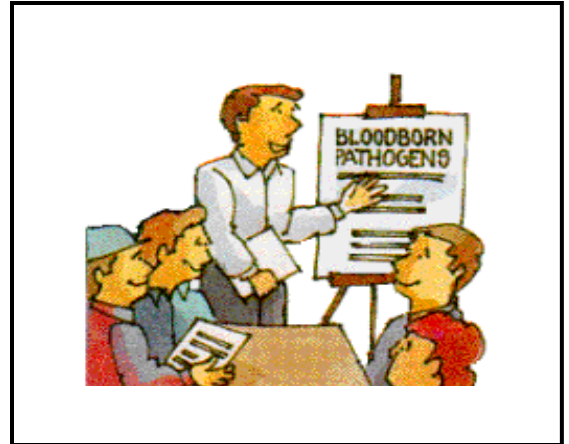


Blood Borne Pathogens

In-Service

Diseases of Blood Borne Pathogens

Blood borne pathogens are microorganisms such as viruses or bacteria that are carried in blood and other body fluids and can cause disease in people. These pathogens include, but not limited to, Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV).



Hepatitis B (HBV)

"Hepatitis" means "inflammation of the liver," and, as its name implies, Hepatitis B is a virus that infects the liver. There is no "cure" or specific treatment for HBV, but many people who contract the disease will develop antibodies, which help them get over the infection and protect them from getting it again. It is important to note, however, that there are different kinds of hepatitis, so infection with HBV will not stop someone from getting another type.

The Hepatitis B virus is very durable, and **it can survive in dried blood for up to seven days**. For this reason, this virus is the primary concern for employees such as housekeepers, custodians, laundry personnel and other employees who may come in contact with blood or other potentially infectious materials in a non-first aid or medical care situation.

Symptoms of Hepatitis B (HBV): The symptoms of HBV are very much like mild "flu". As the disease continues to develop, jaundice (yellow skin) and darkened urine will often occur. After exposure it can take 1-9 months before symptoms become noticeable.

Hepatitis C (HCV)

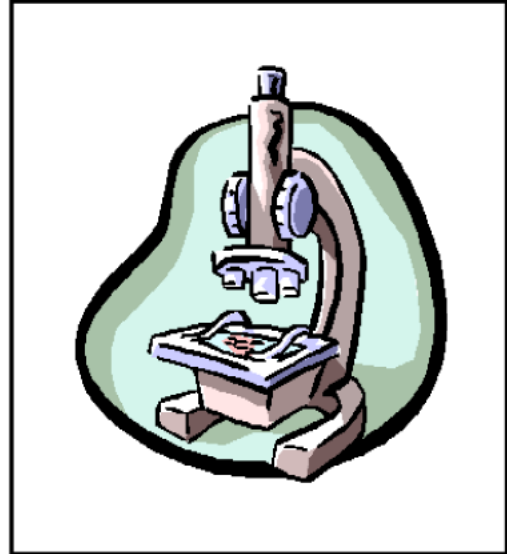
Hepatitis C virus (HCV) infection is the most common chronic blood borne infection in the United States. Most people with this virus are chronically infected and might not be aware of their infection because they are not clinically ill. HCV is transmitted primarily through exposures to blood. Risk factors include blood transfusion, injecting drug use, exposure from a sex partner or household member who has had a history of hepatitis.

Symptoms:

Many patients have no symptoms prior to development of liver cirrhosis (damage). The present symptoms are usually mild fatigue, poor appetite, joint and body aches, nausea, and mild abdominal discomfort.

Human Immunodeficiency Virus (HIV)

A virus called the human immunodeficiency virus, or HIV causes AIDS, or acquired immune deficiency syndrome. Once a person has been infected with HIV, it may be many years before AIDS actually develops. HIV attacks the body's immune system, weakening it so that it cannot fight other deadly diseases. AIDS is a fatal disease, and while treatment for it is improving, there is no known cure. The HIV virus is very fragile and will not survive very long outside of the human body. It is primarily of concern to employees providing first aid in situations involving fresh blood or other potentially infectious materials. Because it is such a devastating disease, all precautions must be taken to avoid exposure.



Symptoms:

Symptoms of HIV infection can vary, but often include weakness, fever, sore throat, nausea, headaches, diarrhea, a white coating on the tongue, weight loss, and swollen lymph glands.

Modes Of Transmission

Blood borne pathogens such as HBV, HCV and HIV can be transmitted through contact with infected human blood and other potentially infectious body fluids such as: semen, vaginal secretions, saliva (in dental procedures), and any body fluid that is visibly contaminated with blood. It is important to know how exposure and transmission are most likely to occur in your job duties. HBV and HIV are most commonly transmitted through:

- Sexual Contact
- Sharing of hypodermic needles
- From mothers to their babies at/before birth
- Accidental puncture from contaminated needles, broken glass, or other sharps
- Contact between broken or damaged skin and infected body fluids
- Contact between mucous membranes and infected body fluids

Anytime there is blood-to-blood contact with infected blood or body fluids, there is a slight potential for transmission. Unbroken skin forms the best barrier against blood borne pathogens. However, infected blood can enter your system through: open sores, cuts, abrasions, acne or any damaged or broken skin such as sunburn or blisters. Blood borne pathogens may also be transmitted through the mucous membranes of the eyes, nose, or mouth. For example, a splash of contaminated blood to your eye, nose, or mouth could result in transmission.

Reducing Your Risks

Reducing your risk of exposure to blood borne pathogens means you need to do more than wear gloves. To protect yourself effectively use:

- Engineering controls
- Work Practice controls
- Personal protective equipment
- Housekeeping
- Hepatitis B vaccine

Engineering Controls

Engineering controls are mechanical systems that are in place in to minimize hazards at the source. Their effectiveness usually depends on you and using them appropriately. Examples of engineering controls are sharps containers, red biohazard bags, and isolyzer.

- Sharp Containers are puncture resistant, leak proof containers used for disposal of contaminated broken glass, needles or lancets.
- Red biohazard bags are used for disposal of bloody waste material such as dressings. **Bloody materials need to be placed in a biohazard bag if the blood is dripping, pouring, squeezable or flaking from the contaminated material.** If it does not meet one of these requirements, it can be disposed in the standard wastebasket.
- Isolyzer is a powder that converts liquid contaminated waste into treated solid waste. The waste then can be scooped and placed in a biohazard container.

Biohazard Sign

A Biohazard symbol is a florescent orange-red symbol marked BIOHAZARD. This symbol is the universal symbol for bio hazardous materials. This symbol warns you that the container holds blood or other potentially infectious material.



Work Practice Controls

Work practice controls are specific procedures you must follow on the job to reduce your exposure to blood or other potentially infectious materials. These practices would include the use of universal precautions, personal hygiene and hand washing.

UNIVERSAL PRECAUTIONS

Most approaches to infection control are based on the concept of “Universal Precautions”, treating all blood and body fluids as if they were potentially infectious. Remember that there are many people who carry infectious diseases that have no visible symptoms and no knowledge of their condition. *Using Universal Precautions resolves this uncertainty by requiring you to treat all human blood and body fluid as if they were known to be infected with HIV, HBV or other blood borne pathogens.*



PERSONAL HYGIENE

Here are some controls based on personal hygiene that you must follow to decrease your risk of exposure. Do not eat, drink, smoke, apply cosmetics, lip balm or handle contact lenses where there is a reasonable likelihood of occupational exposure. Minimize splashing, spraying, spattering and generation of droplets when attending to an injured student or co-worker. Do not keep food and drink in refrigerators, freezers, shelves, cabinets or on countertops where blood or other potentially infectious materials are present.

HANDWASHING

The most important work place practice control is hand washing. Good hand washing keeps you from transferring contamination from your hands to other parts of your body or other surfaces you may contact later. You should wash your hands with nonabrasive soap and running water every time you remove your gloves and other personal protective equipment. If your skin or mucous membranes come in direct contact with blood or other body fluids, **wash or flush the area with water immediately.** Where hand washing facilities are not available, such as the playground, you should use antiseptic towelettes or hand cleanser. Use these as a temporary measure only. You must still wash your hands with soap and running water as soon as you can.



Personal Protective Equipment (PPE)

The type of personal protective equipment (PPE) appropriate for your job, varies with the task and the degree of exposure you anticipate. Equipment that protects you from contact with blood or other potentially infectious materials may include gloves, masks, gowns, face shields, goggles and/or resuscitation mouthpieces. PPE must be appropriate for the task

and fit properly to protect you from BBP. You must use appropriate PPE each time you perform a task with potentially infectious material. PPE is considered appropriate if it doesn't permit blood or other potentially infectious material to pass through or reach clothing, skin, eyes, mouth or other mucous membranes under normal condition of use. Gloves are the most commonly used PPE. Gloves should be made of latex, nitril, rubber, or other water impervious materials. If you know you have cuts or sores on your hands, you should cover these with a bandage or similar protection as an additional precaution before putting on your gloves. You should always inspect your gloves for tears or punctures before putting them on. **If a glove is damaged, don't use it!**

Glove Removal:

Gloves should be removed when they become contaminated or damaged, or immediately after finishing the task. You must follow a safe procedure for glove removal, being careful not to contaminate your hands.

- With both hands gloved, peel one glove off from top to bottom and hold it in the gloved hand.
- With the exposed hand, peel the second glove from the inside, tucking the first glove inside the second.
- Dispose of the entire bundle promptly.
- Never touch the outside of the glove with bare skin.
- Every time you remove your gloves wash your hands with soap and running water as soon as possible.



Goggles and Face Shields:

Anytime there is a risk of splashing or vaporization of contaminated fluids; goggles, face shields and/or other protection should be used to protect your face. Splashing could occur while cleaning up a spill, or while providing first aid or medical assistance.

Aprons/Cover gowns:

Aprons/gowns may be worn to protect your clothing and to keep blood or other contaminated fluids from soaking through to your skin. Normal clothing that becomes contaminated with blood should be removed as soon as possible because fluids can seep through the cloth and come into contact with skin.

Hepatitis B Vaccinations

Employees who have routine exposure to blood borne pathogens (such as; nurses, first aid responders, social workers, custodians, those who perform medical procedures and laundry personnel) shall be offered the Hepatitis B vaccine series at no cost to themselves unless:

- They have previously received the vaccine series.
- Antibody testing has revealed they are immune.
- The vaccine is contraindicated for medical reasons.

The series consists of 3 vaccinations given over a 6 month period of time. Although your employer must offer the vaccine to you, you do not have to accept this offer. You may opt to decline the vaccination series, in which case you will be asked to sign a "Declination form".

Even if you decline the initial offer, you may choose to receive the series at anytime during your employment thereafter, for example, if you are exposed on the job at a later date. If the vaccine is administered immediately after exposure it is extremely effective at preventing the disease. There is no danger of contracting the disease from getting the vaccine, and once vaccinated, a person does not need to receive the series again.

Name _____

Date _____

Blood Borne Pathogens In-Service Quiz

1. Please list three blood borne pathogens:

1. _____

2. _____

3. _____

2. How many days can the Hepatitis B virus survive in dried blood?

3. How long can it take for Hepatitis B virus symptoms to become noticeable?

4. What are two common symptoms of the Hepatitis C virus?

1. _____

2. _____

5. Fill in the blanks: HIV attacks the body's _____ weakening it so that it cannot fight other deadly diseases.

6. When is HIV primarily a concern for employees to take necessary precautions to avoid exposure?

7. List 3 ways that HBV and HIV are most commonly transmitted:

1. _____

2. _____

3. _____

8. Please give an example of an engineering control used to reduce risk of exposure to blood borne pathogens.

9. Please give an example of work place controls used to reduce risk of exposure to blood borne pathogens.

10. Please give two examples of personal protective equipment used to reduce risk of exposure to blood borne pathogens.

11. How many vaccinations are given over a period of 6 months when given the Hepatitis B vaccine series?

12. True or False: You are required to obtain this vaccination series.

Body Mechanics and Movement In-Service

Body Mechanics for Common Activities

Using proper body mechanics can prevent back injury, help speed up recovery if you are already injured and prevent further injury after your back has healed. The following are some suggestions for activities that you may use with daily activities.

Body Mechanics Basics:

1. **Test the load.** Before you lift, check the weight and make sure you can lift it safely. If not, get help or use an assistive device.
2. **Keep your back in its natural curve.** Bend at the hips and/ or knees. With the low back erect, the forces are distributed safely.
3. **Maintain a wide base of support.** A solid and wide base will help reduce the possibility of slipping.
4. **Hold objects as close to you as possible.** This reduces stress on the back.
5. **Do not twist when carrying.** Move or change directions with the feet. This decreases the stress and load on the back.
6. **Tighten stomach muscles when lifting.** This helps the abdominal area to help in the lift and reduce strain on the low back.
7. **Think before you lift.** First think how you will lift the object. Plan the path and make sure it is clear.
8. **Lift with the legs or the large muscles.** Using the large muscle groups helps diminish the forces on the low back.
9. **Maintain good communication if two or more people are involved.** Good timing on a lift reduces the likelihood of jerky or sudden unexpected movements.
10. **Move obstacles out of the way.** Making sure the path is clear (clearing away toys, tools, loose rugs, etc.) decrease the risk of slipping or falling.
11. **Push rather than pull.** It is easier to utilize your weight advantage when pushing.
12. **Eliminate repetitive lifting duties if possible.** Place things or supplies that you constantly need or use at a better height initially to decrease lifting activities.

When getting out of car, first open the door completely, then swing the legs out to the side and pivoting on the buttocks so the entire body moves as a unit. Do not twist the low back. Place one hand on the seat and the other hand on the car frame. Scoot forward and place feet under the hips, lean forward, and push with one hand while pulling with the other hand, and use the leg muscles to come up to a standing position. To sit down, reverse the procedure.

When retrieving things from a low shelf, instead of bending over and twisting it is better to kneel down or squat in front of the shelf, pick up the objects holding them close to body, and then stand up using the strong leg muscles and keeping the back straight.

Many activities require standing for a while such as **brushing your teeth, ironing, washing dishes, or folding laundry.** First to avoid fatigue, try to break these duties up into smaller time periods. Second, place one foot on a step or ledge. Do not bend at the waist, instead bend at the knees and keep back straight. Third, use one hand to provide support. And lastly, try to do the activity at a comfortable height.

When doing activities that are above chest level such as washing windows, painting, changing light bulbs, or hanging pictures, always use a stable step stool so that these activities are at a better level. Another alternative is to use a long handled reacher or brush.

These are several things to remember when performing duties such as vacuuming, sweeping, shoveling, or raking. Stay close to the work area. Use the arms and leg muscles while keeping the back straight. Avoid twisting movements. Use body weight to help with the job.

Pulling:

Remember try to think of a way to push first. First test the load to see how easy it is to pull. Make sure the path is clear. Stand facing the object, placing the hands on the object. Place one leg behind the other. Bend the knees and keep the back straight. Tighten the abdominal muscles and slowly pull with the arms and legs. Once moving, continue to pull in a slow and steady manner. When ready to stop pulling, slowly ease up, and return to a standing position.

Carrying:

When carrying things like boxes or other items that can be held, hold the object close to the trunk. Do not twist.

If carrying things like suitcases or handbags, observe the following rules:

1. Try to carry equal weight in both arms.
2. Then picking up the bags, keep back straight and bend at the knees,
3. Do not twist while carrying the bags.
4. Lower bags by bending knees, not the back.

Pushing:

First, test the load to see how easy it is to push. Make sure the path is clear. Stand facing the object, placing the hands on objects. Place one leg behind the other, Bend the knees and keep the back straight. Tighten the abdominal muscles and slowly push with the arms and legs. Once moving, continue to push in a slow and steady manner. When ready to stop pushing, slowly ease up, and return to a standing position.

Lifting Options Relating to Daily Tasks

Following are examples of different lifting situations which you may find yourself facing in everyday life.

Basic squat lift: This lift is useful for something of moderate size and weight such as a laundry basket, a box of clothes, or a bag of groceries.

Begin standing close to the object to be lifted. Squat down, keeping the back straight and firmly grasp the container. Pick the container up and hold close to body as you tighten the stomach muscles. Next, stand up slowly and smoothly letting the large leg muscles do the work.

The over head lift: This lift is used when lifting objects down from a high surface such as a shelf. If the object is higher than head level, use a stepstool. Move up closer to shelf. Place one leg in front of the other. Shift weight slightly to the front leg. Reach up and firmly grasp object in both hands while keeping back straight. Slowly lift object off of shelf as you shift weight back onto both feet. Carefully lower object down to chest.

The 2 person lift: This is used when the object is either too heavy for one person or is too large, bulky, or cumbersome for one person. This may be a table, a large box, or a mattress. If the object cannot be entirely held close to your body, or there is any doubt, get help. Both people stand on either side of object as close as possible. Communicate between each other as to who will count for the lift and which direction you will go. The lift performed is the squat lift. Squat down, keeping the backs straight and firmly grasp the object. The lead person gives a 1-2-3 count and both people lift on the 3 count by tightening abdominal muscles and slowly straightening legs.

Reducing the load: When possible it may be better and easier to break up the lift into several smaller lifts, such as with a box of books.

Sleeping;

When you have back pain, sleeping can be very difficult. For this reason, how you sleep can have a great impact on your rest and recovery. Following are some things you may try which may help to give relief during your sleep.

1. Sleep on a firm and flat mattress.
2. If you have had a recent injury you may be advised to stay in bed and rest flat on your back. This should be limited to only 1 – 2 days. After that time you should try sitting occasionally and participate in short walks.
3. While sleeping on your back, it may help to place a [pillow under your knees](#).
4. If sleeping on your back is too painful, try lying on your side with one of your knees up near your chest. Placing a pillow or [spacer](#) between the knees may also help.
5. While lying in bed, do not raise your arms over your head.
6. If your bed is too soft, it may help to place a piece of plywood between the mattress and springs. 5/8 or 3/4 inch should work fine.

Many back pains are from improper body mechanics during daily activities. If you currently have back pain, there are several ways of getting in and out of bed to decrease the discomfort while you are healing.

To move from lying on back, bend knees up and roll to your side. Slide legs off edge of bed with knees bent. Push up with your arms, using the legs as a counter weight and sit up. To move from sit to lying down, reverse the procedure. Begin sitting on bed. Lower yourself down to your side, using your arms to help guide and control the movement. Once you are lying on your side, you may slide the legs up onto bed. To roll on your back, keep knees bent and roll onto back.

Proper Sitting and Standing Posture

Improper posture can create many types of back pain. The spine has three natural curves, one in the neck, one in the mid back, and one in the low back. It is important to maintain these curves so the body stays “stacked up” properly. When an improper posture is maintained for extended periods of time the muscles can become weak and fatigued, resulting in burning or sharp pain, headaches, as well as muscle spasms. Some muscle groups become overstretched while other muscle groups become shortened. The ligaments (tough cord like tissue that provides stability for the spine) also can become irritated with improper posture, resulting in back aches and stiffness. This abnormal posture condition is called **Postural Dysfunction**.

Postural Dysfunction and its symptoms can generally be resolved with proper treatment.

Therapeutic exercise is used to stretch the sort muscles and provide strengthening/endurance to

the weak muscles. Posture reeducation helps to provide instruction on proper posture and how to avoid further episodes of pain.

Other forms of treatment may be used along with exercise and education. These “modalities” such as moist heat, electrical stimulation, ultrasound, and deep tissue massage help to relieve the symptoms until the muscle imbalances can be corrected.

The basic Rules of posture are as follows:

1. The head should sit directly over the neck, chin tucked in slightly and not jutting forward; the ears should be over the shoulders.
2. The shoulders should be level and “squared” back, not slumped or rounded forward.
3. The mid back should be straight up and not slumped forward.
4. The hips should be in line with the shoulders and the ankles should be in line with the hips.
5. When sitting the hips and knees should be at 90 degree angles.
6. A **lumber support** can help maintain a natural curve in the low back.

You should try to attain this posture as often as possible during your day. At first your muscles will not have the endurance to keep your posture correct all day, but as you begin using your proper posture it will become easier and you will find your pain and spasm will begin to diminish.

Ergonomics

Ergonomics is the study of how to adapt the work place to the person. In other words the work environment should be adapted to YOU, not the other way around. This is important because when the work station fits your needs, fatigue and stress decrease and your comfort increases. In the long run you are more efficient and you decrease your risk of getting a repetitive trauma disorder. Repetitive disorders are things like carpal tunnel syndrome or “tennis elbow” (tendonitis).

Repetitive stress conditions occur when tendons, muscles, and nerves are placed under stresses and strains that at first seem very slight, but over time can eventually cause wear and tear to the soft tissues of our bodies. There are many different aspects of wear and tear and if one can decrease or eliminate any of these aspects, then the risk for this type of injury can also decrease. Since it is your body, it is your responsibility to try to identify these risks and take an involved part in reducing the risks. Things to consider are items like how much force is involved in a job, how long are you subjected to that force (not just hours in a day but how much repetition), what kind of rest do you get, and how long you have to maintain static postures. These are also other items which relate to the environment, for instance, lighting, vibrations, temperatures, and so on. And finally, one should always consider your overall general health.

Following are some questions which you should ask about your job or duties, and suggestions to ways to adapt your work place. If you find these are some areas that may place you at risk, contact your employer or health professional to arrange getting things changed.

1. Are you using proper body mechanics? If not, obtain information on proper body mechanics and use the concepts during activity.
2. Are you keeping the tools that you need within close and easy reach? If not, rearrange your space or hang tools up so everything is convenient to reach.

3. Are you using correct tools? Do they fit your hands properly and are they padded if there is vibration involved? If not, check with your supervisor to have the proper tools and any needed accessories issued to you.
4. Are you taking regular and periodic breaks so your hands and body are not subjected to too much fatigue? If not, plan and implement consistent yet short breaks throughout the day, perhaps using a timer so you don't get excessively involved in the activity and forget to take rest periods.
5. Are you eating proper meals and maintaining a regular exercise program? If not, consult with the proper health professional regarding proper diet, basic exercise/stretching as well as getting enough sleep and rest.
6. Is your computer or desk station set up so that you have a good posture, and that you are not always twisting in one direction over and over? If not, make sure the chair and desk station is set up correctly. Be sure there is proper lighting.
 - a) Hips and knees should be at 90 degrees, feet flat on floor/footrest.
 - b) Shoulders should be relaxed (not elevated) and elbows should be held at 90 degrees.
 - c) Monitor should be at eye level.
 - d) Keyboard should be positioned so wrists are not bent up or down or twisted.
 - e) A lumbar roll or support should be used to provide low back support.
 - f) If you do other types of desk work, tilt the work up instead of lowering head and neck.

If you have any questions, check with your doctor or health professional.

Work Cited:

Proper Body Mechanics for Daily Activities, Ergonomics. Pain Point Pillow Source Therapeutic Care Products. December 7, 2011. Retrieved from: <http://www.painpointpillowsource.com/page/1008391>

Name _____

Date _____

Body Mechanics and Movement

1. Fill in the blanks: Using proper body mechanics can prevent _____, help speed up _____ if you already have an injury and _____ further injury after your back has healed.
2. Multiple choice: Which of the following is not recommended in body mechanic basics?
 - a. Maintain a wide base of support.
 - b. Hold objects as close to you as possible.
 - c. Pull rather than push.
 - d. Keep your back in a natural curve.
3. Name one suggestion to avoid fatigue and injury when standing for long periods of time.
4. Why is it important to use a step stool when doing activities that are above chest level?
5. What is the other alternative to using a step stool?
6. Fill in the blank: How you sleep can have a great impact on your _____ and _____.
7. How many natural curves does the spine have and where are they?
8. Why is it important to maintain these curves?
9. When should you follow the basic rules of posture?
10. Who should you contact if you have any questions?

Boundaries In-Service

B O U N D A R I E S

MAS Home Care of Maine has a very strict policy regarding boundaries. Providing in-home support services you need to be able to maintain appropriate boundaries in order to provide great services. Here are the boundaries MAS requires from all employees:

- ❖ Do not inform the child or families you work with about other children and families receiving services through MAS.
- ❖ You are not allowed to visit the child or families when you are off the clock.
- ❖ Families are on a “need to know basis” and you are not to share personal information about yourself or people involved in your personal life.
- ❖ Respect the family and their home.
- ❖ Remember you are a mandated reporter and worker, not a friend.
- ❖ You cannot babysit for the family.
- ❖ You cannot provide respite services for the family.
- ❖ You may not accept gift/presents from the families.
- ❖ You are not allowed to take money from your families.
- ❖ You may not bring a child or family member to your home (a child/family should not even know where you live).
- ❖ You may not meet your friends in the community when you are working with your clients.

Working with children and families can be enjoyable, rewarding, challenging, frustrating and entertaining. It also needs to occur in a positive, respectful and safe environment where children aren't put at risk and adults are protected from accusations of abuse.

As an adult, it is your responsibility to establish and maintain clear professional boundaries with children, young people and the families we work with.

Learning to set healthy boundaries can feel uncomfortable, even scary, because it may go against the grain of the survival skills we learned in childhood - particularly if our caretakers were physically, sexually, or emotionally abusive to us. For example, we may have learned to repress our anger or other painful emotions because we would have been attacked and blamed for expressing the very pain the abuse had caused. Thus, attempting to set healthy boundaries as an adult may initially be accompanied by anxiety, but we must learn to work through these conditioned fears, or we will never have healthy relationships. But this process of growth takes time, and our motto should always be, "Progress not perfection."



Boundaries aren't always easy to maintain, particularly if there's only a few years difference between you and the families we work with. Yet a very real power imbalance exists that can't be overlooked. You're in a position of authority. You have more experience. And you're older than the children/young people in your care. And, because they are in your care, you need to make sure you don't overstep professional boundaries.

The following questions will help you decide if you're maintaining those boundaries:

- Am I treating all children and families in a similar manner or do I act differently towards one particular child or family?
- Do I talk, dress or act differently when I'm with a particular child or family?
- Would I behave this way if other adults were present?
- Would I feel comfortable if I observed this behavior in another adult?
- Could my actions have negative consequences?
- If I were a parent, would I want an adult behaving this way towards my own children?

Here are some tips for setting healthy boundaries,

- When you identify the need to set a boundary, do it clearly, preferably without anger, and in as few words as possible. Do not justify, apologize for, or rationalize the boundary you are setting. Do not argue! Just set the boundary calmly, firmly, clearly, and respectfully.
- You can't set a boundary and take care of someone else's feelings at the same time. You are not responsible for the other person's reaction to the boundary you are setting. You are only responsible for communicating the boundary in a respectful manner.
- At first, you will probably feel selfish, guilty, or embarrassed when you set a boundary. Do it anyway, and tell yourself you have a right to take care of yourself. Setting boundaries takes practice and determination. Don't let anxiety or low self-esteem prevent you from taking care of yourself.
- When you feel anger or resentment, or find yourself whining or complaining, you probably need to set a boundary. Listen to yourself, and then determine what you need to do or say. Then communicate your boundary assertively. When you are confident you can set healthy boundaries with others, you will have less need to put up walls.
- When you set boundaries, you might be tested, especially by those accustomed to controlling you, abusing you, or manipulating you. Plan on it, expect it, but be firm. Remember, your behavior must match the boundaries you are setting. You cannot establish a clear boundary successfully if you send a mixed message by apologizing for doing so. Be firm, clear, and respectful.
- Most people are willing to respect your boundaries, but some are not. Be prepared to be firm about your boundaries when they are not being respected. If necessary, put up a wall by ending the relationship. In extreme cases, you might have to involve the police or judicial system by sending a no-contact letter or obtaining a restraining order.
- Learning to set healthy boundaries takes time. It is a process. You will set boundaries when you are ready. It's your growth in your own time frame, not what someone else tells you. Let your counselor or support group help you with pace and process.
- Develop a support system of people who respect your right to set boundaries. Eliminate toxic persons from your life - those who want to manipulate you, abuse you, and control you.
- Setting healthy boundaries allows your true self to emerge – and what an exciting journey that is.

Healthy boundaries create healthy relationships. Unhealthy boundaries create dysfunctional ones. By establishing clear boundaries, we define ourselves in relation to others. To do this, however, we must be able to identify and respect our needs, feelings, opinions, and rights. Otherwise our efforts would be like putting a fence around a yard without knowing the property lines

Boundaries In-Service Quiz

PROFESSIONAL BOUNDARIES SCENARIOS

The purpose of these scenarios is for professionals to reflect upon behavior within their practices and identify situations which may involve crossing or violating a boundary. Review each scenario, select a response from the following options, and explain why you chose that response.

Response	
1	There is nothing wrong with this behavior
2	This behavior is permitted only in certain circumstances
3	This behavior is wrong and the professional should stop immediately.

Scenario	Response	Explanation
1. A client or client's parent tells their worker that they are interested in him/her. The worker informs the client or parent that this type of relationship is forbidden. The client continues to engage in flirtatious behavior. The worker speaks to their supervisor about boundaries and changing workers for this family.		
2. A professional tells his/her client or client's parents that he/she is having marital problems.		
3. A professional tells his/her client that he/she is having financial problems		
4. A client gives their worker an expensive gift, which the worker graciously accepts.		
5. A professional in a rural location meets the parent of one of his/her clients on a social occasion. The two enter a romantic relationship and the professional continues to provide service to the		

client.		
6. A parent asks a worker if they can help with some handy work at the home as they are not capable of doing it. The worker explains to the parent that this is not part of their role in working with their child and they are not permitted to assist with handy work.		
7. A parent offers their worker money to pick up dinner for the family. This does not relate to the client's goals. The worker decides to do as the parent requests but only this once.		
8. A professional creates a facebook page with personal information, photos, and contacts. On that same page, the professional begins adding clients as friends.		

CHILD DEVELOPMENT CHART - FIRST FIVE YEARS

Harold Ireton, Ph.D.

	SOCIAL	SELF-HELP	GROSS MOTOR	FINE MOTOR	LANGUAGE
5-0 yrs.	Shows leadership among children.	Goes to the toilet without help.	Swings on swing, pumping by self.	Prints first name (four letters).	When asked, for example, "What is an orange?" answers, "A fruit."
4-6	Follows simple rules in board or card games.	Usually looks both ways before crossing street.	Skips or makes running "broad jumps."	Draws a person that has at least three parts - head, eyes, nose, mouth, etc.	Reads a few letters (five+).
4-0 yrs.	Protective toward younger children.	Buttons one or more buttons.	Hops around on one foot, without support.	Draws recognizable pictures.	Prints a few letters or numbers.
3-6	Plays cooperatively with minimum conflict and supervision.	Washes face without help.	Hops on one foot without support.	Cuts across paper with small scissors.	Follows a series of three simple instructions in order.
3-0 yrs.	Gives directions to other children.	Toilet trained.	Rides around on tricycle, using pedals.	Draws or copies a complete circle.	Talks in long, complex sentences (10 or more words).
2-6	Plays games like tag, hide and seek.	Dresses self with help.	Walks up and down stairs - one foot per step.	Cuts with small scissors.	Answers questions like, "What do you do with a cracker? a hat?"
2-0 yrs.	Plays a role in "pretend" games like house or school - mom, dad, teacher.	Washes and dries hands.	Stands on one foot without support.	Draws or copies vertical () lines.	Speaks clearly - is understandable most of the time.
18 mos.	Plays with other children - cars, dolls, building.	Opens door by turning knob.	Climbs on play equipment - ladders, slides.	Scribbles with circular motion.	Talks in sentences at least four words long.
12 mos.	"Helps" with simple household tasks.	Takes off open coat or shirt without help.	Walks up and down stairs alone.	Turns pages of picture books, one at a time.	Has a vocabulary of at least 20 words.
9 mos.	Usually responds to correction - stops.	Eats with spoon, spilling little.	Runs well, seldom falls.	Builds towers of four or more blocks.	Follows two-part instructions.
6 mos.	Shows sympathy to other children, tries to comfort them.	Eats with fork.	Kicks a ball forward.	Scribbles with crayon.	Names a few familiar objects in picture books.
Birth	Sometimes says "No" when interfered with.	Feeds self with spoon.	Walks without help.	Picks up two small toys in one hand.	Asks for a drink or food, using words or sounds.
	Greets people with "Hi" or similar.	Insists on doing things by self such as feeding.	Stands without support.	Stacks two or more blocks.	Uses at least ten words.
	Gives kisses or hugs.	Lifts cup to mouth and drinks.	Walks around furniture or crib while holding on.	Picks up small objects - precise thumb and finger grasp.	Talks in single words.
	Waves "Bye-bye."	Picks up a spoon by the handle.	Crawls around on hands and knees.	Uses two hands to pick up large objects.	Says "Mama" or "Dada" for parent, or similar.
	Plays social games, "peek-a-boo," "patty-cake."	Feeds self cracker.	Sits alone... steady, without support.	Transfers toy from one hand to the other.	Understands phrases like "No-no" and "All gone."
	Pushes things away he/she doesn't want.	Comforts self with thumb or pacifier.	Turns around when lying on stomach.	Picks up toy with one hand.	Makes sounds like da-da, ma-ma, ba-ba.
	Reaches for familiar people.	Reacts to sight of bottle or breast.	Lifts head and chest when lying on stomach.	Looks at and reaches for faces and toys.	Responds to name - turns and looks.
	Distinguishes mother from others.				Babbles.
	Social smile.				Laughs out loud.
					Makes sounds - ah, eh, ugh.
					Cries in a special way when hungry.

School Accommodations and Modifications

Some students with disabilities need accommodations or modifications in their educational program in order to be successful in school. The Individuals with Disabilities Education Act (IDEA) and its regulations do not offer a definition for an accommodation or modification. However, there is general agreement as to what the terms mean.

An accommodation allows a student to complete the same assignments as other students, but permits a change in the timing, formatting, setting, scheduling, response or presentation. An accommodation does not alter what the test or assignment measures. Examples of accommodations include a student who is blind taking a Braille version of a test, or a student taking a test alone in a quiet room.

A modification adjusts the expectations for an assignment or a test. It permits a change in what a test or assignment measures. Examples include: a) a child is permitted to complete only part of a standard; b) a child is given an alternate assignment at a different level instead of the standard assignment.

Accommodations or modifications should be written into a student's Individualized Education Program (IEP).

Some children may have a disability that is not severe enough for them to receive special education. An option for this child may be to develop a Section 504 Plan. Section 504 is a federal law that prohibits discrimination against persons with disabilities. A Section 504 plan may list the changes needed in a child's educational program for him or her to be successful. Any changes must be based on the child's disability and fulfill the purpose of meeting individual needs. It's important to include the student, if appropriate, when discussing accommodations and modifications. A first step is to ask the child what would be helpful in classes where he or she is having difficulty.

Below are examples of modifications and/or accommodations. These ideas may be helpful when educating students with disabilities. Keep

in mind that any accommodation or modification an IEP team or Section 504 team chooses must be based on individual needs. Accommodations or modifications must be provided if written in the child's IEP or 504 plan.

Textbooks and Curriculum

Books

- Provide alternative books at a simpler reading level.
- Provide audiotapes of textbooks. Have the child follow the text while listening.
- Provide summaries of chapters.
- Provide high interest reading material at or slightly above the student's comfortable reading level.
- Use peer readers.
- Use marker to highlight important text sections of assignments.
- Use word-for-word sentence fill-ins.
- Provide two sets of textbooks. Keep one at home for the forgetful student.
- Use index cards to write down major themes.
- Provide the student with a list of discussion questions before reading the material.
- Give page numbers to help the student find answers.
- Provide written materials in alternative formats such as Braille or large print.

Curriculum

- Shorten assignments to focus on mastery of key concepts.
- Shorten spelling tests to the most functional words.



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- Substitute alternatives for written assignments (clay models, posters, panoramas, collections, etc.).
- Specify and review often exactly what the student will need to learn to pass.
- Modify expectations based on student needs (e.g., “When you have read this chapter, you should be able to list three reasons for the Civil War.”).
- Give alternatives to long written reports (e.g., several short reports, preview new audiovisual materials and write a short review, give an oral report).

Classroom Environment

- Review the classroom rules frequently.
- Evaluate classroom structure against the student’s needs (flexible structure, firm limits, etc.).
- Keep workspace clear of unrelated materials.
- Keep classroom quiet during intense learning times.
- Reduce visual distractions in the classroom (mobiles, etc.).
- Provide a computer for written work.
- Seat the student close to the teacher or a positive role model.
- Permit use of a study carrel. (Have more than one so that a student is not singled out.)
- Seat the student away from windows or doorways.
- Provide a clear view of the chalkboard, teacher, movie screen, etc.
- Keep extra supplies of classroom materials (pencils, books) on hand.
- Use alternatives to word puzzles or word finds.
- Maintain adequate space between desks.

Instruction and Assignments

Directions

- Use both oral and printed directions.
- Give directions in small steps and in as few words as possible.
- Number and sequence the steps in a task.
- Have student repeat the directions for a task.

- Provide visual aids.
- Show a model of the end product of directions (e.g., a completed math problem or quiz).
- Stand near the student when giving directions or presenting a lesson.

Time/transitions

- Alert student several minutes before a transition from one activity to another is planned; give several reminders.
- Provide additional time to complete a task.
- Allow extra time to turn in homework without penalty.
- Provide assistance when moving about the building.

Handwriting

- Use worksheets that require minimal writing.
- Use fill-in questions with space for a brief response rather than a short essay.
- Provide a “designated notetaker” or photocopy of other student or teacher notes. (Do not require a poor notetaker or a student with no friends to make this arrangement.)
- Provide a print outline to accompany each videotape of filmstrip.
- Provide a print copy of assignments or directions written on the blackboard.
- Omit assignments that require copying, or let the student use a tape recorder to dictate answers.

Grading

- Use daily or frequent grading averaged into a grade for the quarter.
- Weight daily work higher than tests for a student who performs poorly on tests.
- Mark the correct answers rather than the incorrect ones.
- Permit a student to rework missed problems for a better grade.
- Average grades out when assignments are reworked, or grade on corrected work.

- Use a pass-fail or an alternative grading system where the student is assessed on his or her own growth.

Tests

- Go over directions orally.
- Teach the student how to take tests (e.g., how to review, to plan time for each section).
- Provide a vocabulary list with definitions.
- Permit as much time as needed to finish tests.
- Allow tests to be taken in a room with few distractions (e.g., the library).
- Read test materials to the student, and allow oral responses.
- Divide tests into small sections of similar questions or problems.
- Use recognition tests (true-false, multiple choice, or matching) instead of essays.
- Allow the student to complete an independent project as an alternative test.
- Give progress reports instead of grades.
- Grade spelling separately from content.
- Provide typed test materials, not tests written in cursive.
- Allow take-home or open-book tests.
- Provide possible answers for fill-in-the blank sections.
- Provide the first letter of the missing word.

Math

- Allow the student to use a calculator without penalty.
- Group similar problems together (e.g., all addition in one section).
- Provide fewer problems on a worksheet (e.g., 4 to 6 problems on a page, rather than 20.).
- Require fewer problems completed to attain passing grades.
- Use enlarged graph paper to write problems to help the student keep numbers in columns.
- Provide a table of math facts for reference.

- Tape a number line to the student's desk.
- Read and explain story problems, or break problems into smaller steps.
- Use pictures or graphics.

Other

- Use Post-it notes to mark assignments in textbooks.
- Check progress and provide feedback often in the first few minutes of each assignment.
- Place a ruler under sentences being read for better tracking.
- Provide overview of long-term assignments so the student knows what to do, and due dates.
- Break long-term assignments into small steps, with daily monitoring and frequent grading.
- Have the student practice presenting in a small group before presenting to the class.
- Hand out worksheets one at a time.
- Sequence work, with the easiest part first.
- Provide study guides and study questions that directly relate to tests.
- Praise student for recording assignments and due dates in a notebook.
- Draw arrows on worksheets, chalkboard, or overheads to show how ideas are related, or use other graphic organizers such as flow charts.

Behavior

- Arrange a "check-in" time to organize the day.
- Pair the student with a student who is a good behavior model for class projects.
- Modify classroom policies that may discriminate against the student (e.g., provide frequent breaks for the student who cannot pay attention for long periods of time)
- Use nonverbal cues to remind the student of rule violations.
- Amend consequences for rule violations (e.g., reward a forgetful student for remembering to bring pencils to class, rather than punishing the failure to remember).

-
- Reinforce (often) when a student displays positive behavior.
 - Develop an individualized behavior intervention plan that consistent with the student's ability and skills.
 - Increase the frequency and immediacy of reinforcement.
 - Arrange for a student to leave the classroom for a designated "safe place" when highly stressed.
 - Develop a system or a code word to let a student know when behavior is not appropriate.
 - Ignore behaviors that are not seriously disruptive.
 - Develop interventions for behaviors that are annoying but not deliberate. For example, place a small piece of foam rubber on the desk of a student who continually taps a pencil on the desktop.
 - Be aware of behavior changes that relate to medication or the length of the school day; modify expectations if appropriate.

MAS Home Care of Maine
Child Development and Educational Needs
In Service

Communication

And

Tips for Handling Clients and Families with Aggressive Behaviors In-service

Respond Instead of React

The most affective style of communication you can use as a professional is assertive communication. As a member of a professional community providing in home support – you may be faced with numerous situations in which you recognize a client/consumer or family member has pushed your “hot buttons”.

Assertiveness is a behavior or skill that helps to communicate, clearly and with confidence, your feelings, needs, wants and thoughts while acknowledging the needs of others. It means that you are able to state your opinions without feeling self-conscious, as well as being able to express your emotions openly. Being assertive will enable you to make clear to others how you wish to proceed in all aspects of your life. At the same time you will value others, respecting their right to an opinion as well

Assertiveness can help control stress and anger and improve coping skills for mental illnesses. Recognize and learn assertive behavior and communication.

Through effective, assertive communication you will be able to express how you wish to move forward. Some strategies for successful communication during times of stress include (but are not limited to):

- Being aware of your emotional triggers or “hot buttons”
- Keeping your emotions in check- and being able to respond mindfully rather than **react** impulsively or emotionally to the situation
- Having a planned and rehearsed response for when your “hot buttons” are pushed
- Don’t hold grudges or place blame
- Acknowledge how the other person is feeling

Is there an issue that needs to be resolved? Before confronting someone, why not write down what you are going to say?

Be polite, concise and include the following elements:

- The nature of the problem; how it affects you; how you feel about it; what you want to change. Be prepared to negotiate if necessary to bring resolution. By using tact and foresight and by making the effort to see the other point of view and acknowledging it, you will place yourself in a position of strength.
- Be prepared to offer a compromise if that fits in with what you are aiming to achieve. **Assertiveness does not mean digging your heels in for the sake of it!**

Aggressive Behaviors

Caregivers and mental health professionals are at a high risk of working with clients who may become physically aggressive. Specifically, children receiving in home support services as they are likely to be individuals with behavioral challenges. Among other things, children may: bite, scratch, kick, hit, and throw things unexpectedly at people. There are generally three things to be thinking about, they are as follows:

1. How you (and the people around your client) react to the aggressive behavior. For example: when hit, most people react both outwardly (by yelling, making pained expressions on their face, pulling away quickly, among other things) and inwardly (getting mad, frustrated, annoyed, upset, or another kind of discomfort).
 - Many children will do behaviors specifically because of the reaction they get from the people around them. It can be very entertaining and interesting for some children to watch their parents/caregivers gesticulate and have tremendous facial expressions. You become like a cartoon and most kids really like cartoons, specifically because of their exaggerated quality. If your client hits you and you make a big deal out of it, he/she is more likely to continue hitting you, because it's fun to watch you make a big deal out of anything.
 - Once you've been hit, protect yourself from it happening again. Redirect your client in a calm and firm manner. Clearly state the expectation for behavior.
 - Do not try and discipline the client ... you are most likely just encouraging the behavior by yelling or speaking with an irritated voice, etc. Rather, have planned consequences for this type of behavior, and follow through consistently.
 - Also, your internal reaction is vital as well. It's not that you are supposed to fake feeling calm, **but that you actually do feel calm.** This is important because we see repeatedly that children can sense how the people around them feel emotionally. If you feel bad (or sad,, angry, frustrated, etc.), this counts as a reaction too! You very well may be encouraging the behavior by having a discomfort.

2. The second thing to check out is: **Am I giving her/him what she/he wants when she/he hits? What need is being met by the hitting/aggressive behavior?**

- A BHP once worked with a mother whose child would throw a 75-minute tantrum every day. “What happens when he finishes his tantrum?” the BHP asked. “I take him to Taco Bell and get him soft tacos,” she said. “Why do you do that?” “Well, he’s cried for so long, I figure if he wants a taco that bad, I’ll give it to him.”
- Inadvertently, she was systematically teaching him that throwing a 75-minute tantrum worked really well to get what he wanted. This is just one example. The idea is to ask yourself, **does the aggressive behavior work to move me? Do I give him/her something because he/she hit me that I wouldn’t have otherwise given?** If so, it’s important that you change that. As long as a child believes that hitting works the best to get things, that will be what they resort to when nothing else is working. So instead, when your child communicates in a way that you want, have that work the best!

As a side note: This is not to encourage you to give your client ice cream for breakfast, lunch and dinner if they ask for it in a nice way. You can still set whatever boundaries you and the treatment team feel are important.

3. Another thing you can try: if he/she starts to display aggressive behaviors, or you see warnings signs that it’s coming soon, offer him/her different physical stimulations. For example, gently squeeze her hands and feet, if he/she allows it, or offer a stress ball he/she can squeeze. Some children get bursts of energy, which can be released by your squeezes. You can also offer a weighted vest, or other sensory tools. You can also offer other kinds of physical activity, like doing a chase game, jumping up and down, or rolling on the floor.

The Unpleasant Elder Client

Let's face it, sometimes people can be just irrational, difficult and downright horrible. Fortunately, they don't make up the majority. So, what do you do when you're faced with an irate client screaming profanities at you? Put the following steps into practice, of course.

Don't take it personally

As difficult as it may be to believe at the time the client is hurling profanities at you, the client does not have a personal issue with you. It could be a case the client has an issue with the company you represent or the service, but not you personally. It could also be a case that he or she has had a bad day and unfortunately, you're paying for it. It's not right but it does happen. If you chose to see their anger as a personal attack on you, it may affect future relations with the client when their anger would have subsided. Maintain the right attitude and refuse to act defensively. You'd be surprised to see how that same client may react on a different day when things are going better for them.

If you're wrong, admit it

Very few things anger clients more than dealing with people who cannot admit they are wrong. If you're in the wrong, demonstrate honesty and professionalism by admitting it. In some cases an apology may suffice. In cases where it is not enough, be prepared to go the extra mile to show that you are serious about remedying the situation. Clients will often judge the level of your service based on how well you handle a difficult situation and will most likely forgive you and continue to use your services if you deal with the situation well.

Following are some ideas about caring for an aggressive Alzheimer's patient. Consider each idea independently of the others.

- Don't confront the person or try to discuss the angry behavior. The person with dementia cannot reflect on their unacceptable behavior and cannot learn to control it.

- Do not initiate physical contact during the angry outburst. Often, physical contact triggers physical violence in the patient.
- Provide the person with a “time-out” away from you. Let them have space to be angry with you. Let them have space to be angry by themselves. Withdraw in the direction of a safe exit.
- Distract the person to a more pleasurable topic or activity.
- Look for patterns in the aggression. Consider factors such as privacy, independence, boredom, pain or fatigue. Avoid those activities or topics that anger the person. To help find any patterns, you might keep a log of when the aggressive episodes occur. If the person gets angry when tasks are too difficult for them, break down tasks into smaller pieces.
- Minimize stress and novelty.
- Maintain calm within yourself. Getting anxious or upset in response may escalate the aggressiveness.

You should understand that most elderly people have endured many changes in their lifestyle. They have withstood: the loss of their job through retirement, reduced income, loss of friends and/or family, and increased physical ailments. Many may worry about lack of money, being alone, being physically incapacitated, and dying. Obviously, they can use a good deal of cheerfulness and reassurance.

Understand their need to maintain their self respect and independence, and them accordingly. Treat them with respect and dignity.

Name: _____ Date: _____

Communication

And Tips for Handling Clients and Families with Aggressive Behaviors – In Service Quiz

1. The most affective style of communication you can use as a professional is

2. **Assertiveness** is a behavior or skill that helps you to: communicate _____ and with confidence, your: feelings, needs, wants, and thoughts, while acknowledging the _____ of others.

3. List 3 strategies for successful communication during times of stress

4. When working with a child who is displaying aggressive behaviors, you should redirect your client in a calm and firm manner, and be ambiguous about what the expected behavior is. **True** or **False**

5. List three question you can ask yourself when confronted with a child displaying aggressive behaviors:

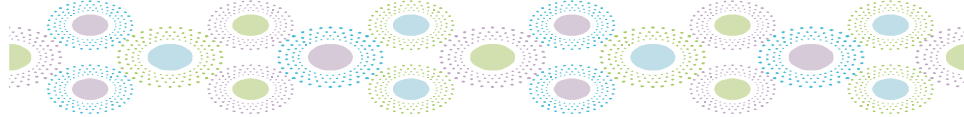
6. When working with elderly – don't confront the person or try to discuss the angry behavior. The person with dementia cannot reflect on their unacceptable behavior and cannot learn to control it. **True** or **False**

7. When working with the elderly – look for patterns in the aggression. Consider factors such as privacy, _____, _____, _____, or fatigue.

8. If you're wrong, you should always try to hide this from the client no matter what. **True** or **False**

Compassion Fatigue: Secondary Traumatic Stress Disorder, Burnout, and Vicarious Trauma In-Service

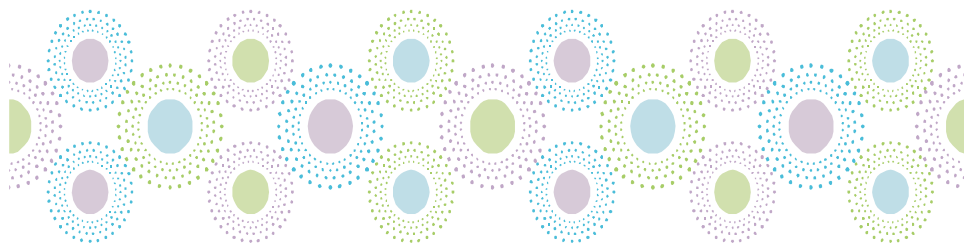
From National Child Welfare Resource Center for Adoption



Definition

- **Definition:** Compassion fatigue refers to a physical, emotional and spiritual fatigue or exhaustion that takes over a person and causes decline in his/her ability to experience joy or to feel and care for others.
- Compassion fatigue is also synonymous with secondary traumatic stress syndrome, vicarious trauma and burnout.
- In 1992, the term “compassion fatigue” was first used to describe nurses worn down from dealing daily with hospital emergencies.
- It is the prolonged occurrence of the natural behaviors and emotions that arise from knowing about a traumatizing event experienced by another.
- Compassion fatigue is a one-way street in which individuals are giving out a great deal of energy and compassion to others over a period of time, yet aren’t able to get enough personal support to reassure themselves that the world is a hopeful place.
- It’s this constant outputting of compassion and caring over time that can lead to these feelings of total exhaustion.

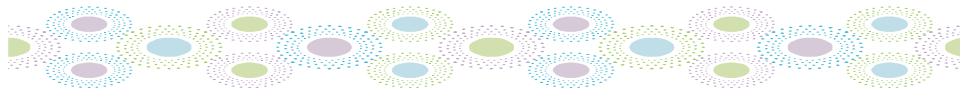
(Figley, 1995; Friedman, 2002)



Causes

- It can affect people in any kind of situation or setting where they're doing a great deal of care giving and expending emotional and physical energy day in and day out.
- It is the stress resulting from helping or wanting to help a traumatized person.
- Compassion fatigue comes from a variety of sources. It often affects those working in care-giving professions—nurses, physicians, mental health workers, clergymen and child welfare practitioners.

(Figley, 1995; Friedman, 2002)



Who is at Risk?

- Although those in the health care field and mental health professions are most at risk for developing compassion fatigue, it is not limited to those arenas. Any caregiver is susceptible.
- Compassion fatigue is a process. It's not a matter of one day, you're living your life with a great deal of energy and enjoyment, and the next, you wake up exhausted and devoid of all energy. Compassion fatigue develops over time—taking weeks, sometimes years to surface.
- It can affect those who don't work outside the home as severely as those that do. For example, someone who is actively engaged in taking care of a family member during a crisis period when there is a higher need to give out feelings or during a long-term illness that requires constant need to attend to their needs with compassion and sensitivity.
- Child welfare practitioners have a much greater susceptibility to compassion fatigue compared to many other professions due to their exposure to the situations that cause children to come into care.
- If you are experiencing compassion fatigue, there is a great likelihood that your capacity to provide professional level services to children or families will be diminished.

(Figley, 1995; Friedman, 2002)



Noticeable Behaviors of Compassion Fatigue in Colleagues

Social

- Terrorization and elimination
- Burnout
- Chronic lateness
- Workaholism
- Inability to maintain balance and objectivity
- Blaming
- Cast out
- Learned helplessness
- Vulnerability
- Diminished sense of personal
- Isolation
- Stuck in negativity
- Cynical
- Divorce/interpersonal problems
- Withdrawal from activities
- Promiscuity

Psychological

- Feelings of dread
- Anguished “survivor” guilt
- Feelings of having given up
- Feelings of evilness and impending doom
- Anger
- Less ability to feel joy
- Increased irritability
- Horror
- Inescapable shock
- Depression
- Sleep disturbances
- Low self-esteem
- Exhaustion
- Crying for no apparent reason
- Use of dark humor
- Poor impulse control
- Relapse to addictions
- Apathy
- Decreased concentration/unable to focus

Behavioral/Physical

- Increased use of drugs and alcohol
- Sweating
- Rapid Breathing
- Increased blood sugar levels
- Increased illnesses
- Hypertension/high blood pressure
- Gastrointestinal complaints
- Brittle nails
- Hot flashes
- Weight changes: over and under eating
- Migraine headaches
- Fatigue/chronically tired
- Cracked teeth/grinding teeth
- Panic attacks
- Physical appearance change
- Bruises
- Sleep Disturbances

Noticeable Behaviors of Compassion Fatigue in Colleagues

Continued...

Work

Performance

- Low Morale
- Low motivation
- Avoiding tasks
- Obsession about detail
- Apathy
- Negativity
- Lack of appreciation
- Detachment
- Poor Communication
- Self-conflicts
- Absenteeism
- Exhaustion
- Irritability

**What should YOU do if you
experiencing compassion fatigue?**

feel you are

If you are experiencing the symptoms of compassion fatigue, contact your direct supervisor immediately. He or she will be able to help you deal with the feelings and emotions you are experiencing.

Also, it is extremely important to practice self-care routinely. Some examples of self-care include: going for a walk, doing yoga, other forms of exercise, journaling, reading, doing crafts or other hobbies, spending time with your family, or any other activity that gives you enjoyment. The most important thing to remember is that you need to talk to your direct supervisor to help alleviate the symptoms.

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Name

Date

**Compassion Fatigue: Secondary Traumatic
Stress Disorder, Burnout, and Vicarious Trauma
In-Service Quiz**

1. What 3 terms are synonymous with compassion fatigue?

- _____
- _____
- _____

2. The feelings of total exhaustion are caused from (fill in the blank):

_____.

3. People most affected by compassion fatigue are (name three):

- _____
- _____
- _____

4. Any _____ is susceptible to compassion fatigue.

5. Compassion fatigue can happen overnight. (Please circle one) True or False

6. _____ have a much greater susceptibility to compassion fatigue, due to their exposure to extreme situations involving _____.

7. Name 3 noticeable social behaviors one might experience if they have compassion fatigue:

- _____
- _____
- _____

8. Name 3 noticeable Behavioral/Physical responses one might experience if they have compassion fatigue:

- _____
- _____
- _____

9. Name 3 noticeable Psychological responses one might experience if they have compassion fatigue

- _____
- _____
- _____

10. Someone who is actively engaged in taking care of a family member during a crisis period when there is a higher need to give out feelings or during a long-term illness that requires constant need to attend to their needs with compassion and sensitivity is at risk of developing compassion fatigue. (Please circle one): True or False

11. How will you reduce your chances of getting compassion fatigue: (in your own words) _____

12. Who will be most affected by your symptoms of compassion fatigue? _____

13. Under social behaviors compassion fatigue can raise your chances of getting illness? (Please circle one) True or False

14. Self care is an important key to avoid compassion fatigue: (Please circle one) True or False

15. If you are experiencing compassion fatigue you should tell your family/client(s) immediately. (Please circle one) True or False

16. Please name three examples of how your work performance symptoms may be if you are experiencing compassion fatigue:

- _____
- _____
- _____

17. Please explain what type of situation/setting compassion fatigue occurs in: _____

18. The term compassion fatigue came about when nurses were coming back from the Vietnam War.

(Please circle one) True or False:

19. Compassion Fatigue is the prolonged occurrence of the natural _____ and _____ that arise from someone else's trauma.

20. If you are experiencing compassion fatigue you should speak to your supervisor immediately!

(Please circle one) True or False

Questions adopted from:

Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel. Beaton, R., and Murphy, S., "Working with people in crisis: Research implications," 51-81.

Figley, C.R., Ed. (2002). *Treating Compassion Fatigue*. New York: Brunner/Rutledge.

Friedman, R. (Winter 2002). The importance of helping the helper. Retrieved from www.vachss.com/friedman.html. May 30, 2007.

Confidentiality

In-Service

Confidentiality- Confidentiality is the safekeeping of privileged information. This includes not only medical information of a client, but also personal information or client/company information. Confidentiality applies not only to clients, but also to all employees of the company and to the agency itself. State and Federal Laws protect privacy and the disclosure of medical information. If you breach confidentiality, you may be breaking the law. Breaches in confidentiality occur when private and protected information is improperly given out. This can be intentional or unintentional.



MAS Home Care of Maine is bound to confidentiality for all clients and employees. Anyone has the right to see their own chart or employee file. Clients and employees have the right to request a copy of their file by writing to the Program Manager. MAS has 2 weeks to make copies of the file to be picked up or mailed to the requesting individual. MAS does not throw any documents in the trash; we have a contract to have documents shredded confidentially.

Health Insurance Portability and Accountability Act (HIPAA)-

What is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law that protects the privacy of a client's personal and health information, provides for electronic and physical security of personal and health information and simplifies billing and other transactions.

Who has to follow the HIPAA law? Everyone

What client information must be protected?

We must protect an individual's personal and health information that is created, kept, filed, used or shared; is written, spoken, or electronic. HIPAA says that this information is: *Protected Health Information (PHI)*.

Examples of PHI (Protected Health Information):

- a person's name
- address
- birth date
- age
- phone and fax numbers
- E-mail address
- Medical records
- Diagnosis
- x-rays
- Photos
- Prescriptions
- lab work and test results
- billing records
- claim data
- referral authorizations
- explanation of benefits
- research records



HIPAA Requires Agencies to: Give each client a Notice of Privacy Practices that describes how the agency can use and share his or her protected health information (PHI), a client's privacy rights, and ask every client to sign a written acknowledgment that he/she received the Notice of Privacy Practices.

Everyone must secure and safeguard PHI so that others cannot see or use it **UNLESS** it is necessary to do the job. Someone who does not protect a client's privacy could lose his or her job, pay fines or even go to jail. Fines are hefty! Jail terms are up to ten years.

Treat a Client's Information as if it were your own information. It is the right thing to do!

At MAS, we follow all HIPAA rules. Here are some of the ways we do:

Client Records: All MAS clients/families have to sign release of information forms so that MAS can communicate with other individuals who are a part of the team. A release of information is necessary for any person who is not the client or legal guardian of the child. If a release is not signed we do not have authorization to speak to any individuals. A release can be signed to **obtain** information; this means MAS can only receive information from the recipient. MAS does not have approval to give information out. If the box is checked to **disclose** information; MAS may answer all questions asked by recipient, although MAS is not allowed to ask questions. The only time that you can check both the **obtain** and **disclose** box is when the release is completed for other physical or mental health providers. Otherwise, a separate release needs to be obtained for each of the **obtain** and release categories.



Progress Notes: Progress notes are written during each shift with a client/family. If the client is a minor all notes must be signed by their legal guardian. A progress note is a legal document once it is signed by the parent/guardian. At MAS, progress notes have a white copy which goes into the client chart on a weekly basis. The yellow “carbon copy” is for the client/family and should be left with clients/families at the end of each shift. Your progress notes are highly confidential and should be turned in weekly to the Program Manager.

Client Charts: All clients’ charts are kept in locked cabinets in the file room at the MAS office. The following employees have access to these charts: the Program Manager, the Clinical Supervisor and the Children’s Services Coordinators. All charts must be signed out from the file room. MAS employees are required to keep client paperwork in a safe, secure

place so it will not be viewed by others or lost. If a MAS employee resigns from the agency or is dismissed they are required to return all client information to MAS. MAS will keep clients charts 7 years after the client turns 21.

Employee Files: All employees have the right to view their employee file; however, no information from an employee file is released without written or verbal permission by the employee. Employee files are kept in locked file cabinets in the human resources office and are handled by HR or Program Manager.



Employee files include copies of the employees' driver's license, automobile registration and insurance; Criminal, DHHS Child Protective, Officer of General Inspector and Motor Vehicle background checks; performance evaluations, education and training certificates, and some medical records.

MAS will keep employee files for 3 years after the employment contract has ended.

Breach of Confidentiality: A breach of confidentiality is when an employee shares information about their client or any client that is serviced by MAS without authorization.



Examples of Common Breaches of Confidentiality:

- If you are talking on your cell phone regarding your client and you are in a public area.
- Telling friends and family who your client is.
- Sharing personal information about your client.
- Working in one client's home and talking about your other client.

- A supervisor informs her staff's peer that she has reprimanded a staff.
- Using a client's or employee's full name on calendars or boards, and by not shredding paper documents after use.
- All faxes must be accompanied with a "Confidentiality" cover sheet.

Limits of Confidentiality-

There are exceptions to every rule and there are times when you may need to break. This means that there may not be a release of information signed but it is ok to break confidentiality. These exceptions include:

Duty to Warn

Court cases have held that when an individual indicates the intention of doing something harmful, dangerous, or criminal to self or others, it is the professional's duty to warn appropriate parties. This includes: The family of an individual who intends to harm her- or himself; Others that the individual actions may harm; Appropriate authorities and emergency responders.

Duty to Report Child Abuse and Dependent Adult/Elderly Abuse

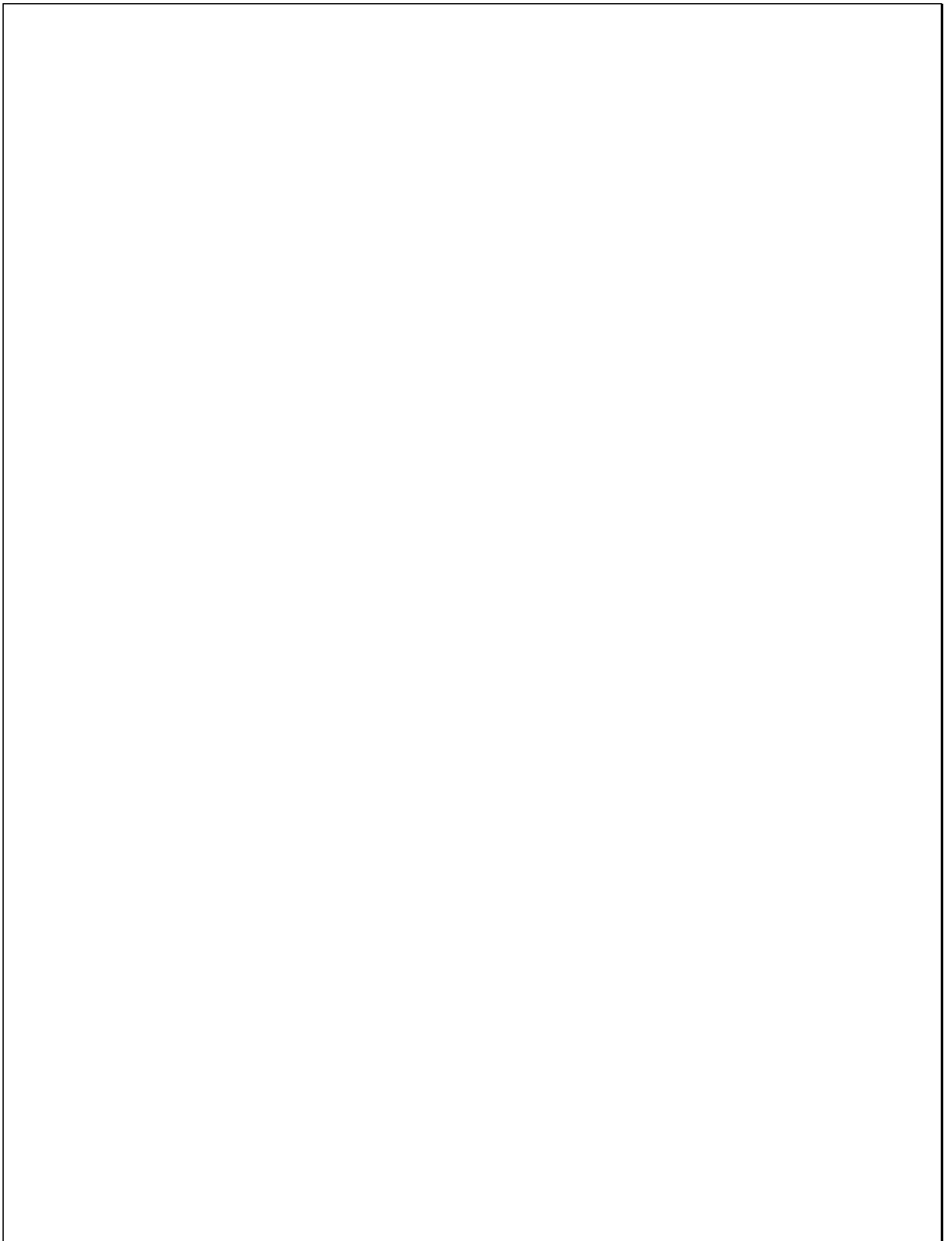
Many states mandate reports to appropriate agencies and authorities whenever there is actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse). Many states also require reporting whenever there is actual or suspected abuse to dependent adults and the elderly.

Court Orders/Subpoena

Client information will be released in response to a court order or valid subpoena issued by the court or other judicial body. No release of information is necessary in this case.

Law Enforcement Investigation

Client information may be released in response to law enforcement when the request is received in writing, signed by an appropriate official, stating that the information is required for an official investigation and citing the specific information required from the client's record. *Information on drug and alcohol abuse, mental health, and HIV/AIDS information may only be released by way of an order of the court.*



Name _____

Date _____

MAS Home Care of Maine Confidentiality In-Service Quiz/ Answers

1. True or False: Confidentiality only applies to clients of MAS Home Care of Maine.

2. HIPPA is a federal law that protects what?

3. A person's name, address, and birth date are all examples of what?

4. What needs to happen in order for MAS to communicate with other individuals that are part of a client's team?

5. True or False: It is ok to openly share information with relatives of a client who are not a legal guardian without a signed release of information.

6. If a client is a minor, who should progress notes be signed by?

7. What are 3 examples of common breaches in confidentiality?
 1. _____
 2. _____
 3. _____

8. Give an example of a time that it is allowed by law to break confidentiality:

MAS Home Care of Maine

Co-occurring Condition In-Service

What is a Co-occurring Condition?

People who have experienced both an emotional/psychiatric and alcohol or drug related issue are said to be persons with “co-occurring conditions” or disorders. ‘Mental health issue’ refers to different kinds of brain disorders; for example, depression (lasting feelings of sadness or helplessness), bipolar disorders (extreme mood swings – highs and lows), or schizophrenia (a partial or complete break from reality) are all examples of disorders where brain chemistry is unbalanced. ‘Alcohol or drug related issue’ refers to the use of alcohol or any illegal drug in a harmful or dangerous way. Not being able to limit or control the use of substances is also considered a brain disorder.

Many people with co-occurring disorders have experienced trauma. The effects of trauma can often affect the way the world is experienced. People with mental health, substance abuse, and trauma frequently have physical health issues as well. Co-occurring conditions can include a number of difficult experiences that improve when a person embraces and develops their own ongoing journey of self-discovery/recovery.

Co-occurring conditions are common, but there are many who are not aware that they could be a person with both diagnoses. One of every two individuals with substance use or mental health issues has experienced the other at some point in their lives. It is estimated that 9 million people in the United States have co-occurring conditions/disorders.

Recovery is a process, not a result. Louie L’Amour once said, “You can be so focused on the destination that you miss out on the journey”. It is helpful if a person gets integrated treatment that looks at all issues at the same time. It takes many domains of our life to make a whole being. The recovery journey captures hope. Embraced with courage, it happens over a lifetime and is a changing, unpredictable process that is often marked by unexpected setbacks. However, on the recovery journey people can and do achieve meaningful lives in personally satisfying ways.

Which came first? It’s not easy to know whether the mental health or substance use issue occurred first. Someone with psychiatric concerns may drink or use drugs for the same reasons others do, such as attempting to feel calmer, happier, or more sociable. Some people are more sensitive to the effects and frequent use of substances and the impact this leaves on their lives.

When people experience relief from the body and mind’s dependency on alcohol or other drugs, positive effects can be seen in job performance, careers, personal ambitions, physical and mental health, not to mention goals, hopes, dreams and values. On the other hand, a person with a substance use issue may develop or experience symptoms of a psychiatric diagnosis which may become compounded over time. For some, this may become clear only after attempting to stop or

cut down on substances that were often used to mask the emotional, physical or mental pain of past and present experiences.

Work Cited:

What is a Co-occurring Condition? October 4, 2011. Taken from: Maine Department of Health and Human Services: <http://www.maine.gov/dhhs/cosii/what-cc.shtml>

MAS Home Care of Maine will not deny services to any persons solely based on substance abuse issues. However, MAS Home Care of Maine will provide education and make appropriate referrals for client's seeking services for co-occurring conditions that are not provided at this site.

Name: _____

Date: _____

Co-occurring Conditions In-Service Quiz

1. Persons with “co-occurring conditions” or disorders are said to be person’s who have experienced what?
2. Fill in the blanks: People with mental health, substance abuse and trauma frequently have _____ issues as well.
3. How many people are estimated to have a co-occurring condition/disorder?
4. Which comes first; substance abuse or mental health issue?
5. Fill in the blanks: MAS Home Care will provide _____ and make appropriate _____ for clients seeking services for co-occurring conditions that are not provided at this site.

MAS Home Care of Maine

Family Support Services In-service

Family Support Services

Family support services promote healthy development by helping parents to enhance their strengths and resolve problems that can lead to child maltreatment, developmental delays, and family disruption. Services include peer support and counseling, early developmental screening, parent education, early childhood development, child care and respite care, home visits, family resource centers, school-linked services, recreation, and job or skills education or training. Programs may address the general population or be targeted to ethnic/cultural minorities, families facing health, mental health, or substance abuse issues, adolescent parents, or kinship caregivers.

Introduction to Family Support

Family support services are community-based services that assist and support parents in their role as caregivers. Family support services promote parental competency and healthy child development by helping parents enhance their strengths and resolve problems that can lead to child maltreatment, developmental delays, and family disruption.

Services include peer support and counseling, early developmental screening, parent education, early childhood development, childcare and respite care, home visits, family resource centers, school-linked services, recreation, and job or skills education or training. Programs may address the general population or target particular groups such as ethnic/cultural minorities, adolescent parents, kinship caregivers, or families facing health, mental health, or substance abuse issues. They can be comprehensive or address a specific goal.

The principles of family support emphasize partnerships between staff and families; families as sources of support; appreciation of cultural, racial, and linguistic differences; family support as a strategy for community building; and the integration of family support values throughout program planning and administration.

Parent Perspectives & Leadership

A core principle of family support services is an emphasis on partnership between professionals and families. Effective family support services involve parents in program design, implementation, and evaluation, and assist parents in meeting goals that are important to them. Programs should be based in ecological and family systems theory and engage parents by

taking into consideration individual characteristics of the parent and family, provider attributes, program components, and neighborhood characteristics.

Family Support Policy & Federal Programs

Federal legislation provides funding for grants to States to provide services that will prevent the unnecessary separation of children from their families, improve their quality of care, and ensure permanency for children by reuniting them with their parents or through adoption or another permanent living arrangement.

Federal programs include the Community Based Child Abuse Prevention (CBCAP) program, the Family Preservation and Family Support Services Act of 1993, the Promoting Safe and Stable Families provisions of the Adoption and Safe Families Act of 1997, and the Safe and Stable Families Amendments of 2001.

Planning & Implementing Family Support Programs

Information and descriptions of efforts to plan and implement family support programs throughout the United States. Includes types of services provided, policies and procedures, mission statements, vision statements, agreements, intake forms, assessments, checklists, permission forms, service plans, and details about funding streams and the programs they support.

Parent Support Groups

Parent support groups help parents overcome feelings of isolation, develop support systems, and learn about successful parenting practices. Parent support groups foster self-acceptance and promote a sense of community. Group members give as well as receive help, share effective coping strategies, and expand their resources for ongoing support. Parent participation in service planning and implementation is stressed in order to enhance client engagement and increase the agency's understanding of client perspectives.

Early Developmental Screening

Children with disabilities are at high risk for abuse and neglect and are more likely to experience maltreatment than children without disabilities. Developmental screening is a procedure designed to identify children who should receive more intensive assessment or diagnosis for potential developmental delays.

Screening results in earlier detection of delays and improved health and well-being for identified children. When delays are detected, parents can be provided with information about what to expect in their child's development, how they can promote development, and the benefits of

monitoring development. Such guidance promotes positive parent-child relationships, reducing the occurrence of child abuse and neglect.

Parent Education

Parent education programs are community-based services that support parents in their roles as caregivers. Their goal is to promote parental competency and strengthen family life, to enhance healthy child and family development. Parent educators help parents strengthen their skills and knowledge of child development, prepare young children for school, and cope with behavioral challenges of children and adolescents. Over time, these programs may help prevent child maltreatment, reduce developmental delays, and enhance parent effectiveness.

Early Childhood Programs

Early childhood programs aim to improve outcomes for young children and their families by offering a variety of support services such as child health and development assessments, early education and care, referral to community resources, and more. Use the following resources to learn more about selected early childhood programs.

Childcare & Respite Care Services

Quality childcare services enhance child development and provide support for all parents, including those at risk of abusive behavior. Such services may provide counseling, parent education, positive role modeling, emergency respite, and referrals to community services. Childcare providers are increasingly considered sources of family support beyond the direct care of children.

Childcare services are often a formal part of child protective services and intensive family preservation services. Respite care—temporary relief for primary caregivers to reduce stress, support family stability, prevent abuse and neglect, and minimize the need for out-of-home placement—is also a vital support to families with children, including foster, kinship, and adoptive families as well as birth families experiencing challenges.

Home Visiting

Home visiting programs offer a variety of family-focused services to expectant parents and families with new babies and young children. They address issues such as maternal and child health, positive parenting practices, safe home environments, and access to services. Use the following resources to learn more about home visiting, selected programs, planning and implementation, evaluation efforts, and more.

Family Resource Centers

Family resource centers provide family support services by creating a central location for health, mental health, educational, and recreational services. As one-stop service and referral organizations, family resource centers are designed to control service duplication and encourage community involvement and cross-generational relationships.

Family resource centers promote community connections that empower families and enhance the lives of young children. Most centers provide core services such as medical care, counseling, parenting classes, and literacy classes; referrals for childcare and specialty medical services; and direct contact with early childhood and child development programs, including Head Start and home visitation.

School-Linked Services

School-linked family support services are characterized by a holistic, ecological view that recognizes that children need a full range of services to be ready to learn and be successful in school, and that parents need assistance to support their child's education, health, growth, and development.

Communities are improving service integration and accessibility by offering a wide array of services within the school or other neighborhood center. Service providers emphasize prevention of behavioral, emotional, academic, and social problems, including child abuse and neglect, juvenile delinquency, and family violence.

Referral & Linkage to Resources

Families need assistance in identifying and accessing resources to meet basic needs and in securing community-based family support services. Child welfare and family resource and support organizations can work together to improve outcomes for families by referring child welfare clients to family resource programs and providing linkages between programs that serve the same clients. Program developers must think strategically about how an existing array of services might be augmented to form a continuum of supports and services for families.

Outreach

The goal of outreach in family support services is to reach families who might not otherwise participate in a family support program, obtain their involvement, and foster their participation in the community. The success of outreach efforts depends on the program providers' ability to form community partnerships; target, educate, and engage families who can benefit from their services; and meet the needs and interests of these families in ways which will prove beneficial to them, their children, and the community.

Education & Job Skill Development

The cycle of poverty can have a long-term effect on children, contributing to and exacerbating child maltreatment, mental illness, substance abuse, homelessness, and other problems that create barriers to obtaining and maintaining employment as an adult.

Education and job programs aimed at enhancing family economic success require workforce development, family economic supports, and community investment. An integrated system of social services and welfare services can help decision-makers identify the services needed to help families meet employment and income goals.

Effectiveness of Family Support Services

Family support services are intended to strengthen families, improve parenting skills, promote child development, and enhance parental confidence. Methods include home visitation, child development assessment, parenting skills education, homemaker services, and social and emotional support services.

Research on the effectiveness of family support services has examined the comparative effectiveness of different program models and the extent to which programs improve outcomes, including preventing maltreatment, decreasing the use of foster care, enhancing placement stability, and reunifying families.

Works Cited:

Family support Services. A service of the Children's Bureau, Administration for Children and Families, US Department of Health and Human Services. Retrieved from [childwelfare.com](http://www.childwelfare.gov/supporting/support_services/):
http://www.childwelfare.gov/supporting/support_services/

Name: _____

Date _____

Family Support Services In-Service

Quiz

1. What are 5 of the possible services provided within Family Support Services?
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
2. Fill in the blank: Family support services promote parental competency and healthy child development by helping parent's _____ their _____ and resolve problems that can lead to child maltreatment, developmental delays, and family disruption.
3. Effective family support services involve who in program design, implementation and evaluation?
4. Fill in the blank: Children with _____ have a higher risk for abuse and neglect than children _____.
5. What is the goal of parent education programs?
6. What is respite care?

7. Family resource centers promote what?

8. What effect can poverty have on children?

9. What is the intent of family support services?

10. How can parental support groups benefit parents?

MAS Home Care of Maine Mandated Reporting In-Service

Who does CPS Serve?

The Department of Health and Human Services Child Protective Services program is a child-centered, family focused social service whose primary goal is to protect children who are reported to be abused or neglected. Another important goal is to support and assist parents so they may safely care for and protect their children. The Department works to meet these goals and keep children safe by providing services and support to children and families.

Abuse Trends

- Total Reports have increased each year.
- Inappropriate reports have increased by 100+ each of the last two years.
- In 2003, DHHS worked at reducing reports to the Alternative Response Program (ARP). For more information on ARP, visit: <http://www.maine.gov/dhhs/ocfs/cw/protection.shtml>.
- Nationally, 64.3% of all cases of suspected child abuse and neglect are unsubstantiated and 22.18% are substantiated.

Summary of Reports Described by Decision

	2007	2008	2009	2010
Total Reports	<19,000	<19,000	17,256	17,457
Appropriate Assigned	6,593	6,178	6,141	5,984
Appropriate Referred to ARP	2,720	2,325	1,707	2,135
Not Appropriate	9,778	9,975	9,408	9,338

Inappropriate Referrals fall into the following four general categories:

1. **Parent/Child Conflict**
 - a. Parent/child conflict: Children and parents in conflict over family, school, friends, behaviors with no allegations of abuse or neglect. Includes adolescents who are runaways or who are exhibiting acting out behaviors that parents have been unable to control.
 - b. **Examples:** Running away, won't follow rules, lots of screaming/hollering/arguing, etc.
2. **Non-Specific Allegations**

- a. Non Specific allegations or allegations of marginal physical or emotional care which may be poor parenting practice but is not considered abuse or neglect under Maine Law.
 - b. **Examples:** Children are dirty, children not properly dressed for weather, parents not providing traditional mealtimes, parents who frequently verbally argue, parents threatening children.
3. **Custody or Visitation**
- a. Conflicts over Custody and/or Visitation of children which may include allegations of marginal/poor care.
 - b. **Examples:** Parents don't agree with former spouse's (parent) current lifestyle, friends, activities or visitation issues around care and supervision.
4. **Families in Crisis**
- a. Families in Crisis due to:
 - i. financial
 - ii. physical
 - iii. mental health or
 - iv. interpersonal problems

BUT...

- There are no allegations of abuse or neglect.

DHHS Response to Referrals

- Response is based on factors such as:
 - The seriousness/complexity of cases receiving services.
 - The number of caseworkers.
 - Availability of resources

Contract Agencies

DHHS has contracts with private agencies to respond to reports of child abuse and neglect. This has resulted in a significant decrease in the number of reports that were not assigned for assessment.

Key Points

- Low to moderate risk reports may be referred to an Alternative Response Program (ARP).
- ARP services are voluntary.
- ARP refers family back to CPS when necessary.

Family Stress Factors During Assessment

Stress factors that are seen most often with child abuse and neglect include family violence, alcohol/drug use by parent/caretaker, mental physical health problems, severe parent/child

conflict, school problems, divorce conflict, emotionally disturbed child, runaway, alcohol/drug misuse by child

. They are contributing factors, not abuse in and of themselves.

Maine's Law on Child and Family Services and the Child Protective Act.

The purpose of the law is to:

- Protect children who are abused/neglected.
- Provide assistance to families to enable them to safely parent their children.

Key Points

- Often an organization will have a protocol that they follow for reporting. Although you may not be the one to make the call, you do have a responsibility to make sure that the report is made. Whoever the designated person is must report all of the information you have given him/her, and must report your suspicion even if he/she doesn't agree with you. You may also be required to fill out an agency form for your records.
- You cannot be disciplined in your job if you make a report.
- The law requires mandated reporters to identify themselves when they call, however, they can request confidentiality.
- Confidentiality means that the caseworker will not reveal your identity unless the case goes to court. (Please keep in mind that only about 10% of all cases goes to court.)
- Sometimes the specific information you are reporting will identify you to the caregivers but this does not mean the Department gave them your name.
- Some agencies have a policy to tell the parents that they are making a report. This can be tricky and you should use discretion in deciding when to tell parents. Sometimes it may put the child in more danger and other times it may help empower the family to make changes.
- We don't recommend telling a child that you are making a report on his/her behalf without telling the parents.
- All reporters who make a report in good faith are immune from liability under the law. This does not mean that you can't be sued. In our world today, people sue other people all the time. What it does mean is that you are protected under the law from liability as long as you are reporting in good faith.
- You are also protected from discriminatory action by your employer for filing a report.
- If you knowingly fail to report a situation where you have reasonable cause to suspect child abuse or neglect, you will be committing a civil violation for which you may be prosecuted and fined up to \$500, However, the sadder outcome is that a child may continue to be seriously abused or neglected without intervention.
- If you fail to report, this could affect your licensure.

Who is required to report to the department?

- An adult person acting in a professional capacity shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.
 - "Any person who has assumed full, intermittent or occasional responsibility for care or custody of the child, regardless of whether the person receives compensation."
 - "Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity regardless of whether that person receives compensation."

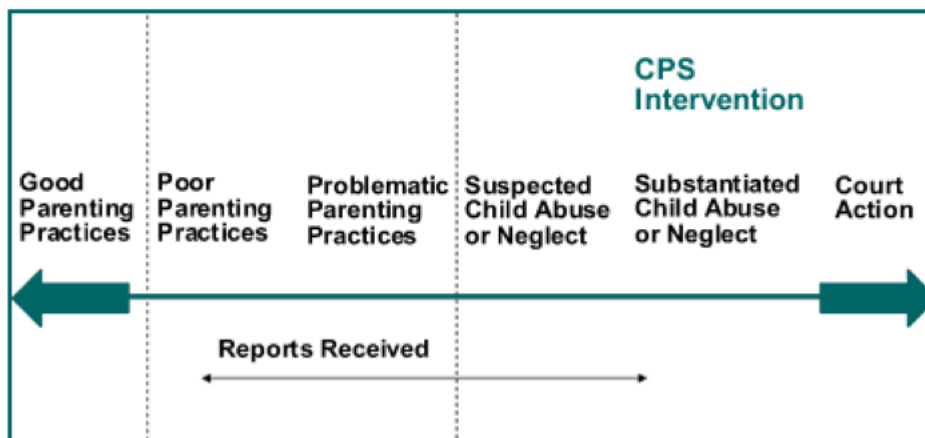
What am I required to report?

- You must report, or cause a report to be made if you know or have reasonable cause to suspect that a child has been or is likely to be abused or neglected.
- Report to DHHS if the abuse is by a caretaker or parent.
- Report to the District Attorney's office if the abuse is by a person not responsible for the child.

When should I make the report?

- A mandated reporter is legally required to report suspected child abuse or neglect to the Child Protective Intake Unit of the Department of Health and Human Services immediately or as soon as possible.
 - When you need to report suspected child abuse, you call the statewide intake unit at 1-800-452-1999 or TTY at 800-963-9490 immediately or as soon as possible. The Intake Unit is available to receive reports 24 hours a day.

Child Abuse and Neglect Continuum



Key Points

- Child Abuse and Neglect has various levels.
- Levels vary from:

- **Poor Parenting Practices** - a practice that may not be the best for the child, but does not put the child in danger (e.g., allowed to drink lots of soda, etc.).
- **Problematic Parenting** - a practice that may lead to a dangerous situation for the child (e.g., leaving the child without proper supervision, etc.).
- **Suspected Child Abuse or Neglect** - a practice that may cause harm or place the the child in a dangerous situation (e.g., leaving the child with no supervision, etc.).

Types of Child Abuse and Neglect

Definition of Child Abuse and Neglect- Abuse and neglect means a threat to a child's health or welfare by:

- Physical, mental or emotional injury or impairment.
- Sexual abuse or exploitation.
- Deprivation of essential needs.
- Lack of protection from these, by a person responsible for the child.
- Failure to ensure compliance with school attendance requirements.

Let's take a closer look at each type of abuse mentioned in this definition.

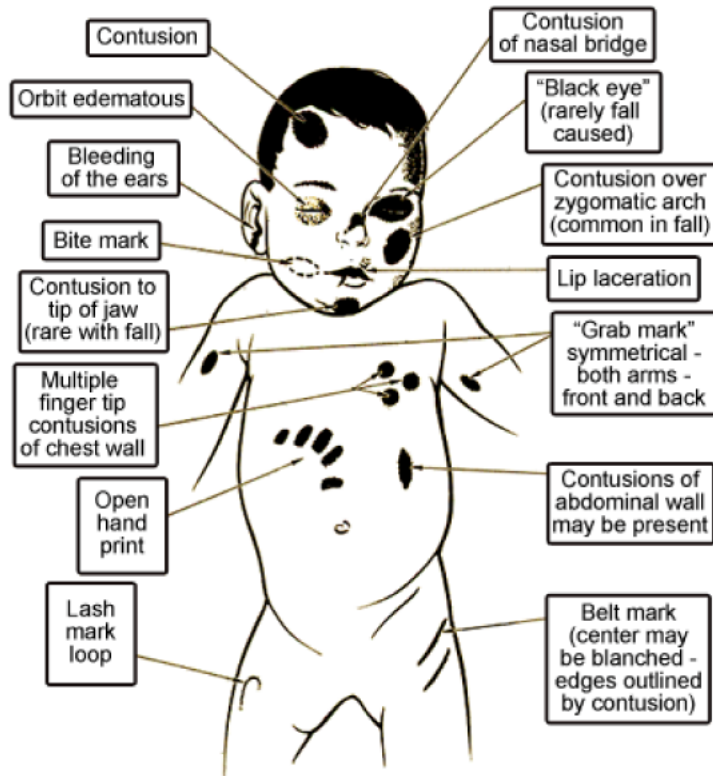
Physical Abuse

Definition of Physical Abuse - Abusive treatment to a child by a parent or caregiver that caused or is likely to cause physical injury. This includes the threat of physical abuse.

Indicators
<p>Physical Indicators:</p> <ul style="list-style-type: none"> • Unexplained injuries such as: <ul style="list-style-type: none"> ○ Bruises, welts, and burns that reflect a pattern or shape from the article that was used to strike the child (such as a hand, belt, stick, or burns from a cigarette). Immersion burns would show a sock-like, glove-like, or doughnut shape. ○ Fractures or dislocations that do not seem likely to have happened on accident.
<p>Behavioral Indicators:</p> <ul style="list-style-type: none"> • Poor self-concept and feels deserving of punishment • Wary of adult contact (flinching) • Behavioral extremes such as aggressiveness or withdrawal, which the child had not previously displayed. • Frightened of parents • Afraid to go home • Reports injury by parents

- Vacant or frozen stare

Here is an example of "inflicted trauma." **Note particularly the dime-sized bruises and the hand print bruise on the upper abdomen.**



Here is an example of "grab marks." **Note the bruises on the arm and how they are bilateral and symmetrical (grab marks), are a particularly classic finding in inflicted trauma.**



Neglect

Definition of Neglect - Failure to provide adequate food, clothing, shelter, supervision, or medical care when that failure causes or is likely to cause injury including accidental injury or illness. Also failure to protect a child from harm resulting in physical abuse, sexual abuse or emotional abuse.

Indicators
<p>Physical Indicators:</p> <ul style="list-style-type: none">• Underweight (failure to thrive) or poor growth pattern• Consistent hunger• Poor hygiene• Inadequately dressed for the weather• Unaddressed physical problems or medical needs• Abandonment
<p>Behavioral Indicators:</p> <ul style="list-style-type: none">• Begging or stealing food• Extended stays at school, or rare attendance at school• Constant fatigue, listlessness, or falling asleep in class• Delays in meeting developmental milestones• Inappropriate seeking of affection• Assuming adult responsibilities and concerns• Delinquency (thefts, juvenile substance abuse)

Here are some examples of neglect:



Emotional Maltreatment

Definition of Emotional Maltreatment - Abusive treatment by a parent/caregiver that has resulted in emotional impairment or distress (low severity emotional abuse does not require

mental health treatment whereas high severity does).

Indicators
<ul style="list-style-type: none">• Eating disorders• Speech disorders• Habit disorders (sucking, biting, rocking)• Neurotic traits (sleep disorders, inhibition of play, unusual fearfulness)• Behavioral extremes such as aggressiveness, disruptive behaviors, or withdrawal, which the child had not previously displayed• Overly adaptive behaviors (inappropriately adult/parentified, inappropriately infantile)• Empty facial appearance

Sexual Abuse

Definition of Sexual Abuse- A parent/caregiver engaged in sexual contact with a child, or forced a child to have sexual contact with others. Sexual offender of children has uncontrolled access to children. Or a parent/caregiver intentionally subjects a child to purposefully suggestive remarks and behaviors, creating a sexualized environment that is likely to result in sexual abuse or exploitation.

Indicators
<p>Physical Indicators:</p> <ul style="list-style-type: none">• Pain, swelling, or itching in genital areas• Pain on urination• Bruises, bleeding, or lacerations in external genitalia vaginal or anal areas• Vaginal or penile discharge• Venereal disease, especially in pre-teens• Poor bowel control• Pregnancy
<p>Behavioral Indicators:</p> <ul style="list-style-type: none">• Reports nightmares or bedwetting• Demonstrates bizarre, sophisticated, or unusual sexual behavior or knowledge• Poor peer relationships and poor physical boundaries with others• Reports sexual assault by caretaker

- Change in performance at school

Who does APS serve?

Adult Protective Services (APS) serves any person 18 years of age and over who is incapacitated or dependent. In addition, APS serves emancipated adults (16+) who are incapacitated or dependent.

Elder Abuse Statistics

13% abuse, 55% self-neglect, 20% caretaker neglect

12% financial exploitation

Elder abuse is under reported and under detected. The elderly are really bed-bound, and 95% of the time there are no witnesses to what goes on in the household.

Conditions That Contribute to the Problem

Social Isolation, History of family violence, Mental state of the abuser (emotional, psychiatric, and substance abuse problems), Dependency of the abuser on the victim.

Incapacitated Adult

Any adult who is impaired by reason of mental illness, mental deficiency, physical illness or disability to the extent that that individual lacks sufficient understanding or capacity to make or communicate responsible decisions concerning that individual's person, or to the extent the adult can not effectively manage or apply that individual's estate to necessary ends.
(Title 17-A; Section 555)

Dependent Adult

A dependent adult is one who has a physical or mental condition that substantially impairs the adult's ability to adequately provide for that adult's daily needs. This includes a resident of a nursing home or assisted living facility. It also includes a person considered a dependent person under Title 17-A;section 555.

Key Points

Adults are presumed to have capacity to give informed consent unless found not to have capacity to make decisions by a Probate Judge in a guardianship hearing. Guardianship will be discussed later.

Informed consent is a decision made with all the relevant information about the issue, with an understanding of the consequences of a decision, and in the absence of duress.

Adults have the right to make their own decisions regardless of how others view those decisions. For example, a competent brittle diabetic who understands the importance of a diet yet chooses not to follow that diet is using poor judgment.

Due to physical or mental impairment, dependent adults require the assistance of others to meet their daily needs.

Some additional definitions you need to know include:

- Abuse
- Sexual Abuse
- Neglect and
- Exploitation
- Abuse

The infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; or the intentional, knowing or reckless deprivation of essential needs. Abuse includes acts and omissions.

(Title 22 3472)

Indicators

Physical Indicators

- Bruises from hitting, shoving, slapping, pinching, or kicking
- Bilateral injuries, or injuries on upper arms, face, neck or clustered on other body parts
- Burns caused by cigarettes or hot objects
- Friction from ropes, chains, or other physical restraints
- Injuries caused by biting, cutting, poking, punching, whipping or twisting of limbs
- Disorientation, stupor or other effects of deliberate overmedication
- Open wounds, cuts, punctures, and untreated injuries, and injuries in various stages of healing
- Person's report of being mistreated
- Abuse or neglect of pets in the home

Behavioral Indicators:

- Easily frightened or fearful
- Exhibiting denial
- Agitated or trembling
- Hesitant to talk openly
- Implausible stories

- Extreme upset when assisted with bathing or other physical care giving
- Depression or poor self-esteem
- Eating disturbances
- Compulsive behavior
- Sleep disorders
- Interactions between victim or abusers
- Inconsistency in how they describe events or accounts for injuries
- Family does not interact with client
- Marital or family discord
- Caregiver lacks knowledge of adult's condition and needed care
- Doctor or hospital hopping
- A person's sudden change in behavior

Sexual Abuse or Exploitation

Contact or interaction of a sexual nature involving an incapacitated or dependent adult without that adult's consent. (Title 22 3472)

Indicators

- Physical Indicators
 - Bruises around the breast or genital area
 - Unexplained venereal diseases or genital infection
 - Unexplained vaginal or anal bleeding
 - Torn, stained, or bloody underclothing
 - Painful urination or sitting
 - Difficulty walking or sitting
 - A person's report of being sexually assaulted or raped.
- Behavioral Indicators:
 - Demonstrates inappropriate sex-role relationship
 - Exhibits inappropriate, unusual, or aggressive sexual behavior
 - Reveals extreme anxiety, including difficulty eating/sleeping, fearfulness, or compulsive behavior
 - Exhibits agitation or anger
 - Feels confused
 - Symptoms of emotional disorders

Neglect

A threat to an adult's health or welfare by physical or mental injury or impairment; deprivation of essential needs or lack of protection from these. It also includes self-neglect. (Title 22 3472)

Indicators

- Physical Indicators:
 - Dehydration

- Neglected bed sores
- Untreated injuries or medical problems
- Poor hygiene
- Hunger, malnutrition
- Pallor, or sunken eyes or cheeks
- Lack of clean bedding or clothing
- Lack of glasses, hearing aid, dentures, prosthetic device
- Skin disorder or rashes
- Lack of prescribed medication
- Person's report of being mistreated
- Behavioral Indicators:
 - Unresponsiveness or helpless
 - Appears detached
 - Exhibits hopelessness
 - Expresses unrealistic expectations about his/her care

Financial Exploitation

The illegal or improper use of an incapacitated or dependent adult or that adult's resources for another's profit or advantage. (Title 22 3472)

Indicators

- Physical Indicators
 - Unusual volume or type of banking activity, or activity inconsistent with victim's ability.
 - Nonpayment of bills
 - Eviction
 - Care of the person is not consistent with the size of the estate
 - Missing property or belongings
 - Suspicious signatures on checks or other documents
 - Caregiver has no means of support
 - Signing blank checks
 - Purchase of items that do not benefit older person, i.e. boats, sports equipment, or real estate
 - Transfer of ownership of property to a "new friend" or relatives with little prior involvement in the elder person's life
 - The person's report of financial exploitation
- Behavioral Indicators:
 - Implausible explanations about his/her finances
 - Unaware or doesn't understand financial arrangements
 - Concerned or confused about missing funds from their account
 - Abrupt changes in a will or other financial documents
 - Change in spending habits

Key Points

Indicators of abuse are actual signs of symptoms that suggest that abuse has occurred or is likely to occur. They may be physical or behavioral.

- Physical indicators include injuries or signs of restraint.
- Behavioral indicators include the conduct of, or interactions between, the victim and the abuser.
- It would not fit your mandate.

Adults have the right to make their own decisions unless adjudicated incapacitated by a Probate Judge.

Self-neglect refers to persons who may have lost the ability to care for themselves due to their physical or mental impairment, as opposed to persons who have chosen an unsafe lifestyle.

A threat to an adult's health or welfare by physical or mental injury or impairment; deprivation of essential needs or lack of protection from these.

Common Characteristics of Abusive Caregivers

- Substance Abuse
- Ongoing mental illness or emotional problems
- Lack of caregiver experience
- Reluctance of caregiver
- History of abuse - more common in families with established patterns or histories of violent behavior.
- Dependency - often the caregiver is dependent on the elder for financial support.
- Very friendly and helpful.
- Personality traits including:
 - Exhibiting hypercritical and impatient behavior
 - Displaying unsympathetic attitude toward the needs of others
 - Blaming the elderly person for caregiving problems
 - Having an unrealistic view of caregiving and lack the understanding of what the adult needs
 - Loss of self-control
 - Feeling of losing their independence

Behavioral Indicators of Abusive Caregivers

- Verbal berating, harassment, or intimidation
- Threats of punishment or depriving of essential needs
- Isolating a person from friends or other family members
- Treating the individual like an infant
- Leaving a person alone for long periods of time
- Withholding affection to gain compliance

- Unwillingness to comply with service providers in planning for care
- Obvious absence of assistance, attitude of indifference or anger toward the victim
- Giving a person no privacy
- Denying a person the right to make decisions
- Demonstrates inappropriate sex-role relationship
- Inconsistent or implausible explanation of injuries
- Handles the person roughly or in a manner that is threatening, manipulative, sexually suggestive or insulting
- Excessive concern about cost of caring for the older person or reluctant about spending money or paying bills.

Suspicious Explanations

- "The injury was an accident."
- "The victim fell."
- "There was no abuse...she bruises easily."
- "It was a gift."
- "She owed me the money."
- "He gave me permissions to have, use, borrow it."
- "I was going to give it back."
- "He refuses services."

Maine law requires that if any of the following individuals suspects that an adult has been abused, neglected or exploited, and there is reasonable cause to suspect that the adult is incapacitated or dependent, then that individual shall immediately make a report to the Department.

Individuals who are mandated to report while acting in a professional capacity:

Ambulance Attendant, Animal Control Officer, Certified Nursing Assistant, Chiropractor, Clergy*, Dentist, Emergency Medical Technician, Emergency Room Personnel, Humane Agent, Registered Nurse, Licensed Practical Nurse, Medical Examiner, Medical Intern, Mental Professional Occupational Therapist, Pharmacist, Physical Therapist, Physician (M.D. and D.O.), Physician's Assistant, Podiatrist, Psychologist, Law Enforcement Official, Social Worker, Speech Therapist, Unlicensed Assistive Personnel (includes Personal Care Assistant/PCA)

*A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications.

Others who are mandated to report include:

- Any other individual who has assumed full, intermittent or occasional responsibility for the care or custody of the adult, whether or not the person receives compensation.
- Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to

the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation.

Works cited:

Mandatory Reporter Training: OCFS – Maine DHHS. Child and Family Services, Maine Department of Health and Human Services. December 8, 2011. Retrieved from:

<http://www.maine.gov/dhhs/ocfs/cps/index.htm>

Mandatory Reporter Training for Suspected Adult Abuse or Neglect. Elder Services: An Office of the Department of Health and Human Services. December 9, 2011. Retrieved from:

<http://www.maine.gov/dhhs/oes/aps/training/apstextonlyunit1.htm>

Name: _____

Date: _____

Mandatory Reporting In-Service Quiz

1. True or False: Parent/Child conflict includes adolescents who are runaways.
2. Circle the factor listed below that is not a DHHS response to referrals
 - a. Seriousness/complexity of receiving services
 - b. Number of abused children
 - c. Number of case workers
 - d. Availability of resources
3. True or False: A mandated reporter is legally required to report suspected adult or child abuse or neglect to DHHS immediately or as soon as possible.
4. True or False: Maine law states that an adult person acting in any capacity shall immediately report of cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child and/ or adult has been or is likely to be abused or neglected. Please explain your answer:
The law states when working in a professional capacity, not any capacity.
5. True or False: Mandated reporters cannot request confidentiality.
6. True or False: You are protected from discriminatory action by your employer for filing a report.
7. True or False: If you knowingly fail to report a situation where you have reasonable cause to suspect child and/or adult abuse or neglect, you are committing a civil violation and may be prosecuted and fired.
8. True or False: Physical Abuse may be rated as mild, moderate, or severe.
9. True or False: Neglect may be caused by failure or non-accidental failure of a caretaker to provide for a child and/ or an adult.
10. True or False: Using words or behaviors that threaten, harshly criticize, ridicule, or harass a child and or adult may be emotional abuse.

11. True or False: Sexual abuse includes any sexual involvement of a parent or caretaker with a child in a sexual act.
12. True or False: Sexual abuse towards adults is considered contact or interaction of a sexual nature involving an incapacitated or dependent adult without that adult's consent.
13. True or False: Leaving a child alone with a younger sibling and going to visit a neighbor is considered a "problematic parenting practice" on the child abuse and neglect continuum.

Works cited:

Mandatory Reporter Training: OCFS – Maine DHHS. Child and Family Services, Maine Department of Health and Human Services. Retrieved from: <http://www.maine.gov/dhhs/ocfs/cps/index.htm>

Mandatory Reporter Training for Suspected Adult Abuse or Neglect. Elder Services: An Office of the Department of Health and Human Services. December 9, 2011. Retrieved from: <http://www.maine.gov/dhhs/oes/aps/training/apstextonlyunit1.htm>

Progress Note In-Service

Children's Services & PSS Home Care

Children's Services:

MAS Home Care of Maine expects all children's services employees to complete progress notes for each shift worked. All employees are required to have the following on their progress notes:

SECTION 28

➤ All objectives need to be written out on your progress notes as stated on the client's treatment plan.

➤ A summary needs to be written out on how you worked on the goal with your client. The summary needs to be measurable for example: 2 out of 5 trials with 4 verbal cues and used hand over hand assistance.

➤ You need to state why you gave the client verbal cues, what assistance did you give example: physical, verbal or hand over hand and why did you redirect client.

➤ Use the methods listed on the treatment plan to help you work with the client on their goals.

➤ Progress notes need to be written in ink and they need to be legible.

➤ Correct title: BHP-RC

SECTION 65HCT

➤ All short-term goals need to be written out on your progress notes as stated on the client's treatment plan.

➤ You need to document how you worked on the goals with the client and family

➤ Use the methods listed on the treatment plan to help you work with the client on their goals.

➤ Correct title: BHP

Progress notes are due every Monday by 2pm. You may turn them into the office Monday-Friday Between the hours of 8am-4pm, put your notes in the "Children's" drop box outside of the building or mail them Saturday night..

FOR BOTH SECTIONS

- Always remember to praise when it is appropriate.
- All the information on the top of the progress note must be completely filled out; clients name, your name and signature, date, time in, time out, total hours and parent/guardians signature.
- The bottom of the progress note has ____ of ____ and you need to fill in the number of pages for example 1 of 4, 2 of 4, 3 of 4 & 4 of 4
- We bill in 15-minute increments. When documenting your hours you need to have the correct and accurate time frames. Ex- 4:15pm = 4.25 hours.
- Your Total hours need to be added up correctly.
- Circle am or pm after your time frames.
- A parent/guardian should NEVER sign a blank progress note
- Once your progress note is completely filled out accurately, the parent/guardian will be asked to sign it.
- The parent/guardian has the right to read, ask questions, add comments, cross statements out they do not agree with and sign their name in any color ink, even crayon, and receive the yellow copy of the progress note.
- Progress notes need to be written in print and legible.
- Progress notes should be objective NOT subjective. Objective statements are untouched and bias. Stick to the facts.
- Avoid subjective statements, which are opinions and perceptions.
- You may not state Johnny is angry today because you are not in Johnny's head and you do not know how he feels. You may state Johnny "seems," "appears" to be angry *because* he was punching the wall or mumbling inappropriate language under his breath or screaming at Mom, etc.



Once your progress note is completely and accurately filled out, signed by parent/guardian you need to offer the parent/guardian the yellow carbon copy. If you have a parent who is unable to process or read what you wrote, you need to explain your progress note to them. If your client is their own guardian, they are required to sign your progress notes. You may have to read and process the contents of your progress note so they understand what you wrote about them and the goals. If they refuse to take the yellow copy, you must turn it into the office. No employee has the right to shred any client/personal information. Once your progress notes have gone through the Quality Care process and no discrepancies are found your notes will be filed into the client's chart and become a legal, state document.

Discrepancies



Any discrepancies on your progress note will be “red flagged” for you to fix. Here is a list of discrepancies:

- No objectives or goals are written out.
- Summary is not measurable.
- No definitions/details for assistance verbal or physical
- No conversations. For example, he said, she said, then I said.
- No judgment statements. They are, He/She is, I think, I know, Parents are, I feel, etc.
- The progress note must be written in one color ink, black or blue ballpoint pen.
- No gel pens or bleed able inks are to be used.
- Note is not legible.
- When making mistakes you must put one line through the word, write “error” and your initials.
- No smiley faces, drawings, putting a big ex at the end of the each goal box, scribbles, using white out, etc.
- You need to spell the client’s name correctly.

If your progress note is red flagged you will be called and required to come into the office to fix them. If this pattern happens a second time you will be spoken to or written up. If we continue to receive incomplete progress notes, you will be suspended off your cases until you come into the office and fix all red-flagged progress notes and complete intensive progress note training.



ends the week and



starts a new week.

Children's progress notes are due every Monday by 2pm.

You may turn them in as follows:



Into the office Monday–Friday Between the hours of 8am -4pm



Put your notes in the “Children’s” drop box outside of the building.



Mail them Friday after your shift.



If you are having someone drop your notes off for you, the progress notes need to be place in a sealed envelope.



*******Please note:** Children's progress notes **CANNOT** be faxed or e-mailed. We must have the original progress note into the office by Monday at 2pm.

Personal Support Specialist (PSS):

➤ As a PSS you are required to turn in a time card each week with your entire week's shifts

➤ Print the client's name legibly (do not have them sign) at the top of the time card.

➤ Make sure that your time in/out and total number of hours are filled in and accurate.

➤ Check off the personal care/meal prep/housekeeping/other tasks that you completed or assisted your client with.

➤ Make sure the client puts their initials at the bottom of each day you worked.

➤ Occasionally you will also need to turn in progress notes for your client.

- Make sure you fill in the client name and date, as well as sign and date the bottom.

- **DO NOT** fill out progress notes for activities that occur normally (i.e. "great day, ate all of his breakfast.", etc.)

- **DO** fill out progress notes for activities/incidents that do not normally occur (i.e. client falls, client refusal of personal care, etc.)

➤ Some clients have private insurance.

- On occasion, the client's insurance company will require progress notes for every shift worked in addition to your timecard.

- You will be notified of this before beginning care with your client.

- If this is the case, please fill out a progress note that matches exactly what you did on your time card with all personal care tasks/activities completed.

Time cards and progress notes (if applicable) are due every Monday by 2pm.

You may turn them into the office Monday-Friday Between the hours of 8am -4pm, put your notes in the "Elder" drop box outside of the building, or mail them Friday night...



ends the week and



starts a new week.

PSS time cards and progress notes (if applicable) are due every Monday by 2pm.

You may turn them in as follows:



Into the office Monday–Friday Between the hours of 8am -4pm



Into the “Elder” drop box outside of the building.



Mail them Friday night after your shift.



If you are having someone drop your notes off for you, the progress notes need to be place in a sealed envelope.



7. When should you turn in your progress notes for:

Children's services? _____

PSS home care? _____

8. What is the difference between an objective and a subjective statement?

9. List 5 examples on how you can get your notes into the office.

- _____
- _____
- _____
- _____
- _____

10. Should you explain your progress note to the parent or guardian? _____
Why?

11. A parent or guardian has a right to do what to our progress notes?

12. List two examples of measurable statements.

- _____
- _____

Safety in Home Health Care In-Service

Tragedies Spark Worker-Safety Awareness

By John V. O'Neill, MSW, News Staff

From NASW News Vol. 49, No. 4, April 2004

The deaths of a young woman, a troubled teenager and the murder of social worker Greg Gaul on an icy day late in January brought almost unbearable shock and grief to the Des Moines social work community and the entire city.

It also renewed the questions of whether social workers and their agencies are doing enough to protect those who deal with clients who are sometimes unstable and occasionally violent or intent on homicide and whether emphasis on safety could limit social workers' ability to be effective with clients.

Gaul was "beloved," the kind of social worker others aspire to be, said his business partner John Stanley. "Most don't have the same amount of qualities Greg had in abundance — the patience and kindness."

The former seminarian had an uncommon amount of success for his 41 years. An MSW graduate of the University of Minnesota, four years ago he helped start Lifeworks, a successful agency that contracts with the State of Iowa to provide in-home child welfare and juvenile justice services.

He was a well-known and well-respected figure among the law enforcement officials, attorneys, judges, social workers, educators and juvenile offenders in the Des Moines area.

"Greg and I started a business together with the philosophy that many people didn't have opportunities and need to have doors opened for them and that the basis of therapy is to be kind and gentle to people," said Stanley.

Gaul had a wife and six children age 10 and under, with another child expected in the spring. Yet he found time to be active in his church and to be a baseball coach, Cub Scout leader and black belt in tae kwon do, involving his children in his pastimes, and he volunteered at a prison for women.

He bought his shoes and shirts at a Salvation Army thrift store. "He was a casual guy. That's what helped people relate to him," said Stanley.

"But he took very seriously what he did. Everyone who came in contact with Greg felt he gave something of himself to them."

Friends don't remember what he was wearing his last day alive.

"Violence has a low base rate and doesn't happen frequently enough to make it easy to predict," said Christina Newhill, associate professor of social work at the University of Pittsburgh.

**Many Think
Client Violence
'Won't Happen
Here'**

Yet violence or threats of violence are reasonably common for social workers during their careers, especially in certain areas of practice, according to data from a 1993 study Newhill conducted of 800 NASW members from Pennsylvania and 800 from California.

Of the 1,129 social workers who responded, 42 percent had experienced no incidents of violence, 25 percent reported property damage, 50 percent were threatened and 24 percent reported attempted or actual physical attacks. The incidence rate of violence or threats of violence was highest in the criminal justice field (79 percent), followed by drug and alcohol services (76 percent) and children and youth services (75 percent). Others were mental health services, 64 percent; developmental disability, 56 percent; school social work, 54 percent; health care, 49 percent; and aging, 44 percent.

Males were almost twice as likely to report physical attacks as females, 39 percent to 21 percent, perhaps because it is perceived as more socially acceptable to attack a man, and sometimes men are asked to act as a sort of security force at agencies, although they have no training for it, Newhill said.

Newhill began to look at the issue of violence to social workers after the 1989 death of Californian Robbyn Panitch, 26, who had recently graduated from the University of Southern California. Panitch was employed in a walk-in clinic when a delusional man walked into her office, closed the door and stabbed her 30 times. Nobody heard anything because the office was soundproof. She had talked to her supervisor about being afraid of the client, and things could have been done to make her safer, said Newhill.

"Agencies feel it doesn't happen very often, and when it does, it's not going to happen here," she said. "Only after a tragedy occurs is action taken. They are in denial."

Gaul had no inkling that the teenager who was to end his life was a threat, said Stanley. If he had he would have asked the child's juvenile court officer or the police to accompany him to the home. "There was nothing in [the teenager's] past to create a major level of concern."

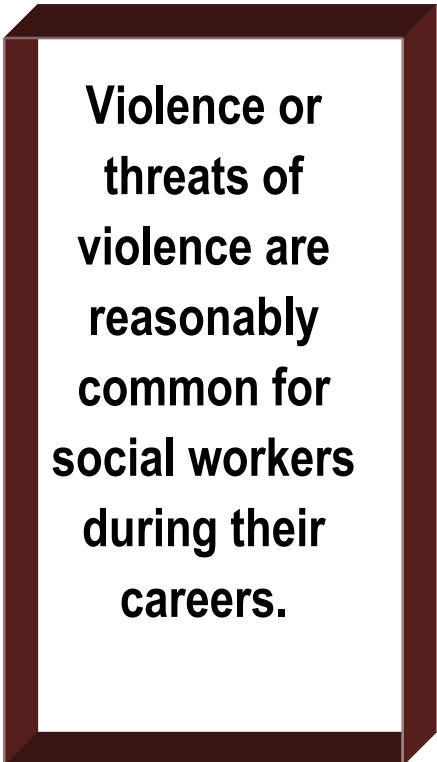
The 16-year-old's parents divorced in 2002. According to news accounts, he had problems living with his mother and moved in with his father and a woman the father lived with in an upscale neighborhood near Des Moines.

The teenager, who reportedly had a history of petty theft of beer, using a car without the owner's permission and drinking, was typical of many teens in the juvenile justice system.

The situation deteriorated late in January, when a 21-year-old recent college graduate was hired to live at the house to keep an eye on the youth while the father and his girlfriend were on vacation out of the country.

When the teenager didn't attend classes on Tuesday, Jan. 27, Gaul received a call from the mother of the young house sitter asking him to check on her daughter.

Gaul, who colleagues say used his therapeutic skill and wits to defuse tense situations, probably had no apprehension when he approached the house that morning. He didn't know that the teenager had murdered the sitter two days earlier.



Violence or threats of violence are reasonably common for social workers during their careers.

After shooting Gaul, the teenager fled in Gaul's car and the next day committed suicide with a shotgun while being pursued by police in Colorado.

Gaul's death is a "message to the rest of us to continue to be thoughtful about what we do," said Leila Carlson, executive director of the NASW Iowa Chapter. "It's easy to get into routines and not treat each case individually, there is so much to get done."

Carlson arranged for Newhill to present a three-hour chapter workshop on workplace safety on March 31 and to meet with a small group of Iowa agency executives so that the discussion on agency safety will continue in Iowa

"The most important thing is for the agency to say openly, 'Let's talk about safety and make it a regular topic at staff meetings,'" said Newhill. Violence to social workers is often underreported, she said. Social workers sometimes think they will be blamed and don't tell supervisors, or sometimes they report it and supervisors don't have a good response.

Newhill's workshop in Iowa was slated to cover a number of characteristics of clients that could alert social workers to potential violence, as outlined in her recent book *Client Violence in Social Work Practice: Prevention, Intervention and Research*. These include:

- Individual and clinical risk factors, such as certain psychiatric symptoms like violent fantasies, personality features like impulsivity, personality disorders and substance abuse.
- Biological risk factors, like low intelligence quotient and neurological impairment.
- Historical risk factors, like a history of violence, early exposure to violence, and unsteady employment.
- Environmental risk factors, like level and quality of social support, peer pressure and access to weapons.

Newhill said the workshop would also cover guidelines for how to make clinical assessments and environmental assessments to determine the potential for client violence and an assessment of social worker safety. The guidelines include inquiring about the client's potential for violence toward others and self, getting to know a neighborhood ahead of time by consulting with colleagues and police and finding out who will be in the home and potential danger there.

Other workshop segments were to cover safe settings for interviews; intervention techniques with potentially violent clients, like speaking softly, avoiding intense direct eye contact and avoiding early interpretations and insights; the physical environment of an office, such as panic buttons or pre-arranged methods to summon help; and how to dress, tucking in scarves and neckties and wearing no necklaces or earrings.

Hundreds of people lined up outside Holy Trinity Catholic Church for Gaul's wake, delaying the start of his memorial service. They packed the church again the next day at his funeral, filling the balcony, standing around the sanctuary walls and sitting on the steps outside.

The Des Moines Register covered Gaul's death and that of the 21-year-old house sitter extensively. "The local press has been very kind, writing stories about Greg and his work and the field of social work and its difficulties," said Stanley.

Many professions — including police work, fire fighting and military service — bring inherent danger, "but it's easy to forget those people who help troubled kids," said the Register.

"Social work is a job where workers are generally unappreciated, underpaid and overworked. These highly educated people could choose to work in other professions. After a few years in the field, many do. . . . But there are those workers who persevere. They stick with the job because they care about kids and know what they do matters."

Agencies need general strategies for safety, said Newhill. These include:

- Raising consciousness so that client violence is seen as a legitimate practice concern.
- Administrators and supervisors taking the lead in promoting safety.
- Offering high quality in-service safety training.
- Developing a user-friendly means of reporting and tracking incidents of violence.
- Establishing protocols with other organizations that agencies have interdependent relations with regarding safety.

Determining the level and intensity of a safety program is difficult, said Stanley, Gaul's business partner and friend. "I've been a social worker for 18 years and never had anybody even spit at me."

Gaul always had a positive outlook, and "I don't think he would want people to respond in fear or hold it [his murder] against people or for it to impact on their ability to work," said Stanley. "Rather than worrying that something could happen to me, I will work on being gentler and kinder to my clients. That's the message I would have gotten from Greg."

"Some danger is part of being human. Humans are capable of incredible good things and incredible horrific things. You just don't know."

Still, said Stanley, Lifeworks, like many other agencies, holds serious and ongoing discussions about how to keep its social workers safe and alive.

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Workplace Violence affects Health Care and Social Service Workers

In a 2004 report issued by the Occupational Safety and Health Administration on workplace violence, 48% of all non-fatal violence against all workers in the United States occurred in the fields of health care and social services.

- 50%-80% of public human service workers have experienced threats, damaged properties and physical attacks during their career.
- 70% of front-line child welfare workers have been victims of violence or threats in the line of duty.
- A review of 585 exit interviews found that 90% of former child welfare workers experienced verbal threats, 30% experienced physical attacks, and 13% had been threatened with weapons.
- Social service workers in the public sector are approximately 17 times more likely to be victims of violent assaults while at work than workers in the private sector.
- Patient dementia was identified as a factor in 87% of physical assaults on nursing assistants (Gates et al., 2003). [Gates, D., Fitzwater, E., & Succop, P. (2003). Relationships of stressors, strain, and anger to caregiver assaults. *Issues in Mental Health Nursing*, 24, 775-793.]
- Patient dementia was linked to 11% of violent events while other psychiatric diseases were linked to another 25%.
- Two out of three physical assaults happen in the medical care and social service industries. (Occupational Safety and Health Administration)
- Workplace violence is one of the most complex and dangerous occupational hazards facing healthcare workers in today's environment. The complexities arise, in part; from a healthcare culture resistant to the notion that healthcare providers are at risk for patient-related violence combined with complacency that violence (if it exists) "is part of the job." (Workplace Violence in Healthcare: Recognized but not Regulated)
- The U.S. Department of Labor released 2009 statistics that ranked paramedics and nursing aides as being the workers most likely to miss work because of injuries. There are 38 incidents of violent assaults per 10,000 nurse's aides.
- A 2009 workplace violence survey found that nearly half of all non-fatal assaults in the United States were caused by healthcare patients.
- Healthcare professionals are **16 times** more likely to be attacked on the job than any other service professional. Add the fact that 80% of actual incidents go unreported, and you can see what amounts to nothing short of an emergency situation. (Warrior Concepts Intl)

The Impact

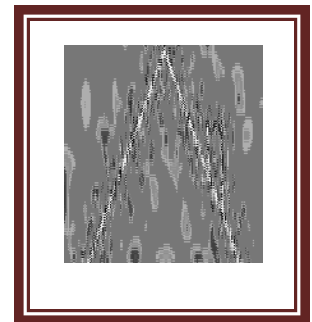
- In 2004, Kansas Social Worker, Teri Zenner, was brutally killed during a routine home visit.
- In 2006, Social Worker, Sally Blackwell was found dead in a field just outside of Austin, TX.
- In 2006, Social Service Aide, Boni Frederick, was beaten to death while overseeing a home visit between a mother and her infant.
- Carrie Lynn Johnson, a 39-year-old home health care nurse from Michigan was doing the job she cared deeply about when someone entered the Detroit home of her patient, shot and killed both of them and then set the house on fire.
- Misty Leann Garrett, a home health nurse technician, was shot after authorities say she refused to be her patient's girlfriend.

Risk Factors

- The prevalence of handguns and other weapons among clients, their families or friends The increasing number of acute & chronic mentally ill patients being released from hospitals without follow- up care
- The increasing presence of gang members, drug or alcohol abusers, trauma patients or distraught family members
- Solo work, often in remote locations with no back up or way to get assistance
- Lack of staff training in recognizing & managing escalating hostile and assaultive behavior

Before the Visit

- Don't wear excessive jewelry.
- Always let someone know where you are going.
- Mentally rehearse the visit and what you need to accomplish.
- Dress casually
- Take your ID with you, but do not wear your ID cord around your neck.
- Wear comfortable shoes with low or no heels.
- Carry a cell phone with you, if possible.



Approaching the House

- Be aware of your surroundings.
- Park your vehicle in a way that you can make a quick exit, if necessary.
- Do not block anyone
- Lock valuables in the trunk of your vehicle.

During the Visit

- Be aware of the exits from the home. Keep yourself between the client & the door.
- Sit near an exit or facing the hallway so you can view hall and bedrooms.
- Use non-threatening body language and remain calm & polite.
- Respect the client's home and their emotions.
- Listen to your instincts and feelings.
- Be cautious and use common sense. Leave if you feel threatened



Just in case...

- Don't reveal too much personal information
- Make sure your vehicle is in good running condition and has enough gas
- When possible, back your vehicle into parking spaces.
- Keep a flashlight and a first aid kit in your vehicle.
- Take dog biscuits along to calm excited/aggressive dogs.

Containing an Aggressive Incident: The Assault Cycle

If the point has been reached where the potential for aggressive acts has been reached, then an assault cycle is entered. There are five phases associated with the Assault Cycle: 1) the trigger phase 2) the escalation phase 3) the crisis phase 4) the recovery phase and 5) a post-crisis/ depression phase.

The Trigger Phase

In this phase, as the name suggests, some event of interpersonal situation triggers an aggressive response within the individual. Generally, the trigger is a stimulus or event that exceeds the client's tolerance for stress. This could be the result of one thing or an accumulation of things. Sometimes the trigger is not obvious and the person's response seems to 'come from nowhere'.

The Escalation Phase

The person's anger and aggression begin to escalate. Stress and frustration increase. Calming measures need to be used. Feelings, emotions, attitudes, and posture all influence the way people view and listen to each other. Explaining something to someone who is feeling upset, angry, or indignant is difficult until the person's feelings have been relieved. Consequently, the person's feelings need to be recognized and acknowledged. A return to the previous stage is possible, and this should be the aim of interventions. De-escalation techniques are used at this time and the earlier they are used, the better.

The Crisis Phase

Physical, emotional and psychological impulses are expressed i.e. property damage, aggression towards others. If escalation to the crisis stage occurs, communication is more difficult. However, if the situation becomes unsafe then personal safety and that of others in the immediate vicinity is of paramount importance. Consequently, the area around the aggressive individual should be evacuated, and help should be sought from appropriately qualified staff in sufficient numbers to safely contain the situation.

Remember: Maintain an assertive position with your body (feet held hip width apart with one foot in front of the other); Always keep the perpetrator at arm's length; Have someone call the police or get help from the nearest possible source; Position yourself near an exit for easy escape.

The Recovery Phase

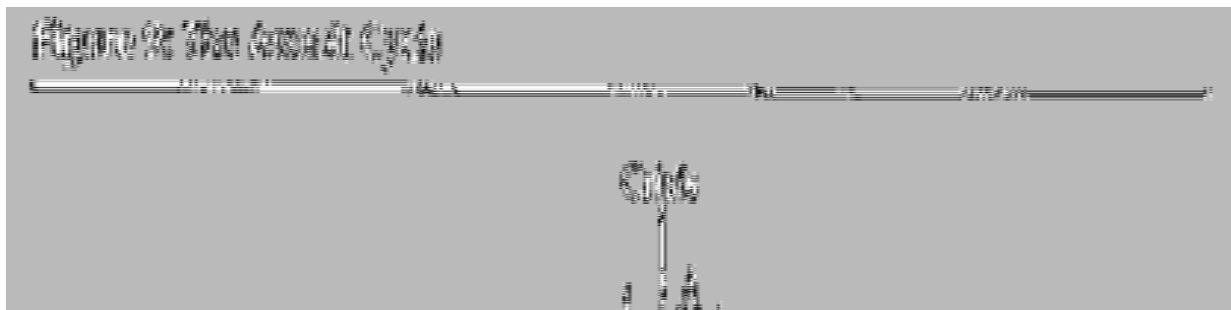
In the recovery phase, the person's level of activity is decreasing. Typically even the most aggressive individual can't keep up the energy level for a prolonged crisis period. The recovery side of the curve tends to be fairly steep. You should continue to calm the individual and de-escalate the situation. Any additional threat could trigger the person again.

Post Crisis/ Depression Phase

This is the end of the assault cycle. The person's anger has played out and he or she is withdrawn, depressed or even remorseful. It is characterized by behavior that falls below base line. The client may require a short rest period or a less active task until back at base line levels.

Warning Signs of Escalation may include:

- Staring
- Rapid breathing
- Flushed appearance
- Tense and anxious body posture
- Pacing
- Constantly shifting body position
- Shouting
- Swearing



You should be aware of the Assault Cycle when working with clients in their homes or community. If there is an incident where your client becomes aggressive or you start to feel unsafe, trust your instincts. At MAS, all clients have crisis plans. Make sure you are comfortable following the crisis plan. Report any crisis level incidents to your direct supervisor immediately and document pertinent information on an incident report form. Remember, your safety ALWAYS comes first.

Fire Safety

What is fire like?

FIRE IS DARK. There is a lot of smoke in a fire. The smoke is very dark. If you don't get out fast, the smoke can get so dark you can't see where you are going. Smoke alarms help tell us to get out fast.

FIRE IS HOT. Fire is hotter than the oven when you're baking something. Fire is hotter than a curling iron. Fire gets so hot it can melt toys and other things. Fire makes things so hot that you could get burned if you touched them.

FIRE HAS POISONOUS SMOKE. Fire uses up the oxygen you need to breathe. The poisonous smoke is the most dangerous part of a fire. If there is smoke in the room, you must get down under it and crawl outside.

FIRE IS FAST. A little spark can start a fire. In just five minutes, a whole room can be on fire . . . all started by one little spark. Know how to get out of your home fast. When your smoke alarm sounds, you don't have much time to get out.



Fire can be hard to put out. You can blow out the fire on a candle. That's because candles are made to hold fire and be put out easily. When fire is not on a tool made to hold fire, it can get big very fast. Even a little fire the size of a candle can get bigger when you try to blow on it. Firefighters have special tools to put out fires. But sometimes even firefighters have trouble putting out a fire.

PLANNING FOR A FIRE EMERGENCY

- Make Sure That There Are at least 2 Exits So People Can Leave.
- Clients who live in a private home should live and sleep near an exit on the 1st floor. It is best that they live and sleep on the 1st floor if they live in a 2 floor home or an apartment house, especially if they are ill or they have a physical problem. It is much easier and quicker to leave a fire from the 1st floor.
- If the client lives in an apartment house with an elevator, they should NEVER use it if there is a fire. They MUST use the stairs. Clients that cannot walk down the stairs must be carried down the stairs or gently slid down the stairs so that they can leave when they are in danger.

Have and Practice a Fire Escape Plan.

You AND your clients must know how they can escape from a fire. If they are confused or not able to understand this plan, you must help them to escape when a fire breaks out. You must teach and practice the escape plan with clients. You should ALWAYS assess and know the following two things:

- At least 2 ways out of every room in the home. If a fire blocks one way out, the second one will have to be used. Windows and doors are good ways out when a person lives and sleeps on the 1st floor. If the person lives and/or sleeps on another floor, they should know where the exit stairs are and how to use an emergency ladder, a ramp or fire escape stairs outside the building. They should NEVER use the elevator in a fire.
- The meeting place outside of the home. Plan an escape route and a meeting place outside the house. Pick a spot, perhaps, across the street or at a neighbor's home, etc. This will help you and your clients to know if everyone is out of the house.



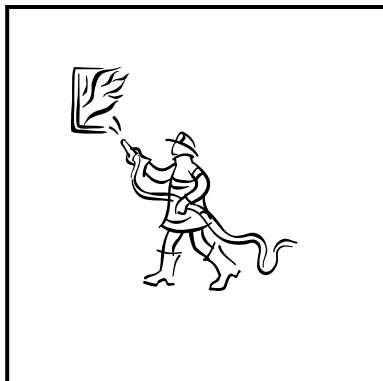
Remember- Practice saves lives!!!

Know and Post Emergency Telephone Numbers.

Clients who live in their own home should always have a telephone and emergency telephone numbers in their bedroom and in other areas of the house.

Emergency telephone numbers that should be posted on or near telephones are:

- Fire department
- Police department
- Ambulance service



WHAT YOU MUST DO IF A FIRE STARTS

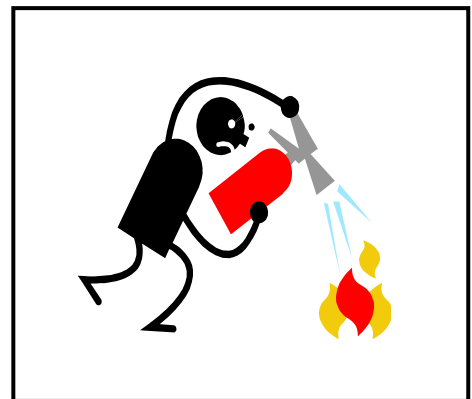
You must act very fast if a fire starts. You must R-A-C-E and follow your fire plan. You must:

- **R-** Rescue all the people that are in danger. The first thing you must do is rescue people that are in danger. Follow your fire plan. Get your client out. Get them out and keep them out.
- **A-** Alarm. You must call the local fire department or pull a fire alarm if there is one.
- **C-** Confine or contain the fire. Close doors and windows.
- **E-** Extinguish the fire if you can safely do it without causing any danger to yourself and others. If the fire is a very small one that you can quickly and safely put out using water or a fire extinguisher, do it. If the fire is too big, get everyone out and call the fire department to put the fire out.
- All personal items should be left behind. No one should go back into the home. They may never get the chance to leave again.

HOW DO YOU USE A FIRE EXTINGUISHER?

Use the P-A-S-S method to use a fire extinguisher:

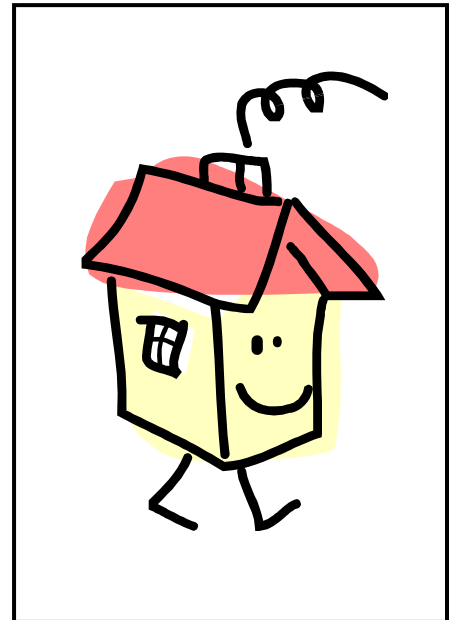
- **P-** Pull the pin
- **A-** Aim at the base, or the bottom, of the fire or flame
- **S-** Squeeze the trigger while holding the extinguisher up straight and
- **S-** Sweep, or move the spray, from side to side to completely cover the fire



WHAT YOU MUST DO IF A ROOM IS FILLED WITH SMOKE

GET LOW AND GO if you discover a room is filled with smoke.

- Yell FIRE and R-A-C-E! Immediately begin the fire plan.
- Instruct your clients to stay low and crawl to the door. Smoke fills a room from the ceiling down. The safest air is near the floor
- Instruct them to touch the exit door with the back of their hand to check whether or not it is hot.
- If the door is hot, tell them NOT open it. Go to another exit. If that door is cool, open it slowly and go to your meeting place outside the home.
- If an exit is unsafe to use, the client should shut the room's door and block off the bottom of the door with a towel or blanket.
- They should be taught to cover their nose and mouth with a wet cloth and to yell for help. They should yell or signal from a window if they can.
- If there is a phone in their room, they should call 911 and tell the fire department where they are blocked in with smoke and a hot door.



HOW CAN I HELP A PATIENT WHEN THEIR CLOTHES ARE ON FIRE?

STOP, DROP & ROLL.

If a person's clothes catch fire, tell them to STOP and NOT run. Tell them to lay down on the floor and cover their face with their hands. They should be told to then roll over and over to smother the flames. You should also cover the person with a blanket or another item to put out the flames.

Do not fan a fire with your hands. This will only make the fire worse!

IF THERE IS A FIRE IN YOUR APARTMENT OR HOME, REMEMBER:

- Drop to the floor and crawl to the nearest exit.
- Close all doors behind you.
- In an apartment, if you must flee, take your key.
- Alert others.
- Meet your family outside the building at a pre-set safe location.
- Of course, call the Fire Department.

Did you know that the type of building a person lives in dictates how to respond to a fire? If a person lives in a small house, brownstone or small apartment building, it's better to leave if there is a fire. If you live in a highrise apartment building and the fire is not in your apartment, it may be better to stay put and wait until the Fire Department comes to help.

IF YOU STAY IN YOUR APARTMENT OR HOME, REMEMBER:

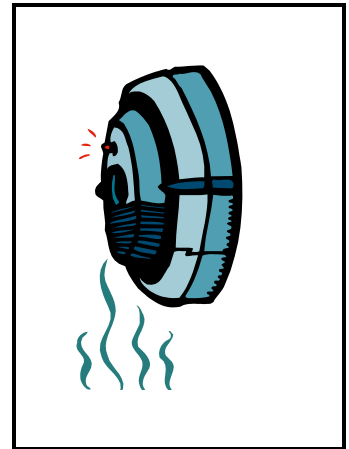
- Call 911 immediately and let them know your location.
- Close all vents where smoke can enter your apartment.
- Place rolled wet towels under the doors if smoke is coming in.
- If you can open a window and no smoke comes in, open it for some fresh air.
- Don't break the windows.
- If you are in danger, wave a white towel or sheet across the windows to alert others.



WHAT THINGS CAN BE DONE TO PREVENT FIRES?

- **Smoke detectors.** Encourage your home care clients to have smoke detectors in every room of the house. Many fires start at night while people are sleeping. Smoke detectors wake people up when a fire starts. Make sure that the batteries are changed often and that they are kept clean and free of dirt or dust. If you hear a periodic "beep" or "chirp" it means that the battery is low and it must be changed immediately.
- **Practice electrical safety.** Never overload electrical sockets. Avoid extension cords. Check all electrical wires for damage. Do NOT use any damaged wires. Damaged wires start fires.

Use the right watt light bulb for the light or lamp. High watts can over heat the lamp or light. This over heating can cause a fire. Use a 60 or lower watt bulb if you are not sure what watt to use.



- **Insure cigarette safety.** All cigarettes should be smoked outdoors. If a client insists on smoking in their own home, they should be told to NEVER smoke in bed. People often start fires when they fall asleep with a cigarette in their hand.
- **Do NOT permit smoking in the house if the client or another member of the house is using oxygen.** Also, keep the oxygen away from any open flames.
- **Avoid the use of space heaters.** Space heaters start fires very often and very fast. If a person wants to use one in their own home, tell them to give it lots of space! They must keep it at least three feet away from everything that can burn, including walls, drapes and upholstered furniture.
- **Keep and maintain a fire safe kitchen.** Cook safely if you prepare meals for your patients or residents. Careless cooking is the #1 cause of house fires!
- **Wear short sleeves or roll up your long sleeves whenever you are cooking.** Long, loose sleeves are more likely to catch fire and they may also overturn pots and cause scalding burns.
- **NEVER leave cooking unattended.** Turn the burner or oven off if you have to leave the area, even if it is only for a few minutes.
- **If a fire starts in the oven, leave the door shut and try to turn the oven off so the fire will die out.** If you have a pan fire, turn the burner off and try to smother it with a lid, a cookie sheet or baking soda. If possible, also use a fire extinguisher. Do NOT use water or flour!

Name: _____

Date: _____

**Safety in Home Health Care
In-Service Quiz**

1. In a 2004 report issued by the Occupational Safety and Health Administration on workplace violence, _____% of all non- fatal violence against all workers in the United States occurred in the fields of health care and social services.

2. List at least 3 risk factors for increased violence in the social work field.

- _____
- _____
- _____

3. What are at least three precautions social workers can take *before the visit*?

- _____
- _____
- _____

4. Where should you position yourself in an apartment or home?

5. What are the five phases of the Assault Cycle?

- _____
- _____
- _____
- _____
- _____

6. What are at least 5 warning signs of an escalation when working with a client/family?

- _____
- _____
- _____
- _____
- _____

7. According to Iowa's Newhill, there are a number of client characteristics that could alert social workers to potential violence. List at least 2 characteristics that Newhill identifies in the article *Tragedies Spark Worker-Safety Awareness*.

- _____
- _____

8. According to Iowa's Newhill, social work agencies need general strategies for safety. **Name 2 of the 5** strategies the Newhill suggests in the *article Tragedies Spark Worker-Safety Awareness*.

- _____
- _____

9. If your client or a family you work with goes into crisis, who should you report the crisis to? _____

10. During the Recovery Phase/Depression phase of the Assault Cycle when the person's anger has played out, the person may present as (list 3 characteristics):

- _____
- _____
- _____

11. With regard to fire safety, what are two things you should always know and assess when entering their home/apartment?

- _____
- _____

12. In the case of a fire, where is the "safest air"? _____

13. What should you do if you or your client's clothes catch on fire?

14. What are two things that can be done to prevent fires while working with clients in their home?

- _____
- _____

15. The type of building a person lives in dictates how to respond to a fire.

Circle one: True or False

Self Care in the Social Work Field In-Service

*“Our bodies are our gardens to which our wills are gardeners.”
– William Shakespeare*

OVERVIEW

Social work professionals often face challenges or obstacles that may cause them to feel overwhelmed and stressed. Notably, those providing direct services, particularly behavioral health and health care, may experience higher levels of stress as a result of their emotionally attenuating practice setting. In response to the stress, and in order to maintain psychological and physiological homeostasis, social workers invoke different strategies to help them cope. In small amounts, stress can be helpful, providing a source of motivation—particularly in situations where one feels like “throwing in the towel”. However, too much stress can be harmful and can threaten the professionals’ physical and mental health, and place them at risk for injury, behavioral and/or serious health-related problems over time (Arrington, 2008).

STRESS-RELATED HEALTH CONCERNS

Stressful work conditions, whether caused by individual or situational factors, can lead to health problems and risk of injury. In one study, participants indicated that they experience health-related problems resulting from the stress they experience at work. Among social workers providing direct services, fatigue, psychological problems, and sleep disorders are the most commonly reported stress-related health concerns. Seventy percent of social workers employed in health care settings report feeling fatigue from stress. Thirty-eight percent of social workers in mental health acknowledged that psychological problems are a stress-related health concern. Additionally, one-fourth of individuals employed as child welfare/family social workers reported they experience sleep disorders (Arrington, 2008).

“The major challenge of social work is that social workers have too many things on their plates. They cannot possibly do everything they need to do and do it well. Burnout is a main reason people are leaving the profession. We are short-handed as it is...”

—Survey Participant

WHY IS SELF CARE IMPORTANT?

Professional self-care is vital to the profession of social work for several reasons:

- Professional self-care is an essential component in competent, compassionate, and ethical social work practice, requiring time, energy, and commitment.
- Promoting the practice of professional self care in social work explicitly acknowledges the challenging and often overwhelming nature of our work.
- Professional self-care places emphasis on primary prevention of these unwanted conditions and implies that tools and strategies should be part of one's overall professional self care plan. Actively preparing social workers with knowledge and skill for overcoming these experiences is key.
- Professional self-care in social work is critical to maintaining ethical and professional behavior and providing competent services to clients across diverse settings.
- Although the practice of professional self care applies to all social workers, it is especially critical for social workers providing care to traumatized populations.
- Acknowledging professional self-care in social work is an important first step in preserving the integrity of social workers and in retaining valued professionals in the profession. Actively preparing social workers to effectively face these conditions will support social workers in maintaining their commitment to the profession.



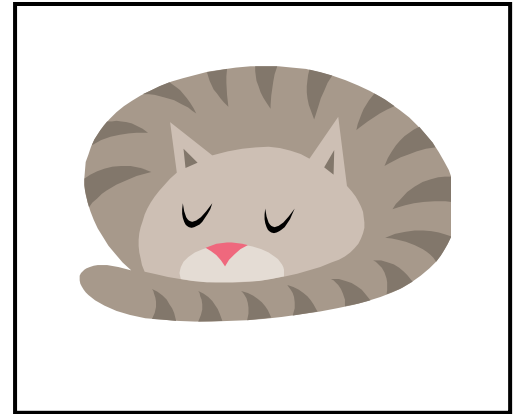
INCORPORATING SELF CARE INTO YOUR LIFE:

1. Process Your Emotions

Keeping your emotions bottled up usually leads to an emotional explosion later on. It's generally healthier to listen to your feelings, process them and try to understand them. Your direct supervisor is there to process with you so use him or her as much as you need (remember, you can't talk about your cases with your personal family and friends, so group supervisions and individual supervisions are offered regularly!). Another great way to process emotions is the act of journaling. When you write about your feelings, and potential solutions to your problems, you can reduce stress in your life and even see some health benefits!

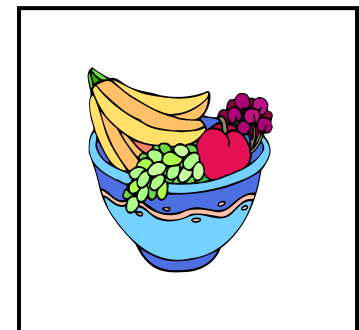
2. Get Enough Sleep

Sleep is very important for your emotional and physical wellbeing. Lack of sleep can negatively impact your ability to handle stress, be productive, and function properly. Unfortunately, busy schedules and stress can make sleep more elusive. And if you really aren't able to get enough sleep at night, don't underestimate the value of a power nap! According to the Mayo Clinic, adults should get approximately 7-9 hours of sleep per night.



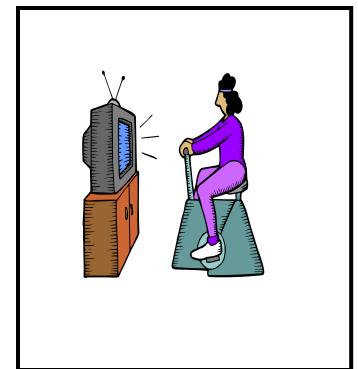
3. Maintain Proper Nutrition

Many people aren't aware of this, but a poor diet can actually make you more vulnerable to stress! While hectic schedules can make it harder to get proper nutrition, a poor diet is not inevitable. Two easy ways to improve your diet is by minimizing caffeine intake and drinking lots of water. The Mayo Clinic suggests drinking approximately 8-9 cups (64-72 ounces) of water each day.



4. Exercise Regularly

Exercise can be great for you physically and mentally. It provides a stress release and keeps your body healthy. It also helps your body release endorphins, which increase your feelings of overall wellbeing. (Hint: Pets make great workout buddies!). For most healthy adults, the Department of Health and Human Services recommends: At least two hours and 30 minutes a week of moderate aerobic activity (think brisk walking or swimming) or one hour and 15 minutes a week of vigorous aerobic activity (such as running) — preferably spread throughout the week and strength training exercises at least twice a week.



5. Maintain Social Support

Social support can keep you healthier and happier, creating a buffer against stress. Learn how to cultivate supportive friendships and expand your social circle so you'll have someone to lean on when stressed. (Don't forget, it's important to provide a supportive ear when your friends need it, too!). Always remember that the work you do is confidential!



6. Find Hobbies

Having some “down time” is important, and hobbies can provide a nice distraction from stress and help you stay ‘in the moment’, which is also a great way to relieve tension. Drawing and gardening are great stress relievers, but just about anything you enjoy can work.

7. Pamper Yourself

Taking care of your body on the outside—with a spa treatment, for example, can work wonders for your internal state. Don’t overlook the importance of pampering yourself on a regular basis, to feel great about yourself and feel ready to take on the world.

8. Keep Your Mind Sharp

If you maintain the attitude that stress is a challenge—rather than a threat, you are better able to handle it. And by keeping your mind sharp, you are more equipped to solve the problems and take on the “challenges” that life presents

9. Have the Right Attitude

Much of what you experience in life can feel more stressful or less so depending of your point of view. Looking at things from an optimistic frame of mind can not only decrease your stress level, but bring you more success in life and more. You can even change ingrained negative thought patterns to more positive ones by using positive affirmations.



QUESTIONS ABOUT SELF CARE

Isn't it Selfish to Put Myself First?

Some others may consider Self Care the territory of the self involved, who have little consideration for others around them. Wrong again! Taking care of your needs lays in a balanced, steady place on the middle of a continuum, with intense selfishness on one end, and extreme sacrificing what you need or want for others' sake on the other end.

In fact, nurturing oneself is a key factor in being able to keep up strength, resolve, motivation and inner resources to continue to give to others, whether that be your immediate partner, family and other important people in your inner circle, or the larger community around you. You might consider that doing too much for others could deprive them of the opportunity to learn how to provide their own self care.

What if I Don't Have Time to Take Care of Myself!

If you do a "self care audit", you will likely find that some of the activities you spend your time on now, could be better spent "recharging your own battery." Studies show that mental acuity decreases after a short period of concentrated study. You likely need more true breaks, not just time killers stolen from study time you rarely spend in any really relaxing or satisfying recreation. All the time management/ life goal experts say put your Self Care into your schedule, just like another class or job shift. How many times do we have to hear, "make a commitment to yourself" before we believe it?

My "Self Care" comes on the tube at 11:30 every night and is accompanied by a large pepperoni. Isn't that enough?

That may be just the ticket for some nights, but do you have enough nurturing choices for the other nights of the week? While not discounting the value of building up your knowledge of 1950's television trivia, the consequences of making this a nightly habit might include indigestion, sleep loss, weight gain, oversleeping in the morning, a feeling of grogginess and little energy lingering the next day.

Maybe you could use some alternatives? Perhaps you could use the comfort of a cozy chat with a special person, or some quiet time with your mind engaged — not just checked out.

Do I Have to Do It Alone?

No, although the best balance is achieved with a combination of time shared with others, as well as some time alone. Your attitude of looking for opportunities to practice Self Care can go with you into almost anywhere.

Still Skeptical?

Experiment! Set up a 30 day trial with yourself and see how you feel before and after.

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Name: _____

Date: _____

Self Care in the Social Work Field

In-Service Quiz

1. Stressful work conditions can lead to health problems and risk of injury.

Circle One: True or False

2. What percentage of social workers employed in health care settings report feeling fatigue from stress? _____

3. What percent of social workers in mental health acknowledged that psychological problems are a stress related health concern? _____

4. 50% of individuals employed as child welfare/family social workers reported that they experience sleep disorders.

Circle One: True or False

5. What are at least 3 reasons that professional self-care is vital to the profession of social work.

- _____
- _____
- _____

6. According to the Mayo Clinic, how much sleep does an adult need on average? _____

7. Name 2 easy ways to improve your diet.

- _____
- _____

8. When you exercise your body releases _____ which increase your feelings of overall well being.

9. What are three ways you can incorporate self-care into your life:

- _____
- _____
- _____

10. Studies show that mental acuity increases after a short period of concentrated study.

Circle one: True or False

Working with Traumatized Children

and Families In-Service

A Brief Overview for Caregivers

Bruce D. Perry, M.D., Ph.D.

www.ChildTrauma.org

Each year in the United States approximately five million children experience some form of traumatic experience. More than two million of these are victims of physical or sexual abuse. Millions more are living in the terrorizing atmosphere of domestic violence. Natural disasters, car accidents, life threatening medical conditions, painful procedures, exposure to community violence – all can have traumatic impact on the child. By the time a child reaches the age of eighteen, the probability that any child will have been touched directly by interpersonal or community violence is approximately one in four.

Traumatic experiences can have a devastating impact on the child, altering their physical, emotional, cognitive and social development. In turn, the impact on the child has profound implications for their family, community and, ultimately, us all.

Traumatic events in childhood increase risk for a host of social (e.g., teenage pregnancy, adolescent drug abuse, school failure, victimization, anti-social behavior, behavioral control, aggression towards others, poor impulse control, self-destructive behaviors, low self-esteem, shame, guilt, learning disorders), neuropsychiatric (e.g., post-traumatic stress disorder, dissociative disorders, conduct disorders) and physical health problems (e.g., heart disease, asthma).



Each year in the United States, more than 1,400 children- nearly 2 children per 100,000- die of abuse or neglect. ¹

1 in 4 children/adolescents experience at least one potentially traumatic event before the age of 16. ²

4 out of 10 U.S. children report witnessing violence; 8% report a lifetime prevalence of sexual assault, and 17% report having been physically assaulted. ³





Children in the child welfare system frequently face other sources of ongoing stress that can challenge a workers' ability to intervene. Some of these sources of stress include:

- *Poverty*
- *Discrimination*
- *Separation from parent/siblings*
- *Frequent moves*
- *School problems*
- *Traumatic grief/loss*
- *Refugee or immigrant experiences*

The deterioration of public education, urban violence and the alarming social disintegration seen in some of our communities can be linked to the escalating cycles of abuse and neglect of our children. For most children, thankfully, a traumatic event is a new experience. And like all new experiences, the unknown will add to the confusing and frightening circumstances surrounding this overwhelming experience.

The trauma may significantly challenge the child's sense of the world. A flood, tornado, car accident, shooting or abuse by a caregiver - all challenge the child's beliefs about the stability and safety of their world. Very young children may not understand what happened and will be confused or even frightened by the reactions of their siblings or caregivers. The acute post-traumatic period is characterized by an attempt by the child to reorganize, reevaluate and restore their pre-traumatic world. Many of the emotional, behavioral and cognitive signs and symptoms

of the acute post-traumatic period are due to these efforts. Unfortunately, children often do not have the same capacity to understanding or explaining most traumatic experiences. Young children may make many false assumptions about the event – “the tornado came because God was mad.”

The impact of a potentially traumatic event depends on several factors, including: the child's age and developmental stage, the child's perception of the danger faced, whether the child was the victim or a witness, the child's relationship to the victim or perpetrator, the child's past experience with trauma, the adversities the child faces following the trauma, and the presence/availability of adults who can offer help and protection. When trauma is associated with the failure of those who should be protecting and nurturing the child, it has profound and far-reaching effects on nearly every aspect of the child's life.

As with most situations, children seek answers and comfort from adults around them, yet we often feel helpless in this role. Indeed, most traumatic experiences challenge

the most mature and experienced adult. While adults do not have all the answers, they can help children better understand the traumatic event and the ways we respond following trauma. What can adults do when they are working with children and families who have experienced a traumatic event?

- Recognize the signs and symptoms of child traumatic stress and how they vary in different age groups.
- Recognize that children’s “bad” behavior is sometimes an adaptation to trauma.
- Understand the impact of trauma on different developmental domains.
- Understand the cumulative effect of trauma.
- Support parents and caregivers who have secondary adversities and traumatic experiences of their own and respond sensitively.
- Make a special effort to integrate cultural practices and culturally responsive mental health services.
- Identify and build on parent and caregiver protective factors.
- Develop trust with children and families through listening, frequent contact, and honesty in order to mitigate previous traumatic stress.
- Avoid making professional promises that, if unfulfilled, are likely to increase traumatization.
- Encourage and promote positive relationships in the child’s life and learn about the community strengths.

Sources Cited

¹United States DHHS. (2007). Child Maltreatment 2005: Washington, DC: US Gov’t Printing Office.

² Costello et al. (2002). J Traum Stress; 5(2):99-112.

³Kilpatrick et al. (2003). US Dept. Of Justice. <http://www.ncjrs.gov/pdffiles1/nij/194972.pdf>

Name

Date

Working with Traumatized Children and Families

In-Service Quiz

1. Each year in the United States approximately _____ experience some form of _____.
2. _____, car accidents, life threatening medical conditions, painful procedures, _____ - all can have traumatic impact on a child.
3. Children who were directly affected by i.e Hurricane Katrina could have symptoms of Post Traumatic Stress Disorder (PTSD).
(Please circle one) True or False
4. Traumatic experiences can have a devastating impact on the child, altering his/her: _____, _____, _____, and _____ development.
5. Children can make false assumptions about a traumatizing event.
(Please circle one) True or False:
6. The impact of potentially traumatic event depends on several factors, (Please list 3):
 - _____
 - _____
 - _____
7. What can adults do to help the child (list at least 3 things)?
 - _____
 - _____
 - _____
8. Each year in the US, more than _____ nearly 2 children per ____ die of abuse or neglect.
9. 1 in 4 children/adolescents experience at least one _____ before the age of _____.
10. 4 out of ____ US children report _____ violence.

11. (Please circle one) True or False: Recognize that a child's "bad" behavior may be just an adaption to trauma.
12. The deterioration of _____, _____ and the alarming _____ seen in some of our communities can be linked to the escalating cycles of abuse and neglect of our children.
13. (Please circle one) True or False: Children in the welfare system may have stressors such as: frequent moves, traumatic grief/loss, discrimination.
14. (Please circle one) True or False: You do not have to integrate culturally responsive mental health services.
15. (Please circle one) True or False: You need to support parents/caregivers who have secondary adversities and traumatic experiences of their own and respond sensitively.
16. Traumatic events in childhood increase risk for a host of social problems. Please list three:
- _____
 - _____
 - _____
17. Different people handle traumatizing/stressful events differently. It is important to not judge the family and guide them through this difficult time.
(Please circle one) True or False
18. If you are having difficulty working with a family/client that has experienced a traumatizing event you should speak to your supervisor.
(Please circle one) True or False
19. It can be exhausting working with a family that has experienced a traumatizing event you should take extra steps of self care.
(Please circle one) True or False.
20. When trauma is associated with the failure of those who should be _____ and _____ the child, it has profound and far reaching effects on nearly every aspect of the child's life.