

VOLUNTEER MANUAL



Quiet Oaks Hospice House

St. Augusta, MN 56301

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Welcome

Welcome to the Quiet Oaks Hospice House Volunteer program! Volunteers are the heart of Hospice, and each of you makes an enormous difference in the lives of our Residents and their families. We appreciate all of the time and energy you are preparing to give to Quiet Oaks. We couldn't do it without you!

The Quiet Oaks Staff

“Works of Love are Always Works of Joy”

Mother Teresa
(1910-1997)

The Volunteer Mission of Quiet Oaks

Every resident and family brings with them a unique array of physical, emotional, social, and spiritual needs. Volunteers join with staff in addressing as many dimensions of their needs as possible. Our mission is to support residents and their families as they share their joys and grief, and enable patients to sleep, eat, and wake in their own rhythm, living their days as fully as possible, while saying their good-byes to the best of their ability.

Patient Confidentiality

We are committed to protecting our resident's privacy and confidentiality. There are occasions when patients do not want it known that they are terminally ill. We must always honor their requests and discuss their condition only within the hospice house. All of our residents and their families deserve to be protected from unnecessary discussion.

OTHER WAYS WE SAFEGUARD RESIDENTS' PRIVACY:

- We never record a resident's name where visitors can see it. Only first names, room numbers and occasionally admission dates, are listed on the Resident Boards in the kitchens.
- We always refer to residents, family members and staff by first names unless requested to do otherwise. A volunteer may never know a resident's last name unless they ask.
- When answering the phone, volunteers never give out resident information. Refer all questions to the nurses.
- Resident charts, when not in use, are locked inside the nurses' station.
- Under no circumstances do we **ever** discuss our residents by name outside the hospice.

Always be conscious of how voices carry around the house. Be very careful to speak softly when discussing one of our residents with staff or family members inside the house.

Quiet Oaks Hospice House Policy

Title: VULNERABLE ADULT ASSESSMENT AND REPORTING

Original 8/07/08

Ref: MN Stat. 626.557

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IT IS THE POLICY OF QUIET OAKS HOSPICE HOUSE that upon admission, the admitting nurse shall perform a vulnerable adult assessment.

INTERNAL REPORTING PROCEDURE

Upon admission, and any time while a resident is living in QOHH, any conduct that is **not an accident** and that produces physical pain or injury or emotional distress, must be reported to the Administration. Administration must give written notice to reporter, within 2 working days, stating whether QOHH reported the incident to the common entry point (CEP). The name of the reporter will not be revealed. If the reporter is not satisfied with the action by QOHH Administration, he/she may report it to the CEP, listed below. The QOHH will not stop any one from reporting a maltreatment incident and will not retaliate against the reporter for doing so.

All residents should know the name of the person to whom they should report a maltreatment incident within our facility.

Stearns County Common Entry Point

(320) 656-6225

1-800-450-3663

About Hospice...

Hospice care is rooted in the centuries-old tradition of preparing gifts for those embarking on a long journey.

Today, hospice is a special kind of caring that helps people with a terminal illness live their final months in comfort and dignity.

Our volunteers are an immensely important part of our mission as they assist our nurses and staff to provide comfort, kindness and caring to all those who enter our “home”.

Our commitment is to help people truly live until they die, without the fear of dying alone, in pain, or with symptoms out of control. We strive to support their families with compassion and care.

This has been our creed since opening our doors on October 22, 2008.

**One of the deepest
secrets of life
is that all that is really
worth doing
is what we do for others**

Lewis Carroll
(1832-1898)

Hospice History and Goals

Hospices, in the Middle Ages, were way stations for weary pilgrims on a journey. They offered loving care to tired, hungry, sick, destitute, and dying people. In the 1960's, Dr. Cicely Saunders, a British physician, dedicated her life to calling attention to the complex and often unmet needs of the terminally ill in modern society. Today, her hospice philosophy continues to guide hospice care around the world. In America alone, there are now more than 5,000 hospices providing specialized care to over one million patients and their families each year. Hospice care is now available in a variety of settings. Regardless of where the care is delivered, however, all hospices share the same unique goals.

Goals:

- **Provide comfort care rather than curative care**
- **Treat the person, not the disease**
- **Emphasize quality, rather than length of life**
- **Consider the entire family, not just the patient; the focus of care**
- **Strive to help patients truly live until they die, without fear of dying in pain, dying alone, or losing control**

History of the Hospice Movement

Throughout history, caring for dying persons has been a heavy responsibility for the living. In the beginning, this responsibility was primarily on families or religious groups. Care was emphasized since cure was rare. An average life expectancy was short, and dying was usually a quick process. Death itself was an accepted part of life.

However, with improved sanitation and food supply, things began to change. In addition, scientific medicine became increasingly effective, and communicable diseases were almost eradicated. Mortality rates in pregnancy and infancy declined sharply, and more people began to live longer. Dying became more the experience of an increasing population of elderly persons and was associated with chronic long-term degenerative diseases.

The increasing population of elderly persons with chronic debilitating diseases posed a societal problem. New approaches had to be developed for the care of the dying. One of the most effective “new approaches” to the care of the dying involved refining the ancient concept of hospice.

Pioneered successfully in England, hospice has become a major force in the treatment of the terminally ill. Today there are many programs in England and in North America through which the dying patient may receive highly specialized palliative care. These hospices are patterned after St. Christopher’s Hospice in Sydenham, England, and share the common goal of keeping the patient pain-free, comfortable and without diminished sensorium during the final stages of his life. This goal is achieved by the sophisticated art and science of palliative care, which was developed largely by Dr. Cicely Saunders of England.

Definition of Hospice

The primary focus of hospice philosophy is based on pain control and recognizes that pain can be physical, psychological, social, spiritual, or any combination of these. Since physical pain influences and is influenced by, the other aspects of pain, a careful assessment is made which involves the following: (a) all members of the health care team (physician, nurse, clergy, social worker, volunteer), (b) the selection of the appropriate drugs at an optimum dosage, and (c) appreciation that the resident’s needs may change rapidly, necessitating frequent readjustment in the medication regimen. Addiction is not a consideration, since dying patients are seldom emotionally dependant on drugs.

In addition to the holistic approach to pain control, which is central to hospice philosophy, there are eight major components of hospice care:

- (a) The provision of care by an interdisciplinary team;
- (b) 24-hour availability of both medical and nursing service;
- (c) Home-care services in collaboration with inpatient facilities;
- (d) Recognition that the resident and family together are the unit of care;
- (e) A bereavement follow-up service;
- (f) Extensive use of volunteers as an integral part of the hospice care team;
- (g) Central administration and coordination of services; and
- (h) Knowledge and expertise in the control of symptoms (physical, psychological, social and spiritual).

The presence of these components distinguishes hospice from other approaches to terminal care.

Significance of the Hospice Movement

The emphasis on holistic health care in nursing education and practice achieved prominence at approximately the same time that the hospice movement began to gain momentum in the United States. The hospice concept complements nursing education's philosophy of the person, both as holistic being and as a member of a complex system of family, friends, society and culture.

Based on the framework of holistic health, it is reasonable to expect that each health professional, volunteer, resident, or family member has a unique understanding of life and origins, social class and family expectations, and religion. In order to be effective, members of the helping professions must first understand themselves in relation to their own social mores and prejudices.

Background

The term "hospice" originally referred to a "house of rest and entertainment for pilgrims, travelers, or strangers . . . for the destitute or the sick." This medieval term is used currently to signify that the doors are open to travelers on a journey from one life to the next.

In the time of the Emperor Julian the Apostate (475 A.D.), Fabiola, who was a Roman matron and disciple of St. Jerome, opened a place of refuge in Syria for the healthy traveler, the sick, and the dying returning from Africa. She recognized and valued active resting, and dying humankind, and cared for all simultaneously.

In the Middle Ages the dying were seen as individuals who were moving more rapidly toward God and thereby could be useful to mankind. Because of this belief, early hospices grew along the routes of the Crusaders, who were traveling in service to God. They offered shelter to any traveler – well, ill, hungry, orphaned, needy or dying. These hospices usually were run by religious orders and became quite numerous. There were 750 in England and 40 in Paris alone. The Knights Hospitallers of the Order of St. John were a primary mode for spread of hospices during the 11th century; after the Crusades, hospices were monastery – based.

However, society's attitude toward the dying changed with the rapid spread of abject poverty. In 1536, the English monasteries were closed by the King and their lands redistributed. Nursing orders were dispersed, and the needy, ill and dying were left, for the most part, unattended. In fact, by 1550 people "irresponsible" enough to be poor and ill could, by command of King Edward VI, be beaten and enslaved.

In the 1600's a French priest named Vincent de Paul was captured by pirates and sold as a slave. After converting his master to Christianity, he returned to France and founded a hospice for galley slaves, an orphanage, missions for the sick and poor, and a nursing order called the Sisters of Charity. The Sisters of Charity were taught that their monasteries were the houses of the sick and their cloisters the streets of the city.

In the 1700's, conscientious individuals, such as Sir Thomas Guy, instituted a system of humanitarian philanthropy, and "voluntary hospitals" were founded to mend the bodies of the sick. Unfortunately, hospitals during the 17th and 18th centuries expressed the societal need for order, efficiency, and social discipline. The care reflected the belief "not that the dying should give up a passage spirit, but that the recuperating body should possess a spirit less likely to fall prey to idleness, drunkenness, and other economic aberrations." The incurable were discharged.

During this turmoil, the Sisters of Charity continued quietly performing their mission of ministry to the poor and dying. Baron von Stein of Prussia was so impressed by the work of these Roman Catholic nuns that he encouraged a young Protestant pastor named Fliedner to found Kaiserwerth, the first Protestant hospice also staffed by nuns. An interesting historical coincidence is that nuns from both of these groups accompanied Florence Nightingale to the Crimea, where competent and compassionate professional nurses first gained worldwide attention.

In the late 1800's, Sister Mary Aikenhead of the Irish Sisters of Charity founded Our Lady's Hospice for the care of the dying at Harold Cross in Dublin. During the same period Madame Garnier organized the Women of Calvary and founded houses to care for the destitute and dying in Paris (1871), St. Etienne (1875), Marseilles (1888), and Rouen (1891). The need for such places had become acute, particularly in Ireland with its potato famine and in England with its Poor Law establishments. At a time when many people believed that pain and sickness were punishment for sin, the hospitals were selecting outpatients for teaching and research, and encouraging the disposition of the incurable to other institutions even less sympathetic.

In 1891, William Hoare of the Merchant Bankers of London appealed through *The Times* for money to establish a home for critically ill. This home was the Hostel of God, which was incorporated by the Anglican Sisters of the Society of St. Margaret in 1896, and which is still run independently of the National Health Services.

Four years later, five of the Irish Sisters of Charity founded St. Joseph's Convent in the East End of London and started visiting the sick in their homes; in 1902, they opened St. Joseph's Hospice with 30 beds for the dying poor. St. Lukes Hospice in Bayswater managed by a Methodist committee, also flourished.

In summary, whether called a hospital, hotel or hospice, these early institutions were the forerunners of the modern hospice. They nurtured skills of providing care for the special pilgrimage of dying.

Emergence of Modern Hospice

Two developments in the 1950's provided necessary impetus for the emergence of the modern hospice. The first was the establishment of the Marie Curie Foundation in England to fight the consequences of malignant disease. The foundation's initial survey revealed the need for more hospices.

The second great development in the 1950's was the arrival of Dr. Cicely Saunders as St. Joseph's Hospice's first full-time medical officer. Dr. Saunders already had qualified as a nurse and as a social worker. After graduating in medicine, she researched the mode of action of narcotics. Dr. Saunders set out to prove that pain for the dying was unnecessary.

Historically, the English system of nursing had a strong tradition of home care. The family long had been recognized and utilized as a support system for the chronically ill patient. Before the discovery of antibiotics, England, along with the rest of Europe, was decimated repeatedly by epidemics. The country also has a history of war on the home front. As recently as World War II, the English were confronted often with the awesome reality of death.

However, despite the relative familiarity of individuals with death and their acceptance of it as a part of living, hospitals gradually usurped the role of the family and became the socially determined place to die. Health-care personnel, in their devotion to curing, began to de-emphasize their responsibility for caring. Saunders wrote of the feelings of guilt, failure, and rejection that so often visit the dying. She charged that these feelings reflected the attitudes of health-care personnel. "Death is feared, all thoughts of it are avoided, and the dying themselves are often left in loneliness . . . and are emotionally isolated.

Dr. Saunders traces the beginning of St. Christopher's Hospice, the prototype for all modern hospices, to her experience with a 40-year-old Polish man from the Warsaw ghetto. They met in 1948 in the general surgical ward of a hospital. Although physically comfortable, he was in emotional and spiritual pain. Dr. Saunders attempted to provide emotional comfort, as they became friends. As they talked, they developed a dream of building a home for patients in similar circumstances. A few days before he died, he told Dr. Saunders that he had willed 500 pounds currency so that he could "be a window in your home."

Over the next 19 years, the fund grew to 500,000 pounds, while Dr. Saunders added medical training to her social work and nursing background. After studying at the Protestant Hospices of St. Luke's in London, Dr. Saunders went to work at St. Joseph's hospice. There, she refined the techniques for controlling pain associated with terminal illness. In 1976, she opened the now renowned St. Christopher's Hospice in Sydenham.

Factors that differentiated St. Christopher's from hospitals include: allowing children to visit and play; personalized care; little patient-staff protocol; and informal social life; and freedom

to issue drugs and liquor as requested. In the garden, there is a metal plaque in memory of the young cancer patient who willed his money in order to start the home.

St. Christopher's originally was established as a charitable foundation. Presently, about three-quarters of daily patient care services are supported by the National Health Service, but other costs and working capital must come entirely from gifts. Public appeals for funds are not made; the majority of its financial obligations are met through contributions from families and friends of the hospice.

St. Christopher's Hospice had a dramatic impact on the care of the dying, both in terms of the number of patients helped and of health-care personnel inspired. Hospice growth in England has been rapid. There were 185 listed hospices in Great Britain by 1980. This number includes private foundations, non-National health Service, and National Health Service hospices.

The Hospice Movement in the United States

Growth of the hospice movement has been slower in the United States. There are many factors associated with this. For one, it mocks the American dream of conquering the world through science, machinery, and youthful vigor.

Americans honor youth and health. The death of a patient is perceived as a humiliation by the average physician in American culture; to the nursing staff in an acute-care hospital, it feels like a personal defeat.

In America, we also must cope with the vestiges of the Puritan attitude that loss of individual power; vigor and self-control is somehow repulsive. The dying are more or less automatically removed from sight into a hospital, where machines may be their only companions at the least. Even nursing homes for the aged and incurably ill maintain the myth that no one actually dies there: dead residents are rushed out the back door so as not to betray the reality of death.

In addition, ours is a highly mobile society. Family units and support systems are continually changed and reformed by such forces as divorce and/or relocation. The elderly or chronically ill are a hindrance to successful mobility and are likely to be separated geographically from family or confined to institutions.

The de-emphasis on the home as a support system was reflected in the decline of home nursing between 1930 and 1970. Although current American society still has little preparation for the restrictions imposed by an invalid in the home, the impact of diagnosis-related groups on hospital funding is bringing about a reversal of this trend. Financial pressure has resulted in a greater number of chronically ill clients being cared for at home and a revitalization of the home nursing field. Attitudes toward death and dying, however, have been slower to change.

Although Dr. Saunders began writing and lecturing in the United States in 1963, the initial response of American society to the hospice concept was sparked by Dr. Elizabeth Kubler-Ross's book, *On Death and Dying*. This book summarized the problems inherent in dealing with the

private issues of death in a public setting. It was published during the Vietnam War, when the attitude of the war was undergoing public scrutiny.

During the same period of time, there was an alternative option proposed by the euthanasia movement. Responding to the loneliness, isolation, lack of family involvement, and unrelieved pain that seemed to be synonymous with individuals dying in acute-care hospitals, concerned individuals in the euthanasia movement advocated the right to die- either by assisting the patient to end his/her life or by discontinuation of treatment. The hospice philosophy confronted the euthanasia or “good death” movement head-on by emphasizing the quality of remaining life and the ability of attending caregivers to provide comfort and care.

In this atmosphere, Florence S. Wald, then Dean of the Yale School of Nursing brought from St. Christopher’s Hospice in England the series of defined and practical aspects of a secular hospice organization. In 1973, Dr. Sylvia Lack agreed to leave her position at St. Christopher’s to become medical director of the Connecticut Hospice. One of her first duties was to apply for a demonstration grant from the National Cancer Institute (NCI). In 1974, a 3-year grant was awarded and the New Haven Hospice began offerings home care to patients. A 44-bed inpatient unit opened in 1980. The success and worth of the Connecticut Hospice stimulated the NCI to fund three other hospice programs in Southern California, New Jersey, and Arizona.

In 1978, there were 30 operational hospices in the United States. However, acceptance if the hospice philosophy continues to grow more slowly in the United States than in England. Reasons for this vary; there is a wide range of issues facing the providers and consumers of hospice care. These issues include the desirability of various organizational models, professional resistance, financial concerns, and evaluation of the efficacy of hospice. Each of these factors will be discussed in turn.

There are a variety of hospice models flourishing in the United States. Examples include the following:

- (a) Community-based models, with primary location either in free standing units or in offices that serve as coordinating points for the hospice home team. These hospices usually have “back-up beds” contracted through a local hospital with which the attending physician is associated. These facilities are used when home care is no longer feasible.
- (b) Hospital-based consultation models, which provide a multidisciplinary consultation team to visit patients throughout the hospital. Follow-up after discharge is provided through hospital’s home-care department.
- (c) Institution-based hospice models, which have a discreet hospice unit within and acute-care facility. Home care is contracted from existing agencies, e.g., the Visiting Nurse Association.

The decision as to which model is most appropriate for a given community, aside from finances, is based on how best to influence patient care. Advocates of freestanding units note that they provide a less institutional, more home-like, and more caring atmosphere. Supporters of the various institution-based models emphasize increased patient access to medical technology and personnel.

The issue of professional resistance to the hospice movement is linked to education and attitudes toward change. Oncologists may not understand the hospice philosophy or may not comprehend the patient's and the family's need for palliative care. Physicians may fear that a referral to hospice and the recognition that "cure" is not a realistic outcome will take away the patient's hope.

Resistance to hospice is seen also in home-care nurses, who may be overwhelmed by the concept of 24-hr availability or the demands associated with taking calls on weekends and holidays. The differing approach to care is also problematic for nurses who are accustomed to shorter, more problem-focused visits and the goal of restoring health.

Professional resistance is a major problem for hospice growth. Some believe the critical factor for decreasing resistance will be a consumer demand as much as professional education. Consumer demand also may influence the resolution of the primary difficulty of hospice programs in the United States- money.

In England, once the decision to allocate funds for a certain program is made, the National Health Service reimburses for services. In the United States, obtaining reimbursement is often difficult. Patients are accepted regardless of ability to pay for service. Without traditional third-party Medicaid and Medicare reimbursements, hospice financial obligations are often difficult to meet. Unfortunately, the current policies of Medicare and Medicaid insurance prohibit full reimbursement for hospice services, such as the administration of drugs for the control of pain or other symptoms within the home, and bereavement visits by hospice staff. Counseling and bereavement counseling may be reimbursed through traditional coverage by third-party payers under the provision for mental health, but only physicians, social workers, clinical psychologists, or psychiatric nurses are eligible for reimbursement. Other nurse and members of the clergy are not. Services not meeting government guidelines for designated care rendered in discrete locations (acute-care facilities, skilled nursing facilities, private homes) by licensed providers of health care also are not funded by third-party payers. Reimbursement is available to nurses and, in some cases, home health aides; however, to be reimbursed, nurses must provide skilled nursing care, which is defined as "hands-on" service. Counseling and supportive care are not reimbursable services. The lack of a specific reimbursement route for hospice care has greatly affected the development of palliative care in the United States.

Reimbursement is not the only difficulty faced by hospice program leaders. Establishing a hospice inpatient facility in the United States involves more than converting a building or home. Federal, state, and local regulations must be met, which requires a lengthy (6 months or longer) process of applying for a Certificate-of-Public-Need. Hospice staff become involved in public hearings, testimonials, and a significant amount of red tape. Once the certificate of need is granted, applications for licensure must be filed with the state and/or county before a hospice can become an operative facility. Legislation and insurance problems must be resolved. Since each state has autonomy within its own separate government, every new hospice must comply with that state's regulations and standards.

The National Hospice Organization was incorporated in 1978 to define the nature of hospice care and to contribute to the understanding of the content and potential of hospice programs. One goal of the organization is to promote restructuring of current legislation to provide for regulations and reimbursement specific to hospice facilities. To achieve this goal, further

research and evaluation of the efficacy of hospice services is needed. Some suggest research in the following areas:

- (a) What is the impact of hospice on the quality of life of terminal patients and their families, as opposed to that of conventional care?
- (b) What are the different costs of caring for terminally ill patients in different hospice models?
- (c) What is the predicted impact of Medicare and third-party reimbursement on organizational structure, staffing and costs of hospices?

Conclusion

In most cases, dying, like birthing, is a process enhanced by the presence and assistance of others. Historians have remarked at the preoccupation of North Americans with death in the 18th and 19th centuries. This preoccupation also reflects the normalcy of contacts with the dying. The individual was involved in the care of the dying, in deathwatches, in preparing bodies for burial, and in officiating at funerals.

One of the effects of living in a society where home care of the dying was common was that the person who participated in the care of the dying felt no guilt at the person's death. This differs from the reaction one sees in bereaved persons today, whose guilty feelings frequently have to do with "unfinished" relationships.

The idea that doctors and nurses must preserve life at all costs is an odd one, and comparatively new, historically. The Hippocratic Oath is sworn to the God of Health, not the God of Life. Health-care professionals should focus on the good health of the holistic person, not mere longevity. With terminal patients, the goal is not to prolong, but to enrich remaining life.

Research into families of patients who have died in hospice shows that hospice care can reduce the amount of anxiety suffered by family members. The evidence suggests that the more the family is involved at the bedside, however stressful this may be for them at the time and however much support they may need from the staff, the better they will cope, both at the time of the patient's death and afterward. With this in mind, the critical factor in hospice growth in the future may well turn out to be consumer demand to be allowed the dignity of death.

Minnesota Hospice Bill of Rights
PER MINNESOTA STATUTES, SECTION 144A.751
TO BE USED BY ALL HOSPICE PROVIDERS

Subdivision 1. **Statement of rights.** An individual who receives hospice care has the right to:

- (1) receive written information about rights in advance of receiving hospice care or during the initial evaluation visit before the initiation of hospice care, including what to do if rights are violated;
- (2) receive care and services according to a suitable hospice plan of care and subject to accepted hospice care standards and to take an active part in creating and changing the plan and evaluating care and services;
- (3) be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices, including the consequences of refusing these services;
- (4) be told in advance, whenever possible, of any change in the hospice plan of care and to take an active part in any change;
- (5) refuse service or treatment;
- (6) know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services;
- (7) know in advance of receiving care whether the hospice services may be covered by health insurance, medical assistance, Medicare, or other health programs in which the individual is enrolled;
- (8) receive, upon request, a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the individual is enrolled. A good faith estimate must also be made available at the request of an individual who is not enrolled in a health plan company. This payment information does not constitute a legally binding estimate of the cost of services;
- (9) know that there may be other services available in the community, including other end of life services and other hospice providers, and know where to go for information about these services;
- (10) choose freely among available providers and change providers after services have begun, within the limits of health insurance, medical assistance, Medicare or other health programs;
- (11) have personal, financial, and medical information kept private and be advised of the provider's policies and procedures regarding disclosure of such information;
- (12) be allowed access to records and written information from records according to section;
- (13) be served by people who are properly trained and competent to perform their duties;
- (14) be treated with courtesy and respect and to have the patient's property treated with respect;
- (15) voice grievances regarding treatment or care that is, or fails to be, furnished or regarding the lack of courtesy or respect to the patient or the patient's property;
- (16) be free from physical and verbal abuse;

- (17) reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:
- (i) the recipient of services engages in conduct that alters the conditions of employment between the hospice provider and the individual providing hospice services, or creates an abusive or unsafe work environment for the individual providing hospice services;
 - (ii) an emergency for the informal caregiver or significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the hospice provider; or
 - (iii) the recipient is no longer certified as terminally ill
- (18) a coordinated transfer when there will be a change in the provider of services;
- (19) know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;
- (20) know the name and address of the state or country agency to contact for additional information or assistance;
- (21) assert these rights personally, or have them asserted by the hospice patient's family when the patient has been judged incompetent, without retaliation; and
- (22) have pain and symptoms managed to the patient's desired level of comfort.

If the hospice provider operates a residential hospice facility, the written notice to each residential hospice patient must include the number and qualifications of the personnel, including both staff persons and volunteers, employed by the provider to meet the requirements of the MN rule on each shift at the residential hospice facility.

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU HOSPICE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR LONG TERM CARE.

Office of Health and Facility Complaints

(651) 201-4201
1-800-369-7994
Fax: (651) 281-9796

Mailing Address:

Minnesota Department of Health
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0970

Office of Ombudsman for Long Term Care

(651) 431-2555

1-800-657-3591

Fax: (651) 431-7452

Mailing Address:

Ombudsman for Long Term Care

PO Box 64971

St. Paul, MN 55164-0971

Licensee name: Quiet Oaks Hospice House

Telephone number: 320-255-5433

Address: 5537 Galaxy Road, St. Augusta, MN 56301

Name/Title of Person Whom Problems or Complaints May be Directed:

Joseph M. Bauer, RN, Executive Director

For informational purposes only and is not required in the Hospice Bill of Rights text:

MN Statutes, section

Subd. 2. Interpretation and enforcement of rights.

The rights under this section are established for the benefit of individuals who receive hospice care. A hospice provider may not require a person to surrender these rights as a condition of receiving hospice care. A guardian of conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving hospice care, persons providing hospice care, or hospice providers licensed under section 144A.

Subd. 3. Disclosure. A copy of these rights must be provided to an individual at the time hospice care is initiated. The copy shall contain the address and telephone number of the Office of Health Facility Complaints and the Office of the Ombudsman for Older Minnesotans and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of the Ombudsman for Older Minnesotans shall be included in notices of change in provider fees and in notices where hospice providers initiate transfer or discontinuation of services.

Revised 9/29/08

Quiet Oaks Administrative Staff

Name/Title/Number	Responsibilities
Joe Bauer/Director	Overall management of the hospice house
Dr. Pat Lalley Medical Director	Develops and maintains the clinical aspects of the hospice house, makes regular resident visits to manage care
Brenda Hansen Director of Nursing	Responsible for resident and family needs, hiring, training, retention or nursing staff Responsible for admitting residents
Elaine Benusa Financial Coordinator	Accounting, human resources
George Hontos House Manager	Maintenance of house and grounds, purchasing, meal planning and food preparation, supervision of volunteers
Connie Bauman Volunteer Coordinator	Recruitment, training, and scheduling of volunteers
Jim Stolpa Bereavement Coordinator	Chaplin

Quiet Oaks Nursing Staff

Nurses

A minimum of two nursing staff are on duty 24 hours each day.

The nursing shifts are 7:00 AM – 3:30 PM,
3:00 PM – 11:30PM
11:00 PM – 7:30 AM

They are each responsible for all residents and family members.

They are in charge of the hospice and all questions or concerns should be directed to them during your shift.

They may ask you to assist them with resident care.

They are responsible for all resident admissions and the waiting list.

They are the contact people for physicians, family, clergy and hospice personnel, funeral homes and pharmacies.

Home Health Aides

They are nursing assistants that work with the nursing staff during the same shift times that are listed above. They are responsible for resident care as assigned and supervised by the nurses.

Our nursing staff is composed of wonderful caregivers. You will be amazed by the skill and compassion with which they do their jobs. They are a joy to work with and deeply appreciate each volunteer's efforts. The nurses and the other staff can be a great help to you during your shifts and are happy to answer any questions you may have.

Other People at Quiet Oaks Hospice House

There are many people besides Quiet Oaks Hospice staff, nurses and volunteers at the hospice daily. Please help them with anything they need and respect their need to meet with residents, families, and staff.

The care of our residents is managed by outside entities, i.e. St. Cloud Hospital Hospice and Heartland Hospice. Their team consists of social workers, nurse case managers, therapists, chaplains, home health aides, durable medical equipment delivery and pharmacy delivery people and they may be in the hospice at any time.

This interdisciplinary team will be working with residents, meeting families, and/or charting in the Oak Room. They will also be picking up or dropping of items at both the front and back doors. A nurse is required to sign for deliveries or pickups of all medical equipment and pharmaceuticals.

Hospice nurse case managers call the hospice frequently to speak to our nurses. If the nurses are unavailable at the moment, please take a message and deliver it to them promptly.

Mortuary personnel come to the hospice after a resident has died to deliver the body to the funeral home. Please be respectful of the work they do, and assist in any way you can.

There are also people who come to install or repair things at the hospice. Please let the Executive Director, House Manager, or other management staff know they are in the hospice house.

Volunteer Training At Quiet Oaks Hospice House

After your initial interview, you will begin the process of becoming a very integral part of our Quiet Oaks team.

You will read the volunteer manual and review it with the volunteer coordinator and begin to understand almost everything there is to know about Quiet Oaks. You will also tour all the areas of the hospice house.

You will then be paired with two separate “seasoned” volunteers and will shadow each of them for one, four-hour shift. After these two sessions you should have a good feel for what being a Quiet Oaks Volunteer is all about. You can work with an experienced volunteer as many times as needed for you to feel comfortable working alone.

You will find our nurses and staff very welcoming and willing to help you develop your skills. They will be happy to answer any questions you may have. Every staff member is dedicated to helping you become the very best volunteer you can be and is equally concerned with your well being and development.

You will not be expected to do any task you are uncomfortable with. We can discuss any issues you may have and design a plan that meets your needs as well as those of the hospice. Your questions will be welcomed, as well as your suggestions.

We will offer in-service events during the year to further enhance your volunteer experience and expand your training. You are advised to attend those in-services that cover infection control and emergency procedures. Other in-services will cover topics of interest or skill building.

You will also have the opportunity to attend hospice volunteer in-services. These will broaden your knowledge of issues in hospice volunteering.

Our goal is to have a volunteer team that embodies the essence of kindness, compassion, respect and caring. We will do our part as staff members to offer guidance and training in that same atmosphere.

Volunteer Job Description

The goal of the volunteer is to assist in the care of residents and families by providing direct support to the Hospice staff.

Requirements: A caring attitude, a high energy level and an understanding of hospice philosophy.

Responsible to: Volunteer Coordinator and staff on duty.

Most important tasks

Answer the phone and welcome guests at the door

Answer resident call lights and inform nurses of resident needs

Help the nurses when requested

Keep the hospice environment neat, clean, and attractive

Assist in the meal preparation for residents and families and set up and clean up after meals

Keep the hospitality counters well stocked with refreshments, check the candy dishes and the refreshment coolers. Refill as needed

Check laundry hampers on a regular basis, Do laundry as needed

Keep the kitchen neat and counters clean, fill and empty the dishwashers

Resident Care

Direct resident care is a responsibility of the nursing staff, however, the staff may ask for volunteer assistance with certain tasks only when volunteer has been appropriately trained and is comfortable.

Housekeeping Issues

Vacuum	Recreation Room Main Floor Suite Upstairs
Bathroom cleaning	Main Floor (both) Upstairs (both)
Dust and clean	Resident Suites Upstairs Recreation Room
Refill beverage coolers	Kitchen and family lounge
Refill candy dishes	Through-out house
Empty garbage cans	Every room in house
Laundry	Wash, dry and put away

Volunteer Job Description

Page 2 of 2

Mop floors All uncarpeted areas
Dishwashing Load, run, put away

Bedroom cleaning Guest room 1
 Guest room 2
 Guest room 3

Check freezer/refrigerator Kitchen and basement
Temps (use log sheet on each unit)

Special Projects:

Window washing

Change out Guest suite (as needed)

Water plants and flowers

Other

Greeting Visitors

The goal is to welcome our visitors and make them feel comfortable at the hospice.

- **Answer doorbell immediately, if possible.** Inquire as to which resident they are here to visit and bring them to the Family Room. Find a nurse and ask about visitors.
- The visitors may not be the residents' family members or friends. They could be coming to work at the hospice. They could also be staff members from various referring health systems or clergy members.
 - Nurses must sign for all pharmacy deliveries.
 - People coming to do work at the hospice should be referred to the management staff.
- If people come to the door and would like a tour they will usually have an appointment with Joe or Brenda. If they do not please inform the Management Staff.

Answering the Telephone

Our goal is to answer the telephone immediately. This assures residents' families and all those who call the hospice that their calls are important to us.

A call is on a line until you do something with it:

- You can place it on hold by pressing the red hold button.
- Answer the call; following the steps below; or take a message and leave it on the nurse's desk in the Oak Room.
- **ALWAYS PLACE A CALL ON HOLD AND GET THE NURSE OR MANAGEMENT TEAM IF YOU ARE UNSURE OF WHAT TO DO WITH IT**

If a family member is calling to check on their family member's status

- Transfer to the nurse's station. If the nurse can pick up they will and you can announce the call and hang up. If there is no answer, please take message and get it back to the Oak Room desk as soon as possible.
- It is **very important** that the message is accurate - be sure to repeat phone numbers and names (have them spell it if you don't understand it) and make sure you know which resident it is regarding and how long they'll be at the number. Include your name or initials on the message so if the nurse has a question they can find you. Be sure to deliver the message to the appropriate area/person.

Note: a volunteer must never give out any information regarding a resident.

If a caller wants to speak to a nurse,

- Transfer to the nurse's station. When available the nurse will pick up. You can announce the call and hang up. If there is no answer, please take a message and get it back to the Oak Room desk as soon as possible.
- If the caller needs to speak with them immediately, go to the resident's room and let them know who is calling. They can come and get the call or tell you to take a message.

Note: The nurses will let you know if they are waiting for a call from a specific person. When the call comes in, please go and find them.

Telephones (Continued)

Page 2 of 2

If the caller wants to talk to a resident

- Refer to the dry erase board in the pantry for information regarding whether or not a resident is accepting phone calls OR ask a nurse if you are not certain. Transfer to the resident's suite as appropriate or take a message.

Note: NEVER transfer a call directly into a resident's room WITHOUT checking the board or with a nurse first.

If a caller wants to speak to any member of the management team

- Let the caller know you will transfer to their desk and that they may get Voicemail if the team member is not available. Press the transfer button and the extension.

Answering Call Lights

Our goal at Quiet Oaks is to respond to resident call lights within 30 seconds every time. This assures the resident and their family that the residents' needs will be met quickly.

Quiet Oaks has a wireless call light system. Every shift, each of the nursing staff will carry a beeper along with two of our volunteers and one of the management staff. When the beeper alarms, it will display the room number and whether it is a pull cord at the bedside, in the bathroom or a pendant that the resident is wearing.

- When the alarm sounds, those with beepers are to move quickly to the room that is displayed on the beeper and immediately reset whatever device has been activated. (For the pull cords, you must push the switch up, for the pendant the button in back must be pushed with a special pen). **It is better to have too many people go to the resident than no one.**
- After resetting the device, greet the resident by name and introduce yourself as _____ a volunteer. How may I help you?
- If they need a nurse, go to find their nurse and tell them what the resident or family wants.
- If you know the nurses are busy in another resident room, find them and ask them how long it will be before they can assist the resident. Return to the resident's room and let the resident and family know how long it will be until the nurse can respond.

Working with the Nurses

Our goal is that the volunteers and the nurses work as a team. Mutual respect and a willingness to help each other make the work environment rewarding and enjoyable.

Two nursing staff run the hospice when they are working.

- They will answer any questions you have and direct your work efforts if you are unsure about what to do next.
- They can deal with any issues that arise with residents and families. Please make them aware of any issues.

Volunteers should check in with the nurses soon after they arrive.

- Either nurse can provide you with the status of the residents.
- Ask them if there are any tasks that need immediate attention. i.e. cleaning resident rooms, doing laundry, cleaning guest rooms.
- A volunteer should let the nurses know of any task limitations they have, lifting heavy objects or bags.

The nurse will let you know if they will be in a resident's room for an extended period or if they are expecting an important phone call.

The nurses must sign for all pharmacy deliveries.

Working with the House Manager

Our goal is for the volunteer to assist the House Manager when requested.

The house manager depends on volunteers to prepare meals for residents, families and guests. The house manager makes every effort to understand the resident's food preferences, dietary restrictions and food allergies. This information is also shared by the nursing staff and will be posted on the white board in the butler's pantry. The house manager may call on you to assist in special projects or other needs of the residents or guests.

Please assist the house manager with:

Resident tray and meal set up.

Unloading and storage of groceries and other kitchen duties.

House cleaning per the daily housekeeping task list.

Other special projects or duties asked of you.

The residents and guests are our number one priority. Our Quiet Oaks Hospice team will do everything possible to provide a welcoming and supportive experience as possible.

General Housekeeping Issues

Our goal is to make sure the house looks its best at all times.

- Make sure the front entry looks good and the mat is vacuumed so visitors will have good first impression.
- Do a quick vacuum of the living and dining rooms if they need it.
- If it's dark in the living rooms, turn on lamps.
- Fill the candy dishes.
- Flowers in the vases should be fresh and alive. Remove all dead flowers and greens. If someone delivers flowers from a funeral, please break them down and put them in vases so they don't look like funeral arrangements. Use the flower work area in the basement.
- Notice cobwebs and remove them.
- If you see something spilled on the carpet, blot with a light colored rag. We have carpet stain remover in the kitchen supply closet.
- Make sure the kitchen counters are clean and empty of dirty dishes.

Serving Meals to Residents

The goal is for the resident to be served meals whenever they want and to eat whatever they want.

- The House Manager makes every effort to understand the resident's food preferences, dietary restrictions and food allergies. When you come on shift and talk to the nurses about the residents, ask what residents can eat or drink and/or refer to the wipe/erase board in the pantry.
- Residents who are able to eat, usually eat some of the food that is prepared at lunch and dinner. Residents can eat whatever they want for breakfast. Morning volunteers or staff usually make breakfast for residents.
- Before lunch and dinner are served, check the wipe/erase board in the pantry to see which residents will be eating and assist them by setting up a tray for those residents.

Note: If the resident has MRSA precautions, all food is served on paper products with plastic utensils. Do not use any items that are not disposable. All of the items brought into the resident's room are disposed of in the garbage bag in the room.

Serving Meals to Family Members

Our goal is to serve lunch at 12:00 noon and a dinner at 5:30 PM

- Meals are served buffet style in the kitchen
- Lunch is usually sandwiches, soup, salad, and dessert.
- Dinner is usually a hot entrée
- Glass dinner ware is used
- We never know how many people will be eating at lunch and dinner. Nursing staff will get a count for the meal and give it to the volunteer about one hour prior to meal time.
- Any item like potato or macaroni salad and lunchmeat or cream soups should be on the table a maximum of one hour. Please put these items out last when you are setting the table. Any of these items that remain on the table after everyone has eaten should be thrown in the trash.
- Please put all meals away and clean up after the food has been out for a maximum of ONE hour.
- Please check with the nurse before you put the food away. Make sure that all residents and family members that want food have eaten.
- Instructions for Saturday and Sunday Meals will be posted in the butlers pantry next to the white board.
- Please check the white board as soon as you come on shift to make sure you understand what you need to do for meal preparation.
- Ask the nurses if you are unsure of what to do or need to help.

Kitchen Clean Up

Our goal is to keep kitchen counters clean and clutter free.

Our goal is to use the dishwashers as the primary method of washing.

- If you wash dishes by hand, Please use a clean dishtowel.
- Please be careful with non-stick (Teflon coated) pots and pans. Washing by hand is best. Do not use any abrasive utensils or pads to wash these items.
- Please wash the sharp knives by hand.
- All metal utensils should be put in the utensil compartment of the dishwasher handles faced up.
- Please use a clean dishrag to wash the pots and pans and sharp knives.
- Please break down resident trays as soon as possible.
- Store all leftovers in refrigerator in plastic storage containers. Date and seal properly.
- Please remember that the dishwashers have long wash cycles. Please start the dishwasher as soon as it is full, so that the dishes will be clean for the next meal. Please look carefully at the dishes before you put them away to make sure they are clean.
- Try and remember where everything goes. We have specific places for everything and having so many wonderful volunteers helping out requires all of us to work together and be consistent.

Resident Laundry Procedure

- **Nursing Staff**
 - Dirty bedding and resident clothing should be put in hamper in resident bathroom.
 - Before using spa, bring laundry basket from laundry room to the spa and place used linens in basket. After resident bath/shower, bring basket to laundry room if washing will be done immediately or bring to soiled utility room if washing is to be done later.
 - Bring any laundry from resident suite and/or from spa to the soiled utility room for sorting.
 - With gloved hands, sort sheets/bedding into one soiled utility room hamper and resident clothing/pjs in the other.
 - After laundry basket holding soiled linens is emptied, clean basket with Cavicide wipe. Store clean laundry baskets on shelf in laundry room.

- **Nursing Staff or Volunteers – PLEASE READ BEFORE DOING WASH (IMPORTANT INFECTION CONTROL NOTE ***gloves are ALWAYS used when touching dirty laundry. DO NOT touch the machine buttons, doorknobs or anything else in room with “dirty” gloves on – thank you!*)**
 - Put on gloves
 - Bring on hamper to the laundry room at a time.
 - Load washer.
 - Discard gloves before touching anything other than “dirty” laundry.
 - Set washer to proper settings.
 - Wash bedding with bedding and wash resident clothing separately.
 - Be sure to remove clean laundry with clean hands (not “dirty” gloves).
 - Fold clean laundry in laundry room on counter and put in clean basket for delivery.

- Some of the resident PJs belong to QO and are easily identified because they have been cut up the back and ties are placed – they are also often marked QO. These are stored in the laundry room.

- Clothing belonging to the resident is marked with resident initials on the apparel tag and can be delivered to the resident suite after washing.
- When washing whites, please use ½ cup bleach. DO NOT BLEACH RESIDENT CLOTHING.
- NO SOILED LINEN CAN BE PUT OR LEFT ON THE FLOOR AT ANY TIME, EVEN IF IN PLASTIC BAG. It needs to be in a hamper or laundry basket on its way to the washer. Dirty laundry is stored in the soiled utility room (across from Suites E & F). If you are not going to wash it now, it should be in the soiled utility room.

TRASH REMOVAL

- There is a trash container in every room in our facility. Please check and remove those that need to be emptied.
- There are two sets of large garbage totes for collection purposes.
- Each garage has a set. There is also a tote for recycling materials.
- Each trash container should have a plastic can liner in them. The can liners can be found on the bottom inside of the garbage can.
- Please don't put any hot liquids in the trash container. The less liquid in the trash bags the better.
- Take an oversized can liner and use as a large collection for small room containers.
- Use the correct can liner for the small room containers. Use the large can liner only as a collection bag.

ALL GARBAGE CANS (EXCEPT THE KITCHEN ONES) SHOULD HAVE A NEW SUPPLY OF LINERS INSIDE ON THE BOTTOM OF THE CAN. IF YOU SEE THAT YOU TOOK THE LAST LINER PLEASE PUT A NEW SUPPLY OF LINERS BACK IN.

THE KITCHEN GARBAGE CAN REPLACEMENT LINERS ARE UNDER THE SINK, OR ON THE SUPPLY SHELF IN THE BASEMENT STORAGE AREA.

Quick Checklist for Room Cleaning
--

Suite _____

Please Read the Room Cleaning Procedures Attached

Check off the item when it has been completed as more than one person may be involved in getting the task finished.

ALWAYS WEAR GLOVES WHEN CLEANING A ROOM, DISPOSE OF GLOVES BEFORE TOUCHING CLEAN ITEMS (BED SHEETS, NEW SUPPLIES)

<input type="checkbox"/> Initial nurse walk through: discard disposables (wash basins, emesis basins, urinals, bedpans), check all closets and drawers, strip bed and remove all linens from room, tag and remove equipment, bag and tag personal items. Remove trash.
<input type="checkbox"/> Spray or wipe <u>all</u> surfaces with Cavicide (except fabrics and TV), including inside drawers and closet shelves, garbage can, telephone, TV remote, call light pendant, light switches, radio/CD, vinyl pillow covers, vinyl mattress protector. Check doors and walls for marks and spills, wipe as needed.
<input type="checkbox"/> Wipe all reusable equipment (i.e. wheelchairs, walkers, commodes) with Cavicide.
<input type="checkbox"/> Do not spray any cleaning liquid on flat screen TV. Wipe dry with cloth.
<input type="checkbox"/> Clean windows, mirrors, etc. with glass cleaner.
<input type="checkbox"/> Clean bathroom, including toilet, sink and floor.
<input type="checkbox"/> Make bed, including quilt and pillows.
<input type="checkbox"/> Stock room with Kleenex, wipes, gloves, and 2 extra pillows on top closet shelf.
<input type="checkbox"/> Vacuum floor.
<input type="checkbox"/> Vacuum window blinds or vents as needed.
<input type="checkbox"/> Clean carpet with extractor.
<input type="checkbox"/> Nurse must do final double check on everything.

Cleaning a Resident Room

Our goal is to get the resident room cleaned as soon as possible after a resident leaves the hospice. The resident room should be fully stocked with typical supplies and ready for the next resident.

- **Nurses are responsible for coordinating the cleaning of the resident room after a death.** The nurses appreciate the help of volunteers in expediting this task. The nurses will work with you to demonstrate the proper procedure.
- **The nurse will walk through first and discard any disposable items, including bath basins, emesis basins, urinals, and bedpans.** Check all the drawers and closets. Tag and remove any medical equipment that needs to be picked up. Any personal items that the family has left behind will be bagged and tagged with the resident's name and the family will be called. These items are then placed in the laundry room for later pick up by the family. Strip bed and remove all linens from room.
- **Always use gloves when cleaning a room.** Gloves are located in the resident bathroom as well as they clean utility room. Disinfect spray or wipes (Calvicide) are located in the clean utility room.
- **Do not spray any liquid cleaner on the TV's.** Wipe with dry dust cloth found with the cleaning supplies.
- **All surfaces including inside of drawers and cabinets should be sprayed with Cavicide disinfectant or wiped with Cavicide wipes.** The telephone, television remote, call light button, light switches and the radio/CD player must be wiped down with disinfectant. Read directions of spray or wipes on container and follow carefully.
- **Wipe down all reusable equipment (i.e. wheelchairs, walkers, commodes, etc.) with Cavicide wipes.** Wipe down all vinyl pillow coverings as well as the vinyl mattress protector on resident bed. Restock tissues, wipes and gloves.
- **Window and mirror must be cleaned with glass cleaner.** Walls and woodwork should be wiped down as needed.
- **Room must be vacuumed.** Carpet should be cleaned using extractor. See House Manager or Director of Nursing for assistance.
- **Make the bed.** See reference sheet for correct order of mattress pad, fitted sheet, draw sheet, fabric soaker pad, a white top sheet, two pillowcases (each covered with vinyl protector, fabric protector and/or 1-2 pillowcases), blanket, a bedcover and a quilt at the foot of the bed.

Cleaning a Resident's Room Continued

- **Two additional clean pillows** (dressed as above) should be placed on the shelf closet. This will let the nurse know that the pillows have been cleaned.
- **Cleaning the bathroom.** Including the toilet, sink, and floor.
- **Window blinds or vents.** If dusty, please carefully vacuum them using the vacuum attachment.
- **Check off** completed items on checklist kept inside the resident closet. A nurse will remove the list after the final walkthrough.
- **The nurse is responsible to do a final check of the room to make sure that it is fully stocked and ready for the next resident.**

The Mechanics of Volunteering at Quiet Oaks Hospice House

Volunteer requirements before starting work at Quiet Oaks:

- Completion of volunteer application including three personal/work related references.
- A Mantoux test is required prior to volunteering

The Volunteer is responsible to return to Quiet Oaks Hospice House within 48 hours to have the test site checked by nurse. This test will only need to be administered once.

- State background check completed.
- Review of current volunteer manual and walk through of all areas with volunteer coordinator, or others designated, including emergency procedures.
- Each volunteer will shadow a “seasoned” volunteer on a minimum of two four-hour shifts before going solo.

Volunteer Manual: There are five volunteer manuals located in the volunteer room, you may check out to read. You will be asked to sign off on it when you return it. It will also be available to read on Quiet Oaks Web page.

Parking: Volunteers will park in the front of the house.

Entry/Exit: You may enter or exit the hospice through the front door. If entering or exiting through the back doors, please be aware that there are residents’ rooms adjacent to these doors. Please open and close the doors quietly and refrain from stomping your feet to brush snow off your shoes. Thank you for your consideration of our residents and families.

Personal Belongings: You may put your purse, keys, and wallets, in the bottom drawer in the credenza in the office area or on the shelf in the volunteer room. However there is not a lock on the drawer. Your coats can be hung on the coat rack in the volunteer room. Boots can be placed under the coats on the mat.

Name Tags: All volunteers must wear a nametag when working. Please leave your nametag on the magnetic board located in the volunteer room.

Manuals: There is a current volunteer manual and a current hospice policy and procedure manual in the desk in the volunteer room for your use.

The Mechanics of Volunteering (Continued)

Time Cards: Each volunteer will keep track of their time worked, at the end of each shift, on a 4 x 6 card in the box on the volunteer desk. Please put the date, shift, and hours worked.

Master Schedule for Volunteer Shifts: Please refer to the large calendar on the volunteer desk. Volunteers may make changes to the schedule on this calendar **only**. Please leave a “post-it” note on the volunteer coordinators desk when you delete your name from a shift. Also leave a note on the volunteer desk for dates you will be out of town or unavailable for other reasons. You may fill open shifts on the calendar at any time.

Notices or Special Events and In-Service Opportunities: Dates and times will be posted on the bulletin board in the volunteer room. Paper brochures with additional information on these events will be on the volunteer desk for you to take. Please take the time to check the board when you are in the hospice house.

Volunteer Memos or RSVP Lists: They will be posted on the bulletin board in the volunteer room for you to read and respond to. Thank you for taking the time to read and respond to these.

Additional Volunteer Information: Letters to all volunteers and schedules will be sent out quarterly.

The candy and hand lotion on the volunteer desk are for your enjoyment. Candy suggestions are always appreciated, especially if you have a favorite candy.

Your suggestions and comments regarding any issues are always welcome. There is a suggestion box on the volunteer desk,

If anyone you know is interested in volunteering at Quiet Oaks Hospice House and you think they would be as wonderful a volunteer as you are, please leave me a “post-it” note with their name, number and a little bit about them along with your name on the volunteer desk.

Volunteer Assignment Guidelines

It is recommended that volunteers work shifts of four hours each. Our shifts run:
9:00 AM – 1:00 PM, 1:00 PM- 5:00 PM, and 5:00 PM – 9:00 PM.

At the beginning of your shift:

- Report to Volunteer Office
- Sign in on your volunteer time card
- Put on your nametag
- Check in with nurse on duty for specific information about residents and jobs to be done.
- You may also check with the House Manager for household information.

At the end of your shift:

- Report to Volunteer Office
- Leave nametag on board
- Complete Volunteer Journal Entry
- Record your hours
- Check calendar for future shifts

Volunteers are to report to the staff any concerns, information or problems made known to them by residents or families which may be pertinent to providing or improving Hospice care.

If you need to cancel a scheduled shift, please call the Volunteer Coordinator at 320-255-5433.

If you are running late, call the hospice house and let the nursing staff know. Let them know when you will arrive.

IF YOU ARE UNABLE TO MAKE YOUR SHIFT AT THE LAST MINUTE
PLEASE CALL THE NURSE ON DUTY AT 320-255-5433 Ex. 71

Our nurses count on you and it makes a real difference in the planning of their shift. Our house just doesn't run the same without our volunteers.

Volunteer Time Card

The VOLUNTEER TIME CARD helps to keep communications open between volunteers. This three ring binder is kept on the volunteer desk. At the end of a shift, please write your entry regarding:

- Checklist of household items done
- Suggestions for the next volunteer
- Observations

TIME CARDS are another extremely important record keeping device. This card provides you with the opportunity to see what a growing gift of time you've given to the Hospice. It's also an essential bookkeeping tool for us because at the end of each fiscal year (June 30) we are **REQUIRED** by state to report the total number of volunteer hours given to the Hospice. Thank you for your cooperation.

Quiet Oaks Hospice House Policy

Title: INFECTION CONTROL: INFORMATION AND TRAINING

Ref. 4664.0290

Original: 8/07/08

Page 1 of 1

IT IS THE POLICY OF QOHH to provide information, training and equipment necessary to protect residents, staff, volunteers and visitors from exposure to infectious diseases.

For each 12 months of employment, all staff/volunteer members who have contact with residents shall complete in-service training about infection control techniques used in Quiet Oaks.

The training must include:

- a) Hand washing techniques
- b) The need for and use of PPE (personal protective equipment - gloves, gowns and masks
- c) Disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades.
- d) Disinfecting reusable equipment
- e) Disinfecting environmental surfaces

Pregnant staff and/or volunteers shall inform QOHH of pregnancy ASAP so that management can take appropriate steps to protect the individual in the event a resident with a known infectious disease is admitted.

PROCEDURE

Staff or volunteers who experience any of the following shall immediately report the incident to QOHH administration:

1. Penetrating injury (needle stick)
2. Mucous membrane contact with resident blood or body secretions
3. Open lesion contact with resident blood or body fluid

See also Infection Control Guidelines and Procedures Policy

Quiet Oaks Hospice House Policy

Title: INFECTION CONTROL GUIDELINES AND PROCEDURES

Ref. 4664.0290

Original: 8/07/08

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I. POLICY

- A. The Practice of Standard Precautions at QOHH is supplemented by the practice of the current isolation systems recommended by the Centers for Disease Prevention and Control (CDC).
- B. All staff, volunteers, and guests are responsible for complying with these isolation guidelines.
- C. Residents have a responsibility to comply with the necessary isolation procedures to the extent of their ability to comprehend. Appropriate isolation measures should be explained to the resident, family, and guests by the nursing staff. This explanation should be documented on the care plan.
- D. This guideline contains two tiers of precautions:
 - 1. Standard Precautions
 - 2. Transmission Based Precautions which include Contact Precautions, Droplet Precautions, and Airborne Precautions.

II. PURPOSE

- A. To assist the QOHH staff to recognize that all body fluids, secretions, and excretions have the ability to transmit pathogens, regardless of the presence of visible blood (except sweat).
- B. To prevent the spread of epidemiologically important pathogens that can be transmitted by Airborne or Droplet Transmission or by Contact with skin or contaminated surfaces.
- C. To help reduce the incidence of infection.

III. DEFINITIONS

- A. Standard Precautions
Designed to guide the healthcare worker in the care of all residents regardless of their diagnosis or infection status. All residents should be treated as if they have a blood borne disease. Synthesizes the major features of Universal Precautions and Body Substance Isolation. Reduces the risk of transmission of Blood borne Pathogens from both recognized and unrecognized sources of infection. These precautions apply to blood, all body fluids, all secretions and excretions except sweat, regardless of whether or not they contain visible blood.
- B. Colonization
Microorganism present in growth but does not invade or damage tissue.
- C. Infection
Microorganism invades and damages tissue.

Quiet Oaks Hospice House Policy

Title: INFECTION CONTROL GUIDELINES AND PROCEDURES

Original: 8/07/08

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- D. Transmission Based Precautions
Designed for residents documented or suspected to be infected or colonized with organisms for which additional precautions beyond standard precautions are needed to prevent transmission of disease. These precautions are based on the route of admission of the illness. There are 3 main routes of organism transmission: Contact, Droplet, and Airborne.
- E. Airborne Precautions
Used for residents with known or suspected disease transmitted by airborne droplet nuclei. These droplet nuclei can remain suspended in the air and can be dispersed widely by air currents.
- F. Droplet Precautions
Used for residents with known or suspected disease transmitted by large particle droplets. These droplets can be generated by the resident during coughing, sneezing, or talking.
- G. Contact Precautions
Used for residents with known or suspected infection or colonization that can be transmitted by direct contact with the resident, or indirect contact with the resident's environment.
- IV. PROCEDURES/GUIDELINES
- A. Standard Precautions
Standard Precautions synthesizes the major features of Universal Precautions and Body Substance Isolation. Universal Precautions is still practiced, but the term "Standard Precautions" is now used. The term encompasses not only precautions with blood but also includes precautions with the following body fluids: 1. All body fluids
2. All Secretions
3. All Excretions (except sweat)
- The term Standard Precautions is used in the care of all residents at QOHH. It applies to all residents receiving care, regardless of their diagnosis or infection status. The following are components of Standard Precautions:
1. Hand Hygiene
 - a. Perform hand hygiene
 - After touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn.
 - Before and after resident contact.
 - After touching any contaminated object.
 - After sneezing or blowing nose.

Quiet Oaks Hospice House Policy

Title: INFECTION CONTROL GUIDELINES AND PROCEDURES

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- Before eating or touching food.
- After using the toilet
- Before and after using gloves.

NOTE: It may be necessary to **perform hand hygiene** between tasks and procedures on the same resident to prevent cross contamination.

- b. Soap and water hand washing must be performed when hands are visibly soiled.
- c. Hand washing Procedure:
 - Remove all jewelry.
 - Wet hands under running water while making sure hands are always held lower than the elbows.
 - Use warm water and lather hands (remembering to scrub thumbs) and wrists well for 10-15 seconds. (10 seconds can be timed by humming “Yankee Doodle”.)
 - Rinse hands thoroughly.
 - Dry hands with paper towels.
 - Use paper towel to turn off faucet

2. **Gloves**

- a. Wear gloves when touching blood, body fluids, secretions and excretions.
- b. Put on clean gloves just before touching mucous membranes or non intact skin.
- c. Remove gloves promptly after use, before touching any non contaminated surfaces, and before going to another resident.
- d. Perform hand hygiene immediately after removal of gloves.

NOTE: Gloves are **NOT** a substitute for **hand hygiene**.

STERILE gloves will be used for procedures requiring sterile technique i.e catheter insertion or sterile dressing changes.

NON-STERILE gloves will be used for procedures involving resident care as needed but where sterile technique is not required. Gloves are required:

- a. when doing oral care or any procedure involving the mucous membranes.
- b. during instrument cleaning.
- c. during decontamination procedures.
- d. when handling linen
- e. during any procedure involving blood or potential blood contact

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3. **Mask, Eye Protection, Face Shield**

A mask and eye protection or a face shield should be worn to protect mucous membranes of the eyes, nose, and mouth during any resident care activity likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

Mask Procedure

1. Put mask on before entering the isolation room, making certain that the mask covers both mouth and nose.
2. **Do not remove** mask while giving care to resident.
3. Change mask immediately if it becomes moist or is contaminated in any way during care.
4. Untie mask when care is finished and hold by ties.
5. Dispose of in proper container.
6. Do not re-use disposable masks, but discard them in the proper container.

4. **Gown**

Wear a gown (nonsterile and fluid resistant) to protect skin and to prevent soiling of clothing during procedures that are likely to generate splashes or sprays of blood, body fluids, secretions, and/or excretions. The use of gowns when indicated by the type of isolation applies to all staff, volunteers and guests who enter the room.

Gowning Procedure

(Put gown on before entering room)

- a. Remove rings and watches.
- b. Roll long sleeves up to elbow.
- c. Perform hand hygiene.
- d. Unfold gown, pull gown over arms with opening in back.
- e. Tie at neck and waist with knot, making certain that the gown covers all clothing and has a tight cuff.

(Remove gown before leaving the room.)

- a. Undo ties at neck and waist.
- b. Grasp gown at shoulders, bring neck of the gown forward, and draw over arms and hands.
- c. Hold gown away from your body while folding outside of gown inward and roll gown.
- d. Place used gown in proper container in room.

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- e. Remove gloves -Perform hand hygiene or handwash if hands are visibly soiled and use paper towels to turn off faucets and open door.
5. Resident Care Equipment
Used resident care equipment is to be considered contaminated and care should be taken to prevent skin and mucous membrane exposures.
Equipment must be cleaned and disinfected prior to use on any resident.
- B. Droplet Precautions
 1. In addition to Standard Precautions, Droplet Transmission involves contact of the conjunctiva, nose, mouth with a resident infected with large particle droplets. These large droplets are generated by the resident during coughing, sneezing, or talking. Large droplets only travel short distances (3-4 feet).
 2. A private room is indicated.
 3. Door to room may remain open.
 4. In addition to Standard Precautions, wear a paper mask when working within 3-4 feet of the resident.
 5. Limit movement and transportation of resident from room. Resident must wear a mask if transport is necessary.
 6. Use barriers of gowns, gloves, and protective eyewear per Standard Precautions.
 7. Diseases that require initiation of Droplet Precautions:
 - Acute Viral Respiratory Illnesses
 - Adenovirus Infection
 - Diphtheria (Pharyngeal)
 - Epiglottitis due to Haemophilus influenzae
 - Erythema infectiosum (Fifth Disease, Parvovirus B19)
 - German Measles (Rubella)
 - Group A Strep Throat / Scarlet Fever
 - Influenza
 - Meningitis; Bacterial (H. influenzae, Meningococcal)
Note: Undiagnosed meningitis require droplet precautions until diagnosis is made. Bacterial meningitis requires droplet precautions. Viral/Aseptic meningitis does not require droplet precautions.
 - Meningococcal Pneumonia
 - Meningococemia (Meningococcal Sepsis)
 - Mumps
 - Parvovirus B19

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- Pertussis
- Pneumonic Plague
- Pneumonia
- Respiratory Syncytial Virus (RSV) – Mask is required for close, prolonged contact in 3 feet radius)
- Undiagnosed rashes in children

F. Contact Precautions

1. In addition to Standard Precautions, Contact Transmission involved direct contact with residents (skin to skin contact when performing resident care activities) or indirect contact (touching) with environmental surfaces in the resident's environment.
2. Private room is indicated.
3. In addition to Standard Precautions, wear gloves when entering the resident suite.
4. Change gloves after having contact with infective material, before touching anything clean.
5. Remove gloves before leaving the resident's environment and wash hands immediately with an antimicrobial agent.
6. After glove removal and hand washing, ensure that hands do not touch potentially contaminated environmental surfaces.
7. In addition to Standard Precautions, wear a gown when entering the room if you anticipate your clothing could become contaminated. Remove gown prior to leaving resident's room.
8. Limit movement and transportation of resident from room.
9. Resident care equipment must be cleaned and disinfected before use on another resident.
10. Diseases that require initiation of contact precautions.
 - Abscess – Major Draining
 - Adenovirus
 - Chicken Pox (Varicella)
 - Congenital Rubella
 - Acute Hemorrhagic Viral Disease
 - Acute Respiratory Viral Infections
 - RSV
 - Adenovirus, Coronavirus, Influenza Virus, Parainfluenza Virus, Rhinovirus
 - Decubitus Ulcer – Major Draining
 - Ebola Virus
 - ESBL Organisms
 - Amebic Dysentery

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- Cholera
- Coxsackievirus Disease
- Campylobacter
- Cryptosporidium
- Clostridium difficile
- Conjunctivitis
- E. coli 0157:H7
- Echovirus Disease
- Giardia Lamblia
- Hepatitis A or E
- Herpes Simplex, disseminated or severe
- Herpes Zoster – localized in immunocompromised resident
- Impetigo
- Lassa Fever
- Lice
- Marburg Virus
- Necrotizing Enterocolitis
- Poliomyelitis
- Rotavirus
- Salmonella
- Scabies
- Shigella
- Staphylococcal Disease – Majoy
- Typhoid Fever

G. Multi Drug Resistant Organisms

1. Methicillin Resistant Staph Aureus (MRSA)
2. Vancomycin Resistant Enterococcus (VRE)
3. Vancomycin Intermediate Resistance Staph Aureus (VISA)
4. Vancomycin Resistant Staph Aureus (VRSA)
5. ESBL Producing Organisms

See also Infection Control: Information and Training Policy

Quiet Oaks Hospice House Policy

Title: Food Service

Ref. 4664.0490; 4664.0480; 4664.0290

Original 8/27/08

Rev. 9/29/08

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IT IS THE POLICY OF QUIET OAKS HOSPICE HOUSE to have a food service that provides services designed to meet the individualized nutritional needs of each hospice resident. Special dietary restrictions must be noted on the resident's plan of care. Food and nutritional supplements must be provided to meet individual needs.

GOALS

- To provide food services to all residents, guests, volunteers and staff within the established policies set forth by the Quiet Oaks Hospice Board of Directors.
- To provide meals and supplements to meet the individualized nutritional needs of each hospice resident. Specialized dietary requirements will be noted on the resident's plan of care.
- To prepare and serve food in a safe manner that will prevent food borne illness from developing.
- To establish and maintain a **First-In-First-Out (FIFO) System** that assures foods are rotated for safe preparation and serving of food.
- Lunch will be available by 12:00 noon, and supper will be served by 5:30. A light breakfast will be served on an as needed basis.
- To take into consideration that many volunteers will be preparing and serving food. The need for standards and procedures established by The House Manager within the established policies set forth by the QOHH Board of Directors will apply to all staff and volunteers.

PROCEDURES

Upon Arrival at QOHH:

- All volunteers are required to sign in prior to performing duties. The Sign-in-Log is in the volunteer check-in room.
- Report to person in charge, any communicable disease you may have or believe to have. Employees and volunteers with a communicable disease may not handle or prepare food.

Quiet Oaks Hospice House Policy

Title: Food Service

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- If needed any use of the bathroom should be done prior to the start of your shift. Hand washing is necessary.
- Remove all jewelry except plain banded rings. Necklaces, bracelets, earrings and other jewelry should not be worn when preparing or serving food.
- One volunteer will check all freezers and refrigerators for proper temperatures prior to the end of the Supper Shift. Check thermometer inside of equipment and enter on Log Sheet attached to unit. If temperatures are not within proper range contact House Manager.

Proper Temperature Ranges

Refrigerator Temperature: 41° F to 33° F

Freezer Temperature: 0° F or below ___

Personal Hygiene:

- Practicing good personal hygiene is important. All food service workers should arrive clean. Volunteers and staff should cover their mouths and noses when coughing or sneezing and then wash their hands before handling food.
- Persons prepping food must properly restrain hair to prevent contamination of food. This can include pulling longer hair back in a pony tail, wearing a hat or hair net.
- Employee and volunteers' outer garments must be clean. Use of supplied aprons is recommended.
- Hand washing properly is very important! Be sure to rub hands and exposed arms up to elbows with soap for at least 20 seconds, then rinse with clean water.
- Use a fingernail brush for areas under fingernails and between fingers.
- Use a single use paper towel to dry hands, not a cloth towel.

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Title: Food Service

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Food Storage:

- No home-prepared or home-canned food is allowed.
- Always use “**FIFO**” for dry storage items. **FIFO** stands for “**First-in-First-out**”. This ensures that food items are used in the order received.
- If food items are not left in the original container, labeling of all containers is required.
- Always store food items **off the floor** of at least six inches.
- All toxic items (non-food) must be stored below food, equipment and utensils. A solid partition may also be used. To physically separate harmful chemicals.
- All foods prepared and stored on site need to be clearly dated.
- Disregard any out dated food items. Check expiration dates.
- Leftover foods will be disregarded after three days.
- Specific resident food items brought to QOHH by a family member will be labeled with resident name, room suite number and date.
- Food items served to residents will not be used again unless it is in an unopened packaged container.

Temperature Control:

Temperature control is the single most important aspect of food safety.

- As foods are thawed, cooked, held, served, cooled, and reheated, they may pass several times through the temperature danger zone (41°F to 140°F). Prevent foods from spending more than 4 hours in the temperature danger zone.

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Heating and Cooking:

- Minimum Temperatures:
 - Eggs and Fish: 145° F for 15 seconds
 - Pork, Game and all Ground Beef: 155° F for 15 seconds
 - Poultry and Seafood (containing stuffing): 165° F for 15 seconds
 - Beef Roasts/Corned Beef – internal temperature of 130° in 121 minutes.
- Microwave Cooking – Foods cooked in a microwave must be cooked to an internal temperature of 165° F.
- Holding heated food – at 140° F or above.

Reheating Food:

- Bring temperature to 165° F within 2 hours for 15 seconds.
- Microwave reheated foods must reach 190° F, then allow to stand covered for 2 minutes.

Cooling Foods:

Potentially hazardous foods must be cooled from 140° F to 70° F within 2 hours. An additional 4 hours is allowed to completely cool the food to 41° F. The faster the foods pass through the danger zone, the better.

Proper Methods of Cooling:

- Divide foods into smaller portions.
- Put into shallow pans.
- Food Depth of 3 inches for food like soup.
- Use ice bath method – Place container in ice and continue to stir and check temperature.

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Cross-Contamination:

- Raw and cooked foods must be kept separate.
- Food contact surfaces that have touched raw food must be cleaned and sanitized before a cooked food touches the same surface.
- Store raw meat, poultry and seafood on lowest shelf of refrigerator.
- Never place cooked food on a plate which previously held raw meat, poultry or seafood.
- Wash your hands often and always between contacting raw foods and ready-to-eat food items.

Thawing Methods:

DO NOT THAW AT ROOM TEMPERATURE.

Four proper methods to thaw foods:

1. In a refrigerator.
2. Under running, potable water at a temperature of 70° F or lower. The product should be thawed within 2 hours.
3. As part of the cooking process. For example: Frozen hamburger patties.
4. In a microwave. Use this method only if the food will be moved immediately to other cooking equipment or finished immediately in the microwave.

Handling of Fruits and Vegetables:

- Pesticide use requires produce and fruit to be thoroughly washed prior to use.
- All produce must be thoroughly washed in drinkable water to remove possible soil residue.
- Fruits and vegetables that have slightly blemished spots, may be accepted if flavor and quality are not affected.

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Dish Washing:

- The use of both dishwashers is the desired method of washing all kitchen dishes and utensils.
- If needed, hand washing of dishes needs to have hot soapy water and a thorough rinse. Allow to drip dry.
- Do not use cloth towels to wipe your hands.

Recycling:

- We have a mandatory recycling policy.
- We have a single source method. This means all paper, tin, aluminum, cardboard and glass can be mixed together. Recycled items should be rinsed.
- Empty recycle container when needed. A large specially marked container is inside garage.

Quiet Oaks Hospice House Policy

Title: EMERGENCY PLAN EDUCATION

Ref. 4664.0500

Original: 8/07/08

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IT IS THE POLICY OF QOHH to communicate the emergency plan to all staff and volunteers at the time of orientation. Each staff person must be knowledgeable of and must implement the emergency plan.

PROCEDURE

Emergency plan areas to be addressed include:

1. Assignment of persons to specific tasks and responsibilities in case of an emergency situation.
2. Instructions related to the use of alarm systems and signals.
3. Systems for notification of appropriate persons outside of the facility.
4. Information on the location of emergency equipment in the facility; and
5. Specification of evacuation routes and procedures.

See also Emergency Plan Policy, Emergency or Unusual Occurrence Policy, and First Aid Policy

Quiet Oaks Hospice House Policy

Title: Emergency Plan

Ref. 4664.0500

Original: 8/07/08

FIRE

IN THE EVENT OF FIRE, the first step is to pull one of the two fire alarms located next to the fire exit doors across from the guest suite and across from Suite H. This will alert everyone in the house that an emergency exists. Call 911. It is the responsibility of the nurses to take charge of the area of the house they are responsible for during their shift. This means to be responsible for the rescuing of any resident or individual in their area of the building. Any rescue attempt should be made **ONLY** if it can be done safely.

If you can do so safely, use a fire extinguisher to put out the flames. Extinguishers are located:

- On wall left of Suite B
- On wall across from Suite G
- In the mechanical room
- In the 2nd floor platform closet
- In the kitchen by the beverage cooler
- In the lower level storage area
- In the garage
- In the cottage

The directions for use of the fire extinguishers are as follows:

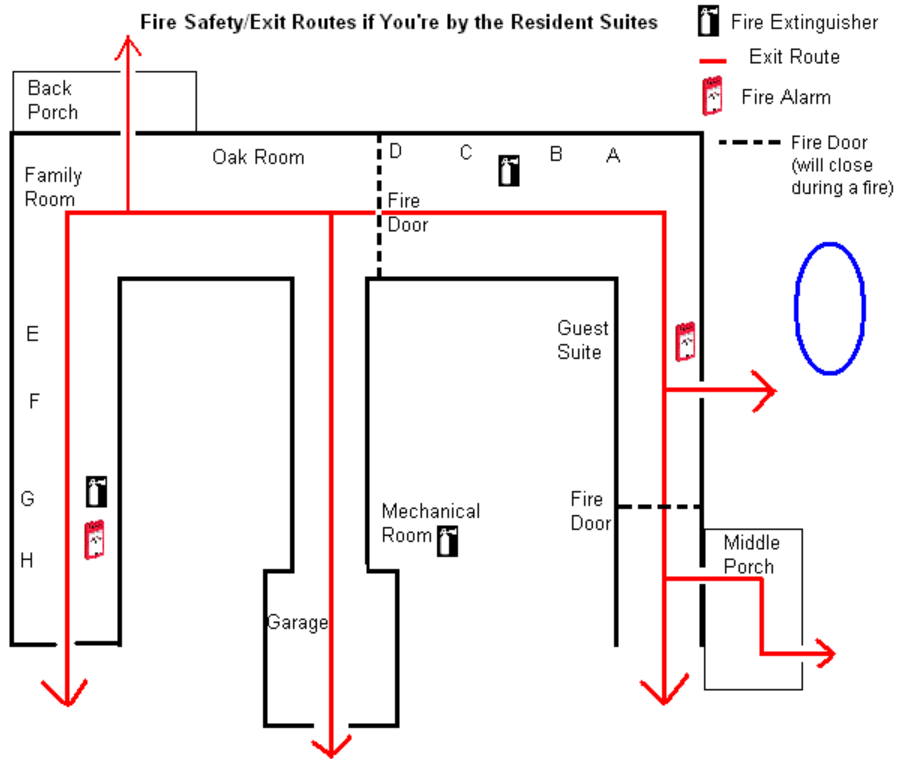
Remember PASS

- **P**ull pin
- **A**im hose
- **S**queeze handle
- **S**weep base of fire

If you can do so safely, close all resident suite doors and remain with the residents until help arrives. Evacuate those that can be safely evacuated.


IMPORTANT: If at any time you feel you are in danger, leave the dwelling immediately and wait for help to arrive.

EXIT ROUTES: (Refer to exit route maps.)

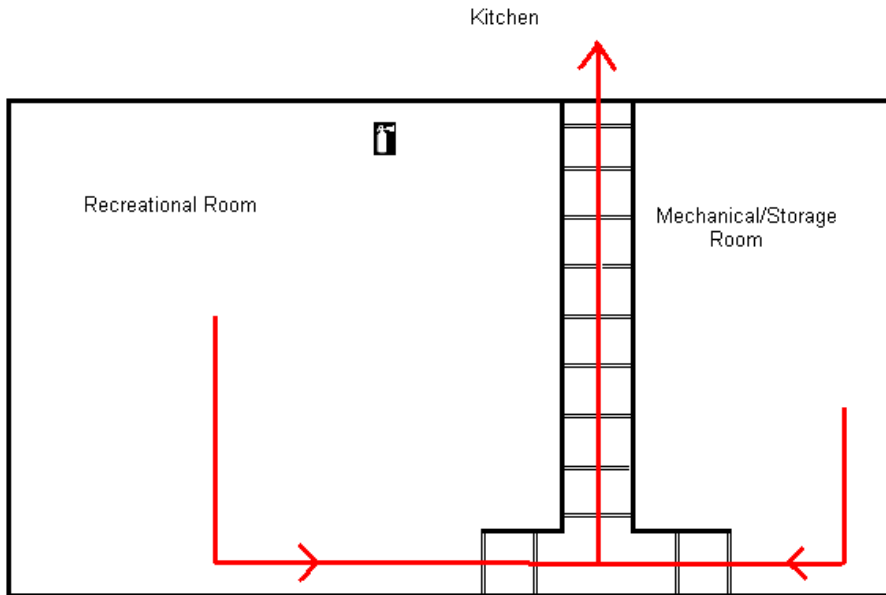


Fire Safety/Exit Routes if in the Rec Room


Exit from basement to the safest exit on the main level


 Fire Extinguisher

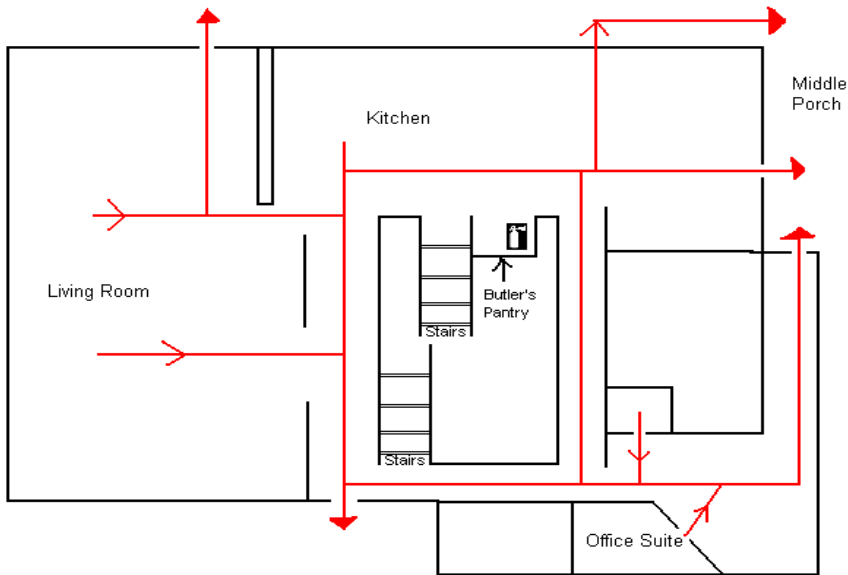
 Exit Route





Fire Safety/Exit Routes if on the Main Level - Not by Resident Suites

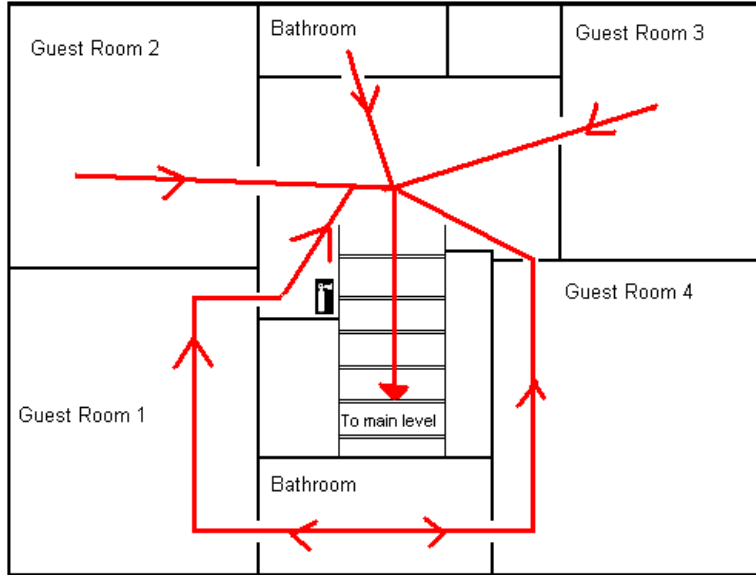
 Fire Extinguisher

 Exit Route



Fire Safety/Exit Routes from Upstairs Bedrooms

-  Fire Extinguisher
-  Exit Route



SEVERE WEATHER EMERGENCY

Listen for weather alerts on weather radios located in the kitchen and in the Oak Room. Notify guests of any severe weather warnings.

IN THE EVENT OF A TORNADO WARNING, move all able/ambulatory residents and guests to a secure area as far away from the windows as possible. If a resident is ambulatory and can be safely moved to the lower level family room, do so. Direct guests to the lower level family room also. Close resident suite doors and curtains/blinds. It is the responsibility of the nurses/volunteers to secure the area of the house they are responsible for during their shift. This means to be responsible for the rescuing, if necessary, of any resident, guest or other individual in their area of the house. The Resident Spa is recommended as the safest room nearest to the resident suites or hallway to garage. Stay in secured area until the “All Clear” is announced by nurse monitoring the weather alert system. Flashlights are available in several areas throughout the house.

OTHER EMERGENCIES

IN THE EVENT OF AN EMERGENCY OF ANY KIND requiring outside assistance from the fire department, police department or paramedics, you can do any one of the following that will result in the police coming together with the fire department and/or an ambulance.

1. Pull any of the fire alarms located at the exits of the hospice.
2. Call 911.

First aid kits are located at the nurses’ station, in the kitchen, upstairs in the guest bathroom, and in the garage.

MISSING PERSONS

IN THE EVENT A RESIDENT IS MISSING, Immediately begin a search of the premises! It is the responsibility of the R.N. on duty to be in charge of this search. If a search of the inside and the perimeter of the building DOES NOT result in finding the resident, immediately notify the police of a missing person by calling 911. NEXT, contact QOHH administration and the resident’s hospice case manager, as well as the resident’s healthcare POA, as appropriate.

NOTIFICATIONS

In the event of any emergency occurring, at the first appropriate moment notify the following people and advise them of what has occurred:

Joe Bauer	(Home)	320-253-3997
Executive Director	(Cellular)	320-420-2018
Brenda Hansen, RN, BSN	(Home)	320-259-9666
Director of Nursing	(Cellular)	320-828-2386
George Hontos	(Home)	320-255-1140
House Manager	(Cell)	320-248-1497
Dr. Pat Lalley	(Home)	320-363-8468
Medical Director	(Pager)	320-493-0012

See also Emergency Plan Education Policy, Emergency or Unusual Occurrence Policy, and First Aid Policy

Quiet Oaks Hospice House Policy

Title: VOLUNTEER TRAINING

Ref. 4664.0180

Original: 8/07/08

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IT IS THE POLICY OF QOHH to have volunteer services in place at all times to assist with the necessary duties of the operation of QOHH. A record of each volunteer will be maintained with regard to their training and the hours spent volunteering at QOHH.

PROCEDURE

Orientation Training:

All volunteers who provide services directly or indirectly to residents must complete a training course prior to providing any services, which can include, but is not limited to:

1. overview of Minnesota Rules 4668.0140 (Orientation to Hospice Requirements), and Minnesota Statutes, sections 144A.75 to 144A.755 (Hospice Statutes);
2. the hospice bill of rights;
3. handling emergencies and use of emergency services;
4. reporting maltreatment of vulnerable minors and adults;
5. handling of resident and/or family complaints and reporting complaints to the Office of Health Facility Complaints;
6. services of the Office of the Ombudsman for Long Term Care
7. hospice philosophy and the physical, spiritual, and psychological aspects of hospice care
8. confidentiality of hospice resident records and communications between hospice residents and hospice provided employees, volunteers, and contractors
9. goals and services of hospice care; and
10. record keeping

A background check must be completed on each volunteer prior to volunteering his or her services.

Title: VOLUNTEER TRAINING

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On-going training/competency:

The volunteers will participate in an in-service training program that will be offered to ensure that all volunteers are competent to perform their assigned services consistent with the hospice resident's plan of care.

Quiet Oaks Hospice House Policy

Title: VULNERABLE ADULT ASSESSMENT AND REPORTING

Original 8/07/08

Ref: MN Stat. 626.557

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IT IS THE POLICY OF QUIET OAKS HOSPICE HOUSE that upon admission, the admitting nurse shall perform a vulnerable adult assessment.

INTERNAL REPORTING PROCEDURE

Upon admission, and any time while a resident is living in QOHH, any conduct that is **not an accident** and that produces physical pain or injury or emotional distress, must be reported to the Administration. Administration must give written notice to reporter, within 2 working days, stating whether QOHH reported the incident to the common entry point (CEP). The name of the reporter will not be revealed. If the reporter is not satisfied with the action by QOHH Administration, he/she may report it to the CEP, listed below. The QOHH will not stop any one from reporting a maltreatment incident and will not retaliate against the reporter for doing so.

All residents should know the name of the person to whom they should report a maltreatment incident within our facility.

Stearns County Common Entry Point

(320) 656-6225

1-800-450-3663

Quiet Oaks Hospice House Policy

Title: HOUSEKEEPING SERVICES

Original: 8/07/08

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IT IS THE POLICY OF QOHH that staff and volunteers are responsible for the day-to-day cleaning and maintenance of QOHH. IT IS THE POLICY OF QOHH to ensure cleanliness and orderliness in the resident's rooms and the entire facility. The floors, walls, and ceilings of all rooms, hallways, and stairways will be kept clean and maintained in good order.

PROCEDURE

All staff members and volunteers are encouraged to treat the hospice as if it were their own. At the end of each shift, it is each staff member or volunteer's responsibility to leave the house in as good a condition as they are able. Daily and weekly household chores have been designated for each shift. The following duties are the responsibility of each shift:

1. Wash, dry and fold any laundry dirtied or left over from the previous shift.
2. Dishes should be washed in dishwasher and put back in the cupboards.
3. Bathroom garbage and kitchen garbage should be emptied at the end of each shift, new liners provided for the receptacles and the full bags taken out to the dumpster.
4. Residents' rooms should be free of dishes and any other debris left over from that shift.
5. Resident garbage cans should be emptied as needed.
6. All uncarpeted floors should be swept and mopped appropriately.
7. All bathrooms will be cleaned, scrubbed and disinfected.
8. All ceiling fixtures will be dusted as needed.

Residents' rooms should be dusted and vacuumed as needed. All the bathrooms cleaned and disinfected daily. All glass, mirrors and windows should be wiped as needed.

Quiet Oaks Hospice House Policy

Title: LAUNDRY SERVICES

Ref. 4664.0430

Original: 8/07/08

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IT IS THE POLICY OF QOHH that all bed linens and towels be changed on a daily basis as needed. All bed liners will be cleaned on premises, using cleaning agents necessary for cleaning contaminated linens. If a resident is known to have allergies to specific cleaning agents, his/her linens shall be laundered separately using non-allergenic cleaning agents. Each resident's room shall have a covered laundry basket.

PROCEDURE

- Gloves shall be worn when handling soiled bed linens and towels.
- Keep soiled linens and towels away from clothing.
- DO NOT lay soiled linens on furniture or floor.
- Put soiled linens in covered laundry basket in the resident's bathroom.
- When laundry basket is emptied, rinse container in a 1:10 bleach solution and flush excess into the sewer system.

Quiet Oaks Hospice House Policy

Title: BEDDING AND LINENS

Original: 8/07/08

Ref: 4664.0430

Page 1 of 1

IT IS THE POLICY OF QOHH that a quantity of linen essential for proper care and comfort of hospice residents is available at all times. Each resident bed will be supplied with suitable pillowcases and bottom and top sheets.

All bedding and bath linen, including mattresses, quilts, blankets, pillows, pillowcases, sheets, bedspreads, towels, and washcloths will be kept clean and in good condition. Clean bedding will be furnished as needed to maintain cleanliness, no less than once each week, and clean towels will be furnished daily to all residents.

All bedding and linens will be handled, stored, processed, and transported in a manner to prevent the spread of infection. See the infection control policy.

Quiet Oaks Hospice House Policy

Title: DRESS CODE

Original: 8/07/08

Rev: 2/26/09

Page 1 of 1

PURPOSE

General appearance is an important part of the Quiet Oaks mission. We ask our staff to be understanding of this and share in our goal of providing a professional image to those we serve. We recognize that we dress for the people we serve and not our personal preferences. Attire should be appropriate to the task you are performing. This applies to all staff and volunteers.

POLICY

1. Attire must be appropriately sized, clean, neat and well cared for.
2. General criteria
 - A. Name badge must be worn at all times and should be unaltered (no pins, tape, stickers, ribbons, etc. on the badge). The name should be clearly visible.
 - B. Hair, including facial hair, is to be clean, neatly groomed, and arranged so as not to interfere with job duties. Hair color should be a natural color only (e.g. no green, pink, purple hair color).
 - C. Fingernails are to be clean, trimmed and polish free. Artificial nails are banned from the hands of direct care givers.
 - D. Tattoos must not be visible while on duty.
 - E. A minimal amount of jewelry may be worn. Minimal is defined as no more than 2 fingers/hand with rings, 2 earrings per ear. No visible pierced jewelry other than earrings is to be worn while on duty. Ear lobe stretchers and tongue jewelry are unacceptable.
 - F. Good personal hygiene is expected. Use of fragrance is discouraged when providing direct care. No gum chewing.
 - G. Clothing:
 - a. Dresses/Skirts/Tops: Dresses and tops must have sleeves. Tops must be long enough so that no skin shows. Hanging length of dresses and skirts may range from just above knee to mid calf. Skirts are prohibited. Blouses, shirts or tops that are low cut and/or tight fitting are prohibited.
 - b. T-shirts and shorts are allowed only as appropriate to task being performed (i.e. yard/garden work, etc.)
 - c. Pants: Capri pants are acceptable. Jeans are acceptable as long as they meet the other criteria of the dress code policy.
 - d. Face coverings (e.g. scarves, veils) are not allowed. Head coverings on top of head that are part of a religious/cultural dress are appropriate. Other hats/head scarves may not be worn while on duty.
 - e. Socks or hose are to be worn by all staff. Sandals/"flip flops" are not allowed while performing indoor duties.

Quiet Oaks Hospice House Policy

Title: VEHICLE PARKING

Original: 8/7/08

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POLICY:

1. To facilitate the comfort of our guest, the area in front of the house, is designated for visitors, guest, and volunteers parking.
2. All paid staff will to park behind the cottage accessed by using Clyde's road (gravel road along side of property).
3. The night nursing staff are permitted to park in the front of the house as space allows.
4. Parking along the side of the driveway in front of the house is **not** allowed at any time.

Quiet Oaks Hospice House Policy

Title: KEYS

Ref. 4664.0510

Original: 8/07/08

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IT IS THE POLICY OF QOHH that key(s) to all locks on exits and egresses in the house will be in possession of the person in charge on every nursing shift.

Quiet Oaks Hospice House Policy

Title: NO SMOKING

Original: 8/07/08

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IT IS THE POLICY OF QOHH that staff and volunteers with direct resident contact follow a No Smoking policy.

PROCEDURES

All smoking material must be extinguished before entering the house.

Residents may be allowed to smoke only outside while under the direct supervision of a staff member, who will stay with the resident until all smoldering materials are properly disposed of.

Guests and volunteers working outside will be permitted to smoke only outdoors in designated area(s).

Quiet Oaks Hospice House Policy

Title: PET ANIMALS

Ref: 4664.0550

Original: 8/10/08

It is the policy of QOHH that pets of the resident may be brought to QOHH for short visits. The following criteria must be met:

1. Family/friends should alert QOHH staff of the request to bring the pet to QOHH;
2. The pet must be up-to-date on vaccinations, including rabies. Documentation must be presented prior to or at the time of the visit;
3. The pet must be on a leash or restrained appropriately (pet carrier, etc) when coming to or leaving QOHH.
4. A family/friend must be present at all times while the pet is visiting to appropriately take care of needs of the pet and to maintain the pet within the resident's room.
5. Extended visits by pets are not allowed.

QOHH's policy is that pets are not permitted to live on the premises.

Quiet Oaks Hospice House Policy

Title: INSECT AND RODENT CONTROL

Original: 8/07/08

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IT IS THE POLICY OF QOHH to have a written contract with an insect and rodent control (exterminator) provider. That cleaning, renovation, fumigation, will be conducted by a licensed pest control provider for the elimination of such pests when necessary.

PROCEDURE

If anyone suspects the need for pest control the following needs to be done:

1. Notify administration of the problem and they will contact the appropriate source.
2. If administration is not available, contact the number listed on the Emergency Phone Number list for pest control.