoidectomy

**Tab.** = tablet

**TB** = tuberculosis

**TBI** = traumatic brain injury

**temp.** = temperature

**THA** = total hip arthroplasty

**THH** = hands held

**THR** = total hip replacement

**TID** = three times a day (*latin: ter in die*)

**TKR** = total knee arthroplasty

**TKR** = total knee replacement

**TLSO** = thoracolumbosacral orthosis

**TO** = telephone order

**TOL** = tolerated

**TPN** = total parenteral nutrition

**TPR** = temperature pulse respiration

**Tr. or TR** = trace

**Trach or TRACH** = tracheostomy

**Trach/vent** = tracheostomy and ventilator

**TSA** = total shoulder arthroplasty

**Tsp** = teaspoon

**TTS** = tight to the shaft

**TTWB** = toe touch weight bearing

**T/V or T&V** = tracheostomy and ventilator

**TX/Tx/tx** = treatment or therapy

## U

**UA** = urinalysis

**UE** = upper extremity

**URI** = upper respiratory infection

**US or U/S** = ultrasound

**UTI** = urinary tract infection

## V

**VA** = Veterans Administration

**VET** = veteran

**Vent** = ventilator

**VFO** = visit frequency order

**VIA or via** = by way of

**v.o. or VO** = verbal order

**VP** = ventriculoperitoneal

**VS** = vital signs

**VSOC** = verbal start of care

**VSS** = vital signs stable

**Vt** = ventilation tube

**VT** = ventricular tachycardia

## W

**W/C** = wheelchair

**WB** = weight bearing

**WBAT** = weight bearing as tolerated

**WBOS** = wide base of support

**WFL** = within functional limits

**WNL** = within normal limits

**WOB** = work of breathing

**Wt.** = weight

## X

**Ẋ** = except

**X** = times, e.g., "suction x 4"

## Y

**Y.O. or yo** = years old

**Yrs.** = years

## DO NOT USE List of Abbreviations

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write “unit”
IU (international Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write “international Unit”
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write “daily”
Q.O.D., QOD, q.o.d, qod (every other day)	Period after Q mistaken for “I” and the “O” mistaken for “I”	Write “every other day”
Trailing zero (X.0 mg)*	Decimal point is missed	Write X mg
Lack of leading zero (.X mg)	Decimal point is missed	Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write “morphine sulfate”
MSO4 and MgSO4	Confused for one another	Write “magnesium sulfate”

\*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Reference from: Joint Commission List of 06-15-2023



# HCHB HH Service Code Description

Last Modified on 07/08/2025 1:29 pm EDT

## Purpose:

To provide an overview of discipline codes, service codes, and buddy codes.

## Regulation:

## Policy:

## Process:

1. All Service Codes are pre-fixed with a discipline code. if '11' is for a Routine visit then a PT11 would be a Physical Therapy Routine Visit or a SN11 would be a Skilled Nursing Routine Visit. Below is a list of the Home Health Discipline Codes:

1. For reference the [Home Health Service Codes 06.26.25.xlsx](#) spreadsheet is available with greater detail for each service code in the HCHB system.

Discipline Codes	
<b>AIDE = Aide Only (No OASIS)</b>	<b>PA = Physical Therapy Assistant</b>
<b>CT = COTA</b>	<b>PDR = RN Pediatric</b>
<b>HH = Home Health Aide</b>	<b>PDS = SN Pediatric</b>
<b>HM = Homemaker</b>	<b>PSY = RN Psychiatric</b>
<b>IVN = Infusion No POC</b>	<b>PT = Physical Therapist</b>
<b>IVR = RN Infusion</b>	<b>RD = Registered Dietician</b>
<b>IVS = SN Infusion</b>	<b>RN = Registered Nurse</b>
<b>LPN = Licensed Practical Nurse</b>	<b>RT = Respiratory Therapy</b>
<b>MS = Medical Social Worker</b>	<b>SN = Skilled Nurse (RN or LPN)</b>
<b>MSWI = Medical Social Worker (In Person)</b>	<b>ST = Speech Therapist</b>
<b>MSWT = Medical Social Worker (Telephone)</b>	
<b>OT = Occupational Therapist</b>	

2. To make a complete Service Code the Discipline Code needs to be followed by a Numerical or Alphabetical code. The descriptions of these codes are listed below, first in the 'Service Codes Description' table are the 'regular' service codes. The second table below houses the 'Medical Treatment - "BUDDY CODES" table. A Buddy Code indicates that something is due on that associated visit and MUST accompany a regular service code.

1. NOTE: Some codes "Appear at the end of a Service Code" to further identify the code. These codes are noted below. A common example of this is the use of 'N' for non-billable supervisory visits. A RN10N would indicate that a Registered Nurse (RN) is completing a Supervision (10) visit that is Non-Billable (N).

Home Health Service Codes Description	CODE
Billable Admission with OASIS Data Collection	00
Billable Evaluation for "Add-on" Discipline	01
Recert with Skill ( OASIS Recert)	02
Recert WITHOUT Skill	03
Transition Recert – Only used for first 60 days on HCHB system	04
ROC/Recert (ROC within the 5 day EOE window)	05
Recert for Add-on Discipline	06
Routine Visit + Supervisory	10
Routine / Subsequent Visit	11
Resumption of Care	15
Oasis Follow UP	17
DC Visit + OASIS Collection (from agency)	18
DC Visit without OASIS collection (from discipline only)	19
Infusion Hi-Tech Visit – Lasting 1.5 HRS	26
Therapy Reassessment Visit	33
Transfer to Inpatient Facility – Data Collection Only (No visit made)	44
Discharge – Data Collection Only (No visit made)	66
Death At Home	88
Transfer to Inpatient Facility	99
Billable in Home (RN10B) - (Appears at the end of a Service Code)	B
DO NOT MOVE (DNM appears at the beginning of the discipline, for example: "DNM-SN") - Used for physician ordered date, INR's that have to be completed on a specific date.	DNM
Lymphedema Visit - (Appears at the end of a Service Code)	LY
OT Admission w/Modified OASIS (OT00(MOD)) - (Appears at the end of a Service Code)	(MOD)
Maintenance Therapy - (Appears at the end of a Service Code)	MT
As part of the Non-Admit process, the Executive Director will change the Service Code to a Non-Admit Service Code. (For example - NADMIT - RN, NADMIT-PT, NADMIT-OT, NADMIT-ST)	NADMIT
N on the end of a code denotes "No Bill" (Appears at end of a Service Code, eg., "OT11N")	N
Phone Visit - (Appears at the end of a Service Code)	P
PRN Routine Visit - (Appears at the end of a Service Code)	PRN
Rapid Subsequent (Appears at end of a Service Code, eg., "SN11RS" )	RS

Medical Treatment – "Buddy" Codes – Indicate something is due and MUST accompany a regular service code.	CODE
Procedure Due	90
Lab Due	91
Wound Pictures Due	92
Wound Measurements Due	93
Indwelling Catheter Change	94
Injection Due	95
IV CAP / Dressing Change Due	96
INR Due	97
RN, PT, OT, or ST - Transfer to Inpatient Facility - Visit Made	99
Advance Beneficiary Notice	ABN
Notice of Medicare Non-Coverage	NOMNC
Reminder that a Recert Visit is due on this date.	RC DUE

From article: HCHB HH Service Code Description | Last Modified on 07/08/2025 1:29 pm EDT



## Skills Checklist

Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

The Nurse is expected to be competent in the areas that are \*\*\* (per scope of practice) and evaluated by qualified Observer for competency. Upon hire, the nurse will complete this Self-Evaluation of all listed skills. (The designated preceptor/nursing manager will assist the employees in any area that has a self-rating of B, to ensure competency).

### Self-Rating

A = I can perform independently

B = I need Review/Have no experience

### Preceptor/Manager Competency assessment method

DOS = Direct Onsite Observation/Skills Lab

O = Oral Questions &amp; Answer

Observer Printed Name/Credentials: \_\_\_\_\_ Initials: \_\_\_\_\_

Observer Printed Name/Credentials: \_\_\_\_\_ Initials: \_\_\_\_\_

Nursing Process/Practices	Self-Rating	Method	Qualified Observer Evaluation	
			Competency	Observer Initial's/date
1.***Demonstrates ability to perform a complete systems head to toe assessment of a patient	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2.***Demonstrates effective communication skills	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3.***Accurately Documents Physician Verbal Orders and Communicates New Orders to Team Members	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
4.***Demonstrates real time documentation to include completing all required documentation in the patient's home i.e., eligibility, skilled need evident in the notes	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
5.***Ability to use Critical thinking and decision making to assure patient's needs are met	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
6.***Donning/Doffing PPE	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
7.***Bag Technique	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
8.***Proper Hand Hygiene/Infection control	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	

Medication Administration	Self-Rating	Method	Qualified Observer Evaluation	
			Competency	Observer Initial's/date
1.***Medication Reconciliation	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Anaphylaxis Management	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. Oral/Sublingual	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. IM Injections & Techniques by location	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
5. Subcutaneous Injections	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
6. Intradermal	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
7. Suppository/Enema/Bowel Programs	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
8. Ophthalmic Administration (eye drops)	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
9. Topical Agents	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
10. Inhaled Agents	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
11. ***IV Therapy	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
1. ***Preparation/Administration of Infusions	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Care of Peripheral IV	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. ***TPN Administration	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
4.***Use/Care of Implanted Ports	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
5.***Use/Care of Central Lines	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
6. Venipuncture	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
7.***Lab draws from venous access device	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	

Wound Care	Self-Rating	Method	Qualified Observer Evaluation	
			Competency	Observer Initial's/date
1.*** Understanding of wound management and various dressing types to promote healing	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Pressure Ulcer Treatment/Staging	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. Care of Graph Sites/Donor Sites	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. Care of Skin Tears	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
5. Suture/Staple removal	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
6. Surgical site care	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
7. Diabetic Wound Care	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
8.***Identification of infection/complication	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
9.***Proper Documentation of wounds	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
10.***Properly Measure Wounds	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
11. Wound photo	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
12.***Wound Vac	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	

Demonstrates Knowledge of Basic Principles / Utilization of Special Types of Equipment	Self-Rating	Method	Qualified Observer Evaluation	
			Competency	Observer Initial's/date
1. T-Tube	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Jackson-Pratt	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3.***Chest Tube	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. Nasogastric Tube Management	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
5. Management of J-Tube	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
6. Mickey Button Management	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
7. PEG Tubes	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
8. Glucometers	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
9. Pulse Oximeters	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
10. INR Machine	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
11.***Multi-layer wraps/compression wraps	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
11. Bladder Scan	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
13.***Ventricular assist device (LVAD) Management	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
14. Cleaning and Maintenance of Equipment	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	

Demonstrates Understanding of Activities Relative to Respiratory Functions	Self-Rating	Method	Qualified Observer Evaluation	
			Competency	Observer Initial's/date
1. Oral Airway Maintenance	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Nasal Airway Maintenance	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. Ambu-Bag	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. Oxygen Therapy	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
5. Oropharyngeal Suctioning	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
6. Nasopharyngeal Suctioning	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
7. Nasotracheal Suctioning	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
8. ***Care and Management of Tracheostomy	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
9. ***Tracheostomy Suctioning	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
10. ***Tracheostomy Replacement	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
11. ***Tracheostomy inner cannula change	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
12. ***Knowledge of Management of Ventilators	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	

Is Able to Assess the Maintenance of Elimination and Nutrition	Self-Rating	Method	Qualified Observer Evaluation	
			Competency	Observer Initial's/date
<b>Urinary</b>				
1. Straight Urinary Catheterization	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Foley Catheter Insertion/Irrigation/Routine Care	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. Suprapubic Catheter Insertion/Irrigation/Routine Care	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. Urostomy/Ileoconduit Management	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
5. Nephrostomy management	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
6. Collection of Urine from closed system	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Gastrointestinal</b>				
1. Ostomies Management	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Gastric Feeding- Intermittent/Bolus/Continuous	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. Knowledge of special diets	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Endocrine System</b>				
1. Diabetic Foot Care	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. Diabetic Patient Education: ex New/Chronic Hypo/hyper signs & Systems	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. Diabetic Ketoacidosis symptoms (DKA)	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> DOS <input type="checkbox"/> O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	

I have evaluated my nursing competency to the best of my ability. Those items I have marked A are areas which I have a working knowledge and past experiences and can perform safely.	Self Eval Date		Initials
* I understand I am responsible for seeking proper resources prior to performing skills for which competency has not been demonstrated during orientation. *	Orientation Completion	Eval Date	Initials

## Comments

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\_\_\_\_\_  
Nurse Signature\_\_\_\_\_  
Printed Name/Credentials\_\_\_\_\_  
Date

***Upon completion of orientation, supervisor to review with the Nurse and send this updated form with all required signatures to the Clinical Manager/Administrator to be added to my personal file, and plan to review annually and as needed.***

\_\_\_\_\_  
Supervisor Signature\_\_\_\_\_  
Printed Name/Credentials\_\_\_\_\_  
Date