Thank you very much for purchasing this Policy Manual. This manual is designed so that implementation of the policies will result in compliance with the CHAP standards for accreditation and Medicare Conditions of Participation for Home Care. The manual is divided into two sections:

*CHAP Core Operational Policies and Procedures*

*and*

*CHAP Home Health Operational Policies and Procedures*

We know you will find it helpful as you prepare for CHAP accreditation, Medicare certification and continue to improve your operational practices.

This manual has been copyrighted by The Corridor Group, Inc. (TCG) and is thereby protected by copyright laws of the United States and foreign countries.

TCG hereby grants Visiting Nurse & Hospice Care license to use documents therein for all internal purposes. TCG requires that Visiting Nurse & Hospice Care will not disclose the contents of such manuals to any third party, or allow any third party to use the manuals for any purpose.
CORRIDOR MEDIA, INC.
MANUAL PURCHASING LICENSE AGREEMENT

This is a legal agreement between the CUSTOMER and CORRIDOR MEDIA, INC. Upon receiving the CD-ROM, the CUSTOMER is agreeing to be bound by the terms of the agreement below.

TERMS USED THROUGHOUT THIS AGREEMENT

All references to customer, patient, facility, site, location, or physical location throughout this document will refer to: Visiting Nurse & Hospice Care located at 2821 West 33rd Street, Erie, PA 16506.

All licensing and usage agreements are assigned specifically to Visiting Nurse & Hospice Care located at 2821 West 33rd Street, Erie, PA 16506.

LICENSE FEE

All fees, taxes, and other applicable charges governed by this agreement are due upon receipt of the CORRIDOR MEDIA, INC. invoice, and prior to shipping of said product.

TERMS OF AGREEMENT

CUSTOMER is entitled to use This CORRIDOR MEDIA MANUAL at the site or location originally purchased for the life of the product for which CUSTOMER has paid.

SITE LICENSE

For each purchase and subject to the terms and conditions of this agreement, CORRIDOR MEDIA, INC. grants CUSTOMER the nonexclusive, nontransferable right to CORRIDOR MEDIA MANUAL. Use in more than one (1) facility or physical location by any means, including but not limited to intranet or Internet sharing requires one (1) paid licensed manual per facility or physical location. This license allows use of the product for the internal business of the CUSTOMER only; commercial use is prohibited, as is use by any party other than CUSTOMER and its employees in the specific site or location originally purchased. CORRIDOR MEDIA, INC. reserves all rights not expressly granted to CUSTOMER.

OWNERSHIP AND CONFIDENTIALITY

CORRIDOR MEDIA, INC. retains ownership of the POLICIES AND PROCEDURES MANUAL. Supporting applications are licensed for use by CUSTOMER and are owned by their respective companies. CUSTOMER agrees not to reverse-engineer any application provided with the product. CORRIDOR MEDIA, INC. grants CUSTOMER the right to modify the manual to meet the CUSTOMER’S specific needs. CUSTOMER assumes all responsibility for the accuracy and effectiveness of all such modifications.

COPY RESTRICTIONS

This SOFTWARE and the accompanying written materials have copyright protection. These manuals are protected by copyright laws of U.S. and foreign countries and are licensed for single locations only. Any reproduction of this document other than for specific use within the CUSTOMER single location is strictly prohibited. Any other copying, duplication, or broadcasting of the SOFTWARE or the accompanying written materials is forbidden. No part of the written materials may be reproduced, transmitted, transcribed, stored in a retrieval system, shared by computer networks, intranets, or the Internet, or translated into any magnetic, optical, chemical, manual, or otherwise, without the prior written permission of CORRIDOR MEDIA, INC. CUSTOMER may be held legally responsible for any copyright infringement that is caused by your failure to abide by the terms of this LICENSE. CORRIDOR MEDIA, INC. requires that the user will not disclose the contents of such materials to any third party, or allow any third party to use the manuals for any purpose.
REVISION OF WRITTEN MATERIALS

CORRIDOR MEDIA, INC. reserves the right to revise this publication and to make periodic content changes. CORRIDOR MEDIA, INC. will notify any person of such revision or changes to be purchased for a fee.

VISITING NURSE & HOSPICE CARE RESPONSIBILITIES

CUSTOMER is responsible for installing the CD-ROM and setting up hardware, for maintaining its computer system, and for keeping network and software in good working condition. CUSTOMER is also responsible for ensuring that computers meet the minimum system configuration.

NO OTHER WARRANTIES

To the maximum extent permitted by applicable law, CORRIDOR MEDIA, INC. disclaims all other warranties, either express or implied, including but not limited to implied warranties of merchantability and fitness for a particular purpose, with respect to the program, the related product manual and written materials, and any accompanying hardware and/or software. This limited warranty gives CUSTOMER specific legal rights. CUSTOMER may have others that vary from state/jurisdiction to state/jurisdiction.

NO LIABILITY FOR CONSEQUENTIAL DAMAGES

To the maximum extent permitted by applicable law, in no event shall CORRIDOR MEDIA, INC. or its suppliers be liable for any other damages whatsoever (including, without limitation, pecuniary loss) arising out of the use of or inability to use the software, even if CORRIDOR MEDIA, INC. has been advised of the possibility of such damages. In any case, CORRIDOR MEDIA, INC.'s entire liability under any provision of this agreement shall be limited to the fee paid by CUSTOMER for the product. Because some states/jurisdictions do not allow the exclusion of limitation of liability for consequential or incidental damages, the above limitation may not apply to CUSTOMER.

BREACH

CUSTOMER's failure to comply with the provisions of this license agreement constitutes a breach and will be cause for CORRIDOR MEDIA, INC. to require return of the POLICIES AND PROCEDURES MANUAL and removal from CUSTOMER's computers of all components thereof. Certain breaches may result in CORRIDOR MEDIA, INC. pursuing legal remedies against CUSTOMER, specifically, but not limited to, unauthorized and unpaid use at multiple sites, copying and/or reverse engineering the program, commercial use of the product, and/or abuse of Help Desk services by continued requests for assistance with problems unrelated to the POLICIES AND PROCEDURES MANUAL.

APPLICABLE LAW

This agreement is governed by the laws of the state of Kansas. If any provision(s) of this agreement are found to be legally invalid, the other provisions shall remain in effect.

RECOMMENDED HARDWARE/SOFTWARE

CORRIDOR MEDIA, INC.'s Recommended Hardware/Software Configuration for the POLICIES AND PROCEDURES MANUAL:

- Microsoft Windows 98 or higher
- Microsoft Word 97 with postscript fonts installed
- Pentium II processor 350 MHz or higher

To install POLICIES AND PROCEDURES MANUAL for Microsoft Word, CUSTOMER must accept this agreement. If CUSTOMER does not agree to the license agreement, please EXIT setup now.
The Corridor Manuals have been provided to you on CD-ROM for use as a tool in customizing and updating the information to meet the needs of your individual program. You must have a CR-ROM drive and Windows® to install this product.

These instructions only address installing the information from the CD-ROM onto your computer. If you need information about how to insert, delete, or search/replace information, please consult the user’s manual that accompanied your word processing software. Information is easily added and/or deleted using the cut/copy/paste function of the software. Since everyone’s computer may read converted data differently, you may notice some changes in spacing, character formats, and, in some cases, where page breaks fall.

Following the instructions below, the files containing your manuals will be automatically installed on your computer into the following path: C:\ Program files\Corridor Products\ Blvd

**Windows 95™ and above using Windows Explorer:**

1. Insert the CD-ROM into your CD-ROM drive. On most computers, the CD-ROM should start automatically
2. If the install program does not start automatically, open Windows Explorer.
3. Select your CD-ROM Drive.
5. Follow the prompts.

**To Access Information after Installation:**

1. Go into Microsoft® Word.
2. Select File.
3. Select Open.
4. Under Drives, select C:.
5. Open the path: Program files\Corridor Products\.
6. Select which file you would like to open.
7. Press Enter.

Please note: We have attempted to make these instructions as simple as possible. However, we understand that some computer systems, i.e., Windows 95 may vary in the steps taken to create a directory, open a file from a CD-ROM, or copy files. If your system differs from these instructions, please retrieve and use these files according to your computer’s specifications.

**NAVIGATION INSTRUCTIONS**

Hypertext links are tools that facilitate navigation within a document. The user is able to go directly to a location within the document without manually scrolling through the pages. Hypertext links are located within this document. While the user always has the ability to navigate the document with the scroll bar, these tools allow easier movement within the document.

All items that are “linked” to another part of the document appear in color on the computer screen. Locate the section of the document that you want to find, click on the colored text and the hyperlink will take you directly to that section.
POLICY NUMBERING AND REFERENCES

Policies have been numbered to identify the manual name, section, policy number and page.

Example:
HH:2-043.1

➢ The HH: represents the Home Health Manual
➢ The 2 represents Section Two
➢ The 043 represents policy 43 within the section
➢ .1 represents page 1 of that policy

<table>
<thead>
<tr>
<th>POLICY CODES</th>
<th>MANUAL REFERENCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>C:</td>
<td>Core</td>
</tr>
<tr>
<td>HH:</td>
<td>Home Health</td>
</tr>
<tr>
<td>H:</td>
<td>Hospice</td>
</tr>
</tbody>
</table>

Policies in each manual have been “crosswalked” to the corresponding Community Health Accreditation Program (CHAP) standards and Medicare Conditions of Participation. The crosswalk also contains a legend identifying the evidence required by CHAP.
CROSSWALK OF POLICIES AND PROCEDURES
WITH CHAP STANDARDS AND
MEDICARE CONDITIONS OF PARTICIPATION
## SECTION ONE
### Structure and Function

<table>
<thead>
<tr>
<th>POLICY/PROCEDURE</th>
<th>EVIDENCE</th>
<th>CHAP STANDARD</th>
<th>MEDICARE COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scope of Services</td>
<td>D, I</td>
<td>HHI.1a</td>
<td>484.14(a), 484.18</td>
</tr>
<tr>
<td>2. Listing of Services Provided</td>
<td>D, I</td>
<td>HHI.1b</td>
<td></td>
</tr>
<tr>
<td>3. Regulatory Compliance</td>
<td>D</td>
<td>HHI.2a</td>
<td>484.12, 484.12(a-b)</td>
</tr>
<tr>
<td>4. Professional Advisory Committee</td>
<td>D, I, O</td>
<td>HHI.2c-g</td>
<td>484.16, 484.52</td>
</tr>
<tr>
<td>5. Home Health Organizational Chart</td>
<td>D</td>
<td>HHI.3a</td>
<td>484.14</td>
</tr>
<tr>
<td>6. Home Health Administrator</td>
<td>D, I, O</td>
<td>HHI.4a-c</td>
<td>484.14(c-d)</td>
</tr>
<tr>
<td>7. Home Health Clinical Policies and Procedures</td>
<td>D</td>
<td>HHI.5b</td>
<td>484.14(g), 484.18(b-c), 484.36(e)</td>
</tr>
<tr>
<td>8. Home Health Record Retention</td>
<td>D, O</td>
<td>HHI.5d</td>
<td>484.48(a)</td>
</tr>
<tr>
<td>9. Scope of the Behavioral Health Program</td>
<td>D</td>
<td>HHI.5c</td>
<td></td>
</tr>
<tr>
<td>10. Scope of the Pediatric Program</td>
<td>D</td>
<td>HHI.5c</td>
<td></td>
</tr>
<tr>
<td>11. Scope of the Obstetrical Program</td>
<td>D</td>
<td>HHI.5c</td>
<td></td>
</tr>
<tr>
<td>12. Telemedicine Program</td>
<td>D</td>
<td>HHI.5e (3)</td>
<td></td>
</tr>
<tr>
<td>13. Telemedicine—Patient Privacy</td>
<td>D</td>
<td>HHI.5e (3)</td>
<td></td>
</tr>
<tr>
<td>14. Telemedicine—Admission Criteria</td>
<td>D</td>
<td>HHI.5e (1)</td>
<td></td>
</tr>
<tr>
<td>15. Telemedicine—Plan of Care</td>
<td>D</td>
<td>HHI.5e (1)</td>
<td></td>
</tr>
<tr>
<td>16. Telemedicine—Patient Education</td>
<td>D</td>
<td>HHI.5e (2)</td>
<td></td>
</tr>
<tr>
<td>17. Telemedicine—Discharge Criteria</td>
<td>D</td>
<td>HHI.5e (1)</td>
<td></td>
</tr>
<tr>
<td>18. Medicare Written Notices</td>
<td>D</td>
<td>CII.1b(11)</td>
<td>484.10(e)</td>
</tr>
<tr>
<td>19. Not in Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Not in Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Internal Control Systems/Accountabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend of Evidence for CHAP Accreditation:**

D = Documents  I = Interview  O = Observation  S = Survey
## Section Two

**Quality of Services and Products**

<table>
<thead>
<tr>
<th>Policy/Procedure</th>
<th>Evidence</th>
<th>CHAP Standard</th>
<th>Medicare COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Home Health Patient Bill of Rights</td>
<td>D</td>
<td>HHII.1</td>
<td>484.10</td>
</tr>
<tr>
<td>2. Intake Process</td>
<td>D</td>
<td>HHII.4</td>
<td>484.18</td>
</tr>
<tr>
<td>3. Admission Criteria and Process</td>
<td>D</td>
<td>HHII.4a</td>
<td>484.18</td>
</tr>
<tr>
<td>4. Care Planning Process</td>
<td>D, I</td>
<td>HHII.4b, HHII.5a</td>
<td>484.18, 484.18(a), 484.18(b), 484.30(a), 484.32</td>
</tr>
<tr>
<td>5. Physician Participation in Plan of Care</td>
<td>D, I</td>
<td>HHII.4c</td>
<td>484.18, 484.18(b)</td>
</tr>
<tr>
<td>6. Verification of Physician Orders</td>
<td>D</td>
<td>HHII.5g, h</td>
<td>484.18(b, c)</td>
</tr>
<tr>
<td>7. Rehabilitation Care Planning</td>
<td>D, I</td>
<td>HHII.5a</td>
<td>484.18(a)</td>
</tr>
<tr>
<td>8. Nutrition Care Planning</td>
<td>D, I</td>
<td>HHII.5a</td>
<td>484.18(a)</td>
</tr>
<tr>
<td>9. Home Health Aide Plan of Care</td>
<td>D, O</td>
<td>HHII.5m, n</td>
<td>484.36(c)</td>
</tr>
<tr>
<td>10. Orientation of Assigned Home Health Aide</td>
<td>D, I, O</td>
<td>HHII.5n</td>
<td>484.14(e)</td>
</tr>
<tr>
<td>11. Support/Chore Worker Service Plan</td>
<td>D, I, O</td>
<td>HHII.5o, p</td>
<td>484.36(d)</td>
</tr>
<tr>
<td>12. Discharge Planning</td>
<td>D, I</td>
<td>HHII.4c</td>
<td>484.14(g)</td>
</tr>
<tr>
<td>13. Continuity of Care</td>
<td>D, I</td>
<td>HHII.4c</td>
<td>484.14(g)</td>
</tr>
<tr>
<td>14. Case Conference/Progress Summary</td>
<td>D</td>
<td>HHII.4d</td>
<td>484.14(g)</td>
</tr>
<tr>
<td>15. Monitoring Patient’s Response/Reporting to Physician</td>
<td>D, I</td>
<td>HHII.4c, HHII.5i</td>
<td>484.14(g), 484.18, 484.18(b)</td>
</tr>
<tr>
<td>16. 60-Day Summary Report</td>
<td>D</td>
<td>HHII.5j</td>
<td>484.14(g)</td>
</tr>
<tr>
<td>17. Patient Notification of Changes in Care</td>
<td>D, I</td>
<td>HHII.4c</td>
<td>484.14(g)</td>
</tr>
<tr>
<td>18. On-Call/Weekend Staffing</td>
<td>D, I</td>
<td>HHII.3</td>
<td></td>
</tr>
<tr>
<td>19. Coordination of Services with Other Providers</td>
<td>D, I</td>
<td>HHII.4c</td>
<td>484.14(g)</td>
</tr>
<tr>
<td>20. Internal Referral Process</td>
<td>D, I</td>
<td>HHII.4c</td>
<td>484.14(g), 484.32, 484.34</td>
</tr>
<tr>
<td>21. Initial and Comprehensive Assessment</td>
<td>D</td>
<td>HHII.5c, d</td>
<td>484.18, 484.18(a), 484.55(a), 484.55(b), 484.55(c), 484.55(e)</td>
</tr>
<tr>
<td>22. Ongoing Assessments</td>
<td></td>
<td></td>
<td>484.18, 484.55</td>
</tr>
</tbody>
</table>

Legend of Evidence for CHAP Accreditation:

D = Documents  I = Interview  O = Observation  S = Survey
## Section Two

**Quality of Services and Products**

<table>
<thead>
<tr>
<th>POLICY/PROCEDURE</th>
<th>EVIDENCE</th>
<th>CHAP STANDARD</th>
<th>MEDICARE COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Reassessments/Recertification</td>
<td>D</td>
<td>HHIII.5d, e</td>
<td>484.18(b), 484.55(b), 484.55(c), 484.55(d), 484.55(e)</td>
</tr>
<tr>
<td>24. Functional Assessment</td>
<td>D</td>
<td>HHIII.5d</td>
<td>484.30(a), 484.32, 484.55</td>
</tr>
<tr>
<td>25. Nutritional Assessment</td>
<td>D</td>
<td>HHIII.5d</td>
<td>484.55</td>
</tr>
<tr>
<td>26. Pain Assessment</td>
<td>D</td>
<td>HHIII.5d</td>
<td>484.55</td>
</tr>
<tr>
<td>27. Assessment of Possible Abuse/Neglect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Medication Profile</td>
<td>D</td>
<td>HHIII.7a</td>
<td>484.18(c), 484.55(c)</td>
</tr>
<tr>
<td>29. Identification of Medication for Administration</td>
<td>D</td>
<td>HHIII.7b</td>
<td>484.18(c)</td>
</tr>
<tr>
<td>30. Administration and Documentation of Medications</td>
<td>D</td>
<td>HHIII.7b</td>
<td>484.55(c)</td>
</tr>
<tr>
<td>31. Patient Self-Administration of Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Home Use and Disposal of Controlled Substances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Intravenous Administration of Medications/Solutions</td>
<td>D</td>
<td>HHIII.7b</td>
<td>484.55(c)</td>
</tr>
<tr>
<td>34. Intravenous Administration of Chemotherapy</td>
<td>D</td>
<td>HHIII.7b</td>
<td></td>
</tr>
<tr>
<td>35. First Dose Policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Crushing of Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Pulse Rate Determination with Certain Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Storage of Medications and Nutritional Products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Medication Labeling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Adverse Drug Reactions</td>
<td>D</td>
<td>HHIII.7c</td>
<td></td>
</tr>
<tr>
<td>41. Anaphylaxis Protocol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Medication Error</td>
<td>D</td>
<td>HHIII.7c</td>
<td></td>
</tr>
<tr>
<td>43. Medication Monitoring</td>
<td>D</td>
<td>HHIII.7a</td>
<td>484.18(c), 484.55(c)</td>
</tr>
</tbody>
</table>

Legend of Evidence for CHAP Accreditation:

- **D** = Documents
- **I** = Interview
- **O** = Observation
- **S** = Survey
## SECTION TWO

*Quality of Services and Products*

<table>
<thead>
<tr>
<th>POLICY/PROCEDURE</th>
<th>EVIDENCE</th>
<th>CHAP STANDARD</th>
<th>MEDICARE COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>44. Investigational Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Do Not Resuscitate/Do Not Intubate Orders</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td>484.10(c)</td>
</tr>
<tr>
<td>48. Cardiopulmonary Resuscitation</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>49. Withdrawal of Life-Sustaining Care</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>50. Care of the Dying Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51. Transfer/Referral Criteria and Process</td>
<td>D</td>
<td>HHIII.5k</td>
<td>484.34, 484.48(a)</td>
</tr>
<tr>
<td>52. Transfer Summary</td>
<td>D</td>
<td>HHIII.5k</td>
<td>484.14(g), 484.48(a)</td>
</tr>
<tr>
<td>53. Discharge Criteria and Process</td>
<td>D</td>
<td>HHIII.5l</td>
<td>484.34, 484.48(a)</td>
</tr>
<tr>
<td>54. Discharge Summary</td>
<td>D</td>
<td>HHIII.5l</td>
<td>484.14(g), 484.48</td>
</tr>
<tr>
<td>55. Contents of Clinical Record</td>
<td>D</td>
<td>HHIII.8a, b</td>
<td>484.48</td>
</tr>
<tr>
<td>56. Assembly of Clinical Record</td>
<td>D</td>
<td>HHIII.8d</td>
<td>484.48</td>
</tr>
<tr>
<td>57. Clinical Record Review</td>
<td>D, I</td>
<td>HHIII.9a, b</td>
<td>484.52(b)</td>
</tr>
<tr>
<td>58. External Databases</td>
<td></td>
<td></td>
<td>484.20(c)</td>
</tr>
<tr>
<td>59. OASIS Data Transmission</td>
<td>D, I, O</td>
<td>HHIII.5d,e,f</td>
<td>484.20</td>
</tr>
</tbody>
</table>

Legend of Evidence for CHAP Accreditation:

D = Documents   I = Interview   O = Observation   S = Survey
# SECTION THREE

*Human, Financial, Physical Resources*

<table>
<thead>
<tr>
<th>POLICY/PROCEDURE</th>
<th>EVIDENCE</th>
<th>CHAP STANDARD</th>
<th>MEDICARE COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Home Health Human Resources</strong></td>
<td>D, I</td>
<td>HHI11.1a</td>
<td>484.12(c), 484.14(d-e), 484.36, 484.36(a-d)</td>
</tr>
<tr>
<td>2. <strong>Home Health Staffing Guidelines</strong></td>
<td>D, I</td>
<td>HHI11.1b</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Responsibilities/Supervision of Clinical Services</strong></td>
<td>D, I, O</td>
<td>HHI11.1e</td>
<td>484.14(d), 484.36(d)</td>
</tr>
<tr>
<td>4. <strong>Supervision</strong></td>
<td>D, I, O</td>
<td>HHI11.1e</td>
<td>484.14(d), 484.36(d)</td>
</tr>
<tr>
<td>5. <strong>Access to Qualified Consultation</strong></td>
<td>D, I, O</td>
<td>HHI11.1e</td>
<td>484.14(d), 484.36(d)</td>
</tr>
<tr>
<td>6. <strong>Consultation for Specialty Services</strong></td>
<td>D, I, O</td>
<td>HHI11.1e</td>
<td>484.14(d), 484.30(a), 484.36(d)</td>
</tr>
<tr>
<td>7. <strong>Communication With Office</strong></td>
<td>D, I, O</td>
<td>HHI11.1e</td>
<td>484.14(d), 484.36(d)</td>
</tr>
<tr>
<td>8. <strong>Home Health Contracted Services</strong></td>
<td>D</td>
<td>HHI11.2a</td>
<td>484.11, 484.14, 484.14(f), 484.36(d)</td>
</tr>
<tr>
<td>9. <strong>Contracted Service Providers</strong></td>
<td>D, I</td>
<td>HHI11.2a</td>
<td>484.11, 484.14, 484.14(f), 484.36(d)</td>
</tr>
<tr>
<td>10. <strong>Training/Inservice Education</strong></td>
<td>D</td>
<td>HHI11.1f, h</td>
<td>484.36(b)</td>
</tr>
<tr>
<td>11. <strong>Competency Assessment</strong></td>
<td>D</td>
<td>HHI11.1g</td>
<td>484.30(a), 484.32, 484.36(b)</td>
</tr>
<tr>
<td>12. <strong>Home Health Aide Training</strong></td>
<td>D, I</td>
<td>HHI11.1c, d</td>
<td>484.36(a), 484.36(b), 484.36(c)</td>
</tr>
<tr>
<td>13. <strong>Home Health Aide Supervisory Visits</strong></td>
<td>D, I, O</td>
<td>HHI11.1e</td>
<td>484.36(d)</td>
</tr>
<tr>
<td>14. <strong>Physician Licensure Verification</strong></td>
<td>D, O</td>
<td>HHI11.1i</td>
<td>484.18</td>
</tr>
<tr>
<td>15. <strong>Home Health Capital Expenditure Plan</strong></td>
<td>D</td>
<td>HHI11.3</td>
<td></td>
</tr>
</tbody>
</table>

**Legend of Evidence for CHAP Accreditation:**

- D = Documents
- I = Interview
- O = Observation
- S = Survey
# SECTION FOUR

*Long Term Viability*

<table>
<thead>
<tr>
<th>POLICY/PROCEDURE</th>
<th>EVIDENCE</th>
<th>CHAP STANDARD</th>
<th>MEDICARE COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Home Health Annual Evaluation</strong></td>
<td>D</td>
<td>HHIV.1</td>
<td>484.14(i), 484.16, 484.16(a), 484.52, 484.52 (a-b)</td>
</tr>
<tr>
<td>2. <strong>Home Health Innovation</strong></td>
<td>D, I, O</td>
<td>HHIV.2a–c</td>
<td></td>
</tr>
</tbody>
</table>

Legend of Evidence for CHAP Accreditation:

- **D** = Documents
- **I** = Interview
- **O** = Observation
- **S** = Survey
## Section Five

*Patient and Family/Caregiver Education*

<table>
<thead>
<tr>
<th>POLICY/PROCEDURE</th>
<th>EVIDENCE</th>
<th>CHAP STANDARD</th>
<th>MEDICARE COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Education Process</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>2. Safe/Effective Use of Medications</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>3. Drug–Food Interactions</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>4. Pain Management Education</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>5. Rehabilitation Techniques</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>6. Appropriate Use of Restraints and Supplies</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>7. Safe/Effective Use of Equipment and Supplies</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>8. Storage, Handling, and Access to Supplies and Gases</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>9. Identification, Handling, and Disposal of Hazardous Waste</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>10. Infection Control Precautions</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>11. Natural Disasters/Emergencies</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>12. Basic Home Safety</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>13. Patient Education Related to Discharge Planning</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>14. Educational Resources</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
<tr>
<td>15. Community Resources</td>
<td>D, I</td>
<td>HHIII.5a</td>
<td></td>
</tr>
</tbody>
</table>

**Legend of Evidence for CHAP Accreditation:**

- **D** = Documents  
- **I** = Interview  
- **O** = Observation  
- **S** = Survey
SECTION SIX
Job Descriptions

<table>
<thead>
<tr>
<th>POLICY/PROCEDURE</th>
<th>EVIDENCE</th>
<th>CHAP STANDARD</th>
<th>MEDICARE COP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Policy Statement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Scope of the Program/Process Methodology</td>
<td>D</td>
<td>HHI.5c, HHI.1g, .1h</td>
<td></td>
</tr>
<tr>
<td>3. Competency Based Orientation</td>
<td>D</td>
<td>HHI.1g, .1h</td>
<td>484.36</td>
</tr>
<tr>
<td>4. Core Competency Skills</td>
<td>D</td>
<td>HHI.1g, .1h</td>
<td>484.36</td>
</tr>
<tr>
<td>5. Annual Core Competence</td>
<td>D</td>
<td>HHI.1g, .1h</td>
<td>484.36</td>
</tr>
<tr>
<td>6. Specialized Services</td>
<td>D</td>
<td>HHI.1g, .1h</td>
<td></td>
</tr>
<tr>
<td>7. Requirements for Supervisors/Preceptors</td>
<td>D</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend of Evidence for CHAP Accreditation:

D = Documents  I = Interview  O = Observation  S = Survey
SECTION SIX

Job Descriptions

ATTACHMENTS

Attachment I: ........................................................................................................ CHAP Crosswalk

Attachment II: .................................................................................................. Medicare Conditions of Participation

Attachment III: .......................................................................................... Home Health Agency Interpretive Guidelines

Attachment IV: ....................................................................................... Home Health Agency Manual

Attachment V .......................................................................................... Additional Resources
<table>
<thead>
<tr>
<th>Section One</th>
<th>Structure and Function</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of Services</td>
<td>HH:1-001</td>
<td></td>
</tr>
<tr>
<td>Listing of Services Provided</td>
<td>HH:1-002</td>
<td></td>
</tr>
<tr>
<td>Regulatory Compliance</td>
<td>HH:1-003</td>
<td></td>
</tr>
<tr>
<td>Professional Advisory Committee</td>
<td>HH:1-004</td>
<td></td>
</tr>
<tr>
<td>Addendum: Professional Advisory Committee Members*</td>
<td>HH:1-004.A</td>
<td></td>
</tr>
<tr>
<td>Home Health Organizational Chart</td>
<td>HH:1-005</td>
<td></td>
</tr>
<tr>
<td>Addendum: Organizational Charts*</td>
<td>HH:1-005.A</td>
<td></td>
</tr>
<tr>
<td>Home Health Administrator</td>
<td>HH:1-006</td>
<td></td>
</tr>
<tr>
<td>Home Health Clinical Policies and Procedures</td>
<td>HH:1-007</td>
<td></td>
</tr>
<tr>
<td>Home Health Record Retention</td>
<td>HH:1-008</td>
<td></td>
</tr>
<tr>
<td>Scope of the Behavioral Health Program</td>
<td>HH:1-009</td>
<td></td>
</tr>
<tr>
<td>Scope of the Pediatric Program</td>
<td>HH:1-010</td>
<td></td>
</tr>
<tr>
<td>Scope of the Obstetrical Program</td>
<td>HH:1-011</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Program</td>
<td>HH:1-012</td>
<td></td>
</tr>
<tr>
<td>Telemedicine—Patient Privacy</td>
<td>HH:1-013</td>
<td></td>
</tr>
<tr>
<td>Telemedicine—Admission Criteria</td>
<td>HH:1-014</td>
<td></td>
</tr>
<tr>
<td>Telemedicine—Plan of Care</td>
<td>HH:1-015</td>
<td></td>
</tr>
<tr>
<td>Telemedicine—Patient Education</td>
<td>HH:1-016</td>
<td></td>
</tr>
<tr>
<td>Telemedicine—Discharge Criteria</td>
<td>HH:1-017</td>
<td></td>
</tr>
<tr>
<td>Medicare Written Notices</td>
<td>HH:1-018</td>
<td></td>
</tr>
<tr>
<td>Not in Use</td>
<td>HH:1-019</td>
<td></td>
</tr>
<tr>
<td>Not in Use</td>
<td>HH:1-020</td>
<td></td>
</tr>
<tr>
<td>Internal Control Systems/Accountabilities</td>
<td>HH:1-021</td>
<td></td>
</tr>
</tbody>
</table>

*Requires state or organization-specific information.
SCOPE OF SERVICES
Policy No. HH:1-001.1

PURPOSE

To describe Visiting Nurse & Hospice Care operations including the geographical service area.

POLICY

Visiting Nurse & Hospice Care will operate an office that will provide a safe and adequate location related to space, facilities, and administrative services.

Visiting Nurse & Hospice Care will be open from 8:00 a.m. to 5:00 p.m., Monday through Friday, except designated holidays or other days decided by the Executive Director/Administrator. Designated organization personnel will be available to patients on an on-call basis during non-office hours. Visiting Nurse & Hospice Care services will be available 24 hours a day, seven (7) days a week.

Home care services are provided on an intermittent basis to patients in their place of residence.

Scope of Services

1. Refer to the Service Area policy C:2000 regarding Visiting Nurse & Hospice Care geographical service areas.

2. Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse and include:
   A. Initial and ongoing comprehensive assessments of the patient's needs, including OASIS assessments at appropriate points in time
   B. Initiating the plan of care and revising as necessary
   C. Providing those services and/or treatments requiring substantial and specialized nursing skill
   D. Counseling and educating the patient and family/caregiver regarding the disease process, self-care techniques, and prevention strategies
E. Initiating appropriate preventive and rehabilitative nursing procedures

F. Preparing clinical and progress notes

G. Coordination of services

H. Referral to other services as needed

I. Informing the physician and other staff of changes in the patient’s needs

J. Evaluating the effectiveness and outcomes of care

K. Supervising licensed practical/vocational nurses and paraprofessionals providing services

L. Assigning home health aides to specific patients

M. Planning for discharge from service

N. Participating in inservice programs

3. Licensed practical/vocational nurses supplement the nursing care needs of the patient as provided by the registered nurse. These include:

A. Providing services in accordance with organization policies

B. Preparing clinical and progress notes

C. Assisting the registered nurse or physician in performing specialized procedures and duties

D. Assisting the registered nurse in carrying out the plan of care

E. Assisting the patient in learning appropriate self-care techniques

4. Home health aide duties include:

A. Assisting with personal hygiene

B. Assisting with ambulation and exercise

C. Assisting with medications that are ordinarily self-administered (per state regulations)

D. Reporting changes in the patient’s condition
E. Providing nutritional support

F. Other supportive tasks as assigned

5. Rehabilitative therapies are provided according to the patient’s plan of care by a registered/certified physical or occupational therapist in accordance with the patient’s plan of care and include:

A. Initial and ongoing assessments to determine the level of functioning, including OASIS assessments at appropriate points in time

B. Developing and revising the plan of care in consultation with the physician and other care team members

C. Goal setting

D. Providing therapeutic treatments

E. Educating the patient and/or family

F. Evaluation of equipment needs to increase functional level

G. Preparing clinical and progress notes

H. Coordinating services in consultation with home health staff

I. Evaluating the effectiveness and outcomes of care

J. Supervising therapy assistants and home health aides, as appropriate

K. Participating in inservice programs

L. Planning for discharge
6. Licensed and/or certified assistants’ (PTA, COTA) duties under the direction of a physical or occupational therapist will include:
   
   A. Performing services planned, delegated, and supervised by the therapist
   
   B. Providing services in accordance with organization policies
   
   C. Preparing clinical and progress notes
   
   D. Participating in teaching the patient and family/caregiver
   
   E. Participating in inservice programs

7. Speech/language pathology services are provided according to the patient’s plan of care by a qualified speech/language pathologist and/or audiologist and include:

   A. Initial and ongoing assessments to identify the patient’s level of functioning and ability to communicate, including OASIS assessments at appropriate points in time

   B. Goal setting

   C. Developing the plan of care in consultation with the physician and other care team members and revising it as appropriate

   D. Preparing clinical and progress notes

   E. Consultation and coordination of services with other disciplines

   F. Patient/family education

   G. Evaluating effectiveness and outcomes of care

   H. Informing the physician and other personnel of changes in the patient’s needs

   I. Discharge planning

   J. Participation in inservice programs

8. Social work services are provided according to the patient’s plan of care by a qualified social worker, or by a qualified social work assistant under the supervision of a qualified social worker, and include:

   A. Assessing psychosocial status

   B. Goal setting
9. Nutrition services are provided by a registered dietician and include:
   A. Assessing the nutritional needs of patient per organization policy and revising the plan of care, as needed
   B. Providing patient and family/caregiver education, as required
   C. Consulting with staff regarding special dietary regimens and nutritional requirements
   D. Preparing clinical and progress notes
   E. Goal setting
   F. Coordinating services with other involved disciplines

10. Physician services are provided by a licensed Doctor of Medicine, Osteopathy, or Podiatry and include:
   A. Diagnosing and treating medical conditions
   B. Prescribing medications and therapeutic regimens
   C. Developing and/or authorizing the plan of care
   D. Approving additions or modifications to original plan of care recommended by professional home care staff
E. Performing periodic review for necessary revisions and changes

F. Submitting signed orders for plans of care and changes in accordance with required time frames

G. Reviewing and/or preparing clinical and progress notes

H. Staff consultation as indicated
LISTING OF SERVICES PROVIDED  
Policy No. HH:1-002.1

PURPOSE

To assure that at least one (1) of the Medicare home health qualifying services is provided directly by organization staff and that all services, whether provided directly or under contractual agreement, will adhere to organization policies and procedures.

POLICY

At least one (1) qualifying service will be provided (nursing, physical therapy, occupational therapy, speech therapy, medical social services, or home health aide services) directly with 100% organizational personnel. A second qualifying service and additional services may be provided under arrangement with another organization. All services provided, whether directly or under contractual agreement, will be guided by organization policies and procedures.

PROCEDURE

1. The scope of services is renewed and revised as necessary by the Executive Director/Administrator.

2. Services will be provided as listed below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Directly</th>
<th>Under Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Skilled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nurse Assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Licensed Practical/Vocational Nurse</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Speech Therapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Social Worker</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nutritionist</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
3. Job descriptions for each position will be maintained by the organization.

4. This scope of services statement will be made available upon request, to patients, referral sources and other interested parties.
PURPOSE

To ensure compliance with local, state, federal, and other regulatory bodies.

POLICY

The organization will maintain evidence of regulatory compliance, including but not limited to:

1. Current state license
2. Medicare and Medicaid provider numbers
3. Business license, as applicable
4. CLIA certification
5. Reports of reviewing bodies (CHAP, FDA, state licensure surveys, OSHA, etc.)
6. D/B/A state registration, as applicable
PURPOSE

To provide a process for the development and implementation of the Professional Advisory Committee.

POLICY

The Governing Body will appoint a multidisciplinary Professional Advisory Committee (PAC). The committee will consist of at least one (1) practicing physician, a nurse with community health or home care experience, representatives of other professional services reflecting at least the scope of organization services (such as physical, speech, or occupational therapy social work and discharge planning), and one (1) member that is neither an owner nor an employee of the organization.

This committee will meet quarterly, or more often as needed, and minutes of each meeting will be recorded. The committee is authorized by the Governing Body to advise the organization on professional issues, to evaluate program and services and to assist the organization to maintain relationships in the community.

GUIDELINES

1. Responsibilities of the Professional Advisory Committee include:

   A. The committee will establish and annually review policies and procedures governing the scope of services provided

   B. Admission and discharge criteria/policies

   C. Medical supervision and plans of care

   D. Emergency procedures

   E. Clinical protocols

   F. Clinical records

   G. Personnel qualifications

   H. Annual program evaluation
2. The committee will refer to state or national association for the most recent Medicare Conditions of Participation regulations.

3. The committee will evaluate the organization’s success in meeting community needs for home care services, provision of adequate and appropriate care to each patient, and progress towards financial stability.

A list of the Professional Advisory Members follows. (See “Professional Advisory Committee Members” Addendum HH:1-004.A.)
ADDENDUM HH:1-004.A

PROFESSIONAL ADVISORY COMMITTEE MEMBERS
## PROFESSIONAL ADVISORY COMMITTEE MEMBERS

<table>
<thead>
<tr>
<th>Members</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ted Thoreson, Committee Chair</td>
<td>590 Freehaven Drive</td>
</tr>
<tr>
<td>MD</td>
<td>Santa Barbara, CA 93108</td>
</tr>
<tr>
<td>Jeff Allen</td>
<td>351 S. Patterson Ave.</td>
</tr>
<tr>
<td>RPT- Goleta Valley Cottage Hospital</td>
<td>Goleta, CA 93111</td>
</tr>
<tr>
<td>Michel Bordofsky</td>
<td>2320 Bath St., Ste 201</td>
</tr>
<tr>
<td>MD</td>
<td>Santa Barbara, CA 93105</td>
</tr>
<tr>
<td>Katina Etsell</td>
<td>15 Langlo Terrace</td>
</tr>
<tr>
<td>RN</td>
<td>Santa Barbara, CA 93105</td>
</tr>
<tr>
<td>Herb Geary</td>
<td>PO Box 689</td>
</tr>
<tr>
<td>VP Pt. Care Services, Cottage Health System</td>
<td>Santa Barbara, CA 93102</td>
</tr>
<tr>
<td>Karolyn Hanna</td>
<td>5235 Toluca Ct</td>
</tr>
<tr>
<td>RN, SBCC, Nursing Program</td>
<td>Santa Barbara, CA 93109</td>
</tr>
<tr>
<td>Jan Ingram</td>
<td>215 E. Padre St.</td>
</tr>
<tr>
<td>RN – Parish Nursing</td>
<td>Santa Barbara, CA 93105</td>
</tr>
<tr>
<td>Larry Mietus</td>
<td>5662 Calle Real, PMB 341</td>
</tr>
<tr>
<td>MD – House Call Medicine</td>
<td>Goleta, CA 93117</td>
</tr>
<tr>
<td>Steve Nance</td>
<td>5571 Ekwill St., Ste A &amp; B</td>
</tr>
<tr>
<td>Pharm D, 5571 Ekwill St., Ste A &amp; B</td>
<td>Santa Barbara, CA 93111</td>
</tr>
<tr>
<td>Tokie Shynk</td>
<td>PO Box 689</td>
</tr>
<tr>
<td>Service Director, Critical Care, Cottage Hospital</td>
<td>Santa Barbara, CA 93102</td>
</tr>
<tr>
<td>Suzette Chafey</td>
<td>222 E. Canon Perdido St.</td>
</tr>
<tr>
<td>RN, MMPH</td>
<td>Santa Barbara, CA 93101</td>
</tr>
<tr>
<td>Babetta Daddino</td>
<td></td>
</tr>
<tr>
<td>RN, Hospice Director, VNHC</td>
<td></td>
</tr>
<tr>
<td>Cheryl Donkin</td>
<td></td>
</tr>
<tr>
<td>Spiritual Counselor</td>
<td></td>
</tr>
<tr>
<td>Holly Gendron</td>
<td></td>
</tr>
<tr>
<td>Director of Serenity House</td>
<td></td>
</tr>
<tr>
<td>Lisa Holden</td>
<td></td>
</tr>
<tr>
<td>Senior Director of Education &amp; Organizational Development, VNHC</td>
<td></td>
</tr>
<tr>
<td>Sam Leer</td>
<td></td>
</tr>
<tr>
<td>LCSW, VNHC, Hospice</td>
<td></td>
</tr>
<tr>
<td>Mary Beth Noggle</td>
<td></td>
</tr>
<tr>
<td>RN, Director Home Health, VNHC</td>
<td></td>
</tr>
<tr>
<td>Debbie Wright</td>
<td></td>
</tr>
<tr>
<td>Director Quality and Compliance, VNHC</td>
<td></td>
</tr>
<tr>
<td>Lynda Tanner</td>
<td></td>
</tr>
<tr>
<td>Executive Director and CEO, VNHC</td>
<td></td>
</tr>
</tbody>
</table>
PURPOSE

To facilitate effective overall management and administration of the home health program and to establish communication channels for all personnel.

POLICY

There will be defined lines of authority that clearly establish responsibility and accountability for all organization personnel.

PROCEDURE

1. Organizational charts will be used to define relationships and lines of authority within the organization. (See “Organizational Charts” Addendum HH:1-005.A.)

2. Organizational charts will be reviewed as part of orientation.
ADDENDUM HH:1-005.A

ORGANIZATIONAL CHARTS
PURPOSE

To define the overall responsibilities of the home health administrator position.

POLICY

The home health Executive Director/Administrator position will be responsible for the direction, coordination, and general supervision of all home health services.

The full extent of the home health Executive Director/Administrator’s responsibilities will be defined in the applicable job description.

The Executive Director/Administrator will be qualified by education and experience including at least two (2) years of health related experience and the knowledge and ability to effectively direct the program.

PROCEDURE

1. The Executive Director/Administrator’s resume, diplomas/transcripts, and reference checks will be retained to validate the individual’s educational qualifications.

2. During the interview process, the individual’s knowledge regarding state regulations, Medicare Conditions of Participation, and other applicable regulations will be assessed. Only an individual with sufficient knowledge of these subjects will be considered for the position.

3. Responsibilities of the position will include but not be limited to:

   A. Planning, organizing, directing and evaluating operations to ensure the provision of adequate and appropriate care and services

   B. Complying with applicable law and regulations of operations

   C. Fiscal planning, budgeting, and management

   D. Recruiting, employing, and retaining qualified personnel

   E. Establishing and maintaining effective channels of communication

   F. Ensuring program personnel have current clinical information and current practices
G. Directing and monitoring performance improvement activities

H. Ensuring staff development including orientation, inservice education, continuing education and competency evaluation

I. Assuring that all clinical services are furnished under the supervision of a physician or registered nurse

J. Ensuring that appropriate service policies are developed and implemented

K. Assuring the development and qualifications for professional services and the assignment of personnel

L. Assuring appropriate staff supervision during all operating hours

M. Ensuring the accuracy of public information materials and activities

N. Appointing a similarly qualified alternate to be available at all times during operating hours in the absence of the Executive Director/Administrator

O. Maintaining ongoing liaison with the Governing Body

P. Implementing Governing Body directives

Q. Informing the Governing Body, staff and Professional Advisory Committee of current organizational, community and industry trends
HOME HEALTH CLINICAL POLICIES AND PROCEDURES

Policy No. HH:1-007.1

PURPOSE

To ensure that patient care and services are guided by current and relevant clinical policies and procedures.

POLICY

The organization will maintain current, up-to-date policies and procedures manuals for clinical personnel to utilize in the provision of patient care and service.

Clinical policies and procedures will be revised according to state/federal guidelines and current clinical practice.

PROCEDURE

1. Clinical policies and procedures manuals may be developed internally utilizing relevant and current professional practice guidelines or may be purchased commercially. Purchased manuals will be individualized to the organization’s practice.

2. Clinical policies and procedures will be reviewed and revised, as indicated, and approved and dated at least annually.

3. Approval of clinical policies and procedures may be completed by the Professional Advisory Committee, the Medical Director, or a clinician with recognized and documented expertise in a specific clinical arena. Final approval will be by the Governing Body.

4. Clinical policies and procedures, professional journals, and discipline-specific practice guidelines will be accessible to personnel at all times.

5. The following clinical policies and procedures will form the minimum framework for Visiting Nurse & Hospice Care policy manual:
   
   A. Plan of care development, implementation, coordination and evaluation
   
   B. Review of the plan of care by the physician and home health staff
   
   C. Verbal orders processing
   
   D. Communication with the physician regarding changes in the patient’s status or needed revision to the plan of care
E. Sixty (60)-day summary reports

F. Care coordination

G. Supervision of paraprofessional services, LPN/LVN's and therapy assistants

H. Medication management protocols, including at a minimum:
   1. Drug utilization review
   2. First dose in the home policy

I. Emergency care protocols

J. Advance Directives

K. Reporting patient abuse, neglect, fraud or exploitation

L. Patient safety

M. Clinical laboratory test processes, as applicable

N. Accepted medical term abbreviations

O. Annual program evaluation

P. Clinical record retention upon discontinuation of operations

Q. Patient consent for release of information
HOME HEALTH RECORD RETENTION
Policy No. HH:1-008.1

PURPOSE

To ensure that clinical records are retained by the organization according to law and regulation.

POLICY

Visiting Nurse & Hospice Care will retain all billing and clinical records for a minimum of seven (7) years past the month of filing of the applicable cost report or until the cost report is settled unless state law stipulates a longer period of time.
SCOPE OF THE BEHAVIORAL HEALTH PROGRAM
Policy No. HH:1-009.1

Intentionally Left Blank
SCOPE OF THE PEDIATRIC PROGRAM
Policy No. HH:1-010.1

PURPOSE
To provide guidelines for the patient receiving pediatric health services.

POLICY
Patients receiving pediatric services will meet established admission criteria and will have a specific pediatric assessment performed by a qualified clinician. (See “Scope of Assessments/Qualifications” Policy No. C:3-008.)

The organization will maintain a current program description including a listing of the scope of services.

PROCEDURE

Admission Criteria
1. In addition to the established routine admission criteria for Visiting Nurse & Hospice Care, pediatric patients will also meet the following criteria:
   A. Meet the currently accepted practice guideline regarding minimum weight upon admission
   B. Have responsible, willing, and able caregivers
   C. Not have clinical or equipment needs exceeding the clinical expertise of personnel

Assessment Process
1. The clinician providing pediatric services will follow the standardized plan of care, which applies to the pediatric patient’s needs.

2. Assessment of the pediatric patient may include as appropriate, but will not be limited to:
   A. Developmental age
   B. Length/height
   C. Head circumference (if applicable)
   D. Weight
E. Level of function related to growth and development

F. Emotional needs

G. Cognitive needs

H. Educational needs

I. Social needs

J. Daily activity needs

K. Pain status, when applicable

L. Rehabilitation needs

M. Support needs

N. Comprehension

O. Effect of patient’s condition on family/caregiver/guardian

P. Immunization status

Q. The family’s and/or guardian’s expectations for and involvement in the assessment, initial treatment, and continuous care of the patient

3. The pediatric patient’s educational needs and daily activities will be assessed on an ongoing basis. Appropriate referrals to community and social services will be made when prolonged home care services are anticipated.

4. Verification of immunization status may be obtained from a third party such as the family/caregiver, physician, school records, etc. Documentation in the clinical records should note the source of the immunization status including name, telephone number, date, etc.

5. Reassessment will occur regularly at each visit to determine:

   A. The patient’s response to care

   B. If there is a significant change in the patient’s condition

   C. If there has been a significant change in the patient’s diagnosis

   D. If there has been a significant change in the patient’s environment or support system
6. Changes in the assessments will be documented and communicated to the appropriate physician. This communication will be documented in the clinical record.

**Discharge Criteria**

1. Organizational discharge criteria will apply to the pediatric patient without exception or addition.

**Staff Qualifications**

1. Skilled nurses providing pediatric health care will:
   
   A. Have one (1) to two (2) years pediatric health care experience
   
   B. Have completed the organization’s orientation and competency assessment for pediatric care
Policies HH:1-011 to HH:1-017 Removed

Page Intentionally Left Blank
PURPOSE

To outline the process by which patients, families and caregivers will understand their financial responsibility for home health services.

POLICY

Upon admission, the admitting clinician will inform the patient and/or his/her representative of his/her payment responsibilities for home health services. The patient will be informed of any subsequent changes in his/her financial responsibility.

PROCEDURE

1. Insurance coverage and patient's responsibility for copayment will be discussed, disclosed, and presented in writing to the patient and family/caregiver. The actual costs for care, if any, will be presented in writing to the patient and family/caregiver. If copay responsibilities are not known, the clinician will provide the patient and family/caregiver with total organization charges until more accurate information can be obtained.

2. If more information is needed for verification of coverage, the clinician will discuss this with the Clinical Supervisor and may alert social services if the patient's financial situation is unclear. The clinician will notify the billing department if a tailored payment plan is required.

3. Patients who incur financial liability must be notified in writing within 30 calendar days from the date the organization is notified of any changes from payers.

4. Medicare patients must be provided with timely, accurate, and comprehensible written notices in any case where a reduction or termination of services is to occur, or where services are to be denied before being initiated. The HHABN process includes a standard written notice in which the agency must insert appropriate language including Option Box 1, 2, and 3 text, depending on the reason for any reduction or termination of home health services.

5. A Home Health Advance Beneficiary Notice (CMS-R-296) (see “Home Health Advance Beneficiary Notice (HHABN CMS-R-296)” Addendum HH:1-018.A) must be provided to Medicare patients whenever they believe they are about to deliver noncovered item(s) and/or service(s) at three points in time, called “triggering events”.

6. Initiation of services—When a home health agency expects that Medicare will not cover any item(s) and/or service(s) delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of one-time item(s) and/or service(s) that Medicare is not expected to cover.
A. **Reduction of services**—When a home health agency reduces or stops some item(s) and/or service(s) during a spell of illness, while continuing others, including when one home health discipline ends but others continue, independent of Medicare coverage.

B. **Termination of services**—When a home health agency ends delivery of either all Medicare-covered care, or all care in total.

**Note:** HHABN Option 2 must be used if the organization has initiated home health services and chooses to terminate services for administrative reasons such as lack of a face-to-face encounter. HHABN Option 2 is a change of care notice and has no bearing on financial liability. The HHA is required to provide the specific reason on the HHABN that termination is due to the failure to meet the face-to-face encounter requirements. If possible, the HHA should provide the notice in advance of the termination date so that the beneficiary has an opportunity to work with the HHA and his/her physician in their complying with this requirement.

7. HHABNs (CMS-R-296) are not required in any of the cases listed below:

A. Any increases in care whether under the original plan of care (POC) or additional orders. Includes noncovered care simultaneous to but exceeding Medicare coverage such as private duty or other insurance coverage

B. Reduction in number, duration of services, or length of visits that are anticipated in the POC, which were communicated in advance to the beneficiary

C. Beneficiary chooses to reduce or terminate services and changes in care are documented in medical record

D. Beneficiary transfers to another covered care agency or other Medicare provider

E. All care (every discipline) ending due to patients’ goals met/physicians’ orders completed (Expedited Determination Notice must be given)

F. Care that is never covered by Medicare under any circumstances and for which the agency will not charge the beneficiary

G. Emergency or other unplanned situations (natural disasters)

H. Changes in personnel/caregivers as decided by the agency

I. Changes in arrival/departure times for agency staff

J. Changes in brand of product (supplies, etc.)
K. Noncovered item(s)/service(s) that are provided as part of care covered under a bundled Medicare payment

L. Initial assessments in cases where beneficiary is not admitted and the agency does not charge

M. Changes in the mix of services delivered in a specific discipline with no decrease in frequency with which that discipline is delivered

N. Changes in the modality affecting supplies used as part of a treatment with no decrease in the frequency with which these supplies are provided

O. When there is no applicable Medicare coverage but another payer/insurer will cover the care

8. Refer to the instructions found in the manual revision attachment to Change Request (CR) 5009, *Medicare Claims Processing Manual*, Chapter 30, Financial Liability Protections, section 60 and its subsections for specific HHABN and Form CMS-R-296 related information, instructions, and additional requirements.

9. When the home health agency plans to stop furnishing all home health services to a patient because it expects that Medicare will not continue to pay for the services, they must provide a completed Generic Expedited Determination Notice entitled “Notice of Medicare Provider Non-Coverage,” Form CMS-10123 to the patient prior to terminating services. The patient or his/her representative must be given the opportunity to request an expedited determination from a QIO. (See “Notice of Medicare Provider Non-Coverage,” Form CMS-10123, Addendum HH:1-018.B.)

10. After reading the, “Notice of Medicare Provider Non-Coverage,” Form CMS-10123 the patient or his/her representative must sign and date the form indicating they have received the notice and understand they can appeal the decision by contacting a QIO.

11. The second or detailed notice, called “Detailed Explanation of Non-Coverage” Form CMS 10124, is given to a patient or his/her representative when QIO review is requested in order to provide more explanation on why coverage is ending. (See “FFS Expedited Review Detailed Notice” Addendum HH:1-018.C.)

12. CMS has provided explicit instructions including, but not limited to, when and how to fill out all required forms, the delivery of notices, time frames for delivery, and who pays for care while the QIO is reviewing the determination. (See “Additional CMS Recourses for Expedited Notices” Addendum HH:1-018.D) Organization leadership is responsible for educating staff on current CMS requirements regarding the HHABN (CMS-R-296) (8-31-2009), FSS ED Notices and FFS Detailed Notice.
13. All written and verbal notifications of the patient’s financial responsibility will be documented in the clinical and billing records. Original versions of the completed HHABN, whether annotated or signed, and copies of signed Expedited Notices will be kept in the patient’s record at the agency.
ADDENDUM HH:1-018.A

HOME HEALTH ADVANCE BENEFICIARY NOTICE (HHABN CMS-R-296)

For the most current version of CMS required form, access the following website to print the form, and obtain directions on how to complete the form:

www.cms.hhs.gov/BNI/03_HHABN.asp
ADDENDUM HH:1-018.B

GENERIC EXPEDITED DETERMINATION NOTICE

“Notice of Medicare Provider Non-Coverage CMS-10123”

For the most current version of CMS required form, access the following website to print the form:

http://www.cms.hhs.gov/BNI/ (FFS ED Notices)
ADDENDUM HH:1-018.C

FFS EXPEDITED REVIEW DETAILED NOTICE

“Detailed Explanation of Non-Coverage CMS 10124”

For the most current version of CMS required form, access the following website to print the form:

http://www.cms.hhs.gov/BNI/

(FFS ED Notices)
ADDENDUM HH:1-018.D

ADDITIONAL CMS RESOURCES FOR EXPEDITED NOTICES

For the most current information from CMS on the Expedited Review Process, access the following websites:

Medicare Claims Processing Manual, Chapter 30
Financial Liability Protections, Section 60

Generic and Detailed Notices in English and Spanish, Word version of notices, Instructions on use of forms, Q&As

http://www.cms.hhs.gov/BNI/

MLN Matters Article on New Expedited Review Process

CMS maintained Directory of QIO’s

www.cms.hhs.gov/qio
INTERNAL CONTROL SYSTEMS/ACCOUNTABILITIES

Policy No. HH:1-021.1

PURPOSE

Visiting Nurse & Hospice Care is committed to prevention, detection, and to taking all appropriate action to assure compliance with all legal and regulatory statutes and to promote honest and ethical behavior in all work-related activities.

POLICY

An ongoing evaluation process will be established utilizing existing and new monitoring procedures to assure compliance. An annual evaluation of the compliance program’s intent and effectiveness will also be completed. Reports will be provided to Administration and the Governing Body. This policy includes key areas for monitoring, and is not intended to be all-inclusive of monitoring activities. Monitoring controls identified are categorized by functional areas and include, but are not limited to, those issues currently targeted by the Officer of the Inspector General. This list will be updated as necessary.

PROCEDURE

1. Administration/Financial
   A. All employees will be informed of the Standards of Conduct and report any suspected violations to their supervisor, or the Corporate Compliance Officer to reasonably ensure that all activities are in compliance with the Standards of Conduct. An annual audit of the Corporate Compliance Plan will be completed.
   B. The organization will have an annual financial audit conducted by its certified public accountants to examine, on a test-basis, evidence supporting the proper handling and reporting of amounts, and disclosures relating to, its financial activity.
   C. Visiting Nurse & Hospice Care will conduct an annual review of the Cost Report to assure proper allocation of costs to specific programs, assess the allowableness of G&A expenses, marketing and advertising expenses and proper recording of related expenses.
      1. Time sheets are reviewed to determine accuracy and completeness. Payroll staff will follow-up on any unusual program code or cost center allocations.
      2. The organization will perform periodic audits of expenditures to determine compliance with organization’s policies. All expenses are monitored to evaluate accuracy and validity.
D. Visiting Nurse & Hospice Care will conduct and document annual reviews with its third party contractors to reasonably ensure that activities are in compliance with the Standards of Conduct and related policies.

E. The organization will conduct an annual review of the Conflict of Interest policy with all employees and Governing Body.

F. The organization will conduct an annual review of compliance with the terms, conditions and covenants contained in its financing loan agreements.

G. Visiting Nurse & Hospice Care will conduct and document an annual review of its billing practices to reasonably ensure that all activities are in compliance with the Standards of Conduct and organization policies, third party billing requirements, and that billing occurs for only those services provided, documented, and for which there are signed physician orders.

2. Human Resources (HR) Department

A. Visiting Nurse & Hospice Care will conduct an annual audit to assure that the Standards of Conduct and the agency personnel policies and procedures are being followed. The audit will include, but is not limited to:

1. Pre-employment interview sheets completed, reference checks completed and documented.

2. Criminal background completed on all new employees. Drivers’ license checks on field staff and driving positions.

3. Systems exist and are effective in tracking performance evaluations, professional licenses, inservice education (including mandatories).

4. Process exists and is effective for investigation/follow-up on work-related injuries.

5. OIG/GSA exclusion checks are completed and documented.

3. Clinical/Documentation Compliance

A. Patient’s Eligibility and Appropriate Documentation

The homebound and skilled care/medical necessity requirements for Medicare coverage are assessed utilizing several methods:

1. Supervisory case conferences with staff

2. Supervisory visits with staff

3. Audits of Start of Care documentation
B. Patient Abandonment/Discriminatory Admission and Discharge Practices

1. Visiting Nurse & Hospice Care will ensure that patients will be admitted and discharged according to the organization policy.

C. Physician’s orders

Mechanisms are currently in place to assure timely signed physician orders prior to billing.

1. Order tracking on a daily basis by the Health Information Management/Department of Medical Records.

2. Staff will send regular follow-up notices to physicians that do not return signed orders in a timely manner.

3. Physician License Verification—A mechanism exists whereby Visiting Nurse & Hospice Care knows that a physician is licensed to practice and whether they have been precluded from the Medicare/Medicaid Program.

D. Payer Changes

A process is in place to assure that payer changes occur on a timely basis and that meets the requirement for patient notification (ABN-Advance Beneficiary Notice) within the required time frames.

E. Home Health Aide Services

This includes the following:

1. Appropriateness of level of worker for tasks needed to be completed

2. Personal care necessary, ordered and provided for payer coverage

3. Care Plan matches orders, aide schedule matches orders and services provided match documentation, orders and bill generated.

F. Medical Records

A process is in place to assure that medical records are appropriately secure and that record retention meets the time frames required by regulation and accrediting bodies.

G. Denial Tracking

Denials for services rendered and bills are tracked and data compiled quarterly to determine any needed corrective action with respect to re-education, specific caregiver problems or any other trends.
SECTION TWO  
Quality of Services and Products

<table>
<thead>
<tr>
<th>Admission to Home Health</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Patient Bill of Rights</td>
<td>HH:2-001</td>
</tr>
<tr>
<td>Intake Process</td>
<td>HH:2-002</td>
</tr>
<tr>
<td>Admission Criteria and Process</td>
<td>HH:2-003</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Planning</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Planning Process</td>
<td>HH:2-004</td>
</tr>
<tr>
<td>Physician Participation in Plan of Care</td>
<td>HH:2-005</td>
</tr>
<tr>
<td>Verification of Physician Orders</td>
<td>HH:2-006</td>
</tr>
<tr>
<td>Rehabilitation Care Planning</td>
<td>HH:2-007</td>
</tr>
<tr>
<td>Nutrition Care Planning</td>
<td>HH:2-008</td>
</tr>
<tr>
<td>Home Health Aide Plan of Care</td>
<td>HH:2-009</td>
</tr>
<tr>
<td>Orientation of Assigned Home Health Aide</td>
<td>HH:2-010</td>
</tr>
<tr>
<td>Support/Chore Worker Service Plan</td>
<td>HH:2-011</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>HH:2-012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coordination/Continuity of Care</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity of Care</td>
<td>HH:2-013</td>
</tr>
<tr>
<td>Case Conference/Progress Summary</td>
<td>HH:2-014</td>
</tr>
<tr>
<td>Monitoring Patient’s Response/Reporting to Physician</td>
<td>HH:2-015</td>
</tr>
<tr>
<td>60-Day Summary Report</td>
<td>HH:2-016</td>
</tr>
<tr>
<td>Patient Notification of Changes in Care</td>
<td>HH:2-017</td>
</tr>
<tr>
<td>On-Call/Weekend Staffing</td>
<td>HH:2-018</td>
</tr>
<tr>
<td>Coordination of Services With Other Providers</td>
<td>HH:2-019</td>
</tr>
<tr>
<td>Internal Referral Process</td>
<td>HH:2-020</td>
</tr>
</tbody>
</table>

*Requires state or organization-specific information.
## SECTION TWO

### Quality of Services and Products

**Assessment**

<table>
<thead>
<tr>
<th>Description</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial and Comprehensive Assessment</td>
<td>HH:2-021</td>
</tr>
<tr>
<td>Ongoing Assessments</td>
<td>HH:2-022</td>
</tr>
<tr>
<td>Reassessments/Recertification</td>
<td>HH:2-023</td>
</tr>
<tr>
<td>Functional Assessment</td>
<td>HH:2-024</td>
</tr>
<tr>
<td>Nutritional Assessment</td>
<td>HH:2-025</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>HH:2-026</td>
</tr>
<tr>
<td>Assessment of Possible Abuse/Neglect</td>
<td>HH:2-027</td>
</tr>
</tbody>
</table>

**Addendum:** Organization List of Private & Public Community Agencies That Provide or Arrange for Assessment of Suspected or Alleged Abuse/Neglect Victims* ................................................................. HH:2-027.A

**Medication Administration**

<table>
<thead>
<tr>
<th>Description</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Profile</td>
<td>HH:2-028</td>
</tr>
<tr>
<td>Identification of Medication for Administration</td>
<td>HH:2-029</td>
</tr>
<tr>
<td>Administration and Documentation of Medications</td>
<td>HH:2-030</td>
</tr>
<tr>
<td>Addendum: Drug/Classifications and Their Routes</td>
<td>HH:2-030.A</td>
</tr>
<tr>
<td>Addendum: Medications Not Approved for Safe Home Administration*</td>
<td>HH:2-030.B</td>
</tr>
<tr>
<td>Addendum: Drug Information for the Nurse*</td>
<td>HH:2-030.C</td>
</tr>
<tr>
<td>Addendum: Advice for the Patient—Drug Information in Lay Language*</td>
<td>HH:2-030.D</td>
</tr>
<tr>
<td>Patient Self-Administration of Medication</td>
<td>HH:2-031</td>
</tr>
<tr>
<td>Home Use and Disposal of Controlled Substances</td>
<td>HH:2-032</td>
</tr>
<tr>
<td>Intravenous Administration of Medications/Solutions</td>
<td>HH:2-033</td>
</tr>
<tr>
<td>Addendum: Medications Approved/Not Approved for Intravenous Administration</td>
<td>HH:2-033.A</td>
</tr>
<tr>
<td>Intravenous Administration of Chemotherapy</td>
<td>HH:2-034</td>
</tr>
<tr>
<td>Addendum: Antineoplastic Medications Approved/Not Approved for Intravenous Administration*</td>
<td>HH:2-034.A</td>
</tr>
<tr>
<td>First Dose Policy</td>
<td>HH:2-035</td>
</tr>
</tbody>
</table>

*Requires state or organization-specific information.
SECTION TWO
Quality of Services and Products

Medication Administration (continued)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crushing of Medications</td>
<td>HH:2-036</td>
</tr>
<tr>
<td>Addendum: Oral Dosage Forms That Should Not Be Crushed*</td>
<td>HH:2-036.A</td>
</tr>
<tr>
<td>Pulse Rate Determination With Certain Drugs</td>
<td>HH:2-037</td>
</tr>
<tr>
<td>Storage of Medications and Nutritional Products</td>
<td>HH:2-038</td>
</tr>
<tr>
<td>Medication Labeling</td>
<td>HH:2-039</td>
</tr>
<tr>
<td>Adverse Drug Reactions</td>
<td>HH:2-040</td>
</tr>
<tr>
<td>Addendum: Advice About Voluntary Reporting</td>
<td>HH:2-040.A</td>
</tr>
<tr>
<td>Anaphylaxis Protocol</td>
<td>HH:2-041</td>
</tr>
<tr>
<td>Medication Error</td>
<td>HH:2-042</td>
</tr>
<tr>
<td>Medication Monitoring</td>
<td>HH:2-043</td>
</tr>
<tr>
<td>Investigational Medications</td>
<td>HH:2-044</td>
</tr>
</tbody>
</table>

Clinical Care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Not Resuscitate/Do Not Intubate Orders</td>
<td>HH:2-047</td>
</tr>
<tr>
<td>Cardiopulmonary Resuscitation</td>
<td>HH:2-048</td>
</tr>
<tr>
<td>Withdrawal of Life-Sustaining Care</td>
<td>HH:2-049</td>
</tr>
<tr>
<td>Care of the Dying Patient</td>
<td>HH:2-050</td>
</tr>
</tbody>
</table>

Transfer and Discharge

<table>
<thead>
<tr>
<th>Topic</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer/Referral Criteria and Process</td>
<td>HH:2-051</td>
</tr>
<tr>
<td>Transfer Summary</td>
<td>HH:2-052</td>
</tr>
<tr>
<td>Discharge Criteria and Process</td>
<td>HH:2-053</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>HH:2-054</td>
</tr>
</tbody>
</table>

*Requires state or organization-specific information.
**SECTION TWO**

*Quality of Services and Products*

<table>
<thead>
<tr>
<th>Clinical Record, Documentation, and Data Collection</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contents of Clinical Record</td>
<td>HH:2-055</td>
</tr>
<tr>
<td>Assembly of Clinical Record</td>
<td>HH:2-056</td>
</tr>
<tr>
<td>Clinical Record Review</td>
<td>HH:2-057</td>
</tr>
<tr>
<td>External Databases</td>
<td>HH:2-058</td>
</tr>
</tbody>
</table>

**OASIS Reporting**

| OASIS Data Transmission                            | HH:2-059   |

*Requires state or organization-specific information.*
HOME HEALTH II
Quality of Services and Products

HOME HEALTH PATIENT BILL OF RIGHTS
Policy No. HH:2-001.1

PURPOSE

To encourage awareness of patient rights and provide guidelines to assist patients in making decisions regarding care and for active participation in care planning.

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights as described. A patient may designate someone to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

To assist with fully understanding patient rights, policies will be available to the organization personnel, patients, and his/her representatives as well as other organizations and the interested public.

This policy supplements the “Patient Bill of Rights” (see Policy No. C: 2-003.)

PROCEDURE

1. The Patient Bill of Rights statement defines the right of the patient to:

   A. Have his or her property treated with respect.

   B. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the organization and must not be subjected to discrimination or reprisal for doing so.

   C. Receive an investigation by the organization of complaints made by the patient or the patients family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for the patient’s property by anyone furnishing services on behalf of the organization, and must document both the existence of the complaint and the resolution of the complaint.

   D. Be informed in advance about care to be furnished and of any changes in the care to be furnished.

   E. Be advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.
F. Be advised in advance of any change in the plan of care before the change is made.

G. Be advised in advance of the right to participate in planning the care or treatment and in planning changes in the care and treatment.

H. Be advised that the Home Health Agency complies with Subpart 1 of 42 CFR 489 and receive written policies and procedures regarding Advance Directives, including a description of an individual’s right under applicable state law and how rights are implemented by the organization.

I. Receive Advance Directives information prior to or at the time of the first home visit, as long as the information is furnished before care is provided.

J. Confidentiality of the clinical records maintained by the organization.

K. Be advised of the organization’s policies and procedures regarding disclosure of clinical records.

L. Be informed, verbally and in writing and before care is initiated of the extent to which:
   1. Payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the organization
   2. Charges for services that will not be covered by Medicare
   3. Charges that the individual may have to pay

M. Be informed verbally and in writing of any changes in payment information as soon as possible, but no later than 30 days from the date that the organization becomes aware of the change.

N. Receive in writing, prior to the start of care, the telephone numbers for the State Home Health Hotline and the CHAP Hotline, including hours of operation, and the purpose of the hotlines to receive complaints or questions about the organization.

O. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.

P. Be informed of organizational ownership and control.

Q. Patient privacy rights related to the collection of the Outcome and Assessment Information Set (OASIS):
   1. The right to be informed that OASIS information will be collected and the purpose of the collection
2. The right to have the information kept confidential

3. The right to be informed that OASIS information will not be disclosed except for legitimate purposes allowed by the Federal Privacy Act

4. The right to refuse to answer questions

5. The right to see, review and request changes on their assessment
INTAKE PROCESS
Policy No. HH:2-002.1

PURPOSE
To establish the process for acceptance and entry of patient into the organization.

POLICY
Referrals will be accepted 24 hours a day, seven (7) days per week. Personnel will be available 24 hours a day to accept patients into home care service.

The organization accepts only those patients whose needs can be met by the services it provides.

PROCEDURE
1. Home health care referrals will be documented in Allscripts.
2. Patient referrals for home care services may be accepted by clinicians, including the director, supervisor, program coordinators, and nurses.
3. Referral information may be accepted by any of the following methods:
   A. Telephone
   B. Fax
   C. Written order
   D. Secure email
4. Referrals may be accepted from any of the following:
   A. Doctors of Medicine, Osteopathy, Podiatry, or Dental Surgery, as well as Psychiatrists and Dentists
   B. Discharge planners from inpatient and outpatient services
   C. Social service agencies
   D. Individual patients or their family/caregiver(s)
   E. Clinician and/or insurance company representative
   F. Other home care organizations
5. During scheduled business hours (office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday), calls will first be received by the receptionist. Patient referral calls will be transferred to a staff member designated to accept referrals.

   A. To accept referrals, information regarding a patient’s demographics, diagnosis, services needed, medications, attending physician, and hospitalization, will be taken in order to make the initial determination of whether the patient’s needs can be met and if he/she meets the eligibility criteria. (See “Admission Criteria and Process” Policy No. HH:2-003.) The information is reviewed for completeness.

   B. When the payer source is private insurance, the insurance coverage will be verified and an insurance information form completed.

   C. Intake information is given to the Clinical Supervisor to accept the referral information and complete a referral and intake form.

   D. If the referral is not from a physician, the patient’s physician (or other authorized licensed independent practitioner) will be contacted to confirm service needs and to obtain verbal orders.

   E. The Clinical Supervisor will assign personnel and schedule an initial assessment visit. The initial assessment visit will be performed either within 48 hours of the referral, or within 48 hours of a patient’s return home, or on the start of care date ordered by the physician (or other authorized licensed independent practitioner).

   F. If service cannot be provided, intake personnel will give the caller the names of other agencies that can provide the required services. A log will be maintained on all patients that cannot be serviced.

6. After scheduled business hours (weekends and evenings) the organization can be accessed through the answering service.

   A. The answering service will contact the nurse on-call via telephone or beeper.

   B. The on-call nurse will complete the initial intake information from the referral source and relay the information as follows:

      1. If the referral is on Saturday or Sunday, the on-call nurse will determine if the patient needs to be seen, or if he/she can wait until Monday morning for follow-up by the Clinical Supervisor.

      2. If the patient must be seen, the on-call nurse will assign the patient to be admitted to service.

      3. If the patient can wait until Monday, the on-call nurse will notify the intake of the information on Monday morning for scheduling by the Clinical Supervisor.
PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

A patient will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

A patient will be accepted for care based on consideration. Consideration will be given to the adequacy and suitability of organization personnel, resources to provide the required services, and the reasonable expectation that the patient’s medical, nursing, rehabilitative, and social needs can be adequately met in the patient’s place of residence.

While a patient will be accepted for services based on his/her medical needs, the patient’s ability to pay for such services, either through state or federal assistance programs, private insurance, or personal assets are factors that will be considered.

The organization reserves the right not to accept a patient who does not meet the admission criteria.

A patient will be referred to other resources if the organization cannot meet his/her needs.

Once a patient is admitted to service, the organization is responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

Admission Criteria

1. The patient must be under the care of a physician. The patient’s physician (or other authorized licensed independent practitioner) must order and approve the provision of any service. A skilled service must be ordered.

2. The patient must desire home care services.

3. Visiting Nurse & Hospice Care will consider for acceptance any patient who is appropriate for home care, regardless of payment source.

4. The patient must reside within the geographical area which the Visiting Nurse & Hospice Care services.
5. The physical facilities and equipment in the patient’s home must be adequate for safe and effective care.

6. Services may be provided to a patient insured by Medicare who has a primary need for skilled nursing, physical and/or speech therapy on an intermittent basis and is homebound. (A patient is considered to be homebound if he/she has a condition that restricts his/her ability to leave his/her place of residence except with the aid of supportive devices, the use of special transportation, the assistance of another person, or if he/she has a condition which is such that leaving his/her home is medically contraindicated.)

7. Acceptance for home care services will be realistically based on the patient’s willingness and ability to function in a noninstitutional environment, and the willingness, ability, and availability of family/caregiver or significant individuals to participate in the care.

8. Eligibility will not be based on the patient’s race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

PROCEDURE

1. The organization will utilize referral information provided by the family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the patient’s physician does not make the request for service, he/she will be contacted for start of care orders prior to the evaluation visit and initiation of services.

2. The Clinical Supervisor will assign clinical organization personnel to conduct initial assessments of eligibility for services within 48 hours of acceptance of referral information and/or discharge from referring facility.

   A. The initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient’s return home, or on the start of care date ordered by the physician (or other authorized licensed independent practitioner).

   B. The patient’s most critical needs for home care services must be identified during the initial assessment and must be met in a timely fashion.

   C. The initial assessment and comprehensive assessment must be conducted by a registered nurse unless physical therapy or speech language pathology is the only requested service for that patient. In those cases, the physical therapist or speech therapist may conduct the initial assessment and the comprehensive assessment. These assessments may be conducted by the occupational therapist if the need for occupational therapy establishes program eligibility.
3. Assignment of appropriate clinical personnel to conduct the initial assessment of patient’s eligibility for admission will be based on:
   A. Patient’s geographical location
   B. Complexity of the patient’s medical needs and level of care required
   C. Organization personnel’s education and experience
   D. Organization personnel's special training and their competence to meet patient’s needs
   E. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient’s physician, the referral source, and the patient, will be notified for approval of the delay.
   A. Such notification and approval will be documented.
   B. If approval is not obtained for the delay, the patient will be referred to another organization for services.

5. A nurse or therapist will attempt to make an initial contact prior to the patient’s hospital discharge if possible or appropriate. The initial home visit will be made within 48 hours after the patient’s discharge from a facility or as ordered by the physician (or other authorized licensed independent practitioner).

6. During the initial assessment visit, the admitting clinician will assess the patient’s eligibility for home care services according to the admission criteria to determine or confirm:
   A. Level of services required
   B. Eligibility (meets admission criteria)
   C. Qualifying face-to-face encounter date, if completed within ninety (90) days prior to admission. (See “Face-to-Face Encounter Procedure” Addendum HH:2-003.A.)
   D. Source of payment

7. Upon acceptance into service, the patient will be provided with an organization brochure and various educational materials providing the patient and family/caregiver with sufficient information on:
   A. Nature and goals of care and service
   B. Hours during which care and service is available
   C. Access to care after hours
D. Care costs, if any, to be borne by the patient

E. Organization mission, objectives, and the scope of care provided both directly and through contractual agreement

F. Safety information

G. Infection control information

H. Emergency preparedness plans

I. Available community resources

J. Complaint/grievance process

K. Written information regarding the availability and indications for use of the state and CHAP Home Health Hot Line telephone numbers

L. Advance Directives

M. Other organization personnel involved in care

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

O. Notice of privacy practices

8. Patient rights and responsibilities will be explained to the patient and family/caregiver. If a face-to-face encounter has not been completed prior to admission, the clinician will explain the requirement that a face-to-face encounter visit with their physician or allowed NP must be completed within thirty (30) days of admission.

9. The admitting clinician will document that the above information has been furnished to the patient and family/caregiver, and they will also document any information not understood by the patient and family/caregiver.

10. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

11. The patient or his/her representative will sign the required forms indicating acceptance of services and receipt of patient rights and privacy information.

12. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, physician, and referral source will follow with appropriate documentation in the clinical record.
13. The admitting clinician will consult with the Clinical Supervisor concerning the patient’s condition following the initial visit. Based on the clinical personnel’s assessment of the patient’s eligibility for admission, the patient will be admitted for services or referred to alternate sources for care.

14. If the patient is accepted for home health care, an initial plan of care will be developed in consultation with the physician and the patient and then submitted to the physician for signature.

15. The initial written assessment will be completed within 24 hours of the initial assessment/admission visit. All documentation needed to develop the plan of care will be completed and turned into the office no later than the next business day.

16. A comprehensive assessment must be completed within five (5) calendar days of the patient’s start of care. (See “Initial and Comprehensive Assessment” Policy No. HH:2-021.)

   A. Each patient must receive a patient-specific comprehensive assessment that identifies the need for home care and that meets the patient’s medical, nursing, rehabilitative, social, and discharge planning needs.

   B. Outcomes and Assessment Information Set (OASIS) data must be collected on all patients receiving skilled services except prepartum and postpartum patients, patients under the age of 18, and patients with payer source other than Medicare or Medicaid. OASIS data collection is not required for patients who are receiving only personal care or support services (receiving only homemaker services). The OASIS data will be collected during the comprehensive assessment. The assessment tool must include the exact use of the current versions of the OASIS data set.

17. The time frames apply for weekend, holiday, and weekday admissions.

18. A clinical record will be initiated for each patient admitted for home health services.

19. If a patient does not meet the admission criteria or cannot be cared for by the organization, the Clinical Supervisor should be notified and appropriate referrals to other sources of care made on behalf of the patient.

20. The following individuals will be notified of non-admits:

   A. Patient

   B. Physician

   C. Referral source (if not MD)

21. A record of non-admits will be kept for statistical purposes, referencing the date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other health care facilities, etc.
22. In the instance where a patient does not meet the stated criteria for admission to the program, the Executive Director/Administrator in consultation with the Medical Director may decide upon exceptions, with the request of the referring party and/or the patient.
ADDENDUM HH:2-003.A

FACE-TO-FACE ENCOUNTER PROCEDURE

(Insert agency specific procedure)

See NAHC guidance for information on elements to include in a face-to-face encounter procedure.

www.nahc.org/regulatory/home.html
PURPOSE

To provide clinical direction to the clinicians providing direct patient care.

POLICY

A written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as patient’s condition warrants. The patient plan of care will be developed or revised within five (5) working days of initiation of each service or of the reassessment of the patient. All clinicians involved in the patient’s care, either directly or indirectly, will contribute to the plan of care. The patient and family/caregiver will participate in decisions regarding the plan of care whenever possible. The care planning process will be documented on the plan of care, individualized discipline specific care plans (if applicable), clinical notes, medication profiles, care conference/summary forms, and discharge/clinical summaries.

The plan of care will be reviewed more frequently than every 60 days when a patient elects a transfer to another home health organization, a significant change occurs in the patient’s condition, or a patient is discharged and readmitted during the same 60-day period.

Definitions

1. **Plan Of Care**: The clinical plan of care includes:
   
   A. Pertinent primary and secondary diagnoses
   B. Food or drug allergies
   C. Homebound status
   D. Goals/outcomes to be achieved
   E. Patient’s mental status
   F. Functional limitations
   G. Activities permitted
   H. Safety measures
   I. Nutritional requirements
   J. Medications and treatments
K. Specific procedures to be performed by therapies, including amount, frequency, and duration

L. Supplies and equipment required

M. Discharge or referral plans

N. Discharge teaching

O. Frequency and duration of visits

P. Prognosis

Q. Rehabilitation potential

R. Other appropriate items such as precautions and contraindications

2. **Clinician**: Any Nurse, PT, OT, ST, MSW, or paraprofessional involved in the care of a patient, either directly or indirectly, including administrative, management, and supervisory personnel.

**PROCEDURE**

1. At the time of the initial assessment, the clinician, along with other involved disciplines, will develop the patient plan of care based upon the patient’s identified needs and will review it with the patient and family/caregiver.

2. All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including but not limited to:

   A. Individualized patient needs and resultant problems related to care, functional status, and family/caregiver support system

   B. Changes in patient’s condition

   C. Clinical drug monitoring, as appropriate

   D. Pain and symptom management, as appropriate

   E. Psychosocial and spiritual needs of patient and family/caregiver, as appropriate

   F. Patient treatment choices
3. Based on the assessment and conclusions, the plan of care will include, but will not be limited to:
   A. Identified patient problems and needs
   B. Reasonable, measurable, and individualized goals
   C. Specific services to be provided
   D. Actions to be taken to meet the patient goals
   E. Type, frequency, and duration of above actions
   F. Equipment and supplies
   G. Prognosis

4. The care planning decisions will be reflected in the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals.

5. The plan of care will be based upon the physician’s (or other authorized licensed independent practitioner’s) orders and will encompass the equipment, supplies, and services required to meet the patient’s needs.

6. Patient receiving physical therapy or speech therapy only will have a plan of care initiated by the primary physical therapist or speech therapist within 48 hours of completion of the initial assessment.

7. The plan of care will be revised as frequently as deemed necessary by the clinicians based on the ongoing assessments of the patient. Revision dates will be noted on the plan of care.

8. The frequency of the review of the plan of care will be based on changes in the patient’s health status, needs, and the environmental factors affecting care. The clinicians will be responsible to revise the plan of care or update the plan at least every 60 days. (See “Reassessments/Recertification” Policy No. HH:2-023.)

9. Changes in the plan of care will be noted with the following documentation:
   A. Assessment
   B. Plan of care with clinical outcome goals
   C. Care plan with specific services/actions to be taken
D. Clinical notes

E. Verbal orders

10. Clinicians will inform the patient’s physician of any changes that suggest a need to alter the plan of care. Changes must be written, dated, and signed by the professional making the changes.

11. The Case Manager is responsible to review the plan of care.

12. Problems and/or needs related to patient’s condition, desires, abilities, family/caregiver support systems, and relevant medication monitoring will be included in the plan of care.

13. Services to be provided will be based on the prioritized needs of the patient. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to determine if goals have been achieved.

14. Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes.

15. The Clinical Supervisor or designee will review the plan of care for all patients.
PHYSICIAN PARTICIPATION IN PLAN OF CARE
Policy No. HH:2-005.1

PURPOSE
To provide guidelines for the physician's participation in home health care services.

POLICY
A physician will direct the care of every home health care patient admitted for service. The attending physician will certify that medical, skilled, rehabilitative, and social services provided by the organization are medically required for the patient. The attending physician will participate in the care planning process by initiating, reviewing and revising therapeutic and diagnostic orders. The care will be provided in compliance with the therapeutic and diagnostic orders and accepted standards and practice.

PROCEDURE
1. Physician (or other authorized licensed independent practitioner) orders will be individualized, based on patient's needs, and include:
   A. Patient diagnoses
   B. Treatments and/or procedures needed, including type, frequency, duration, and goals
   C. Medications to be administered and/or monitored
   D. A description of equipment and related supplies provided by the organization
   E. A description of any medical, physical, psychosocial, or environmental precautions, limitations, and activities permitted

2. The attending physician's verbal certification will be obtained at the time the plan of care is established.

3. The attending physician will certify the need for the home health care services by signing the plan of care/treatment within 30 days of the start of care.

4. The attending physician's recertification will be obtained in intervals of at least every 60 days when the patient's plan of care is reviewed, the patient recertified, and more often, if warranted.

5. At initial certification, the attending physician/allowed NP/hospitalist must perform the face-to-face encounter and compose a brief narrative that describes how the patient's clinical condition as seen during the encounter supports the patient's homebound status and need for skilled care. This encounter can occur up to ninety (90) days prior to start of care or
The attending physician will recertify the need for continuing home health care services and provide an estimate of how long the services will be needed no sooner than five (5) days prior to the recertification date for patients receiving OASIS reassessments.

9. All original plans of care/treatment forms will be filed in the patient's clinical record.

10. If a patient changes physician, the clinicians will not continue services until obtaining new written orders from the physician (or other authorized licensed independent practitioner) assuming the patient’s care.

11. If a patient is under the care of more than one (1) physician, the nurse and/or physical therapist will be responsible to the designated primary physician. All other physicians should be made aware of the services being provided to the patient.

12. If a patient is referred by a hospitalist, who treated the patient during hospitalization, an attending physician who will follow the patient and be responsible for ongoing care must be determined and documented. (The hospitalist can provide the face-to-face encounter certifying that the patient’s clinical condition supports homebound status and need for skilled services.)
VERIFICATION OF PHYSICIAN ORDERS
Policy No. HH:2-006.1

PURPOSE

To ensure that accurate physician (or other authorized licensed independent practitioner) orders are obtained in accordance with applicable law and regulation.

POLICY

Orders will be obtained from a licensed physician (or other authorized licensed independent practitioner) for care and services to be provided to home health patients.

Orders will be taken only by professional, licensed home health personnel (registered nurse or qualified therapist).

A qualified individual will review each order or prescription before care is provided. The sole exception for verification will be with emergency orders or prescriptions where a delay for verification would likely result in an adverse result for the patient.

PROCEDURE

1. An order or prescription will be verified when there is a question or discrepancy in the order/prescription and when the order is communicated by someone other than the physician or his/her agent. The order or prescription reviewed may be the original order, a facsimile copy if permitted by law, or the direct transcription of a verbal order.

2. All telephone orders will be received and processed in accordance with state and federal laws and regulations.

3. All telephone orders or verbal orders will be “read back” to the physician (or other authorized licensed independent practitioner) or designee to assure accuracy.

4. Orders will be documented in Allscripts electronically dated and signed by the professional receiving the order.

5. A copy of the physician's (or other authorized licensed independent practitioner's) order will be kept in the clinical record.

6. The original of the order form will be delivered to the physician (or other authorized licensed independent practitioner) for signature.
7. When the signed order form is returned to Visiting Nurse & Hospice Care, the copy will be removed from the clinical record and destroyed, and the original will be retained in the clinical record.

8. Signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law and regulation.
PURPOSE

To provide clinical direction to therapists providing direct patient care.

POLICY

Qualified rehabilitation professionals will develop and implement the rehabilitation care plan with the patient, family, and caregivers. Rehabilitation plans and goals will guide the provision of rehabilitation services and are appropriate to the patient’s environment, needs, and severity of disease. Rehabilitation outcomes will promote optimal levels of functioning. Discharge planning from services will be integrated into the functional rehabilitation assessment.

All services will be provided in accordance with accepted standards of practice by or under the direction of a qualified physical, occupational, or speech therapist.

PROCEDURE

1. When rehabilitation needs are identified, the patient’s physical status and functional abilities will be evaluated by a rehabilitation professional before instruction and treatments are initiated.

2. Based on this functional assessment, the rehabilitation professional will develop and implement the rehabilitation plan with the patient and family/caregiver. The patient will be encouraged to make choices about his/her participation in rehabilitation. The rehabilitation professional will encourage patient and family/caregiver participation in implementing the rehabilitation plan by:

   A. Identifying interventions to reach reasonable goals
   B. Coordinating and collaborating on rehabilitation interventions
   C. Documenting the patient’s treatment choices, response to interventions, progress toward goals and objectives, and changes in condition (See “Care Planning Process” Policy No. HH:2-004.)

3. The patient and family/caregiver will receive information regarding potential benefits and risks of rehabilitation services in order to make informed decisions. Their expectations will be considered and documented in the rehabilitation plan.

4. After the initial assessment and as treatment progresses, the patient will be reassessed on an ongoing basis every 30 days and prior to or on therapy visit 13 and, if necessary, visit 19. Patient goals will be revised based on reassessment data.
5. Rehabilitation goals and plans will be based on, but not limited to, the following:
   
   A. The patient's personal goals and expectations
   
   B. Individualized needs for rehabilitation that are consistent with the patient's diagnosis, age, severity of disease, prognosis, and disability

6. Rehabilitation goals and plans are designed to help the patient achieve and maintain his/her optimal level of functioning, self-care, and independence by:
   
   A. Managing the patient's specific health problems
   
   B. Maximizing the patient's emotional well being in accordance with the diagnosis, prognosis, and treatment program

7. Discharge planning is initiated early in treatment based on ongoing assessments and stated expectations for achieving treatment goals and objectives. Criteria for discharge or termination of services may vary based on age, disability, treatment setting, and the plan for professional services (See “Discharge Criteria and Process” Policy No. HH:2-053.)
PURPOSE

To provide guidelines for clinicians in the provision of appropriate nutrition care.

POLICY

Patient with identified nutrition care needs will be referred to an appropriate, qualified registered dietician, when indicated.

Definitions

1. Nutrition Care: The interdisciplinary nature of nutrition care, including physicians, nurses, dieticians, pharmacists, and others as appropriate; interventions and counseling on appropriate nutrition intake by integrating information from nutrition assessments.

2. Assessment: The comprehensive approach to defining nutrition status, using a nutrition screening, and interdisciplinary assessment process.

3. Education: The role of nutrition care and treatment.

4. Coordination: The communication of nutrition status and recommended nutrition care planning among all disciplines involved in the care of the patient.

PROCEDURE

1. During the initial assessment, the admitting clinician will assess the patient’s nutritional status. The nutritional assessment will include information as identified in “Nutritional Assessment” (see Policy No. HH:2-025.)

2. Based on the results of the assessment, food and nutrition therapies will be ordered as part of the plan of care prescribed by the physician (or other authorized licensed independent practitioner).

3. The admitting clinician will arrange for a nutritional consultation when:
   A. The patient is at moderate or high nutrition risk.
   B. Nutrition care planning is complex.
   C. There is need for a further nutrition assessment by a specially trained and educated clinician.
   D. Organization personnel are not able to provide complete nutrition therapies.
4. During routine home visits, clinicians will continually educate patients, when appropriate, regarding:

   A. Proper conditions of sanitation to protect food and nutrition therapies from contamination and spoilage
   B. Proper temperatures of food storage, utilizing appropriate thermometers and maintaining temperature records, when appropriate
   C. The control of lighting, ventilation, and humidity to prevent condensation of moisture and growth of molds, when appropriate
   D. Thorough cleaning and sanitizing of all work surfaces, supplies, and equipment after each use
   E. Appropriate hand washing prior to and during preparation of food/nutrition solutions

5. Ongoing monitoring to determine the extent to which goals are achieved and patient's nutrition needs/problems are met/resolved will include the following activities, when appropriate:

   A. Monitoring patient's response to food/nutrition therapy
   B. Reviewing the appropriateness of choice of food/nutrition therapy, regimen, and route
   C. Communicating conclusions verbally and/or in writing to other home care team members
   D. Identifying/monitoring the patient who is not receiving adequate nutrition intake
   E. Identifying/monitoring the comfort levels of patient who chooses not to take food/nutrition therapy
   F. Increasing the monitoring level for transitional feedings from parenteral to enteral or oral to enteral, as applicable

6. Potential problems for patient's nutritional status will be reported to the clinician's immediate Clinical Supervisor and, when appropriate, the patient's physician.

7. When a patient has been prescribed a special diet, the clinician will provide the patient and family/caregiver with written and verbal information regarding the diet.
8. The effectiveness and appropriateness of nutrition therapies will be monitored on an ongoing basis through evaluation of goals, outcomes of therapies, and during case conferences. This evaluation will be communicated to all disciplines involved in the care of the patient.

9. Clinical staff that may be administering enteral or parenteral feedings will have a demonstrated competency on file and will have participated in additional education. (See “Scope of Assessments/Qualifications” Policy No. C:3-008.)
PURPOSE

To define the process for the development and use of the home health aide plan of care.

POLICY

Each patient receiving home health aide services will have an individualized plan developed by an appropriate professional and utilized to direct the care performed by the assigned aide.

PROCEDURE

1. The patient’s Case Manager, upon initialization of aide services, will develop the home health aide plan of care, consistent with the comprehensive plan of care and physician (or other authorized licensed independent practitioner) orders.

2. The home health aide plan of care will be individualized to the specific patient and will include at least:
   A. Type of services/procedures to be provided
   B. Frequency of visits
   C. Diagnosis/prognosis, if relevant to care
   D. Functional limitations
   E. Patient’s mental status
   F. Activities permitted
   G. Nutritional requirements
   H. Specific procedure to be performed, including amount, frequency, and duration
   I. Safety measures, including use of specific equipment
   J. Instructions for completion of documentation
   K. Reporting changes in patient’s condition and needs
   L. Allergies
3. The Case Manager will review the home health aide plan of care with the aide assigned to the case. The Case Manager will document communication regarding the initial plan of care with the Aide.

4. The home health aide plan of care will be revised at least every 60 days based upon a professional reassessment of the patient and at any time the patient’s change of condition warrants revision.

5. The Case Manager will review changes to the home health aide plan of care with the assigned aide. The Case Manager will document communication regarding the changes in the plan of care with the Aide.

6. The home health aide plan of care will be reviewed with the patient to ensure understanding of the aide’s role in the home.

7. The Case Manager or other appropriate clinician will supervise the home health aide at least every two (2) weeks to ensure care is provided according to plan.
PURPOSE

To define the process for the communication of patient information and assignment of responsibilities to paraprofessional personnel caring for the patient.

POLICY

When making patient care assignments, consideration will be given to the needs of the patient, the home health aide’s competencies, and the specific care that is to be provided.

Home health aides will receive patient information in the form of an aide assignment prior to caring for the patient. This will include information about the physical, psychosocial, and environmental aspects of care.

Patient care communication may include verbal or written instruction and demonstration. The communication about assigned responsibilities may include on-site orientation when appropriate, and at the very least, telephone contact prior to caring for the patient.

PROCEDURE

1. The personal care and support services provided will be based on the initial and ongoing assessments of patient needs as conducted by a nurse or therapist in the patient’s home.
   
   A. The nurse or therapist will be responsible for the initial assessment and assignment of the home health aide. Assessments are updated every 60 days and as the patient’s condition changes.
   
   B. The functional status, psychological status, and availability of support will be considered in determining the frequency of visits and plan of care.

2. The home health aide will review the duties to be performed and the arrangements for providing services as stated in the plan of care, and he/she will discuss this with the nurse or therapist.
   
   A. An orientation or placement visit is scheduled in the patient’s home by the clinician, whenever feasible.
   
   B. A home health aide assignment sheet is completed, reviewed with the home health aide, and signed by either the nurse or therapist and the home health aide. Return demonstration will be requested, as appropriate.
3. Each patient receives care in accordance with the plan of care and related instructions.

   A. The home health aide assignment sheet correlates with the orders on the plan of care (485).

   B. The aide will complete visit documentation on each patient. If electronic documentation is utilized, notes will be sent daily.

   C. When a health problem is identified or a significant change in a patient's physical condition is noted, the aide will report this information to the coordinator and/or a Clinical Supervisor in the office.
Intentionally Left Blank
PURPOSE

To promote patient independence, safety, and use of community resources prior to patient discharge from the organization.

POLICY

Discharge planning will be initiated for every patient upon admission to the organization. Patients will not be discharged without appropriate preparation. The patient’s continuing care needs will be assessed on an ongoing basis, as well as at discharge. Information will be provided to assist the patient in planning his/her discharge, including referral and transfer.

PROCEDURE

1. During the initial assessment, the clinician will:
   
   A. Assess the following and identify:
      
      1. Anticipated date of discharge
      
      2. Resources available, including persons and finances
      
      3. Anticipated changes in living situation
      
      4. Areas that might require assistance
   
   B. Document the patient discharge potential on the plan of care.
   
   C. Provide information regarding the patient discharge potential at case conferences with other team members, as appropriate.

2. Clinicians will assist patients regarding their discharge by:
   
   A. Consulting with the patient and family/caregiver regarding the need for discharge from the organization
   
   B. Serving as a referral source for patient and family/caregiver in obtaining follow-up support services
   
   C. Consulting with the patient and family/caregiver regarding the provision of discharge information
D. Participating in a conference with the patient and family/caregiver regarding the patient discharge plans, if requested

E. Sending a post discharge letter to the patient’s physician

3. Clinicians will inform the appropriate Clinical Supervisor in the event that problems arise in discharge planning and obtain appropriate assistance.

4. All communication and information regarding discharge planning will be documented in the clinical record.

(See “Discharge Criteria and Process” Policy No. HH:2-053.)

(See “Patient Education Related to Discharge Planning” Policy No. HH:5-013.)
PURPOSE

To ensure continuity of care for patient while receiving home care services.

POLICY

Consideration will be made at all times to fostering continuity of care by assigning consistent personnel to the patient, whenever possible. This includes limiting the number of identified organization personnel, whenever possible, that are caring for the patient. The exception is for on-call visits and weekend and holiday coverage.

Continuity of care will be ensured by:

1. Periodic communication between team members concerning the patient’s progress and special needs as evidenced in case conference reports and clinical notes.

2. Participation of team members in a case conference that is held at least every 60 days. (See “Case Conference/Progress Summary” Policy No. HH:2-014.)

PROCEDURE

1. The clinician will be responsible for:

   A. Communicating with all personnel caring for the patient including the physician

   B. Updating physicians’ (or other authorized licensed independent practitioner’s) orders and obtaining lab test results as needed

   C. Updating the plan of care

   D. Updating his/her own discipline’s plan of care

   E. Communicating changes in orders and findings to the Clinical Supervisor or designee, or other team members as necessary

   F. Communicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided

   G. Discharge planning

   H. Scheduling nursing and home health aide visits
I. Scheduling and conducting home health aide supervisory visits

J. Updating the HHA plan of care

2. If the patient is not receiving skilled nursing care and is receiving rehabilitation services, the rehab professional in cooperation with the Clinical Supervisor will be responsible for section 1A – 1J of this policy.

3. The Clinical Supervisor will review the patient census and staffing levels on a daily basis and will make patient assignments which consider:

A. Geographic area

B. Patient needs and skills required

C. The skill, education, training, and availability of personnel

D. Language and communication requirements

E. Patient acuity

F. The clinician’s caseload

G. Previous organization personnel assigned to case

H. Patient request for personnel

4. The Clinical Supervisor will consult the Clinical Director or Executive Director/Administrator regarding any daily staffing issues that cannot be resolved.
PURPOSE

To define the process for case conferences and documenting patient progress in the clinical record.

POLICY

Case conferences will be held at the start of care and at least every 60 days to review and discuss all multidisciplinary cases.

Items of discussion will include, but will not be limited to, the type and frequency of service by each discipline involved, changes in the patient’s overall status, problems, possible resolutions, progress towards goals, and any necessary revisions in the plan of care.

Case conferences will include utilization review; therefore, all clinicians—both direct and contract personnel—working with patients will participate in case conferences.

PROCEDURE

1. Each multidisciplinary patient will have a case conference during the month following the certification month.

2. For each patient, the Case Manager will lead the conference and discuss:
   
   A. Physical status of the patient
   
   B. Clinical implications of diagnoses and treatment prescribed
   
   C. Patient treatment choices
   
   D. Changes in condition since last conference
   
   E. Interventions for all disciplines and patient response
   
   F. Teaching plan and its effectiveness
   
   G. Progress toward goals
   
   H. Indications for recertification
   
   I. Discharge plan
3. A record will be kept indicating who participated in the meeting and which patients were discussed. The record will list patients by name and clinical record number.

4. A case conference/progress summary, written by the appropriate discipline(s) seeing the patient, will be documented in Allscripts in Clinical Notes and/or Coordination of Care section of Assessment.
MONITORING PATIENT’S RESPONSE/ REPORTING TO PHYSICIAN
Policy No. HH:2-015.1

PURPOSE
To provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician.

POLICY
Clinicians will monitor, document, and report the patient’s response to care and treatment provided on each home visit. Progress of goals will be measured at regular intervals.

Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient.

PROCEDURE
1. During each home visit, the clinician will monitor the patient's response to care against the established goals including, but not limited to:
   A. Care interventions and treatments
   B. Medications
   C. Teaching

2. During case conferences as well as the recertification process, the care will be evaluated to determine achievement of goals.

3. The patient’s physician will be contacted on the same day when any of the following occur:
   A. Significant changes in the patient's condition
   B. Significant changes in the patient's psychosocial status, family/caregiver support, home environment
   C. Inability to achieve goals within the specified time frame
   D. Changes in the patient’s expected response to treatment or medications
E. Changes that have occurred regarding diagnosis, prognosis, or treatment (including procedures, medications, precautions, and limitations)

F. When there is any problem implementing the plan of care

G. When results are received for relevant laboratory tests ordered

H. Patient is to be discharged from the organization or a specific service is to be discontinued

4. All conferences or attempts to communicate with physician will be documented in the clinical record.

A. Documentation of the physician notification will include:
   1. Date and time contacted
   2. Patient name
   3. Name of physician notified or his/her representative
   4. Reason for notification
   5. Physician’s response
   6. Action taken or orders obtained
   7. Professional’s signature and title

B. Documentation of attempted physician notification will include:
   1. Date and time
   2. Patient name
   3. Name of physician attempting to notify
   4. Reason for notification
   5. Name of person taking message

5. When unable to contact the patient’s physician for medical consultation warranted by change in patient’s condition, the following procedures will be followed:

A. The nurse or therapist will immediately notify the Clinical Supervisor or designee regarding the need for medical consultation and problems encountered.
B. An attempt will be made by the Clinical Supervisor or designee to contact the patient’s physician.

C. If the Clinical Supervisor or designee is unable to contact patient’s physician, the Clinical Supervisor or designee will notify the organization’s Medical Director of the change in patient condition and the inability to contact patient’s physician to request medical consultation.

6. Based on the communication with the physician (or other authorized licensed independent practitioner), a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided according to the revised plan of care.

7. The plan of care will be updated according to the organization’s policies and procedures. (See “Care Planning Process” Policy No. HH:2-004.)

8. A written summary report will be sent to the attending physician at least every 60 days. (See “60-Day Summary Report” Policy No. HH:2-016.)
PURPOSE

To define the process for completion of the 60-day summary of patient care.

POLICY

A 60-day summary will be completed for each patient at the end of the episode when the patient will be recertified. The summary will be forwarded to the attending physician involved in the patient's care.

PROCEDURE

1. Upon determination that a patient requires ongoing care and will be recertified for an additional episode of care, the patient’s Case Manager will complete a 60-day summary.

2. Information required in the 60-day summary report to the physician may include:
   A. Reason for admission or last recertification, as applicable
   B. A summary of care and treatments/procedures provided
   C. A summary of the patient’s response to treatment
   D. A summary of changes to the plan of care
   E. Why recertification for ongoing care is necessary

3. A copy of the 60-day summary report is included on the 485 for recertification.
PURPOSE

To define the organization requirements for patient notification of changes in care.

POLICY

The patient will be notified within 24 hours of any significant changes in the agreed-upon schedule or plan of care.

PROCEDURE

Visit Schedule

1. Clinicians will contact the patient the night prior to a visit to verify the approximate time of the visit (within a two-hour time span).

2. Any significant changes will be called into the office (e.g., moving a visit from morning to afternoon).

3. When a significant variation of tentative time for visit (i.e., greater than one (1) hour) is anticipated, the clinical personnel will notify the patient of the change and verify acceptance.

4. When a visit cannot be made because of unforeseen problems, personnel will immediately notify the office.

Plan of Care Changes

1. Whenever the plan of care is changed, including services, frequencies, treatments, etc., the patient will be notified at the time of the visit.

2. Documentation of the notification will include:

   A. Date and time of notification

   B. Specific changes in the plan of care

   C. Patient response or acceptance
Changes in Liability for Payment

1. The patient will be advised verbally and in writing of any changes in the initial information regarding his/her liability for payment within 30 days from the date the organization becomes aware of the changes.

2. Documentation of the notification will be made in the clinical and billing record.

PURPOSE
To define the on-call system for addressing 24-hour coverage of services.

POLICY
Patient care needs are the highest priority; therefore, weekend and evening staffing will be scheduled accordingly. Clinical Staff are expected to perform visits on an as-needed basis, including weekends.

There will be on-call staff available after office hours Monday through Friday, and 24 hours a day on weekends. Staff on-call will be:

1. Administrative call by a senior management staff member
2. Clinical call by a registered nurse (all registered nurses will participate in an on-call rotation)

PROCEDURE
1. On admission, each patient will be made aware of the organization’s 24-hour availability.
2. The on-call schedule will be developed on a monthly basis by the Clinical Director or designee. The schedule will be forwarded to the answering service and on-call staff.
3. The on-call staff can be reached by calling the home health number. After hours, this number will be forwarded to the answering service.
4. Reports will be given to the on-call nurse daily Monday through Friday. Supplies and records will be available to the on-call staff through direct access to the office.
5. Clinical staff must respond to a page within 15 minutes and be able to reach a patient within one (1) hour. (There may be rare exceptions, depending on how far away the patient lives and if the staff member is with another patient at the time of the page.)
6. In the event that the patient has an emergency need, the on-call staff member will call 911 on behalf of the patient and report to the patient’s home immediately as appropriate.
7. The on-call nurse will report his/her evening and/or weekend patient care activities to the Supervisor or Designee, that require follow-up.
8. All on-call activities concerning a patient will be documented on the on-call communication form. If an on-call visit is necessary, the activities of the visit will be documented in the clinical note.
PURPOSE

To ensure the coordination of services provided by the organization and by other service providers.

POLICY

A Case Manager will be assigned to be responsible for coordinating services provided to the patient by the organization, including services provided directly and through contract. The Case Manager will act as liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services.

PROCEDURE

1. All referrals to other service providers will be documented in the clinical record.

2. The other service provider will be responsible to contact the physician (or other authorized licensed independent practitioner) for orders for evaluation and treatment.

3. The Case Manager will be responsible for the coordination between service providers, which will include, but not be limited to:
   
   A. Organization personnel's understanding of each organization's/individual's responsibility in providing care.
   
   B. Initiation of communication with other organizations/individuals when there are significant changes in the patient's overall care.
   
   C. Monitoring duplication or conflict of services provided by various organizations or individuals. If anyone is aware of duplication or conflict, attempts to correct the situation are necessary.

4. Issues arising from the above will be communicated to the Clinical Supervisor or designee.

5. Ongoing communication regarding specific patients will be the responsibility of the Case Manager.

6. Ongoing communication regarding issues and concerns with the organizations or individuals providing care will be the responsibility of Visiting Nurse & Hospice Care management team.
INTERNAL REFERRAL PROCESS
Policy No. HH:2-020.1

PURPOSE
To outline the process to make a referral for additional services.

POLICY
Referrals to other disciplines will be processed as any other referral.

PROCEDURE
1. All internal referrals to other disciplines will be documented within the clinical record.
2. When a clinician identifies that an additional service is needed, he/she will contact the physician to obtain an order and complete an internal referral form.
3. The complete internal referral form will be given to the Clinical Supervisor or scheduler, who will assign the appropriate clinician.
4. The clinician assigned to provide additional services will contact the physician (or other authorized licensed independent practitioner) for orders for evaluation and treatment.
INITIAL AND COMPREHENSIVE ASSESSMENT
Policy No. HH:2-021.1

PURPOSE

To provide guidelines for the initial assessment of patients admitted to service and for completing the plan of care.

POLICY

An initial patient assessment will be performed and documented in the patient’s clinical record by a registered nurse, physical therapist, or speech therapist. The initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient’s return home, on the start of care date ordered by the physician (or other authorized licensed independent practitioner), or at the patient/family request with the approval of the physician (or other authorized licensed independent practitioner).

A comprehensive patient assessment will be completed within five (5) calendar days of the patient’s start of care.

The assessment will be patient-specific and comprehensive to include the patient’s need for home care, rehabilitative care, social, and discharge planning needs. The assessment will also include the exact use of the current versions of the Outcomes and Assessment Information Set (OASIS). This assessment will measure patient outcomes from data collected at the start of care and at the following defined intervals thereafter:

1. The last five (5) days of every 60-day episode beginning with the start of care date (recertification)
2. Upon transfer
3. Significant change in condition resulting in a new case mix
4. Within 48 hours of the patient’s return home from a 24-hour hospital admission for other than diagnostic testing
5. At discharge

PROCEDURE

1. The initial assessment and comprehensive assessment must be conducted by a registered nurse unless physical therapy or speech language pathology is the only requested service for that patient. In those cases, the physical therapist or speech therapist may conduct the initial assessment and the comprehensive assessment. These assessments may be conducted by the occupational therapist if the need for occupational therapy establishes program eligibility.
2. The comprehensive assessment for each patient must be completed in its entirety by a single clinician.

3. During the initial and comprehensive patient assessment, all baseline data to be used in measuring the patient’s progress towards goals and other relevant information will be documented in the patient’s clinical record, including at least the following information, if applicable:

   A. Outcomes and Assessment Information Set (OASIS) data must be collected on all patients receiving skilled services except prepartum and postpartum patients, patients under the age of 18, and patients whose care is reimbursed by a private insurance company. OASIS data collection is not required for patients who are receiving only personal care or support services (patients receiving only homemaker services). The OASIS data will be collected during the comprehensive assessment. The assessment tool must also include the exact use of the current versions of the OASIS data set.

   B. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, pain status, height/weight, nutritional status, and other relevant data related to pertinent physical findings.

   C. Patient’s functional status, including but not limited to, the degree of self-care, and the amount and level of assistance needed in the following areas:

      1. Eating
      2. Meal preparation
      3. Toileting/continence
      4. Transfer
      5. Ambulation
      6. Shopping, cleaning, laundry
      7. Bathing
      8. Dressing
      9. Use of telephone
     10. Mobility

   D. Patient’s medical and psychosocial history, including pertinent diagnosis and prognosis.
E. The patient’s psychosocial status, including emotional barriers to treatment, cognitive limitations, memory, and orientation.

F. The patient’s and family/caregiver’s educational needs, abilities, motivation, and readiness to learn.

G. Name and address of the patient’s physician.

H. Name of the hospital, other agencies, and persons involved in the past and present care of the patient.

I. An evaluation of the home environment and assessment of emergency preparedness of the patient.

J. Presence of any Advance Directives for care or discussions with patient and, as appropriate, family/caregiver, regarding the withholding of resuscitative services or the withdrawal of life-sustaining treatment.

K. Wishes regarding care, treatment and end-of-life decisions.

L. Equipment presently in the home and potentially needed by patient.

M. Any identified symptoms of pain.

N. Review of medication history, as applicable to care and service and current medication use, including prescription, over-the-counter medications and herbal medications, and identifying drug interactions, duplicative drug therapy, and noncompliance with therapy.

O. Patient and family/caregiver support systems and the type of care the family/caregiver is available, capable, and willing to provide.

P. Cultural and religious practices.

Q. Involvement of family/caregiver, neighbors, or other individuals or organizations.

R. Laboratory results.

S. Medical, alcohol, and other drug history.

T. Preventive and periodic health screening, including TB screening, if appropriate.

U. Immunizations, when appropriate.
V. Specific, individualized patient needs and problems pertinent to the care being provided.

W. Past medical and surgical care including dates of onset/exacerbation.

X. Anticipated discharge needs.

4. The comprehensive assessment should determine:

A. Patient problems/needs/strengths
B. The patient's continuing need for home care
C. That the patient meets payment eligibility requirements (e.g., homebound status)
D. Patient prognosis
E. Baseline information to be used to measure the patient's progress toward achievement of desired outcomes
F. Plan of care, including type of services, frequency, and duration
G. The ability of the organization to adequately meet the patient's medical, nursing, rehabilitation, social and discharge planning needs

5. A plan of care will be developed from the information gathered during the initial and comprehensive assessment. The patient's physician is consulted for approval if additions or modifications to the plan of care are required after the assessment is completed.

6. The Clinical Supervisor or designee will be responsible for the review of the plan of care.
PURPOSE

To provide guidelines for assessments of patient during ongoing care.

POLICY

The scope and intensity of ongoing assessments will be determined by the patient’s diagnoses, condition, desire for care, response to previous care, and the care setting.

PROCEDURE

1. During each home visit the appropriate clinician will re-evaluate the patient according to the problems identified during the initial visit and thereafter.

2. Using the standards of care identified by the organization, the clinician will reassess the patient for:
   A. Blood pressure, pulse, respirations, temperature
   B. Weight (once each week, if indicated by disease process)
   C. Pain status when applicable
   D. Breath sounds
   E. Skin integrity
   F. Bowel sounds; elimination (urinary and bowel)
   G. Appetite/diet, nutritional status
   H. Mental status
   I. Functional status
   J. Safety/home environment
   K. Patient and family/caregiver support
   L. Progress toward goals and patient needs and problems
   M. Compliance to treatment and/or medications
3. Re-assessments should focus on:
   A. Patient’s response to care
   B. Changes in patient condition
   C. Changes in patient diagnoses
   D. Changes in patient’s care environment or support systems

4. When a patient is receiving only personal care and support services, the reassessment will occur at least every six (6) months or more often, as necessary.

5. Based on each reassessment, the plan of care, including problems, needs, goals, and outcomes will be reviewed and revised accordingly by the clinician.

6. Based on the findings of the reassessment, change/verbal orders will be generated and forwarded to the physician (or other authorized licensed independent practitioner) as needed.

7. The physician will be notified to verify any changes in medications, including over-the-counter medications (which might interact or be duplicative with other patient medications), and treatment/interventions that require physician approval.

(See “Verification of Physician Orders” Policy No. HH:2-006.)
PURPOSE

To outline the requirements for ongoing updates to the comprehensive assessment (reassessments) and recertification.

POLICY

The comprehensive assessment must be updated and revised every 60 days beginning with the start of care. A comprehensive assessment, including all required OASIS data elements, must be performed to measure patient progress towards outcomes.

The total plan of care must be renewed at least every 60 days, or more often as warranted by the condition of the patient. Any assessment findings that suggest a need to alter the plan of care will be reported to the patient's physician.

OASIS assessments for recertification, significant change in condition, transfer, resumption of care and discharge will be completed within the mandated time frames.

PROCEDURE

1. Each clinician will follow the policies and procedures for ongoing assessments for each home visit. (See “Ongoing Assessments” Policy No. HH:2-022.)

2. For each new episode of care, a comprehensive assessment will be completed no earlier than five (5) days before and no later than one (1) day before the calendar day on which the new episode of care will begin.

3. The update of the comprehensive assessment must, at a minimum, include:
   
   A. Completion of all follow-up date items of OASIS and any changes in patient status
   
   B. Drug regimen review of all medications for drug interactions, potential adverse effects and drug reactions, duplicative drug therapy, ineffective drug therapy, significant side effects, significant drug interactions
C. Documentation of changes in the patient’s assessment finding

4. Each patient will be reassessed using a comprehensive OASIS assessment tool for the review and revision of the plan of care when:

   A. There is a significant change in the patient’s condition, care environment and/or support system

   B. Transfer of a patient to an inpatient facility

   C. The patient returns home after an inpatient admission lasting 24 hours or longer for any purpose other than diagnostic testing

   D. The patient is discharged

5. The physician will be notified of any of the above situations.

6. Documentation in the clinical record should support the assessment as well as the actions taken in response.

7. After the reassessment is conducted (no sooner than five (5) days prior to the recertification date for patients receiving OASIS reassessments), a case conference will be held and documented in the clinical record.

8. The physician will be contacted to verify the continued need for care and his/her agreement with the continued plan of care.

9. An interim order to continue home care services will be prepared and sent to the physician (or other authorized licensed independent practitioner).

10. The updated plan of care will be prepared and sent to the physician for review and signature in a timely manner.
PURPOSE

To provide guidelines for the appropriate assessment of patient who may have functional limitations requiring assistance and services from the organization.

POLICY

During the initial assessment, the patient will have his/her functional status assessed for provision of appropriate services. When rehabilitation needs are identified, a qualified rehabilitation professional will perform an in-depth functional assessment prior to the initiation of treatment.

PROCEDURE

1. During the initial assessment, the clinician performing the admission visit will assess the patient’s functional status, including but not limited to the following:

   A. Level of independence in the environment of care (home, school, work) for the following:
      1. Eating
      2. Toileting
      3. Transfers
      4. Walking
      5. Shopping
      6. Cleaning
      7. Laundry
      8. Bathing
      9. Dressing
   B. Mobility status
   C. Pain status
D. Problems with continence
E. Ability to operate and maintain equipment
F. Communication level and skills
G. Memory
H. Cognitive level
I. Orientation
J. Emotional response to current health status
K. Dental and oral hygiene

2. Once the level of functioning is determined, the clinician will determine which additional services or further functional assessments the patient may benefit from, including home health aide, therapies (physical, occupational or speech), and medical social worker services.

3. If another service is needed, the physician (or other authorized licensed independent practitioner) will be contacted to obtain an order. Once approved, a referral will be made to that discipline for the initiation of services.

4. When rehabilitation needs are identified and an order has been received from a physician (or other authorized licensed independent practitioner), the patient’s physical status and functional abilities will be evaluated by a qualified rehabilitation professional prior to the initiation of instruction or treatment.

5. The patient’s functional rehabilitation status will be assessed, including but not limited to, the following:
   A. Current level of functioning
   B. Self care responsibilities
   C. Independence
   D. Quality of life

6. Based on this functional assessment, the rehabilitation professional will develop and implement a rehabilitation plan with the patient and family/caregiver.
PURPOSE

To provide guidelines for the appropriate assessment of patients who may require a nutritional assessment by a qualified clinician.

POLICY

When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment.

PROCEDURE

1. During the initial assessment, the following information may be obtained as part of the baseline data (including by not limited to):
   
   A. Diet/appetite
   B. Height/weight
   C. Body mass index
   D. Digestive disorders
   E. Dysphasia/swallowing difficulties
   F. Factors affecting nutritional status, including but not limited to:
      
      1. Nausea/vomiting
      2. Diarrhea/constipation
      3. Emotional issues
      4. Oral hygiene/dental care
      5. Environment for meals
   G. Hydration/fluid intake
2. Based on the above, if the patient is determined to have any of the following, the clinician will contact the patient’s physician (or other authorized licensed independent practitioner) and obtain follow-up orders or an order for a nutritional consult:

   A. Nutrition, altered, less than body requirements
   B. Nutrition, more than body requirements

3. Documentation in the clinical record should reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult.
4. The registered dietician will make entries into the clinical record regarding plans, discussions, and interventions related to the nutritional consult.
PURPOSE

To provide guidelines for the appropriate identification and assessment of patient who may experience pain.

POLICY

Each patient will receive at least an initial pain assessment. When pain is identified, a more comprehensive pain assessment will be completed when warranted by the patient's condition. Pain assessments will be age-appropriate and will be documented to facilitate regular reassessment and follow up by clinicians.

PROCEDURE

1. During the initial assessment, the patient will be asked a general screening question regarding current or recent pain as part of the baseline data. Clinicians will consider the patient’s personal, cultural, spiritual, and ethnic beliefs when assessing pain or discomfort.

2. When the patient or the clinician identifies pain, the following in-depth pain assessment information should be obtained whenever possible:

   A. Pain intensity using a rating scale (on a scale of 0 – 10: 0 = no pain; 10 = unbearable pain). Pain intensity should include current pain, worst pain, and least pain using the scale. A separate, age appropriate, pain scale may be used for children.

   B. Pain location.

   C. Pain quality, patterns of radiation, and character. Use the patient's own words whenever possible.

   D. Pain onset, duration, variations, and patterns.

   E. Alleviating and aggravating factors.

   F. Present pain management regimen and effectiveness.

   G. Pain management history to include a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, and manner of expressing pain.

   H. Effects of pain—these include impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc.
I. The patient’s pain goal, including pain intensity and goals related to function, activities, and quality of life.

J. Physical exam or observation of the site of pain.

K. Secondary symptoms related to pain such as nausea, vomiting, respiratory distress or nutritional compromise.

3. If patient is unable to communicate pain using the rating scale, is cognitively impaired, or is a child, the clinician will assess behavioral factors that signal pain or discomfort and include this information in the assessment.

4. For parents or caregivers of a child who exhibits or reports pain, information will be provided regarding the parent’s role in interpreting their child’s behavioral changes that may indicate pain or discomfort.

5. Pain assessments will be documented in the clinical record, and information will be communicated to other caregivers.
ASSESSMENT OF POSSIBLE ABUSE/NEGLECT  
Policy No. HH:2-027.1

PURPOSE

To provide guidelines for identification of suspected abuse victim for care and referral to community resources. These guidelines stipulate when and how to report suspected Dependent Adult/Elder Abuse and Child Abuse.

POLICY

The organization will report all suspected cases of abuse, neglect, or exploitation in compliance with appropriate state statutes to appropriate protection organizations.

Dependent Adult/Elder Abuse

"Elder," means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). "Dependent Adult," means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete form SOC 341 for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult.

Copies of the most current REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE form as well as instructions for completing, it can be found at the State of California website by using the following link: http://www.dss.caahwnet.gov/Forms/English/SOC341.pdf. (COPY THIS LINK INTO THE INTERNET EXPLORER SEARCH BAR.)

The original SOC 341 report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
REPORTING PARTY DEFINITIONS
Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Health Practitioner (WIC) "15610.37 ‘Health practitioner’ means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

WHAT TO REPORT
Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abortion, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

MULTIPLE REPORTERS
When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

FAILURE TO REPORT
Failure to report by mandated reporters (as defined under “Reporting Party Definitions”) any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.
EXCEPTIONS TO REPORTING
Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

1. The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
2. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
3. The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
4. In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

DISTRIBUTION OF SOC 341 COPIES
Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.

Suspected Child Abuse
California Penal Code Section 11164-11174.3, known as the Child Abuse and Neglect Reporting Act (CANRA), defines a "child" as a person under the age of 18 years.

MANDATED CHILD ABUSE REPORTERS
Mandated child abuse reporters include all those individuals and entities listed in Penal Code Section 11165.7. A "mandated reporter", as pertains to VNHC employees, is defined as any of the following:

• A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
• A clergy member, as specified in the California Penal Code means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

TO WHOM REPORTS ARE TO BE MADE
Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department, or the county welfare department. (PC Section 11165.9.)
REPORTING RESPONSIBILITIES

• Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. (PC Section 11166(a).)

• No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

• A mandated reporter must complete and submit the Suspected Child Abuse Report form (SS 8572) even if some of the requested information is not known. (PC Section 11167(a).)

DEFINITIONS OF CHILD ABUSE

Examples of child abuse listed in the penal code (PC Sections 11165.1 to 11165.6) include:

• sexual abuse meaning sexual assault or sexual exploitation
• neglect meaning the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.
• the willful harming or injuring of a child or endangering of the person or health of a child
• unlawful corporal punishment or injury meaning a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition.
• child abuse or neglect including physical injury or death inflicted by other than accidental means upon a child by another person

INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

Copies of the most current Suspected Child Abuse Report form (SS 8572), as well as instructions for completing, it can be found at the State of California website by using the following link: http://ag.ca.gov/childabuse/pdf/ss_8572.pdf (COPY THIS LINK INTO THE INTERNET EXPLORER SEARCH BAR.)

DISTRIBUTION

Reporting Party: After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
ADDENDUM HH:2-027.A

ORGANIZATION LIST OF PRIVATE AND PUBLIC COMMUNITY AGENCIES THAT PROVIDE OR ARRANGE FOR ASSESSMENT OF SUSPECTED OR ALLEGED ABUSE/NEGLECT VICTIMS

Adult Protective Services (805) 681-4550
Child Protective Services (805) 367-0166
MEDICATION PROFILE

Policy No. HH:2-028.1

PURPOSE

To define the use of the medication profile in evaluating a patient’s medication regimen.

POLICY

Patients receiving medications administered by the organization will have a current, accurate medication profile in the clinical record, updated for each change to reflect current medications, and new and/or discontinued medications.

PROCEDURE

1. Upon admission to home health, the admitting nurse will initiate a medication profile to document the current medication regimen.

2. A drug regimen review will be performed at the time of initial and comprehensive assessment, when updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of a new medication. The review will identify drug/food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy. The interdisciplinary team will confer with an individual with education in drug management to ensure the drugs and biologicals meet the patient’s needs.

3. During subsequent home visits, the medication profile will be used as a care planning and teaching guide to ensure that the patient and family/caregiver, as well as other clinicians, understand the medication regimen. This includes, but will not be limited to:
   A. Using the medication profile to evaluate the use of the drugs in the home setting
   B. Using the medication profile to teach purpose of medication, dosages, routes, administration times, side effects, contraindications, and appropriate outcomes.
   C. Using the medication profile as a communication tool for other clinicians involved in care
   D. Therapeutic appropriateness of the choice of drug, dose, frequency, and route of administration.

4. Based on review of the medication profile, changes in the plan of care may be required.

5. Any conclusions and findings of patient medication use or monitoring should be communicated to the pharmacist, when appropriate, and other clinicians.

6. Deviations from taking medications as ordered will be documented in clinical notes, and the physician (or other authorized independent practitioner) will be notified.
IDENTIFICATION OF MEDICATION FOR ADMINISTRATION
Policy No. HH:2-029.1

PURPOSE

To provide general guidelines for the safe administration of medications.

POLICY

Orders for the administration of medications must be given by a physician (or other authorized independent practitioner) and include patient name, the name of the medication, dosage, dilution, route, frequency of administration, and rate of infusion, if applicable, as well as orders for anaphylaxis and laboratory work, when appropriate.

Note: If the drug order is verbal or given by or through electronic transmission, it must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist or physician. The individual receiving the order must ‘read back’ the order, record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations.

PROCEDURE

1. Prior to medication administration, the nurse will be familiar with the patient’s medical history and will review present medication regimen, including allergies to foods and drugs.

2. The nurse will review the written physician’s (or other authorized independent practitioner’s) orders prior to medication administration.

3. It will be the nurse’s responsibility to be knowledgeable of the medication to be administered, including indications, normal dosage range, dilution, route of delivery, rate of delivery, precautions, side effects, expected therapeutic effect, proper antidote, and incompatibilities, as applicable.

4. Medications will be properly labeled with the patient’s name, an additional patient identifier, name of drug, dosage, diluent, date of preparation, expiration date, initials of preparer, and any special instructions, as applicable.

5. The nurse will review the medication label for name, additional patient identifier, drug, dosage, and prescription.

6. The nurse will validate patient name and listed patient identifier with the patient or family/caregiver, as appropriate.

7. All medications will be checked for stability by visualizing the medication and observing for, but not limited to, the following:
A. Deterioration, as evidenced by particulate matter
B. Discoloration, cloudiness
C. Dampness
D. Intactness, including seals
E. Expiration date
F. Storage facilities/containers

8. If the medication is not stable for administration, the nurse will hold the medication and contact the appropriate pharmacy for replacements.

9. Prior to administration, the nurse will verify and/or review information to determine that the medication is not contraindicated for the patient based on the following:
   A. Known medication allergies
   B. Known food allergies
   C. Medication incompatibility for potential interaction
   D. Patient’s physical or mental condition
   E. Relevant laboratory results
   F. Previous reactions to medications

10. If potential contraindications are identified, the nurse will contact the pharmacists and physician involved in the care of the patient for further instructions.

11. The nurse will document medication teaching, side effects, administration, and other related information in the clinical record.
PURPOSE

To provide guidelines for the safe administration of medications by licensed personnel.

POLICY

Licensed nursing personnel will administer and document only those medications which have been ordered by the physician, as a part of the plan of care.

Registered nurses may administer oral, subcutaneous, intramuscular, and intravenous medication. (See “Intravenous Administration of Medications/Solutions” Policy No. HH:2-033 and “Intravenous Administration of Chemotherapy” Policy No. HH:2-034.)

Licensed vocational nurses will administer oral, subcutaneous, intramuscular injections and IV fluid per California Nurse Practice Act. Certification and competency demonstrated for peripheral IV fluid administration will be documented in the clinician's personnel file.

Non-licensed personnel may, with instruction, supervise and assist the patient's self-administration of medication. Non-licensed personnel may document assisting the patient in his/her self-administration of medication.

Visiting Nurse & Hospice Care will make available to home health personnel the current editions of drug reference materials or software such as but not limited to: Medispan, PDR, Nursing Drug Handbook, or Nursing Drug Guide to be used as drug information and patient education sources for consistency of referenced professional information. These reference materials will provide information concerning drug indications, drug interactions, pharmacology/pharmacokinetics, side/adverse effects, and patient consultation guidance, dosing information, and dosing forms. The pharmacies dispensing patient medications also independently checks for drug interactions, pharmacology/pharmacokinetics, and potential side/adverse effects.

PROCEDURE

1. As part of the assessment process, a drug history will be taken and a comparison made between the physician's (or other authorized independent practitioner's) orders and the current medication the patient is taking. Any discrepancies or contradictions should be reported to the physician for resolution.

2. The nurse will provide instruction to the patient which includes medication administration, route, how medication relates to disease process, contraindications, side effects, and adverse reactions.
3. Licensed nurses will administer medications ordered by the physician (or other authorized independent practitioner) which are not listed in the Medications Not Approved for Safe Home or Serenity House Administration list (See "Addendum HH:2-030.B.")

A. For those ordered medications that cannot be safely administered and monitored, the physician (or other authorized independent practitioner) will be contacted for discussion.

B. Medication administration will occur upon successful completion of the competency skills checklist. This will include identification of precautions and requirements for treatments such as equipment required, assessments for adverse reactions, laboratory results to be reviewed prior to administration, guidelines for physician notification, and infection control practices.

4. Nurses who are providing intermittent home care visits will document only those medications that they administer, not medications the patient self-administers during the absence of nursing personnel.

5. Patients in the inpatient unit who wish to self-administer medications will need:

A. A physician or Independent Nurse Practitioner’s order

B. Will follow the guidelines prescribed by the inpatient unit for self-administration of medications.

6. Medications will be administered within 60 minutes before or after the prescribed times. Deviance from this time frame will be noted on the medication profile with an explanation made in the clinical notes.

7. Medications refused, held, and/or omitted will be indicated on the medication profile with an explanation made in the clinical notes. The attending physician will be notified in compliance with inpatient unit regulations. An incident report will be filed for medication errors.

8. If, in the judgment of the nurse, it would be beneficial to the patient to document his/her self-administered medications, a patient self-medication checklist may be prepared and left in the home for the patient’s use. This document will be used as a service only and will not be incorporated into the clinical record.
ADDENDUM HH:2-030.A

DRUG/CLASSIFICATIONS AND THEIR ROUTES
<table>
<thead>
<tr>
<th>Classification</th>
<th>Route</th>
<th>By Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotics, Antimicrobials</strong></td>
<td>PO, IM, Inhalation</td>
<td>RN, LVN</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>RN</td>
</tr>
<tr>
<td><strong>Cardiovascular Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inotropics &amp; Antiarrythmics</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Beta-Adrenergic Blockers</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antianginal</td>
<td>PO, SL, Inhalation, Topical</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Alpha-Adrenergic Blockers</td>
<td>PO</td>
<td>RN/LVN</td>
</tr>
<tr>
<td>• Antihypertensives</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Central Nervous System Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Analgesics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>RN</td>
</tr>
<tr>
<td>• Anticonvulsants</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antidepressants</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Anti-Parkinson’s</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antipyretics</td>
<td>PO, Suppositories</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antianxiety Agents</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antipsychotics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Sedatives/Hypnotics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Autonomic Nervous System Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adrenergics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>RN</td>
</tr>
<tr>
<td>• Cholinergics</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Anticholinergics</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Skeletal Muscle Relaxants</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>RN</td>
</tr>
<tr>
<td><strong>Respiratory Tract Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antihistamines</td>
<td>PO, IM, SC</td>
<td>RN, LVN</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>RN</td>
</tr>
<tr>
<td>• Bronchodilators</td>
<td>PO, IM, SC, Inhalation</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Expectorants, Antitussives</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
</tbody>
</table>
### DRUG/CLASSIFICATIONS AND THEIR ROUTES

<table>
<thead>
<tr>
<th>Classification</th>
<th>Route</th>
<th>By Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastrointestinal Tract Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antacids, Antiflatulants</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Digestive Enzymes</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antidiarrheals</td>
<td>PO, SC</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Laxatives</td>
<td>PO, Suppository, Enema</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antiemetics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antiulcer Agents</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Hormonal Agents</strong></td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Agents for Fluid &amp; Electrolyte Balance</strong></td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Hematologic Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hematinics</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Anticoagulants</td>
<td>PO, SC</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Hemostatics</td>
<td>In wound/ulcer</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Antineoplastic Agents</strong></td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Immunomodulation Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Immunosuppressants</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Vaccines and Toxoids</td>
<td>PO, SC, IM, Intradermal</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Immune Serums</td>
<td>IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>Not Given</td>
</tr>
<tr>
<td><strong>Biological Response Modifiers</strong></td>
<td>SC, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Ophthalmic, Otic, Nasal Drugs</strong></td>
<td>Eye, Ear, Nose</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Topical Agents</strong></td>
<td>Topical</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Nutritional Agents</strong></td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
</tbody>
</table>
ADDENDUM HH:2-030.B

MEDICATIONS NOT APPROVED FOR
SAFE HOME OR SERENITY HOUSE ADMINISTRATION
## MEDICATIONS NOT APPROVED FOR SAFE HOME OR SERENITY HOUSE ADMINISTRATION

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Route</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood and Blood products</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Adrenergic agonists</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Antiarrhythmics, ie. Diltiazem</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>IV infusion/push</td>
<td>IV Valium and Ativan are acceptable to give</td>
</tr>
<tr>
<td>Antihypertensives, ie: Enalapril, Methyldopate HCI, Metoprolol Tartrate, Labetalol HCI, Atenolol</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Chemotherapeutic IV drugs</td>
<td>IV infusion/push</td>
<td>May be given for HH by IV chemo certified nurse</td>
</tr>
<tr>
<td>General anesthetic agents</td>
<td>IV infusion/push</td>
<td>Ketamine may be administered per protocol for Palliative Sedation</td>
</tr>
<tr>
<td>Insulin drip</td>
<td>IV infusion/push</td>
<td>Insulin may be added to TPN</td>
</tr>
<tr>
<td>IV medications requiring Cardiac monitoring, ie: Atropine, Cogentin, EDTA, Hydralazine, Interleukin - 2</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Digoxin</td>
<td>IV infusion/push</td>
<td>requires case by case approval</td>
</tr>
<tr>
<td>Dilantin</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Desferol (Test dose must be given)</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>L-Aspariginase</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Neuromuscular blocking agents</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Pentobarbital</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Potassium aliquots (or runs, or riders)</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Phenergan (Promethazine)</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Sufentanil Citrate</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Thrombolytics (unless for catheter clearance) ie: Streptokinase</td>
<td>IV infusion/push</td>
<td></td>
</tr>
</tbody>
</table>
PURPOSE

To promote the correct administration of medication by patients and families/caregivers, or licensed nursing staff.

POLICY

Visiting Nurse & Hospice Care will encourage patient and family/caregiver participation in his/her own care and will provide teaching about the correct administration of medications by patient and family/caregiver as ordered by the attending physician (or other authorized independent practitioner) or as purchased over the counter. Teaching will also include the safe storage of medications.

(See “Safe/Effective Use of Medications” Policy No. HH:5-002.)

PROCEDURE

1. The clinician will provide an opportunity for the patient to administer his/her own medications. The medications listed at the time of admission and recertification will be considered part of the plan of care.

2. The clinician will:
   
   A. Teach the patient the purpose and side effects of medications and the patient's role in identifying and preventing medication errors.
   
   B. Assist the patient in setting up medications for the first time.
   
   C. Assess patient’s ability to self-administer medications correctly and document the patient’s response and understanding to teaching.
   
   D. Answer questions/concerns expressed by the patient and family/caregiver regarding the patient's self-administration of medications.
   
   E. Document information given to the patient regarding the medication, date, and time medications are to be given; teaching of side effects; and any pertinent observations made during the visit, such as patient's needs, outcome, etc., in the patient's clinical record, as appropriate.
   
   F. Complete the medication profile form at admission and recertification.
   
   G. Assess patient’s use of over the counter (OTC) and herbal medications; document with start date.
H. Instruct patient and family/caregiver regarding safe storage of medications. Consideration should be given to the following:

1. Medications should be stored separately from other poisonous drugs and chemicals.

2. Medications should be removed from storage during instruction and administration times.

3. Medications should be kept out of the reach of children, pets, and confused or disoriented patients.

4. The nurse will plan with the patient and family/caregiver for the safe therapeutic storage of drugs during the assessment process.

5. Drugs requiring refrigeration should be stored inside the refrigerator.

6. Urine testing and other diagnostic materials should be stored away from all medications, heat, light, and moisture.
PURPOSE

To ensure the appropriate use and disposal of controlled substances in accordance with applicable state and federal regulations.

POLICY

Visiting Nurse & Hospice Care voluntarily adheres to a controlled drug reporting process.

PROCEDURE

1. Controlled substances will be distributed directly to the patient or his/her representative. The dispensing pharmacist is responsible for monitoring the amount of drug issued and the length of time between renewals.

2. In cases where organization personnel are in the home 24 hours a day, a drug count will be made by the licensed personnel at the time of shift change.

3. The accounting process for controlled drugs will be recorded on the narcotic count record, which will be maintained as a part of the clinical record.

4. An informal documentation procedure for the patient and family/caregiver may be outlined for use when organization personnel are not present in the home.

5. When a home care patient no longer has a need for a controlled substance the clinician will instruct the patient and/or the family/caregiver to dispose of the drugs.

6. The clinician will document in the clinical record that the patient and family/caregiver was instructed to dispose of medications and took responsibility to do so.

7. Organization personnel will not dispose of any patient medications.
ADDENDUM HH:2-032.1A

DRUG DISPOSAL INSTRUCTIONS

Drug Disposal

http://www.pharmacy.ca.gov/publications/dont_flush_meds.pdf
INTRADEVENOUS ADMINISTRATION OF MEDICATIONS/SOLUTIONS
Policy No. HH:2-033.1

PURPOSE
To establish the conditions for administration of intravenous medications/solutions in the home.

POLICY
Registered nurses with documented competency may establish peripheral intravenous (IV) lines and administer IV medications and solutions under the orders of a physician (or other authorized independent practitioner). (See “Medications Not Approved for Safe Home or Serenity House Administration” list (See “Addendum HH:2-030.B.)

PROCEDURE
1. A physician’s (or other authorized independent practitioner) order will be obtained for approved IV medications and solutions.

2. All orders for IV medications and solutions will specify dilution, route, frequency of administration, and rate of infusion.

3. The patient receiving IV medications and solutions should have received his/her first dose of prescribed medicine in a hospital setting, in a physician's office, or under the supervision of a physician or his/her representative prior to admission to Visiting Nurse & Hospice Care, without evidence of allergic reaction. Otherwise, prior approval of dispensing pharmacist will be obtained with consultation regarding any special considerations for administration.

In the case that the first dosages of medication or solution is given in the home without prior administration, the nurse will remain in the home for at least 30 minutes after discontinuing the IV infusion. (See First Dose Policy No. HH:2-035.1)

1. IV medications and solutions will only be administered through a peripheral or central venous line.

2. Laboratory work, as indicated for each medication or solution, will be ordered by the physician (or other authorized independent practitioner).

3. Only medications and solutions that are prepared by a pharmacy, and are properly labeled with the patient’s name, name of drugs, dosage, dilution, date of preparation, expiration date, initials of preparer, and any special instructions will be administered, except in the case of emergency kit usage.

4. Patient-specific anaphylaxis kits will be supplied by the home infusion company in the following instances (see “Anaphylaxis Protocol” Policy No. HH:2-041.):
A. Patient is receiving an approved first time dose of medication
B. Patient has numerous medication allergies
C. At physician's (or other authorized independent practitioner's) request/order

5. A physician must be notified if any of the following circumstances occur:
   A. If clinical findings are abnormal
   B. If laboratory findings are abnormal
   C. If any allergic or toxic symptoms are exhibited by the patient
   D. If drug regimen review shows an alternative pharmacotherapeutic plan that could achieve safer, more effective, and more economical patient care
   E. If anaphylaxis occurs and/or different medication is required to treat
   F. When proper placement of a central venous catheter is questioned
   G. If repeated difficulty occurs in establishing a peripheral line

6. If a physician orders an IV Medication listed on the Medications Not Approved for Safe Home or Serenity House Administration list (Addendum H:2-057.B.) or the IV use of the medication is questionable, the following process must be followed if an exception is to be made:
   A. Determine the medication and patient need.
   B. Program Director consults with Pharmacist consultant to establish that medication is safe for Intravenous Administration in the Home Health, Hospice or Inpatient Hospice setting.
   C. Approval of Administration of that medication will be made in writing and a signed copy of the approval will be filed in the patient’s chart.
   D. In order for a medication to be removed from the Medications Not Approved for Safe Home or Serenity House Administration list, there must be approval by the Directors of Home Health, Hospice, Serenity House, and Medical Director. The approval to remove will be placed in the policy manual until the policy is reviewed and updated.
PURPOSE

To delineate the process for the safe administration of intravenous chemotherapy in the home setting.

POLICY

Intravenous chemotherapeutic agents will be administered by a chemotherapy-certified registered nurses. Registered nurses who administer chemotherapy medications may do so only under the following conditions:

1. Antineoplastic medications that are ordered must be approved by a pharmacy consultant and the Director of Home Health prior to administration on a case by case basis.

2. The first cycle of an antineoplastic drug will be given in the physician's office or hospital setting without evidence of adverse reaction prior to administration in the home setting. (All Taxol is to be given as first dose in hospital.)

3. The physician (or other authorized independent practitioner) ordering the antineoplastic drug for home administration will also order:
   A. Dose as mg/m² and actual calculated dose, dilution, route of administration, absolute dosage, frequency, number of doses of the drug to be administered, length of infusion, and total lifetime dose, when appropriate
   B. Orders for antiemetic drugs prn when appropriate
   C. Orders for treatment of extravasation prn if the drug is a vesicant
   D. Orders for treatment of anaphylaxis prn
   E. Orders for heparin prn, when appropriate
   F. Laboratory work as applicable

4. Venous access will be adequate for administration of chemotherapeutic drugs (blood return must be demonstrated prior).

5. The home environment will be compatible with safe administration of IV chemotherapeutics.

6. Organization will be given an opportunity to assess the patient or chart in the hospital, if appropriate.
7. Chemotherapeutic drugs will be prepared by a pharmacy and received in the patient’s home, ready for administration. They will be properly labeled with the patient’s name, name of drug, dosage, diluent, date and time of preparation, expiration date, initials of preparer, and any special instructions (e.g., refrigerate). If a drug is a vesicant, a “vesicant” label should be attached.

PROCEDURE

1. The registered nurse administering the chemotherapeutic drug will:

   A. Review all orders for IV medications for proper procedure and protocol.

   B. Review individual drug protocol before each administration.

   C. Verify with the physician (or other authorized independent practitioner) that the medication order and the prepared medication from the pharmacy are the same.

   D. Recheck calculations of drug order and compare dosage to individual drug protocol.

   E. Review laboratory results. (Refer to each antineoplastic drug to determine laboratory work.)

   F. Do baseline nursing assessment of patient. (Refer to each antineoplastic drug to review relevant clinical findings.)

   G. Explain the procedure to the patient and discuss potential side effects, including anaphylaxis.

   H. Place the patient in a comfortable position and in a well-lit area.

   I. Give pretreatment medications, if ordered.

   J. Select appropriate site for placement of peripheral IV line. When giving vesicant drugs, avoid wrist veins and the antecubital fossa.

   K. After peripheral line placement, check patency by instilling 5 to 10 ml of sterile normal saline.

   L. Check patency of the central venous line by aspirating 3 to 5 ml of blood.

   M. If IV site is patent, the needle should be taped so that the insertion site is easily seen.

   N. When giving more than one (1) drug in a series, always give the vesicant drug first.

   O. Observe site continuously for signs of extravasation.
P. Use volumetric pumps when administering continuous IV infusion.

Q. Flush catheter/cannula with 5 ml of sterile normal saline between the last administration of chemotherapeutic agents and following the last drug.

R. When administration of IV chemotherapy is complete, remove all drug-contaminated supplies and dispose of them using hazardous waste standards.

S. Observe the patient throughout intermittent administration of chemotherapy for symptoms of anaphylaxis or side effects. When patient is receiving continuous IV infusion, instruct patient and family/caregiver in symptoms of anaphylaxis, in side effects, and when appropriate, in symptoms of extravasation and appropriate interventions.

T. Remain in the home for at least 30 minutes following IV push administration of drug and following the start of IV infusion of drug.

U. Provide follow-up education:
   1. Give date for next chemotherapy administration.
   2. Explain how emergency care can be summoned.
   3. Arrange, if necessary, for appropriate laboratory work.

2. A physician must be consulted prior to administration of IV chemotherapy in the following circumstances:

A. If clinical findings are abnormal (refer to each antineoplastic drug to determine relevant clinical observations).

B. If laboratory findings are abnormal (refer to each antineoplastic drug to determine relevant laboratory work).

C. When proper placement of central venous catheter is questioned.

3. The nurse will follow recommended safety guidelines. Strict adherence to protocol aimed at nurse safety may greatly reduce the possibility of toxic side effects from exposure to chemotherapeutic medications. A spill kit will be available during chemotherapy administration.

A. Hand hygiene should be performed before and after administration.

B. Use doubled gloves when handling tubing and administering the drug.

C. Use aseptic technique/standard precautions throughout procedure.
D. Luer-Lok syringes and IV tubings should be used in drug administration.

E. Take action to prevent needle punctures.

F. Use packaged 4x4-inch gauze pads at syringe or needle tip when expelling excess air.

G. Use leak-proof, puncture-resistant disposal containers.

H. Extravasation kit will be available in the home.

I. Have patience and take adequate time (NEVER RUSH) during administration of drug.

J. Patient and family/caregiver should be instructed to take necessary precautions with contaminated linen/excreta (e.g., gloves, hand washing).

Site Infiltration/Extravasation Protocol

A. Signs and symptoms of infiltration during IV administration of vesicant antineoplastic drugs include edema, blanching, pain, redness, stinging, and burning near injection site and proximal to the injection site upward along the vein.

B. Infiltration/extravasation apply to the following drugs:
   
   — Dactinomycin
   — Daunorubicin
   — Doxorubicin hydrochloride
   — Mithramycin
   — Mitomycin C
   — Nitrogen mustard
   — Vinblastine sulfate
   — Vincristine sulfate

C. Discontinue injection of chemotherapeutic agent IMMEDIATELY.

D. Aspirate 3 to 5 ml of blood from IV (if possible).

E. Remove IV needle from patient.

F. Administer drug as ordered by attending physician (or other authorized independent practitioner) to counteract intravasation.

G. Immediately apply ice bag. Instruct patient to continue using ice bag as much as possible for 24 hours.

H. Notify physician immediately of extravasation and obtain further physician (or other authorized independent practitioner) orders for care of site.
I. Instruct patient to call physician if there is pain, infection, or ulceration.

J. Patient to be seen by physician within 72 hours. Instruct patient to arrange for appointment.

PURPOSE

To define the process for the safe administration of a first dose medication in the home setting.

POLICY

Whenever possible, the first dose of any IV medication or therapy should be administered under the direct supervision of a physician (or other authorized independent practitioner) in order to assess the safety and appropriateness of the drug and administration techniques.

FIRST DOSING IN THE HOME IS ALWAYS CONSIDERED AN EXCEPTION AND ALL OTHER OPTIONS SHOULD BE EXPLORED.

Criteria for First Dosing

1. An appropriate and complete physician's (or other authorized independent practitioner's) order must be obtained that specifies the drug, dose, route, frequency, infusion time (if appropriate), and allergic or anaphylactic precautions.

2. All attempts to obtain information regarding the patient's past medication allergies or anaphylactic reaction will be made.

3. The patient must be assessed as clinically stable at the time the decision is made to administer the first dose of medication at home and prior to the actual administration of the first dose.

4. The patient must be at least three (3) years old and weigh at least 15 Kg.

5. The patient will be alert, cooperative, and able to respond in such a way as to report symptoms.

6. The patient must reside in an area where there is access to emergency medical service.

7. The drug will be administered by an IV-qualified registered nurse.

8. The nurse will remain in the home to observe the patient for at least 30 minutes after discontinuing the infusion, or for at least one (1) hour after initiating a continuous infusion.
Some examples of IV therapies that may be suitable for first dose in the home are:

- Antibiotics
- SQ/IV pain management (not anesthetics)
- Chemotherapy
- Hydration
- Parenteral and enteral nutrition
- Specific Drugs such as: Epogen

Therapies NOT suitable for first time dosing are:

- Intraspinal pain management and anesthetic pain management
- IgG
- Investigational drugs
- Specific drugs such as: Terbutaline, Aminophylline, Amphotericin, Dextron
- Innovar
CRUSHING OF MEDICATIONS
Policy No. HH:2-036.1

PURPOSE
To provide guidelines for crushing medications.

POLICY
Certain drugs may not be crushed. As a matter of policy, the organization adheres to the following list of medications as noncrushable medications. (See “Oral Dosage Forms That Should Not Be Crushed” Addendum HH:2-036.A.)

The nurse Case Manager will determine if a medication may be safely crushed.

PROCEDURE
1. The nurse will determine whether or not a medication may be crushed based on the drug manufacturer’s information contained in the package inserts or information published in a reliable medical drug reference.

2. Should a question arise as to the “crushability” of any medication, the situation should be referred to the consultant pharmacist immediately.

   Note: If solid form is unsuitable for patient, contact consultant pharmacist for alternatives.

3. The nurse will instruct patient and family/caregiver regarding the safe crushing of medication.
ADDENDUM HH:2-036.A

ORAL DOSAGE FORMS THAT SHOULD NOT BE CRUSHED
ORAL DOSAGE FORMS THAT SHOULD NOT BE CRUSHED

Visiting Nurse and Hospice Care’s Do Not Crush Code:

1. **Enteric Coated Tablets** – An enteric coating resists the action of stomach fluids and disintegrates or dissolves in the intestines.

2. **Time Release Capsules** – Medication is released over a period of usually 8 to 12 hours. The beads or contents within the capsule dissolve at different times. The capsules may be emptied to facilitate administration, but the contents should be crushed or chewed.

3. **Time Release Tablets** – Medication is released over a period of 6 to 12 hours. Different types include:
   a. **Slow Release Core** – The outer coating dissolves first for an initial dose of medication; then the core dissolves slowly for a prolonged release.
   b. **Mixed Release Granules** – Regular and slow release granules dissolve immediately and prolonged release of medication.
   c. **Multilayer Tablets** – The first layer dissolves quickly for a loading dose, and the remaining layers dissolve at a slower rate to obtain constant blood levels of the medication.
   d. **Porous Inert Carriers** – A small plastic pellet containing many small passages filled with the medication slowly releases medication into the gastric fluids.
   e. **Soluble Matrix** – A wax matrix slowly releases medication into the gastric fluids to prevent gastric upset.
   f.

4. **Phenothiazine Drugs** – There is the possibility of irritation, a bitter taste, and temporary local anesthesia if crushed. Syrups and liquid concentrates are available and recommended.

5. **Sublingual, Chewable, and Buccal Tablets** – Swallowing, chewing, or crushing may prevent complete absorption, as these tablets rapidly dissolve in the oral fluids in the mouth.

6. **Miscellaneous** – Crushing should be avoided with some other medication for various reasons (i.e. bitter taste, caustic, Liquid-filled, etc.). If a liquid form is available, it is recommended. If there is no other alternative and the medication must be crushed, obtain order from physician to crush, crush well and add to a vehicle such as applesauce, jelly, or peanut butter and immediately after administration flush well with juice or another liquid.

*Note:* Medications not to crush are listed on the following pages
### COMMON MEDICATIONS NOT TO CRUSH

<table>
<thead>
<tr>
<th>CODE</th>
<th>DRUG</th>
<th>CODE</th>
<th>DRUG</th>
<th>CODE</th>
<th>DRUG</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>ACCUTANE</td>
<td>3</td>
<td>CONCERTA</td>
<td>3</td>
<td>EFICAC-24</td>
</tr>
<tr>
<td>3</td>
<td>ACIPHEX</td>
<td>3</td>
<td>CONSTANT-T</td>
<td>2</td>
<td>ELIXOPHILLIN-SR</td>
</tr>
<tr>
<td>3</td>
<td>ACUTRIM</td>
<td>2/3</td>
<td>CONTACT 12-HR capsule/caplet</td>
<td>1</td>
<td>E-MYCIN</td>
</tr>
<tr>
<td>6</td>
<td>ADALAT</td>
<td>1</td>
<td>COTAZYM-S</td>
<td>3</td>
<td>ENTEX-PSA</td>
</tr>
<tr>
<td>3</td>
<td>ADALAT-CC</td>
<td>1</td>
<td>COVERA-HS</td>
<td>3</td>
<td>ENTEX-LA</td>
</tr>
<tr>
<td>2</td>
<td>AEROLATE-III/JR/SR Caps</td>
<td>1</td>
<td>CREON</td>
<td>3a</td>
<td>ENTOZYME</td>
</tr>
<tr>
<td>2</td>
<td>AGGRENIX</td>
<td>2</td>
<td>CREON-10 &amp; 20</td>
<td>5</td>
<td>ERGOMAR</td>
</tr>
<tr>
<td>3</td>
<td>ALLEVE Cold &amp; Sinus</td>
<td>2</td>
<td>DECONAMINE –SR Capsule</td>
<td>1</td>
<td>ERYC</td>
</tr>
<tr>
<td>3</td>
<td>ALLEREST 12-hr caplet</td>
<td>3</td>
<td>DEPAZIN Tab</td>
<td>1</td>
<td>ERY-TAB</td>
</tr>
<tr>
<td>1</td>
<td>AMMNONIUM CHLORIDE</td>
<td>6</td>
<td>DEPAKENE</td>
<td>1</td>
<td>ERYTHROMYCIN BASE (film coated)</td>
</tr>
<tr>
<td>2</td>
<td>ARTANE Sequel</td>
<td>DEPAKOTE</td>
<td>3</td>
<td>ASKALITH –CR Tablet</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>ARTHROTEC</td>
<td>DESOXYN Gradument</td>
<td>2</td>
<td>FEDAHIST GYROCAP/ TIMECAP</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>ASACOL</td>
<td>6</td>
<td>DESYREL</td>
<td>6</td>
<td>FELDENE</td>
</tr>
<tr>
<td>1</td>
<td>ASPIRIN Enteric-Coated</td>
<td>2</td>
<td>DEXATRIM</td>
<td>1</td>
<td>FEOSOL</td>
</tr>
<tr>
<td>3</td>
<td>ASBRON-G Inlay Tablet</td>
<td>2</td>
<td>DEXADRINE S. Capsule</td>
<td>6</td>
<td>FERROFOLIC-500</td>
</tr>
<tr>
<td>1</td>
<td>AZULFIDINE Entab</td>
<td>2</td>
<td>DIAMOX Sequence</td>
<td>3</td>
<td>FERO-GRAD-500</td>
</tr>
<tr>
<td>3</td>
<td>BAYER 8-hr Caplet</td>
<td>2</td>
<td>DILACOR-XR</td>
<td>3</td>
<td>FERRO-SEQUEL</td>
</tr>
<tr>
<td>3</td>
<td>BAYER Low Adult Strength 81 mg</td>
<td>6</td>
<td>DILANTIN Kps/ator</td>
<td>1/6</td>
<td>FERROUS SULFATE</td>
</tr>
<tr>
<td>3</td>
<td>BELLERGAL-S</td>
<td>2</td>
<td>DILATRATE-SR</td>
<td>2</td>
<td>FUMATINIC</td>
</tr>
<tr>
<td>2</td>
<td>BETACHRON-ER</td>
<td>2</td>
<td>DILATIAZEM-SR</td>
<td>5</td>
<td>GAS-X</td>
</tr>
<tr>
<td>10</td>
<td>BIAXIN granular susp. Will clog tube</td>
<td>3</td>
<td>DIMETAPP Extentab</td>
<td>3</td>
<td>GLUCOTROL-XL</td>
</tr>
<tr>
<td>1</td>
<td>BISACODYL</td>
<td>3</td>
<td>DISOBROM</td>
<td>3</td>
<td>GLYNASE Micronized Pres-Tab</td>
</tr>
<tr>
<td>3</td>
<td>CALAN-SR</td>
<td>3</td>
<td>DISOPHROL Chronotab</td>
<td>3</td>
<td>GRISEOFULVIN Microsiz/ Ultra-Microsize</td>
</tr>
<tr>
<td>6</td>
<td>CARAFATE (dissolve in 15 cc warm water)</td>
<td>3</td>
<td>DITROPAN-XL</td>
<td>1</td>
<td>HALFPRIN</td>
</tr>
<tr>
<td>2</td>
<td>CARDENE-SR</td>
<td>3</td>
<td>DONNATAL Extentab</td>
<td>3</td>
<td>HEMASPAN</td>
</tr>
<tr>
<td>2</td>
<td>CARDIZEM-CD/SR</td>
<td>3</td>
<td>DONNAZYME</td>
<td>3</td>
<td>HIMIBID-DM</td>
</tr>
<tr>
<td>2</td>
<td>CARTIA-XT</td>
<td>1</td>
<td>DORYZ</td>
<td>3</td>
<td>HUMIBID-LA</td>
</tr>
<tr>
<td>3</td>
<td>CECLOR-CD</td>
<td>6</td>
<td>DOXIDAN</td>
<td>2</td>
<td>HUMIBID SPRINKLE</td>
</tr>
<tr>
<td>3</td>
<td>CHARCOAL PLUS</td>
<td>6</td>
<td>DRISDOL</td>
<td>2</td>
<td>HUMIBID-DM SPRINKLE</td>
</tr>
<tr>
<td>3</td>
<td>CHLOR-TRIMETON ALLERGY 8 hr &amp; 12 hr Tabs</td>
<td>3</td>
<td>DRIXORAL</td>
<td>6</td>
<td>HYDERGINE-LC</td>
</tr>
<tr>
<td>6</td>
<td>CHLORAL HYDRATE</td>
<td>1</td>
<td>DYNABAC</td>
<td>5</td>
<td>HYDERGINE Sublingual</td>
</tr>
<tr>
<td>3</td>
<td>CHLOREDYL-SA</td>
<td>3</td>
<td>DYNACIRC-CR</td>
<td>6</td>
<td>HYTAKEROL</td>
</tr>
<tr>
<td>10</td>
<td>CIPRO susp. Will clog tube/ swallow – do NOT chew</td>
<td>1</td>
<td>DULCOLAX</td>
<td>3</td>
<td>IBERET/IBERET-500</td>
</tr>
<tr>
<td>3</td>
<td>CLARITIN-D / 24 hr.</td>
<td>1</td>
<td>EASPRIN</td>
<td>3</td>
<td>IBERET FOLIC-500</td>
</tr>
<tr>
<td>5</td>
<td>CLARITIN Red-Tab (dissolve on tongue w/out water)</td>
<td>1</td>
<td>E-BASE</td>
<td>3</td>
<td>IMDUR</td>
</tr>
<tr>
<td>10</td>
<td>CLARITHROMYCIN susp. Will clog tube / swallow, do NOT chew</td>
<td>1</td>
<td>EC-NAPROSYN</td>
<td>2</td>
<td>INDERAL-LA Capsule</td>
</tr>
<tr>
<td>6</td>
<td>COLACE Capsule</td>
<td>1</td>
<td>ECOTRIN</td>
<td>2</td>
<td>INDERIDE-LA Capsule</td>
</tr>
<tr>
<td>2</td>
<td>COMHIST-LA</td>
<td>1</td>
<td>EES-400</td>
<td>2</td>
<td>INDOCIN-SR</td>
</tr>
<tr>
<td>2</td>
<td>COMPAZINE S. Capsule</td>
<td>2</td>
<td>EFFEXOR-XR</td>
<td>3</td>
<td>IODO-NIACIN</td>
</tr>
<tr>
<td>4</td>
<td>COMPAZINE Tablet</td>
<td>7</td>
<td>EFFOR-K</td>
<td>2</td>
<td>IONAMIN</td>
</tr>
<tr>
<td>CODE</td>
<td>DRUG</td>
<td>CODE</td>
<td>DRUG</td>
<td>CODE</td>
<td>DRUG</td>
</tr>
<tr>
<td>------</td>
<td>---------------------</td>
<td>------</td>
<td>---------------------</td>
<td>------</td>
<td>---------------------</td>
</tr>
<tr>
<td>2</td>
<td>ISO-BID</td>
<td>3</td>
<td>OXY-CONTIN</td>
<td>3</td>
<td>SLOW-MAG</td>
</tr>
<tr>
<td>3</td>
<td>ISOPTIN-SR</td>
<td>1</td>
<td>PABALATE</td>
<td>1</td>
<td>SODIUM SALICYLATE</td>
</tr>
<tr>
<td>5</td>
<td>ISORDIL</td>
<td>1</td>
<td>PANCREASE</td>
<td>5</td>
<td>SORBITRATE</td>
</tr>
<tr>
<td></td>
<td>Chewable/sublingual</td>
<td></td>
<td></td>
<td></td>
<td>Chewable/sublingual</td>
</tr>
<tr>
<td>2/3</td>
<td>ISORDIL Tembid</td>
<td>2</td>
<td>PAVABID Plateau-Caps</td>
<td>3</td>
<td>SORBITRATE-SA</td>
</tr>
<tr>
<td>5</td>
<td>ISUPREL Gloset</td>
<td>3</td>
<td>PCE-333/500 Caps</td>
<td>4</td>
<td>SPARINE</td>
</tr>
<tr>
<td>3</td>
<td>K-DUR</td>
<td>3</td>
<td>PBZ-SR</td>
<td>4</td>
<td>STELAZINE</td>
</tr>
<tr>
<td></td>
<td>(can dissolve in water)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>K-LYTE</td>
<td>2</td>
<td>PENTASA</td>
<td>3</td>
<td>SUDAFED 12hr</td>
</tr>
<tr>
<td>3</td>
<td>K-TAB</td>
<td></td>
<td>PERDIEM Granules</td>
<td>3</td>
<td>SULAR</td>
</tr>
<tr>
<td></td>
<td>(wax-coated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>KAON-CL</td>
<td>6</td>
<td>PERI-COLACE capsule</td>
<td>6</td>
<td>SURFAK Capsule</td>
</tr>
<tr>
<td>2/3</td>
<td>KCL (any brands)</td>
<td>4</td>
<td>PHENERGAN</td>
<td>3</td>
<td>SUSTAIRE</td>
</tr>
<tr>
<td>3</td>
<td>KLR-CON</td>
<td>2</td>
<td>PHENYTOIN EXTENDED</td>
<td>6</td>
<td>SYMMETREL Capsule</td>
</tr>
<tr>
<td>7</td>
<td>KLOVESS</td>
<td>3</td>
<td>PLENDIL</td>
<td>6</td>
<td>TAGAMET</td>
</tr>
<tr>
<td>7</td>
<td>KLR-CON-EF</td>
<td>3</td>
<td>POLARdRINE Repetab</td>
<td>3</td>
<td>TARKA</td>
</tr>
<tr>
<td>3</td>
<td>KLOTRIX</td>
<td>2/3</td>
<td>POTASSIUM CHLORIDE</td>
<td>3</td>
<td>TAVIST-D Tablet</td>
</tr>
<tr>
<td>6</td>
<td>LANOXICAP</td>
<td>2</td>
<td>PRELU-W</td>
<td>3</td>
<td>TECZEM</td>
</tr>
<tr>
<td>5</td>
<td>LEVSO sublingual</td>
<td>3</td>
<td>PREMARIN</td>
<td>3</td>
<td>TEGRETOL-XR</td>
</tr>
<tr>
<td>2</td>
<td>LEVSOINEX Timecap</td>
<td>3</td>
<td>PREMESIS</td>
<td>2</td>
<td>TELDRIN Spanule</td>
</tr>
<tr>
<td>3</td>
<td>LEXCEL</td>
<td>3</td>
<td>PREMPRO</td>
<td>3</td>
<td>TEN-K</td>
</tr>
<tr>
<td>3</td>
<td>LITHBID Tablet</td>
<td>2/9</td>
<td>PREVACID</td>
<td>3</td>
<td>TENUATE Dospan</td>
</tr>
<tr>
<td>3</td>
<td>LODE-XL</td>
<td>2/9</td>
<td>PRILOSEC</td>
<td>6</td>
<td>Tessalon Perle</td>
</tr>
<tr>
<td>2</td>
<td>MACROBID</td>
<td>6</td>
<td>PRE-BANTHINE</td>
<td>2</td>
<td>THEOBID Duracaps</td>
</tr>
<tr>
<td>1</td>
<td>MANDELAMINE</td>
<td>3</td>
<td>PRECAINAMIDE-SR</td>
<td>2</td>
<td>THEOBID-JR Duracaps</td>
</tr>
<tr>
<td>5</td>
<td>MAXALT-MLT (dissolve on tongue w/out water)</td>
<td>3</td>
<td>PROCAN-SR</td>
<td>3</td>
<td>THEOCLEARN-La</td>
</tr>
<tr>
<td>3</td>
<td>MELATONEX (long acting melatonin)</td>
<td>3</td>
<td>PROCANBID</td>
<td>2</td>
<td>THEOCLEARN-La</td>
</tr>
<tr>
<td>4</td>
<td>MELLARIL</td>
<td>3</td>
<td>PROCARDIA-XL</td>
<td>2</td>
<td>THEO-24</td>
</tr>
<tr>
<td>2</td>
<td>MEPROSPAN</td>
<td>6</td>
<td>PROCARDIA brand capsule</td>
<td>3</td>
<td>THEO-DUR</td>
</tr>
<tr>
<td>3</td>
<td>MESTINON Timespan</td>
<td>4</td>
<td>PROLIXIN</td>
<td>2</td>
<td>THEO-DUR Sprinkle</td>
</tr>
<tr>
<td>2</td>
<td>MICRO-K Extendcab</td>
<td>3</td>
<td>PRONESTYL-SR</td>
<td>3</td>
<td>THEOFLAIR-SR</td>
</tr>
<tr>
<td>2</td>
<td>MINOCIN Pellet-filled capsule</td>
<td>8</td>
<td>PROPECIA</td>
<td>3</td>
<td>THEOPHYLLINE-SR</td>
</tr>
<tr>
<td>6</td>
<td>MOTRIN</td>
<td>8</td>
<td>PROSCAR</td>
<td>3</td>
<td>THEO-SAV</td>
</tr>
<tr>
<td>3</td>
<td>MS-CONTIN</td>
<td>3</td>
<td>PROTONIX</td>
<td>3</td>
<td>THEOSPAR-SR</td>
</tr>
<tr>
<td>3</td>
<td>NALDECON</td>
<td>3</td>
<td>PROVENTIL Repetab</td>
<td>2</td>
<td>THEOVENT</td>
</tr>
<tr>
<td>3</td>
<td>NAPRELAN</td>
<td>3</td>
<td>QUIBRON-T SR</td>
<td>3</td>
<td>THEO-X</td>
</tr>
<tr>
<td>1</td>
<td>NAPROSYN Enteric-coated</td>
<td>3</td>
<td>QUINAGLUTE Duratab</td>
<td>2</td>
<td>THORAZINE Spanule</td>
</tr>
<tr>
<td>3</td>
<td>NIASPAN</td>
<td>3</td>
<td>QUINALAN</td>
<td>4</td>
<td>THORAZINE Tablet</td>
</tr>
<tr>
<td>2</td>
<td>NICO-400 Capsule</td>
<td>3</td>
<td>QUINIDEX Extentab</td>
<td>3</td>
<td>TIAMATE</td>
</tr>
<tr>
<td>2</td>
<td>NICOBID Tempule</td>
<td>2</td>
<td>RESPIRAE – 60/120</td>
<td>2</td>
<td>TIAZAC</td>
</tr>
<tr>
<td>3</td>
<td>NIFEDIPINE-SR</td>
<td>3</td>
<td>RESPBID</td>
<td>2</td>
<td>TOPAMAX SPRINKLE</td>
</tr>
<tr>
<td>6</td>
<td>NIMOTOP</td>
<td>3</td>
<td>RITALIN-SR</td>
<td>3</td>
<td>TOPRAL-XL</td>
</tr>
<tr>
<td>2</td>
<td>NITRO-BID Plateau-Cap</td>
<td>1</td>
<td>ROBIMYCIN Robitabs</td>
<td>3</td>
<td>T-HYL</td>
</tr>
<tr>
<td>5</td>
<td>NITROGLYCERIN</td>
<td>3</td>
<td>RONDEC-TR</td>
<td>3</td>
<td>TRANXENE-SD</td>
</tr>
<tr>
<td>2</td>
<td>NITROGLYCERIN-TD Cap</td>
<td>3</td>
<td>RU-TUSS Tablet</td>
<td>3</td>
<td>TRENTAL</td>
</tr>
<tr>
<td>5</td>
<td>NITROSTAT</td>
<td>3</td>
<td>SLEDANE-D</td>
<td>3</td>
<td>TRIAMINIC-12</td>
</tr>
<tr>
<td>6</td>
<td>NOCTEC</td>
<td>3</td>
<td>SINEMET-CR</td>
<td>4</td>
<td>TRILAFON</td>
</tr>
<tr>
<td>3</td>
<td>NOLAMINE</td>
<td>3</td>
<td>SINGLET</td>
<td>3</td>
<td>TRINALIN Repetab</td>
</tr>
<tr>
<td>3</td>
<td>NORMEX</td>
<td>2</td>
<td>SLO-BID Gyrocaps</td>
<td>2</td>
<td>TUS-ORNadle Spanule</td>
</tr>
<tr>
<td>2</td>
<td>NORMACE-CR</td>
<td>3</td>
<td>SLO-NIACIN</td>
<td>3</td>
<td>TYLENOL Ex-Relief Cap.</td>
</tr>
<tr>
<td>2</td>
<td>NOVAFED</td>
<td>2</td>
<td>SLO-PHYLLIN Gyrocaps</td>
<td>6</td>
<td>UNICAP</td>
</tr>
<tr>
<td>2</td>
<td>NOVAFED-A</td>
<td>3</td>
<td>SLO-PHYLLIN-GG</td>
<td>3</td>
<td>UNI-DUR</td>
</tr>
<tr>
<td>2</td>
<td>ORAMORPH-SR</td>
<td>3</td>
<td>SLOW-K</td>
<td>3</td>
<td>UNIPHYL</td>
</tr>
<tr>
<td>2</td>
<td>ORNADE Spanules</td>
<td>3</td>
<td>SLOW-FE Tablet</td>
<td>2</td>
<td>VALRELEASE</td>
</tr>
<tr>
<td>2</td>
<td>ORUVAIL</td>
<td>3</td>
<td>SODIUM FLORIDE</td>
<td>3</td>
<td>VERAPAMIL-SR</td>
</tr>
</tbody>
</table>
EXPLANATION OF CODES LISTED ABOVE
FOR COMMON MEDICATIONS NOT TO CRUSH:

Some medications and dosage forms should not be crushed. If there are any questions regarding the crushing of medications, call the pharmacy.

DO NOT CRUSH CODE:

1. Enteric-Coated Tablets/Preps: An enteric coating resists the action of stomach acid and dissolves in the intestines.
2. Time Release Capsules: Medication is released over a period of usually 8 to 12 hours. The beads or contents within the capsules often dissolve at different times. The capsules may be emptied to facilitate administration, but the contents should not be crushed or chewed.
3. Time-Release Tablets: Medication is released over a period of 6 to 12 hours. Different types include: slow-release core, mixed-release granules, multilayer tablets, porous inert carriers, and soluble matrix.
4. Phenothiazine Drugs: There is the possibility of irritation, a bitter taste, and temporal local anesthesia if crushed. Phenothiazines are available as syrups or liquid concentrates – equivalent liquid doses are recommended.
5. Lingual, Sublingual, Chewable, and Buccal Tablets: Swallowing, chewing, or crushing may prevent complete absorption, as these tablets rapidly dissolve in the fluids in the mouth.
6. Miscellaneous: Crushing should be avoided for various reasons: bitter taste, caustic, liquid-filled, etc. – a liquid form of the drug is recommended. If there is no other alternative and the medication must be crushed, obtain order from physician to crush, add to a vehicle such as applesauce, and flush well with juice or another liquid immediately after administration.
7. Effervescent: Dissolve in water.
8. Pregnant women or women attempting to become pregnant: Should avoid handling these crushed medications.
9. Contents should NOT be crushed: Open cap, sprinkle uncropped contents on applesauce or administer in juice via enteral tube.
10. Suspension should NOT be chewed OR administered via enteral tube, due to granular/microcapsular formulation which will clog the tube.
STORAGE OF MEDICATIONS AND NUTRITIONAL PRODUCTS
Policy No. HH:2-038.1

PURPOSE
To ensure that medications and nutritional therapy solutions are properly handled and stored.

POLICY
Medications and nutritional therapy solutions will be properly stored in the organization and patient’s environment.

The clinician will be responsible for instructing the patient and family/caregiver regarding the safe storage of medications. “Safety” is defined both in terms of patient’s safety and protection of the drug against damage from heat, sun, etc.

PROCEDURE
1. Storage of medication in the organization will be consistent with applicable law and regulation.
2. Investigational medications and cytotoxic medications will be stored in a secure location and appropriately identified.
3. Medications used for external use and disinfectants will be stored separately from internal and injectable medications.
4. All medications, chemicals and biologicals will be labeled for contents, with expiration dates clearly identified.
5. Medications and nutritional therapy solutions will be stored under conditions that enhance stability. Elements to be considered include:
   A. Appropriate storage temperatures utilizing appropriate thermometers and temperature logs
   B. Protecting solutions from contamination and spoilage
   C. Controlling lighting, ventilation, and humidity
   D. Prevention of moisture, condensation, and mold growth
   E. Thorough cleaning and sanitizing of all surfaces, supplies, and equipment after each use
6. The environment where medications or nutritional therapies are prepared will be appropriate to the therapy preparations, whether in the office or in the patient’s home. As appropriate to the setting, areas to consider include:

   A. Functionally separate areas for sterile product preparation
   B. An environment suitable to preparation of sterile products
   C. Safety equipment to protect personnel preparing cytotoxic or hazardous medications
   D. Clutter free, clean work surface for medication preparation or nutritional therapy solutions

7. Medication and nutrition therapy preparation will only be done by personnel with documented competencies regarding medication and nutrition therapy preparation.

8. The nurse will plan with the patient and family/caregiver for the safe therapeutic storage of drugs in the home. Consideration will be given to the following:

   A. Medications should be stored separately from other poisonous drugs and chemicals.
   B. Medication should be removed from storage during instruction and administration times.
   C. Medications should be kept out of the reach of children, pets, and confused or disoriented patients.
   D. Drugs requiring refrigeration are to be stored inside the refrigerator.
   E. Urine testing and other diagnostic materials are to be stored away from all medications, heat, light, and moisture.
PURPOSE

To promote safe medication administration through appropriate labeling.

POLICY

Medications will be administered only from properly labeled containers. No self-prescribed (patient) medications will be given by Visiting Nurse & Hospice Care personnel.

PROCEDURE

1. All prescriptions will be labeled by the pharmacist with the following: pharmacy name and number, prescription number, patient’s name, date of filling, physician’s name, name and strength of medication, directions for administration, and expiration date.

2. Medications will not be borrowed from one patient to administer to another.

3. If necessary, the clinician will obtain additional medication information.

4. Medications will not be administered from non-labeled containers.

5. If there is any reason to suspect the drug found in a container is not the drug labeled, the medication will not be given.

6. Labels will be carefully checked for expiration date, and the medication should be checked for stability (i.e., without indication of deterioration, dampness, cloudiness, discoloration, etc.).
PURPOSE

To provide guidance for instructing patient, family/caregiver and staff in identification of adverse reactions to medications and in reporting them in a timely manner. To provide guidelines for the nurse, to implement actions when adverse drug reactions occur, in coordination with the pharmacist and physician.

POLICY

All nursing personnel will be prepared to identify and react to adverse drug reactions. The process for defining, identifying, and reviewing significant adverse reactions will be collaborative in nature, among nursing, pharmacy, and others as appropriate. All adverse drug reactions will be reported both internally and externally to appropriate agencies, as needed.

Patients and families/caregivers will receive instruction regarding medication side effects, signs and symptoms of adverse reactions, and any necessary emergency response measures.

Definition

1. **Adverse Drug Reaction:** An undesirable or unintended event that occurs due to administration of a medication, which results in:
   - Discontinuation of a drug
   - Modification of a dose of medication
   - Supportive treatment or additional treatment with prescription medication
   - A condition which is life-threatening
   - Prolonging or requiring hospitalization
   - A disability
   - Death

The World Health Organization defines an adverse drug reaction as, “Any response to a drug which is noxious and unintended, and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function.”

PROCEDURE

1. Patient and family/caregiver will be verbally instructed regarding identification of potential adverse drug reactions on initiation of therapy. Patient and family/caregiver will be instructed to call the pharmacist and/or nurse immediately if signs and symptoms of adverse drug reactions develop. This instruction will be documented and authenticated in the clinical record..

2. For patient receiving antibiotics (particularly IM or IV, antiarthritic and/or any drugs known to increase one’s risk for anaphylaxis or severe side effects), the physician (or other authorized independent practitioner) may be contacted prior to administration to obtain orders for anaphylaxis protocol.
3. Whenever adverse drug reactions are observed by the clinician and/or reported by the patient, the clinician should advise the patient to hold the next dose until the physician can be consulted.

4. All adverse reactions will be promptly reported to the patient's physician in order to minimize patient's health risks and discomfort.

5. If the patient is at risk for further complications of an emergent nature, the clinician will initiate appropriate emergency measures as per organization policy.

6. If the patient shows signs and symptoms of anaphylaxis, the clinician will follow the anaphylaxis protocol. (See “Anaphylaxis Protocol” Policy No. H:2-068.)

7. All adverse reactions will be reported through the incident reporting process. (See “Incident Reporting” Policy No. C:2-070.) Once reported, they will be reviewed and analyzed for any significant trends, patterns, or unusual occurrences that may impact patient care.

8. If the adverse drug reaction results in serious injury, illness, or death, the Director of Quality will be notified immediately.

   A. The FDA’s Med Watch Reporting Form will be completed by the pharmacist having knowledge of the ADR, and the form will be mailed/faxed to the FDA as appropriate in serious or unexpected adverse drug reactions. The FDA Med Watch Reporting Form can be obtained from the FDA by calling 1-800-FDA-1088 or at the website www.fda.gov.

9. All adverse drug reactions will be reviewed as part of the performance improvement program.

10. As part of the yearly organization evaluation, the adverse drug reporting process will be reviewed for its effectiveness in detecting reactions and the organization’s ability to respond and improve the medication administration process. In addition, the organization will assess the usefulness of the definitions used for adverse drug reactions.
ADDENDUM HH:2-040.A

ADVICE ABOUT VOLUNTARY REPORTING
ADVICE ABOUT VOLUNTARY REPORTING

Report experiences with:
— medications (drugs or biologics)
— medical devices (including in vitro diagnostics)
— special nutritional products (dietary supplements, medical foods, infant formulas)
— other products regulated by FDA

Report SERIOUS adverse events. An event is serious when the patient outcome is:
— death
— life-threatening (real risk of dying)
— hospitalization (initial or prolonged)
— disability (significant, persistent, or permanent)
— congenital anomaly
— required intervention to prevent permanent impairment or damage

Report even if:
— you’re not certain the product caused the event
— you don’t have all the details

Report product problems — quality, performance, or safety concerns such as:
— suspected contamination
— questionable stability
— defective components
— poor packaging or labeling

How to report:
— only fill in the sections that apply to your report
— use section C for all products except medical devices
— attach additional blank pages if needed
— use a separate form for each patient
— report either to FDA or the manufacturer (or both)

Important numbers:
— 800-FDA-0178 to FAX report
— 800-FDA-7737 to report by modem
— 800-FDA-1088 for more information or to report quality problems
— 800-822-7967 for a VAERS form for vaccines

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor’s office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

Confidentiality: The patient’s identity is held in strict confidence by FDA and is protected to the fullest extent of the law. The reporter’s identity may be shared with the manufacturer unless requested otherwise. However, FDA will not disclose the reporter’s identity in response to a request from the public, pursuant to the Freedom of Information Act.
ANAPHYLAXIS PROTOCOL
Policy No. HH:2-041.1

PURPOSE

To provide guidelines for the clinician to follow in the event of anaphylactic reaction.

POLICY

Visiting Nurse & Hospice Care's nurse will implement the anaphylaxis protocol for emergency use in the event of anaphylactic reaction during administration of IV medications. Emergency medications will be given according to a physician's (or other authorized independent practitioner's) order.

Signs and Symptoms of Anaphylaxis

1. Respiratory distress: dyspnea, wheezing, choking, cyanosis
2. Dermatologic changes: urticaria, erythema, angioedema, pruritus
3. Gastrointestinal complaints: nausea, vomiting, abdominal cramps, diarrhea
4. Vascular response: rapidly falling blood pressure, chills, sweating

PROCEDURE

Prior to IV Medication Administration

1. Obtain baseline nursing assessment and vital signs.
2. Review patient's prior response to medication. Specifically inquire about allergies.
3. Instruct patient as to signs and symptoms to report at once.
4. Be prepared to call 911 if necessary.
5. Have anaphylaxis kit within reach.

If symptoms of anaphylaxis occur during IV medication administration:

1. Stop flow of drug.
2. Continue to evaluate signs and symptoms rapidly.
3. Administer medications from an anaphylaxis kit according to physician described directions.
4. Notify physician (or other authorized independent practitioner) and follow orders received.
5. Monitor patient's vital signs. If patient is hypotensive, keep him/her supine and elevate his/her legs.
6. Remain with patient until paramedics arrive.
7. If cardiopulmonary arrest occurs, begin resuscitation unless patient has current DNR order.
PURPOSE

To provide a process for identifying, reporting, and reviewing medication errors.

POLICY

Any medication error will be documented on the VNHC incident report; and reported to the attending physician. This report will be forwarded to the Clinical Director and Clinical Supervisor. The process for defining, identifying, and reviewing significant medication errors will be collaborative among nursing, pharmacy and others, as appropriate. The medication error rate will be monitored and reported per the performance improvement program.

Definition

Medication Error: Any error, which includes, but is not limited to the following:

A. Wrong medication, wrong time, wrong dose, wrong route of administration, extra dose, or omission of ordered drug by the nurse.

B. Patient and family/caregiver does not follow physician (or other authorized independent practitioner) orders or nurse instructions in administering medications—e.g., titrating of IV opiates outside of the physician’s (or other authorized independent practitioner’s) ordered titration parameters.

PROCEDURE

1. If an error is made in medication administration, the personnel making or discovering the error will notify the attending physician.

2. The Clinical Supervisor will be notified of the physician’s, or other authorized independent practitioner’s), comments and correction to orders, if applicable.

3. The patient will be observed for any untoward effects of the medication error and will report such effects to the attending physician.

4. If appropriate, the pharmacist will be notified for any further actions that may be required.

5. For wrong time errors or omissions, the nurse will correct the medication schedule.

6. Events and actions resulting from the error are objectively outlined in the clinical notes and incident report.

7. The error will be noted on the patient’s medication profile.
8. All medication errors will be reviewed as part of the performance improvement program.
PURPOSE

To define the ongoing medication monitoring process for the patient.

POLICY

Ongoing patient medication monitoring will use a collaborative approach between the clinicians, physicians, pharmacists, patients, and families/caregivers.

The results of medication monitoring will be used to improve the patient’s medication regime. The ongoing monitoring will occur in accordance with the established goals of therapy and be used to:

1. Evaluate the continued use of a medication in the current regimen.
2. Evaluate patient adherence to the prescribed medication regimen.

PROCEDURE

1. The clinician will assess the effect of medications on the patient. The assessment will identify potential contraindications, drug interactions, duplicative drug therapy, significant adverse reactions, and noncompliance with drug therapy.

2. The clinical effects of medications will be assessed through direct observation during home visits, review of assessment information, as well as clinical results of diagnostic studies.

3. Review of the information gathered from the above activities will be shared by the clinician with appropriate physicians and pharmacists, as well as during case conferences with other home care team members.

4. The information obtained through patient medication monitoring will be documented in the patient’s clinical record and, if applicable, in the pharmacy record.
INVESTIGATIONAL MEDICATIONS
Policy No. HH:2-044.1

PURPOSE

To define the organization’s policy for use of investigational medications.

POLICY

Experimental drugs will be administered per “Experimental Research and Investigational Studies” (see Policy No. C:1-015.)
HH:2-045 & HH:2-046 Removed and Replaced as C:2-082 & C:2-083

Page Intentionally Left Blank
PURPOSE

To facilitate a patient’s choice regarding the extent to which emergency medical care will be instituted.

POLICY

The organization will follow patient’s Advance Directives completed according to the requirements of the jurisdiction of the state in which the patient resides. (See “Advance Directives” Policy No. C:2-006.)

The organization supports the patient’s right of autonomy to make choices regarding his/her care, and encourage the patient to discuss this issue with his/her significant others. In the event that the patient is without the capacity to make treatment decisions for himself/herself, this decision shall be made by an appropriate surrogate.

A written Do Not Resuscitate (DNR) order signed by the patient’s physician (or other authorized independent practitioner) must be on file in the patient’s clinical record and admission folder in the patient’s home. If there is no DNR order or valid Advance Directives and the patient expires in the presence of a CPR-trained staff person, CPR will be initiated according to the American Heart Association’s Healthcare Provider.

PROCEDURE

1. A DNR/DNI decision will be made by the attending physician in consultation with the patient or other legally responsible person when, in the judgment of the physician, the patient suffers from an incurable medical condition, death is reasonably imminent in all medical probability, and a life threatening condition exists in which resuscitation would not be expected to render substantial improvement in the ultimate outcome.

2. The order will be written only by the attending physician (or other authorized independent practitioner).

3. Upon receipt of a DNR/DNI order, the following documentation will occur in the clinical record:

   A. A summary of the medical situation, including the Case Manager’s discussion with the attending physician and a statement of the therapeutic plan for comfort care.

   B. An account of the discussion with the patient and/or legal representative, preferably by the attending physician, or an explanation as to why a discussion has not occurred.
C. The DNR/DNI order will be clearly identified in the clinical record.

D. A copy of the DNR/DNI order will be kept in the patient's home.

4. DNR/DNI status will be communicated as follows:

   A. The Case Manager will advise the Clinical Supervisor.

   B. The Case Manager will notify other personnel involved in the case within 24 hours and document this notification in the clinical record.

   C. The Case Manager will immediately notify the home health aides' office:

      1. If the patient is new to home health aide service, “Do Not Resuscitate” will be written in the special instruction section of home health aide assignment sheet.

      2. If the patient has ongoing home health aide service, a new home health aide assignment sheet will be created with “Do Not Resuscitate” written in special instruction section.

      3. On the home health aides' weekly schedules, the letters “DNR” will be written next to the names of the patients with Do Not Resuscitate orders.

      4. When home health aides receive revised assignments via telephone, they will be told which patients have DNR status.

5. The order will be recertified every 60 days or upon request of concerned parties.

6. The DNR/DNI order will be re-evaluated under the following conditions:

   A. When there is a significant change in patient condition, it will be the responsibility of the clinician, within the standard of practice, to communicate to the attending physician (or other authorized independent practitioner) any change in the patient's condition that impact the DNR/DNI order.

   B. At the request of the patient or his/her representative.

7. The DNR/DNI orders may be revoked at any time verbally or in writing by:

   A. The competent patient

   B. The incompetent patient's legal representative

   C. The attending physician in consultation with a competent patient or an appropriate surrogate decision maker
8. Organization personnel informed of or provided with a revocation of DNR/DNI by the patient or patient’s representative will immediately record the revocation request in the patient's clinical record, cancel the order, and notify the physician (or other authorized independent practitioner) responsible for the patient's care.

9. If the patient is not capable of making his/her decisions regarding medical care, a decision should be reached after consultation between the physician and one (1) of the following, according to the hierarchy of decision makers:

   A. A court appointed guardian
   B. A proxy designated by a durable power of attorney for health care authorized according to law
   C. A spouse
   D. An adult child
   E. A parent
   F. An adult sibling
   G. A nearest relative

10. All communication between organization personnel and the patient and family/caregiver regarding resuscitation of the patient will be documented in the clinical record.
PURPOSE

To outline the responsibilities of organization personnel in initiating cardiopulmonary resuscitation.

POLICY

All clinical personnel will be CPR certified in accordance with the American Heart Association’s (AHA) guidelines for the Healthcare Provider or Red Cross for the Professional Rescuer upon hire and as directed thereafter by the AHA.

In the event of an arrest, witnessed or not, and in the absence of Advance Directives, 911 (or emergency rescue squad) will be called and BLS initiated and followed per AHA guidelines. (See “Advance Directives” Policy No. C:2-006, and “Do Not Resuscitate/Do Not Intubate Orders” Policy No. HH:2-047.)
WITHDRAWAL OF LIFE-SUSTAINING CARE
Policy No. HH:2-049.1

PURPOSE

To outline the responsibilities of organization personnel in withdrawing life-sustaining care.

POLICY

The decision to withdraw life-sustaining care will be made by the patient and family/caregiver (or his/her legal representative) and the physician in consideration of any Advance Directives. Visiting Nurse & Hospice Care will comply with a written order from the attending physician (or other authorized independent practitioner) to withdraw life-sustaining care.


PROCEDURE

1. Upon admission, the patient receiving life-sustaining care and his/her family/caregiver will be informed of the organization policy regarding the withdrawal of this care.

2. All communication between organization personnel and the patient and family/caregiver or the physician regarding withdrawal of life-sustaining care will be documented in the clinical record.

3. If a decision to withdraw life-sustaining care is made, organization personnel will comply with a written order from the attending physician (or other authorized independent practitioner).
PURPOSE
To provide guidelines for the care of the dying patient.

POLICY
The organization recognizes the importance of each patient's and family/caregiver's unique and individual needs within the home care setting. Care provided for the dying patient will be responsive and respectful, and will be planned, implemented, and monitored in order to:

1. Optimize the patient's comfort and dignity
2. Manage pain and symptoms through interventions that alleviate and/or control pain and assess the patient's level of pain control
3. Identify secondary symptoms, determine their response to treatment, and take actions to limit them
4. Consider the psychosocial, emotional, and spiritual needs of the patient and family/caregiver
5. Implement bereavement care that supports the patient's and family/caregiver's coping mechanisms throughout the grief process

PROCEDURE
1. At the start of care, and on an ongoing basis, organization personnel will assess the dying patient for:
   A. Comfort/pain level and response to pain management plan
   B. Coping mechanisms, strengths of the patient and family/caregiver unit, and participation in the grief process/bereavement
   C. Psychosocial, emotional, and spiritual needs
   D. Presence of secondary symptoms and response to treatment
2. An individualized plan of care will be developed in cooperation with the patient and family/caregiver, physician, and other disciplines (if indicated) which facilitates:
A. Physical/psychological comfort measures

B. Pain management (control or alleviation) according to physician (or other authorized independent practitioner) orders which may include analgesia and noninvasive or nonpharmacological interventions

C. Prevention of secondary symptoms, including but not limited to: nausea, vomiting, diarrhea, stomatitis, alopecia, GI disturbances, blood dyscrasia, etc.

D. Prompt identification of secondary symptoms if they should occur, and physician notification of such

E. Monitoring of the response to treatment of secondary symptoms

F. Support for development of the patient’s/family’s/caregiver’s coping mechanisms, including but not limited to, verbalization of feelings, referral to social services, hospice, etc.

G. Recognition of the patient’s needs related to dignity, self-respect, and personal preferences

H. Support for the grieving process

3. With each patient visit, the nurse will follow the plan of care, assess the need for change, update the plan of care, and document accordingly. Aspects of care that must be reflected in the clinical record, when applicable, include:

A. Pain management—The origin, location, severity (on a scale of 0 – 10: 0 = no pain, 10 = unbearable pain), and alleviating and exacerbating factors for pain/discomfort

B. Preventative and treatment/measures provided for secondary symptoms and/or pain/discomfort, and the response to treatment

C. Psychosocial interventions to facilitate development of coping mechanisms and the grieving process, and the patient’s and family/caregiver’s response

D. Referrals to community resources

4. Case conferences will reflect coordination and communication between various team members relative to the patient’s and family/caregiver’s evolving physical, psychological, emotional, spiritual and bereavement needs (See “Case Conference/ Progress Summary” Policy No. HH:2-014.)
5. Organization personnel will adhere to:

A. The desires made known by patient through the use of an advance medical directive executed according to state regulations and policy (See “Advance Directives” Policy No. C:2-006.)

B. Do Not Resuscitate orders written by the patient’s physician (or other authorized independent practitioner) in accordance with state regulations and policy (See “Do Not Resuscitate/Do Not Intubate Orders” Policy No. HH:2-047.)
TRANSFER/REFERRAL CRITERIA AND PROCESS
Policy No. HH:2-051.1

PURPOSE
To outline the process for transferring or referring a patient to another service provider.

POLICY
When a patient's needs change significantly and he/she requires care that cannot be provided by the organization, a transfer/referral to another service provider will be made.

When the patient’s plan of care changes and this change results in a transfer or referral, the patient, his/her representative, as well as his/her primary physician, will be notified and involved in planning decisions.

Transfer/Referral Criteria
Home health care services for a patient will not be arbitrarily terminated. They may be transferred/referred only for the following reasons, which will be documented in the clinical record:

1. Medical reasons
   A. A determination of the inappropriateness of continuing the services
   B. A change in the patient’s medical or treatment program

PROCEDURE
1. The patient will be given immediate notice and assistance in selecting other health care services appropriate to his/her needs.

2. When a patient is referred to another organization, service, or individual, the patient will be informed of any financial benefit to Visiting Nurse & Hospice Care.

3. The physician (or other authorized independent practitioner) will be notified and an order will be obtained to transfer the patient.

4. The physician (or other authorized independent practitioner) who writes the patient transfer order will verbally confirm the transfer arrangements and give the appropriate information to the receiving health care provider.
5. The clinician or designee will:
   A. Inform the patient and family/caregiver of the physician (or other authorized independent practitioner) transfer order.
   B. Involve the patient and family/caregiver in the transfer.
   C. Serve as a liaison between the patient, the family/caregiver, and the physician relative to the transfer arrangements.
   D. Notify all internal or external providers of care for the patient.

6. All communication with the receiving provider, physician, and patient will be documented in the clinical record.

7. Within 48 hours of transfer, the clinician will complete a transfer summary. (See “Transfer Summary” Policy No. HH:2-052.)

8. Within 72 hours of transfer, the clinical records clerk will send a copy of the transfer summary or clinical record to the receiving provider.

9. A copy of the transfer summary will also be sent to the physician.

10. The clinician will update the comprehensive assessment, including required OASIS data elements, as required by regulation.
PURPOSE

To define the requirements for the documentation of a patient transfer to another organization and/or internally to an affiliated organization.

POLICY

All patients transferred from the organization will have a transfer summary completed and filed in the clinical record.

PROCEDURE

1. Within 48 hours of transfer, the transferring clinician will complete a transfer summary that includes, as appropriate:
   A. The reason for transfer
   B. The physical and psychosocial status at the time of transfer, including specific medical, psychosocial, or other problems requiring interventions or follow-up
   C. Continuing symptom management needs
   D. Medication profile
   E. A summary of the care provided and the progress toward achieving goals
   F. Any instructions and/or referrals provided to the patient
   G. The existence of any Advance Directives known to the organization
   H. Date of face-to-face encounter, if during initial certification
   I. The date of transfer, which is the date of the last visit made

2. Completed transfer summaries will be given to a clinical records clerk who will send a copy to the receiving organization, or a copy of the clinical record, within 72 hours of transfer and will file the original in the clinical record.

3. A copy of the transfer summary will be sent to the physician within 72 hours of transfer.
PURPOSE

To outline the process for discharging a patient from service.

POLICY

When the patient’s plan of care changes and this change results in discharge or reduction of services, the patient or his/her representative, as well as his/her primary physician, will be notified and involved in planning decisions.

A discharge summary will be completed and filed in the clinical record. (See “Discharge Summary” Policy No. HH:2-054.)

Definitions

1. **Termination/Discharge**: Discontinuance of all organization services by the organization.

2. **Reduction of Services**: A change in the patient’s service plan in which one (1) or more existing services are discontinued.

Discharge/Reduction of Services Criteria

1. Services will be terminated when the patient meets one (1) or more of the discharge criteria:
   
   A. A change in the patient’s medical or treatment program that requires a change to a different level of care.
   
   B. A change in the patient’s condition requires care or services other than that provided by the organization.
   
   C. If appropriate, the goals of home care have been attained or are no longer attainable.
   
   D. There is no longer anyone to provide supportive/custodial care.
   
   E. The patient or family/caregiver refuses or discontinues care.
   
   F. The patient or family/caregiver refuses to cooperate in attaining the objectives of home care.
   
   G. Conditions in the home are no longer safe for the patient or organization personnel.
   
   H. Family/caregiver has been prepared and is capable of assuming responsibility for care.
I. The patient moves from the geographic area served by the organization.

J. The patient's physician (or other authorized independent practitioner) has failed to renew orders, or the patient has changed physicians and orders cannot be obtained from the new physician to support patient's needs.

K. The physician gives orders that are not consistent with the stated diagnosis as required by law and fails to give the needed orders when requested by the organization.

L. If the physician face-to-face encounter was not completed prior to the initial certification, the patient or family/caregiver refuses to obtain a physician face-to-face visit within 30 days of start of care.

M. The organization is closing out a particular service or all of its services.

N. The patient expires.

PROCEDURE

1. The organization will verbally notify the patient of the decision to terminate or reduce services within one (1) visit prior to the time the change in service is to occur (i.e., prior to the last scheduled visit).

2. Prior notice will not be necessary when services are discontinued by the patient or physician; however, action taken must be documented in the clinical record and a discharge summary completed. A copy of the discharge instructions will be mailed to the patient.

3. An update to the comprehensive assessment, including required OASIS data elements, will be completed, as required by regulation.

4. For a patient requiring continuing care, assistance will be given to the patient and family/caregiver in order to manage continuing care needs after the organization services are discontinued. Discharge instructions will be provided.
A. Discharge planning will identify needs the patient may have.

B. Arrangements for such services will be coordinated by the organization when applicable.

5. The decision to terminate or reduce services must be documented in the clinical record citing the circumstances and notification to the patient, the responsible family/caregiver or representative, and the patient's physician. The Clinical Supervisor or designee is accountable for the decision and the required documentation.

6. Each clinician making the final visit for his/her discipline will complete the sections of the discharge notice for discontinuing a discipline. (See “Discharge Summary” Policy No. HH:2-054.)

7. If more than one (1) discipline is providing care, the discipline being discontinued will be specified on the interim order.

8. A discharge summary will be completed for all discharged patients. A copy may be mailed to the primary physician. (See “Discharge Summary” Policy No. HH:2-054.)

9. The clinician will update the comprehensive assessment, including required OASIS data elements, as required by regulation.

10. All discharge paperwork will be due in the office within 72 hours of the discharge date. This will include the discharge order, discharge summary, plan of care, medication profile, and OASIS.

11. The discharge record will be organized according to the organization policy regarding clinical record contents. Documentation will be reviewed by the Clinical Supervisor or designee and completed within 30 days of the discharge, at which time it will be removed from the active files.
PURPOSE

To define the requirements for documentation of discontinuation of a service and when patients are discharged from the organization.

POLICY

Each patient discharged from a service and from the organization will have a written discharge summary completed.

PROCEDURE

1. Each clinician who provides care will complete a discharge summary at the time his/her discipline is discharged, which may include as appropriate:
   A. The date of discharge, the date the physician and patient informed of discharge
   B. The reason for discharge
   C. The name of the organization to which the patient is being transferred, if applicable
   D. The status of problems identified at admission and during the provision of care
   E. The progress towards goals/desired outcomes
   F. Medical status at discharge including continuing symptom management needs
   G. The overall status of the patient
   H. A summary of the care or services provided

2. The discharge summary and other relevant clinical record documents will be completed and submitted within 72 hours of discharge from service.

3. A copy of the discharge summary will be provided to the patient’s physician.

4. The organization will complete all necessary audits to determine the completeness of the patient’s clinical record within 30 days of the last home visit and discharge date. The discharge record will be organized according to policy for clinical records contents and removed from the active files.
PURPOSE

To outline the requirement and components of a clinical record.

POLICY

A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient’s problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel.

(See “Clinical Data Collection” Policy No. C:2-026.)

PROCEDURE

1. The following information will be available in the clinical record for patients receiving skilled care:
   
   A. Patient’s name, clinical record number, sex, address, phone number, date of birth, and his/her legally authorized representative
   
   B. Name and telephone number of family/caregiver and patient representative to be contacted in the event of an emergency/death
   
   C. Reason for service
   
   D. Referral source
   
   E. Primary and secondary diagnoses and prognosis
   
   F. Patient database including physical, psychosocial, and environmental data, and family profile
   
   G. Legal representative, when applicable
   
   H. Legible, complete, and individualized diagnostic and therapeutic orders authenticated within the time frame defined by the organization or according to law and regulation
      (See “Verification of Physician Orders” Policy No. HH:2-006)
   
   I. Relevant diet or dietary restrictions, if any
J. Allergies or sensitivities
K. Suitability or adaptability of the home to planned services
L. Safety measures to protect the patient from injury or harm
M. Functional limitations related to care and services provided
N. Signed and dated progress notes for each discipline
O. Record and findings of initial and ongoing assessments
P. Procedures and/or treatments rendered
Q. Every dose of medication administered by organization personnel and any adverse drug reaction
R. Identity of other individuals and organizations known to be involved in patient care
S. Description of patient’s activity restrictions related to care and service
T. Care planning activity based on the patient’s problems, needs, and expected outcomes
U. Educational needs of patient and family/caregiver
V. Patient and family/caregiver education provided
W. Name, address and telephone number of patient’s physician
X. Relevant communication to the patient’s physician
Y. Transfer/discharge summaries and other summary reports (60-day) sent to the physician, as required by law and regulation and organization policy
Z. Advance Directive information and documentation as required by organization policy
AA. Consents for care as required by law and regulation and organization policy
BB. Documentation of the assessment data collected, actions and interventions performed, and patient response to care provided
CC. Current medication profile including prescription and nonprescription medications, herbal products and home remedies, including dose, frequency, and route of administration, with ongoing updates to the patient’s medication regimen, including new, changed and discontinued medications; adverse reactions, significant side effects, drug allergies, and contraindications
DD. Potential drug/food interactions

EE. Relevant diagnostic and therapeutic procedures, treatments, and tests and their results

FF. Documentation of communication to the organization receiving the patient when a patient is transferred

GG. Medical equipment provided by the organization or related to care and service provided
PURPOSE

To establish a consistent, organized structure for the clinical record.

POLICY

All clinical records will be assembled and maintained according to organization policy and applicable state and federal law. The structure will be defined and approved by the management team. Any changes must be approved by that team.

PROCEDURE

1. The contents of the record will be assembled as follows:

   (If utilizing electronic medical records, the following information would need to be retrievable.)

   **Section I: Patient Data**
   
   A. Referral and Intake Forms
   B. Insurance Verification Forms
   C. Family/Caregiver Resource Data Form
   D. Transfer Forms from other organization
   E. Consent for Treatment
   F. Discharge/Transfer Forms (upon discharge)

   **Section II: Physician Orders**
   
   A. Plan of care/Treatment
   B. Verbal Orders
   C. Pharmaceutical Orders
Section III: Clinical Notes

A. Case Conference Forms
B. Communication Notes
C. 486 (if requested)

Section IV: Plan of Care

A. Nursing Care Plan
B. Medication Profile
C. Home Health Aide Assignment

Section V: Nurses Clinical Notes

A. Initial Assessment, Comprehensive Assessment, and Ongoing Assessments
B. Clinical Notes

Section VI: Home Health Aide Notes

A. Home Health Aide Clinical Notes
B. Supervisory Clinical Notes

Section VII: Social Service Notes

A. Initial Assessment and Ongoing Assessments
B. Social Service Notes

Section VIII: Therapy/Rehabilitation Notes

A. Initial Assessment Evaluation and Ongoing Assessments
B. PT, OT, ST, and Nutrition Notes
Section IX: Lab and Special Reports

A. Lab Results

Section X: Advance Directives

A. Living Will

B. Durable Power of Attorney for Health Care

C. DNR/DNI

Section XI: Miscellaneous

A. Communication with insurers, other clinicians, etc.

B. HME and Supply documentation

2. Documentation will be assembled in chronological order, most recent first.

3. Documentation will include that which is provided directly by the organization and by contracted personnel.

4. All personnel, including contracted personnel, will only use organization-approved forms.
PURPOSE

To define the process for periodic and ongoing review of the patient’s clinical record.

POLICY

Clinical records will be reviewed at least quarterly by qualified organization personnel to assure that documentation entered is reliable, timely, valid, and accurate.

PROCEDURE

Ongoing Review

1. Each clinical record will be reviewed on an ongoing basis by the Clinical Supervisor, Performance Improvement Coordinator, Clinical Director, or designees for:
   A. The timeliness of entries into the clinical record
   B. Compliance with organizational policy
   C. Compliance with the established plan of care
   D. The completeness of clinical records
   E. The accuracy of clinical records
   F. The appropriateness of services rendered
   G. The need for continued care

2. As a result of this review, action will be taken as necessary to improve care. The Clinical Supervisor, Performance Improvement Coordinator, Clinical Director, or designees will identify issues with documentation and, based on the review, if the issue:
   A. Is applicable to an individual, the individual will be counseled
   B. Is applicable to the organization as a whole, will refer the issue to the management team for review
**Quarterly Review**

1. The clinical record review will consist of a process based on the following guidelines:

   A. The review will consist of a random sample selection of both active and inactive cases.
      
      1. The sample will represent 10% of each program’s annual unduplicated admissions with a maximum of 120 sample records per year.
      
      2. Of the 10% sample, 5% will be active patient clinical records and 5% will be discharged patients.
      
      3. The sample will be proportionate to the area census.
   
   B. The review will encompass a representation of all professional disciplines defined in the scope of services.
   
   C. Each professional discipline will participate in review of clinical records for their service.
   
   D. No person involved in the care of a patient may participate in the review of that patient’s record.
   
   E. All records reviewed will be secured for confidentiality.
   
   F. All records will be reviewed in the designated area.
   
   G. All records will be reviewed using a clinical record review tool to:
      
      1. Determine the adequacy of the plan of care and to determine if further service is necessary and appropriate
      
      2. Determine that data is reliable, valid, and accurate

2. The Performance Improvement Coordinator will incorporate the review and analysis of Outcome Based Quality Indicators (OBQI) reports as part of the organization’s quarterly clinical record review. The OBQI record review and analysis will focus on case mix and adverse events report data. The record review will include:

   A. Adverse events with the most clinical relevance to the organization based on the case mix report
   
   B. Adverse events with the highest incidence as compared to the reference group

3. Record review findings will be documented and the data collated and analyzed.
4. Results will be utilized for improvements in patient care and incorporated into performance improvement plans and activities.

5. A summary of the results and corresponding analysis will be presented to the following:
   
   A. Performance Improvement Committee
   
   B. Professional Advisory Committee
PURPOSE

To ensure access to external information to assist organization personnel in performing their functions, and for comparative purposes.

POLICY

The organization and its personnel may access external databases and bodies of expert knowledge, when available, in the performance of their functions. These functions include the evaluation of organization performance and the identification of deviations from expected trends.

External databases, when available, will be used for comparative analysis for improving organizational performance.

The organization will contribute to external databases when required by law or regulation and accrediting bodies as appropriate to the organization’s mission and scope of service. The organization will maintain confidentiality and security of information when contributing or using an external database for comparative purposes.

Benchmarking software products will provide quarterly reports of selected benchmarks.
PURPOSE

To outline the OASIS data transmission requirements.

POLICY

The organization will adhere to all OASIS data transmission requirements as outlined in the Medicare Conditions of Participation, Reporting of OASIS Information 42 CFR 484.20.

PROCEDURE

1. The organization will encode and transmit completed OASIS data for each applicable patient within thirty (30) days of completing the appropriate OASIS data set.

   A. OASIS data is collected and completed by the qualified clinician as part of the comprehensive assessment at the required time points (i.e. start of care, resumption of care, follow-up, transfer to inpatient facility with or without discharge, discharge to community, and death at home.)

   B. The organization may take up to thirty calendar days after the date of completion of the comprehensive assessment to enter the OASIS data into their computers using HAVEN or HAVEN-like software that conforms to all CMS data transmission specifications available on the OASIS website.

   C. All OASIS data items must be complete, i.e. locked, in order to accurately compute the information necessary for billing Medicare patients under the prospective payment system.

2. The encoded OASIS data must accurately reflect the patient’s status at the time of assessment.

   A. The organization will conduct clinical and data entry audits to verify that collected OASIS data are consistent with reported OASIS data.

   B. The final validation reports will be reviewed for accuracy purposes.

   C. Discrepancies identified will be corrected following organization approved processes.
3. The organization must electronically transmit accurate, complete and encoded OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly.

   A. The computer system supports a direct telephone connection for the transmission of OASIS data to the State agency or CMS OASIS contractor, transmits the export files, and receives validation information.

   B. If the organization utilizes a contracted vendor, the vendor must provide the organization with either an electronic copy or summary of the validation information.

4. A tracking mechanism will be utilized by the organization to ensure accuracy and timeliness of OASIS data and transmission.

**Note:** Current OASIS Reporting Regulation published 12/23/2005 at www.cms.hhs.gov/OASIS/03_Regulations.asp
SECTION THREE
Human, Financial, and Physical Resources

Policy No.

Home Health Human Resources ................................................................. HH:3-001
Home Health Staffing Guidelines ................................................................. HH:3-002
Responsibilities/Supervision of Clinical Services ........................................ HH:3-003
Supervision ................................................................................................... HH:3-004
Access to Qualified Consultation ................................................................. HH:3-005
Consultation for Specialty Services ............................................................... HH:3-006
Communication With Office ........................................................................ HH:3-007
Home Health Contracted Services ................................................................ HH:3-008
Addendum: Home Health Contracted Services Review ................................ HH:3-008.A
Contracted Service Providers ........................................................................ HH:3-009
Training/Inservice Education ....................................................................... HH:3-010
Competency Assessment .............................................................................. HH:3-011
Home Health Aide Training .......................................................................... HH:3-012
Home Health Aide Supervisory Visits ........................................................... HH:3-013
Physician Licensure Verification .................................................................. HH:3-014
Home Health Capital Expenditure Plan ......................................................... HH:3-015

Note:
Job Descriptions can be found in Section 6 of this manual.
Clinical Competency Assessment Skills Checklists can be found as Appendices at the end of Section 6 of this manual.

*Requires state or organization-specific information.
HOME HEALTH HUMAN RESOURCES
Policy No. HH:3-001.1

PURPOSE
To ensure that the home health program maintains adequate human resources to meet caseload demands.

POLICY
The home health program will recruit and retain qualified personnel. Documentation of these efforts will be evidenced in the home health personnel and health record for each employee hired by the organization.

Staff will be selected based on education, experience, specialized training, communication, and interpersonal skills in accordance with job description requirements.

PROCEDURE
1. Professional staff recruited and hired by Visiting Nurse & Hospice Care will be graduates of schools approved or accredited by their respective professional organizations.

2. Pre-employment interviews will be conducted to determine the individual’s qualification for the position.

3. Prior to hire, the organization will secure multiple reference checks, health reports as required by the state or policy, criminal record checks when required by law, and proof of citizenship or documentation of resident status.

4. Professional personnel will submit copies of their diplomas or transcripts showing successful completion of the approved/accredited program. These copies will be retained in the individual’s personnel file.

5. Clinical personnel will maintain active licensure or certification. Verification of current licensure or certification will be filed in the personnel record.
HOME HEALTH STAFFING GUIDELINES
Policy No. HH:3-002.1

PURPOSE
To ensure that staffing guidelines adequately meet workload demands.

POLICY
Staffing guidelines will be developed and reviewed on an ongoing basis.

PROCEDURE
1. Staffing assignments will be determined and documented by the Clinical Supervisor or designee.
2. Visit schedules will be written and available to Case Managers.
3. Supervisors and staff will comply with the current organizational staffing guidelines.
PURPOSE

To define the process for supervision of clinical services provided by Visiting Nurse & Hospice Care.

POLICY

Nursing and home health aide services will be under the supervision of a registered nurse who has at least two (2) years of home or community based health care experience.

Supervision of clinical care and services will be available 24 hours a day, seven (7) days a week.

Supervisor-to-patient care personnel ratios will depend on the acuity level of the patients and case mix, and be in compliance with applicable law or regulation.

The Clinical Director will be responsible for the clinical direction of the organization and take reasonable steps to assure that:

1. Services are available.

2. Care and services provided by organization personnel and contracted organization personnel are coordinated and integrated.

3. Policies and procedures, which guide and support the provision of care and services, are developed and implemented.

4. Recommendations for required resources are made.

The Clinical Director will be qualified and possess appropriate clinical training and experience, as verified by:

1. Education, training, and previous work experience

2. Current professional licensure

3. Interview for understanding of care and service being provided as well as population being served

4. Management experience and clinical knowledge
PROCEDURE

1. The Clinical Director will oversee the day-to-day clinical operations.

2. On a daily basis, staffing will be reviewed in combination with the patient census, acuity, etc.
   
   A. If staffing is problematic, the Clinical Director, in coordination with the Clinical Supervisors, will review options, which include, but will not be limited to:
      
      1. Use of outside, contracted organization personnel
      2. Use of overtime by organization personnel
      3. Use of office nursing personnel (i.e., Clinical Supervisor, intake, QA/I nurses, etc.)
   
   B. Any issue not resolved will be brought to the attention of the Executive Director/Administrator

3. The Clinical Director will monitor the care and service provided by organization personnel and contract personnel. Monitoring includes the review of performance improvement results, incident reports, infection reports, clinical record review results, etc. Any noted trends of individual performance will be used during the evaluation process.

4. The Clinical Director participates as a member of the following:
   
   A. Senior Management Team
   B. Professional Advisory Committee
   C. Clinical Operations Committee
   D. Performance Improvement Committee

5. Recommendations regarding resources (personnel and other) and services will be made to the Executive Director/Administrator as well as at the appropriate committee.

6. The Clinical Director will have access to qualified clinical consultation for services outside his/her expertise, through the use of the Medical Director and other resources as appropriate.

7. The Clinical Director will assure that the following supervision is maintained within the organization:
A. Home health aides, personal care and environmental support/chore service workers:
   1. Home health aide supervisory visits will be conducted on-site at least every two (2) weeks by skilled personnel. Supervisory visits can be made in conjunction with the home health aide or in his/her absence. A direct observation supervisory visit will be made at least every six (6) months.
   2. Patients receiving personal care services will be contacted monthly, and a direct observation supervisory visit will be completed on site every 60 days.
   3. Patients receiving environmental support/chore services will be contacted every 60 days, and a direct observation supervisory visit will be completed on site every six (6) months.

B. Licensed practical/vocational nurses will be supervised by a registered nurse per state regulations or at least monthly.

C. Physical therapy assistants and certified occupational therapy assistants:
   1. Physical therapy assistants will be supervised by a physical therapist, and certified occupational therapy assistants will be supervised by an occupational therapist at least every month unless state regulations require more frequent supervision. At the discretion of the physical/occupational therapist, supervisory visits may be made in conjunction with the therapy assistant. A direct observation supervisory visit will be made at least every six (6) months or as directed by the state practice act, whichever is more frequent.

D. Supervisory visits will be made more often if indicated by patient’s and/or organization personnel's need.

E. Supervisory visits will be documented, dated, and signed by the supervising professional.

F. Clinical personnel that report to a supervisor of a different discipline will have the opportunity for consultation and review with a professional manager in their discipline to ensure adherence to and accountability for professional standards of clinical practice.
PURPOSE
To ensure that qualified personnel direct patient care.

POLICY
All skilled nursing and other therapeutic services will be provided under the supervision or direction of a qualified Clinical Supervisor or designee.

PROCEDURE
1. A registered nurse is available on the premises or by telephone/electronic paging 24 hours a day.
2. The Clinical Supervisor or designee will be available for consultation 24 hours a day via an electronic paging system. The process for contacting the designated Clinical Supervisor will be reviewed during personnel orientation.
3. A registered nurse (or therapist, when appropriate) will be available whenever home health aide services are provided. Home health aide services will be supervised every fourteen (14) days.
4. All clinicians will be observed in the home by a Clinical Supervisor at least once per year.
5. A summary of the field supervisory visits will be documented utilizing an observation tool. The results will be shared with the clinician. A copy will be retained in the personnel file.
6. If services are contracted from another organization, that organization will be expected to comply with Visiting Nurse & Hospice Care personnel supervision policies.
7. Supervision of patients who are not patients of the organization and whose services are provided through a contract with another organization will be in accordance with the contracting organization's plan of care and contract.
8. When a Clinical Supervisor does not have experience related to the clinical specialty area, he/she will consult with the Clinical Director, Executive Director/Administrator, or an appropriate supervisory consultant. (See “Access to Qualified Consultation” Policy No. HH:3-005.)
PURPOSE

To provide guidelines for accessing qualified consultation.

POLICY

The organization will maintain a system for accessing consultation with a qualified individual whenever a Clinical Supervisor does not have the appropriate clinical training and/or experience for a clinical specialty area.

PROCEDURE

1. Whenever a Clinical Supervisor is confronted with a patient situation out of his/her area of expertise, the Clinical Supervisor may:
   a. Contact the Medical Director
   b. Contact organization personnel who have the clinical experience/expertise
   c. Contact another organization whose Clinical Supervisors have the clinical experience/expertise
   d. Contact specialists in the clinical specialty area (e.g., pharmacy, respiratory therapy, psychiatry, oncology) at an affiliated hospital
   e. Contact specialists in the clinical specialty area at a local area medical center and/or medical school
   f. Contact any appropriate trade organization specializing in the clinical area

2. Documentation of the contact, including name of individual, discussions, recommendations, and actions taken will be filed in the Clinical Supervisor's office.
CONSULTATION FOR SPECIALTY SERVICES
Policy No. HH:3-006.1

PURPOSE

To ensure for the provision of a qualified consultant when a question related to a clinical specialty area arises.

POLICY

Individuals possessing appropriate clinical training, experience, and evaluation in a clinical specialty area (e.g., pharmacy, psychiatry, or oncology), in identified clinical settings (i.e., university medical centers, teaching institutions, hospitals, etc.), will be consulted when a question concerning clinical specialty and/or practice arises.

PROCEDURE

1. The clinician will notify the Clinical Supervisor of the need for clinical consultation.

2. The clinician will contact the clinical consultant and coordinate a consultation.

3. The clinician will obtain orders as appropriate from the patient’s physician (or other authorized independent practitioner).

4. The clinician will document appropriate instructions in the clinical record.
COMMUNICATION WITH OFFICE
Policy No. HH:3-007.1

PURPOSE

To define the organization’s expectation for communication between clinicians and the office.

POLICY

Clinicians will contact the office daily to confirm their schedules and caseload, and to receive reports on patients.

PROCEDURE

1. Clinicians will obtain their daily schedules through Allscripts in order to:
   A. Confirm their schedule for the day
   B. Receive any necessary reports on patient to be visited
   C. Confirm caseload with Clinical Supervisor or designee

2. Clinicians will communicate, through Allscripts, with the office to verify that all planned visits for the day were made, report availability for visits the next day, and receive reports on admission or changes for the next day's schedule.

3. Clinicians cannot alter the schedule for assignment of cases without the prior approval of Clinical Supervisor or designee. The clinician must alert the Clinical Supervisor of any requests.

4. If an emergency arises or if any organization staff member is ill and it is impossible to fulfill his/her obligations, it is mandatory that the staff member contact the organization as soon as possible to report the absence. It is essential that all organization personnel contact the office as soon as the workday begins if advance notice could not be given.
HOME HEALTH CONTRACTED SERVICES
Policy No. HH:3-008.1

PURPOSE
To specify the contents of a Medicare Certified Home Health written agreement by defining the nature and scope of services provided by clinicians and others not directly employed by the organization.

POLICY
Senior management will be responsible for the availability of care and services to meet the needs of the patients served. When the organization provides care and services through another source, the patients will be entitled to the same level of performance from that source as from the organization itself. These contracted services will be defined by a written agreement, before individuals from that source will be permitted to provide services on behalf of the organization.

PROCEDURE
1. The written agreement between the organization and the contract service/individual will define the nature and scope of services.

2. The following Medicare COP requirements for written agreements will be included in all home health contracts in addition to those requirements as listed in “Annual Organization Evaluation” (see Policy C:4-007):
   A. Patients will be accepted for care only by Visiting Nurse & Hospice Care.
   B. Primary organization maintains control of, supervises, coordinates, and evaluates care provided. Methods to ensure Primary organization control are described within the contract.
   C. Procedures for scheduling visits and periodic patient evaluation.
   D. Mechanism to ensure that contracted clinicians possess current professional licensure and/or certification, as applicable.
   E. Mechanism for orienting contracted personnel to the primary organization’s policies, procedures and processes.
   F. Mechanism for contracting parties to participate in the patient development of patient’s plan of care.
G. Timeframes for placement of contracted staff and contingency staffing plans.

H. Confidentiality of all protected health information.

3. When home health aide services are provided under contract, Visiting Nurse & Hospice Care retains the following responsibilities:

A. To ensure the quality of care provided by the home health aide.

B. Perform home health aide supervision as per regulation.

C. To ensure that the home health aides have successfully completed mandated training and competency requirements.

4. The above elements of the written agreements will be used for all contracted services. Any deviation from the approved format must be approved by the Executive Director/Administrator.

5. The organization’s annual evaluation process as defined in “Annual Organization Evaluation” (see Policy C:4-007) will additionally, monitor, evaluate, and audit the contracted services to ensure compliance with the Medicare Condition of Participation.
ADDENDUM 3-008.A

HOME HEALTH CONTRACTED SERVICES REVIEW
HOME HEALTH CONTRACTED SERVICES REVIEW

The following components must be included in all home health contracts.

<table>
<thead>
<tr>
<th>Contract Requirements</th>
<th>CHAP Standard</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Specific services or products to be provided by the contracted organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Contractor adheres to organization’s policies and procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Education, training, and qualifications required of contracted employees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Mechanism for contractor to participate in Performance Improvement activities, as applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Procedures for documenting and submitting notes that verify provision of contracted services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Procedures for submission of invoices and methods for reimbursement for contracted services provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Effective date of the contract</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Terms for renewal and/or termination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Patients are accepted for care only by Visiting Nurse &amp; Hospice Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Methods for Visiting Nurse &amp; Hospice Care to control, coordinate and evaluate contracted services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Procedures for scheduling visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Procedures for periodic evaluation of patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Mechanism to ensure contracted personnel maintain current licensure and/or certification, as applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Responsibility for development of the patient’s plan of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Timeframes for placement of contracted staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Contingency staffing plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Maintenance of confidentiality for protected health information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Contract signed and dated by authorized principles of each party</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of contract completed by: ________________________________

Date: ________________________________
PURPOSE

To ensure that contracted services are provided by trained and qualified professionals and paraprofessionals.

POLICY

Visiting Nurse & Hospice Care will verify and document the training and qualifications for professional and paraprofessionals who provide services to the organization’s patients via contractual agreement. (See “Written Agreements for Contracted Services” Policy No. C:3-027.)

PROCEDURE

1. Documentation of training and professional qualifications may be maintained by Visiting Nurse & Hospice Care or by the contracted organization. If maintained by the contracted organization, verification by Visiting Nurse & Hospice Care will occur at least annually.

2. Documentation will be maintained for at least the following items:
   
   A. Successful completion of an approved training course
   B. Demonstration of skills competency
   C. Completion of organization’s orientation
   D. Current personnel records containing the documentation required by Visiting Nurse & Hospice Care
PURPOSE

To delineate organization policies for inservice education programs designed to increase competence in a specific area and improve overall organization performance of major functions and processes.

POLICY

1. Visiting Nurse & Hospice Care will provide training and education to give personnel opportunities to learn new skills and improve/expand existing knowledge. Training topics may include information regarding the organization’s professional standards of care/practice, performance improvement monitoring results, updates in patient care techniques/resources, and safety/infection control requirements.

2. Mandatory inservices will be attended by all disciplines.

3. Attendance at education programs will be required relative to job classification.

4. Professional personnel will receive at least the number of continuing education units to maintain their licenses.

5. Paraprofessional personnel will receive education as follows:
   A. Aides (CNAs/HHAs) must receive at least 12 hours of inservice training per calendar year. This may be provided while the aide is furnishing care to patients.

PROCEDURE

1. The written plan for annual inservices will include, but not be limited to:
   A. Safety
   B. Infection control
   C. Psychosocial considerations
D. Skills updates
E. Issues related to patient populations served
F. Ethical issues
G. Medical Device Act

2. Personnel will receive notification of organization-sponsored programs at least one (1) week in advance.

3. A record will be maintained for each session, including:
   A. Program objectives
   B. Content outline
   C. Speaker (and his/her qualifications)
   D. List of attendees

4. An inservice log will be kept to track the number of inservice hours the aides (CNAs/HHAs) have obtained on a cumulative basis.

5. During the ongoing supervision and competency reviews, the supervisors will evaluate if the training and education has improved the competence of the organization personnel.
COMPETENCY ASSESSMENT
Policy No. HH:3-011.1

PURPOSE
To outline the process of assessing professional and paraprofessional competence.

POLICY
The competence of all organization clinical personnel (employed, contract, or volunteer) will be assessed during orientation, during the probationary period, periodically throughout the course of the year and during the annual performance evaluation. Educational activities will be based, in part, on the outcomes of the competency evaluation.

Competency of supervisors and/or management staff will be assessed by the individual’s immediate supervisor and may include peer review as a component of the process.

PROCEDURE

Orientation and Probationary Period

1. As part of the orientation process, a preceptor/Clinical Supervisor will be assigned to each new person.

2. Using a Competency Skills Performance Checklist, and the Orientation Checklist, the preceptor/Clinical Supervisor will observe the new personnel performing the required skills and activities.

3. Upon completion of the checklists, the new personnel will end orientation and probationary period.

Ongoing Assessments

1. Competency assessments will be completed at least one (1) time per year. Additional competencies may be required for performance issues, new technology, or other appropriate indications.

2. Using a Competency Skills Performance Checklist developed specifically for each clinical job category, the Clinical Supervisor will evaluate the competence in performing and rendering care according to organization policies and standards of practice.

3. Clinical personnel will make a joint visit with a Clinical Supervisor annually for direct observation assessment.
4. Based on the identified clinical needs during reviews, the inservice education plan will incorporate training on issues where trends and patterns are identified for all personnel.

5. Isolated episodes relating to individual performance will be addressed on an individual basis. Actions may include one-on-one counseling and/or mentoring, reviewing resource information, inservice training or continuing education.

**Annual Performance Evaluation**

1. During the annual performance evaluation, personnel's competence in performing specified activities will be evaluated.

2. Personnel will be asked to demonstrate their core competencies in specific areas relating to their job description and functions (i.e., home health aides demonstrate skills for ADLs, bathing, toileting, etc.; nurses performing Infusion Therapy demonstrate skills for venipuncture, accessing ports; medical word processors demonstrate skill for word processing.)

3. Improving skills for competency will be part of the annual performance evaluation and performance plans for the next year, as well as establishing individual goals for personal/professional growth and development.
Intentionally Left Blank
PURPOSE

To establish guidelines for the responsibilities and the frequency of supervisory visits for home health aide personnel.

POLICY

Nursing personnel or therapists, as appropriate, must be available to the home health aide for consultation at all times during the aide’s working hours. The registered nurse or therapist must conduct supervisory visits to the patient’s residence at regular intervals.

PROCEDURE

1. The frequency of supervisory visits will be based upon the needs of the patient after the plan of care is established. They must be conducted at least every two (2) weeks.

2. The overall performance of the home health aide will be evaluated at least annually for competency.

3. The registered nurse and/or appropriate therapist will be responsible for:
   A. Supervision of all services provided for in the plan of care
   B. Specific training in personal care skills and other procedures related to the care of the patient
   C. Regular consultations (i.e., case conferences) with the home health aide
   D. Documentation of all pertinent clinical notes, which may include observations made by the aide
   E. Annual skill competency evaluations and supervisory reports

4. Supervisory visits and overall supervision will be documented in the clinical record.
   A. Supervisory visits will be documented in the clinical record.
   B. Ongoing supervision will be documented within the plan of care, home health aide assignment sheet, and clinical notes.
PURPOSE

To ensure that all physicians or licensed independent practitioners are properly licensed to practice medicine in the organization's service areas.

POLICY

Orders will only be received from physicians licensed to provide care in the state(s) served by the organization.

PROCEDURE

1. The organization will verify that all referring physicians or licensed independent practitioners are licensed to practice in the state(s).

2. The physician (or other authorized independent practitioner) license must be verified when the individual provides orders to the organization for the first time and annually thereafter.

3. Physician or licensed independent practitioner licensure will be verified by:
   A. Ascertaining that the individual is a practitioner “in good standing” with the appropriate State Board of Licensure
   B. Contacting the local Medical Society or State Board of Licensure
   C. Accessing Medical Society or State Board of Licensure information on the Internet
   D. Receiving updated notice from the Board of Licensure listing probationed, suspended, or revoked licenses

4. The organization will maintain documentation that verification was done.

5. Verification will be reviewed at least annually or upon expiration of license.
PURPOSE

To ensure compliance with Medicare Condition’s of Participation in regards to Capital Expenditure planning.

POLICY

On an annual basis, senior management, including at least the Executive Director/Administrator, CFO, and program directors, will develop a three (3) year Capital Expenditure plan which includes the current year.

The overall Capital Expenditure plan and annual operating budget is reviewed and revised annually as directed by the Governing Body. (See “Annual Operating Budget” Policy No. C:3-029.)
SECTION FOUR
Long Term Viability

Home Health Annual Evaluation ................................................................. HH:4-001
Home Health Innovation ............................................................................. HH:4-002

*Requires state or organization-specific information.
PURPOSE

To insure the home health annual evaluation methodology is compliant with the Medicare Conditions of Participation.

POLICY

The home health organization will conduct an annual evaluation as described in “Annual Organization Evaluation” (see Policy No. C:4-007.)

Minutes of the Professional Advisory Committee will reflect that a review of services, programs, and policies was completed.
HOME HEALTH INNOVATION
Policy No. HH:4-002.1

PURPOSE

To ensure that the corporate philosophy for innovation is incorporated throughout the home health services.

POLICY

In addition to the corporate focus on innovation, home health management personnel will ensure that:

1. The program identifies and reaches market segments or populations in need of its services using innovative approaches to meet community needs.

2. There is a continuous evaluation and update of services delivered based on community needs and changes in the industry.

3. Specialty programs will be developed, maintained, or changed to increase market share.

4. Personnel will be updated on the newest technology or products to ensure up-to-date service delivery.

5. Community education and awareness of home health services will be promoted by all personnel.
SECTION FIVE

Patient and Family/Caregiver Education

Policy No.

Patient Education Process ................................................................. HH:5-001
Safe/Effective Use of Medications ..................................................... HH:5-002
Drug–Food Interactions ..................................................................... HH:5-003
Pain Management Education .............................................................. HH:5-004
Rehabilitation Techniques ................................................................. HH:5-005
Appropriate Use of Restraints and Supplies ........................................ HH:5-006
Safe/Effective Use of Equipment and Supplies ..................................... HH:5-007
Storage, Handling, and Access to Supplies and Gases ....................... HH:5-008
Identification, Handling, and Disposal of Hazardous Waste .............. HH:5-009
Infection Control Precautions ............................................................ HH:5-010
Natural Disasters/Emergencies ......................................................... HH:5-011

Addendum: Guidelines for Emergency Management* ......................... HH:5-011.A

Basic Home Safety ............................................................................... HH:5-012

Addendum: Fall Reduction Program* .................................................. HH:5-012.A

Patient Education Related to Discharge Planning .............................. HH:5-013
Educational Resources ........................................................................ HH:5-014
Community Resources ........................................................................ HH:5-015

*Requires state or organization-specific information.
PURPOSE

To provide guidelines for the provision of health information and instruction to patients and family/caregivers.

POLICY

Patients and family/caregivers will receive education in verbal, visual, and written format, as appropriate. The scope of teaching will be determined by assessing the needs, abilities, learning preferences, and readiness to learn of the patient and family/caregiver, as well as by the plan of care. Education will be the responsibility of each clinician and will focus on:

1. Facilitating the patient’s and family/caregiver’s understanding of his/her health status, health care options, and consequences of options
2. Encouraging patient participation in decision-making about health care options
3. Increasing patient and family/caregiver potential to follow the plan of care
4. Maximizing care skills of the patient and family/caregiver
5. Enhancing the patient’s and family/caregiver’s knowledge and ability to cope with and manage pain
6. Increasing the patient’s and family/caregiver’s ability to cope with the health status, prognosis and outcomes
7. Enhancing the patient’s and family/caregiver’s role in continuing care
8. Promoting a healthy lifestyle
9. Maintaining the patient’s health status
10. Assisting the patient’s and family/caregiver’s ability to cope with death, if applicable

PROCEDURE

1. The clinician will assess, plan, implement, and evaluate the following on each patient and family/caregiver, as appropriate:
   A. The atmosphere for conducive learning
B. The pertinent information needed by the patient and family/caregiver in relation to the care being rendered

C. The level of knowledge of the patient and family/caregiver in relation to the diagnoses, plan of care, required activities by patient and family/caregiver, lifestyle changes, etc.

D. The ability and readiness of the patient and family/caregiver to learn

E. Personal, cultural, spiritual, ethical, and religious practices that might affect learning and care expectations and treatment

F. Emotional barriers that might affect learning

G. Desire and motivation to learn

H. Physical and/or cognitive limitations, as well as communication and language barriers to learning

2. Based on the above, the assessments will be used as the basis for planning patient and family/caregiver education. In the event that any barriers to learning exist, these barriers, as appropriate, will be discussed with the patient and family/caregiver as well as the Clinical Supervisor. If they cannot be overcome, the patient’s physician will be contacted.

3. When appropriate, the clinician will use preprinted, organization-approved patient teaching materials. When not available, the clinician will identify available written or visual materials to aid in the education process.

4. If a patient’s condition prevents him/her from participating in instruction, family/caregivers will receive the information/instruction.

5. If a patient lives alone and there is no one able or willing to receive the instruction, the physician will be informed, and this information will be documented in the clinical record.

6. Unless otherwise ordered by the physician (or other authorized licensed independent practitioner), the patient and family/caregiver will receive verbal and, as appropriate, written instructions on:

   A. The patient’s disease process and prognosis

   B. The medical regimen

   C. Medication management and administration

   D. Food and drug interactions

   E. Nutrition interventions, modified diets, and oral health
F. Prescribed treatments

G. Pain management

H. Consequences of noncompliance

I. Basic home safety

J. Personal hygiene and grooming

K. Infection prevention and control

L. Safe, effective use of equipment and supplies

M. Environmental and mobility safety

N. Emergency preparedness

7. Documentation of patient and family/caregiver education will consist of:
   A. Describing what was taught to the patient (if using preprinted materials, document the name of the handout)
   B. Describing the patient’s response to the teaching, including the level of understanding and the ability to repeat or demonstrate what was taught
   C. Describing any additional learning needs not currently met
   D. Describing teaching planned for subsequent visits

8. When applicable and available, audiotapes, videotapes, books, booklets, etc. will be made available to patients to assist in the educational process.

9. Community resources will be accessed, as appropriate and available, based on patient and family/caregiver needs.

10. Patient and family/caregiver education will be interdisciplinary, as appropriate to the plan of care. At case conferences, patient education and learning needs and processes should be discussed by all clinicians involved with the care.

11. The patient’s and family/caregiver’s knowledge, skills, and behaviors will be assessed during home visits through an interactive process. Reinforcement of instruction will be provided as needed.

12. Individual needs and learning styles will be evaluated when identifying appropriate methods and resources for patient education.
SAFE/EFFECTIVE USE OF MEDICATIONS
Policy No. HH:5-002.1

PURPOSE
To provide guidelines for the instruction of patients/family/caregivers regarding the safe, effective use of medication.
To promote correct administration of medication by patients and families/caregivers.

POLICY
Patients and family/caregivers will receive information regarding the safe and effective use of medications, in accordance with applicable organization policies.

Visiting Nurse & Hospice Care will encourage patient and family/caregiver participation in his/her own care and will provide teaching about the correct administration of medications by the patient or family/caregiver as ordered by the attending physician (or other authorized licensed independent practitioner) or purchased over the counter. Teaching will also include the safe storage of medications.

PROCEDURE
1. Upon admission, the patient and family/caregiver will be assessed as to his/her knowledge and skill required for safe and effective use of medications.

2. The components of the medication assessment used to determine patient and family/caregiver knowledge and skill related to medication administration will include, but will not be limited to:

   A. Name, dosage, route, duration, time and usage of medication, intended use as well as expected actions of drug therapy

   B. Preparation, self-administration, and use of medication, including over-the-counter products

   C. Safeguards against contamination

   D. Compounding and administration techniques (if applicable)

   E. Side effects, adverse reactions/interactions as well as contraindications

   F. Self-monitoring of drug therapy
G. Proper storage and expiration dating of medications

H. Refill information

I. Actions to take in the event of a missed dose

J. Proper disposal of unused or expired medications

K. Other information, as applicable

3. Based on the assessment, the clinician should review written organization information available for patient and family/caregiver instruction.

4. Using the written information, the clinician will review the key points required, based on patient knowledge and skills as well as identified needs. This may include:

   A. Teaching the patient the purpose and side effects of medications, and the patient’s role in identifying and preventing medication errors.

   B. Assisting the patient in setting up medications for the first time.

   C. Assessing the patient’s ability to self-administer medications correctly, and document the patient’s response and comprehension.

   D. Answering questions/concerns expressed by the patient and family/caregiver regarding the patient’s self-administration of medications.

   E. Instructing the patient and family/caregiver regarding safe storage of medications:

      1. Medications should be stored separately from other toxic drugs and chemicals.

      2. Medication should be removed from storage during instruction and administration times.

      3. Medications should be kept out of the reach of children, pets, and confused or disoriented patients.

      4. The nurse will plan with the patient and family/caregiver for the safe, therapeutic storage of drugs during the assessment process.

      5. Drugs requiring refrigeration should be stored inside the refrigerator.

      6. Urine testing and other diagnostic materials should be stored away from all medications, heat, light, and moisture.
5. The clinician will include information, when appropriate, regarding poison control center numbers, allergies, pharmacy numbers, and emergency actions.

6. Documentation of patient and family/caregiver instruction in the clinical record will include:
   A. Information taught
   B. Patient and family/caregiver understanding
   C. Return demonstrations
   D. Response to teaching
   E. Updating medication profile
PURPOSE

To provide guidelines for the instruction of patient and family/caregiver on potential drug–food interactions and counseling on nutrition intervention and/or modified diets.

POLICY

Patient and family/caregiver will receive information regarding potential drug–food interactions, and written and verbal instructions about nutrition and diets in accordance with applicable organization policies.

PROCEDURE

1. Upon admission, each patient and family/caregiver will receive information on food, drug, and alcohol interactions, describing the most common types of interactions known.

2. If the patient is receiving medications not listed in the information, the patient’s pharmacist and/or physician will be contacted for any additional information.

3. The information will be reviewed with the patient in relation to the medications the patient is currently receiving.

4. During subsequent home visits, the information will be used as a resource whenever there is a change in the patient’s medication regimen.

5. When a patient is on a special or modified diet or receiving nutritional interventions, written or verbal information will be discussed with the patient and family/caregiver including as appropriate, but not limited to:

   A. Purpose of the diet or nutritional supplement

   B. Relationship to disease process

   C. Lifestyle modifications

   D. Foods to avoid

   E. Foods to be encouraged

   F. Oral health
G. Storage of the nutritional therapy solution to ensure stability, if applicable, including protecting solutions from contamination and spoilage and controlling lighting, ventilation, and humidity to prevent moisture or mold growth

6. Documentation of patient and family/caregiver instruction in the clinical record will include:
   
   A. Information taught
   
   B. Patient and family/caregiver understanding
   
   C. Return demonstrations
   
   D. Response to teaching
   
   E. Additional learning needs
PURPOSE

To provide guidelines for the instruction of patients and family/caregivers regarding pain and the management of pain as a part of treatment.

POLICY

As identified, patients and family/caregivers will receive information regarding pain and the management of pain as an integral part of care.

PROCEDURE

1. Clinicians will identify patients with pain or who are at risk for pain during initial and ongoing patient assessments.

2. The patient and family/caregiver will receive verbal or written instructions, as appropriate, regarding:
   A. The pain process
   B. The risk for pain
   C. The pain assessment process
   D. The importance of effective pain management
   E. Methods for pain management, when identified as part of treatment
   F. Potential limitations of pain management modalities
   G. Side effects of pain treatment

3. Documentation of patient and family/caregiver instruction and understanding in the clinical record will include:
   A. Information taught
   B. Patient and family/caregiver understanding
   C. Response to teaching
   D. Additional learning needs
PURPOSE

To provide guidelines for the instruction of patients and family/caregivers in habilitation or rehabilitation techniques to facilitate adaptation and/or functional independence.

Definitions

1. **Habilitation**: Educational, medical, social, and other measures undertaken for individuals born with limited functional abilities.

2. **Rehabilitation**: The combined and coordinated use of educational, medical, social, and vocational measures for training or retraining individuals disabled by disease or injury. The goal is to enable individuals to achieve their highest possible level of functional ability.

POLICY

Patients will be assessed for habilitation or rehabilitation potential, and they will receive referrals and information as needed. (See “Functional Assessment” Policy No. HH:2-024.)

PROCEDURE

1. Upon admission, the patient will be assessed regarding functional limitations that need to be addressed to ensure adaptation to the home environment.

2. The functional assessment will include, but will not be limited to, activities of daily living:
   
   A. Dressing
   B. Feeding
   C. Hygiene
   D. Activity/exercise
   E. Homemaking/housekeeping
   F. Toileting/elimination
3. Based on the assessment, a physician's (or other authorized licensed independent practitioner's) order will be obtained, and a referral will be made to physical, speech, and/or occupational therapy, as needed.

4. The patient's physical status and functional abilities will be evaluated by a rehabilitation professional before instruction and treatment is initiated.

5. The therapists, when involved in the care of the patient, will be responsible for instructing the patient in habilitation or rehabilitation techniques in response to identified needs and patient treatment choices.

6. Verbal and/or written information regarding habilitation or rehabilitation techniques will be provided to the patient and family/caregiver, based on his/her ability to adapt to his/her environment.

7. Information regarding potential benefits and risks of habilitation or rehabilitation services will be provided to the patient in order to make an informed decision regarding services and treatment.

8. Documentation of patient and family/caregiver instruction in the clinical record will include:
   A. Information taught
   B. Adaptations made to the environment
   C. Patient and family/caregiver understanding
   D. Return demonstrations in use of rehabilitation equipment, if appropriate
   E. Response to teaching
   F. Additional learning needs
PURPOSE

To provide guidelines for the instruction of family/caregivers regarding the appropriate, safe, and effective use of restraints, alternatives to the use of restraints, and attention to the needs of the patient in restraints.

POLICY

Families/caregivers will receive information regarding the appropriate, safe, and effective use of restraints, alternatives to the use of restraints, and attention to the needs of the patient in restraints.

Definitions

A restraint is any method (chemical or physical) of restricting a patient’s freedom of movement, physical activity, or normal access to the body.

1. **Physical Restraints**: Specially designed devices including: an arm board, side rails on a bed, a wrist or hand restraints, or lap belts. Household materials intended for other purposes can also be used as a restraint, such as a sheet tied around the waist and chair, or a sheet tucked over a patient and under the mattress to keep him/her in bed.

2. **Support Devices**: Special equipment that maintains and improves a patient’s ability to function. These devices can include wedge cushions to provide support and positioning, special chairs, special splints, and specially designed eating utensils.

3. **Chemical Restraints**: Any drugs that are used to control behavioral symptoms as a substitute for good care practices. Behavioral symptoms are actions used when a patient is unable to communicate verbally due to a medical condition, which expresses distress. Some examples of behavioral symptoms include anger, agitation, screaming, continuous wandering, pacing, repetitive actions, or paranoia.

4. **Psychoactive Drugs**: These are the most common drugs that are used as chemical restraints. Psychoactive drugs include major tranquilizers or antipsychotics, sedatives/hypnotics, antidepressants, and minor tranquilizers or anxiolytics and other drugs used to treat a physical illness that has psychoactive effects.

PROCEDURE

1. Upon admission, each patient will be assessed regarding devices or medications being used within the home as restraints.
2. The clinician will, through interview and observations, determine the patient and family/caregiver level of understanding in the appropriate use of the restraint.

3. If the family/caregiver has identified knowledge and skill deficits, the clinician will provide additional instructions to the family/caregiver, including:
   A. How the device or medication acts as a restraint
   B. Correct and appropriate application of the device or the use of the medication
   C. Attention to the needs of the patient while the device or medication is being used
   D. Any alternatives to the use of the device or medication purely as a restraint

4. The organization will maintain generic written and pictorial teaching tools for common devices used as physical restraints. These tools will be used whenever the family/caregiver chooses to restrain the patient. The teaching tools will include:
   A. Definition of the restraint
   B. Why family/caregivers choose to use restraint
   C. The dangers associated with the use of the restraint
   D. Alternatives to using the restraint

5. Teaching materials will be provided for family/caregivers of patients, which address the potential for psychoactive medications to be used as chemical restraints. The material may be provided by the pharmacist directly to the family/caregivers or to the organization nursing personnel to discuss with them during home visits. The materials will include:
   A. The definition of a chemical restraint
   B. The actions and uses for a psychoactive drug
   C. At what point this type of drug is considered a chemical restraint

6. Clinicians will assess on an ongoing basis the appropriate use of devices or medications used as restraints. Any suspected abuse/neglect will be reported, according to organization policy. (See “Assessment of Possible Abuse/Neglect” Policy No. HH:2-027.)

7. Documentation of instruction in the clinical record should include:
   A. Information taught
   B. Patient and family/caregiver understanding
C. Return demonstrations

D. Response to teaching
SAFE/EFFECTIVE USE OF EQUIPMENT AND SUPPLIES
Policy No. HH:5-007.1

PURPOSE

To provide guidelines for the instruction of patients and family/caregivers regarding the safe, effective use of medical equipment and/or supplies.

POLICY

Patients will receive information regarding the safe and effective use of home medical equipment (HME) and supplies provided by Visiting Nurse & Hospice Care, in accordance with applicable organization policies including, but not limited to, “Safe and Appropriate Use of Medical Equipment and Supplies” (see Policy No. C:2-069) and “Medical Equipment Malfunction” (see Policy No. C:2-071.) When medical equipment is supplied by another organization, organization personnel will be supportive in the patient teaching role.

PROCEDURE

1. Upon admission, the patient assessment will document the use of any medical equipment or supplies being used in the home. The HME company providing the equipment and any patient instruction materials to be left in the home will be identified.

2. The clinician will, through interview and observation, determine patient and family/caregiver level of understanding of the use of any equipment and supplies ordered for care, treatment, and service.

3. If the patient and family/caregiver have knowledge and skill deficits regarding the use of the HME or supplies and the clinician has a sound knowledge base regarding the equipment or supplies, the clinician may provide additional instruction to the patient and family/caregiver.

4. If the patient and family/caregiver have knowledge and skill deficits regarding the use of the HME and the clinician does not have a sound knowledge base regarding the equipment, the clinician should contact the HME company to further instruct the patient and family/caregiver.

5. The organization will maintain generic patient teaching tools from the HME company for common pieces of HME found in the home, including, but not limited to:

   A. Oxygen
   B. Humidifiers
   C. Oxygen concentrators
D. Oxygen cylinders
E. Suction machines
F. Mechanical lifts
G. Trapeze bars
H. Pressure pads/pumps
I. TENS units
J. Canes, walkers, wheelchairs
K. Hospital beds
L. Lift chairs
M. Bathroom aids

6. Specific operational information related to these items will be obtained from the HME company providing the equipment. This includes information such as:

A. Basic purpose and description of the equipment
B. Basic operating instructions
C. Troubleshooting
D. Safety precautions and warnings
E. Cleaning and/or disinfecting
F. Infection control precautions as applicable
G. Backup equipment and accessories, if applicable
H. Emergency plans, when applicable
I. Correct use of the equipment
J. Checklists, when appropriate
K. Maintenance to be performed by patient and family/caregiver
L. Storage and/or transport of equipment
7. If equipment operation has not been explained to the patient by the HME company, the clinician should provide or arrange education or contact the company to provide further information and/or instruction, as needed.

8. Documentation of patient and family/caregiver instruction in the clinical record will include:

   A. Information taught
   B. Patient and family/caregiver understanding
   C. Return demonstrations
   D. Response to teaching
PURPOSE

To provide guidelines for the instruction of patients and family/caregivers in storage, handling, and access to supplies and medical gases.

POLICY

Patients will receive information and instruction regarding storage, handling, and access to supplies and medical gases to promote safe usage.

Definitions

1. Medical Equipment: Any assistive device or piece of equipment used by home health personnel, patient, and/or family/caregiver to meet the patient's needs such as wheelchairs, walkers, canes, lifts, monitors.

2. Home Health Supplies: Those disposable items used by home health personnel, patients, and/or family/caregivers to meet the patient's home health needs, such as sterile dressings, syringes, catheters, tubing, and gloves.

3. Gases, Oxygen and Related Equipment: Any equipment used to deliver the gas to the patient, such as oxygen tank and tubing.

PROCEDURE

1. Upon admission, the patient assessment will include any medical gases and/or sterile supplies to be used in the home setting, as well as the name of the home medical equipment company providing such service/equipment.

2. The selection, delivery, set-up, initial instruction, and maintenance of home medical equipment are the responsibility of the equipment company.

3. The initial home assessment will include, but will not be limited to:

   A. Use of oxygen and oxygen-related equipment, including medical gas cylinders

   B. The areas where medical gases are stored

   C. The environment, including temperature where gases are stored

   D. Use of sterile supplies related to care being provided by the organization
4. Upon admission, the patient and family/caregiver using supplies (sterile and non-sterile) will designate an appropriate area in the home for storage.

5. The patient and family/caregiver will be instructed, as applicable, on:
   A. Storage of medical gases in a stable, ventilated, protected area
   B. Protection from heat extremes
   C. Safe filling of portable oxygen units
   D. Proper handling of sterile supplies
   E. Response to emergency situations and/or accidents in the home
   F. Delivery of and access to supplies

6. Documentation of patient and family/caregiver instruction in the clinical record will include:
   A. Information taught
   B. Adaptations made to the environment
   C. Patient and family/caregiver understanding
   D. Return demonstrations in use of medical equipment and/or supplies, if appropriate
   E. Response to teaching
   F. Additional learning needs
IDENTIFICATION, HANDLING, AND DISPOSAL OF HAZARDOUS WASTE
Policy No. HH:5-009.1

PURPOSE

To provide guidelines for the instruction of patients and family/caregivers in the identification, handling, and disposal of hazardous materials and wastes.

POLICY


PROCEDURE

1. Upon admission, the patient assessment will include educational needs related to the identification, handling, and disposal of hazardous materials and wastes.

2. The assessment will include, but will not be limited to:
   A. The potential need for and use of puncture-resistant needle containers
   B. The potential need for and use of bags for soiled dressing/linens
   C. The potential need for and use of gloves and protective clothing

3. The assessment will include the appropriate actions for both the clinician as well as the patient and family/caregiver while receiving home health services.

4. Each patient who has the potential for handling and disposing of hazardous materials will receive information on OSHA's bloodborne pathogens standards, as well as the home safety information that addresses hazardous waste in the home setting.

5. The materials should be reviewed initially with the patient and family/caregiver to assess their understanding of the actions to be taken to protect themselves. Completion of this instruction and full understanding are necessary prior to the patient and family/caregiver assuming care and performing interventions that may put them at risk.

6. On subsequent visits, clinicians will observe patient and family/caregiver performing appropriate care activities using information learned from the clinicians. Failure to perform activities according to accepted standards will result in re-instruction.
7. Documentation of patient and family/caregiver instruction in the clinical record will include:

A. Information taught

B. Adaptations made to the environment

C. Patient and family/caregiver understanding

D. Return demonstrations in use of equipment/procedures, if appropriate

E. Response to teaching

F. Additional learning needs
PURPOSE
To provide guidelines for the instruction of patients and family/caregivers in infection control precautions.

POLICY
Patients will receive information and instruction regarding infection control precautions, as well as teaching about preventing infection. (See “Standard Precautions” Policy No. C:2-046, and “Hand Hygiene” Policy No. C:2-048.)

PROCEDURE
1. Upon admission, the assessment will include patient and family/caregiver knowledge regarding infection control.

2. Based on the assessment and patient needs, the patient and family/caregiver will receive information and instruction on standard precautions, including such information as:
   A. Hand washing
   B. Protecting skin membranes
   C. Use of antiseptic cleaners
   D. Disposing of sharps in puncture-resistant containers
   E. Breaking of needles
   F. Food and drink in the patient area
   G. Transmission of infections
   H. Personal protective equipment
   I. Cleaning and decontamination schedules, if appropriate
   J. Handling of soiled laundry and linen
   K. Emergency responses
3. When appropriate, the patient and family/caregiver will receive verbal and written information on standard precautions.

4. The use of standard precautions must be demonstrated by the patient and family/caregiver prior to them assuming responsibility for care.

5. Ongoing assessments should continually address the use of standard precautions.

6. Documentation of patient and family/caregiver instruction in the clinical record will include:
   A. Information taught
   B. Adaptations made to the environment
   C. Patient and family/caregiver understanding
   D. Return demonstrations in use of equipment, if appropriate
   E. Response to teaching
   F. Additional learning needs
PURPOSE

To provide guidelines for specific instruction and information for patients and families/caregivers in relation to emergency preparedness and actions to take in the event of a natural disaster and/or emergency.

POLICY

Patients and families/caregivers will receive information on an emergency management plan during the initial visit. (See “Guidelines for Emergency Management” Addendum HH:5-011.A.)

PROCEDURE

1. Upon admission, the patient and family/caregiver will be assessed regarding their emergency management plan for the home, and any special needs will be noted.

2. The patient’s and family/caregiver’s understanding will be assessed on an ongoing basis. Instruction will be in accordance with applicable organization policies, including, but not limited to, “Emergency Management Plan” (see Policy No. C:2-010).

3. The patient and family/caregiver will be assessed and instructed regarding the components of an emergency preparedness/natural disaster plan that will include, but not be limited to:
   A. Emergency phone access, including ambulance, police, fire, gas, electric, water
   B. Emergency supplies, including food, water, heat, light, day-to-day necessities, and needed medical supplies
   C. Disaster follow-up, including battery-powered access to local radio stations
   D. Procedures to follow if care is disrupted by a natural disaster
   E. Actions to take in preparation and during natural disasters, such as flood, storms or earthquakes
   F. Actions to take in case of fire
   G. Evacuation plans for the home
4. Written information will be presented and reviewed, based on patient and family/caregiver knowledge, skills, and identified needs.

5. The Case Manager will document all patient and family/caregiver education information in the clinical notes. Noncompliance and/or lack of understanding will be documented, and a plan for instruction will be developed as part of the plan of care.
ADDENDUM HH:5-011.A

GUIDELINES FOR EMERGENCY MANAGEMENT
SEVERE WEATHER/EARTHQUAKES

1. Have emergency equipment and medical supplies readily available.
2. Close all drapes.
3. Move away from windows.
4. CLOSE exit doors.
5. Go to inside room of building with no windows, if available.
6. Do not enter damaged portions of the building until instructed.
7. Monitor weather bulletins/radio announcements.
8. Do not exit building until instructed.
9. REMAIN CALM. DO NOT PANIC.
FLOODS

(Flood warnings, alerts, or an actual flood)

Precautions before the flood:

1. Make sure emergency supplies and equipment are readily available.
2. Do not touch any electrical equipment unless it is dry.

Precautions if evacuation of building is ordered:

1. Travel only routes designated.
2. Do not try to cross a stream or other water areas unless you are sure it is safe.
3. Monitor local radio broadcast.
4. Watch for fallen trees, live wires, etc.
5. Watch for washed-out roads, earth slides, broken water lines, etc.
6. Watch for areas where rivers, lakes, or streams may flood suddenly.

After the flood:

1. Do not enter the building until an all-clear has been given.
2. Do not use any open flame devices until the building has been inspected for possible gas leaks.
3. Do not turn on any electrical equipment that may have gotten wet.
4. Shovel out mud while it is still moist.

Flash floods:

1. Remember, flash floods can happen without warning.
2. When a flash flood warning is issued, take immediate action.
3. Follow all instructions issued without delay.
SNOW EMERGENCY
(Snow emergency or winter storms)

1. Keep a one (1) to two (2) week supply of heating fuel, food, and water on hand in case of isolation at home.

2. Keep your car properly serviced, with snow tires and filled with gas.

3. Keep emergency supplies in the car:
   A. Container of sand
   B. Shovel
   C. Windshield scraper
   D. Tow chain or rope
   E. Flares
   F. Blanket
   G. Flashlight

4. Dress appropriately—wear several layers of loose, lightweight, warm clothing, mittens, and winter headgear to cover head and face.

5. Carry a cellular phone (if available).

6. Drive with all possible caution. If caught in a blizzard, seek refuge immediately. Keep car radio on for weather information

7. If your car breaks down—turn flashers on or hang a cloth from the radio aerial; stay in your car. If your car is stuck in snow or traffic jam and car is running, crack windows to prevent carbon monoxide poisoning and keep exhaust pipe free of snow. If engine is not running, you do not need to crack windows.
Additional or alternate guidelines should be included by the organization based on its hazard vulnerability analysis and subsequent plan.

(See “Emergency Management Plan” Policy No. C:2-010.)
PURPOSE

To provide guidelines for the instruction of basic home safety.

POLICY

Patients will receive information regarding basic home safety in accordance with applicable organization policies including, but not limited to, “Environmental Safety—Patient” (see Policy No. C:2-065) including:

1. Fire response
2. Electrical safety
3. Environmental and mobility safety
4. Bathroom safety
5. Medication safety

PROCEDURE

1. Upon admission, the patient’s home will be assessed using the home safety assessment and checklist.

2. Based on the results of that assessment, the patient and family/caregiver learning needs will be identified.

3. Using the assessment, written and verbal information appropriate to the patient’s environment will be used as a basis for patient instruction.

4. The information that will be reviewed with every patient will include:
   
   A. Fire safety – Smoking, smoke detectors, fire escape route, burns, electric blankets, heating pads, oxygen therapy precautions, space heaters, cooking safety, flammable liquids, and storage of papers and boxes.

   B. Electrical safety – Extension cords, electrical cords, overloaded circuits, outlets, light bulbs, grounding, and electrical appliances.
C. Environmental and mobility safety – Fall prevention techniques, wheelchair safety, walker safety, exits/passageways, use of handrails, loose carpets, stairway safety, adequate lighting, emergency medical plan, disaster plan. (See “Fall Reduction Program” Policy No. HH:5-012.A)

D. Bathroom safety – Nonskid mats, slippery surfaces, grab bars, water temperature.

5. During subsequent home visits, clinicians will continually assess the patient and family/caregiver compliance to home safety and re-instruct when safety issues surface.

6. Documentation of patient and family/caregiver instruction in the clinical record will include:

A. Information taught

B. Adaptations made to the environment

C. Patient and family/caregiver understanding

D. Return demonstrations in use of equipment, if appropriate

E. Response to teaching

F. Additional learning needs
ADDENDUM HH:5-012.A

FALL REDUCTION PROGRAM

(Insert Organization’s Fall Reduction Program here. Note: Guidelines for developing your organization’s program included.)
These are suggested Fall Reduction Program components that should be included in your agency-specific program. Your program should be developed by an interdisciplinary team. This list is a guideline and is not all-inclusive.

1. Determine what fall risk assessment tool (s) will be used.
   A. Home health: To “get credit” for performing Fall Risk Assessment on OASIS, must:
      1. Be multifactorial; example: Missouri Alliance for Home Care tool at www.homecaremissouri.org/projects/falls/index.php AND
      2. Include a validated tool; example: Timed Up and Go (TUG) or Tinetti
   B. Hospice: Tool to be determined by organization

2. Determine the definition of what a “fall” is and how it will be reported.
   A. Incident forms should include areas for reporting witnessed and non-witnessed falls
   B. Incident forms should have areas for time of day the fall occurred, where the fall occurred, what the patient was doing when the fall occurred and if the fall resulted in an injury, a trip to the ER or hospital admission
   C. Fall incidents should be tabulated, trended and shared with appropriate committees (e.g. PI, QAPI, Safety committees) and staff. The data can be used for PI or QAPI projects.

3. Determine the patient education information you will utilize.
   A. Materials need to be written at an appropriate education level and culturally appropriate as determined by your patient demographics
   B. Handouts should include information on the risks and causes of falls, home safety and modifications for fall prevention (e.g. stair railings, proper lighting, proper footwear) and ways to reduce risk

4. Develop a staff education program that includes but is not limited to:
   A. Major risk factors for falling, such as taking certain classes of medications, vision issues, and strength and balance deficits
   B. How to perform a fall risk assessment
C. How to plan and implement the correct interventions based on the assessment results

D. How to complete appropriate OASIS items (home health only)

E. When to appropriately refer to other disciplines

F. How to complete incident reports for patient falls reporting
PURPOSE

To provide guidelines for organization personnel in the planning for discharge and patient and family/caregiver education related to that discharge.

POLICY

Patient will be active participant in the planning of discharge from home care services and will be verbally informed of the date and reason for discharge. Patients will receive instructions upon discharge to facilitate self-care and health care follow-up.

(See “Discharge Planning” Policy No. HH:2-012.)

PROCEDURE

1. Discharge planning and instruction will begin upon admission to the organization.

2. On admission, the clinician will inform the patient and his/her family/caregiver as to the expected length of service, emphasizing the need to resume, to the extent possible, a return to a functioning level of care and activity.

3. During subsequent visits, the patient and family/caregiver should be continually assessed as to his/her readiness to be discharged from home care, including instruction needed to assure a smooth transition.

4. As part of the discharge planning process, the clinician will focus patient instruction on care and service requirements when home care is no longer needed.

5. Organization personnel will assist the patient regarding his/her discharge by:

   A. Consulting with the patient and family/caregiver regarding the need for discharge

   B. Serving as a referral source for patient and family/caregiver in obtaining follow-up support services

   C. Consulting with the patient and family/caregiver regarding the need for discharge instruction

6. Discharge instruction will begin prior to the last visit. Instructions may include, but will not be limited to:

   A. Medication instruction
B. Activities of daily living instructions

C. Care instructions such as wound, diet, symptom control, etc.

D. Contaminated waste disposal

E. Standard precautions

7. Documentation of patient and family/caregiver instruction in the clinical record will include:

   A. Information taught
   B. Adaptations made to the environment
   C. Patient and family/caregiver understanding
   D. Return demonstration in use of equipment, if appropriate
   E. Response to teaching
   F. Additional learning needs

8. The clinician discharging the patient will provide written and verbal instructions. A copy of written instructions on a discharge instruction form will be given to the patient; the original will be maintained in the clinical record.
PURPOSE

To provide guidelines for identifying and providing educational resources required to achieve learning objectives for patients and family/caregivers.

POLICY

The organization will select and provide educational resources for the patient, based on patient and family/caregiver educational needs.

PROCEDURE

1. The organization will provide educational resources that include, but are not limited to:
   A. Members of the home health team
   B. Written instructions developed by home health pertinent to services, treatments, medications, etc.
   C. Written information provided by the community, as well as by regional and national companies and associations
   D. Written information provided by the patient’s hospital
   E. The patient’s physician
   F. Community resources

2. Educational methods will be based on the patient’s and family/caregiver’s ability to comprehend information and individual learning styles and may include, but will not be limited to, any of the following methods of instruction:
   A. Verbal instruction
   B. Written instruction
   C. Demonstration and return demonstration
   D. Verbal demonstration
   E. Role playing
   F. Videos/DVDs
G. Computer CD/websites

3. When appropriate, the organization will arrange for additional education to be provided by community resources.

4. Patient and family/caregiver education will be provided in a language and at a level the patient and family/caregiver can be expected to understand, including the use of special devices, interpreters, and other aids needed to meet the patient’s specialized needs.
PURPOSE

To provide guidelines for the use of community resources for patient and family/caregiver education.

POLICY

Organization personnel, as well as the patient and family/caregiver, will have access to community resources in the provision of patient education appropriate to patient and family/caregiver needs.

PROCEDURE

1. The organization will maintain a list of community resources and appropriate contacts that have patient education materials available for use in the home health setting.

2. Resources available may include, but will not be limited to:
   
   A. American Diabetic Association
   
   B. American Heart Association
   
   C. American Lung Association
   
   D. Cancer Society
   
   E. Drug and pharmaceutical companies
   
   F. National groups supporting diseases, such as ALS, MS, etc.
   
   G. Support groups, such as Ostomy, Y-Me, etc.

3. The organization will use this information in conjunction with other materials developed by the organization.

4. Use of community and outside resources should be documented in the clinical record.
### Section Six

**Job Descriptions**

<table>
<thead>
<tr>
<th>Policy Statement</th>
<th>HH:6-001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not in Use</td>
<td>HH:6-002</td>
</tr>
<tr>
<td><strong>Scope of the Program/Process Methodology</strong></td>
<td>HH:6-003</td>
</tr>
<tr>
<td><strong>Competency Based Orientation</strong></td>
<td>HH:6-004</td>
</tr>
<tr>
<td><strong>Core Competency Skills</strong></td>
<td>HH:6-005</td>
</tr>
<tr>
<td><strong>Annual Core Competence</strong></td>
<td>HH:6-006</td>
</tr>
<tr>
<td><strong>Specialized Services</strong></td>
<td>HH:6-007</td>
</tr>
<tr>
<td><strong>Requirements for Supervisors/Preceptors</strong></td>
<td>HH:6-008</td>
</tr>
</tbody>
</table>

---

POLICY

Visiting Nurse & Hospice Care defines job responsibilities unique to the specific services provide or operations of the office. Job descriptions are provided to each employee who is hired. Job descriptions are available through Human Resources.
PURPOSE

To ensure that the competence of clinical organization personnel is assessed, maintained and improved on a continuing basis.

POLICY

The organization defines and implements an objective, measurable assessment system to evaluate the competency of all clinical personnel.

Organization personnel will demonstrate knowledge and proficiency of skills appropriate to their assigned responsibilities, including an ability to perform specified duties determined by the organization. Skills will be maintained and improved through continuing education programs, based on the analysis of trends and outcomes identified through the Clinical Competency Program, on-site supervision and established reviews.

Skill proficiency can be determined by: verbal or written examination; skill demonstration in a lab setting or patient’s home; or by completion of a specialized training course specific to a clinical procedure (i.e., PICC Certification).

PROCEDURE

1. The organization establishes and annually re-evaluates its job specific “Competency Based Orientation Checklist” which reflects duties commonly required in the performance of clinical positions.

2. The organization will establish and annually evaluate a group of specific skills related to patient care responsibilities and complexity of care provided by personnel. Competencies must be successfully demonstrated before organization personnel complete orientation.

3. The organization will clearly identify and define the skills which are essential to observe for the determination of competence, for each job category. In the identification of core competence, the essential skills will be demonstrated upon hire and annually thereafter. 100% of the designated core competencies must be met for the determination of competence.

4. Specific competencies will be developed for high risk, low volume, problem prone, and specialty service care areas. (See “Specialized Services” Policy No. HH:6-007.) Personnel providing service in the defined target areas will receive specialty training and provide demonstrated competence prior to the provision of specialty service.
PURPOSE

To evaluate skills and experience upon hire using a standard tool.

POLICY

The organization ensures that the competency of all personnel is assessed on hire, prior to providing care to organization patients.

GUIDELINES

Orientation is intended to prepare the employee to perform the duties of a new role with a competent level of skill. Competency Based Orientation (CBO) is a method of learning which stresses performance of competencies which relate directly to the employee’s job description. There is flexibility in the time and sequence of the orientation activities.

A preceptor(s) will be assigned to each orientee. The primary role of the preceptor(s) is to facilitate the learning and socialization of the new employee during the orientation program.

PRECEPTOR OBJECTIVES

1. Present information needed to function in the home health agency.
2. Observe specific tasks to assure satisfactory performance of essential duties and procedures.
3. Identify problems and additional learning needs as early as possible in the orientation process.

ORIENTEE OBJECTIVES

1. Assess the Physical and Functional characteristics, Psychosocial characteristics, past and current medical history, current medication and treatments, patient/family educational needs, discharge planning needs, and environmental and/or equipment needs of each patient assigned.

4. Evaluate the effect of discipline specific interventions.
5. Exhibit professional behavior.

6. Provide high quality of service in all aspects of job performance.

COMPETENCY ORIENTATION SKILLS CHECKLIST GUIDELINES

1. Organization personnel are given the appropriate job category Orientation Checklist during the orientation process.

2. Organization personnel rate their knowledge and abilities in the various procedures routinely performed in the course of their jobs on the self-assessment position of the checklist.

3. If organization personnel work in a specialized area (i.e., Infusion Therapy) they must complete the Basic Inventory plus the specialty Orientation Skills Checklist. (Example: registered nurse who does IV therapy completes the Basic Registered Nurse and Infusion Nurse.)

4. The method to evaluate each indicator will be documented on the checklist.

5. When the Competency Orientation Skills Checklist is completed, it is reviewed by the preceptor and the Clinical Supervisor. Additional training and education is performed as indicated until competence is demonstrated.
CORE COMPETENCY SKILLS
Policy No. HH:6-005.1

PURPOSE

To identify and define the specific core competency skills for clinical personnel.

POLICY

Organization personnel will be provided with core competency statements relative to the skills required for their particular positions.

PROCEDURE

1. The organization will define the mandatory core competency skills for each discipline based upon the nature of their job responsibilities and complexity of care required.

2. Core competency skills will be reviewed with new personnel during their orientation.

3. Each core competency skill has a corresponding set of performance criteria. (See “Annual Core Competence” Policy No. HH:6-006.)

4. Core competency skill areas may be changed based upon data trends, regulatory requirements, services provided, or organization personnel needs.
ANNUAL CORE COMPETENCE
Policy No. HH:6-006.1

PURPOSE

To ensure that all organization personnel are able to display competence in skills specific to the organization’s needs on an annual basis.

POLICY

The organization will implement an objective, measurable system to evaluate competency. The performance criteria lists the required behaviors organization personnel must demonstrate to be deemed proficient in the skills required.

PROCEDURE

1. Organization personnel will demonstrate proficiency in the performance criteria/skills during the orientation period, and at least annually thereafter as part of the annual performance evaluation process.

2. If organization personnel are not required to perform a specific aspect of care or task as a routine part of their job responsibilities, the performance criteria is simply labeled “Not Applicable” or “N/A” by a qualified evaluator.

3. Organization personnel are deemed proficient only when 100% of the applicable performance criteria are demonstrated.
PURPOSE

To define the specialized services and related personnel qualifications to provide safe, effective care.

POLICY

Visiting Nurse & Hospice Care will ensure that any clinical personnel providing any of the following services will have special training and demonstrated skills competence. The following services are defined as high risk, low volume and problem prone:

1. Care of ventilator dependent patients
2. Vesicant chemotherapy
3. PICC line insertions
4. Midline catheter insertions
5. Accessing implanted ports
6. Epidural catheter management
7. Intrathecal catheter management
8. Other (invasive, high-risk) procedures or services as determined by the Executive Director/Administrator or Clinical Director.

PROCEDURE

Prior to providing any of the defined services, organization personnel must possess specific training and experience with the required associated skill. Specialty training/experience includes:

1. A certificate of completion from a training program sponsored by a professional organization (Intravenous Nurses Society, Oncology Nurses Society, and Hospice Nursing Association). The training course includes a didactic and skill demonstration component.

2. A certificate of completion from a training program sponsored by an organization, organization, or hospital that meets the criteria for continuing education by the State Board of Nursing, Professional Standards of Practice and is approved by the American Nurses Association. The course includes both didactic and skills demonstration.

3. In addition to meeting the above requirements for education and training, organization personnel must also demonstrate proficiency to a qualified individual through direct observation prior to performing this service independently.
**PURPOSE**

To define level of clinical knowledge and expertise required for clinical supervision.

**POLICY**

Organization supervisory personnel will have demonstrated clinical knowledge/experience appropriate to their assigned responsibilities, and complete a clinical skills competency on a defined, regular basis.

**PROCEDURE**

1. Personnel who may supervise include the following:
   
   A. Personnel who supervise direct care organization personnel.
   
   B. Evaluators/preceptors that perform proficiency determinations.
   
   C. Consultants/contracted personnel that assume those duties.

2. Personnel who supervise will demonstrate clinical competency by:
   
   A. Completion of appropriate Orientation Skills Checklist for discipline.
   
   B. Demonstration of competencies and annual re-demonstration.
   
   C. Appropriate education and experience required in the job description, and required by regulatory requirements.
   
   D. Meeting organization requirement for inservice programs intended to maintain and improve skill competency.

3. If the Supervisor does not have appropriate clinical training or experience in a specialty area, they will seek qualified consultation.

4. Supervisors will monitor personnel skills through direct observation at regular, defined intervals.

5. Documentation of the observed skills, along with the purpose for the joint visit, will be maintained and filed with personnel files.
ATTACHMENTS

Attachment I: CHAP Crosswalk

Attachment II: Medicare Conditions of Participation

Attachment III: Home Health Agency Interpretive Guidelines

Attachment IV: Home Health Agency Manual

Attachment V: Additional Resources
ATTACHMENT I

CHAP CROSSWALK
### CHAP Crosswalk

<table>
<thead>
<tr>
<th>CHAP Standard</th>
<th>Policy/Procedure</th>
<th>Policy #</th>
</tr>
</thead>
<tbody>
<tr>
<td>CII.1b(11)</td>
<td>Medicare Written Notices</td>
<td>HH:1-018</td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Executive Director/Administrator</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Finance Director</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Controller</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Human Resources Director</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Information Systems Director</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Marketing/Community Relations Director</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Clinical Director</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Clinical Records Manager</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Clinical Supervisor</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Managed Care Coordinator</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Referral/Intake Supervisor</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Performance Improvement Coordinator</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Home Care Coordinator</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Infusion Therapy Nurse Coordinator</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Registered Nurse</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Licensed Practical/Vocational Nurse</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Certified Home Health Aide</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Nurse Assistant</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Physical Therapist</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Physical Therapy Assistant</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Speech–Language Pathologist</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Certified Occupational Therapy Assistant</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Social Services Supervisor</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Medical Social Worker</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Registered Dietician</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Secretary/Receptionist</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Billing Manager</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Accounting Clerk</td>
<td></td>
</tr>
</tbody>
</table>
## CHAP CROSWALK

<table>
<thead>
<tr>
<th>CHAP STANDARD</th>
<th>POLICY/PROCEDURE</th>
<th>POLICY #</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIII.1c</td>
<td>Data Entry/Computer Operator</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Billing/Collections Clerk</td>
<td></td>
</tr>
<tr>
<td>CIII.1c</td>
<td>Filing/Data Processing Clerk</td>
<td></td>
</tr>
<tr>
<td>CIII.2a</td>
<td>Professional Services Agreement For Medical Director</td>
<td>HH:6-002</td>
</tr>
<tr>
<td>CIII.2b</td>
<td>Professional Services Agreement For Medical Director</td>
<td>HH:6-002</td>
</tr>
<tr>
<td>HHII.1</td>
<td>Home Health Patient Bill of Rights</td>
<td>HH:2-001</td>
</tr>
<tr>
<td>HHII.1i</td>
<td>Physician Licensure Verification</td>
<td>HH:3-014</td>
</tr>
<tr>
<td>HHII.3</td>
<td>On-Call/Weekend Staffing</td>
<td>HH:2-018</td>
</tr>
<tr>
<td>HHII.4</td>
<td>Intake Process</td>
<td>HH:2-002</td>
</tr>
<tr>
<td>HHII.4a</td>
<td>Admission Criteria and Process</td>
<td>HH:2-003</td>
</tr>
<tr>
<td>HHII.4b</td>
<td>Care Planning Process</td>
<td>HH:2-004</td>
</tr>
<tr>
<td>HHII.4c</td>
<td>Physician Participation in Plan of Care</td>
<td>HH:2-005</td>
</tr>
<tr>
<td>HHII.4c</td>
<td>Discharge Planning</td>
<td>HH:2-012</td>
</tr>
<tr>
<td>HHII.4c</td>
<td>Continuity of Care</td>
<td>HH:2-013</td>
</tr>
<tr>
<td>HHII.4c</td>
<td>Monitoring Patient’s Response/Reporting to Physician</td>
<td>HH:2-015</td>
</tr>
<tr>
<td>HHII.4c</td>
<td>Patient Notification of Changes in Care</td>
<td>HH:2-017</td>
</tr>
<tr>
<td>HHII.4c</td>
<td>Coordination of Services with Other Providers</td>
<td>HH:2-019</td>
</tr>
<tr>
<td>HHII.4c</td>
<td>Internal Referral Process</td>
<td>HH:2-020</td>
</tr>
<tr>
<td>HHII.4d</td>
<td>Case Conference/Progress Summary</td>
<td>HH:2-014</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Care Planning Process</td>
<td>HH:2-004</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Rehabilitation Care Planning</td>
<td>HH:2-007</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Nutrition Care Planning</td>
<td>HH:2-008</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Do Not Resuscitate/Do Not Intubate Orders</td>
<td>HH:2-047</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Cardiopulmonary Resuscitation</td>
<td>HH:2-048</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Withdrawal of Life-Sustaining Care</td>
<td>HH:2-049</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Safe/Effective Use of Medications</td>
<td>HH:5-002</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Drug–Food Interactions</td>
<td>HH:5-003</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Pain Management Education</td>
<td>HH:5-004</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Rehabilitation Techniques</td>
<td>HH:5-005</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Appropriate Use of Restraints and Supplies</td>
<td>HH:5-006</td>
</tr>
</tbody>
</table>
# CHAP Crosswalk

<table>
<thead>
<tr>
<th>CHAP STANDARD</th>
<th>POLICY/PROCEDURE</th>
<th>POLICY #</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHII.5a</td>
<td>Safe/Effective Use of Equipment and Supplies</td>
<td>HH:5-007</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Storage, Handling, and Access to Supplies and Gases</td>
<td>HH:5-008</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Identification, Handling, and Disposal of Hazardous Waste</td>
<td>HH:5-009</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Infection Control Precautions</td>
<td>HH:5-010</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Natural Disasters/Emergencies</td>
<td>HH:5-011</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Patient Education Process</td>
<td>HH:5-001</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Basic Home Safety</td>
<td>HH:5-012</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Patient Education Related to Discharge Planning</td>
<td>HH:5-013</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Educational Resources</td>
<td>HH:5-014</td>
</tr>
<tr>
<td>HHII.5a</td>
<td>Community Resources</td>
<td>HH:5-015</td>
</tr>
<tr>
<td>HHII.5c</td>
<td>Initial and Comprehensive Assessment</td>
<td>HH:2-021</td>
</tr>
<tr>
<td>HHII.5d</td>
<td>Initial and Comprehensive Assessment</td>
<td>HH:2-021</td>
</tr>
<tr>
<td>HHII.5d</td>
<td>Reassessments/Recertification</td>
<td>HH:2-023</td>
</tr>
<tr>
<td>HHII.5d</td>
<td>Functional Assessment</td>
<td>HH:2-024</td>
</tr>
<tr>
<td>HHII.5d</td>
<td>Nutritional Assessment</td>
<td>HH:2-025</td>
</tr>
<tr>
<td>HHII.5d</td>
<td>Pain Assessment</td>
<td>HH:2-026</td>
</tr>
<tr>
<td>HHII.5d</td>
<td>OASIS Data Transmission</td>
<td>HH:2-059</td>
</tr>
<tr>
<td>HHII.5e</td>
<td>Reassessments/Recertification</td>
<td>HH:2-023</td>
</tr>
<tr>
<td>HHII.5e</td>
<td>OASIS Data Transmission</td>
<td>HH:2-059</td>
</tr>
<tr>
<td>HHII.5f</td>
<td>OASIS Data Transmission</td>
<td>HH:2-059</td>
</tr>
<tr>
<td>HHII.5g</td>
<td>Verification of Physician Orders</td>
<td>HH:2-006</td>
</tr>
<tr>
<td>HHII.5h</td>
<td>Verification of Physician Orders</td>
<td>HH:2-006</td>
</tr>
<tr>
<td>HHII.5i</td>
<td>Monitoring Patient’s Response/Reporting to Physician</td>
<td>HH:2-015</td>
</tr>
<tr>
<td>HHII.5j</td>
<td>60-Day Summary Report</td>
<td>HH:2-016</td>
</tr>
<tr>
<td>HHII.5k</td>
<td>Transfer/Referral Criteria and Process</td>
<td>HH:2-051</td>
</tr>
<tr>
<td>HHII.5k</td>
<td>Transfer Summary</td>
<td>HH:2-052</td>
</tr>
<tr>
<td>HHII.5l</td>
<td>Discharge Criteria and Process</td>
<td>HH:2-053</td>
</tr>
<tr>
<td>HHII.5l</td>
<td>Discharge Summary</td>
<td>HH:2-054</td>
</tr>
<tr>
<td>HHII.5m</td>
<td>Home Health Aide Plan of Care</td>
<td>HH:2-009</td>
</tr>
<tr>
<td>HHII.5n</td>
<td>Home Health Aide Plan of Care</td>
<td>HH:2-009</td>
</tr>
<tr>
<td>CHAP STANDARD</td>
<td>POLICY/PROCEDURE</td>
<td>POLICY #</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>HHII.5n</td>
<td>Orientation of Assigned Home Health Aide</td>
<td>HH:2-010</td>
</tr>
<tr>
<td>HHII.5o</td>
<td>Support/Chore Worker Service Plan</td>
<td>HH:2-011</td>
</tr>
<tr>
<td>HHII.5p</td>
<td>Support/Chore Worker Service Plan</td>
<td>HH:2-011</td>
</tr>
<tr>
<td>HHII.6</td>
<td>Waived Testing</td>
<td>HH:2-045</td>
</tr>
<tr>
<td>HHII.6</td>
<td>Home Glucose Monitoring</td>
<td>HH:2-046</td>
</tr>
<tr>
<td>HHII.7a</td>
<td>Medication Profile</td>
<td>HH:2-028</td>
</tr>
<tr>
<td>HHII.7a</td>
<td>Medication Monitoring</td>
<td>HH:2-043</td>
</tr>
<tr>
<td>HHII.7b</td>
<td>Identification of Medication for Administration</td>
<td>HH:2-029</td>
</tr>
<tr>
<td>HHII.7b</td>
<td>Administration and Documentation of Medications</td>
<td>HH:2-030</td>
</tr>
<tr>
<td>HHII.7b</td>
<td>Intravenous Administration of Medications/Solutions</td>
<td>HH:2-033</td>
</tr>
<tr>
<td>HHII.7b</td>
<td>Intravenous Administration of Chemotherapy</td>
<td>HH:2-034</td>
</tr>
<tr>
<td>HHII.7c</td>
<td>Adverse Drug Reactions</td>
<td>HH:2-040</td>
</tr>
<tr>
<td>HHII.7c</td>
<td>Medication Error</td>
<td>HH:2-042</td>
</tr>
<tr>
<td>HHII.8a</td>
<td>Contents of Clinical Record</td>
<td>HH:2-055</td>
</tr>
<tr>
<td>HHII.8b</td>
<td>Contents of Clinical Record</td>
<td>HH:2-055</td>
</tr>
<tr>
<td>HHII.8d</td>
<td>Assembly of Clinical Record</td>
<td>HH:2-056</td>
</tr>
<tr>
<td>HHII.9a</td>
<td>Clinical Record Review</td>
<td>HH:2-057</td>
</tr>
<tr>
<td>HHII.9b</td>
<td>Clinical Record Review</td>
<td>HH:2-057</td>
</tr>
<tr>
<td>HHIII.1a</td>
<td>Home Health Human Resources</td>
<td>HH:3-001</td>
</tr>
<tr>
<td>HHIII.1b</td>
<td>Home Health Staffing Guidelines</td>
<td>HH:3-002</td>
</tr>
<tr>
<td>HHIII.1c</td>
<td>Home Health Aide Training</td>
<td>HH:3-012</td>
</tr>
<tr>
<td>HHIII.1d</td>
<td>Home Health Aide Training</td>
<td>HH:3-012</td>
</tr>
<tr>
<td>HHIII.1e</td>
<td>Responsibilities/Supervision of Clinical Services</td>
<td>HH:3-003</td>
</tr>
<tr>
<td>HHIII.1e</td>
<td>Supervision</td>
<td>HH:3-004</td>
</tr>
<tr>
<td>HHIII.1e</td>
<td>Access to Qualified Consultation</td>
<td>HH:3-005</td>
</tr>
<tr>
<td>HHIII.1e</td>
<td>Consultation for Specialty Services</td>
<td>HH:3-006</td>
</tr>
<tr>
<td>HHIII.1e</td>
<td>Communication With Office</td>
<td>HH:3-007</td>
</tr>
<tr>
<td>HHIII.1e</td>
<td>Home Health Aide Supervisory Visits</td>
<td>HH:3-013</td>
</tr>
<tr>
<td>HHIII.1f</td>
<td>Training/Inservice Education</td>
<td>HH:3-010</td>
</tr>
<tr>
<td>HHIII.1g</td>
<td>Competency Assessment</td>
<td>HH:3-011</td>
</tr>
<tr>
<td>CHAP STANDARD</td>
<td>POLICY/PROCEDURE</td>
<td>POLICY #</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>HHI.1g</td>
<td>Scope of the Program/Process Methodology</td>
<td>HH:6-003</td>
</tr>
<tr>
<td>HHI.1g</td>
<td>Competency Based Orientation</td>
<td>HH:6-004</td>
</tr>
<tr>
<td>HHI.1g</td>
<td>Core Competency Skills</td>
<td>HH:6-005</td>
</tr>
<tr>
<td>HHI.1g</td>
<td>Annual Core Competence</td>
<td>HH:6-006</td>
</tr>
<tr>
<td>HHI.1g</td>
<td>Specialized Services</td>
<td>HH:6-007</td>
</tr>
<tr>
<td>HHI.1h</td>
<td>Training/Inservice Education</td>
<td>HH:3-010</td>
</tr>
<tr>
<td>HHI.1h</td>
<td>Scope of the Program/Process Methodology</td>
<td>HH:6-003</td>
</tr>
<tr>
<td>HHI.1h</td>
<td>Competency Based Orientation</td>
<td>HH:6-004</td>
</tr>
<tr>
<td>HHI.1h</td>
<td>Core Competency Skills</td>
<td>HH:6-005</td>
</tr>
<tr>
<td>HHI.1h</td>
<td>Annual Core Competence</td>
<td>HH:6-006</td>
</tr>
<tr>
<td>HHI.1h</td>
<td>Specialized Services</td>
<td>HH:6-007</td>
</tr>
<tr>
<td>HHI.2a</td>
<td>Home Health Contracted Services</td>
<td>HH:3-008</td>
</tr>
<tr>
<td>HHI.2a</td>
<td>Contracted Service Providers</td>
<td>HH:3-009</td>
</tr>
<tr>
<td>HHI.3</td>
<td>Home Health Capital Expenditure Plan</td>
<td>HH:3-015</td>
</tr>
<tr>
<td>HHI.1</td>
<td>Home Health Annual Evaluation</td>
<td>HH:4-001</td>
</tr>
<tr>
<td>HHI.2a</td>
<td>Home Health Innovation</td>
<td>HH:4-002</td>
</tr>
<tr>
<td>HHI.2b</td>
<td>Home Health Innovation</td>
<td>HH:4-002</td>
</tr>
<tr>
<td>HHI.2c</td>
<td>Home Health Innovation</td>
<td>HH:4-002</td>
</tr>
</tbody>
</table>
ATTACHMENT II

MEDICARE CONDITIONS OF PARTICIPATION

We recommend accessing www.access.gpo.gov/nara/cfr/waisidx_01/42cfr484_01.html to download the most recent Federal/Medicare Conditions of Participation.
ATTACHMENT III

HOME HEALTH AGENCY INTERPRETIVE GUIDELINES


to download the Home Health Agency Interpretive Guidelines.
ATTACHMENT IV

HOME HEALTH AGENCY MANUAL

ATTACHMENT V

ADDITIONAL RESOURCES

We recommend the following websites to download the most current information. Please print and insert applicable documents here.

OASIS: www.cms.hhs.gov/oasis
Centers for Disease Control: www.cdc.gov
Occupational Safety and Health Administration (OSHA): www.osha.gov

State-specific Websites:
State Home Health Association website
State Professional Practice Acts
Other

The following website can be used to access all federal forms for provider use:

http://www.cms.hhs.gov/forms