



2015-2016

Common Rehab Abbreviations

Rehabilitation and post-acute hospitalization facilities

1. **IPR: Inpatient rehab:** A separate hospital admission from the acute hospital where patients work intensely (3/hours/day), with a rehabilitation team including physicians and therapist for a short duration (days to weeks) in order to achieve specific functional goals that will allow the patient to safely return home or back to another facility. May include training with DME/AE and care giver training.
 - a. **Admission requirements:**
 - i. Need for medical observation
 - ii. Ability to participate in and progress with 3 hours of therapy/day in two or more disciplines
 - iii. A viable discharge plan (patient should be able to return home safely after rehab with whatever supervision, assistance, DME/AE are available.
2. **SAR- Sub-Acute Rehabilitation:** unit within a nursing home, it is designed for patients to work with therapies less intensely than IPR (90 min/day) for potentially longer periods (weeks to months) before returning home. Home is the goal.
3. **LTAC- Long term acute care facility:** for patients that need long term medical care, such as ventilation, wound care, or IV antibiotics. Rehabilitation services such as P, OT, and speech therapy is available, though participation and progression are not required.
4. **ECF- Extended Care Facility:** a nursing home facility that provides supervision and assistance, but little rehabilitation services. Patient may or may not return home
5. **AFC- Adult Foster Care-** Residents are medically stable and generally don't require therapies, they require supervision but minimal to no assistance.
6. **OP- Out patient therapies-** Patient goes to physical/occupational/speech therapy facility on an outpatient basis. Does not include physician or psychiatrist supervision, but generally requires a prescription from a physician that included specific goals, instructions, frequency, duration, and intensity.



2015-2016

FIM- functional independence measure: scoring system to evaluate level of ability of ADLs and AIDLs. Scale is 1-7. 7 being the highest level of function and 1 denoting dependence

7. I- **Independent:** able to perform task safely independent of any assistance
6. Mod-I- **Modified independent:-** able to safely perform task with use of an assistive devise (AD) or home modification or modified technique or training
5. SBA- **Stand by assist:** caregiver had no contact with patient but available if needed
4. CGA- **Contact guard assist-** hands on, but no effort needed of care giver
3. MIN-A **Minimum assistance-** care giver provides (0-25%) of effort
2. MOD-A **Moderate assistance-** care giver provides (25-50%) of effort
1. MAX- A **Maximum assistance-** care giver provides (50-75%) of effort
1. Tot- A **Total assistance-** Care giver provides (75-100%) of effort
- D- **Dependant-** Care giver provides (75-100%) of effort
- S- **Supervision**
- A- **Assistance**

Prosthetics

1. RRD - Removable rigid dressing
2. I-POP -immediate post operative prosthetics
3. TT - trans tibial prosthetic
4. PTB -patella tibial bearing (Total contact socket)
5. ISNY -icelandic scandanavian new york TT prosthetic
6. TF - trans femoral prosthetic
7. TR - trans radial prosthetic
8. TH - trans humeral prosthetics
9. TD -terminal devise: a prosthetic hand or hook
10. VO -voluntary opening- body powered opening slit hook TD
11. VC -voluntary closing: body powered closing slit hook TD
12. SACH -Solid ankle cushioned heel: a prosthetic foot
13. DER -dynamic elastic response prosthetic foot (Energy storing)



2015-2016

Orthotics

1. AFO – Ankle foot orthosis
2. KO- Knee orthosis
3. KAFO- Knee ankle foot orthosis
4. CSO- craig scott orthosis (a type of KAFO)
5. HKAFO- Hip Knee ankle foot orthosis
6. SOMI- sterna occipital mandibular immobilizer
7. PRAFO- pressure relief ankle foot orthosis
8. RHO- resting hand orthosis
9. LSO- lumbosacral orthosis
10. TLSO- thoraco lumbo sacal orthosis

Disease states

1. TBI- traumatic brain injury
2. SCI- spinal cord injury
3. GBS- guillain-barre syndrome- most common form of AIDP
4. AIDP- acute inflammatory demyelinating polyneuropathy.
5. CIDP- chronic inflammatory demyelinating polyneuropathy.
6. RSD- reflex sympathetic dystrophy (now called Chronic regional pain syndrome- CRPS)
7. SD- somatic dysfunction
8. MSD- multiple somatic dysfunctions
9. TOS- thoracic outlet syndrome
10. CTS- carpal tunnel syndrome
11. ALS- anterolateral sclerosis (Lou gerhig's disease)
12. MS- multiple sclerosis
13. LEMS- lambert eaton myasthenia gravis syndrome- presynaptic NMJ syndrome
14. MG- myasthenia gravis- post-synaptic NMJ syndrome
15. CP- cerebral palsy
16. PSS- paget Schrotter syndrome or effort thrombosis of upper extremity
17. HO- heterotopic occification
18. DISH- diffuse idiopathic skeletal hyperostosis
19. MD- muscular dystrophy
20. DMD- duchenne muscular dystrophy
21. NF- neurofibromatosis
22. NF-1- neurofibromatosis type 1
23. NF-2 neurofibromatosis type 2
24. HNPP- hereditary neuropathy with liability to pressure palsies
25. CMT- charcot marie tooth (Type 1 and 2)



2015-2016

- 26. CIM- critical illness myopathy
- 27. CVA- cerebral vascular accident
 - a. ACA- anterior cerebral artery
 - b. MCA- middle cerebral artery
 - c. PCA- posterior cerebral artery
 - d. BA- basilar artery
 - e. ICA- internal carotid artery
 - f. ECA- external carotid artery
- 28. TIA- transient ischemic attack
- 29. PN- peripheral neuropathy
- 30. VTE- venous thromboembolism
- 31. CVD- cardiovascular disease
- 32. CAD- coronary artery disease
- 33. PD- parkinson's disease
- 34. COPD- chronic obstructive pulmonary disease

Physical medicine and rehabilitation basics

Physical medicine and rehabilitation is a medical specialty dedicated to maximizing function and quality of life. Physiatrists have advanced training and skill in the diagnosis, treatment, and prevention of functional disabilities of all types.

Impairment: any loss of psychological , physiological, or anatomical structure or function. (or any deficit in physical exam) it represents a problem at the tissue and organ level

Activity Limitation (old term- disability) any restriction resulting from an impairment of normal ability for a human being

participation restriction: (old term= handicap)- a disadvantage for a given individual resulting from impairment or disability. It limits the fulfillment of normal function of an individual of a given age, gender, society and culture. A problem at the societal level: wheelchair restriction

interdisciplinary approach distinguishes PMR from other medical specialties. :

Team works to evaluate function ability and disability in order to:

1. Set therapeutic goals.
2. Determine the most appropriate therapeutic setting
3. Monitor progress and make recommendations to team members, patient, family members, care providers, or guardians regarding patient needs and requirements.



2015-2016

The 13 rehab diagnoses (The 60% part of the 60:40 Rule for inpatient rehab)

1. Stroke
2. SCI
3. Congenital deformity
4. Major multiple trauma
5. Hip fracture
6. Brain injury
7. Neurological disorders
8. Burns (Must be 3rd degree)
9. Active, polyarticular RA, psoriatic arthritis, seronegative spondyloarthropathies.
10. Amputations
11. Systemic vasculitis with joint inflammation
12. Severe advanced osteoarthritis- must involve > 2 major joints, not including any joints with a prosthesis and there must be evidence that the patient failed outpatient rehab.
13. Lower limb total joint replacement. Must be either Bilateral, traumatic, age > 85, B MI > 50

Nerve compression injury

1. **Physiologic or metabolic conduction block:** local deprivation of O₂ based on circulator arrest (acute compartment syndrome) inhibiting impulse transmission in intact nerves. Generally via compression. Conduction is restored once compression is relieved
2. **Neuropraxia- (Seddon) :** local conduction block with axon preservation due to compression which causes acute myelin damage at the nodes of ronvier. With decompression conduction returns in weeks to months with local re-myelination. Large fibers are more vulnerable and presents as a mixed lesion (May be painful). **Conduction block-** is the electrodiagnostic finding associated with neuropraxia
3. **Axonotomesis-** loss of continuity of axons with endoneurial sheath intact. Function recovery reflects time for nerves to re-grow (approx 0.6- 0.8mm/ wk), unless regrowth is complicated by intraneural scarring or some other process
4. **Neurotomesis-** loss of continuity of axon as well as elements of nerve trunk including endoneurial tubes, perineurium and epineurium. Complete severation or complete disorganized by scar tissue. Requires surgery for functional recovery. (Not painful)

Important definitions

1. **Pain:** an unpleasant or uncomfortable sensation or perception associated with noxious stimuli, tissue damage, or nerve damage. (CNS or PNS)
2. **Parasthias-** abnormal sensations, typically tingling sensation
3. **Dysathenias-** uncomfortable abnormal sensations



2015-2016

4. **Allodynia**- perception of pain from non-noxious stimuli
5. **Hyperalgesia**- increased sensitivity to pain from noxious stimuli
6. **Anesthesia**- lack of sensation, numbness
7. **Nociception**- neurologic transmission of painful stimuli normally the CNS will interpret this as pain. Can be due to pressure, heat chemical, as well as inflammation
8. **Neuropathic pain**- pain caused by damaged nerve cells rather than by nociception, in either CNS(thalamus damage in CVA which causes “thalamic pain” typified by intense burning quality.) or the PNS (As with peripheral neuropathy which also is often described as either burning or freezing in quality).
9. **Aphasia**- literally the inability to speak, generally it is used in place of dysphasia. To avoid confusion with dysphagia.
10. **Dysphasia**- impairment of ability to speak don't use this word, it is confused with dysphagia
11. **Dysphagia**- impairment of the ability to swallow
12. **Apraxia**- unable to perform skilled or purposeful movements (... that were previously learned...) despite retention of requisite strength, motor skills, and comprehension. Commonly from CVA/CNS damage to temporal region.
13. **Anosignosia**- without knowledge of ones deficits, commonly in a patient with stroke of non-dominant lobe (Right side) MCA (Parietal and cortical) who is unaware of their deficits. Often accompanied by left hemiparesis
14. **Prosopagnosia**- unable to recognize faces.

DTRs or MSR (Muscle stretch reflex)

- 0 no response
- 1 requires distraction or gendraisic maneuver to illicit
- 2 normal
- 3 brisk but within normal limits
- 4 hyperreflexic. (No clonus)

Clonus is noted separately, when noting clonus note the number of beats. (2-3 beats may be physiologic but greater than 3 beats are pathologic.



2015-2016

Manual muscle testing (MMT)- note grade does not indicate bulk or tone: these should be noted on exam

- 0 no contractile activity can be felt in the gravity eliminated position
- 1 the muscle/muscles contraction can be palpated without joint movement while the patient is performing the action in the gravity-eliminated position.
- 2 Full or partial range of motion with gravity-eliminated (Parallel to the plane of the floor)
- 3 Full range of motion against gravity (perpendicular to the floor)
- 4 Full range of motion against some resistance (Less than full resistance)
- 5 Full range of motion against full resistance

Modified ashworth scale for grading spasticity

Spasticity- velocity dependant increase in tonic stretch reflex. Hyper-excitability may be due to decreased activation of antagonistic alpha motor neurons by means of UMN damage, revealing primitive reflexes and spasticity. Normally muscle stretch reflexes are inhibited by activation of antagonist muscles. This is modified by descending pathways leading to inhibitor inter-neurons. If UMN disease, like a CVA, impairs this inhibition the result is spasticity.

- 0 No increase in muscle tone
- 1 Slight increase in muscle tone, manifested by a catch and release, or by minimal resistance at the end ROM when the affected part is moved in flexion and extension
- 1 + slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder (<50%) of the ROM.
- 2 More marked increase in muscle tone through most of ROM (>50%) but affected parts easily moved
- 3 Considerable increase in muscle tone, passive movement difficult
- 4 Affected part rigid in flexion and extension

2015-2016

TBI

Prognostic indicators are:

1. Glasgow coma scale best score in 1st 24 hours
2. Length of coma
3. Duration or posttraumatic amnesia (PTA)

		Glasgow Coma Scale					
		1	2	3	4	5	6
Eyes	Does not open eyes	Opens eyes in response to painful stimuli	Opens eyes in response to voice	Opens eyes spontaneously	N/A	N/A	
Verbal	Makes no sounds	Incomprehensible sounds	Utters inappropriate words	Confused, disoriented	Oriented, converses normally	N/A	
Motor	Makes no movements	Extension to painful stimuli (<u>decerebrate response</u>)	Abnormal flexion to painful stimuli (<u>decorticate response</u>)	Flexion / Withdrawal to painful stimuli	Localizes painful stimuli	Obeys commands	

The scale comprises three tests: eye, verbal and motor responses. The three values separately as well as their sum are considered. The lowest possible GCS (the sum) is 3 (deep coma or death), while the highest is 15 (fully awake person).

TBI severity by GCS score

- 5-7** 53% death or vegetative state
- <8** **Severe TBI also defines a coma**
- 8-10** mod-good recovery in 68%
- 11** mod-good recovery in 87%
- 9-12** **moderate TBI**
- >13** **mild TBI**



2015-2016

Rancho Los Amigos: Cognitive scale describes level of function in TBI patients.

1. **No Response- total A-** to pain touch sound or sight
2. **Generalized reflex- total A-** to pain
3. **Localized response- total A-** blinks to light, turns to or away from sounds, responds to discomfort. Inconsistent.
4. **Confused and agitated- Max A-** alert and active, may be aggressive or have bizarre or non-purposeful behavior
5. **Confused and non-agitated- Max A-** pays gross attention to environment, but distractible and required redirection.
 - a. becomes agitated with overstimulation
 - b. may be conversational with inappropriate speech
6. **Confused and appropriate- Mod A** – inconsistent orientation to time and place.
 - a. Recent memory impairment
 - b. Begins to recall the past
7. **Automatic/appropriate- Min A for ADLS-** performs daily routine in familiar environment in non-confused but automatic fashion, skills deteriorate in unfamiliar environment, lacks realistic planning for the future
8. **Purposeful and appropriate - SBA**
9. **Purposeful and appropriate- SBA on request**
10. **Purposeful and appropriate- Mod I**

Functional K levels medicare guidelines

K0= no ability or potential- to ambulate or transfer, a prosthesis will not enhance QOL

K1= Household Ambulator- potential to transfer or ambulate on level surface at fixed cadence

K2 = limited community ambulatory- potential to amb/ transfer on low level barriers (Stairs, curbs, uneven surfaces)

K3= community ambulatory-potential to amb/ transfer with variable cadence. Can traverse most environmental barriers. May have vocational barrier

K4= active adult/athlete/ child- potential to amb/transfer that exceeds basic skills. Including high impact, stress, or energy levels.

DVT- 40-50% of CVA patients, 10% of CVA patients will get PE.



2015-2016

Spinal cord injury (SCI)- injury resulting in disruption of the spinal cord or in the case of cauda equine of the nerve roots. Often reserved for injury from trauma, but may be from non-traumatic diseases of the spinal cord such as tumors, MS, transverse myelitis.

Skeletal level of injury vs neurologic level of injury.

Skeletal level= level of greatest vertebral damage by radiography

Neurologic level=level of injury determined by ASIA

Motor level= lowest level with 5/5 strength or 3-4/5 strength with 5/5 strength one level above

Sensory level= lowest level with intact 2/2 sensation for both pinprick and light touch

ASIA – American spinal injury association- based on 3 criteria

1. **Neurologic level of motor and or sensory injury**
 - a. Named after the most caudal level without motor or sensory injury.
2. **Complete (no sensory in sacral segment) or incomplete (Sacral sparing)**
3. **Notation of clinical syndromes if applicable.**
 - a. **Central cord**- arms affected more than legs, bladder dysfunction- retention)
 - b. **Anterior cord**- preservation of dorsal columns- MVP intact other 2/3rds of cord is affected in variable degrees.
 - c. **Brown sequard**- hemisection of cord. Lose same side MVP, keep opposite side hot cold , pain and light touch.
 - d. **Conus medularis**- L1-L2 vertebral level injury- usually normal motor function, may have absent Bulbocavernosus reflex, usually symmetric findings, saddle anesthesia, areflexic bowels and bladder
 - e. **Cauda equina**- L2- sacrum vertebral level injury- flaccid paralysis of involved roots, absent bulbocavernosus reflex, usually asymmetric findings, sensory loss in root distribution, may have loss of bowels and bladder.



2015-2016

ASIA-

- A. **Complete-** no motor or sensory preservation in sacral segments
- B. **Incomplete-** sensory preserved but not motor below level of lesion.
- C. **Incomplete-** motor function is spared below lesion but more than ½ of key muscles below are < 2/5.
- D. **Incomplete-** motor function is spared below lesion but more than ½ of key muscles below are > 3/5.
- E. **Normal-** full recovery from prior SCI

Note: consider C or D if :

- 1. both anal sensation and anal tone is preserved
- 2. There is any motor function > 4 levels below MOTOR level.

Determine zone of partial sparing= can have preserved function at +/- three levels below lesion. (Penumbra)

Sensation- graded bilaterally along dermatomes by light touch and pinprick compared to face

- 1. Sensation absent for light touch and unable to feel sharp pin prick
- 2. Diminished sensation but some is intact (feels sharp but different from the face for pinprick)
- 3. Intact sensation (Normal equivocal to face and discerns dull from sharp)

level	action	muscle--> nerve
c5	elbow flexors	biceps brachii-->musculocutaneous N
c6	wrist extensors	Extensor Carpi radialis --> radial N
c7	elbow extensors	Triceps --> radial N.
c8	finger flexors (Distal phalanx of middle finger)	Flexor digitorum profundus--> medial and ulnar N.
t1	finger abductors	abductor digiti minipi (Quinti) --> ulnar N
l2	hip flexors	iliopsoas --> L2-L3 venral rami and femoral N
l3	knee extensors	Quadriceps --> femoral N.
l4	ankle dorsiflexors	tibialis anterior --> deep peroneal N.
l5	great toe extensor	Extensor Hallucis Longus--> deep peroneal N
s1	ankle plantal flexors	Gastrocnemius and Soleus --> tibial N.



2015-2016

EMG/NCS

upper extremity muscle	Root	Nerve	lower extremity muscle	root	nerve
Deltoid	c5-6	Axillary	adductor longus	L3	Obturator
Biceps	c5-6	Musculocutaneous	vastus medialis	L3	Femoral
pronator teres	c6-7	Median	rectus femoris	L3	Femoral
extensor digitorum communis	c7	Radial	anterior tibialis	L4-L5	Deep Peroneal
Triceps	c7	Radial	posterior tibialis	L5-S1	Posterior tibial
flexor carpi ulnaris	c8	Ulnar	biceps femoris (Short head)	L5-S1	Common peroneal
flexor carpi radialis	c7	Median	tensor fascia lata	L5	Superficial gluteal
abductor pollicis brevis	c8-t1	Median	medial gastroc/soleus	S1	tibial N.
first dorsal interosseous	c8-t1	Ulnar	lateral gastroc/soleus	S1	tibial N.
Infraspinatus	c5-6	Suprascapular	extensor hallucis	L5	Common peroneal
extensor indicis	c7-c8	radial(Deep)	peroneus longus	L5-S1	Common peroneal
abductor digiti minimi	c8-t1	ulnar (Deep)	first dorsal interosseous plantar	S1-S2	lateral plantar

Decubitous ulcer classification

Stage 1: non-blanchable erythema of intact skin heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, indurations or hardness may be indicators

Stage 2: partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow center

Stage 3: full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through the underlying fascia. The ulcer presents with or without undermining of adjacent tissue

Stage 4: full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. Undermining and sinus tracts also may be associated with stage 4 pressure ulcers.

Reverse staging: Clinical studies indicate that as dep ulcers heal, the lost muscle, fat and dermis is NOT replaced. Instead granulation tissue fills the defect before re-epithelialization. Given this information, it is not appropriate to reverse stage a healing ulcer. For example. A pressure ulcer STAGE 3 does not become a stage 2 than stage 1. You must chart instead the progress by noting and improvement in the characteristics (Size , depth, amount of necrotic tissue, amount of exudate)



2015-2016

Suggested issues to address in standard PMR PLAN:

1. **Admitting diagnosis**(CVA, TBI, Trauma)
2. **Impairments** (Ambulation, Adls, Transfers, cognition, speech ETC.
3. **Pain**(Medications ETC. What type of pain is it? Neuropathic. MSK?)
4. **Sleep**(How well are they sleeping.)
5. **GI**(Diarrhea, Constipation. Bowel program ETC)
6. **GU**(Foley, PVRs?, Bladder scan with cath?)
7. **Skin** (Decubes, stage, rotations)
8. **Cognitive/behavioral-** (agitation, speech therapy, meds)
9. **DVT prophylaxis** (Lovenox, heparin, arixtra)
10. **Length of ABX**
11. **Seizure prophylaxis** (often used in TBI patients)
12. **Nutrition** (are they eating well? Weight loss? Calorie count)
13. **Other medical issue (PMH)**-(HTN, DM2, CHF)
14. **Disposition** (home v ecf, home care?)
15. **ELOS – Estimated length of Stay** (Usually determined in team rounds)
16. **Goals** (ambulate 200f with mod-I , steps. Etc)



Department of Physical
Medicine and Rehabilitation

Oakwood

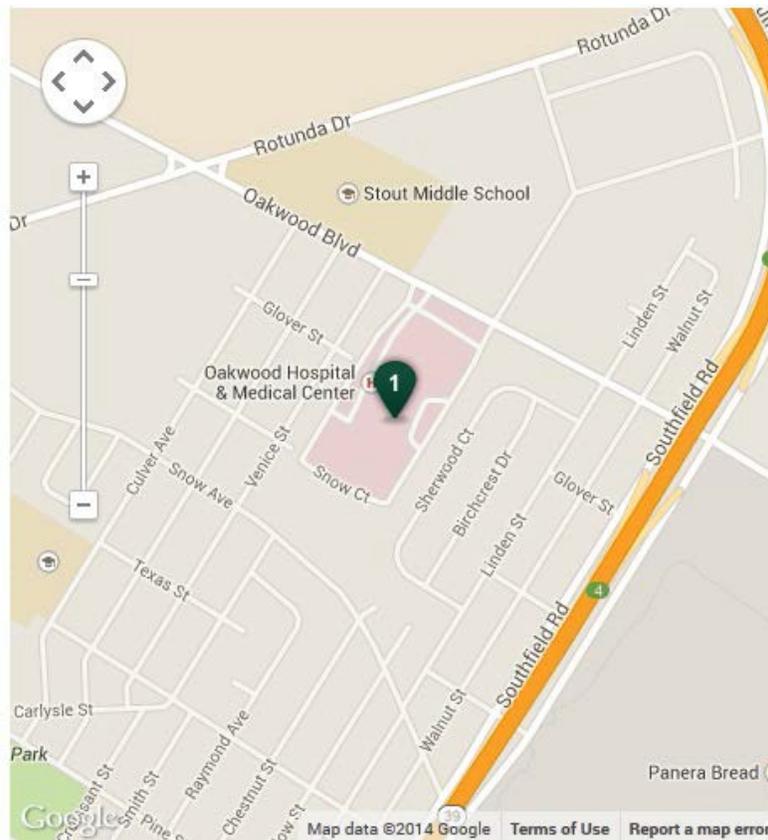
2015-2016

Outpatient Clinic Location

(Connected to Oakwood Hospital and Medical Center, near water fountain, gift shop and pharmacy):

18181 Oakwood Blvd, Suite 411
Dearborn, MI 48124
313-438-7373

Contact:
Beverly Feikens
313-438-7379





School of Medicine

Department of Physical
Medicine and Rehabilitation

Oakwood

2015-2016 Academic Year Residents and Fellow



Omaina Bokhari, MD[PRG-1]
obokhari@med.wayne.edu



Wendy Contreras, MD[PRG-1]
wcontrer@med.wayne.edu



Melissa Kawa, MD[PRG-1]
mkawa@med.wayne.edu



Rene Ruggiero, MD[PRG-1]
ruggier@med.wayne.edu



Braden Boji, MD[PRG-2]
bboji@med.wayne.edu



Adil Hussain, DO[PRG-2]
adilhussain@med.wayne.edu



Arun Idiculla, MD[PRG-2]
aidicull@med.wayne.edu



Paul Yoo, DO[PRG-2]
pyoo@med.wayne.edu



Maryam Berri, MD[PRG-3]
mberri@med.wayne.edu



Mark Diamond, MD [PRG-3]
mdiamon@med.wayne.edu



Michael Kasprzak, DO [PRG-3]
mkasprza@med.wayne.edu



Joe Mendez, MD [PRG-3]
jlmendez@med.wayne.edu



Tad DeWald, MD [PRG-4]
tdewald@med.wayne.edu
Chief Resident



Kevin Orloski, MD [PRG-4]
korloski@med.wayne.edu



Kelly Own, MD [PRG-4]
kown@med.wayne.edu
Resident Champion



Pierre Rojas, DO [PRG-4]
projas@med.wayne.edu
Chief Resident



Parag Shah, MD [PRG-4]
phshah@med.wayne.edu



Steven Bou, MD[PRG-5]
Brain Injury Medicine Fellow
sbou@med.wayne.edu

HUMAN RESOURCES POLICY AND PROCEDURE

PERSONAL APPEARANCE – DRESS CODE

OBJECTIVE: To provide general guidelines for attire which emphasize Oakwood Healthcare System (OHS) belief that attire is important in terms of patient care, employee identification, safety, and security. These guidelines will service as one method to portray a professional image to our patients and customers.

POLICY: Personal neatness, cleanliness, hygiene, and appropriate apparel best convey a professional image to patients, visitors, and other employees of OHS. Appropriate business attire/designated department uniform is the standard dress for OHS.

PROCEDURE: Management
Unless otherwise specifically approved by Division Presidents, Managers are expected to dress in formal business attire. "Casual Fridays" or other designated days when it is not required are established by the respective site Presidents.

Employee

General guidelines for appropriate dress include:

1. The guidelines set forth in this policy and procedure are to be interpreted in concert with all other policies and procedures of the system. Specifically, but not all-inclusive, these guidelines must not conflict with Infection Control and Safety policies and procedures or departmental needs. In the event two or more policies establish conflicting or differing guidelines, that policy which is more stringent will have authority.
2. Identification badge will be worn visibly, at chest level, at all times while on the facility premises. Badge should be worn with name and picture displayed prominently. Certification pins or pins

HUMAN RESOURCES POLICY AND PROCEDURE

provided by the organization are acceptable on badge as long as it does not cover name or picture, or magnetic strip. Additionally, only buttons which have been provided by and/or approved by the corporation may be worn as part of this dress code.

3. Apparel is clean, free from wrinkles and in style consistent with the individual employee's position and function in the organization.
4. Hair must be clean, neatly styled in a professional business-like manner.
 - Employees with direct clinical patient care contact must secure it in such a manner that it does not touch equipment or patients. When leaning forward, it cannot fall in front of the face.
 - Tinted/bleached hair must be professional in appearance.
 - For men, mustaches and beards must be clean and styled appropriately as to not interfere or detract from job responsibilities or performance.
5. Jewelry
 - It must be appropriate for a patient care setting.
 - Earrings are not to exceed the size of a quarter, and a maximum of two (2) per ear allowed.
 - Rings – not more than two rings per hand (wedding set is counted as one ring).
 - Bracelet/watch – only two (2) bracelets and a watch allowed. They may be on either wrist.
 - Necklace – no more than two (2) necklaces allowed.

HUMAN RESOURCES POLICY AND PROCEDURE

6. Shoes

- Department appropriate shoes and hosiery/socks are required at all times.
- Must be clean and worn at all times.
- Open toe shoes and canvas or high top tennis shoes are not acceptable in the clinical setting.
- Heels should not be higher than three (3) inches.
- Shoes with laces must be laced and tied at all times.

7. Hose, stockings or socks must be worn by all personnel. Any exposed portion of the leg must be completely covered.

8. Undergarments are to be worn at all times and are not to be visible through outerwear.

9. Body Sculpting/Tattoos/Piercing (includes all body piercing except ears). Tattoos that are obscene, advocate sexual, racial, ethnic, or religious discrimination are not acceptable to have showing during work hours. Tattoos which cover one-fourth of the exposed skin are inappropriate, and must be covered. Body Sculpting may not be visible while at work. Piercing, other than that which is discussed in #5, above, may not be visible while at work. This is not intended to be applied to traditional plastic surgery situations.

10. Certain dress is inappropriate under any circumstances. This includes stretch/jogging/sweat pants, T-shirts, tank tops, sweat shirts, cut-off or jean shorts, Capri pants, sport shirts, denim jeans, overalls, flannel, fishnet or transparent garments, beach/party wear, spandex, sockless, sandals, and tight fitting clothes. Tops cannot be: low cut, made

HUMAN RESOURCES POLICY AND PROCEDURE

of see-through fabric or be too short where the abdomen is exposed.

11. Regardless of the clothing, jewelry, etc, the employee chooses to wear, it must be tidy and unstained. Specifically, it must not dangle or interfere with patient care or cause a safety risk.

12. A "business casual" day, on which informal business attire may be worn, where appropriate, can be observed on Fridays only, and at the discretion of the Division President. The clothing styles listed in procedure step #10 above are considered inappropriate on "business casual" days. However, formal business attire/designated departmental uniform is to be worn if any contact with external customers, patients, or outside agencies is likely to be part of the workday.

13. Department uniforms may be the official formal business dress in designated units of OHI if everyone in the unit complies and if the uniforms have been approved by the respective Human Resources Department.

14. Head Coverings

- Head coverings are generally not allowed. Any exceptions to this must be presented to the Division President/Business Unit leader for review and approval as explained in the General section of this policy.

15. Nails

- Nails must be maintained in a manner which is consistent with the Infection Control Policies of the organization. Nails must be clean and neatly manicured in professional, business-like

HUMAN RESOURCES POLICY AND PROCEDURE

manner which will not interfere with the employee's completion of their work assignments. Polished or colored nails must be professional in appearance.

16. In those instances where an employee's religious or cultural beliefs and/or practices conflict with the policy, they are to address their concerns to their direct supervisor. The supervisor will review the information presented, and discuss with the appropriate Division President/Business Unit Leader.

17. Exceptions to this policy for the purposes of special events are limited to approval by the Division President/Business Unit Leader. Examples may include but are not limited to: Red Wings Day (wear your Red Wings jersey to work), School Spirit Day (wear your favorite school's jersey to work), golf, picnics, etc.

Department Head

1. Establish and distribute specific dress guidelines for department consistent with the policy.
2. Employees reporting for work dressed inappropriately should be sent home to modify clothing, without pay. Return to work should occur the same shift. Employee is required to punch out/in.
3. Administer corrective action for repeated violations.

General

Changes or variations to these guidelines will be made only on the basis of the work performed by a particular department and must be reviewed by the Human Resources Department and forwarded to the appropriate Division President/Business Unit Leader for approval. Any approved

HUMAN RESOURCES POLICY AND PROCEDURE

changes will be forwarded to the Human Resources Department in writing.

Appropriate Formal Business Attire	Appropriate Informal Business Attire	Inappropriate Attire
Designated department uniform		
Slacks	Corduroy, cotton, wool, khaki, stirrup (not spandex) pants	Jeans, overalls, spandex, capris, sweat suits, jogging pants, tight-fitting, torn, ripped, or bleached pants
Blouses, dress shirts, with collar and tie, dress sweaters	Sport shirts, polo shirts, golf shirts with collars, blouses, knit tops	T-shirts, tank tops, sweat shirts
Business suits, sport coat, skirts	Skirts must be a reasonable length, neat denim dresses acceptable	Short skirts, strapless dresses, spaghetti strap style dresses, backless, tank, or halter dresses
Skorts, of appropriate length	Skorts, of appropriate length	All shorts
Appropriate undergarments, hosiery/socks are required at all times	Appropriate undergarments, hosiery/socks are required at all times	Fishnet, transparent garments, sockless
Department appropriate footwear	Department appropriate footwear	Sandals, thongs
Jewelry that does not interfere or become hazardous in the course of performing individual job responsibilities	Jewelry that does not interfere or become hazardous in the course of performing individual job responsibilities	Jewelry that interferes or becomes hazardous in the course of performing individual job responsibilities
<u>Miscellaneous</u> Hair, mustaches, and beards are clean and styles appropriately as to not interfere or detract from job responsibilities or performance	<u>Miscellaneous</u> Hair, mustaches, and beards are clean and styles appropriately as to not interfere or detract from job responsibilities or performance	<u>Miscellaneous</u> Spandex shorts, spandex tops, spandex pants. Tight-fitting clothes that may be offensive Beach/party/play wear