Job Description/Performance Evaluation

Title: Personal Care Attendant

Job Summary:
Primary functions: provide personal assistance and/or health-related services to patients/clients in their place of residence; provide a safe and clean environment; work cooperatively with the patient/client and family; and report observations and problems to the Supervisor.

Reporting Responsibility: Bienestar Care Services - Liz Martinez (per Agency)

Job Qualifications:

Education:	If under 18 years of age, must be either a high school graduate or enrolled in a vocational education program
Licensure:	Must have current driver's license or reliable transportation to travel to assignments
Experience:	If at least 18 years of age, have proof of competency through education and/or experience or demonstrate competency to perform tasks as assigned. If under age 18, must successfully demonstrate competency to perform tasks assigned.
Skills:	Must be able to follow written and verbal instructions and be competent to perform tasks assigned by supervisor. Demonstrates interest in the welfare of those who are elderly and/or disabled. Must successfully complete a Competency Evaluation Skills Checklist and pass a written Skills Test as required if performing G-Tube feedings.
Background Checks:	Must agree to and pass a criminal history check and an Employee Misconduct Registry check.

Environmental and Working Conditions:
Works in client's residence in various conditions; possible exposure to blood, body fluids and infectious diseases; must have the ability to work a flexible schedule and travel locally; some exposure to unpleasant weather.

Physical and Mental Effort:
Prolonged standing and walking required. Must have the ability to lift up to 50 pounds and move clients. Requires working under some stressful conditions to meet deadlines, to identify client needs, to make quick decisions and to meet client and family psychosocial needs. Requires hand-eye coordination and manual dexterity. Must have the ability to use durable medical equipment in the home.

Essential Functions:	**Evaluation:**
Promote positive, supportive, and respectful communication to the client and family and Agency personnel	
Provide an environment that promotes respect for the client's privacy and property	
Provide personal assistance or health-related tasks to client according to the Individualized Service Plan	
Appropriately report changes to ensure continuity of care	
Practice accepted infection control principles	
Provide a clean, safe, and comfortable environment	
Utilize skills necessary to perform services according to the Agency's policy	
Contribute to the management and efficient operation of the Agency and demonstrate effective time management skills	
Demonstrate commitment, professional growth and competency by attending required in-services	
Promote the Agency's philosophy and administrative policies to ensure quality of care	

Statement of Understanding:
I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I will adhere to Agency compliance with laws and regulations in a professional manner. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Signature: _____ **Date:** _____

Evaluation Codes:
1 – Does not meet job requirements/expectations **2** – Occasionally meets job requirements **3** – Normally meets job requirements
4 – Meets and occasionally exceeds job requirements **5** – Regularly exceeds job requirements

Comments/Goals: _____

_____

Use back for additional comments/goals.

Signature: _____ **Date:** _____

Evaluator/Title: _____ **Date:** _____

Statement of Understanding:
I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I will adhere to Agency compliance with laws and regulations in a professional manner. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Signature: _____ **Date:** _____

Evaluation Codes:
1 – Does not meet job requirements/expectations **2** – Occasionally meets job requirements **3** – Normally meets job requirements
4 – Meets and occasionally exceeds job requirements **5** – Regularly exceeds job requirements

Comments/Goals: _____

_____

Use back for additional comments/goals.

Signature: _____ **Date:** _____

Evaluator/Title: _____ **Date:** _____

VERBAL ORIENTATION CHECK LIST

INFORMATION RECEIVED	YES	NO	N/A
Criminal history check	X		
Release of employment information	X		
Workers' compensation information	X		
Employee Handbook	X		
Abuse, Neglect and Exploitation	X		
Solicitation	X		
Rights of the Elderly	X		
HIV/AIDS	X		
Hepatitis B	X		
Tuberculosis	X		
Drug Policy	X		
Body Mechanics	X		
Emergency Preparedness Plan	X		

I have received, read and understand policies and procedures given to me. I have received, read and understand additional material provided including my job description, and modified self-study materials. I agree to have any questions clarified. I understand and agree to follow these policies, procedures and guidelines.

Print Name: _____

Signature: _____ Date: _____

I confirm that the employee named above has received all materials indicated, has had questions answered and is competent to provide services to patients/clients.
The employee has received a score of _____ on all quizzes pertaining to his/her orientation.

Agency Representative Print Name: _____

Agency Representative Signature: _____

Date: _____

TB Fact Sheet/Risk and Symptom Screening

Tuberculosis (TB)

Tuberculosis (TB), caused by the *Mycobacterium tuberculosis* complex, is transmitted by the inhalation of infectious aerosol droplets created when a person with active pulmonary TB coughs, sneezes, or shouts. A person may have no symptoms (asymptomatic), but still have latent TB infection that may develop into active TB at some point. After exposure, TB skin tests may become positive within two to twelve weeks.

Risk Factors

Check any of the following risk factors that apply:

Groups with a higher risk of exposure and infection*

- ☐ Low income / medically underserved populations
- ☐ Residents or employees of congregate living facilities (e.g., homeless shelters, long-term care facilities, correctional facilities)
- ☐ Infants, children, or adolescents who are exposed to adults in high-risk categories
- ☐ Foreign-born persons, recently arrived (within five years) from areas with a high incidence of TB, such as Asia, Africa, eastern Europe, and Latin America and Russia, or those who frequently travel to areas with a high incidence of TB
- ☐ Close contact with individuals with pulmonary TB, persons who inject illicit drugs, or other locally identified high risk substance users (e.g., cocaine users)

*Flexibility is needed in defining local high priority groups for screening

Groups with a greater risk to profess from latent TB infection to active disease

- ☐ Individuals with HIV/AIDS, silicosis, diabetes, chronic renal failure, more than 10% below normal body weight, hematologic disorders (e.g., leukemias and lymphomas), and other specific malignancies (e.g., carcinoma of the head or neck)
- ☐ Those receiving certain medical treatments that may increase risks, such as prolonged corticosteroid use, other immunosuppressive treatments, bone marrow or organ transplant, intestinal bypass, or gastrectomy
- ☐ Persons with a history of untreated or inadequately treated TB disease

Signs and Symptoms of TB Disease in the Lungs*

Check if you have any of the following symptoms:

- ☐ Sweating at night
- ☐ Unexplained weight loss
- ☐ Loss of appetite
- ☐ A bad cough lasting more than three weeks
- ☐ Coughing up blood or sputum (phlegm from deep inside the lungs)
- ☐ Chills
- ☐ Fever
- ☐ Weakness or fatigue
- ☐ Chest pain

*Symptoms of TB disease in other parts of the body depend on the area affected

- ☐ I am not experiencing any of the above symptoms
- ☐ None of the above risk factors apply to me

I understand if I am experiencing any of the above symptoms, follow-up will be required. Additionally, I understand if I have any of the above symptoms at any time in the future, I am to report to management immediately and follow-up will be required at that time.

Signature: _____ Date: _____

Hepatitis B Vaccination

Due to occupational exposure to blood or other potentially infectious materials, employees may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available to employees at no cost. Please indicate below acceptance or declination to receive the vaccine.

Hepatitis B is a bloodborne virus which can cause a range of symptoms from mild to serious, and possibly result in fatal liver damage to those who become infected. The virus can be transmitted through contact with infectious fluids of a person who has the hepatitis B virus. The Agency teaches the concepts of standard precautions concerning safe client care and the use of PPE to avoid unnecessary exposure.

The synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals over a six-month period. It has proven to be 80-90% effective in protecting against contracting the disease. There may be hypersensitivity to the vaccine, and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of under 3% of injections.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast, or the hepatitis antigen, and will only be given with a personal physician's recommendation in the cases of pregnancy or the presence of other infections of an immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

Acceptance: I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the hepatitis B vaccine.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Declination: ☐ I have been given the opportunity to be vaccinated for hepatitis B at no charge. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material and decide I want to be vaccinated with hepatitis B vaccine, I may receive the vaccination series at no charge to me.

☐ I have already received the hepatitis B vaccine series at an earlier date. Select one:

☐ I will be providing a copy of the record to the Agency.

☐ I will NOT be providing a copy of the record to the Agency.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Confidentiality of Client Information

- I plan to utilize electronic documentation of client care.
- I will ensure confidentiality and security of client information by password protecting the device or program utilized.
- I agree to change the password at least quarterly or following a breach of security.
- I will not provide my password to anyone.
- I will use an electronic signature, if acceptable to payor source. Authentication will be available if requested by the Agency.
- I have been informed of the Agency's Medical Record Information Confidentiality Policy and Safeguarding Medical Record Content Policy, and I agree to abide by these policies.

_____

Printed Name

_____ _____

Signature Date

CONFIDENTIALITY/CONFLICT OF INTEREST DISCLOSURE STATEMENT

CONFIDENTIALITY/NON-DISCLOSURE OF COMPANY OR CLIENT INFORMATION:

Access to any confidential or proprietary information will be limited to the minimum required for the performance of duties as relates to each individual=s job. Any confidential information created, received, maintained, used, disclosed, accessed, or transmitted in the performance of job duties will be maintained and protected from unauthorized disclosure.

The Health Information Portability and Accountability Act (HIPAA) ensures the client=s right to privacy of Protected Health Information to be maintained at all times. Any information related to the care of clients through this Agency will be held as confidential. All information, written or verbal, will be disclosed only to appropriate health care personnel, appropriate staff, those with a Aneed to know basis@, or to individuals the client requests.

CONFLICT OF INTEREST DISCLOSURE STATEMENT:

I acknowledge I have read the policy and procedure regarding conflict of interest and the procedure for disclosure. I understand that if I have an outside relationship that is personal, professional, or otherwise, with a client, vendor, or potential business associate, I must disclose the nature of that relationship to my supervisor, or Administrator as soon as the relationship is established. I also understand that I forfeit any voting privileges, decision making capacity, and input from any activities associated with said relationship.

☒ I have no conflict of interest to report.

☐ I, as a staff member or a Governing Body member, am providing the following disclosure of potential conflict of interest:

_____

_____

_____

Printed Name

_____ _____

Signature Date

Reported conflict of interest reviewed by the Governing Body with the following decision(s) made:

_____

_____

_____ _____

Governing Body Member Signature Date

Personal Protective Equipment (PPE) Competency Checklist

Last Name, First:	Job Title: Attendant
Evaluator:	Date:
Type of Validation: ☒ Orientation ☐ Annual/Periodic Review ☐ Other:	

Donning and Doffing of Personal Protective Equipment (PPE)			
Skills	**Competency**		
	YES	**NO**	**Comments**
Identifies the proper PPE to gather and verbalizes all appropriate PPE is available at point of use.	X		
Verbalizes proper steps in examining PPE for defects.	X		
(PPE should ideally be put on outside of the home prior to entry. If unable to put on all PPE outside of the home, it is preferred that face protection (i.e., respirator and eye protection) be put on before entering home.) Demonstrates the ability to follow the proper sequence for donning PPE in the following order:	X		
1. Hand hygiene using hand sanitizer for 20 seconds, cleansing all parts of the hands, fingers, and nail beds;	X		
2. Dons gown: fully covering torso from neck to knees and arms to ends of wrists; wrap around back; tie/fasten in back of neck and waist;	X		
3. Dons N95 respirator while ensuring air-tight fit;	X		
4. Performs seal check;	X		
5. Dons face shield: placing over face and eyes; adjust to fit as needed; and	X		
6. Dons gloves to cover wrist of gown.	X		
Enters the patient home.	X		
(PPE should ideally be removed outside of the home and discarded after visit. If unable to remove all PPE outside of the home, it is preferred that face protection (i.e., respirator and eye protection) be removed only after exiting the home.) Demonstrates the ability to follow the proper sequence for doffing PPE in the following order	X		
1. Exits patient home.	X		
2. Doffs gloves: Grasp outside of glove with opposite gloved hand, peel off using glove in glove technique. Discards in appropriate waste container.	X		
3. Doffs gown: Untie lower ties first and upper last without contamination using arm cross method. Pull away from neck and shoulders, touching inside of gown. Folds or rolls into bundle and discards in appropriate waste container.	X		

Personal Protective Equipment (PPE) Competency Checklist

4.	Doffs mask/face shield: Grasp bottom, untie lower ties first and upper last, pulling up and away from head. Avoid touching front of mask/respirator. Discards in appropriate waste container or stores mask for reuse per policy.	X		
5.	Discards all PPE by placing in external trash can before departing location. PPE should not be taken from the home in staff vehicle.	X		
6.	Performs hand hygiene using hand sanitizer.	X		

Applicant Signature:	**Date:**
Evaluator Signature:	**Date:**

Hand Hygiene Competency Checklist

Name: _____ Attendant _____

Last First Job Title

Evaluator Name: _____ Date: _____

Type of Validation: X Orientation Annual Other:

Skills	Competency		
	Yes	No	Comments
Hand Hygiene with Soap and Water:	X		
1. Identifies and gathers the appropriate supplies;	X		
2. Wets hands with water using temperature that is comfortable;	X		
3. Applies an amount of product recommended by the manufacturer to hands, and rubs hands together vigorously for at least 20 seconds, covering all surfaces of hands, fingers and nailbeds;	X		
4. Rinses thoroughly with water;	X		
5. With hands held upright, dries thoroughly with a clean paper towel; and	X		
6. Turns the faucet off using a dry paper towel to touch the handle, protecting clean hands from the contaminated handle.	X		
Verbalizes and/or Demonstrates When Hand Hygiene	X		
1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids;	X		
2. Before eating and after using the restroom; and	X		
3. After known or suspected exposure to clostridium difficile, infectious diarrhea during norovirus outbreaks, or if exposure to *Bacillus anthracis* is suspected or proven.	X		

Hand Hygiene Competency Checklist

Hand Hygiene with Alcohol-Based (60-95%) Hand Rub:	X		
1. Applies product to palm of one hand (Follows the manufacturer's recommendations regarding the volume of product to use).	X		
2. Rubs hands together covering all surfaces of hands and fingers until hands are dry, this should take around 20 seconds.	X		
Verbalizes and/or Demonstrates When Hand Hygiene Indicated:	X		
1. Prior to initial entry into the supply bag;	X		
2. Before having direct contact with the patient;	X		
3. After direct contact with the patient;	X		
4. After contact with body fluids or excretions, mucus membranes, wound dressings and used supplies (PPE);	X		
5. After known or suspected exposure to infections or infectious diseases;	X		
6. Before handling or preparing medication;	X		
7. Before moving from a contaminated-body site to a clean-body site on the same patient during patient care;	X		
8. After having contact with inanimate objects (including medical equipment) in the patient's environment;	X		
9. Before contact with or the preparation of food items and beverages; and	X		
10. After removing gloves.	X		

Signature of App: _____ Date: _____

Signature of Evaluator: _____ Date: _____

COMPLIANCE PLEDGE

(Completed On Hire and Annually)

The undersigned is a current Governing Body member, owner, officer, director, or person who performs billing or coding functions on behalf of the Agency or an employee of the Agency. In that capacity, the undersigned hereby affirms that:

I have received the Agency Standards of Conduct, have had an opportunity to have questions regarding the Standards of Conduct answered, and agree to conduct myself in accordance with same in all dealings with or on behalf of the Agency;

I have completed the Compliance Training and Education Program as required by the Agency Compliance Program;

I am not aware of any actual or potential unreported activity by any person or entity acting for or in conjunction with the Agency which is known or believed by me to be in violation of any applicable federal or state law, rule, or regulation;

I understand the importance of compliance with applicable laws, rules, and regulations to the Agency and to the government and third-party payers;

I understand that all Agency representatives are expected to report any suspected violations of these laws, regulations, or rules to their supervisor or the Compliance Officer. I understand that I must also report any suspected violations of the policies or the standards and procedures of the program, and that I may anonymously report any suspected violations through the Compliance Dropbox or the Hotline # 972-332-4214 ;

I understand that conduct in accordance with the Agency Compliance Program will be a condition of my continued relationship with the Agency. I understand that failure to comply with the program may subject me to sanctions or discipline, including but not limited to termination of employment, and/or privileges; and

I am not currently and have not been subject to any criminal charge or conviction involving any government business nor any conviction, exclusion action, disciplinary action, debarment or proposed debarment, or loss or limitation of licensure, privilege, or employment as a result of any alleged violation of applicable state or federal law, rule or regulation.

Signed this _____ day of _____, 20_____.

_____

Signature

_____

Printed Name

Attendant

_____

Title or Job Description

Bienestar Care Services
Employee Covid-19 Orientation Checklist

Employee Printed Name: _____

All employees under Bienestar Care Services are required to complete a training form Covid-19. Screenings were only required for July 2022 - July 2022.

- ➔ Daily Employee/Client Screening (Via Phone & Office Visits)
- ➔ Face Mask Policy
- ➔ Mask Seal Test
- ➔ Covid-19 Symptoms (For All Variants)
- ➔ Sick & Infection Policies
- ➔ Covid-19 Testing
- ➔ Monitoring & Reporting Any Active Infections
- ➔ Exposure & Log
- ➔ What Happens If An Employee Test Positive
- ➔ What Happens if A Client/Family Member Test Positive
- ➔ PPE Guideline
- ➔ PPE Release Form
- ➔ Prevention Guidelines
- ➔ Stay At Home Orders
- ➔ Alerts & Reporting
- ➔ Outbreaks
- ➔ Texas Covid-19 Information
- ➔ Local & State Depts For Reporting

By signing the form below, I understand all Covid-19 Policies and will comply with the Agency Policies & Procedure. Failure to comply can result in my termination. These policies became effective on July 22, 2020.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

Pandemic Inservice Sign In Sheet

Agency: Bienestar Care Services

Date: _____ **Time In:** _____ **Time Out:** _____

Name of In-Service: Orientation Employee In-Service

Presented By: Liz Martinez

Signature of Presenter: _____ **Date**:_____

- [x] Emergency Preparedness and Response Plan - Pandemic Specific Information
- [x] Updated and/or new policies related to pandemic
- [x] Hand Hygiene Recommendations
- [x] Personal Protective Equipment (PPE) Recommendations
- [x] Cleaning and Management of Supplies and Equipment Recommendations
- [x] Return to Work Criteria for Healthcare Workers
- [x] Work Schedule/Employee Time Off/Overtime/Family Medical Leave Act (FMLA)

In Attendance:

	Name	Title
1.		Attendant
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		

In-Service/Exercise Sign In List

Agency: _____

Date: _____Time In: _____Time Out: _____

Name of In-Service: _____

Presented By: _____

Presenter Signature: _____Date: _____

❑ Emergency Preparedness and Response Plan

Subject Summary: The Agency's Emergency Preparedness and Response Plan, policies, and procedures reviewed. Topics included definitions, risk assessment analysis, continuity of operations, patient/client triage, communication / disaster calling tree, securing office building, IT systems, utility disruptions, off-site location, employee responsibilities, and media / information management through all phases of plan.

❑ Planned Drill (The planned drill may be limited to the Agency's procedures for communicating with staff)

❑ Actual Emergency Event

❑ Annual Fire Drill

Complete the Agency Emergency Preparedness Plan Evaluation or the Evaluation of Emergency Preparedness Exercise or Event Sheet and any additional information and attach to this Sign In Sheet.

In Attendance:

Name	**Title**
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
6. _____	
7. _____	
8. _____	
9. _____	
10. _____	

1933 Proctor Drive Grand Prairie TX 75052
Office 972.332.4214 **Fax** 469.895.9867

Attendant Exposure Control - HP B & Bloodborne Pathogens

The agency will provide training and education to the topics listed below that are related to Hepatitis B and Bloodborne pathogens. This training will be conducted upon hire and annually thereafter.

All information will reference the following;

- Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81 and State List of Notifiable Conditions, updated annually (found under the Texas Department of State Health Services website, Infectious Diseases).
- The Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 and Appendix A relating to Bloodborne Pathogens
- The Health and Safety Code, Chapter 85, Subchapter I, concerning the prevention of the transmission of human immunodeficiency virus and hepatitis B virus

Topics:

- Human immunodeficiency virus
- Hepatitis B virus
- Blood borne pathogens
- Prevention of transmission
- Agency's Infection & Exposure Control policy
- Documentation and reporting of any infection

Statement of Understanding

By signing below I acknowledge that I have fully read and understood the exposure and infection control policy. I understand that if I have any questions or concerns about this policy, it is my responsibility to discuss this with the agency.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Employee Handbook & Attendant Orientation Manual

I, _____, confirm that I received the agency's employee handbook along with the Attendant Orientation Manual. The signature below confirms the receipt and Acceptance. I also confirm that I have read and understood everything listed in the handbook And orientation manual. I accept the responsibility of following all it's policy and procedures.

_____
Employee Signature & Date

_____
Agency Representative Signature & Date

External Entities/Individual Confidentiality Agreement

Agency: _____ Date: _____

Confidentiality: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to the 1996 Health Information Portability and Accessibility Act (HIPAA).

Due to the nature of our business, external entities/individual may gain, directly or indirectly, sensitive, and protected health information (PHI)/confidential information on clients and staff members. I agree to safeguard the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc.

If the external entities / individual is in doubt as to whether or not certain information may be shared, he or she should consult with the Privacy Officer or Agency Administrator.

_____

External Entity/Individual

Workplace Violence Prevention Program Employee Survey

Agency Name: _____

❑ Annual ❑ Post Incident ❑ Post Change in Operations

To provide a work environment that exceeds the normal expectation, we are asking for your assistance in identifying areas that we can improve and to assist in identifying new or previously unnoticed risk factors, deficiencies or failures in work practices. Please take the time to complete this survey.

1. What daily activities, if any, expose you to the greatest risk of violence?

   _____
   _____
   _____

2. What, if any, work activities make you feel unprepared to respond to a violent action?

   _____
   _____
   _____

3. Can you recommend any changes or additions to the workplace violence prevention training you received?

   _____
   _____
   _____

4. Can you describe how a change in a client's daily routine affected the precautions you take to address the potential for workplace violence?

   _____
   _____
   _____

Thank you for completing this form. It will provide us with a method to maintain Agency quality and to identify any problems. Your feedback will enable the Agency, and those being served by the Agency, to provide useful information to design, implement and evaluate the Workplace Violence Prevention Program.