Orientation Section

General & Clinical Orientation

Medicare Certified Orientation Manual

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General Orientation

Section 1: Introduction

Welcome

We are committed to positive employee relations. Each employee is a valuable team member and extremely important to this Agency.

This Employee Manual provides general guidelines pertaining to the Agency's policies and procedures. It is the employee's responsibility to understand and follow these policies. Your manager will answer any questions that arise regarding the Agency's procedures.

We may delete, suspend, or discontinue any of these policies at any time in order to meet regulatory or Agency needs. Employees will be notified of changes through the proper communication source.

This Agency has a responsibility to provide you with positive guidance, adequate policies, and supplies. Management encourages comments, suggestions, and possible solutions.

Without you there would be no Agency!

TEAM – Together Everyone Achieves More

Staff members are essential to the success of any agency. Together, you are the true strength of the Agency.

Integrity – "We make a living by what we get, but we make a life by what we give." – Winston Churchill

Home Health Overview

A home health agency has the primary function of delivering health care services to people in their place of residence.

Home care is one of the fastest growing industries in the nation, and the trend is expected to continue.

One reason for the growth is that home care provides many advantages, some of which include:

- Patients/clients can be with loved ones.
- Studies have shown that being at home can actually speed up the healing process.
- Individuals can enjoy more independence and freedom in their own environment.
- Prevention or postponement of institutionalization for most patients/clients.
- Health care can be more cost effective (less expensive) in the home.
- Patients/clients are less likely to get infections in the home than in the hospital.

- An increased emphasis on health maintenance and preventative health may broaden the focus of home care to include well care in addition to illness care.
- The future of home care will be shaped by the focus of keeping health care costs down, as well as increasing industry competition and a higher demand for quality.

The Medicare Program is a national health insurance offered by the federal government. Home health is a covered service to qualified patients/clients. The Home Health Agency must be certified to provide care and be reimbursed from Medicare.

Conditions of Participation (CoP) outline minimum health and safety requirements for Home Health Agencies. Each of the conditions have minimum standards that must be met to be qualified for Medicare certification. Note: These Conditions of Participation are the basis for the Agency's policy and procedures.

Regulatory agencies that oversee an agency's program include:

- State licensing and/or survey agency
- Centers for Medicare & Medicaid Services (CMS) contracts with state licensing and survey agencies for oversight of CoP adherence for Medicare certification
- And there are three voluntary accreditation organizations:
    - The Joint Commission (TJC)
    - Community Health Accreditation Partner (CHAP)
    - Accreditation Commission for Health Care (ACHC)

Agency Mission and Philosophy

Our mission is to participate as an active part of the community, and to provide and continuously improve home health care services to meet the needs of the patient/client by delivering value driven, high quality, compassionate care.

We believe in the importance of caring for each patient/client with honesty, respect, and dignity by adapting to the needs of each patient/client and providing individualized care.

Overview of the Agency

Organizational Chart

The organizational chart provides a visualization of the chain of command from licensee to patient/client. The staff will be informed of any pre-designated individuals fulfilling alternate roles. Ask your supervisor for a current copy.

Scope of Services

Skilled Nursing	Registered Nurse (RN) Licensed Vocational/Practical Nurse (LVN/LPN)
Home Health Aide	(HHA)
Physical Therapy	Physical Therapist (PT) Physical Therapist Assistant (PTA)
Speech and Language Therapy	Speech-Language Pathology Services (SLP, ST)
Occupational Therapy	Occupational Therapist (OT) Occupational Therapist Assistance (OTA)
Social Work	Medical Social Worker (MSW)

Geographic Coverage

The Agency determines the geographical area served. Ask your supervisor for a current list of counties served. Patients/clients living outside of the geographical area may not be admitted.

How to Access Agency Policies and Procedures

Policies will be referenced throughout this Orientation and you will need to read them. When a policy is required reading you will see it noted in a grid. For example:

Online Bookmark	Title of Policy
Human Resources (HR)	Drug-Free Workplace

It is important that you know how to access the Policy Manual as you are expected to follow Agency policies. Your agency has an online manual. Ask your supervisor for access to the Policy and Procedure Manual. The policy sections will be found under Bookmarks on the left side. The easiest way to find the policy is to use the Search option at the top right of the tool bar and enter the title of the policy. The first entry will be where the policy is found in the Table of Contents then use the down arrow by the Search box to go to the policy. If the agency has printed the policy manual, you can find the referenced policy in the Table of Contents and then find it in the manual.

Online Bookmark abbreviations for policy sections:

Leadership	LD
Human Resources	HR
Rights and Ethics	RI
Assessment	PE
Provision of Care	PC

Education	PF
Environment Safety and Equipment Management	EC
Management of Information	IM
Quality Assessment Performance Improvement	QAPI
Surveillance, Prevention, and Control of Infection	IC

Section 2: Agency and Employee Commitment and Responsibilities

Community and Customer Relations

Our image and reputation within the community influences the amount of business the Agency receives. The employee's attitude, behavior and work ethics affect this reputation.

As a member a team, it is essential to represent the Agency in a positive manner not only by following policies and procedures, but also providing care that is both caring and quality.

Good customer relations are critical to the success of the Agency. Our customer is anyone who uses the Agency's services. This includes not only the patients/clients and their families but also referral sources – physicians, discharge planners, case managers who are all considered external customers, and our co-workers who are our internal customers.

A commitment to provide quality care with respect and genuine concern for our customer will result in better performance for the Agency overall, and personal satisfaction for the employee.

Discrimination and Harassment

This Agency is an equal opportunity employer and is committed to provide an environment free from discrimination and sexual harassment.

The Agency will not discriminate in employment with respect to race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law.

The Agency will not discriminate in patient/client provision of services with respect to race, color, national origin (including limited English proficiency and primary language), age, sex (includes, but is not limited to sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity and sex stereotypes), disability, source of payment, basis of relationship or association, or any other status protected by federal and state law.

It is the responsibility of each employee to respect the rights of co-workers and patients/clients. An employee who believes that he or she has been the subject of unlawful harassment by anyone with a business relationship to this Agency should report the incident immediately to their supervisor. All charges will be thoroughly investigated.

Nondiscrimination Requirements

Civil right laws provide protection against discrimination in the Agency program. The Agency with 15 or more employees will designate a civil rights coordinator to oversee and ensure the Agency's compliance with all applicable civil rights requirements. Language barriers may arise during Agency care, as to provide effective communication for an individual with limited English proficiency, the Agency is required to provide patients a Notice of Nondiscrimination and a Notice of Availability of Language Assistance Services and Auxiliary Aids and Services "Notice of Availability" at specific times, in a language they understand to meet the patient and their representative's needs.

Review the following policy:

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Nondiscrimination Requirements

Reasonable Accommodation

The Agency will make accommodations for otherwise qualified individuals with disabilities to perform the essential functions of their position provided the accommodations are reasonable, do not create an undue hardship on the Agency, and are without risk of harm to others.

The Agency will not discriminate against any individual who, with or without reasonable accommodation can perform the essential functions of the job. This applies to all employment practices including recruitment, hiring, compensation, training, advancement, termination, advertising, and benefits.

Employment opportunities will not be denied to anyone because of the need to make reasonable accommodations to the individual's disability or transitory impairment (an impairment with an actual or expected duration of six months or less).

Management has the authority to make reasonable accommodations within the workstation or work site of the individual. The accommodation should not create a financial hardship on the Agency. The Agency will define undue financial hardship for accommodations using the Enforcement Guidance from the Americans with Disability (ADA).

Management and the employee will collaborate on an appropriate and cost-effective accommodation.

The employee may challenge the decision of the Agency by filing a complaint with the Office for Civil Rights at 1-800-368-1019.

Management will periodically monitor the effectiveness of the accommodation.

Review the following policy:

Online Bookmark	Title of Policy
Human Resources (HR)	Americans with Disability (ADA)/Accommodations

Pregnant Workers Fairness Act

Federal laws require the Agency to provide reasonable accommodations to an employee's known limitations related to pregnancy, childbirth, or related conditions, unless the accommodations will cause the employer an undue hardship.

Review the following policy:

Online Bookmark	Title of Policy
Human Resources (HR)	Pregnant Workers Fairness Act

Lactation Accommodations

Review the following policy and procedure to understand the rights of a breastfeeding employee, as well as read about the responsibilities of the Agency.

Online Bookmark	Title of Policy
Human Resources (HR)	Lactation Accommodations

Drug-Free Workplace

The Agency and its employees are responsible for maintaining a safe, healthy, and productive work environment. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession, or use of a controlled substance or alcoholic beverages while in the workplace or on agency time. Violation of this policy will result in disciplinary action up to and including termination of employment. The Agency may require an employee to submit to drug and alcohol screening under certain conditions.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Human Resources (HR)	Drug-Free Workplace

Smoke-Free Workplace

The Agency is concerned about the working environment and the health of their personnel. Therefore, the Agency maintains a smoke free workplace and complies with all state and local smoking laws. Employees may smoke in designated areas. Smoking is prohibited in the residence of a patient/client.

HIPAA and Confidentiality

The Health Insurance Portability and Accountability Act has been part of the healthcare landscape since 2003.

Title I – Protects people who have lost or changed their jobs from losing their health insurance.

Title II – Protects patient/client health information, or protected health information (PHI), and gives patients/clients more control over, and access to, their health information.

- HIPAA is intended to protect the privacy of people receiving healthcare if the provider of that care conducts even one covered transaction electronically. The covered transactions are:
    - Healthcare claims or equivalent encounter information
    - Healthcare payment and remittance advice
    - Coordination of benefits
    - Healthcare claim status
    - Enrollment and disenrollment in a health plan
    - Eligibility for a health plan
    - Health plan premium payments

- Referral certification and authorization
- First report of injury
- Health claims attachments
- Other transactions that the Secretary of the Department of Health and Human Services may prescribe by regulation

- Covered Entities – A Home Health Agency is a covered entity.
- Business Associates
  - Those who do not work for the Agency but who would have access to the patient's/client's protected health information (PHI).
  - A general rule is if the Agency has a relationship with a non-employee that involves PHI for purposes other than treatment, then a business associate relationship may exist.

The Administrative Simplification (A/S) requirements for healthcare providers have been divided into three components:

- Transactions Rule
  - The basic intent is to establish a comprehensive set of standards for the electronic transmission of health information. Electronic transmission includes using:
    - Internet
    - Extranet (information is accessible only to collaborating parties)
    - Leased lines
    - Email
    - Texting
    - Private networks
    - Social networks
    - Transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk
- Privacy Rule
  - The Privacy Rule is intended to give individuals a level of protection of their individually identifiable health information and to provide more control over how their health information is used and disclosed. The protected health information (PHI) is electronic, paper, or oral information related to an individual's health condition that is found in:
    - Patient/client medical records
    - Patient/client billing records

        - Databases
        - Formal and informal discussions
    - The identifiers included in PHI of the individual, his or her relatives, employers, or household members that can be used or disclosed without authorization for purposes of research, public health, or healthcare operations as long as there are limits placed on its use are:
        - Name
        - Postal address information other than town/city, state, and zip code
        - Telephone number
        - Fax number
        - Electronic mail (email) address
        - Social security number
        - Medical record number
        - Health plan beneficiary number
        - Account number
        - Certificate/license number
        - Vehicle identifiers and serial numbers, including license plate numbers
        - Web Universal Resource Locators (URLs)
        - Internet Protocol (IP) address numbers
        - Biometric identifiers, such as fingerprints or voice prints
        - Full face photographs or other comparable images
    - The Agency must ensure that its staff protects PHI in all settings and at all times. Staff should not discuss patients/clients while in public places, patients'/clients' names should not be announced over the intercom, whiteboards should not be in public places, etc. Patient/client information should not be discussed at home.

- Security Rule
    - The Security Rule adopts standards for the security of electronic health information to assure the confidentiality of electronic protected health information (ePHI). It includes:
        - Administrative procedures to guard data integrity, confidentiality, and availability, such as:

- Data backup plan
- Disaster recovery plan
- Access authorization
- Virus checking
- Termination procedures such as removal from access lists and turning in keys and access cards

- Physical safeguards to guard data integrity, confidentiality, and availability, such as:
  - Access controls
  - Secure workstation location
  - Need to know procedures
  - Sign in and escorting visitors, if appropriate
- Technical security services to guard data integrity, confidentiality, and availability, such as:
  - Access controls
  - Automatic log off
  - Password or PIN
  - Unique user identification
- Technical security mechanisms to guard against unauthorized access to data that is transmitted over a communications network, such as:
  - Message authentication
  - Integrity controls
  - Encryption
  - Audit trail
  - Electronic signature

- An agency can use PHI for:
  - Treatment, payment, and healthcare operations.
  - Treatment activities of any healthcare provider.
  - For payment activities of the entity to which PHI is disclosed.
  - For the healthcare operations of another covered entity if:

- Both the Agency and the other covered entity has or has had a relationship with the individual and the PHI pertains to that relationship.
- The disclosure is for specified healthcare operations purposes including quality assessment and improvement activities, case management or care coordination, training, accreditation activities, licensing activities, fraud and abuse detection, research, public health and in emergencies affecting life or safety, judicial proceedings, to provide information to the next-of-kin, for identification of the body of a deceased person, and compliance.

In all instances, the Agency must make reasonable efforts to limit the PHI used, disclosed, or requested to the minimum amount necessary to achieve the purpose of the use, disclosure, or request. This also means the Agency must decide the minimum amount of PHI needed by employees to perform their duties. The exception is that it does not apply to a disclosure made for treatment purposes.

The government takes compliance with HIPAA regulations very seriously. Enforcement is maintained by the following entities:

- Privacy Standard
  - U.S. Department of Health & Human Services Office for Civil Rights
- Security Standard
  - Centers for Medicare & Medicaid Services
- Transaction and Code Set Standards
  - Centers for Medicare & Medicaid Services

<u>Penalties for Non-Compliance:</u>

If a privacy violation is reported and substantiated, there could be civil or criminal penalties.

- Civil Penalties
  - $100 per incident up to a maximum of $25,000 per person, per year, per standard.
- Criminal Penalties
  - Up to $50,000 and one year in prison for obtaining or disclosing PHI.
  - Up to $100,000 and up to five years in prison for obtaining PHI under false pretenses.
  - Up to $250,000 and up to 10 years in prison for obtaining or disclosing PHI with the intent to transfer, sell, or use it for monetary gain or malicious harm.

The following are some tips for maintaining compliance with the HIPAA requirements:

- Familiarize yourself with the HIPAA regulation.
- Know the name of the Privacy Officer and Security Officer.

- Know the location of HIPAA Policies and Procedures.
- Know the location of the Privacy Notice and HIPAA forms.
- Know where all protected health information (PHI) is in the Agency.

The following are just a few questions to ask when examining HIPAA compliance in the Agency. This is not all-inclusive list.

- Is PHI visible on white boards, desks, by the copier, by the fax machine, or on computer screens?
- Are medical records stored in a record room or file cabinets?
    - Are they locked?
    - Who has access?
    - Are there sign out logs for medical records?
- Do you use travel charts with PHI that are taken off premises?
    - How is PHI protected?
    - Is it visible in the car?
    - What happens if it gets lost?
    - What happens to PHI in the travel chart when it is no longer needed?
- Do you send PHI via fax?
    - How are you sure it is sent to and received by the correct recipient?
    - Is there a confidentiality statement on the cover page?
- Do you send PHI via email?
    - Is your email secure and HIPAA compliant?
    - How do you confirm the email address for the recipient is correct?
- Do you store PHI on a cloud?
    - Is your cloud secure and HIPAA compliant?
    - How is access limited to the information?
- Do you send PHI using text messaging? (You should NOT!)
- Do you use paper that has PHI on it as scrap paper or use the other side in the fax machine or copier?
- Do you shred PHI that is no longer needed?
    - Who is responsible for shredding?
    - Do you use a shredding company?

  - Is PHI waiting to be shredded in a secure area?

- Do you discuss patients'/clients' PHI in public places, such as the kitchen, bathroom, or elevator? (You should NOT!)
- Do you call out from room-to-room about patients/clients? (You should NOT!)
- Do telephone conversations that include PHI, such as taking orders or scheduling, take place in private areas away from where visitors are?
- Do you use a patient's/client's phone to make calls about other patients/clients such as to a doctor's office? (You should NOT!)
- Do you have a firewall on your computer system?

Sample Confidentiality Statements

Fax:

- The documents accompanying this fax transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this patient/client information is prohibited from disclosing the information to any other party. If you have received this transmission in error, please notify the sender immediately and destroy the information that was faxed in error and keep any information you may have viewed confidential.

Email:

- This email transmission and any attachments contain confidential information belonging to the sender, which is legally privileged. The information is intended solely for the use of the individual(s) or entity addressed. If you are not the intended recipient, you are hereby notified that any copying, disclosure, distribution, or use of this email and/or attachment is strictly prohibited. If you received this transmission in error, please delete it from your computer system and notify (the sender) at (sender's email address).
- Please be aware that this email transmission is not guaranteed to be 100 percent secure from hackers. Be aware that others could possibly read what is in this email. We have done what we can to keep our email transmissions secure but do need to caution both parties of this possible security breach with confidential information. If you have any questions, please contact the sender of this email.

Please take PHI seriously!

Professional Conduct

The Agency expects all employees to act responsibly, abide by all applicable laws, and adhere to acceptable business principles.

The employee is expected to exhibit a high degree of personal integrity at all times. This involves sincere respect for the rights and feelings of others and refraining from behavior that might be harmful to you, your co-workers, and/or the Agency.

Your conduct reflects on the Agency, consequently you are encouraged to observe the highest standards of professionalism.

Licensed professionals are expected to know their professional practice acts and standards, and practice within the scope of them.

Attendance

Please notify your manager/supervisor if you must miss work or will arrive late because of an illness or some other reason. Arrangements must be made to handle the workload so notification must be in advance if possible.

Employees who have multiple or extended absences may be required to submit a written doctor's excuse.

The Agency recognizes that the cultural values and/or religious beliefs of employees may periodically require an adjustment of certain work responsibilities and obligations. The Agency will attempt to make accommodations to requests from employees that can be justified based on cultural values and/or religious beliefs.

Professional Appearance and Dress Code

The Agency requires high standards of cleanliness and good grooming. Your personal appearance reflects on the Agency and needs to project a professional image and credibility that the patients/clients expect from the Agency.

Avoid extremes in personal grooming and dress while at work and while on agency business. Management and office based personnel are to dress in business/office attire.

Questions regarding appropriateness of clothing or appearance should be addressed to the manager/supervisor.

Telephone Usage

Patient/Client Home

- The patient's/client's telephone should never be used for personal phone calls.
- If you must call the Agency ask permission.
- Do not release a patient's/client's phone number.

Office Phones

- The Agency staff are encouraged to use the phones in the office to contact patients/clients, physicians, other staff, and community resources.
- Personal calls should be limited in duration and locality.
- Long distance lines are to be used for agency business only.

Telephone Courtesy

When receiving or making a business telephone call remember that you represent the Agency to the other person on the line.

Good telephone etiquette includes:

- Answer the phone promptly and courteously.
- Identify yourself and the Agency.
- Always offer assistance.
- Always take complete messages, including date, time, and phone number.
- Attempt to transfer calls at a minimum.
- Have someone receive your calls when you are away.
- Close your calls in a courteous manner.

Quality Assessment Performance Improvement (QAPI)

The purpose of the Quality Assessment Performance Improvement (QAPI) Program is to enhance the organization's performance by fulfilling the mission and philosophy. The program is ongoing and focused on patient/client outcomes that are measurable. Our delivery systems are reviewed and analyzed in order to provide quality care and outcomes. We are dedicated to responding to the needs of our customers. Our customers are defined as patients/clients, physicians, employees, the community, and payer sources. The Agency will attempt to do the right thing, to accomplish the right outcome, and treat the patient/client in a caring and respectful manner. It is an effective, ongoing, data driven, and agency-wide program that is collaborative in effort and includes all departments and disciplines.

We develop important measures/indicators that focus on the following:

- Patient/client care through audits of both active and discharged patient/client charts
- Agency processes
- Patient/client satisfaction surveys
- Perceived or potential problem areas

- Workplace Violence Prevention Program Employee Survey
- Potentially avoidable events and OASIS generated reports

We also monitor, trend, and identify significant outcomes that are essential to optimal care:

- Patient/client and employee infections
- Unprofessional conduct and misconduct
- Medication administration and errors
- Incidents and complaints, including the Agency's response to these
- Effectiveness and safety of all services provided including:
    - Competency of clinical staff
    - Promptness of service delivery
- Determination that services have been performed as outlined in the plan of care

You may be asked to participate in QAPI activities. Some of the responsibilities may include, but are not limited to:

- Review findings of chart audits and personnel file audits.
- Review trends identified through infection, complaint, incident, and satisfaction survey tracking.
- Review trends found through adverse event investigations.
- Review findings related to safety issues identified.
- Make recommendations for improvement through action plans.
- Monitor and evaluate improvement.
- Participate in the Workplace Violence Prevention Program.
- Be a part of a Performance Improvement Project (PIP). These projects reflect the scope, complexity, and past performance of the Agency's services and operations.

If you identify an issue with quality or have a recommendation to improve quality you may discuss this with management.

Policies supporting the QAPI Program are found in the QAPI Section of the Policy and Procedure Manual.

Agency leaders ensure that the needed resources and mechanisms identified in the planning are available to evaluate and improve any and all work processes as needs are identified.

Patient/Client Complaints

The Agency respects the right of the patient/client to voice complaints without fear of retaliation. A patient/client and/or family member may occasionally voice a complaint.

Listen to the complaint!

- Listening and acting may resolve the problem before it is uncontrollable.
- Notify the Agency management immediately.
- Document the complaint on a complaint form and submit it immediately.

Upon admission, the patient/client has been informed of their right to call the state complaint hotline, if an issue cannot be resolved at the Agency level. The patient/client has been informed of the Medicare hotline number as well.

The Agency encourages rapid resolution of an issue in order to respect the patient's/client's rights and to avoid an unnecessary complaint survey.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Resolution of Patient Conflicts, Grievances, or Complaints

Fraud and Abuse in Home Care

The Agency code of conduct defines acceptable, disruptive, and inappropriate behavior of individuals working at all levels in the Agency, including management, clinical, and administrative staff, as well as governing body members. Areas included are fraud and abuse, as well as business and patient/client ethics. A discussion of each follows.

Fraud and abuse in home care is a primary focus by government regulatory agencies. When fraud and abuse is investigated and proven, individuals and agencies are prosecuted. This can include the loss of one's professional license, loss of agency licensure, monetary paybacks and penalties, and prison.

The Agency will not tolerate fraud and abuse.

Activities with a potential for fraud and abuse will be monitored. They include, but are not limited to the following:

- Over-utilization of services
- Falsified information about patient/client eligibility
- False clinical record documentation
- Illegal compensation
- Falsification of visits performed

- Patient/client solicitation
- Illegal remuneration (incentives paid for patient/client referrals)

Review the following policy and procedure:

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Billing Process/Advance Beneficiary Notice/False Claims

Business Ethics

The Agency expects employees to conduct their relationships with those doing business with the Agency in a professional manner and with regard for maintaining high standards of conduct and personal integrity.

Please adhere to the following:

- Confidential information regarding employees, patients/clients, and the Agency's business should not be discussed.
- The material belonging to this Agency including forms, documents, programs, and patient/client documentation must be protected.
- Employees are not to accept gifts of money.
- Employees are not to accept any gifts of value in connection with agency business.
- Employees are not to borrow from or lend money to other employees or patients/clients.
- Employees may not handle patient/client funds except if specifically directed by treatment plans.
- Employees must report any action taken against their professional licensure to this Agency.

Patient/Client Care Ethics

The Agency will participate in the consideration and resolution of ethical issues that arise during patient/client care.

Ethical issues related to patients/clients are difficult to define. Examples include:

- Patient/client safety
- Patient/client and family participation in medical decisions
- Interpretation of Advance Directives
- The scope of a patient's/client's right to accept or refuse care

- Confidentiality
- The patient's/client's right to freedom of choice and dignity
- High tech care and medical experimentation
- Care for patients/clients without insurance or other payment resources

As an employee it is your right and responsibility to report any ethical issue that arises to your supervisor.

Ethics Committee

The Agency has established an ethics committee that will review and resolve any ethical issues that occur in the Agency.

Agency leaders and patient/client care staff, the patient/client and/or caregiver, and the patient's/client's physician will participate in the consideration and resolution of ethical issues that arise during patient/client care.

Agency leaders will participate in the consideration and resolution of ethical issues that arise regarding business practices.

All information concerning ethical issues shall be considered confidential. Ethical issues requiring a decision/resolution may include, but are not limited to:

- The withholding or withdrawal of treatment
- Informed consent
- High technology and medical experimentation
- Patient/client safety
- Standards of care
- False advertising
- Marketing
- Fraudulent billing practices
- Admissions or transfers
- Confidentiality

Cultural Diversity

In order to provide effective care to people from other countries and at times, people who are from various parts of the United States, it is important to have a basic understanding of cultural diversity and to develop baseline cultural competencies.

What is culture? One definition includes those beliefs, values, and practices shared by a group. The group may be ethnic, regional, religious, or based on some other identifying characteristic such as age. An individual from another culture may have different beliefs from yours or those that are considered "normal" for a particular geographic area. The beliefs may impact communication, interaction with others, nutritional preferences, and views about illness and healthcare.

How one communicates and views illness or injury, for example, influences how he or she expresses pain, if at all. In some cultures, it is not accepted to express pain. In others, the expression of pain might be minimized. The expression may be through verbal or non-verbal means. Providing information to the person in his or her own language may help them feel more at ease and may foster their understanding the material more effectively.

You do not need to be an expert in every type of culture, but you should develop a baseline understanding for those cultures from which your patients/clients may come and those beliefs they may practice. Your patients/clients and their families will sense your respect for their culture. This will enhance their trust in you. It may promote compliance with care and lead to improved health. Your awareness of their culture will help patients/clients feel better about the care being provided.

Although not often thought of as a "cultural diversity", age differences play an important part in the interactions between a patient/client and the caregiver. A younger person may not accept his or her diagnosis as readily as an older person who might see it as "just part of growing older." Additionally, keeping in mind "political correctness", an older man probably means nothing negative by calling the nurse "honey" or "sweetheart", but a younger nurse might see that as harassment.

If your services are being provided to people from a specific culture on a regular basis, then learn more about that culture. An internet search will reveal many sources of information about the culture. Also, the public library and/or library at the local high school or college may have materials that will help. Attend events such as fairs and festivals held by a cultural group.

Treating each patient/client as an individual and respecting his or her cultural beliefs and practices will build trust and promote effective response whether to the care you provide or to telephone assistance.

Section 3: Human Resources and Personnel Administration

Personnel File Maintenance

Federal and state laws require the Agency maintain accurate complete personnel files. Compliance requires each employee submit dated materials before the expiration date and notify the Agency of changes in address, phone number, changes on W-4, or other pertinent data.

Dated materials may include:

- Professional license
- Driver's license
- CPR certification
- Insurance liability
- In-services received outside the Agency

Annually you will be asked to:

- Complete required in-services
- Complete TB Fact Sheet/Symptom Screening
- Participate in the annual evaluation (if applicable)

Visits may be withheld if the personnel file is not current.

Background Checks

Background checks will be performed for verification of employability in compliance with applicable federal, state, and local laws on required staff, who have direct contact with patients/clients.

Criminal history checks and registry searches of required staff will be kept confidential. Information will not be released or disclosed to any person or agency except on court order or with the consent of the person who is the subject of the information. A criminal history check may also be conducted periodically on required staff that have face-to-face contact with patients/clients.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Human Resources (HR)	Background Checks

Employee Education

The Agency will orient each employee as necessary and appropriate to their respective job responsibilities and Agency policies and procedures prior to performing job duties independently (including reassignments). New employees will be oriented to Agency policies applicable to the new employee's position and will sign an acknowledgment of reading, understanding, and complying with the policies. The Employee Orientation policy provides a list of topics the Agency will review during orientation.

The Agency is interested in the continuing education of its employees, and therefore will present ongoing in-services or education programs which are appropriate to job responsibilities and to the maintenance of necessary skills.

The staff will be oriented upon hire regarding alternative communication needs and to contact the Administrator, Clinical Manager, civil rights coordinator, or designee if a patient/client needs alternative communication assistance.

- Mandated in-services include:
    - Risk Management/Safety in the Home Care Environment
    - Safe Medical Device Act
    - Infection Control
    - Exposure Control – Bloodborne and Airborne Pathogens
    - Respiratory Protection Program
    - Advance Directives
    - Chemicals in the Workplace
    - Abuse, Neglect, and Exploitation
    - Health Insurance Portability and Accountability Act (HIPAA)/Confidentiality
    - Emergency Preparedness
    - Patient/client Rights and Responsibilities
    - False Claims
    - Safety and Workplace Violence Prevention Program
- Home health aides must have at least 12 hours of in-services per year.
- Management staff should attend two seminars annually to increase management expertise.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Human Resources (HR)	Employee Orientation
Human Resources (HR)	Agency Inservices and Education

Employee Performance

The Agency evaluates staff performance on a continuous basis and formally on an annual basis.

The purpose of this evaluation is to recognize employee performance and identify areas of strengths and weakness.

Employee Grievance/Complaint Resolution

An Agency with 15 or more employees will implement the grievance procedure. The employee is encouraged to discuss any concerns or suggestions, or any matter relating to your job with your supervisor immediately. The civil rights coordinator will be involved with alleged discrimination concerns. The Agency will follow and comply with all provisions set forth in the grievance procedure.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Human Resources (HR)	Employee Grievance/Complaint Resolution

Progressive Discipline

The Agency uses an established progressive discipline procedure in cases of misconduct or unacceptable performance.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Human Resources (HR)	Progressive Discipline Policy

Section 4: Compensation

Work Schedules

Work schedules may vary depending on the need of the Agency to provide needed coverage. You may be required to periodically change your schedule.

If you have any plans that require time off, let the office know as soon as possible. A minimum of one week notice is required to assure proper staff/coverage of office and patients/clients.

If an emergency comes up or you are ill, inform the office as soon as possible.

Time Records

The Agency complies with all applicable laws that require records be maintained of hours worked by employees. Record your time on the required form. The employee is responsible for the accuracy of their own records.

Paychecks

The pay weeks run:

❑ Sun – Sat ❑ Mon – Sun ❑ Tues – Mon ❑ Wed – Tues

❑ Thurs – Wed ❑ Fri – Thurs ❑ Sat – Fri

Paychecks are distributed on:

❑ 1st and 15th

❑ 1st and 16th day of month

❑ 15th and last day of month

❑ Weekly on _____ (day of week)

❑ Every two weeks on _____ (day of week)

❑ Other _____

Deductions

The Agency is required by law to make certain deductions for federal, state, and local tax withholdings and for social security benefits, premiums, savings plans, insurance, etc. Additionally, as applicable by law, the Agency is required to comply with any notice of garnishment or garnishment summons.

Overtime

Occasionally employees are requested to work a reasonable amount of overtime unless physically ill or involved in urgent personal business.

Professional per visit staff are considered exempt employees and are not eligible for overtime pay.

Non-exempt employees are eligible for overtime pay and receive compensation at one and one-half times regular rate for time worked in excess of 40 hours in a work week.

Holidays

Paid holidays for full time administrative employees:

- ❑ New Year's Day, January 1st
- ❑ Good Friday
- ❑ Memorial Day
- ❑ Independence Day, July 4th
- ❑ Labor Day
- ❑ Thanksgiving Day
- ❑ Day after Thanksgiving
- ❑ Christmas Eve, December 24th
- ❑ Christmas Day, December 25th
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

Family Medical Leave Act (FMLA)

FMLA applies to any public or private employer of 50 or more employees. To be eligible an employee has to have worked at least 1250 hours within the last 12 months; has to have worked at least 12 months total time for the employer; and be employed at a facility at which at least 50 employees are employed within a seventy-five-mile radius. Due to the 1250 hour requirement, many part-time employees will not be eligible for FMLA leave.

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

Eligible employees are entitled to 12 work weeks of leave in a 12-month period for:

- The birth of a child and to care for the newborn child within one year of birth.
- The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement.
- To care for the employee's spouse, child, or parent who has a serious health condition.
- A serious health condition that makes the employee unable to perform the essential functions of his or her job.

- Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty."
- Twenty-six work weeks of leave during a single twelve-month period to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

If FMLA is needed, please contact your supervisor at least 30 days in advance if foreseeable or as soon as practicable.

Jury Duty

Jury duty leave is job-protected leave. An employee who is on jury duty is entitled to protection against termination or other adverse action by the employer. Paid leave for jury duty is not required and is determined by the Agency's policy. Federal law states that an employer is not required to pay for time not worked, which includes time spent on jury duty. Please see the Agency Administrator for a copy of your Agency's policy.

Section 5: Safety/OSHA

OSHA

The Occupational Safety and Health Act (OSHA) was created to protect employees from hazards in the workplace. The Agency maintains all OSHA records, complies with posting and reporting requirements, and participates with all OSHA office inspections as requested.

Risk Management

The Agency is committed to a safe workplace that is free from hazards with all employee areas safeguarded while on the job. Safety is a top priority.

The Agency endeavors to provide adequate training to employees to enable them to work safely. Management is expected to enforce and practice safe work procedures. Please inform management of any conditions which might put the employee and/or patient/client at risk or contribute to an unsafe environment.

Management and employees must work together to practice sound risk management, to work safety, to report all incidents promptly, and to correct unsafe conditions.

Personal Safety

Employees are encouraged to take precautions. To promote personal safety, adhere to the following:

- Leave valuables at home or locked in your vehicle, desk, or locker.
- Be sure your vehicle is locked at all times, whether you are in or out of it.
- Take only a small amount of money to work.
- Store your purse or wallet, briefcase, and/or supply bag and supplies in a secure area in your car, out of sight of routine passers-by.
- If someone attempts to rob you, do not resist, or hesitate to give up your purse or bag. Call the police immediately. Write down everything you remember about the incident.
- If you feel unsafe carrying your supply bag, carry supplies in a paper bag.
- Be aware of your surroundings. If you note suspicious activities, do not risk your safety, just leave, and call the office.
- Be cautious around elevators, and if you are at all suspicious of another passenger, wait for another elevator.
- Request that patients/clients have all pets confined or restrained during the home visit,
- Ensure you have an unobstructed exit from your workstation.

- Possessing firearms or weapons, concealed or otherwise, on or in agency property may threaten the safety of yourself and others. Handguns (concealed and/or open carry) may be prohibited or allowed in the workplace, as permitted by state law. The Agency policy must specify whether the agency prohibits or permits the presence of weapons in the workplace. Failure to comply with this policy will result in discipline and potential criminal charges. (The policy is listed under the Workplace Violence Prevention Program section of the Orientation Manual.)
- Illegal drug or alcohol use or possession may threaten the safety of yourself and others. You may not use or possess them on agency property or while conducting agency business.
- If threatened by a co-worker or intruder, do not argue, beg, plead, or minimize his or her comments and stay calm.
- To assist employees in responding to an active shooter event and in order to preserve life and address the reality of an active shooter event, guidelines have been established to guide the Agency's response to maximize survivability.
- In any emergency or disaster situation, stay calm.
- Use safe work practices and follow all directives.
- Do not open suspicious packages.
- Do not work alone in the office.
- Do not walk to your car alone after dark – have a "buddy system".

Driving Safety

- Keep your car in good running condition.
- Always keep your car doors locked and the windows up when in slow traffic or at a traffic light.
- Have a spare set of keys in an appropriate location.
- Carry your keys in your hand. This enables you to get into your car immediately and it is also a form of self-defense. (Hold the key ring in the palm of your hand and put a key between each of your four fingers with the sharp ends sticking out.)
- Have enough fuel for the day's travel.
- Do not pick up hitchhikers.
- If you see a stranded motorist, drive to the nearest phone, or use your cell phone and call the police.
- If you fear you are being followed, drive to the nearest police, fire, or gas station.
- If a person tries to car jack your car, give it to them.

- Plan your route. Know exactly where you are going ahead of time. Contact the patient/client or the office if directions are not clear.
- Park as close to your destination as possible.
- Park in well lighted areas.
- If you have car trouble, turn on your flashers, raise the hood, tie a white cloth on the door, or put a "Call Police" sign in the window. Stay in your car with the doors locked and windows closed. Ask anyone who stops to call the police; do not go with this person.

Body Mechanics

Employees are encouraged to follow the basic principles of good body mechanics:

- Maintain good posture and proper body alignment. Keep your back straight with knees slightly bent and your body weight evenly distributed on both feet.
- Place your feet about 12 inches apart to maintain a broad base of support when lifting.
- Use groups of larger stronger muscles that are found in the shoulders, upper arms, thighs, and hips to lift an object.
- Position yourself so that you are close to the object you are lifting.
- Use both arms and hands to lift, move, and/or carry a heavy object.
- Pivot with your feet and turn your whole body to change direction. Avoid twisting the neck or back.
- Push, pull, or slide heavy objects, when possible.
- Ask for assistance to lift loads that may be too heavy or too large. Count "one, two, three" with the person assisting you and lift the load smoothly to avoid strain. Avoid sudden jerky movements.
- Stand close to your work area. Avoid reaching and bending, when possible.
- Face your work area, this prevents unnecessary twisting.
- Bend your hips and knees, keep your back straight and push, using the thigh muscles when lifting a heavy object from the floor. Never bend at the waist.
- Wear sensible, closed-toe, low heeled shoes.
- Use a back-belt if instructed by your supervisor.
- Immediately report any employee injury to the office.

Fire Safety Procedures

The Agency promotes fire safety precautions both in the patient's/client's home and at the office.

Office

To know what to do in case of a fire, remember the letters in the word RACE:

R Remove people from the area of danger.

A Alarm – Activate the fire alarm, if applicable, and/or call the fire department.

C Contain the fire. Close all doors and windows as you leave the area of the fire.

E Extinguish the fire. Try to extinguish a small fire, but if the fire gets larger or out of control leave the area immediately.

- Have emergency numbers near the phone.
- Plan escape routes and the place outside to gather prior to an emergency.
- Know where the evacuation plans are posted.
- Install a smoke alarm in the kitchen area. Check and/or replace the batteries when you change the clocks in the spring and fall.
- Know where the fire alarm(s) is(are) if your office has them.
- Know where fire extinguishers are located and know how to use them.
- To avoid injury from smoke, stay low and cover your mouth with a wet cloth or towel. If you are trapped in a room, block the bottom of the door with towels, blankets, clothes, linens, or cloth.
- Feel the doors before you open them. Do not open a door if it is hot or if you see smoke coming from around the door.
- If your clothing catches on fire, stop, drop to the ground, and roll to smother the flames.
- After the event, talk about the response and what could be improved.

Patient/Client Residence

Agency staff are responsible for the safety assessment of the patient/client and any needed education pertaining to safety. This must be documented in the patient/client chart.

Workplace Security

Security in the office is everyone's responsibility! It includes security of the property itself, the Agency's assets, and security for the employees while at work. It is part of your responsibility to follow the Agency's security procedures to protect the Agency's property, your fellow employees' property, and yours.

Agency Property and Assets

The Agency's property is considered to include, but not be limited to, the grounds, the office site, desks, telephones, and computers. Physical security may include (in no particular order):

- Well-lit parking areas, areas for walking to or from the office, and entrances.
- Well-lit workspaces, hallways, restrooms, etc.
- Sign – Only authorized persons allowed on property.
- Sign – No Solicitation.
- Limit access to employees, authorized visitors, and business associates only.
- Identification badges for employees .
- Identification badges with separate design to be worn by visitors and business associates.
- Require all visitors and business associates to sign in.
- Require all visitors and business associates to be escorted when on the premises.
- Sign – Limited cash is on premises. Keep petty cash, checkbooks, etc. in a locked drawer or safe.
- Cameras inside and outside with motion sensors.
- Ensure the doors close completely and have adequate locking systems, as well as a fire department-approved crash bar or alarm.
- Establish a code phrase to be used over the intercom (if it is safe to do so) in the event of an intrusion.
- Engrave all agency equipment with the Agency's name.
- Employees should sign a confidentiality agreement not to disclose the Agency's trade secrets, proprietary information, or assets.
- Limit the use of agency equipment off-site. If a laptop, cell phone, etc., is taken off-site, the individual should sign it out with the understanding it is his or her responsibility to protect and return it.
- Avoid dangerous clutter that blocks pathways and/or stairs.
- Perform periodic inspections to identify and evaluate workplace security hazards.
- Store chemical and flammable items or substances in separate, safe, and secure areas.
- All employees will be taught about Material Safety Data Sheets and will know where these are kept in the Agency.
- Employees will not steal or willfully damage agency property.

- The Agency follows the requirements of the HIPAA Security Rule to assure the confidentiality of electronic protected health information and for the security of electronic health information. This includes, but is not limited to:
    - Administrative procedures to guard data integrity, confidentiality, and availability.
    - Physical safeguards to guard data integrity, confidentiality, and availability of information.
    - Technical security services to guard data integrity.
- Management is responsible for securing the Agency's vital information.
- Management encourages employees to report workplace security hazards.

Workplace Safety

The Occupational Safety and Health Act (OSHA) was created to protect employees from hazards in the workplace. The Agency maintains all OSHA records, complies with posting and reporting requirements, and participates with all OSHA office inspection as requested.

Workplace Violence Prevention Program

The Agency has zero tolerance for violent behavior or threats in the workplace.

Possessing firearms or weapons, concealed or otherwise, on or in Agency property may threaten the safety of yourself and others. Handguns (concealed and/or open carry) may be prohibited or allowed in the workplace, depending on Agency policy, and as permitted by state law.

Agency policy must specify whether the Agency prohibits or permits the presence of weapons in the workplace. Failure to comply with this policy will result in discipline and potential criminal charges.

The Agency is committed to ensure safe and healthful working conditions for Agency employees and to provide protection for Agency employees, patients and their families and caregivers from violent behavior and threats of violent behavior occurring while providing Agency services.

The Agency will have a written Workplace Violence Prevention Program (WPVPP) to be developed (implemented and modified) by a workplace violence prevention committee, participation of employees and management.

The Agency's management will conduct (in cooperation with employees) a worksite and job hazard analysis of the workplace to identify any existing or potential hazards (risk factors) that may lead to incidents of workplace violence, and to assist in the identification or development of appropriate training.

The WPVPP will include the Agency's identified potential hazards that may occur in the Agency worksites and will list out control measures to minimize risks and procedures for various situations.

All employees (including physicians, contract employees, supervisors and clinical managers) will be trained in workplace violence prevention upon hire prior to being assigned job duties; when reassigned and on an annual basis.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Environment Safety and Equipment Management (EC)	Safety and Workplace Violence Prevention Program (Form)

Environmental safety at the office may include, but is not limited to:

- Exits
- Stairways
- Storage areas

Exits

According to OSHA, there must be exit routes for employees to leave the workplace safely during emergencies.

For the most part, there should be at least two exit routes, remote from one another, to provide alternate means for employees to leave the workplace safely during an emergency. An exit door must be able to be readily opened from the inside without keys, tools, or special knowledge. A device that locks only from the outside, such as a panic bar, is permitted. An exit door must be free of any device or alarm, which, if it fails, could restrict emergency use of an exit.

An exit door must be free of signs or decorations that obscure its visibility.

Each exit route must be illuminated adequately and must be clearly visible and marked by a distinctive sign reading “Exit.”

Signs must be posted along the exit route indicating the direction of travel to the nearest exit. Any doorway or passage that might be mistaken for an exit must be marked “Not an Exit” or with an indication of its actual use.

The line-of-sight to an exit sign must be uninterrupted.

Stairway Safety Tips

- Never run on stairs.
- Stair treads prevent slips and falls.
- Staircases should be well lit.
- Wipe up spills and remove any clutter.
- Handrails should be mounted directly on the wall by brackets attached to the lower side so there is nothing in the way of your hand. The surface along the top and sides should be smooth so you do not get slivers.

Storage Areas

Storage areas should be conveniently located. Doors should be marked “Not an Exit” or “Storage.” The room should be well lit and well organized. There should be an aisle at least three feet wide for safe movement within the storage area.

The Agency is responsible for maintaining patient/client records safely after discharge. Do not let the file cabinets become overly full so that records are damaged when trying to stuff them into drawers. Doing so could lead to hurting yourself, too!

If cleaning products or other combustibles are kept in the storage room, be sure the containers are well labeled and tightly closed. There should be adequate space between them and any other item to allow for good ventilation.

If “sharps” are returned to the office, they should be placed in the area designated for medical waste.

Respiratory Protection Program (RPP)

The Agency is required to follow and comply with the Occupational Safety and Health Administration (OSHA) Standards titled “Respiratory Protection” in Title 29 CFR, Section 1910.134, and/or an OSHA approved state plan, as applicable to the Agency setting.

The Agency will designate a qualified Respiratory Program Administrator to oversee the RPP. The RPP includes medical evaluations, training, fit testing, respirators, etc., at no cost to employees.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Surveillance, Prevention, and Control of Infection (IC)	Respiratory Protection Program

Exposure Control

The Agency is committed to providing a safe working environment for employees who may experience exposure to bloodborne and airborne pathogens. Tuberculosis requirements are found in the Exposure Control Plan (reference following). Please review all of the information, taking time to understand the Agency’s plan for patients/clients and staff. Direct any questions or concerns to your immediate manager. The Agency will ensure that a copy of the Exposure Control Plan is accessible to employees.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Surveillance, Prevention, and Control of Infection (IC)	Exposure Control Plan

Standard Precautions
All employees will use standard precautions. Standard precautions is an infection control method which requires employees to assume all human blood and specific human body fluids are infectious for HIV, HBV, HCV, and other bloodborne pathogens and must be handled accordingly.

All employees will use airborne precautions and follow the Respiratory Protection Program for patients/clients known or suspected to be infected with micro-organisms transmitted by airborne droplet nuclei (i.e., tuberculosis, measles).

Hepatitis B
Employees are encouraged to receive the Hepatitis B vaccine series. The series is available to employees at no cost after training. The form must be completed for acceptance or declination. The employee may obtain the vaccine at a later date if they so decide.

Personal Protective Equipment
Personal protective clothing and equipment are available to employees who have the potential to come in contact with blood or body fluids. infectious materials or respiratory pathogens/contaminants.

Equipment may include face shields, gowns, gloves, masks, eye covers, and pocket resuscitation masks and respirators.

Hazardous Waste
Employees must educate the patient/client on proper disposal of sharps in a puncture proof container, e.g., a hard plastic or metal container with a screw top or reenforced top with heavy duty type tape.

Employees must educate the patient/client on proper disposal of wound dressings by placing soiled bandages, disposable pads/sheets, medical gloves, masks, and gowns in securely fastened plastic bags before placing them in the garbage can with other trash.

Infection Control
The Agency maintains an ongoing Infection Control Program in an attempt to improve patient/client health outcomes. Both patient/client and employee infections are tracked. The Infection Control Program is part of the QAPI Program.

Infection Reporting

- The employee should report patient/client infections on the appropriate form to their immediate supervisor.
- An employee infection or exposure should be reported to immediate supervisor as soon as the employee is aware of it.

- Management will determine if the employee can safely perform duties without exposing co-workers or patients/clients.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Surveillance, Prevention, and Control of Infection (IC)	Infection Control Program

Hand Hygiene

All employees will follow the hand hygiene policy. Hand hygiene supplies are provided by the Agency.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Surveillance, Prevention, and Control of Infection (IC)	Hand Hygiene

Emergency Preparedness and Response

The Disaster Coordinator is responsible for implementation and monitoring of the Emergency Preparedness and Response Program. Ask your supervisor who is designated as the Agency's Disaster Coordinator.

The Agency will use the Emergency Preparedness Potential Disaster Staff Training for information regarding all of the potential disasters and safety tips. If there are any concerns or patient/client needs in any disaster, contact the office.

During a declared public health emergency (PHE), government agencies may issue immediate and frequent notices of changes in regulatory requirements for healthcare providers. To permit the Agency's leadership to respond quickly to the changing regulatory requirements, implement policy revisions and to ensure Agency staff are informed on the rapidly changing operational and patient/client care requirements, the Agency will follow the Emergency Policy Changes policy.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Environment Safety and Equipment Management (EC)	Emergency Preparedness and Response Plan
Environment Safety and Equipment Management (EC)	Emergency Policy Changes

Adverse/Inclement Weather

When inclement weather becomes a danger to agency personnel, only those patients/clients that need medical intervention within 24 hours will be seen.

Patients/clients will be notified of changes in schedule and rescheduled as weather permits.

The Agency's emergency management plan will be implemented.

Equipment Safety and Maintenance

The Agency will ensure safe appropriate use of equipment by agency staff.

Education on the safe use of equipment (i.e., glucose meters, pulse oximeters, coagulation monitors, etc.) will be an ongoing function.

Staff will follow manufacturer's guidelines for maintenance and quality controls. Any staff aware of any equipment defect or hazard should report it to agency management.

Occurrence/Violence Incident Reports

The Agency documents and reports all occurrences/violent incidents (accidents, injuries, safety hazards, employee unprofessional and misconduct, and workplace violence) that deviate from routine operations and might result in injury or potential harm to the patient/client, caregiver, or staff.

The staff member involved or the first one to become aware of the occurrence or violent incident will complete the form and give it to their immediate supervisor.

The Patient/Client/Employee Occurrence/Violence Incident Report is confidential and may not be copied.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Environment Safety and Equipment Management (EC)	Occurrence/Violence Incident Reporting

Clinical Orientation

Section 6: Professional Direct Care Staff

Patient/Client Care Policies and Procedures

On-Call for Patient/Client Care

The purpose of on-call is to ensure that patient/client care needs are met safely and appropriately after agency office hours, during weekends, and on holidays.

The Agency assigns appropriately designated staff coverage for visits that need to be made after office hours, on weekends, or on holidays.

The Agency ensures that an RN is available 24 hours a day, seven days a week to respond to calls. The RN can be contacted through the on-call phone or through the procedure listed in the policy.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Provision of Care (PC)	On-Call for Patient/Client Care

Upon admission, agency staff will educate the patient/client and the caregiver on the process to access care from the Agency or from another health care provider after regular business hours.

Alternative Communication

The agency patient/client census includes a diverse group; therefore, it is necessary to meet a patient's/client's needs in order to provide appropriate and safe care. A patient/client (including companions) may not be able to speak or understand the language spoken by the Agency staff or may be visually, hearing, or speech impaired.

Information must be provided to patients/clients (including companions) in plain language they understand, in a manner that is accessible, and timely to protect the privacy and independent decision-making ability of the individual with disabilities or limited English proficiency (LEP):

- Individuals with disabilities, including accessible websites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, and the Nondiscrimination in Health Programs and Activities Final Rule.
- Individuals with LEP through the provision of language services auxiliary aids and services at no cost to individual, including but not limited to oral interpretation and written translations.

Plain language (also called “Plain English”) is communication the patient/client/companion and/or representative can understand the first time they read or hear it. Language that is plain to one set of readers may not be plain to others. Written material is in plain language if the audience can:

- Find what they need.
- Understand what they find.
- Use what they find to meet their needs.

The term “Auxiliary Aids and Services” may include services and devices such as qualified interpreters on-site or remote through audio or video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing. Appropriate auxiliary aids and services for individuals who are blind or have low vision may include services and devices such as qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

The admitting clinician will assess the patient’s/client’s and companion’s communication needs during the initial visit. This will include determining appropriate alternative methods of communication required to assist with communication. Some of the Agency’s documents may be translated into languages that are common in the populations served by the Agency.

Admission paperwork will include a Notice of Nondiscrimination and the Notice of Availability of Language Assistance Services and Auxiliary Aids and Services, (“Notice of Availability”), provided in English and at least the top 15 languages most commonly spoken by individuals with LEP of the state in which the Agency operates. For individuals with disabilities who require auxiliary aids and services, alternate formats are available. These notices will also be given upon request, annually and when certain documents (electronic and written) are provided.

The Agency also posts these notices on their website and in a clear and prominent place within its physical location. Family members or friends of a LEP person (not qualified as an interpreter to interpret or facilitate communication) may not be used as a translator unless it is a temporary measure while the Agency is finding a qualified interpreter in an emergency. (please refer to the policy for the list of Agency restrictions regarding meaningful access for individuals with LEP.

The Agency will take appropriate and reasonable steps to secure the appropriate alternative communication method to be used. Notify management if your patient/client or their companion require special assistance.

The Agency is responsible for the costs incurred for obtaining the necessary assistance.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Alternative Communication

Advance Directives

Many are uncomfortable discussing terminal illness, but since patients/clients can be kept alive indefinitely with artificial life sustaining procedures, the patient/client must be educated regarding their right to express, in writing, treatment choices if they become seriously ill or unable to communicate. This is the law.

It is required that the patient/client be informed about Advance Directives during the admission process. In the event the patient/client has a Do Not Resuscitate (DNR) order, the admitting nurse should make every attempt to obtain a copy for the Agency record. It is also helpful, if the patient/client has a medical power of attorney, for the Agency to have the name and phone number of that individual.

A list of the DNR patients/clients should be readily available in the on-call book.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Advance Directives

Patient/Client Rights and Responsibilities

At admission, the patient/client receives verbal and written information regarding their rights and responsibilities in a language and manner the individual understands. It is the responsibility of all clinical staff to adhere to patient/client rights and provide additional patient/client education as needed.

When providing written informational materials to patients/client (including companions), the Agency will provide a Notice of Nondiscrimination and a Notice of Availability of Language Assistance Services and Auxiliary Aids and Services to members of the public (i.e. referral sources and community organizations) as necessary to provide meaningful access for individuals with LEP (including companions with LEP) for effective communication (i.e. publications and communications). These notices will be provided at the time of admission, upon request, and on an annual basis. Please refer to the Patient/Client Acknowledgment of Nondiscrimination Notices located in the Forms section under the Admit Pack and the Clinical labels.

The Agency will not discriminate in the provision of services with respect to race, color, national origin (including limited English proficiency and primary language), age, sex (includes, but is not limited to sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity and sex stereotypes), disability, basis of relationship or association, source of payment or any other characteristic protected by federal and state law.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Patient/Client Rights and Responsibilities

Medical Emergency Management

The admitting clinician will assess the patient/client to determine what level of assistance would be needed in case of an emergency. This level will be documented and maintained in case of an emergency.

The admitting clinician will educate the patient/client and/or significant other on what constitutes an emergency and what to do in the event of an emergency.

The patient/client must be educated in an understandable, user friendly manner to ensure that they are able to manage the disease process and medications. The education occurs initially and throughout the patient's/client's certification and at discharge. It is the responsibility of all professional staff to reassess patient/client needs and understanding of how to respond during an emergency situation.

Change in Patient/Client Condition and Verbal Orders

When a change occurs in the patient's/client's condition requiring a change in the POC, a verbal order is used to update the POC. A verbal order is defined by the CoPs as, "a physician, physician assistant, nurse practitioner, or clinical nurse specialist order that is spoken to appropriate personnel and later put in writing for the purposes of documenting as well as establishing or revising the patient's plan of care." The CoPs require verbal orders to be timed as well as dated and signed.

Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians and/or non-physician practitioners issuing orders for the plan of care. Documentation of this communication may be on the visit note and/or communication note except for the physician and/or non-physician practitioner issuing the verbal order for change which would require a verbal order.

Verbal orders supersede orders on the POC and previous verbal orders.

Verbal orders are only valid for the duration listed in the order, or the "TO" date of the POC, whichever comes first.

Verbal orders taken by an LVN/LPN must be co-signed by an RN.

These orders must also be followed specifically, and staff assigned to the patient/client must be aware of these changes.

Abuse, Neglect, and Exploitation

The Agency attempts to identify suspected or alleged victims of abuse and report or refer abuse and/or neglect of the patient/client.

Staff are expected to immediately report an assessment of a patient's/client's condition that might indicate abuse, neglect, or exploitation to the Agency's supervisor. Symptoms that may indicate a need for further investigation include the following:

- Injuries to the trunk of the body that indicate intentional rather than accidental harm.
- Injury with a patterned appearance to it, i.e., marks from a belt or a ring.
- Bruised skin from a grasp.
- Patient/client reports an abusive incident.

If there is cause to believe abuse, neglect, or exploitation of the patient/client has occurred by a staff member, representative, or contractor, it should be reported immediately to the manager and to the appropriate state office.

Management will investigate the situation and report findings to the patient's/client's attending physician and to the appropriate agency according to state regulations.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Provision of Care (PC)	Abuse, Neglect, and Exploitation

Pain

Effective pain management is best achieved by a team approach involving patients/clients, families, and healthcare providers. The clinician should:

- Discuss pain and its management with patients/clients and families. Encourage patients/clients to be active participants in their care.
- Reassure patients/clients who are reluctant to report pain that there are many safe and effective ways to relieve pain.
- Consider the cost of proposed drugs and technologies.
- Share documented pain assessment and management with other clinicians treating the patient/client.
- Know State/local regulations for controlled substances.

Supplies

The Agency stocks standard supplies. Any supplies used for a patient/client must be ordered by the physician and/or non-physician practitioner, either on the plan of care (POC) or on a verbal order.

When a patient/client requires special supplies or large quantities of supplies, notify the person responsible for supplies immediately. Occasionally it may take several days to obtain certain items.

Regulation requires that both routine and non-routine supplies be tracked by the Agency. This includes patient/client supplies and supplies used for maintaining standard precautions (i.e., Band-Aids, tape, gowns, masks, etc.).

Under the PPS system of reimbursement, supplies are "bundled" into the episode payment. This means that Medicare patients/clients who have been receiving supplies from another supplier may need to obtain supplies from the home care agency during their stay on service. It is important to inform the Clinical Manager if you discover, from your patient/client, that he or she is receiving supplies from another supplier.

Medical Equipment

In today's home care environment, patients/clients have the opportunity to use many types of home medical equipment. Also called durable medical equipment (DME), the items are intended to withstand repeated use by non-professionals and are appropriate for home use.

There must be a doctor's order. Medicare or private insurance may pay for the DME. The clinician will document its use in the patient's/client's record.

Note: Medicare does not pay for commode extenders, tub benches, or other bathroom equipment.

The clinician will assess the patient's/client's and/or caregiver's ability to set up, monitor, and change equipment reliably and safely, as well as clean, store, or dispose of equipment or supplies using proper technique learned from the DME supplier.

The DME supplier is responsible for proper delivery and initial setup of the equipment. The DME representative should ensure the home environment is suitable and safe for proper usage of the equipment. The DME representative is responsible for training the patient/client, family, and caregivers on the proper usage and maintenance of the equipment. There should be a 24 hour contact number and/or information provided in the event of equipment malfunction or another emergency.

The clinical staff will reinforce using the DME correctly and review any areas of non-compliance with the patient/client regularly. It is expected the patient/client will follow the manufacturer's instructions and those given by the DME representative.

Notify the supervisor if the patient/client needs equipment.

The Agency will also follow the requirements of the Safe Medical Device Act to identify, report, and correct medical device incidents. These include serious injury and death to the patient/client. The Administrator, or designee, will be responsible for determining when a reportable event has occurred and will complete all required documentation, including the Food and Drug Administration's (FDA) reports, if applicable.

Transfer and Discharge

Criteria for transfer or discharge are based on 42 CFR 484.50(d) and found in the following policy:

Review the following policy and procedure:

Online Bookmark	Title of Policy
Assessment (PE)	Patient/Client Transfer, Discharge, and Agency Dissolution

Transfer and Discharge Notices
These forms are required to be given to the Medicare fee-for-service patient/client in the following situations:

- Advance Beneficiary Notice (ABN) – When the patient/client no longer meets Medicare coverage criteria, e.g., is no longer homebound.
- Home Health Change of Care Notice (HHCCN) – When services or supplies are changed or decreased, e.g., the physician and/or non-physician practitioner discontinues wound care services earlier than expected.
- Notice of Medicare Non-Coverage (NOMNC) – Two days prior to discharge to provide the patient/client with information to appeal the discharge.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Assessment (PE)	Patient/Client Transfer and Discharge Notices

Documentation

Documentation Guidelines in Home Care
The home health record is a written account of the patient's/client's history, status, and progress. It contains a plan of care (orders), patient/client care forms, and business and financial data.

Documentation and Standards

- The record is the data base for planning individualized care for the patient/client and serves to communicate information to all health professionals involved in the patient's/client's care.
- It serves an important legal function. It documents evidence for the patient's/client's care.
- It also serves an important financial function. It documents evidence for patient's/client's insurance claims, including Medicare.
- It serves to protect the professional and the Agency from liability issues that could result in loss of licensure. The phrase "if it was not charted, it was not done" reminds us that the best evidence of an event is usually what is in writing. Because most malpractice claims occur long after the events take place, when recollection can be unclear, the written record is given great significance. The written record can be the best indicator of what actually happened because it was written at the time of the event.

- Just as crucial to the ability to provide nursing or professional services in the home, is the ability to justify what the patient's/client's needs are, what the nurse or other professional does in the home, and why it is done. Documenting the care provided is just as important as the quality of care provided. The attention to detail is necessary and the importance of accuracy and comprehensiveness is critical.

General Documentation Issues Required by Law

- The record must be accurate. Poor documentation can lead to errors in the care of the patient/client. All care requires a physician's and/or non-physician practitioner's order, which must be current, documented, and available for all staff providing care impacted by the order.
- A statement made by a patient/client and/or family can be recorded in quotation marks to indicate the source of the information. In general, conclusions should be avoided, and the actual data recorded.
- Initial and ongoing assessments and interventions must be documented in the record. The RN case manager should be notified of any change in patient's/client's condition. Staff should record who was notified of changes in the patient's/client's status, including times and dates. Any other follow-up care should then also be documented.
- In the home care situation, it is important to document objective facts and direct observations.

Basic Principles of Effective Documentation

- Draw a single line through an error. Then date and sign the correction.
- Never white-out, erase, or write over a previous entry, whether handwritten or computer generated.
- Entries must be made in a timely manner, i.e., clinical notes must be completed the day care is provided and filed in the record within 14 business days or as required to comply with state regulations.
- Avoid contradictions or inconsistencies in the chart.
- Date when reports are received. Date and time orders when received.
- Use standard abbreviations.
- If additional information is remembered later, write it as an addendum titled "late entry" with date, signature, and title.
- All documentation should be legible and include the date, time, signature, and title.
- All entries should be written in ink.

Documentation Tips

- Use such words as:
    - Observation and assessment

- Teaching and instruction
- Performance of skilled procedures
- Specific observations rather than general

- Use complete and accurate documentation, and reflect the care actually given at each visit.
- Be as brief and concise as possible.
- Be sure documented care reflects the patient's/client's diagnosis and plan of care (orders).
- Write clinical notes so they can stand alone.
- Elaborate on factors effecting the lack of progress.
- Always document phone conversations with the patient/client, physician and/or non-physician practitioner, or home care providers.
- Any instructions to the patient/client to make an appointment or follow-up with the physician and/or non-physician practitioner should be noted.

Summary

The importance of documentation in the medical record relates to the fact that this record is:

- The only written source for reference and communication among members of the home care team.
- The only text that supports insurance coverage and/or denial.
- The only evidence of the basis on which patient/client care decisions were made.
- The only legal record.
- The primary foundation for the evaluation of the care provided.
- The objective source for the Agency's licensing, accreditation, and state surveyor review.

Documentation is the key!

The clinician needs to "paint a picture" for anyone who is reading the record.

Please note approved abbreviations for documentation in following policy.

Online Bookmark	Title of Policy
Management of Information (IM)	Interfacing Standardized Information

Documentation to Support Medical Necessity

Documentation to support skilled services are as follows from CMS's Medicare Benefit Policy Manual, Chapter 7.

As is outlined in home health regulations, as part of the home health agency Conditions of Participation (CoPs), the clinical record of the patient/client must contain clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10, "Home Health Agency Billing", instructions specify that for each claim, agencies are required to report all services provided to the beneficiary during each episode, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's/client's achievement towards his or her goals as outlined in the plan of care. In this way, the notes will serve to demonstrate why a skilled service is needed. Therefore, the home health clinical notes must document as appropriate:

- The history and physical exam pertinent to the day's visit, including the response or changes in behavior to previously administered skilled services, and the skilled services applied on the current visit.
- The patient/client and/or caregiver's response to the skilled services provided.
- The plan for the next visit based on the rationale of prior results.
- A detailed rationale that explains the need for the skilled service in light of the patient's/client's overall medical condition and experiences.
- The complexity of the service to be performed.
- Any other pertinent characteristics of the beneficiary or home.

Clinical notes should be written so that they adequately describe the reaction of a patient/client to his or her skilled care.

Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's/client's care should not be used. For example, terminology such as the following would not adequately describe the need for skilled care:

- Patient/client tolerated treatment well.
- Caregiver instructed in medication management.
- Continue with the POC.

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

Agency Forms

Medication Profile

A complete and comprehensive medication review will be performed by the registered nurse upon admission. The profile must be current at all times; therefore, it is the responsibility of all clinical staff to ensure it is updated with all new (within 30 days), changed (within 60 days), and/or discontinued medications. When any professional, licensed staff is made aware of a medication change, the RN should be notified.

Medications directly prescribed by the physician and/or non-physician practitioner (i.e., a new medication bottle or prescription) may be documented on the patient/client visit note and the medication list once the medication is in the home.

Medication orders given from physician and/or non-physician practitioner to the clinician or those given to the patient/client and verified by the clinician, will be documented on a verbal order and added to the Medication Profile.

Care Coordination

Communication Notes

Any communication that does not occur during a home visit should be documented on a communication note. Communication between disciplines, with physicians and/or non-physician practitioners, community resources, patient, representative(s), family, significant others, and caregivers should be documented on the communication note.

This form assists in documenting the coordination of care and services, between the patient, representative, other disciplines, and physician(s) and/or non-physician practitioner(s) if an order is not required.

Progress/Summary/Team Conference Notes

This is used to document the care that has been provided as well as the skilled care that will be provided. It documents coordination of care between the disciplines and physician(s) and/or non-physician practitioner(s).

The summary describes the events that occurred. This supports the need for continued care.

- Prioritize patient/client needs in a chronological order.
- Emphasize the need for therapy services or additional disciplines.
- Document the homebound status.
- Evidence the need for home health aide care.
- All disciplines providing care.

- All outside entities providing services.
- The summary should be mailed or faxed to the physician, while maintaining the original in the patient/client chart. Notation of the summary being sent to the physician should appear on the form.

Transfer Summary

A transfer summary for a planned transfer must be completed and sent to the receiving entity prior to or simultaneously with the initiation of patient/client services at the new entity; or within two business days of becoming aware of an unplanned transfer if the patient/client is still receiving care in the healthcare entity at the time when you become aware of the transfer.

The content of the transfer summary typically contains the same components as listed below for a discharge summary.

Discharge Summary

A summary must be completed at discharge and sent to the primary care practitioner or other healthcare professional(s) who will be responsible for providing care and services to the patient/client after discharge from the Agency within five business days of the discharge. The summary includes:

- Admission and discharge dates.
- Physician responsible for the home health plan of care.
- Reason for admission to home health.
- Type of services provided and frequency of services.
- Laboratory date(s).
- Medications the patient/client is on at the time of discharge.
- Patient's/client's discharge condition.
- Patient/client outcomes in meeting the goals in the plan of care.
- Patient/client and family post-discharge instructions.

If SN, PT, OT, or ST discharge prior to the final agency discharge, a discipline specific discharge should be completed and sent to the ordering physician and/or non-physician practitioner.

Documentation that is submitted will be reviewed for thoroughness, completeness, and skill. If it is incorrect, the Agency will contact the staff person to correct it as soon as possible.

Section 7: Admission and Recertification

Criteria for Admission

Eligibility criteria for patient/client admission to the Agency are based on the following policy.

Online Bookmark	Title of Policy
Assessment (PE)	Criteria for Patient/Client Admission and Recertification

Depending on the payer source, criteria may vary.

Criteria for Medicare Coverage

You will have the responsibility of admitting patients/clients to the Agency within 48 hours of referral, within 48 hours of the patient's/client's return home, or on the ordered start of care date. Medicare patients/clients must be admitted by an RN if nursing is ordered. If no nursing, then the Physical Therapist, if ordered or Speech Language Pathologist, if ordered may admit. The following information will assist you in understanding the admission process with a focus on Medicare fee-for-service requirements.

A patient/client must meet criteria for services to be covered and reimbursed under Medicare.

1. The Patient/client must be Homebound.
    a. An individual shall be considered "confined to the home" (homebound) if the following two criteria are met:
        i. Criteria One:
            - Because of illness or injury, the patient/client needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave the place of residence.
            - OR
            - Have a condition such that leaving home is medically contraindicated.
    b. If the patient/client meets one of the Criteria One conditions, then the patient/client must also meet two additional requirements defined in Criteria Two.
        i. Criteria Two:
            - There must exist a normal inability to leave home.
            - AND
            - Leaving home must require a considerable and taxing effort.

- Psychiatric conditions manifested by a refusal to leave home or it is unsafe for the patient/client or others if the patient/client leaves home, may render the patient/client homebound.

- AND
- Homebound status is not affected by frequent absences from the home when the reason to leave is to receive medical treatment, such as:
  - Attendance at a state licensed adult day care
  - Doctors' office visits
  - Outpatient kidney dialysis
  - Outpatient chemotherapy or radiation therapy
- The patient/client is allowed brief and infrequent absences from the home for non-medical reasons.

c. Continued care of a Medicare patient/client who is not homebound is considered fraud.

2. Patients/clients must be under the care of a physician.
   a. A medical plan of care (POC) must be established by the attending physician in conjunction with the home health professional staff.
   b. The physician's signature on the POC must be obtained prior to billing for reimbursement from Medicare.
   c. The POC must be reviewed by the physician at least every 60 days.
3. The physician must certify that:
   a. Home health services are or were needed because the patient/client is homebound.
   b. The patient/client needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services has ceased. Where a patient's/client's sole skilled service need is for skilled oversight of non-skilled services (management and evaluation of the care plan), the physician must include a brief narrative describing the clinical justification of this need as part of the certification and recertification, or as a signed addendum to the certification and recertification.
   c. A plan of care has been established and is periodically reviewed by a physician.
   d. The services are or were furnished while the patient/client is or was under the care of a physician.

4. The patient/client must require skilled care.

    a. Skilled services are those which are medically reasonable to the treatment of the patient's/client's illness or injury at a reasonable frequency to meet the patient's/client's need. Skilled care is care that requires the skills of a licensed nurse, physical therapist, or a speech therapist, or the ongoing care of an occupational therapist.

    b. Skilled nursing services must be intermittent. There must be a medically predictable and recurring need for care which would require more than one skilled nursing visit.

    c. Medicare will pay for daily skilled nursing visits for approximately three weeks. Daily skilled visits are defined as seven days a week. Orders for daily skilled visits for longer than three weeks of care other than insulin administration must have an end-in-sight documented.

    d. Home health aide visits can only be performed when a skilled service is being provided by an RN or LVN/LPN, PT, ST, or continuing an OT.

    e. Venipuncture is not a qualifying skill. It is a covered/billable service if another qualifying skill is provided.

    f. Feeding a patient/client through a G-tube is not considered skilled.

5. Care must be reasonable and necessary.

    a. Skilled services are those services that are reasonably necessary to the treatment of a patient's/client's illness or injury.

6. The patient/client must have a face-to-face (F2F) encounter. MLN Matters Number: SE1219 provides the below F2F information.

    a. Face to Face Requirements:

        i. For initial home health certifications only, the certifying physician must document that the physician himself or herself, an allowed non-physician provider (NPP), or another physician caring for the patient/client in an acute or post-acute facility who has privileges at the facility had a face-to-face encounter with the patient/client.

        ii. The face-to-face encounter must occur 90 days prior to the home health start of care date or within thirty days after the start of care.

        iii. The inclusion of the physician's F2F encounter note is a requirement.

        iv. Prior to billing, the home health agency should ensure that all certifications are complete to include the face-to-face documentation that has been clearly titled, dated, and signed by the certifying physician.

b. Those to Perform the Face-to-Face Encounter:

i. Medicare-enrolled physicians who are also the certifying physician.

ii. The following physicians are allowed to perform the face-to-face encounter and inform the certifying physician:

- Physicians (Medicare-enrolled or otherwise) who cared for the patient/client in an acute or post-acute facility during a recent acute or post-acute stay and have privileges at the facility.
- Because physicians in their residencies (Medicare-enrolled or otherwise) do not have privileges at acute or post-acute facilities, if they are performing the encounter and informing the certifying physician, they must inform the certifying physician under the supervision of their teaching physician who must have such privileges.
- NPPs allowed to perform the face-to-face encounter include:
  - A nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician in accordance with state law.
  - A certified nurse midwife under the supervision of the certifying physician, as authorized by state law.
  - A physician assistant under the supervision of the certifying physician.
- NPPs are subject to the same financial restrictions with the home health agency as the certifying physician.

c. Face-to-Face Documentation Requirements:

i. Documentation must be clearly titled, dated, and signed by the certifying physician, whether as part of the certification form itself, or as an addendum. It must also include the date the face-to-face encounter was performed.

ii. The face-to-face documentation must be that of the certifying physician and cannot be altered or changed in any way by the home health agency.

iii. The face-to-face documentation is part of the certification, and the certification is required at the time the home health agency bills Medicare.

iv. The face-to-face documentation can include, or exist as, check boxes so long as it comes from the certifying physician.

v. If the physician who cared for the patient/client in the acute or post-acute facility chooses to use documentation that is compiled from the patient's/client's medical record (e.g., a discharge summary) to inform the certifying physician of how the clinical findings of the face-to-face encounter

support Medicare home health eligibility for that patient/client, the compiled documentation must be reflective of the clinical findings of that face-to-face encounter as observed by that physician caring for the patient/client in the acute or post-acute facility, thus serving as that physician's communication to the certifying physician. Further, if the certifying physician chooses to use the encounter documentation from the informing physician as his or her documentation of the face-to-face encounter, the certifying physician must sign and date the documentation, demonstrating that the certifying physician received that information from the physician who performed the face-to-face encounter, and that the certifying physician is using that discharge summary or documentation as his or her documentation of the face-to-face encounter. One physician signature, from the certifying physician, suffices if the face-to-face encounter documentation is co-located with the physician's certification of eligibility. Otherwise, if the face-to-face documentation is attached as an addendum to the certification (a separate document), the face-to-face documentation and certification each require a signature from the certifying physician.

d. Palmetto GBA article published on 04/06/2017 titled "'Connecting the Dots' for Face-to-Face Documentation" states:

    i. The inclusion of a F2F encounter document is a requirement. It is also required that recognition be provided by the certifying physician that an alternate physician created the F2F record on a specific date. There are multiple options that satisfy this requirement. The mechanism to "connect the dots" is often likely to be provided by the home health agency. These are possible options:

        - The plan of care document is a record that is readily available and must include a signature of the certifying physician. There are multiple avenues for including the F2F recognition on the POC (485).

        - The date of the F2F encounter may be noted on the POC, the statement may include the name of the physician completing the F2F. This option may be the simplest approach if the F2F document is already in-house with the agency since the date of the F2F encounter and physician who prepared it will be known. A copy of the F2F that was prepared by an alternate physician must be forwarded to the certifying physician for their records.

        - These same elements may appear on an addendum. The POC and its addendum require the signature of the certifying physician and the signature will validate the existence of the F2F encounter document when the date of the F2F is identified as such on the POC. A copy of the F2F that was prepared by an alternate physician must be forwarded to the certifying physician for their records.

- The home health agency may choose to send a separate communication to the certifying physician advising the certifying physician of the F2F encounter date and the physician who completed it. The certifying physician should be instructed to sign, date, and return the communication. A copy of this communication must be included with the F2F records being forwarded. Additionally, a copy of the F2F that was prepared by an alternate physician must be forwarded to the certifying physician for their records.
- The F2F may be faxed to the certifying physician with a request that it be signed, dated, and returned.
- An attestation is often utilized as a supplemental document. The information specifying the date of the F2F (and the physician who prepared it) when signed and dated on the attestation by the certifying physician validates a F2F encounter.
- Again, a copy of the F2F that was prepared by an alternate physician must be forwarded to the certifying physician for their records.
- Electronic signatures are acceptable.

Admission Process

The admitting clinician makes the admission visit on the designated start of care date.

The following documents are required for admission:

Document	Comments	Original Left in Home	Copy Left in Home	Original Submit to Office within 24-48 Hours
Consent Form	Must be completed in advance of providing direct care or education and signed by the patient or legal representative, if applicable.		X	X
Patient/Client Rights and Responsibilities	Provided in a language and manner the patient or representative understands in advance of providing direct care or education.	X		
Notice of Nondiscrimination and Notice of Availability of Language Assistance Services and Auxiliary Aids and Services	Notices left with patient/client/companions. Signed Patient/Client Acknowledgment of Nondiscrimination Notice is returned to the office.	X		Acknowledgment returned to office

Agency policy on Discharge and Transfer	Provided in a language and manner the patient or representative understands in advance of providing direct care or education.	X		
OASIS Comprehensive Assessment	Complete assessment of the patient at the time of the visit and prior 24 hours.			X
** Medication Profile/List	Medication schedule/instructions including, medication name, dosage and frequency and which medications will be administered by Agency personnel and personnel acting on behalf of the Agency. The information must be written in plain language avoiding the use of medical abbreviations.		X	X
Safety Handout/Assessment	Note patient specific concerns, education. Must include hazardous waste disposal if applicable.	X		
Patient/Client Individual Emergency Plan/Emergency Preparedness	Individualize to the patient/client. Note in OASIS SOC assessment the plan/triage code.	X		
Contact information to include name, address, and telephone number for:	Agency Administrator, Agency Clinical Manager, Agency on Aging, Center for Independent Living, Protection and Advocacy Agency, Aging and Disability Resource Center, and Quality Improvement Organization	X		
*Document to provide patient/client with treatments and any other pertinent instructions	Any treatments to be administered by Agency personnel and personnel acting on behalf of the Agency, including therapy services. Any other pertinent instructions related to the patient/client's care and treatments that the Agency will provide, specific to the patient's care needs	X		
*Visit frequency calendar	A calendar or another method to provide the patient/client with their visit schedule, including frequency of visits by Agency personnel and personnel acting on behalf of the Agency	X		
Home Health Aide Care Plan (if aide services are ordered)			X	X
Vital Signs Log (optional)		X		

Plan of care or worksheet (optional)	All orders for the 60 day episode. A worksheet may be used by Agency to develop the Plan of Care.			X

*Once the comprehensive assessment is completed (within five days of the initial visit) and the plan of care is approved by the responsible physician, the *documents must be provided to the patient and/or their representative.

If therapy and/or social work services are ordered, their evaluation visit will be made within four days of referral or as ordered.

Documentation that is submitted will be reviewed for thoroughness, completeness, and skill. If it is incorrect, the Agency will contact the staff person to correct it as soon as possible.

Documentation

Consent Form

The purpose of this form is to obtain consent to treat, release medical records and bill for services. It also serves to document patient/client education regarding financial obligation, patient/client rights, Advance Directives, and the complaint procedure. It should be filled out completely. The consent is signed/witnessed by agency staff. If someone other than the patient/client signs the consent, there should be an explanation of the relationship and why the patient/client is unable to sign.

42 CFR §484.50(b) Exercise of Rights states:

- §484.50(b)(1) If a patient has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction, the rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf.
- §484.50(b)(2) If a state court has not adjudged a patient to lack legal capacity to make health care decisions as defined by state law, the patient's representative may exercise the patient's rights.
- §484.50(b)(3) If a patient has been adjudged to lack legal capacity to make health care decisions under state law by a court of proper jurisdiction, the patient may exercise his or her rights to the extent allowed by court order.

Comprehensive Assessment

Regulation requires the OASIS data set to be incorporated with the clinical assessment to be a comprehensive assessment. See Section 7. OASIS for details.

The following policy includes required content of the comprehensive assessment.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Provision of Care (PC)	Initial Patient/Client Comprehensive Assessment

Advance Directives

It is required that the patient/client be informed about advance directives as recognized by the state (e.g., Living Will, Out of Hospital DNR, Medical Power of Attorney) during the admission process. In the event the patient/client has an advance directive the admitting clinician should make every attempt to obtain a copy for the Agency's record. If the patient/client has a Medical Power of Attorney, the name and phone number should be documented.

The admitting clinician will:

- Identify if the patient/client has advance directives.
- Assist the patient/client and/or significant other with a decision regarding DNR in the event death is imminent.
- Provide written materials and document patient/client education on Advance Directives.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Admit Pack (AP)	Patient Rights and Responsibilities, Advance Directives and DNR

Home Safety Assessment

The safety education must be individualized to the patient's/client's needs instead of providing generic safety information (i.e., COPD patients/clients need education on oxygen safety, patients/clients receiving injections require instructions on disposal of biohazard waste).

The admitting clinician must educate the patient/client when appropriate concerning:

- Fire prevention safety
- Prevention of falls and other injuries
- Bathroom safety
- Weather precautions
- Poison prevention
- Hazardous waste/sharps disposal
- Oxygen/medical gases safety

Medication Profile

A complete and comprehensive medication review will be performed by the RN upon admission. All medications – prescription, over-the-counter, herbals, oxygen, samples, home remedies, etc. – are included. All medications are reviewed to identify any potential adverse effects and drug reactions

including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and non-compliance. All medications are reconciled with orders.

Once the comprehensive assessment is completed (within five days of the initial visit) and the plan of care is approved by the responsible physician, the medication schedule/instructions will be provided to the patient/client. The medication administration instructions must be written in plain language, avoiding the use of medical abbreviations and include medication name, dosage, frequency, and if to be administered by agency personnel or contracted personnel.

In the event the orders are for therapy only, the therapist will be responsible for documenting medications which the RN will review as above, and date and co-sign.

Plan of Care (POC)

Each patient/client must receive the home health services that are written in an individualized Plan of Care that identifies patient/client-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathic medicine, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient/client under a Plan of Care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.

Each patient/client must participate in developing an individualized Plan of Care, including any revisions or additions. The individualized Plan of Care must specify the care and services necessary to meet the patient/client-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the Agency anticipates will occur as a result of implementing and coordinating the Plan of Care. The individualized Plan of Care must also specify the patient/client and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Provision of Care (PC)	Plan of Care

The content of the individualized Plan of Care is listed in the above policy. Further explanation of some items:

- The patient's/client's mental status is most generally screened by asking questions on orientation to time, place, and person.
- Psychosocial status may include, as relevant to the Plan of Care, interpersonal relationships in the immediate family, financial status, homemaker/household needs, vocational rehabilitation needs, family social problems, transportation needs, and cognitive status.
- The risk of ER visits and hospitalizations is greatly influenced by increased concerns or needs identified in status elements (1), (2), (6), (7), (9), and (10).
- A measurable outcome is defined as a change in health status, functional status, or knowledge, which occurs over time in response to a healthcare intervention. For example, a patient's/client's goal may be to be able to walk to the kitchen and prepare a light meal. The

measurable outcome may be to improve ambulation if ambulation is the reason the patient/client is currently unable to go to the kitchen. Or the outcome may be to improve dyspnea if the reason is shortness of breath. The Agency's interventions will allow the patient/client to progress toward the Agency's goals (increase strength to ambulate twenty feet or complies with energy conservation measures to ambulate twenty feet). The Agency's goals, as met, help the patient/client improve their outcome of ambulation or dyspnea.

Home Health Aide Care Plan

If the patient/client requires the services of an aide, a care plan must be completed prior to the patient/client receiving personal care. The copy of the care plan may be left in the patient's/client's home folder.

Assignment of aide duties must indicate tasks and frequency of each. Assigning "per patient/client request" is not generally recommended, however, it is acceptable to allow patient/client choice if it is also documented that the patient/client is cognitively capable of making the decision and functionally able to complete the task.

Note any special problems or services the patient/client may have and instruct the aide on patient/client specific care. Indicate parameters of blood pressure, temperature, etc., so the aide is aware when to notify the supervising clinician.

The care plan should be updated as the patient's/client's condition changes (e.g., a patient/client discharged from the hospital initially may require a bed bath, but as improvement is made the patient/client may be able to shower).

The aide should not perform any services that are not ordered on the care plan. If the patient/client requests other tasks not assigned, the aide must notify the supervising clinician to revise the aide care plan.

Recertification Process

At the end of the initial 60-day episode, a decision must be made as to recertify the patient/client for a subsequent 60 day episode or not. According to the regulations at 42 CFR §424.22(b)(1), recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Unless there is a 1) patient/client-elected transfer or 2) discharge with goals met and/or no expectation of a return to home health care (these situations trigger a new certification), Medicare does not limit the number of continuous episodes of recertification for patients/clients who continue to be eligible for the home health benefit.

<u>Recertification Requirements per MLN Matters Number: SE1436</u>

- The recertification documentation must be signed and dated by the physician who reviews the plan of care.
- The physician must indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT, or SLP services).

- The physician must estimate the length of time skilled services will be required. The length of service must be individualized to the patient/client and reflect a realistic expectation of patient's/client's need for care. For example, a slow healing wound may realistically require 120 days. It is not acceptable to have a recurring 60 day expectation on each plan of care.

It must be clear that the last two bullets are from the physician/physician's office and not the clinician.

Recertification Documentation

The following documentation is completed at the time of recertification:

- A new comprehensive assessment, including OASIS.
- A thorough review of all medications with an update of the medication profile.
- A plan of care is developed for the new episode of care, including the certification statement from the physician with the estimate of how much longer the skilled services will be required.
- The aide care plan is reviewed and revised as needed.
- A written summary may be required by the Agency to summarize the care provided in the current episode and to explain the ongoing need for the new episode. Ask the supervisor for the Agency's process.

Section 8: Outcome and Assessment Information Set (OASIS)

Introduction

The assessment document that is used in the Agency incorporates the OASIS data elements and comprehensive assessment data. In order to understand this assessment, there must first be an understanding of some facts about OASIS data items or "M items". The assessment form is comprised of both clinical assessment information as well as "M items". These become the "Comprehensive Assessment". The OASIS items alone do not include all the assessment information that is needed in order to adequately describe the condition of the patient/client. The forms provided by the Agency also provide a section on the assessments to document the skilled care provided on that visit. It is important, in order to be compliant with the regulations, that no additional nurse's note is used with the OASIS form.

OASIS

- Outcome and Assessment Information Set or OASIS.
- Designed to measure home health patient/client care outcomes.
- Measures changes in a patient's/client's condition between two time points.
- Quality of care is measured by patient/client outcomes.
- Patient/client risk factors are taken into consideration.

Data Collection

OASIS data must be collected on the following patients/clients in a Medicare certified agency:

- Patients/clients 18 years or older (collect on a private insurance patient/client but do not transmit at this time)
- Non-maternity patients/clients
- Excludes patients/clients receiving only homemaker or chore services
- What are the time frames required for collection, data entry, and submission to CMS national data base?

Data is collected at specific points in the course of treatment. All of these assessments, with the exception of transfer to inpatient facility and death at home, require the clinician to have an in-person encounter with the patient/client during a home visit.

- Start of Care (SOC) – Patient/client must be seen within 48 hours of referral and the assessment must be completed within five days with SOC date as day "0".
- Resumption of Care (ROC) – Resume care after a qualifying inpatient stay of more than 24 hours. Complete the ROC assessment within 48 hours of return home, the Agency's notification of return home, or the actual ordered ROC date.

- Recertification – No earlier than five days prior to end of certification (56th through the 60th day). If an ROC occurs in this time frame, then only an ROC assessment is required, along with the recertification documents such as the new POC, aide care plan, medication profile, etc.
- Other Follow-Up – Defined by agency policy. CMS defines it as a change in the patient's/client's condition that requires a change in the plan of care and was not expected in the original plan of care. The assessment is completed within 48 hours.
- Transfer to Inpatient Facility (24 hours or longer) – Patient/client is not discharged but is placed on agency "hold". Complete OASIS transfer assessment within 48 hours of transfer or agency notification. If the patient/client remains in the hospital at the end of the episode, the patient/client must be discharged from the Agency. However, no additional OASIS assessment is required, simply a discharge summary.
- Transfer to Inpatient Facility and Agency Discharges – Complete OASIS transfer form and an agency Discharge Summary within 48 hours of transfer or agency notification.
- Discharge from the Agency – Complete OASIS Discharge Assessment form and an agency Discharge Summary within 48 hours of discharge.
- Death at Home – Complete the OASIS Death at Home Assessment if a patient/client dies at home or en route to the hospital. Complete the assessment within 48 hours of the death or agency notification.

<u>OASIS Data Collection and Documentation Responsibilities</u>

- OASIS data items are considered "discipline neutral" which means data may be collected by an RN, PT, or ST/SLP. There are forms that include discipline specific assessment items available. The Agency may prefer that the RN complete all the OASIS assessments.
- OT may collect the OASIS data when there is a continued need for OT after all other services have discharged, and OT is the qualifying service.

<u>Administrative Staff Responsibilities</u>

- Develop tracking mechanism to ensure documentation is submitted in required time frames.
- OASIS assessments should be reviewed to ensure that the data is complete and timely. If it is incorrect, clinician will be contacted to correct it as soon as possible due to the time constraints on OASIS submission. It is critical that assessments be submitted timely.
- OASIS transmission must follow the same sequence as the OASIS data collection. If a patient/client is transferred to an inpatient facility and returns to the Agency, the transfer OASIS must be transmitted prior to the resumption of care OASIS.

Consequences of Non-Compliance

An agency may:

- Be fined for untimely submission of the OASIS.
- Not receive reimbursement for the patient/client care that has been provided.
- Be terminated from the Medicare program.

Conventions/Rules for Completing OASIS

Listed below are conventions, or general rules, that should be observed when completing OASIS. Item-specific guidance is provided in Chapter 3 of the OASIS Guidance Manual. The OASIS Guidance is updated periodically to provide additional clarification based on "Frequently Asked Questions" sent to CMS.

Each patient/client scenario, clinical status, and social and environmental situation is unique, requiring professional/clinical judgment and care coordination. In the event you cannot resolve your understanding of the OASIS questions, discuss with the supervisor.

General OASIS Item Conventions

- Understand the time period under consideration for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.
- For OASIS purposes, a quality episode must have a beginning (that is, an SOC or ROC assessment) and a conclusion (that is, a Transfer or Discharge assessment) to be considered a complete quality episode.
- If the patient's/client's ability or status varies on the day of the assessment, report the patient's/client's "usual status" or what is true greater than 50% of the assessment time frame, unless the item specifies differently.
- Minimize the use of NA and unknown responses.
- Some items allow a dash response. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient/client is unexpectedly transferred, discharged, or dies before assessment of the item could be completed. CMS expects dash usage to be a rare occurrence.
- Responses to items documenting a patient's/client's current status should be based on independent observation of the patient's/client's condition and ability at the time of the assessment without referring back to prior assessments. Several process items require documentation of prior care, at the time of, or since the time of the most recent SOC or ROC OASIS assessment. These instructions are included in item guidance for the relevant OASIS questions.

- Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (for example, it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at start of care, or to examine the care notes to determine if an ordered intervention was implemented at transfer or discharge). However, when assessing physiologic or functional health status, direct observation is the preferred strategy.
- When an OASIS item refers to assistance, this means assistance from another person. Assistance is not limited to physical contact and can include verbal cues and/or supervision.
- Complete OASIS items accurately and comprehensively and adhere to skip patterns.
- Understand the definitions of words as used in the OASIS.
- Follow rules included in the specific OASIS Item Guidance (Chapter 3 of the OASIS Guidance Manual).
- Stay current with evolving CMS OASIS guidance updates. CMS may post updates to the Guidance Manual up to twice per year, and releases OASIS Q&As quarterly.
- Only one clinician may take responsibility for accurately completing a comprehensive assessment. However, for all OASIS data items integrated within the comprehensive assessment, collaboration with the patient/client, caregivers, and other healthcare personnel, including the physician, pharmacist, and/or other agency staff, is appropriate and would not violate the one clinician convention. When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources and selecting the appropriate OASIS item response(s) within the appropriate time frame and consistent with data collection guidance.
- The use of the term “specifically” means scoring of the item should be limited to only the circumstances listed. The use of “for example” means the clinician may consider other relevant circumstances or attributes when scoring the item.

<u>Conventions Specific to ADL/IADL Items</u>

- Report the patient’s/client’s physical and cognitive ability to perform a task. Do not report on the patient’s/client’s preference or willingness to perform a specified task.
- The level of ability refers to the level of assistance (if any) that the patient/client requires to safely complete a specified task.
- While the presence or absence of a caregiver may impact the way a patient/client carries out an activity, it does not impact the assessing clinician’s ability to assess the patient/client in order to determine and report the level of assistance that the patient/client requires to safely complete a task.
- Understand what tasks are included and excluded in each item, and select the OASIS response based only on included tasks.

- If the patient's/client's ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.
- Consider medical restrictions when determining ability. For example, if the physician and/or non-physician practitioner has ordered activity restrictions, consider this when selecting the best response to functional items related to ambulation, transferring, bathing, etc.

Each agency is responsible for monitoring the accuracy of the assessment data and the adequacy of the assessment process. All documentation needs to be consistent throughout all the forms completed (i.e., POC, visit notes, summary reports, etc.).

The Agency is required to submit all OASIS assessments to the national database specified by CMS within 30 days of the M0090 date.

For more information see the OASIS Guidance Manual.

Section 9: Skilled Nursing

Medicare Criteria for Skilled Nurse Coverage

Medicare reimburses home health agencies for specific nursing services. These include Observation and Assessment, Teaching and Training, and specific Direct Care that requires the skills of a nurse, as well as Management and Evaluation of the Care Plan when nursing skills are required to oversee unskilled care. Specific descriptions and examples can be found in the CMS Medicare Benefit Policy Manual, Chapter 7, Home Health Services Section 40.1.

1. Observation and Assessment

   "Observation and assessment of the patient's/client's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's/client's condition that requires skilled nursing personnel to identify and evaluate the patient's/client's need for possible modification of treatment or initiation of additional medical procedures until the patient's/client's clinical condition and/or treatment regimen has stabilized. Where a patient/client was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

   Information from the patient's/client's home health record must document the rationale that demonstrates that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient/client, then the services would be covered. However, observation and assessment by a nurse is not reasonable and necessary for the treatment of the illness or injury where fluctuating signs and symptoms are part of a longstanding pattern of the patient's/client's condition which has not previously required a change in the prescribed treatment." – Medicare Benefit Policy Manual 40.1.2.1

2. Management and Evaluation of a Patient's/Client's Care Plan

   "Skilled nursing visits for management and evaluation of the patient's/client's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's/client's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's/client's recovery and medical safety in view of the patient's/client's overall condition." – Medicare Benefit Policy Manual 40.1.2.2

3. Teaching and Training Activities

"Teaching and training activities that require skilled nursing personnel to teach a patient/client, the patient's/client's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's/client's functional loss, illness, or injury.

Where it becomes apparent after a reasonable period of time that the patient/client, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary. The reason why the training was unsuccessful should be documented in the record. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's/client's illness, functional loss, or injury.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the patient/client are to be considered. Where the teaching constitutes reinforcement, an analysis of the patient's/client's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the patient/client returns home. Where the patient/client needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's/client's condition that requires re-teaching, or where the patient/client, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/client and/or caregiver response to the education." – Medicare Benefit Policy Manual 40.1.2.3

4. Administration of Medications

"Although drugs and biologicals are specifically excluded from coverage by the statute (§1861(m)(5) of the Act, the services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

A. Injections

Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. Where these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the patient's/client's illness or injury, and there must be a medical reason that the medication cannot be taken orally. Moreover, the frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections." – Medicare Benefit Policy Manual 40.1.2.4

i. Vitamin B-12 Injections are covered for specified anemias, specified gastrointestinal disorders, and specified neuropathies, for example:

1. Pernicious anemia
2. Macrocytic anemia
3. Megaloblastic anemia
4. Fish tapeworm anemia
5. Gastrectomy
6. Malabsorption syndromes
7. Surgical and mechanical disorders
8. Posterolateral sclerosis

The above diagnosis must be documented on POC or verbal order. B-12 deficiency is not sufficient to support the need for B12 injections. It is treated with diet. The frequency of administration must be appropriate; maintenance is usually monthly.

ii. Insulin Injections

1. Patient/client physically, mentally, or medically unable to self-inject.
2. No willing or able caregiver.
3. Documentation supports need for insulin.
4. No "end point" to care required, however if other skilled nursing services are being performed daily, an "end-point" must be documented for these services.

Prefilling insulin syringes is not considered a skilled nursing service.

B. Oral medication administration, administering eye drops or topicals do not require the skills of a nurse. Skilled teaching may be appropriate in some cases to ensure proper administration by the patient/client or the caregiver.

5. Tube Feedings

"Nasogastric tube, and per cutaneous tube feedings (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization. and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's/client's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services". – Medicare Benefit Policy Manual 40.1.2.5

6. Nasopharyngeal and Tracheostomy Aspiration

"Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the patient's/client's illness or injury, would be covered as skilled nursing services". – Medicare Benefit Policy Manual 40.1.2.6

7. Catheters

"Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients/clients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally require skilled care once every 60-90 days and this frequency of service would be considered reasonable and necessary. However, where there are complications that require more frequent skilled care related to the catheter, such care would, with adequate documentation, be covered". – Medicare Benefit Policy Manual 40.1.2.7

8. Wound Care

"Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. Moreover, the plan of care must contain the specific instructions for the treatment of the wound.

NOTE: This section relates to the direct, hands on skilled nursing care provided to patients/clients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (See §40.1.2.1) or skilled

teaching of wound care to the patient/client or the patient's/client's family". – Medicare Benefit Policy Manual 40.1.2.8

Wound assessment should be documented every visit to include the nature of drainage (color, odor, quantity, consistency) and condition/ appearance of the wound bed and surrounding skin. Wounds should be measured (length, width, and depth) weekly.

9. Ostomy Care

"Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications. The teaching services and the patient/client and/or caregiver responses must be documented". – Medicare Benefit Policy Manual 40.1.2.9

10. Venipunctures

Venipunctures are covered if ordered by a physician and/or non-physician practitioner and there is another skilled service being performed. It cannot stand alone as the qualifying skill. Services must be reasonable and necessary for the illness or injury, and the frequency of lab is:

A. Consistent with accepted standards of medical practice

B. Consistent with the nature of the treatment

11. Psychiatric Nursing

"The evaluation, psychotherapy, and teaching needed by a patient/client suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.

Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for nonpsychiatric diagnoses or to monitor the condition of a patient/client with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's/client's normal living situation". – Medicare Benefit Policy Manual 40.1.2.15

Medicare does not require a psychiatrically trained nurse to administer or assess psychotropic medications.

12. Services Covered Under End Stage Renal Disease (ESRD) Program

    "Services that are covered under the ESRD program and are contained in the composite rate reimbursement methodology, including any service furnished to an ESRD beneficiary that is directly related to that individual's dialysis, are excluded from coverage under the Medicare home health benefit. However, to the extent a service is not directly related to a patient's/client's dialysis, e.g., a nursing visit to furnish wound care for an abandoned shunt site, and other requirements for coverage are met, the visit would be covered. Within these restrictions, beneficiaries may simultaneously receive items and services under the ESRD program at home at the same time as receiving services under the home health benefit not related to ESRD". – Medicare Benefit Policy Manual 80.5

Case Management

The RN is responsible for the case management of the home health patient/client which includes:

- Care coordination.
- Supervision and management of patient/client care.
- Required documentation.
- Supervision of the LVN/LPN and home health aide.
- Appropriate internal, external, and community referrals.

After completing/reviewing a comprehensive assessment, the case manager will make appropriate referrals for other services, including internal (i.e., therapy, social services, or aide), external (i.e., contracted therapy), or community services (i.e., Meals on Wheels) that are needed to meet patient/client needs. An important part of case management is to coordinate care among all disciplines (PT, OT, ST, MSW, and aide) as well as with the physician, the patient/client, the caregiver/family, and other providers involved in the patient/client care.

It is critical that frequent communication occur between the LVN/LPN and RN, and that care is provided within the scope of practice defined by the nurse practice act. LVN/LPN supervisory visits must be at least every 60 days at the patient's/client's residence. The LVN/LPN does not have to be present.

Verbal orders must be signed, timed, and dated by the RN who is providing or supervising the ordered service. Any orders taken by an LVN/LPN must be co-signed by the RN.

The RN is responsible for developing and overseeing the Home Health Aide Care Plan. The aide must report any problems to the RN. Home health aide (HHA) supervisory visits must be at least every 14 days at the patient's/client's residence. The HHA does not have to be present.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Human Resources (HR)	Employee Supervision

Nursing Clinical Progress Note

[Insert agency-specific skilled nursing note and instructions.]

The nursing clinical progress note is used to document the care provided on each nursing visit. It also provides a place for documentation of both home health aide and LVN/LPN supervisory visits. Ask the supervisor for instructions on how to complete the progress note.

Medication Safety and Compliance

The RN will complete a comprehensive assessment of the patient/client and will document any allergies, side effects or adverse effects of medications. The nurse will also assess the patient's/client's knowledge of and compliance with the medication regimen. The nurse will include an assessment of the patient's/client's physical and cognitive ability to safely manage the medications with or without reminders. The nurse will assess if the patient/client has adequate financial resources to obtain needed medications and may refer to social services for additional resources if needed. The nurse will complete the medication profile, listing all prescription and over-the-counter (OTC) medications, herbal remedies, samples, vitamins, and minerals. The nurse will review the medication list for potential contraindications, duplications, adverse reactions, and food and drug interactions at admission and as medications are newly ordered (within 30 days), changed (within 60 days), or discontinued. The medication list must be kept current and updated to reflect all medication changes. A copy of the medication list without abbreviations is left in the patient's/client's home and is kept updated.

The plan of care should include teaching the patient/client and/or caregiver about the medications including proper storage, how to take the medication, the purpose, expected effects, and possible side effects of each medication. A reminder system such as a pillbox may be used to help the patient/client comply with the regimen. It is important to remember the filling of a pillbox is not a skilled service under the Medicare benefit. However, teaching a patient/client or caregiver how to use the pill box is skilled.

The patient's/client's response to the medication regimen should be routinely assessed and any adverse reactions or complications must be reported to the physician.

There must be an order from a physician and/or non-physician practitioner for a nurse to administer any medication (or treatment) before it is given to the patient/client.

The nurse administering medication or delegating the administration of medication must be qualified and must follow all the regulations established by the state's board of nursing. Please refer to the state's nursing practice act. In addition to the nursing practice act, the nurse must follow other rules including the state's licensing standards, Medicare's rules, and the Agency's policies on the administration of medication. The nurse should follow the rights of medication administration set by nursing standards.

There might be medication errors made by the nurse, patient/client, or caregiver. These must be reported immediately and documented according to the Agency's policy.

When a medication is discontinued or has passed its expiration date, the nurse may not dispose of the medication, but should instruct the patient/client and/or caregiver on safe medication disposal. It is no longer considered safe for the environment for medications to be flushed down the toilet. Federal guidelines indicate they should be taken out of their original container and thrown in the trash. The Office of National Drug Control Policy recommends mixing them with an undesirable substance such as kitty litter or used coffee grounds or putting them in a nondescript container such as an empty can. Some communities have a pharmaceutical take-back program for gathering unwanted medications at a central location for safe disposal.

Care of the Dying Patient/Client

As a healthcare professional, you can make a difference in the end of life experience of the dying patient/client and their family. Being diagnosed with a terminal illness produces many different reactions in people. These may include emotional reactions such as disbelief, fear, anger, depression, and guilt.

Fear or apprehension is a common initial reaction. People fear pain or disability.

Apprehension may result from a sense of losing control over life. The ability to manage our lives is tied closely with self-image and self-respect.

Guilt may result from not being able to accomplish all the tasks or needing assistance with activities of daily living. Guilt feelings about “letting down” your family or friends may envelop the patient/client.

Depression may be characterized by withdrawal, melancholy, and helplessness.

Grief is experienced by nearly everyone. It is an emotional response to a significant loss and may be experienced when the individual first expects the loss or by the family, after the loss.

The Stages of Grieving:

- Denial is characterized by shock or disbelief, and may have physical symptoms as pallor, faintness, nausea, and confusion.
- Anger is characterized by impatience, uncooperativeness, bitterness, feelings of helplessness, sarcasm, and increasing awareness.
- Bargaining is characterized by exhaustion or depression, or final attempts to avoid reality.
- Depression is characterized by withdrawal, melancholy, and the gradual acceptance of reality.
- Acceptance is characterized by contemplativeness and serenity, and the ability to talk about the loss.

It is important to understand and support the family as they lose their loved one. It is also important that you understand your own feelings about death and dying in order to provide care and support to the dying patient/client and their family.

Section 10: Therapy

Medicare Criteria for Therapy

Therapy services are a critical part of the patient's/client's plan of care which is developed in conjunction with the patient/client, caregiver, family, and physician.

The patient/client must require skilled care.

- Skilled services are those which are medically reasonable to the treatment of the patient's/client's illness or injury.
- Skilled care is care that requires the skills of a physical therapist, or a speech therapist (or ongoing care of an OT).
- Therapy services may be a covered service if:
    - Require inherent complex service.
    - Requires a skilled therapist to perform the services.
    - Requires the supervision of a skilled therapist when the service is performed.
    - Services ordered by the physician and/or non-physician practitioner.

Services must be reasonable and necessary for the treatment of the patient's/client's particular medical needs.

- Amount frequency and duration of services must be reasonable.
- Services must be consistent with the nature and severity of the patient's/client's illness or injury.
- Services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's/client's condition, meeting the initial assessment and reassessment standards discussed below.
- Services must be provided with the expectation that:
    - The evaluation and reevaluation must be reasonable and necessary to be covered.
    - The services are necessary to establish a safe and effective program.
    - The condition of the patient/client will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements. Therapy is not considered reasonable and necessary under this condition if:
        - The patient's/client's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.

- Therapy is not required to effect improvement or restoration of function where a patient/client suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient/client gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's/client's illness or injury, under this condition. However, if the criteria for maintenance therapy is met, therapy could be covered under that condition.

Initial therapy assessment requirements must be met.

- For therapy only orders, the qualified therapist will perform the patient's/client's evaluation within 48 hours of the order or referral, and four days if skilled nursing establishes the initial contact with the patient/client. A qualified therapist (not an assistant) will assess the patient's/client's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results will be documented in the clinical record.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines will functionally assess the patient/client. The therapist will document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

Reassessment at least every 30 days. Reassessment clock is not measured by episode but by the patient's/client's full course of treatment.

- At least every 30 days, a qualified therapist (not an assistant) must provide the ordered therapy service and functionally reassess the patient/client using objective measurements to allow comparison to prior measurements. The therapist will document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy or lack thereof. The 30 day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).
- Where more than one discipline of therapy is being provided, at least every 30 days, a qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess the patient/client using objective measurements to allow comparison prior measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy or lack thereof. In multi-discipline therapy cases, the qualified therapist would reassess functional items (and measure and document) those which correspond to the therapist's discipline and care plan goals. In cases where more than one discipline of therapy is being provided, the 30 day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

Assessment/Evaluation

A discipline specific assessment/evaluation form will be completed to validate initial and reassessment requirements. The plan of care is developed in conjunction with the evaluation and must include:

- Type of Modality/Procedures – Should describe the specific nature and frequency of the therapy to be provided such as, ultrasound, hot packs, whirlpool, and/or gait training.
- Frequency of Visits – The frequency of therapy services to be rendered.
- Duration – Length of time over which the services are to be rendered. May be expressed in days, weeks, or months. For example, "3w2" which means three times per week for two weeks.
- Diagnosis – Should include the therapy diagnosis if different from medical diagnosis. For example, the medical diagnosis might be "Rheumatoid Arthritis"; however, the shoulder might be the only area being treated, so the therapy diagnosis might be "frozen shoulder"; limited movement due to pain.
- Functional Goals – Should reflect the therapist's and/or physician's description of what the patient/client is expected to achieve as a result of therapy and must include anticipated date of achievement for short-term and long-term goals.
- Rehabilitation Potential – The therapist's and/or physician's expectation concerning the patient's/client's ability to meet the goals at initiation of treatment.

Goals

From PGBA Jurisdiction 11 Home Health "WRITING THERAPY GOALS":

"The Guide to Physical Therapist Practice identifies a 'goal' as a remediation of impairments and uses the term 'outcomes' for 'minimization of functional limitation, optimization of health status, prevention of disability, and optimization of patient/client satisfaction. The Guide defines 'function' as 'those activities identified by an individual as essential to support physical, social, and psychological well-being and to create a personal sense of meaningful living'. The American Physical Therapy Association recommends the following components:

- Identification of the person
- Description of the movement or activity
- A connection of the movement/activity to a specific function
- Specific conditions in which the activity will be performed
- Factors for measuring the outcome
- Time frame for achieving the goal

O'Neill and Harris proposed writing goals that contain the following elements:

Who, What, Under what conditions, How well, By when

'Who' will always be the patient/client. The goals should never be written as 'the therapist will do….' The behavioral statement must reflect the beneficiary performance. Caregivers may be involved in the beneficiary's care, but they are not the focus of the goal.

'What' is the activity the beneficiary will perform. The activity should be observable, repeatable and have a definite beginning and end. Statements like 'the patient/client will get stronger' and 'the patient/client will show improvement' are poorly written.

'Under what conditions' is the condition under which the beneficiary's goal achievement is measured. These may be environmental factors such stairs or grassy surfaces or may be beneficiary factors such as 'with a cane'.

'How well' describes the assistance needed. This may be maximum assistance, moderate assistance, minimal assistance or totally independent. This should relate to the baseline assessment information, i.e., 'requires maximum assistance to ambulate. Experiences SOB on exertion after ambulating 10 feet with cane'.

'By when' is the target date to achieve the goal. Goals should be short or long term. A long term goal is the outcome the patient/client is expected to achieve. Short term goals are goals which lead to the accomplishment of a long term goal. It is helpful, but not required, to label the goals with the word short and long, but the goals should be written in a manner where there are measurable time frames that indicate whether they are short or long. There is no set time frame that defines short versus long. If both short term goals and long term goals are not applicable, the documentation should specify this and explain."

Beneficiaries generally have more than one goal. A good way to assess the medical necessity of each goal is to ask, 'What difference does performing this activity mean to the beneficiary?' The documentation of the beneficiary encounter should relate back to the goals. Willard and Spackman recommend the RUMBA test:

- Relevant: functional goals and achievement; patient/client-specific
- Understandable: legible and avoid jargon; use of accepted standard terminology
- Measurable: includes frequency and duration, how long it occurred or how many times
- Behavioral: measurable occurrences
- Achievable: reasonable

References:

Guide to Physical Therapist Practice. Rev ed. Alexandria, Va: American Physical Therapy Association; 1999.

O'Neill DL, Harris SR. Developing goals and objectives for handicapped children. Phys Ther.1982; 62:295–298.

Randall, Kenneth E., and McEwen Irene, R. Writing Patient centered Functional Goals. Physical Therapy December 2000 vol. 80 no. 12 1197-1203.

Willard & Spackman's 'Occupational Therapy', 11th Edition (2008).

APTA: Defensible Documentation for Patient/Client Management: Components of Documentation within the Patient/Client Model (2011) last updated on 10/30/2014.

Medical Equipment

Patients/clients may need medical equipment to assist in ambulation or to assist in adapting their environment. The Agency uses several home equipment supply companies. Notify the supervisor if the patient/client needs equipment.

Note: Medicare does not pay for commode extenders, tub benches, or other bathroom equipment.

Therapy Progress Note

[Insert agency-specific skilled therapy note and instructions.]

The therapy progress note is the form that is utilized to document the care that is provided on each therapy visit. Ask the supervisor for instructions on how to complete the progress note.

Section 11: Medical Social Services

Medical Social Services Coverage Criteria

Medical social services that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services where the patient/client meets the qualifying criteria listed below:

- Be confined to the home.
- Under the care of a physician.
- Receiving services under a plan of care established and periodically reviewed by a physician.
- Be in need of skilled nursing, physical therapy, or speech-language pathology care on an intermittent basis or have a continuing need for occupational therapy.

In addition:

- The services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's/client's medical condition or rate of recovery.
- The plan of care indicates how the services which are required necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively.

Where these requirements for coverage are met, services of these professionals which may be covered include, but are not limited to:

- Assessment of the social and emotional factors related to the patient's/client's illness, need for care, response to treatment, and adjustment to care.
- Assessment of the relationship of the patient's/client's medical and nursing requirements to the patient's/client's home situation, financial resources, and availability of community resources.
- Appropriate action to obtain available community resources to assist in resolving the patient's/client's problem.
- Counseling services that are required by the patient/client.
- Medical social services furnished to the patient's/client's family member or caregiver on a short-term basis when the Agency can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's/client's medical condition or to the patient's/client's rate of recovery. To be considered "clear and direct", the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's/client's medical treatment or rate of recovery. Medical social services to address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

Skilled Medical Social Services

- The patient/client has an underlying social or emotional problem impeding the patient's/client's treatment and recovery.
- The patient/client is having difficulty coping with illness/disability, e.g., loss of independence, confinement, reliance on others.
- The patient/client lacks an adequate support system, e.g., receives little or no support from family/friends.
- The patient/client is experiencing financial problems, e.g., difficulty paying utility bills, medical bills, rent, inadequate food supply, etc.
- The family is unable to cope with illness, e.g., indecision about responsibilities, unrealistic expectations.
- The patient/client and/or family needs information on placement, e.g., skilled care, personal care, etc.
- The patient/client has a diagnosis that will qualify for services through specific disease related agencies, e.g., American Cancer Society, American Diabetes Society, Multiple Sclerosis Foundation, Arthritis Foundation, Alzheimer's Association, etc.

Medicare does not cover medical social services if:

- Services of a medical social worker to complete or assist in the completion of an application for Medicaid. Federal regulations require the state to provide assistance in completing the application to anyone who choose to apply for Medicaid.
- Continued social services for more than two to three visits to assist in the removal of family members or caregivers who obstruct, contravene, prevent, or interfere with the patient's/client's medical treatment or recovery of the patient/client.

CMS examples from Publication 100-02, Section 50.3 Medical Social Service.

Example 1:

The physician has ordered a medical social worker assessment of a diabetic patient/client who has recently become insulin dependent and is not yet stabilized. The nurse, who is providing skilled observation and evaluation to try to restabilize the patient/client notices during her visits that the supplies left in the home for the patient's/client's use appear to be frequently missing, and the patient/client is not compliant with the regimen although she refuses to discuss the matter. The assessment by a medical social worker would be reasonable and necessary to determine if there are underlying social or emotional problems impeding the patient's/client's treatment.

Example 2:

A physician ordered an assessment by a medical social worker for a multiple sclerosis patient/client who was unable to move anything but her head and who had an indwelling catheter. The patient/client had experienced recurring urinary tract infections and multiple infected ulcers. The physician ordered

medical social services after the Agency indicated to the physician that the home was not well cared for, the patient/client appeared to be neglected much of the time, and the relationship between the patient/client and family was very poor. The physician and the Agency were concerned that social problems created by family caregivers were impeding the treatment of the recurring infections and ulcers. The assessment and follow-up for counseling both the patient/client and the family by a medical social worker were reasonable and necessary.

Example 3:

A physician is aware that a patient/client with atherosclerosis and hypertension is not taking medications as ordered and adhering to dietary restrictions because he is unable to afford the medication and is unable to cook. The physician orders several visits by a medical social worker to assist in resolving these problems. The visits by the medical social worker to review the patient's/client's financial status, discuss options, and make appropriate contacts with social services agencies or other community resources to arrange for medications and meals would be a reasonable and necessary medical social service.

Example 4:

A physician has ordered counseling by a medical social worker for a patient/client with cirrhosis of the liver who has recently been discharged from a 28 day inpatient alcohol treatment program to her home which she shares with an alcoholic and neglectful adult child. The physician has ordered counseling several times per week to assist the patient/client in remaining free of alcohol and in dealing with the adult child. The services of the medical social worker would be covered until the patient's/client's social situation ceased to impact on her recovery and/or treatment.

Example 5:

A physician has ordered medical social services for a patient/client who is worried about his financial arrangements and payment for medical care. The services ordered are to arrange Medicaid if possible and resolve unpaid medical bills. There is no evidence that the patient's/client's concerns are adversely impacting recovery or treatment of his illness or injury. Medical social services cannot be covered.

Example 6:

A physician has ordered medical social services for a patient/client of extremely limited income who has incurred large unpaid hospital and other medical bills following a significant illness. The patient's/client's recovery is adversely affected because the patient/client is not maintaining a proper therapeutic diet, and cannot leave the home to acquire the medication necessary to treat their illness. The medical social worker reviews the patient's/client's financial status, arranges meal service to resolve the dietary problem, arranges for home delivered medications, gathers the information necessary for application to Medicaid to acquire coverage for the medications the patient/client needs, files the application on behalf of the patient/client, and follows-up repeatedly with the Medicaid state agency.

The medical social services that are necessary to review the financial status of the patient/client, arrange for meal service and delivery of medications to the home, and arrange for the Medicaid state agency to assist the patient/client with the application for Medicaid are covered. The services related to the assistance in filing the application for Medicaid and the follow-up on the application are not covered

since they must be provided by the state agency free of charge, and hence the patient/client has no obligation to pay for such assistance.

Example 7:

A physician has ordered medical social services for an insulin dependent diabetic whose blood sugar is elevated because she has run out of syringes and missed her insulin dose for two days. Upon making the assessment visit, the medical social worker learns that the patient's/client's daughter, who is also an insulin dependent diabetic, has come to live with the patient/client because she is out of work. The daughter is now financially dependent on the patient/client for all of her financial needs and has been using the patient's/client's insulin syringes. The social worker assesses the patient's/client's financial resources and determines that they are adequate to support the patient/client and meet her own medical needs but are not sufficient to support the daughter. She also counsels the daughter and helps her access community resources. These visits would be covered, but only to the extent that the services are necessary to prevent interference with the patient's/client's treatment plan.

Example 8:

A wife is caring for her husband who is an Alzheimer's patient/client. The nurse learns that the wife has not been giving the patient/client his medication correctly and seems distracted and forgetful about various aspects of the patient's/client's care. In a conversation with the nurse, the wife relates that she is feeling depressed and overwhelmed by the patient's/client's illness. The nurse contacts the patient's/client's physician who orders a social work evaluation. In the social worker's assessment visit, the social worker learns that the patient's/client's wife is so distraught over her situation that she cannot provide adequate care to the patient/client. While there, the social worker counsels the wife and assists her with referrals to a support group and her private physician for evaluation of her depression. The services would be covered.

Example 9:

The parent of a dependent disabled child has been discharged from the hospital following a hip replacement. Although arrangements for care of the disabled child during the hospitalization were made, the child has returned to the home. During a visit to the patient/client, the nurse observes that the patient is transferring the child from bed to a wheelchair. In an effort to avoid impeding the patient's/client's recovery, the nurse contacts the patient's/client's physician to order a visit by a social worker to mobilize family members or otherwise arrange for temporary care of the disabled child. The services would be covered.

Social Worker Requirements

The Medicare Conditions of Participation (CoP) require medical social workers in home care to have a Master of Social Work degree and one year of healthcare experience. Social worker assistants should have a Bachelor of Social Work degree, one year of healthcare experience, and must be supervised by an LMSW.

Section 12: Home Health Aide

Introduction

Agency management believes the home health aide is a valuable and essential member of the home care team.

Goals of Home Health Care

Promote Self-Care and Independence

- Encourage the patient/client to participate in their care.
- Ask if they need assistance rather than jumping in to help if they are slow.
- Allow the patient/client to maintain decision-making control within the limits of the care plan.

Maintain Patient/Client Safety

- Know the proper transfer methods.
- Overexertion increases the possibility of accidents.
- Know your physical abilities and limitations.
- Know your patient's/client's physical abilities and limitations.
- Follow the written orders and instructions on the Home Health Aide's Care Plan.

Treat the Patient/Client with Dignity

- Respect for an individual's privacy is very important.
- Respect the right of privacy for dressing, bowel and bladder elimination, and bathing.
- Treat your patient/client with age-appropriate demeanor.
- Avoid talking about the patient/client to another family member or guest in the patient's/client's presence as if he or she is not there.
- Explain to the patient/client what task you are going to perform before the procedure or treatment. This builds trust and encourages cooperation.
- Many patients/clients are lonely and need social interaction. Personal care and conversation are very important to these patients/clients as you may be the only person they see or talk with that day or that week.

General Guidelines

The home health aide services that may be ordered include:

- Assist the patient/client with oral and personal hygiene which may include brushing of teeth, bathing, and/or assisting patient/client to shower, skin, and nail care.
- Dress and undress the patient/client.
- Assist the patient/client with feeding and meal preparation.
- Change bed linens, dispose of refuse, and remove soiled linen to maintain a clean and orderly patient/client care environment.
- Assist the patient/client with bed pans, urinals, or commode chair.
- Position, lift, turn, and assist patient/client with ambulation.
- Assist the patient/client with medications by reminding the patient/client and opening containers.
- Report patient/client or caregiver comments or behavior related to care.
- Collect, report, and document data, such as vital signs and weight.

The home health aide should not:

- Give medications.
- Diagnose or prescribe treatments or medications.
- Take oral or phone orders from a physician and/or non-physician practitioner.
- Insert or remove tubes from a patient's/client's body.
- Supervise other aides.
- Perform sterile procedures.
- Tell anyone about the patient's/client's diagnosis or treatment.

In-Services

In accordance with federal requirements, 12 hours of in-services a year are required. These do not have to be obtained through the Agency. A complete record of your in-services must be in your personnel file to show that you are eligible to work as a home health aide.

Professional Conduct

- The Agency expects employees to act responsibly and abide by rules and regulations of the Agency. Staff should maintain the highest level of integrity and honesty in all aspects of work.

- Areas of dishonesty include theft, misrepresentation of hours or visits worked, and/or misrepresentation of expenses incurred.
- The employee's conduct reflects on the Agency; therefore, employees are encouraged to observe the highest standards of professionalism.
- Gifts or money should not be solicited from the patient/client or family.
- Employees are not to borrow from or lend money to patients/clients.
- Smoking is not allowed in the patient's/client's home.

Patient's/Client's Rights

Home health aides must respect the patient's/client's rights when giving care. How to do this.

- Treat the patient/client with respect. Call the patient/client Mr., Mrs., or Ms. as appropriate.
- Speak respectfully when talking with the patient/client.
- Treat the patient's/client's property with respect. Property includes clothing, furniture, home, etc.
- Inform the patient/client what you are about to do when providing care.
- Provide the care as if the supervisor is observing and checking the skills.
- The patient/client can refuse all or part of care.
- Maintain confidentiality.

A breach of confidence by the home health aide may be grounds for legal and/or disciplinary action.

Confidentiality

Due to the nature of your work, you will be exposed to sensitive and confidential information. This information must never be used as the basis for social conversation or gossip.

Failure by an employee to observe confidentiality may result in disciplinary action up to and/or including termination.

Communication Skills

The Agency encourages all employees to work together as a team. To achieve this goal, it is necessary to have open communication.

Concerns and suggestions with possible solutions should be brought to the attention of the supervisor. Bringing these concerns immediately to the supervisor, allows the issues to be addressed and resolved quickly.

Communication – The exchange of information between two or more people.
Four basic elements of communication are:

- Sender
- Receiver
- Message
- Feedback – check understanding

Verbal Communication – Using words and language.

Nonverbal Communication – Sending messages without the use of words such as body language (gestures, posture, facial expressions), touch, tone of voice, and smells.

Guidelines for Effective Communication

- Introduce yourself to the patient/client.
- Explain all tasks to the patient/client in a way they can understand.
- Respect others.
- Use tact. Think before you speak.
- Give and receive feedback. This lets you know that the message was understood. Ask for clarification as needed.
- Verbal and nonverbal messages must match. Be aware of your body language.
- Control the volume of your voice. Use pleasant, friendly, and courteous tone.
- Speak clearly.
- Face the individual with whom you are talking.
- Communicate to the patients/clients in writing, or with a spelling board or picture board if necessary.
- Use good listening skills.
- Focus on what is being said.
- Be open to other viewpoints.
- Avoid being judgmental.
- Be aware that words can hold different meanings for different people.
- Repeat what you heard in your own words.
- Be aware of the speaker's emotions.
- Control your responses, even if the other person is rude or difficult.

Barriers to Effective Communication

- Language or cultural differences.
- Poor communication skills.
- Sensory impairment – hearing loss, blindness.
- Cognitive impairment – confusion, disorientation.

Provision of Care

Home Health Aide Care Plan

- A Home Health Aide (HHA) Care Plan is completed by the RN. This identifies the patient's/client's care needs. The aide can only perform the tasks that are checked.
- At times, the Care Plan may become outdated. For example, when a patient/client comes home from the hospital, they may only be able to tolerate a bed bath, but as they become stronger and healthier, they may need a shower or bath. The Care Plan will need to be updated. Notify the RN/Case Manager or the supervisor if you feel the care checked is no longer appropriate.
- It is very important to check the Care Plan every visit as the RN may have updated and changed the plan.
- Vital signs are performed as stated on the Care Plan. The aide should report any findings outside of the parameters.
- Any special instructions or precautions should be documented on the Care Plan. If you need explanation or education regarding these instructions/precautions, call the supervisor before performing.
- Assigned tasks to be performed will be checked either "every visit" or "patient/client choice."
- Notify the supervisor immediately if the Care Plan does not match the tasks that need to be provided for the patient/client.

Remember, any duties which are not included on the Care Plan cannot be performed!

Home Health Aide Visit Note

- A Home Health Aide Visit Note is completed for each visit.
- The documentation should be written in ink and be legible.
- Both the aide and the patient/client and/or family validate care has been performed by signing the visit note.
- If there are any changes in the patient's/client's condition notify the RN/case manager, and document the change and the notification.
- Notify the RN if patient/client refuses care or the visit.

Reporting Patient/Client Observations

If the aide observes any changes in patient/client condition or if the patient/client and/or caregiver reports any problems, the aide must report immediately to the RN.

Guidelines for Charting

- All entries must be written in ink.
- Entries must be neat and legible.
- Document the following information for all comments:
    - Date and time.
    - What you reported.
    - Whom you reported it to.
    - Any instructions you were given.
    - Your signature and title at the conclusion of your entry.

Example

Comments: 03/19/15 10:15 A.M. Reported elevated B/P of 205/115 to Mary Smith, RN. Instructed to retake B/P in 20 minutes. Jane Jones, HHA
10:35 A.M. B/P 190/110. Reported this to Mary Smith, RN. Jane Jones, HHA.

- Record the patient's/client's own words when possible; use quotation marks.
- Avoid such words such as "normal", "good", or "adequate."
- Document only what you observed or performed.
- Never document a procedure or task until it has been completed.
- Never white-out or erase an entry.
- If you make an error, draw a single line through it, then date and sign it.

Approved Medical Abbreviations

Approved medical abbreviations are listed in policy. Home health aides will follow policy.

Online Bookmark	Title of Policy
Management of Information (IM)	Interfacing Standardized Information

Communication Note

- The Communication Note, or similar electronic format, is used to inform or document a change in patient/client condition, or a telephone conversation with the patient/client and/or family member, etc.
- It is used if a visit is attempted and not completed.
- If you have questions about completion of this form for a specific incident, talk with the supervisor.

Tips for Time Management

- Organize your schedule for the week.
- Review your schedule and care plans the day before the visits are scheduled.
- Call the patients/clients to confirm their visit(s).
- Start a Visit Note with the patient's/client's name and date.
- Organize supplies needed by the patient/client. Put them in zip lock bags with the patient's/client's name.
- When scheduling multiple patients/clients, schedule visits by area. This uses your time and fuel more efficiently.
- Complete the Visit Note as soon as possible after the visit to ensure accurate documentation and timeliness of submission.

Supervision of Aide Services

Supervision of home health aides is as follows:

- A registered nurse (RN) performs a supervisory visit in the patient's/client's residence at least every 14 days either with the aide present or absent.
- If a patient/client is receiving only skilled therapy services, then a skilled therapist may make the supervisory visit.
- If an issue is identified during the supervisory visit, the supervising clinician will make the next scheduled patient/client visit with the aide. If the issue is validated, the aide will complete the competency evaluation before being assigned further patients/clients.
- An RN may perform a "joint" supervisory visit at any time and one is required at least annually. This supervision occurs with the aide present while furnishing patient/client care.

Safety

Personal Safety

Below are some general guidelines to assist with various safety issues:

- Maintain good body mechanics.
- Immediately report any injury to the designated supervisor.
- Wear closed toe shoes.
- Wear ID at all times. You may want to carry additional forms of identification in your pocket as well as the Agency's phone number.
- When walking, avoid groups of people lingering on the street.
- Do not take short cuts down alleys, through buildings, or across private property. Avoid narrow or confined spaces.
- Be familiar with your surroundings.
- Present yourself in a confident manner. Do not appear nervous or anxious.
- Never walk into a home uninvited. Never walk into a vacant home.
- If you have a reason to suspect illegal drug use or alcohol abuse by a patient/client or patient's/client's family member, report this to the supervisor.
- If any weapons are present in a patient's/client's home, either ask that they be put away or leave. Report this to the supervisor immediately.
- When changing the patient's/client's bed linen, carefully handle linens and be aware of sharp items such as needles, which might be in the patient's/client's bed.
- Do not allow strangers to enter the patient's/client's home.
- If there is a conflict with a patient/client or family member, maintain a professional attitude, and notify the supervisor at once.
- If a patient/client becomes violent, leave the environment, and notify the supervisor at once.

Note: Do not take safety for granted. If in doubt, leave and contact the supervisor immediately.

Equipment Safety

Notify the supervisor immediately if an injury is sustained as a result of equipment or appliance use.

- Obtain instructions on how to properly use equipment. Be aware of appropriate alarms, safety devices, precautions, and troubleshooting measures.
- Follow manufacturer's instructions regarding care of the equipment.
- Report any equipment problems such as loose wheels, worn straps, or frayed wires. Only use electrical cords, equipment, and appliances that are in good repair.

- Equipment that does not function properly should not be used. Notify the supervisor.
- Check equipment before using for cracks, chips, or sharp rough edges.
- Be aware of overloaded electrical outlets and correct if necessary.
- Use grounded (three pronged) plugs whenever possible.
- Keep electrical cords and extension cords out of pathways.
- Have the patient/client or caregiver set the hot water heater at a maximum of 120° F.
- Turn off electrical equipment before unplugging it.
- Keep electrical equipment away from sinks and bathtubs.
- Be alert to improper usage of space heaters.
- Report patient's/client's use of heating pads, electrical blankets, etc., so the patient/client can receive proper instructions.
- When using a wheelchair for transfers, make sure the patient's/client's feet are on the footrests and their arms are inside the wheelchair.
- Lock the wheels of the wheelchair when transferring the patient/client to and from the wheelchair.
- Crutches, canes, and walkers must have non-skid tips to prevent falls.
- Use side rails appropriately.
- Consult the supervisor immediately if you observe any safety hazards.

Oxygen Safety

- A "NO SMOKING" sign should be posted in each room oxygen is used. If a patient/client or family member smokes during oxygen use, report this to the supervisor. Remind visitors not to smoke.
- Make sure the oxygen tank is kept away from heat sources.
- Remove flammable liquids such as oil, grease, nail polish removers, and alcohol from the room where the oxygen tank is kept.
- Remove electrical equipment such as hair dryers and electrical razors from the room, as these items may generate sparks which can lead to a fire.
- Wool and synthetic blankets or clothing may cause static electricity. Have the patient/client use cotton blankets and clothing.
- Do not use petroleum based products near oxygen flow, for instance do not use Vaseline on lips or nose.

Bathroom Safety

The patient/client will not be left unattended in the bathroom during any bathing procedure. If a patient/client requests to be left alone, the patient/client must be advised of inherent risk and the patient's/client's decision must be documented.

- Gather all supplies necessary for completion of the bath prior to assisting the patient/client to the bathroom.
- Weak or unsteady patients/clients should not be allowed to stand in the shower. A shower chair or tub bench may be necessary. Report this to the supervisor.
- Handrails (grab bars) should be used when getting the patient/client in and out of the shower or tub.
- There should be a non-skid bathmat or abrasive strips on the bottom of the tub to prevent falls.
- Clear pathways of clutter or furniture.
- Provide good lighting. Suggest the use of a night light in the bathroom, if appropriate.
- Keep the floor free of water or spills.
- Never provide a tub bath or shower unless it is ordered on the Care Plan. If the patient/client requests one, report this to the supervisor.

Life Threatening Emergency Guidelines

- If an emergency arises, contact the supervisor immediately.
- Activate EMS immediately (call 911). Stay with the patient/client until the emergency response team arrives and report appropriate information to the EMS personnel.
- At the conclusion of this visit, document completely on the Visit Note the details and care provided.
- Lifesaving measures are not given to patients/clients who have been issued a Do Not Resuscitate (DNR) order. A copy of this order and the signed authorization will be found in the patient's/client's home, and you will be made aware of these patient/client.

Abuse, Neglect, and Exploitation

Adult abuse can happen in any home or at any socioeconomic level.

Abuse may occur in various ways:

- Bodily harm.
- Inadequate food or water.
- Hazardous living conditions.

- Needed care not provided.
- Lack of basic necessities, i.e., electricity, heat, water, etc.

The home health aide has close contact with the patient/client and would be able to identify potential abuse.

When abuse is suspected, notify the supervisor or case manager immediately. Do not confront or accuse a family member or caregiver.

Physical signs of abuse or neglect:

- Burns, bruises, welts, or fractures.
- Signs of restraints (i.e., rope burns).
- Malnutrition or dehydration (i.e., sunken eyes, weight loss).
- Soiled furniture, clothing, or bed linens.
- Signs of excessive, lack of, or outdated medications.
- Needed personal care not provided.
- Pressure ulcers (bed sores).
- Absence of eyeglasses, hearing aids, or dentures.
- Untreated medical conditions.
- Left alone for extended periods without care.
- Person locked away; no visitors allowed.
- Food or water withheld.
- Unexplained paranoia, excessive fears.
- Confusion, denial of problems, depression.
- Unwillingness to discuss situation, unreasonable excuses.

Environmental indications of abuse or neglect:

- Hazardous living conditions.
- Food is not present or is spoiled.
- Home is infested with rats, roaches, or lice.
- Frequent moving.
- Lack of electricity, heat, water, toilet, refrigeration.
- Exorbitant prices for rent, repairs, services, etc.

Behavior of family/caregiver that may suggest abuse or neglect:

- Hostile, secretive, poor self-esteem, frustrated.
- Denial of problem or blaming disabled adult.
- Alcohol abuse, drug use, recent family crisis.
- Mounting resentment by caregiver.
- History of violence or mental illness in family.
- Inconsistent explanations for injuries, problems.
- Refusal to discuss situation or allow visits.
- Excessive fear or suspicion.
- Poor relationship between adult and caregiver.
- Depression, isolation, reduced self-esteem.
- Self-destructive behaviors.

Signs of exploitation:

- Unexplained/sudden inability to pay bills, overdue rent, utilities shut off.
- Signing of papers they do not understand.
- Disappearance of personal property, household items.
- Changes in power of attorney, will, or payee.
- Excessive payment for care and/or services.
- Parasitic relationship.

If you suspect abuse, you can do something about it! First, recognize the signs. Then report the situation to the supervisor.

Exposure Control/Work Practice Controls

Please read following policies:

Online Bookmark	Title of Policy
Surveillance, Prevention, and Control of Infection (IC)	Exposure Control Plan
Surveillance, Prevention, and Control of Infection (IC)	Hand Hygiene

All agency staff providing patient/client care will follow above policies.

Tips:

- Always use gloves when performing patient/client care. This is to protect you. Gloves are removed by turning one glove inside out, placing the first glove in the palm of the second gloved hand, and then turning the second glove inside out over the first glove.
- Laundry should be held away from the body using gloved hands.
- Broken glass (i.e., glass thermometers) should not be picked up directly with your hands.
- Each patient/client should have a thermometer for their use only. After using the thermometer, wipe it with alcohol and store it in the holder.
- Report to the supervisor immediately if you have a needle stick injury or if you see needles in the trash or bed.
- The supervisor will educate the patient/client on how to dispose of needles properly. If your patients/clients use needles in the home, let the patient/client handle the needle – not you!
- Personal protective equipment (PPE) includes gloves, gowns, face shields with mask and eye cover, and pocket resuscitation masks. The Agency will supply this equipment.

Cleaning Equipment

Review the following policy and procedure:

Online Bookmark	Title of Policy
Surveillance, Prevention, and Control of Infection (IC)	Cleaning and Management of Supplies and Equipment

Death and Dying

Overview

The home health aide must be able to examine his or her feelings about death, and they must be aware of the feelings and behaviors of the dying patient/client. The patient's/client's feelings will influence the care provided by the aide, and the aide's feelings will influence the manner in which care is provided to the patient/client.

Emotional Reactions to Dying

There is no time to prepare for death when it comes accidentally or swiftly, but most persons who approach death because of advanced age or a terminal illness go through a sequence of feelings and behavior.

According to Dr. Elisabeth Kubler-Ross, dying persons and their families typically progress through a sequence of reactions: denial, anger, bargaining, depression, and acceptance.

- Denial and isolation are the first reactions of persons who learn they are terminally ill. People refuse to believe they are dying. They are denying when they talk about the future and avoid talking about their illness. Gradually they begin to face the possibility of death, but some people remain in the state of denial until death.
- Anger occurs when they recognize the reality of the outcome of their illness; they ask, "Why Me?" and feel angry that they are dying while others are allowed to live. Do not take the patient's/client's anger personally. Anger is normal and healthy.
- The bargaining reaction is characterized by the making of promises to God or some other higher power to do something special to change their lives if the dying person is allowed to continue living. They want to buy more time.
- Depression occurs when terminally ill persons become weaker and they and those around them are unable to perform even simple tasks because of deep sadness. This is normal. The home care team and the aide need to give physical and emotional help as dying persons grow weaker. They may need to review their lives and their sorrow. Listening may be most important, words may not be needed. A touch of the hand and warm accepting silence is therapeutic. Much will depend on the relationship established earlier.
- Acceptance is the final reaction of dying persons. It comes if they are given enough time. They will no longer be angry or depressed, having already mourned their loss. Depending on their awareness, they can make plans from a religious, philosophical, social, and emotional standpoint, almost becoming detached from the situation. Acceptance does not mean that death is near.

In prolonged illness, dying persons and their families may go through all these stages, almost in the sequence outlined. But more frequently they may revert back and forth between stages.

Death and Dying Summary Sheet

Physiological Changes

Physical changes occur in the body as death approaches. These changes may be gradual or sudden. Body systems decline further, and the patient/client becomes less responsive. Noticeable signs of death include:

- Loss of muscle control.
- Gastrointestinal functions slow down leading to abdominal distention, nausea and vomiting, and the patient/client may be incontinent.
- Circulatory failure.
- Respiratory failure in which the patient/client may have irregular, slow, rapid, or shallow respirations.
- Urinary output may decrease.

- The patient's/client's eyes may stare blankly, and the pupils become fixed and dilated.

Patient/Client Needs

The following are some special concerns in caring for the dying:

- Following plans developed for meeting the needs of the patient/client and family.
- Providing personal care, physical care, and comfort are a continuing need.
- Maintaining strength through exercise and nutrition.
- Maintaining routines, yet staying flexible, allowing the patient/client to decide when certain care should be given.
- Modifying procedures to allow for comfort.
- Explaining what is being done even if the patient/client does not seem to respond.
- Listening attentively.
- Protecting the patient's/client's privacy and independence.
- Demonstrating real concern, acceptance, and understanding in helping to meet the psychological and emotional needs of the patient/client and family.
- Encouraging family members to talk with patients/clients and with each other about what they are feeling.

Sensory Needs

- The room should be well lit with indirect lighting. Avoid bright lights and glare.
- Ask questions that can be answered with a simple "yes" or "no". Continue to talk to the patient/client even when they cannot verbally respond.
- Hearing is one of the last functions lost. Even if the patient/client is not conscious, they may be able to hear. Continue to talk to the patient/client as care is provided and encourage the family to do the same.
- Use touch as a comfort measure if the patient/client wishes to be touched.

Oral Hygiene

- Use the appropriate mouth swabs, moistened with water, to prevent mouth irritation and to make swallowing easier.
- Report the following to the supervisor:
    - Excessive mucous in the mouth.
    - Inability to swallow.

- Sores in the mouth.

- Clean the patient's/client's nose carefully to remove crusting. Apply lubricating jelly to the nostrils and lips.

Elimination

- Provide good perineal care and protect the bed appropriately.
- Diaper the patient/client if ordered.
- Keep the patient's/client's skin clean and dry at all times.
- Refer to the Home Health Aide Care Plan for orders to provide enemas and/or catheter care.

Comfort and Position

- Give frequent baths, good skin care, and change gowns and linen as often as necessary.
- Use light bed coverings – heavy blankets may make the patient/client feel too warm leading to restlessness.
- Good skin care and oral hygiene promotes comfort.
- Frequent turning and good body alignment promote comfort and prevents skin breakdown. Be alert to pressure points. Position the patient/client appropriately with pillows.
- Elevate the head of the bed to make breathing easier.
- Place objects of importance (emotional and physical) close to the patient/client.
- Such items as bedside commodes, lotion, and drinking water should be close by to conserve the patient's/client's energy.
- Listening to the patient's/client's stories or reading a family diary, upon the patient's/client's request, may be helpful and dearly appreciate.

Section 13 Texas Specific Orientation

The information in this section is Texas specific. State standards that have not already been addressed in Orientation are discussed here in order of the Orientation Manual sections.

Table of Contents

General Orientation

Introduction

Welcome to a Texas Medicare Certified Home Health Agency

What is Licensed and Certified?

Licensed = Meets state standards to operate a home health agency.

Certified = Meets Medicare Conditions of Participation to operate a home health agency.

Both require routine surveys to maintain the current status.

Patients in this agency may come from a variety of payor sources. Primarily, the payor source will be the Medicare program. However, since it is a licensed and certified agency, the patients must meet criteria to qualify for these services and receive care according to the Medicare standards.

Regulatory agencies that oversee an agency's program include:

Texas Health and Human Services (HHS) - State Licensure

Overview of the Agency

Scope of Services

The Scope of Services offered by the Agency are defined for each discipline.

Online Bookmark	Title of Policy
Opening Documents	Scope of Services TX

Discrimination and Harassment

The Agency does not discriminate in patient/client provision of services with respect to race, color, national origin, age, sex, disability, marital status, religion, or source of payment according to Title VI of the Civil Rights Act.

Quality Assessment Performance Improvement (QAPI)

To meet compliance with TAC §558.287 the Agency will maintain a Quality Assessment and Performance Improvement program that is implemented by a QAPI Committee. The QAPI Committee will consist of, at a minimum, the Administrator, supervising nurse or therapist, and individuals representing the scope of services provided by the Agency.

The QAPI Committee will meet twice a year or more often if needed and will maintain a written record of the meetings with appropriate signatures. The Governing Body will ensure training will be provided for employees serving as members on the QAPI Committee. The QAPI Plan will be reviewed and updated at least once within the calendar year, or more often if needed.

The Agency leaders (including the Governing Body, Managers, and QAPI Committee) will participate in an annual evaluation of the organization's performance in relation to its written organizational plan, mission, vision and philosophy. A written summarization with recommendations for improvement or change will be presented to the Governing Body annually and retained at the Agency's administrative offices. The Governing Body will establish immediate goals for improvement or change and will incorporate recommendations into the organizational plan.

Online Bookmark	Title of Policy
Quality Assessment Performance Improvement (QAPI)	Quality Assessment Performance Improvement TX
	Agency Evaluation Process TX

Patient/Client Complaints

The patient/client, their representative (if any) and/or caregiver, is informed in writing, at the time of the initial assessment to notify the Administrator or designee at the Agency regarding any conflicts, grievances or complaints and the time frames for initiation and resolution and that a complaint against the Agency may also be directed to Texas Health and Human Services Commission (HSSC), Complaint and Incident Intake.

The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination in writing by mail, fax, e-mail, or via the OCR Complaint Portal.

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Resolution of Patient/Client Conflicts, Grievances, Complaints TX

Fraud and Abuse in Home Care

Illegal Remuneration/Non-Solicitation of Referrals

- The Agency fully complies with the state's solicitation of patients/clients and failure to disclose regulations as provided in the Texas Occupations Code, Chapter 102.
- "Soliciting Patients Offense" means a person commits an offense if the person knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency.
- "Failure to Disclose Offense" means a person commits an offense if the person, in a manner otherwise permitted under Section 102.001 of the Texas Occupations Code, accepts remuneration to secure or solicit a patient for a licensed, certified, or registered by a state health care regulatory agency and does not, at the time of the initial contact and at the time of referral disclose to the patient the person's affiliation, if any, with the person for whom the patient is secured or solicited and the person will receive, directly or indirectly, remuneration for securing or soliciting the patient

Billing Process/Advance Beneficiary Notice/False Claims

- All employees have a responsibility to report suspected and actual violations resulting in false claims and/or billing fraud and/or abuse to their supervisor and/or the Compliance Officer immediately.
- Suspected and actual violations resulting in false claims, billing fraud and/or abuse may be made to the Texas Health and Human Services Office of Inspector General either online at https://oig.hhs.texas.gov/report-fraud-waste-or-abuse or by calling the toll free hotline at 1-800-436-6184.

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Illegal Remuneration/Non-Solicitation of Referrals TX
	Billing Process/Advance Beneficiary Notice/False Claims TX

Human Resources and Personnel Administration

Employee Education

In Texas, Mandated in-services include:

- Rights of the Elderly (for staff who provide care to patients sixty [60] years old or older)

Online Bookmark	Title of Policy
Admit Pack	Rights of Elderly TX
Human Resources (HR)	Agency In-services and Education TX

Drug Free Workplace

- The Agency will provide a copy of the Drug Free Workplace policy to anyone applying for services from the Agency, employees on hire and any person who requests the information.

Personnel Classifications and Coverage Backup Staffing

- The Agency will for pediatric patients/clients, use the client's designee who is willing and able to provide the necessary services and has agreed to provide back-up services without coercion from the agency. The Agency will maintain a signed written agreement from the client's designee. The Agency will not coerce a patient/client to accept backup services.

Employee Orientation

- Personnel who are direct care staff and who have direct contact with patients/clients (employed by or under contract with the agency) will sign a statement that they have read, understand, and will comply with all applicable agency policies. Personnel will be informed of changes in techniques, philosophies, goals, patient's/client's rights, and products relating to patient's/client's care.
- Health Insurance Portability and Accountability Act (HIPAA) - HIPAA education is to be completed within 60 days from the hire date as it relates to the Agency's particular course of business and each employee's scope of employment and will include training per Texas Health and Safety Code (HSC), Title 2, Subtitle I, Chapter 181, Subchapter C "Access to and Use of Protected Health Information".
- If the duties of an Agency employee are affected by a material change in state or federal law concerning protected health information, the employee shall receive training necessary and appropriate for the Agency employee to carry out his/her duties, within a reasonable period, but not later than the first anniversary of the date the material change in law takes effect.

Employee Supervision

Each physical therapy assistant and occupational therapy assistant visit notes will indicate the name of the supervising therapist. Supervising occupational therapist is the individual is readily available to answer questions about a patient/client intervention at the time of the provision of services.

Delegation

Agency staff will acknowledge, observe and implement registered nurse (RN) delegation, when applicable.

Nursing Peer Review

The Agency will fulfill the requirements of the Texas Nursing Practice Act for the purpose of evaluating if a nurse (registered nurse or a vocational nurse) has engaged in unacceptable nursing practice. The Agency will implement nurse peer review (NPR) activities through a Nursing Peer Review Committee (NPRC).

Online Bookmark	Title of Policy
Human Resources (HR)	Drug Free Workplace TX
	Personnel Classifications and Coverage Backup Staffing TX
	Employee Orientation TX
	Employee Supervision TX
	Delegation TX
	Nursing Peer Review TX

Compensation

Jury Duty

Both Texas and federal law states that an employer is not required to pay for time not worked which includes time spent on jury duty. Please see the Agency administrator for a copy your Agency's policy.

Clinical Orientation

Professional Direct Care Staff

Advance Healthcare Directives

Most of us are uncomfortable discussing terminal illness, but since patients/clients can be kept alive indefinitely with artificial life sustaining procedures, the patient/client must be educated regarding their right to express, in writing, their treatment choice if they become seriously ill or unable to communicate. This is the law.

It is required that the patient/client be informed about advance directives during the admission process. In the event the patient/client has a Do Not Resuscitate (DNR), the admitting nurse should make every attempt to obtain a copy for the Agency record. It is also helpful, if the patient/client has a medical power of attorney, for the Agency to have the name and phone number of that individual.

A list of the DNR patients/clients should be readily available in the on-call book.

There are four ways to express choices in Texas:

- Living Will – Allows the person to direct the physician not to administer artificial life sustaining procedures if the condition is defined as one in which death is imminent without these procedures.
- Medical Power of Attorney for Healthcare – Allows the person to appoint an agent to make specific treatment decisions if unable to make these decisions for them self.
- Out of Hospital DNR – Texas has implemented a specific procedure and DNR form to be utilized when a terminally ill patient decides to withdraw or withhold life sustaining measures or resuscitation.
- Mental Health Directive – This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment.

A patient may revoke these decisions at any time. The physician and appropriate caregivers should be informed of this decision.

If at any time the patient either revokes a decision or decides to implement Advance Directives, the office should be notified.

Informed Consent Process

The Agency will communicate with an adult surrogate, who may speak for the patient/client, for any adult patient/client who is comatose, incapacitated, or otherwise mentally or physically incapable of communication. The policy lists the adult surrogate in order of priority, who may consent and the procedure the Agency will follow to document the consent.

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Advance Directives Informed Consent Process TX

Patient/Client Rights and Responsibilities

At admission, the patient/client receives verbal and written information regarding their rights and responsibilities in a language and manner the individual understands. It is the responsibility of all clinical staff to adhere to patient/client rights and provide additional patient/client education as needed. Patients/clients over the age of 60, also receive the Rights of the Elderly at admission.

Online Bookmark	Title of Policy
Rights and Ethics (RI)	Patient/Client Rights and Responsibilities TX

Abuse, Neglect, and Exploitation

The Agency attempts to identify suspected or alleged victims of abuse and report or refer abuse and/or neglect of the patient/client.

Staff are expected to immediately report an assessment of a patient's/client's condition that might indicate abuse, neglect, and exploitation to the Agency supervisor. Symptoms that may indicate a need for further investigation include the following:

- Injuries to the trunk of the body that indicate intentional rather than accidental harm.
- Injury with a patterned appearance to it, i.e., marks from a belt or a ring.
- Bruised skin from a grasp.
- Patient/client reports an abusive incident.

If there is cause to believe abuse, neglect, or exploitation of the patient/client has occurred by a staff member, representative, or contractor, you should report it immediately, meaning within twenty-four (24) hours, to Agency management and to:

- Texas Department of Family and Protective Services at 1-800-252-5400, or through the DFPS secure website at www.txabusehotline.org.
- Texas Health and Human Services Commission (HHSC) at 1-800-458-9858.

Management will investigate the situation and report findings to the patient's/client's attending physician and to the appropriate agency according to state regulations.

Online Bookmark	Title of Policy
Provision of Care (PC)	Abuse, Neglect, and Exploitation TX

Transfer and Discharge Notices

In addition to the Medicare required notices, in Texas, a five-day notice is required for transfer/ discharge. See policy for specific requirements for delivery by mail and instances when an Agency may transfer or discharge without a five-day notice.

Transfer notification will be made to the patient/client or the patient's/client's parent, family, spouse, significant other or legal representative, to the patient's attending physician and/or non-physician practitioner or practitioner if he or she is involved in the Agency's care of the patient. The Agency will ensure that the patient/client transfer information is provided to the receiving entity prior to or simultaneously with the initiation of patient/client services at the new entity, and will provide notice of transfer as required by State law. See policy on Patient/Client Transfer and Discharge Notices.

Should a patient/client leave the service area, an Agency may provide services to a patient/client outside the agency's licensed service area, but within the State of Texas for a limited time (TAC §558.220) and in coordination with the patient's/client's physician and/or non-physician practitioner. If notified of the move outside the service area and Agency services do not continue, the Agency may place services on hold, transfer and discharge or discharge the patient/client.

Review the following policy and procedures:

Online Bookmark	Title of Policy
Assessment (PE)	Patient/Client Discharge Notices Addendum TX
	Patient/Client Transfer, Discharge, and Agency Dissolution TX

Infection Control

In addition to the federal infection control program requirements, the agency will also comply with the Texas requirements: Communicable Disease Prevention and Control Act, Health and Safety Code Chapter 81 and the List of Notifiable Conditions, updated annually (found under the Texas Department of State Health Services website, Infectious Diseases); and

The Health and Safety Code, Chapter 85, Subchapter I, concerning the prevention of the transmission of human immunodeficiency virus and hepatitis B virus.

Online Bookmark	Title of Policy
Surveillance, Prevention & Control of Infection	Infection Control Program TX

Management of Information- Medical Record

Timelines

The Agency will comply with Texas Administrative Code (TAC) 558.301 which requires all clinical and progress notes be written the day service is rendered. All medical record information will be incorporated into the patient's/client's medical record within 14 working days.

Medical Record Information Retention and Destruction

The Agency will comply with TAC 558.217 and 558.301 in relation to the retention and destruction of patient/client records. If the Agency closes with an active client roster, the Agency will transfer a copy of the active patient/client record with the patient/client to the receiving agency in order to ensure continuity of care and services.

Online Bookmark	Title of Policy
Management of Information	Timelines TX
	Medical Record Information Retention and Destruction TX

Provision of Care

Orders for Care

When Medicaid is the payor, Plans of Care should be signed within 30 days and verbal orders should be signed within 14 calendar days.

Implementing Care and Treatment

The Clinical Manager/Supervising Nurse will oversee the following when coordinating the assignments of procedures to the staff.

Monitoring Patient Care/Coordination Care

The effective exchange of information, reporting and coordination of care will occur between personnel providing care and services whether provided directly or under arrangement, to other providers of healthcare services involved in patient/client care.

Medication Administration

For any patient/client that the Agency staff administers medications, the staff member will report any adverse reaction to a supervisor and document this in the patient/client's record on the day of occurrence. If the adverse reaction occurs after regular business hours, the staff member will report the adverse reaction as soon as it is disclosed.

Medication Possession and Transport

Staff will comply with TAC 558.303 and Texas Health and Safety Code 81.003 and 142.0063 as it relates to medication possession and transport.

Online Bookmark	Title of Policy
Provision of Care	Orders for Care TX
	Implementing Care and Treatment TX
	Monitoring Patient Care/Coordination Care TX
	Medication Administration TX
	Medication Possession and Transport TX

Admission and Recertification

Advance Directives

It is required that the patient/client be informed about Advance Directives as recognized by the state during the admission process. In Texas, Advance Directives include:

- Living Will / Directive to Physician
- Out of Hospital DNR
- Medical Power of Attorney
- Declaration of Mental Health

In the event the patient/client has an Out of Hospital DNR, the admitting clinician should make every attempt to obtain a copy for the Agency's record. If the patient/client has a Medical Power of Attorney, the name and phone number should be documented.

The admitting clinician will:

- Identify if the patient/client has Advance Directives.
- Assist the patient/client and/or significant other with a decision regarding an OOH-DNR in the event death is imminent.
- Provide written materials and document patient/client education on Advance Directives.

Review the following form:

Online Bookmark	Title of Policy
Admit Pack (AP)	Patient Rights and Responsibilities TX
	Advance Directives TX
	Out of Hospital DNR TX

Safety/OSHA

Emergency Preparedness and Response Plan

The Agency is required to complete an internal review of the Emergency Preparedness and Response Plan at least annually, and after each actual emergency response, to evaluate its effectiveness and to update the plan as needed. Specified management personnel will be involved in the development, maintenance, and implementation of the plan.

The Agency is also required to register and utilize HHSC's Emergency Communication System and to enroll specific individuals in accordance with instructions from HHSC.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Environmental/Safety/Equipment Management (EC)	Emergency Preparedness and Response Plan
Texas Regulations	Emergency Preparedness and Response Plan

Safety and Workplace Violence Prevention

The Agency has a choice to prohibit or allow handguns in the workplace. Should the Agency permit the possession of handguns in the workplace, the Agency will comply with state's laws for the lawful carrying of handguns in the workplace. Additionally, the Agency will establish a workplace violence prevention committee to develop a workplace violence prevention plan to ensure protection of the Agency's healthcare providers and employees from violent behavior and threats of violent behavior occurring at the Agency or while providing agency services. The Agency will make available upon request, an electronic or printed copy of the Agency's WPVPP to each Agency healthcare provider or employee.

Texas also has requirements for the Agency to post a notice to the employees reporting workplace violence or suspicious activity to the Department of Public Safety.

Should the Agency prohibit handguns in the workplace, the Agency will provide notice to the public by written communication by the display of signs for laws §30.06 and §30.07 of the Texas Penal Code in both English and Spanish.

Review the following policy and procedure:

Online Bookmark	Title of Policy
Environmental/Safety/Equipment Management (EC)	Safety and Workplace Violence Prevention Program-TX
QAPI Section (Ongoing Monitoring)	Workplace Violence Prevention Program-TX (Form)

Social Worker Requirements

The Medicare Conditions of Participation (CoP) require medical social workers in home care to have a Master of Social Work degree (LMSW in Texas) and one year of health care experience. Social work assistants should have a Bachelor of Social Work degree (LBSW in Texas), one year of healthcare experience, and must be supervised by an LMSW.

There are some rules from the Texas Behavioral Health Executive Council that are very important to note:

- LMSWs in the home care setting make many critical interventions that are considered “clinical practice” such as counseling patients and families for anxiety and depression. Other interventions are considered “non-clinical practice” that include case management activities such as community resource linkages and long-term planning / placement. Because this “mixture” exists and is essential in the home care setting, even full-time / part-time salaried agency LMSWs must have clinical supervision by a Licensed Clinical Social Worker (LCSW) to put them in compliance with the law in terms of the “clinical” aspect of their home care social work practice. LBSW social workers are not allowed to do “clinical practice” of social work in any setting.
- LMSWs and LBSWs who work on a “contract” basis for home care can only provide “non-clinical practice” to be in compliance with the law.

Section 14 Accreditation Specific Orientation Medicare Certified

Community Health Accreditation Partner (CHAP)

The information in this section is CHAP accreditation specific. CHAP standards that have not already been addressed in Orientation are discussed here in order of the Orientation Manual sections.

Table of Contents

General Orientation

Introduction

Welcome to a CHAP Medicare Certified Home Health Agency

What is Licensed and Certified?
Licensed – Meets state standards to operate a home health agency.

Certified – Meets Medicare Conditions of Participation to operate a home health agency.

Both require routine surveys to maintain the current status.

Patients/clients in this agency may come from a variety of payor sources. Primarily, the payor source will be the Medicare program.

Our Agency is Accredited by Community Health Accreditation Partner (CHAP)

CHAP accreditation is a voluntary professional peer review administered by a private organization.

CHAP standards are higher than state or federal requirements and are patient/client care focused.

Human Resources and Personnel Administration

Employee Education

Compliance Training and Education

All Relevant Covered Persons will have special training in addition to the general training upon initial orientation and at least annually.

- Covered Persons – All owners, officers, directors, and employees of the Agency; and all contractors and agents who provide patient/client care items or services, or who perform billing or coding functions on behalf of the Agency.
- Relevant Covered Persons – Includes all covered persons involved in the preparation or submission of claims or cost reports for reimbursement from any federal healthcare program.

Additional mandated in-service topics include the Medical Device Act.

Employee Performance

Home health aides will receive a 90-day probationary evaluation.

All employees are required to perform a self-evaluation at the time of the employer evaluation.

All employees are required to work with the employer on mutual goal setting that will also be reviewed with the employee evaluation.

Joint visits annually are required as part of the annual performance evaluation.

Patient/Client Complaints

The patient/client will also be provided the CHAP hotline number and hours of operations to make a complaint if issues are not resolved by the Agency level.

The Agency encourages rapid resolution to an issue in order to respect the patient's/client's rights and to avoid an unnecessary complaint survey. The resolution of the complaint must be reported back to the complainant.

Safety/OSHA

Exposure Control

Tuberculosis Requirements

The Agency is committed to providing a safe working environment for employees who may experience exposure to bloodborne and airborne pathogens.

Tuberculosis requirements for CHAP are found in the Exposure Control Plan. Please review all of the information, taking time to understand the Agency's plan for patients/client and staff. Direct any questions or concerns to your immediate manager.

Online Bookmark	Title of Policy
Surveillance, Prevention, and Control of Infection (IC)	Exposure Control Plan

Medical Device Act

The Agency's goal is for staff to provide safe and appropriate use of equipment owned and/or used by the Agency.

The Agency will provide adequate training to employees on appropriate reporting of medical device incidents. The Agency will educate all staff in the safe use of equipment owned and/or utilized by the Agency and will notify staff in a timely manner of any identified equipment hazards, defects, and recalls.

The Agency will document and report all occurrences (accidents, injuries, safety hazards, medical device incidents) that deviate from routine Agency operations and might result in injury or potential harm to a patient/client, caregiver, or agency staff.

Employees will inform management of any equipment/medical device that has failed and/or caused harm to a patient/client, caregiver, or employee and ensure that the equipment/medical device is not used until appropriately investigated and reported.

<u>Medical Device Reporting</u>

Medical Device – Any item that is used for the diagnosis, treatment, or prevention of a disease, injury, or other condition and is not a drug or biologic. Medical devices may include equipment, implants, disposable, and radioactive contrast media.

Serious Injury/Illness – An illness or injury that is one of the following:

- Life threatening.
- Results in permanent impairment of a body function or damage to a body function.
- Necessitates immediate permanent impairment of a body function or permanent damage to a body function.

Agency staff will complete a report using FDA Form 3500A when it is suspected or determined that a device has caused serious injury to a patient/client, or when a device has caused a patient/client death.

Agency management will ensure isolation of the identified device(s) and any accessories or ancillary devices, such as disposables being used so that the device will not be used until the investigation has been completed and/or corrective action has been implemented to ensure the device is safe for use.

Agency management, or designee, will investigate in conjunction with appropriate personnel that may include device user, manufacturer, or supplier.

Result of investigation will be documented on the FDA Form 3500A. Data to report includes:

- Patient/client information
- Type of adverse event/description of the event
- Relevant laboratory/test data and patient/client history
- Manufacturer and identification of the suspect device and certain other information about the device as asked on the form
- Initial reporter of the event
- Agency name, address, and contact
- Where and when the report was sent

Causes may include, but are not limited to the following:

- Device failure
- User error
- Maintenance error
- Packaging error
- Tampering
- Support system failure
- Environmental factors
- Patient/client reaction

Management staff will report the following:

- Patient/client deaths within ten working days to the manufacturer of a device and the FDA.
- Serious illness or injury within ten working days to manufacturer who will report to the FDA.

In addition to individual device reports, agency management/designation will submit an annual report on FDA Form 3419A, on January 1st of each year, of incidents to the FDA which will include the following data:

- Identification of the Agency's complete name and address
- CMS provider number or FDA assigned reporting number
- Reporting year and report date
- Name, title, and address of the contact person
- Lowest and highest report numbers of the reports submitted to the FDA and/or manufacturer during the year
- Product name, serial number, and model number
- Name and address of device manufacturer
- Brief description of event

Reports may be completed online at http://www.fda.gov. Or may be submitted via mail to:

Food and Drug Administration
Center for Devices and Radiological Health
Medical Device Reporting
User Facility Report
P.O. Box 3002
Rockville, MD 20847-3002

The Agency will maintain a copy of the report for a minimum of five (5) years after discharge of the patient/client and for any additional time as deemed necessary in the event of an audit, litigation, or other dispute until after settlement. Refer to the Agency policy on Retention of Records.

If an Agency believes that there is a public health emergency, it should contact the FDA Emergency Operations Branch, Office of Regional Operations, HFC-162, by phone at 301-443-1240, or by sending a fax to 240-276-3454.

Clinical Orientation

Professional Direct Care Staff

Orders

Within 60 days or prior to billing for the service provided, the Agency will obtain physician and/or non-physician practitioner signatures on the patient's/client's plan of care, as well as obtaining physician and/or non-physician practitioner signatures for supplemental verbal orders.

Admission and Recertification

Pre and Post Accreditation

There is a pre-accreditation and post-accreditation consent and Patient/Client Rights for CHAP. The pre-accreditation forms do not include the CHAP complaint information and are used prior to a new Agency's initial survey. The patient/client rights include the right to be informed of the Agency ownership and control.

Skilled Nursing

LVN/LPN Supervisory Visits

LVN/LPN supervisory visits must be completed at least every 60 days at the patient's/client's residence. The LVN/LPN does not have to be present. The RN supervises to ensure the LVN/LPN is providing appropriate care according to the plan of care.

Therapy

Supervisory Visits

A supervisory visit by the appropriate discipline's skilled therapist will be completed at least every 60 days and as necessary based on patient/client acuity by means of a visit to the patient's/client's home. Additional supervisory activities may include regularly scheduled patient/client record audits and/or conferences.

Medical Social Services

Supervisory Visits

The masters prepared social worker will provide clinical supervision as required, to the bachelors prepared social worker assistant, by means of case conference, joint visit or both depending on the needs of the patient/client and skills of the assistant.

Home Health Aide

Care Plan

The frequency of tasks on the care plan cannot be “PRN”. “Client Choice” could be used as a frequency if it is clear on the care plan the patient/client is cognitively capable of making the decision and functionally able to complete the task.

If the patient/client requires the services of an aide, a care plan must be completed with evidence of the aide receiving orientation to the care plan prior to the patient/client receiving personal care.