PAID FAMILY CAREGIVER

Training Materials
2025

AGENDA

- General Topics
- Team Topics
- Documentation
- Safety
- Medications
- Respiratory
- Neurological
- Nutrition
- Genitourinary
- Integumentary
- Social Determinates of Health Information

GENERAL TOPICS

CPR

Resource:

American Heart Association | To be a relentless force for a world of longer, healthier lives

CPR

CPR – or Cardiopulmonary Resuscitation – is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple the chances of survival after cardiac arrest.

- Immediate CPR can double or triple chances of survival after cardiac arrest.

Why Is CPR Important?

- Keeping the blood flow active – even partially – extends the opportunity for a successful resuscitation once trained medical staff arrive on site.

Pediatric BLS for Lay Rescuers

STEP 1

Make sure the scene is safe.

Check to see if the person is awake and breathing normally.

STEP 2

Shout for help.

If you're alone

- **With a cell phone,** phone 9-1-1, perform CPR (30 compressions and then 2 breaths) for 5 cycles, and then get an AED
- **Without a cell phone,** perform CPR (30 compressions and then 2 breaths) for 5 cycles, and then phone 9-1-1 and get an AED

If help is available, phone 9-1-1. Start CPR while you send someone to get an AED.

STEP 3

Repeat cycles of 30 compressions and then 2 breaths.

- **Child CPR**

  Push in the middle of the chest at least one third the chest depth or approximately 2 inches with 1 or 2 hands.

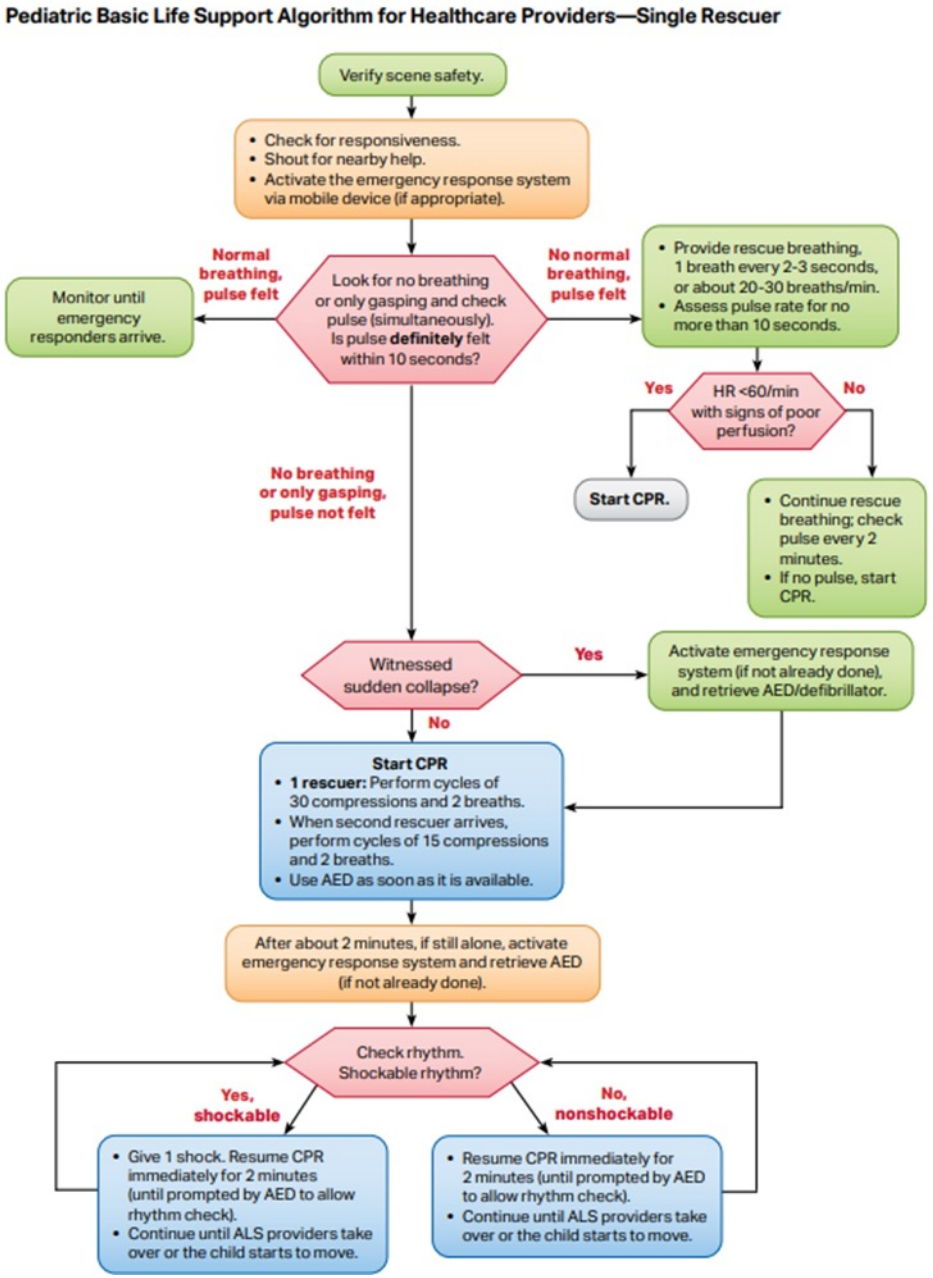
- **Infant CPR**

  Push in the middle of the chest at least one third the chest depth or approximately 1½ inches with 2 fingers.

Use the AED as soon as it arrives.

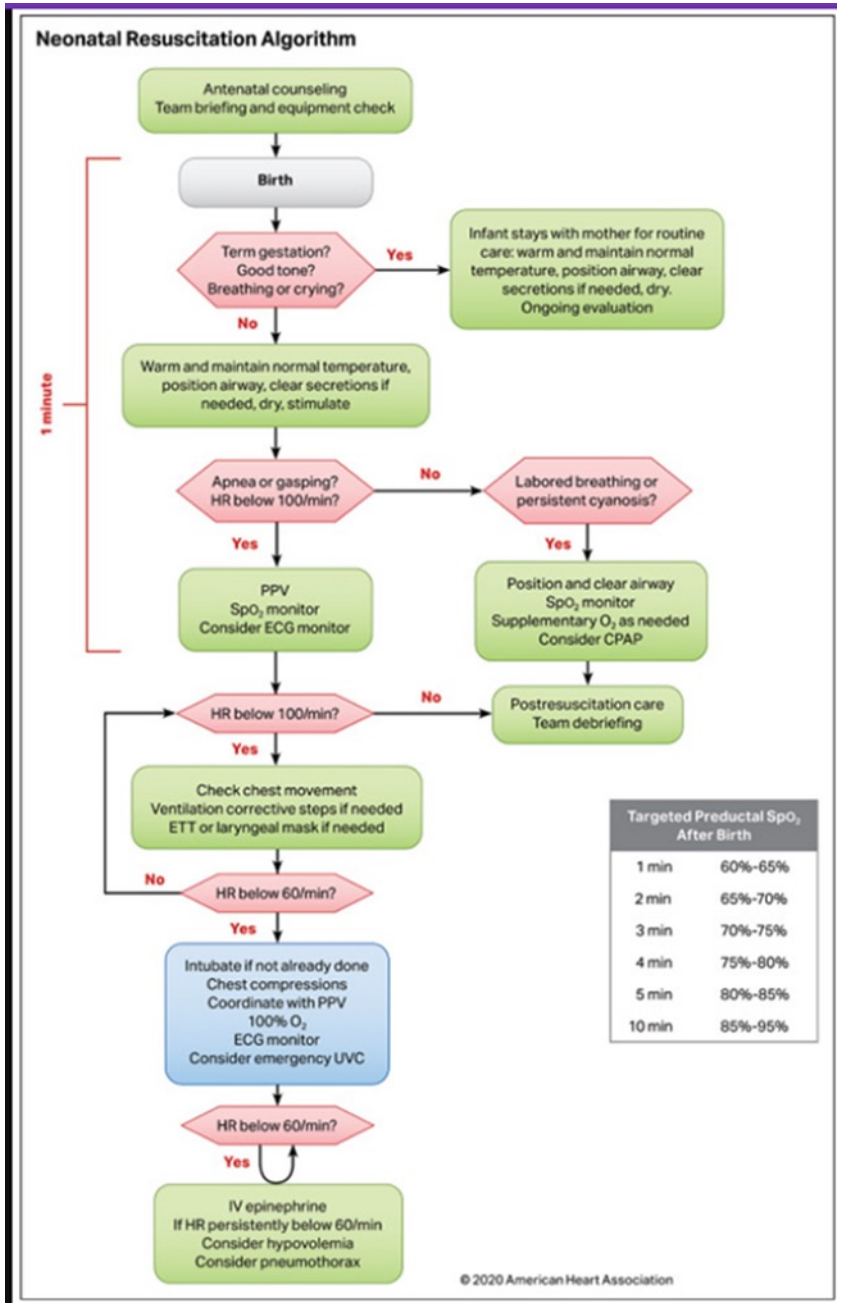
Continue CPR until EMS arrives.

- CHILDREN - [ALGORITHMS | AMERICAN HEART ASSOCIATION CPR & FIRST AID]



PEDIATRIC BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS- SINGLE RESCUER

Neonatal Resuscitation Algorithm



ADULT BASIC LIFE SUPPORT

AGENCY SPECIFIC NEW EMPLOYEE ORIENTATION

Each agency will have their own new employee orientation, that will need to be completed. Please reach out to your nursing agency for information on New Employee Training.

COMMON MEDICAL ABBREVIATIONS

A

A/O - alert and oriented

A&P - assessment and plan

ABCDE - airway, breathing, circulation, disability, exposure

ABD - abdominal

Abn - abnormal

ABX - antibiotics

AC - before meals

AC/HS - before meals / at bedtime

ACLS - advanced cardiac life support

Ack - acknowledge

AD - advance directive

ADA - Americans with disabilities act

ADAT - advance diet as tolerated

ADD - attention deficit disorder

ADE - adverse drug event

ADHD - attention deficit hyperactivity disorder

Ad lib - as desired

ADLs - activities of daily living

Asp - aspiration

B

BB - bed bath

BBL - bed bath and linen changed

Bilat - bilateral

BiPAP - bilevel positive airway pressure

BLE - bilateral lower extremities

BLS - basic life support

BM - bowel movement

BMI - body mass index

BP - blood pressure

BR - bedrest, bathroom

BS - blood sugar, bedside

BSC - bedside commode

BUE - bilateral upper extremities

C

C/O - complaints of

Cath - catheterization

CDI - clean, dry, intact

CNS - central nervous system

CO2 - carbon dioxide

CPAP - continuous positive airway pressure

CPR - cardiopulmonary resuscitation

CPT - chest physiotherapy

COMMON MEDICAL ABBREVIATIONS

D
D - day
D/T - due to
DC, D/C - discharge, discontinue
DM - Diabetes Mellitus
DME - durable medical equipment
DNR - do not resuscitate
DOB - date of birth
DX - diagnosis

E
ED - emergency department
EENT - eye, ear, nose, and throat
EHR - electronic health record
EMAR - electronic medication administration record
EMR - electronic medical record
EMS - emergency medical services
EMTALA - emergency medical treatment and labor act
EN - enteral nutrition
ENT - ear, nose, and throat
EOP - emergency operations plan
ER - emergency room
Eval - evaluation

F
F/U - follow up
FH - family history
FL OZ - fluid ounce
FNS - food and nutrition service
Freq - frequency

G
G - gram, gauge
Gal - gallon
GERD - gastroesophageal reflux disease
GI - gastrointestinal
GJ tube - gastrostomy jejunostomy tube
GLF - ground level fall
GM - gram
GTT - drop
GU - genitourinary

COMMON MEDICAL ABBREVIATIONS

H

H&P - history and physical

H2O - water

HA - headache

HEENT - head, ears, eyes, nose, and throat

MGT - management

HH - home health

HHC - home health care

HIPAA - Health insurance portability and accountability act

HOB - head of bed

HOH - hard of hearing

HPI - history of present illness

HS - at bedtime

HT - height

HTN - hypertension

Hum - humidified

HX - history

Hyper - above normal

Hypo - below normal

I

I&O - intake and output

IADLs - instrumental activities of daily living

IDC - indwelling catheter

IPPV - intermittent positive pressure ventilation

IS - incentive spirometer

ISOL - isolation

IV - intravenous

IVF - intravenous fluids

J

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K

KG - kilogram

COMMON MEDICAL ABBREVIATIONS

L

L - left

LB - pound

LM - liters per minute

LOC - level of consciousness

LOS - length of stay

LPN - licensed practical nurse

LRI - lower respiratory infection

M

M – meter or minute

MAR - medication administration record

MCG - microgram

MDI - metered-dose inhaler

MEQ - milliequivalents

MG - milligram, magnesium

MGT - management

MGMT - management

Min - minute

ML - milliliter

MM - millimeters

MM Hg - millimeters of mercury

MN - midnight

MOM - milk of magnesia

mono - mononucleosis, monocytes

MRI - magnetic resonance imaging

MSDS - material safety data sheet

COMMON MEDICAL ABBREVIATIONS

N

N/V - nausea and vomiting

NA - sodium

NAD - no abnormality detected, no apparent distress

NC - nasal cannula

NEB - nebulizer

Neg - negative

Neuro - neurological

NG - nasogastric

NGT - nasogastric tube

NIBP - noninvasive blood pressure

NIPPV - nasal intermittent positive pressure ventilation

NKA - no known allergies

NKDA - no known drug allergies

NL - normal limits

NPO - nothing by mouth

NS - normal saline

NSAID - nonsteroidal anti-inflammatory drug

O

O2 - oxygen

O2 sat - oxygen saturation

OSA - obstructive sleep apnea

Outpt - outpatient

OX - oximetry

OZ - ounce

COMMON MEDICAL ABBREVIATIONS

P

P - pulse

PCM - primary care manager

PCP - primary care provider

PED - pediatric

PEG - percutaneous endoscopic gastrostomy

PHI - protected health information

PICC - peripherally inserted central catheter

SP - status post

SSI - sliding scale insulin

STAT - immediately

PLT - platelets

PMH - past medical history

PN - parenteral nutrition

PO - by mouth

POC - point of care

Pos - positive

PPE - personal protective equipment

PR - pulse rate

Prec - precautions

PRN - as needed

PROM - passive range-of-motion exercises

PSH - past surgical history

PT - patient or physical therapy

Pulm - pulmonary

Q

Q - every

Q4H - every four hours

QAM - every morning

QPM - every night

QD – every day

Q Day – evert day

QT - quart

COMMON MEDICAL ABBREVIATIONS

R
R - right, respirations
RA - room air
Reg - regular
Rehab - rehabilitation
Resp - respirations, respiratory
Ret - retention
RN - registered nurse
ROM - range of motion
ROS - review of systems
RR - respiratory rate
RRR - regular rate and rhythm
RX - prescription

S
S - second
Sat - saturation
SDS - safety data sheets
SE - side effect
Sec - second
SL - sublingual
SOB - shortness of breath
STI - sexually transmitted infection
SUBQ - subcutaneous
SW - social worker

T
T - temperature
T2DM - type two diabetes mellitus
Tab - tablet
TBI - traumatic brain injury
TBSP - tablespoon
Temp - temperature
Tol - tolerate
TSP - teaspoon
TX - treatment
TV - tidal volume

COMMON MEDICAL ABBREVIATIONS

U

U - unit

UA - urinalysis

Unk - unknown

UO - urine output

UOP - urinary output

URI - upper respiratory infection

US - ultrasound

UTD - up to date

UTI - urinary tract infection

V

VAX - vaccination

Vit - vitamin

VS - vital signs

VSS - vital signs stable

X

X - times

Y

Y/O - years old

YD - yard

YR - year

Z

SOONERCARE OUT OF STATE SERVICES

Beginning Sept. 1, 2019 the Oklahoma Health Care Authority (OHCA) will enact changes to the agency's out-of-state (OOS) services policies. These changes will continue to ensure members have access to quality care while controlling program costs. They will not impact routine medical care for SoonerCare members.

In 2019 the Oklahoma legislature passed HB 2341, which limited SoonerCare members' services to in-state providers when possible. These changes to OOS services will allow OHCA to maintain compliance with federal and state regulations.

These revisions clearly define coverage and reimbursement for services rendered by providers that are physically located outside of Oklahoma. The policy also outlines provider participation requirements and documentation requirements for out of state service requests.

WHAT SOONERCARE MEMBERS NEED TO KNOW

Members living near the Oklahoma state border, who regularly see a SoonerCare-contracted provider across the border, should see no changes, as long as the provider's office is within 50 miles of the Oklahoma border. In the case of a provider's office being more than 50 miles away from the Oklahoma border, an out of state prior-authorization will be required.

Medical care needed due to an accident or medical emergency while a member is travelling in another state is still eligible for compensation once medical necessity is determined.

Single-case agreements and contracts will not be allowed under the rule changes. SoonerCare members currently receiving OOS services through single-case agreements will be transitioned to regularly-contracted SoonerCare providers that OHCA medical staff have determined can provide the same level of care at OHCA's regularly contracted rates.

Self-referrals will no longer be permitted and members will be responsible for incurred medical costs if they do not receive the proper prior authorization for OOS services. Members who think they need out-of-state services should discuss the apparent need with their primary care provider.

OUT OF STATE POLICY

Please reference the SoonerCare website for any questions or clarifications on the out of state policy

SoonerCare Out-of-State Services Rule Changes

DUTY TO REPORT

REPORTING CHILD ABUSE AND NEGLECT

- Statewide 24-hour child abuse hotline 1-800-522-3511

WHAT IS CHILD ABUSE?

Child abuse is defined by law as harm or threatened harm to a child's health and safety by a person responsible for the child's health and safety. This includes a parent, a legal guardian, a foster parent, or a person 18 years of age and older with whom the child's parent cohabitates, or any other adult residing in the home of the child.

HARM OR THREATENED HARM INCLUDES:

- Physical Abuse: non-accidental physical injury to a child under 18 years of age. Even though the injury is not an accident, there may not have been intent to hurt the child. Physical abuse indicators may be:
  - Physical Indicators - questionable bruises, welts, burns, abrasions, fractures or lacerations; or
  - Behavioral Indicators - extreme aggressiveness or withdrawal, being frightened of parents, or afraid to go home.

- Neglect: failure or omission to provide food, clothing, shelter, medical care, supervision, or special care made necessary by the physical or mental condition of the child. Neglect indicators may be:
  - Physical Indicators - consistent lack of supervision,
  - Behavioral Indicators - frequently absent or tardy.

HARM OR THREATENED HARM INCLUDES:

- Sexual Abuse or Exploitation: includes, but is not limited to, rape, incest, lewd or indecent acts or proposals, and allowing, permitting, or encouraging a child to engage in prostitution or pornography. Sexual abuse indicators may be:
  - Physical Indicators – torn, stained, or bloody underclothing; or
  - Behavioral Indicators – bizarre or unusual sexual behavior or knowledge; detailed and age-inappropriate understanding of sexual behavior; or suicide threats or attempts.
- Emotional Abuse: mental injury from incessant rejecting, terrorizing, isolating, exploiting, corrupting, and denying emotional responsiveness. Indicators may be:
  - Behavioral Indicators - overly compliant or demanding, extreme passivity or aggression, inappropriately adult, or infantile; or
  - Caretaker Indicators - blames or belittles the child, treats child as the family scapegoat, unreasonable demands, or impossible expectations without regard to the child's development capability.

WHO IS REQUIRED TO REPORT SUSPECTED CHILD ABUSE?

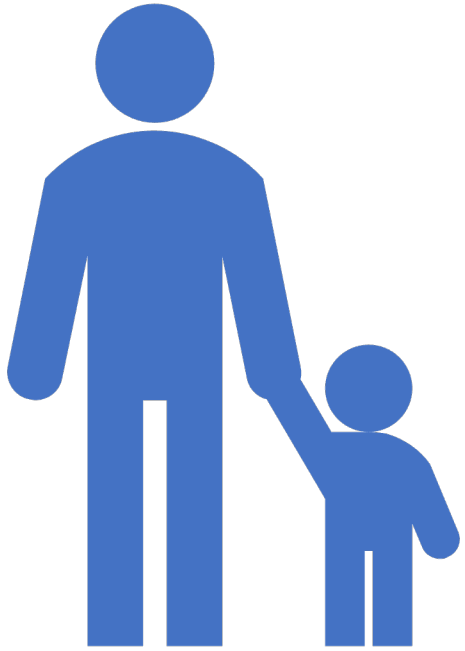
- State law requires every health care professional, teacher, and every OTHER person who has reason to believe that a child under 18 years of age is being abused or neglected, or is in danger of being abused or neglected, must report the suspicion of abuse or neglect promptly to the Oklahoma Department of Human Services (DHS).

WHO IS REQUIRED TO REPORT SUSPECTED CHILD ABUSE?

Failure to report suspected abuse or neglect is a crime. No person, regardless of their relationship to the child or family, is exempt from reporting suspected abuse or neglect. However, a person reporting in good faith is immune from both civil and criminal liability.

By law, reporting child abuse or neglect is an individual responsibility. As the individual who suspects abuse or neglect, you are legally responsible for making certain that the report is made to DHS.

- If you have obtained the information leading to your suspicions from a professional relationship, your legal responsibility is NOT satisfied by merely reporting your suspicions to a supervisor. If applicable, it is important to follow your agency's or school's procedures regarding informing a supervisor of your concerns, but permission to report is not necessary. You must not let organizational procedures or policies obstruct your duty to report PROMPTLY to DHS.



WHO IS REQUIRED TO REPORT SUSPECTED CHILD ABUSE?

- A report is a request for a safety evaluation to gather facts and protect the child. The individual making the request does not need proof of the abuse or neglect prior to reporting. Investigation and validation of child abuse and neglect reports are the responsibility of DHS or law enforcement officials. If you become aware of additional incidents after the initial report was made, another report to DHS with the additional concerns and information should be made.

IS THE REPORT I MAKE CONFIDENTIAL?

- DHS policy and state law require strict maintenance of the confidentiality of reporters of child abuse or neglect. If the incident does become court involved, information on the reporter could be requested by the court. It is rare, however, for the reporter's identity to be made known in court. Anonymous reports are also accepted, but providing your name and contact information may help the child welfare worker contact you in regards to obtaining more information or with additional questions.

HOW DO I REPORT A SUSPICION OF CHILD ABUSE?

- Promptly contact DHS, Child Welfare Services by calling the statewide, 24-hour Hotline number, 1-800-522-3511. Accurately reporting the nature of the abuse or neglect is critical. Do not overstate or minimize the extent of the suspected abuse or neglect.

WHAT INFORMATION SHOULD I BE READY TO REPORT?

- The names, addresses, ages and whereabouts of the child and the child's parents, or other persons responsible for the child's welfare, such as at the school, work, daycare, or hospital;
- Information pertaining to support systems for the family, other individuals who may be aware of the abuse or neglect, or any safety-related issues child welfare may need to be aware of prior to making contact with the family, such as domestic violence, presence of weapons, or use of illegal substances;
- The nature and extent of the abuse or neglect;
- Any historical information on the family related to the safety and well-being of the children and their parents or other identified caretakers; and
- Any other information you believe might be helpful in establishing the cause of the injuries and the identity of the person responsible.
- If a reporter does not have all of the information listed above, he or she should go ahead and report the details of what is knows concerning the suspicion of abuse or neglect.

WHAT HAPPENS AFTER THE REPORT IS MADE?

- The report is screened to determine if the allegation meets the statutory definition of abuse and neglect and if the report falls within the scope of DHS' responsibility. If the alleged abuse is perpetrated by someone other than a caretaker, DHS is required to forward the report to law enforcement. DHS is mandated to investigate or conduct assessments regarding allegations of abuse or neglect by a parent or caretaker. DHS established the following timeframes to determine the urgency of the response.

WHAT HAPPENS AFTER THE REPORT IS MADE?

- Priority One - The report indicates the child is in present danger. The situation is responded to immediately the same day the report is received.
- Priority Two - The response time is based on the child's vulnerability and risk of harm. A report designated as an investigation is responded to in a shorter time period than an assessment. An investigation is initiated in no more than five-calendar days from acceptance, unless a special circumstance exists that prevents the initiation. An assessment is initiated in no more than ten-calendar days from acceptance.

WHAT HAPPENS WHEN AN INVESTIGATION IS ASSIGNED?

A child protective services (CPS) investigation is conducted when the allegations in the report indicate there is serious abuse or neglect resulting in an immediate safety threat to a child. An investigation is accepted and assigned by the two different priorities.

After a report is accepted for investigation, as much information as possible is gathered about the reported allegations and family dynamics that jeopardize the child's safety and the protective capacity of the family is assessed.

WHAT HAPPENS WHEN AN INVESTIGATION IS ASSIGNED?

- All reports are submitted to the District Attorney's office upon completion. When the child or children are deemed unsafe, a safety plan can be implemented to control the safety threats or court action may be recommended. DHS can submit a request to the District Attorney's office for the court to order removal of the child or children from the home. They can also be placed in protective custody by the police. DHS staff does not have the authority to remove a child from their home.

- During the investigation, each alleged child victim is seen or interviewed first, followed by each sibling, each family member responsible for the child's health, safety, or welfare, the alleged perpetrator, and other persons with information. The CPS investigation determines the findings and identifies if child abuse or neglect is:
    - Ruled Out;
    - Unsubstantiated; or
    - Substantiated

WHAT HAPPENS IF AN ASSESSMENT IS ASSIGNED?

- A CPS assessment means a comprehensive review of child safety and an evaluation of family functioning and protective capacities conducted in response to a child abuse or neglect referral that does not allege a serious and immediate safety threat to a child. A CPS assessment is conducted when the report concerns abuse or neglect that is not serious or extremely dangerous. A report assigned as an assessment is responded to in 10-calendar days or less after acceptance. No findings are made on CPS assessments.

ARE SOME REPORTS OF SUSPECTED ABUSE NOT ASSIGNED BY DHS?

- Yes, there are situations that do not meet the legislative mandate for a DHS investigation. Usually, this is because:
    - insufficient information was provided to locate the family and child;
    - the report does not meet the legal definition of abuse and neglect; or
    - the alleged perpetrator is a person other than a parent or caretaker, such as a neighbor or teacher.
- Examples of screened-out reports may include: adolescents with behavioral problems, such as delinquency or truancy, which is not related to abuse or neglect; parent/child conflicts where no abuse or neglect is occurring; or overreactions to poor parenting practices.

WHAT INFORMATION SHOULD THE REPORTER EXPECT FROM DHS AFTER A REPORT IS MADE?

- After a report is made, the reporter may obtain information on the report's status, which may include whether the case was investigated, assessed, or screened out. When the report was screened out, reporters may be informed of the reason for this decision. When the report was accepted for investigation or assessment, reporters may be told the investigation's finding or that the assessment was concluded. Investigation findings and concluded assessments are forwarded to the District Attorney's office in accordance with Oklahoma law. Reporters are not, however, entitled to investigation or assessment details. Anonymous reporters are not entitled to receive information on the status of the report since child welfare has no way of verifying their identity.

WHAT INFORMATION SHOULD THE REPORTER EXPECT FROM DHS AFTER A REPORT IS MADE?

- If you are unsatisfied with the way an investigation was handled, you can provide critical feedback through the supervised structure of an investigating agency. Within DHS, first contact the child welfare supervisor on the investigation. If you are still unsatisfied, proceed through the chain of command to the district director and the regional deputy director.

THE DIFFERENCE BETWEEN ABUSE AND DISCIPLINE

For children to grow up and become productive membersof society subject to society's norms, values, and rules, all children need discipline. Discipline is a learning process designed to teach appropriate behaviors. Unlike discipline, abuse is not a learning process. Abuse inflicts pain to stop behavior. It does notteach alternative, correct behavior. Therefore, abused children do not learn correct behavior. They learn to avoid punishment.

The intent of the reporting law is not to interfere withappropriate parental discipline, but to respond to extreme or inappropriate parental actions. Actions that are excessive or forceful enough to leave injuries or cause damage to the psyche are considered abusive.

GUIDELINES FOR CHILDREN LEFT ALONE

- In Oklahoma, there are no statutory or public policy requirements regarding the age a child must be in order to be left alone. The safety and well-being of children is considered to be a parental responsibility. It is a parental decision to determine if a child, six years of age and older, is mature enough to care for himself or herself in anadult's absence.

CONSIDERATIONS WHEN LEAVING A CHILD ALONE

Does the child have the maturity to be left alone regardless of the child's age?
How long will the child be left alone?
Will the child be alone during the day or at night?
Is the surrounding neighborhood safe?
Is there immediate access to an adult?
Does the child have the knowledge to know what to do in an emergency?
Is the child caring for other children?
Does the child know how to use household appliances properly?
Are other children visiting the home?
Does the child know the parents' whereabouts at all times?
Is the child comfortable being left alone?

RECOMMENDED GUIDELINES FOR PARENTAL DECISION MAKING

Preschool/Kindergarten

Infants and children under six years of age should never be left alone without adult supervision.

Grade School

In general, a grade school child, who demonstrates the ability to be responsible and mature, may be left alone one to two hours during the day with access to a responsible adult and no responsibility for caring for younger children.

Middle School

In general, a middle school child, who demonstrates the ability to be self-sufficient, may be left alone for up to four hours during the day and evening. The child may care for one to two younger children, if there is constant access to a responsible adult.

CPS RESPONSE TO REPORT OF CHILDREN LEFT ALONE

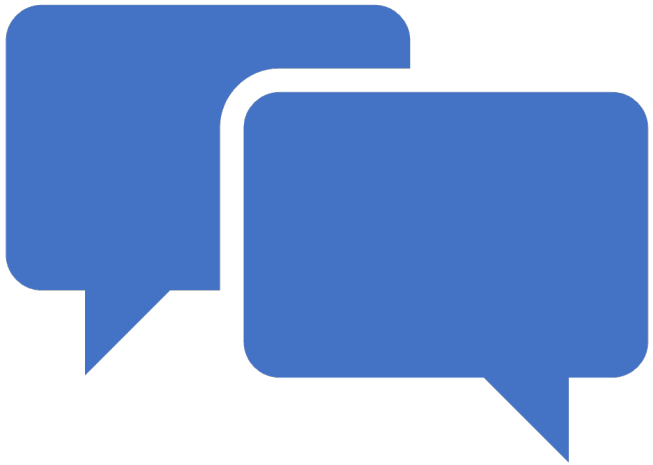
- The focus of DHS Child Welfare Services is to respond to situations where children are reported to be unsafe or at the risk of harm. Action is contingent upon the child's age and the degree of danger.

- DHS staff cannot remove children from their home; however, if it is determined that the child cannot take care of himself or herself and there is no responsible adult available, the child may be placed into police protective custody.

TEAM TOPICS

COMMUNICATION WITH THE TEAM- YOU ARE A PART OF THE CARE TEAM

- Effective communication within a healthcare team is crucial for patient safety, quality of care, and a positive patient experience. Clear, concise, and open communication among team members, fosters collaboration, reduces errors, and promotes better outcomes.



KEY ASPECTS OF EFFECTIVE COMMUNICATION IN HEALTHCARE

Active Listening

- Pay close attention to what others are saying, ask clarifying questions, and repeat the information back to ensure understanding.

Clear and Concise Language

- It is ok to use simple language when communicating with the care team. You are not expected to know the medical terminology. Describe and explain to the best of your ability the situation or care you are providing. (example: when describing a heart rate, it is ok not to use tachycardia or bradycardia but rather describe it as a fast heart rate or slow heart rate)

Open and Honest Communication

- Do not be scared to speak up and address concerns openly. It is ok if you do not understand something or something sounds wrong, question what is being asked.

Collaboration and Shared Decision-Making

- Involve all relevant team members in planning and care. Seek input from those around you.

KEY ASPECTS OF EFFECTIVE COMMUNICATION IN HEALTHCARE

Documentation

- Maintain clear and accurate records of communication with the care team, changes made to the plan of care (verbal orders or written orders) and of the care you provide.

Active Participation

- Ask questions, voice concerns, express what does or does not work for your family member when it comes to their care. Remember you are their advocate.

Verbal and Nonverbal Communication

- Be mindful of both what you say and how you say it and be aware of nonverbal cues like body language.

Respectful Communication

- Communicate with respect, empathy, and compassion.

BENEFITS OF ACTIVE COMMUNICATION

- Improved Safety:
  - Clear communication reduces the risk of errors and adverse events.
- Enhanced Experience:
  - You and your family will feel supported with effective communication throughout the care team.
- Better Outcomes:
  - Effective communication can lead to faster recovery, reduced hospital stays, and improved quality of life for your family member.
- Increased Team Morale and Job Satisfaction:
  - Open communication creates a more positive and collaborative work environment.
- Reduced Conflicts and Misunderstandings:
  - Clear communication helps prevent misunderstandings and conflicts within the team.
- Document all communication:
  - Keep a record of discussions, decisions, and actions taken by the team.

SELF-CARE FOR THE CAREGIVER

- As a caregiver, prioritizing self-care is crucial. Caregiver burnout is a real and serious issue. Taking care of someone else can be deeply rewarding, but also emotionally, mentally, and physically draining.

SELF-CARE STRATEGIES TO HELP PREVENT BURNOUT

- Prioritize Your Own Health
- Sleep: Aim for 7–9 hours of quality sleep.
- Nutrition: Eat balanced meals; don't skip them.
- Exercise: Even 15–30 minutes a day (walking, stretching) can reduce stress and boost energy.
- Set Boundaries
  - Know your limits. It's okay to say no to family and friends.
  - Don't feel guilty about taking breaks or needing help.
- Take Regular Breaks
  - Schedule downtime, even if it's just 10 minutes to step outside or breathe deeply. While working as a Paid Family Caregiver, please follow the agency's policy for breaks.
- Stay Socially Connected
  - Maintain friendships and social activities.
  - Join a support group (in-person or online) for caregivers.
  - Disconnect from Toxic social forums.

SELF-CARE STRATEGIES TO HELP PREVENT BURNOUT

- Ask for and Accept Help
- Create a list of specific tasks others can help with
    - o Meals
    - o Errands
    - o Household Chores
- Don’t wait until you’re overwhelmed to ask.

- Practice Mindfulness or Stress-Reduction Techniques
    - Meditation
    - Yoga
    - Deep breathing
    - Journaling
    - Prayer
    - There are a lot of different ways to practice mindfulness or stress reducing techniques, find what works for you.

SELF-CARE STRATEGIES TO HELP PREVENT BURNOUT

Don’t Neglect Your Own Passions

Carve out time for hobbies or activities that bring you joy and make you feel like yourself.

Talk to a Professional

A therapist or counselor can help you process emotions and cope with stress in healthy ways.

WHEN TO REPORT SYMPTOMS TO THE CASE MANAGER/AGENCY

- Caregivers should report to their Agency any changes in a client's condition, including those reported during doctor's appointments, as soon as they become aware of them. This includes both positive and negative changes, especially if the changes indicate a decline in the client's health or safety.
- Importance of Reporting:
- Reporting changes promptly allows the Agency and Care Team to adjust the care plan, potentially preventing further complications or ensuring the client receives appropriate support.

EXAMPLES OF REPORTABLE CHANGES:

Any new symptoms or worsening of existing symptoms.
Changes in functional abilities
Mental instability, such as confusion, agitation, or changes in behavior.
Bruises, injuries, or signs of abuse or neglect.
Changes in eating or sleeping habits.

- Changes in bathroom habits.
- Unusual complaints of pain.
- Any emergency, crime, or dangerous situation.
- Changes or problems in housing, household make-up, or caregiver arrangements.

WHEN TO REPORT SYMPTOMS TO THE CASE MANAGER/AGENCY

- Reporting to the Right Person:
  - Caregivers should follow their agency's process for reporting changes.
- Documentation:
  - It's important to document all reported changes in shift notes or other relevant records.
- Agency Responsibilities:
  - Agencies are responsible for ensuring their staff are properly trained to report changes in condition and that they have a clear reporting process in place.

NEED TO FOLLOW UP ON APPOINTMENTS/PLANS OF CARE

- A caregiver should follow up on appointments and plan of care immediately after the doctor's visit or when a new plan of care is submitted and then consistently throughout the caregiving period.

KEY FOLLOW-UP ACTIVITIES

- Immediately After Appointments:
  - Review notes: Ensure understanding of all instructions and recommendations.
  - Update calendar: Add follow-up appointments and tests to keep track of future needs.
  - Discuss appointments with the agency: Share the visit's outcomes and any changes to the care plan.
- Regularly Throughout the Caregiving Period:
  - Follow up on test results: Ensure results are obtained and discussed with the provider.
  - Monitor symptoms and medications: Keep a notebook to track changes in health and medications.
  - Discuss concerns with the provider: Regularly communicate any questions or worries about the care recipient's health.
  - Update the care plan: Revise the care plan annually or more frequently as needed based on changes in health or medications.

DOCUMENTATION

DOCUMENTATION

- Documenting health notes effectively is crucial for maintaining accurate medical records and ensuring continuity of care. Here are some best practices:
  - Be Clear: Keep notes straightforward.
  - Be Accurate: Double-check entries for correctness, including patient details and medical history.
  - Use Standard Formats: Common formats include SOAP (Subjective, Objective, Assessment, Plan) and DAP (Data, Assessment, Plan).
  - Document in Real Time: Writing notes immediately after a patient interaction helps maintain accuracy.
  - Ensure Confidentiality: Follow HIPAA guidelines to protect patient information.

WHAT DO I DOCUMENT?

1.Medications.

a. Times given

b. All medications

c. Any times there is a as needed medication provided.

i. Why was it given?

ii. After it was given – did it help?

iii. Reporting medication errors – according to the agency's policy

d. Did the child have any reactions to the medication.

e. Treatments like nebulizers & chest physiotherapy.

i. Any time that this is administered – was there wheezing, coughing, or nasal flaring?

ii. The time given, and then afterwards, did it work?

iii. What does the child look like & sound like, and oxygen saturation level.

iv. Any tracheostomy care – like changing trach ties (if you are approved to provide the treatment).

WHAT DO I DOCUMENT?

v. Suctioning –

1. What time?
2. Was there mucous suctioned?
3. Did it help the child breathe better?
4. Was it deep suctioning, or suctioning the mouth only, or the nose?

f. What do I document about AFOs or braces?

i. If the child's skin looked intact before you apply the braces

ii. The time that the AFOs or braces are put on.

iii. The time that the AFOs or braces are removed.

iv. Any irritability with the child when the AFOs or braces are put on.

v. Once you take off the AFOs or braces what does the child's skin look like?

vi. Are there any red spots or blisters?

vii. Or is the skin soft and no marks or blisters?

WHAT DO I DOCUMENT?

g. Standers

i. Time child was placed in the stander

ii. Time taken out of the stander.

iii. Are there any red spots or blisters?

iv. Or is the skin soft and no marks or blisters?

v. Child's behavior during the time in the stander.

2. Feeding activities –

a. When do feedings start?

b. When do feedings stop?

c. Was it difficult to feed the child?

d. Did they gag?

e. If the child is tube fed, did you have to slow the feeding?

f. Were there any residual formula/contents in the stomach before you started the next feeding? How much was it?

WHAT DO I DOCUMENT?

3. What do I document when my child has a seizure or seizure like activity?
    a. The time the seizure activity started.
    b. The time the seizure stopped.
    c. Any symptoms like jerking or eye rolling that you saw during the seizure. Medical terms do not matter, it is the description and what you did, that matters.
    d. Did you have to give any rescue medications?
    e. Anything that the provider specifically ordered concerning the child's seizure.

If you notice an increase in the number of seizures, you may need to call the Nurse Case Manager with the home health agency and the doctor's office for the child to be seen or for the child to have medication adjustments.

WHAT DO I DOCUMENT?

4. Skin Care
    a. Times you changed the bedding and pads.
    b. Times you change the undergarments.
        i. Was it urine (pee)?
            1. Did it have a bad odor?
            2. Is the child fussy when they urinate?
        ii. Was it poop?
            1. Was the poop runny or formed?
            2. Is there an increased frequency of stools?
            3. If a member is on TPN, they will have an increased number of stools, and it is typically acidic stool.
            4. Taking care of these children's skin and frequent skin/undergarment care is essential & this should be documented.

WHAT DO I DOCUMENT?

c. Skin breakdown

i. What does the skin look like - red, getting bigger (it is okay to measure it),

ii. Treatments applied, placing positioners, like hand rolls/grips to prevent contracted hands, or pillows for legs/knees.

d. Ostomy care - What does the site look like?

i. When you change the bag.

ii. Any ointments or medications applied.

iii. If the skin around the site looks red or inflamed or different than it has been, it is important to let the RN Case Manager know this. This may need to be called into the provider.

HOME SAFETY – EMERGENCY PLAN

Written plan

- What type of emergencies could happen?
  - Power outage, fire, tornado, medical emergency, etc.
- Where are the closest first responders and hospital in case of medical emergency?
  - Inform local fire department and EMSA providers that individual with special health care needs present in advance of emergency
- How will I receive emergency alerts and warnings?
  - TV, radio, cell phone
- What is my shelter plan?
  - Is it safe to remain in the home, and if so where is the safest location in the home?
  - What types of supplies would be needed if needed to shelter for prolonged period?
    - Food, water
    - Fully stocked emergency kit including medications, formula and supplies (oxygen, trachs, GT, etc.)
    - Generator if equipment such as ventilator is needed
- What is my evacuation route?
  - Where will we go if we are unable to remain in the home?
    - Family or friends house, hospital, designated shelter?
  - Are any special vehicles or supplies needed to safely transport the child?
  - Make sure everyone in the home knows where the emergency bag is in case need to leave quickly
  - Are there any specific designated evacuation routes?

Diet

WIC or Formula Plan	
WIC Office in Your County:	Phone:

Outpatient Therapy (Physical, Occupational, Speech)	
Company Name:	Phone:
Address:	Fax:
Comments:	
Company Name:	Phone:
Address:	Fax:
Comments:	
Company Name: Phone:	
Address:	
Comments:	

Follow-up Appointments		
Primary Care Provider (PCP):	Address:	Phone:
Date/Time:		Fax:
Special Instructions:		
Specialty:	Address:	Phone: After hours:
Date/Time:		Fax:
Special Instructions:		
Specialty:	Address:	Phone:
Date/Time:		Fax:
Reason for consult:		
Specialty:	Address:	Phone:
Date/Time:		Fax:
Reason for consult:		
Specialty:	Address:	Phone:

Discharge Plan for:

Oklahoma Children's Hospital Heart Center OU Health

Demographics		
Date of Birth:	Admit Date:	Allergies: no known allergies
Diagnosis:	Interventions/Surgeries:	

Discharging Pharmacy		
The Children's Hospital - Pharmacy 1200 N Children's Ave., Suite 2A	Phone: 405.271.2156	Fax: 405.271.2158

Medications		

Medical Equipment & Supplies (DME)	
Company Name: Case Manager:	Phone:
Product: Oxygen setup, pulse oximeter, trach supplies, portable suction, nebulizer, GT supplies, feeding pump, formula.	Fax:
OCH Inpatient Case Manager: Ashley She set up your DME in the hospital. Call her with questions.	Phone:

SAFETY

Medical information

- Paper copy and virtual copy

WHEELCHAIR SAFETY

What do I need to know about my child's wheelchair?

If your child has a custom wheelchair, check the owner's manual for specific information. Many wheelchairs have these features:

- 2 wheel locks with handles near each wheel. When locked, they prevent the chair from moving. Do not apply wheel locks while the wheelchair is moving.
- A seatbelt to help keep your child in place and prevent them from falling out of the chair.
- 1 or 2 footrests to support your child's feet.
- A cushion to help increase comfort, improve posture and protect the skin over the sitting bones.
- Other types of support to position and keep your child in place, such as lateral trunk supports. Lateral trunk supports may or may not swing out of the way. They help keep your child upright and straight in the chair.

Your child's wheelchair may have other features to meet your child's needs. It may tilt, or it may be a power wheelchair.

To help keep the wheelchair in good condition:

- Know the vendor name and phone number. Most often, this is on a sticker on your child's wheelchair.
- Make sure your child's chair has routine care to help keep it in good repair and prevent accidents.
- Call the vendor at least every 4 to 6 months to see if the wheelchair needs any repairs or if your child has grown.

How do I prepare for a safe transfer?

Your child's therapist can teach you how to safely transfer your child. Some guidelines include:

- Put the wheelchair close to your child. Place the chair so that it makes it easy for you to pivot or rotate your child into the chair. Be sure the area is clear, safe and free from clutter.
- Lock the wheel locks on the wheelchair.
- If your child is in a hospital bed, make sure the bed brake is locked.
- Remove the footrests from the wheelchair or swing them fully away.
- Remove or flip up the armrest. Do this on at least 1 side closest to the bed or surface where you are moving your child.
- Unbuckle the seatbelt.
- Make sure the cushion is secure and in the right place.
- Think about a plan for how you will move your child. Have an extra person nearby if needed.
- It is best to use a gait belt for extra safety. This is a special belt that goes around your child's waist.
- Ask for help if your child has lines or tubes connected to them or if your child is too big for you to safely lift by yourself.

WHEELCHAIR SAFETY

How do I transfer my child safely?

Your child's doctor will give you specific instructions about how much your child can help with the transfer. This may depend on how much weight your child can put on their arms or legs.

Your therapist can teach you how to move your child safely with or without special equipment. Some guidelines include:

- Have your child move to the edge of the bed or chair. Get as close to them as possible. If your child can help you with the transfer, remind them what you need them to do.
- Place 1 of your feet and that knee between your child's legs. Or, stand so that your toes are up against your child's toes (toe to toe).
- Bend at your hips and knees. Keep your back straight.
- Lift your child by holding them at their waist or crossed arms. Do not pull on their arms or have them reach around your neck to help. Your therapist may also give you a gait belt to use.
- Lift your child all the way before turning. Do not twist your body while lifting.
- Use slow, controlled movements.
- Be prepared to lift your child fully in case they cannot help you. If you need help to safely transfer your child, have an extra person nearby. Tell them what you need them to do ahead of time.

Once your child is in the wheelchair, make sure they are as safe as possible:

- Make sure they sit up straight with their bottom as far back in the seat as possible.
- Buckle the seatbelt. Make sure it fits snuggly at their hips to help prevent them from sliding.
- Attach and secure any straps, headrests, armrests and footrests that help hold them in place.
- Place their things in a bag on the back of the chair. Avoid placing too many things in their lap.
- Make sure to keep breathing equipment that may be needed in the area. This is so you can get to it quickly in case of emergency.
- If your child has a weaker side, it may be easier for them to help if you move them towards the stronger side.

Other tips include:

- Help your child change their position at least every 30 minutes to make sure they do not have any pressure areas and their skin stays protected. You may use a timer to help with this.
- Put your hand on their chest when going downhill. You can also wheel the chair down the hill backwards if the hill is steep.
- Make sure tip bars are in place to prevent the wheelchair from tipping backwards. This is important when going up a hill or curb.
- Plan where you are going ahead of time when possible. Use ramps if available.

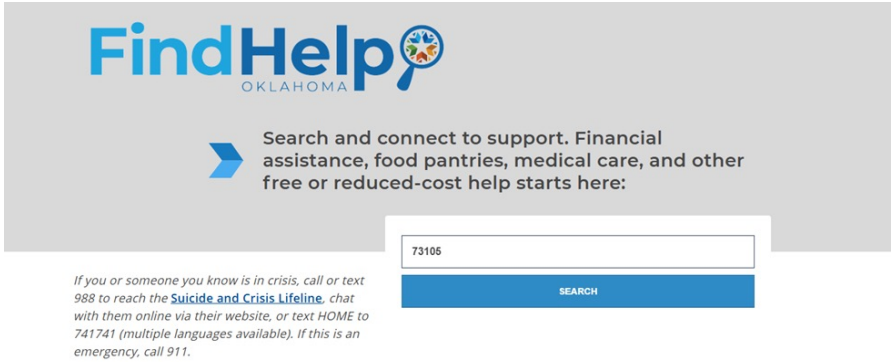
CAR SEAT SAFETY

- It is important to ensure that all individuals are buckled appropriately and that all height and weight regulations are followed to ensure safety.
- SAFE KIDS Oklahoma has locations including Bethany Children's which can provide discounted car seats and ensure car seats are installed correctly.
- Many children with special needs can travel in conventional car seats with specific modifications based on the child. Needed modifications should be discussed with the individual's physician, rehab therapists or a car seat specialist.
- As children outgrow conventional car seat and need long term adaptive car seats, families can work with their rehab therapists to find and order an appropriate seating device.
- Some children who are unable to follow safety instructions may require prolonged used of a 5 point harness or safety vests to prevent unbuckling while car is in use.
- Some children may require temporary adaptive car seats including those with omphaloceles and those requiring hip, thigh or spine casting. Physicians and rehab therapists should discuss these situations with families prior to discharge.

SOCIAL DETERMINANTS OF HEALTH

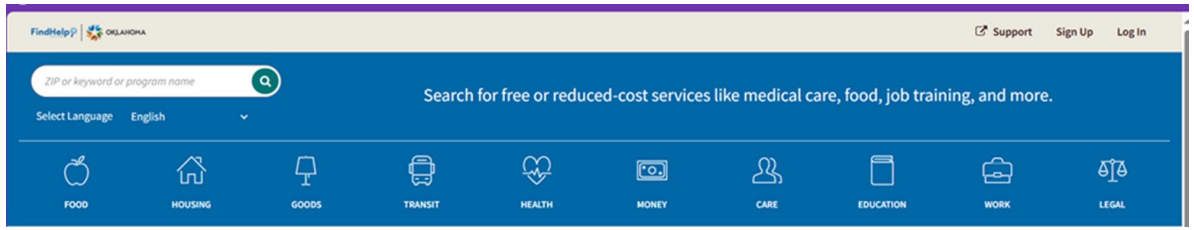
COMMUNITY RESOURCES & FIND HELP

- To find resource help of many kinds, select the link: Findhelp or type in Findhelp.ok.gov in the search engine.
- It will take you to a page that looks like this:



FIND HELP

- You can put in your zip code and the site directs you to resources available to you in your area in the following areas:



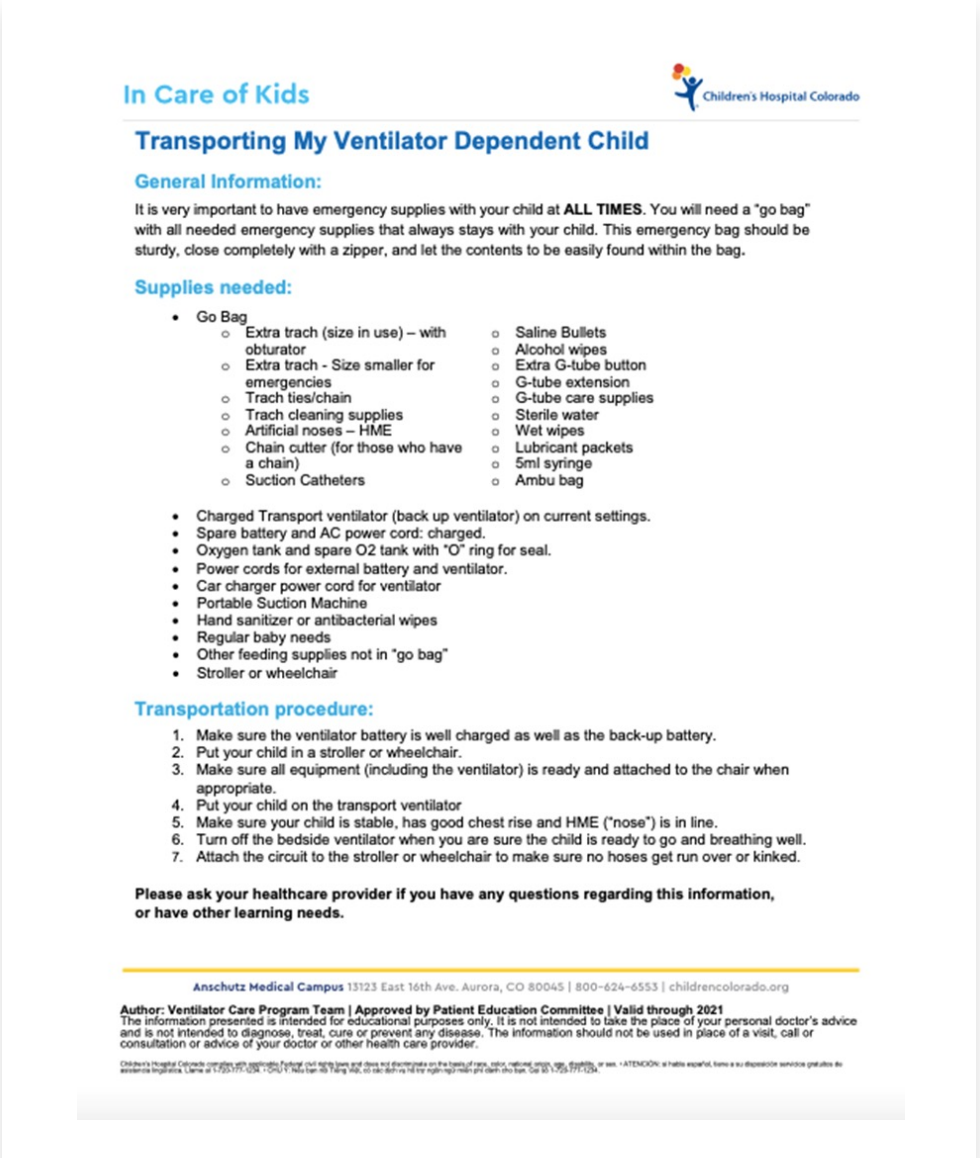
COMMUNITY RESOURCES

OHCA does have Social Service Coordinators:

- Social Coordinators assist with community-based service referrals such as support groups, food banks and utility assistance.
- Social Service Coordinators review and coordinate requests related to meals and lodging for the distant care services described above.
- More information about the above services can be obtained by calling Population Care Management and asking for a Social Service Coordinator's help, Monday through Friday, 8:00 a.m. to 5:00 p.m. at 877-252-6002.

TRAVEL OUTSIDE OF THE HOME

- Have a master list of needed equipment prepared in advance.
- Have a pre-packed go bag with all basic and emergency supplies that may be needed.
- Make sure all equipment is charged and that bring power cords.
- Plan how you will carry equipment in advance.
- Be prepared for emergencies.
- Bring emergency information.



In Care of Kids

Children's Hospital Colorado

Transporting My Ventilator Dependent Child

General Information:

It is very important to have emergency supplies with your child at **ALL TIMES**. You will need a "go bag" with all needed emergency supplies that always stays with your child. This emergency bag should be sturdy, close completely with a zipper, and let the contents to be easily found within the bag.

Supplies needed:

- Go Bag
  - Extra trach (size in use) – with obturator
  - Extra trach - Size smaller for emergencies
  - Trach ties/chain
  - Trach cleaning supplies
  - Artificial noses – HME
  - Chain cutter (for those who have a chain)
  - Suction Catheters
  - Saline Bullets
  - Alcohol wipes
  - Extra G-tube button
  - G-tube extension
  - G-tube care supplies
  - Sterile water
  - Wet wipes
  - Lubricant packets
  - 5ml syringe
  - Ambu bag
- Charged Transport ventilator (back up ventilator) on current settings.
- Spare battery and AC power cord: charged.
- Oxygen tank and spare O2 tank with "O" ring for seal.
- Power cords for external battery and ventilator.
- Car charger power cord for ventilator
- Portable Suction Machine
- Hand sanitizer or antibacterial wipes
- Regular baby needs
- Other feeding supplies not in "go bag"
- Stroller or wheelchair

Transportation procedure:

1. Make sure the ventilator battery is well charged as well as the back-up battery.
2. Put your child in a stroller or wheelchair.
3. Make sure all equipment (including the ventilator) is ready and attached to the chair when appropriate.
4. Put your child on the transport ventilator
5. Make sure your child is stable, has good chest rise and HME ("nose") is in line.
6. Turn off the bedside ventilator when you are sure the child is ready to go and breathing well.
7. Attach the circuit to the stroller or wheelchair to make sure no hoses get run over or kinked.

Please ask your healthcare provider if you have any questions regarding this information, or have other learning needs.

Anschutz Medical Campus 13123 East 16th Ave. Aurora, CO 80045 | 800-624-6553 | childrencolorado.org

Author: Ventilator Care Program Team | Approved by Patient Education Committee | Valid through 2021

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767