Clinical Staff Meeting Agenda
June 26, 2024

Meeting Agenda:

- Developing the Home Health Aide Care Plan

- DNA Status Requirements

- Agency Service Buttons

- Transfer DC summary
    - Not entering into correct section
    - Plan of Care synopsis – last page

- Orders/Care Plans / Medications
    - Attached – policies regarding orders
    - Review at every visit
    - We must have an orders for all services we provide

- Daily Clinical Meeting Feedback
    - Format changes?
    - Ideas to make more information/ meaningful?

Post December 2023 Survey Training

HHA Care Plan and HHA Supervision

Objective of Training

- Staff will understand that our agency was deficient in both development of a complete care plan and did not meet the requirements for aide supervision.
- Staff will understand what is needed to be included for a complete aide care plan
- Staff will understand the requirements for aide supervision
- Staff will understand charting requirements to document supervision

HHA Care Plan

Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).
This STANDARD is NOT MET as evidenced by:
Based on review of charts, the skilled clinician failed to develop complete and accurate aide written instructions.

Examples from survey:

- The Non-Skilled Care Plans, included "lotion" to the skin and failed to include barrier ointment to the sacral area or any special treatment of the sacral area while bathing.
- Failure to ensure that home health aide care plans are complete has the potential for unmet patient needs.

Correction Needed:

Ensure more detail in the bottom narrative section when developing the care plan. Agency button has been updated in the “SUP/CLINICAL DIRECTIVE” section. This section only appears when an aide is included in the patient disciplines. Include these examples as appropriate to the narrative section of the care plan. These can be copied and pasted to the care plan.

**INSERT SPECIAL PRECAUTIONS & FUNCTIONAL LIMITATIONS **- BOTTOM Section

Additional Non Skilled Care Plan Activity Narrative (at the bottom) must be completed. Fill in any functional or directives that cannot be captured in the sections above. Examples below:

If Bath is included, must indicate how bathes, tub, shower, partial or full bath
Notify RN/PT if patient has difficulty breathing, any skin breakdown, pain, confusion, nausea, vomiting or falls.

Total HIP RESTRICTIONS
Do not bend hip past 90 degrees
No internal rotation of the hip
No hip adduction past midline

DM SYMPTOMS OF LOW BLOOD SUGAR
Fatigue Weakness Nervousness Anxiety Trembling Headache Sweating Hunger Dizziness Nausea Visual Disturbances Tingling of lips/tongue Chilliness Unsteadiness Drowsiness

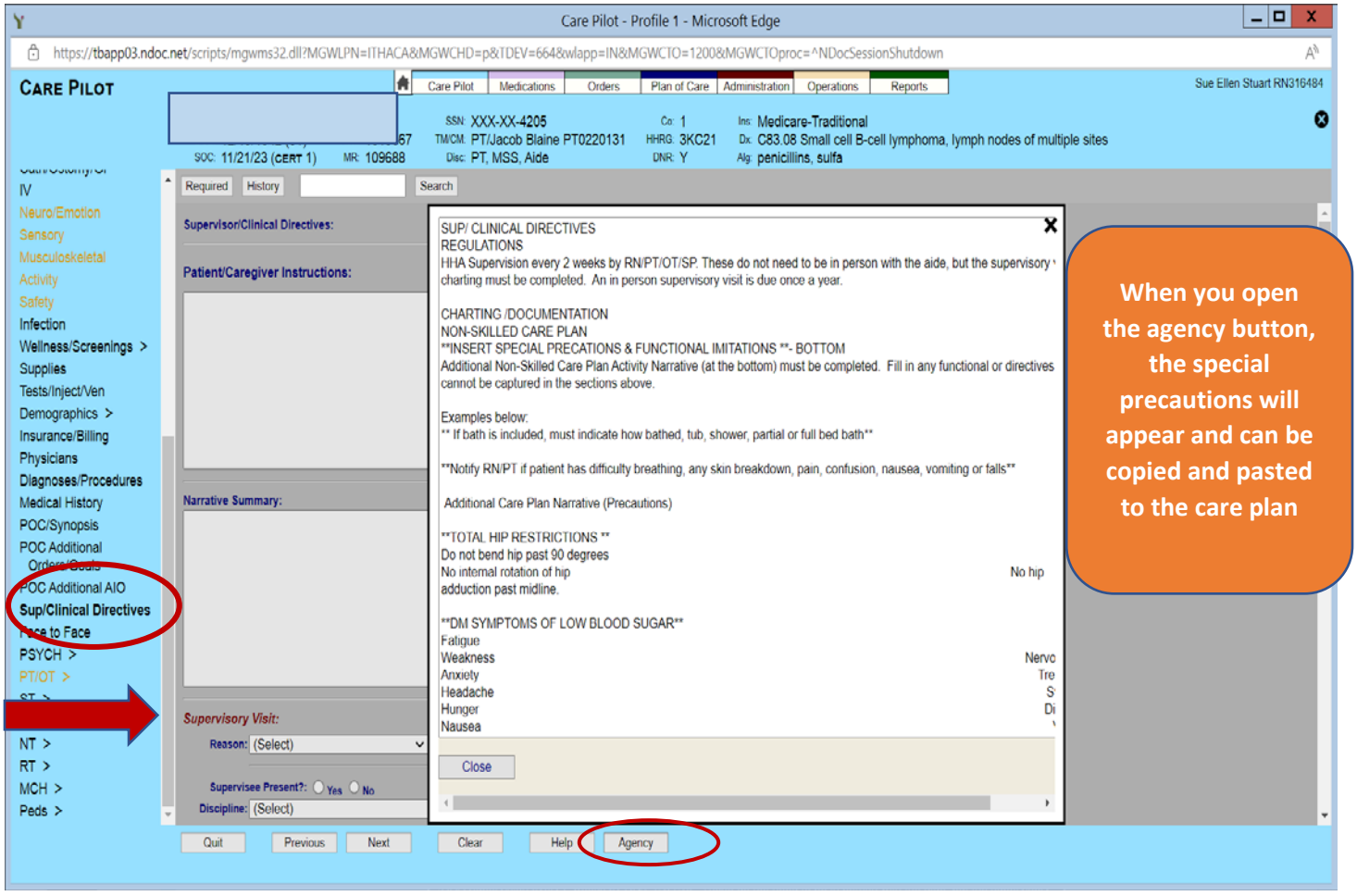
DM SYMPTOMS OF HIGH BLOOD SUGAR
Frequent Urination Thirst Lack of Appetite Headache Sense of Fatigue Nausea/Vomiting Stomach Cramps/Pain Mental Dullness Rapid, deep breathing Dizziness

COUMADIN PRECAUTIONS
Observe for abnormal bleeding- especially in urine, stool, nose, gums, under skin

O2 PRECAUTIONS
No smoking, no open flames

SEIZURE PRECAUTIONS
Protect from injury, do NOT hold person tight, do not place anything in mouth

ASPIRATION PRECAUTIONS
May need to give soft food, thickened liquids, and small bites. Sit up to eat.



HHA SUPERVISION

Regulation: CFR(s): 484.80(h)(1)(i)

- (h) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.
- (ii) If an area of concern in aide services is noted by the supervising registered nurse or other appropriate skilled professional, then the supervising individual must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.
- (iii) A registered nurse or other appropriate skilled professional must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.

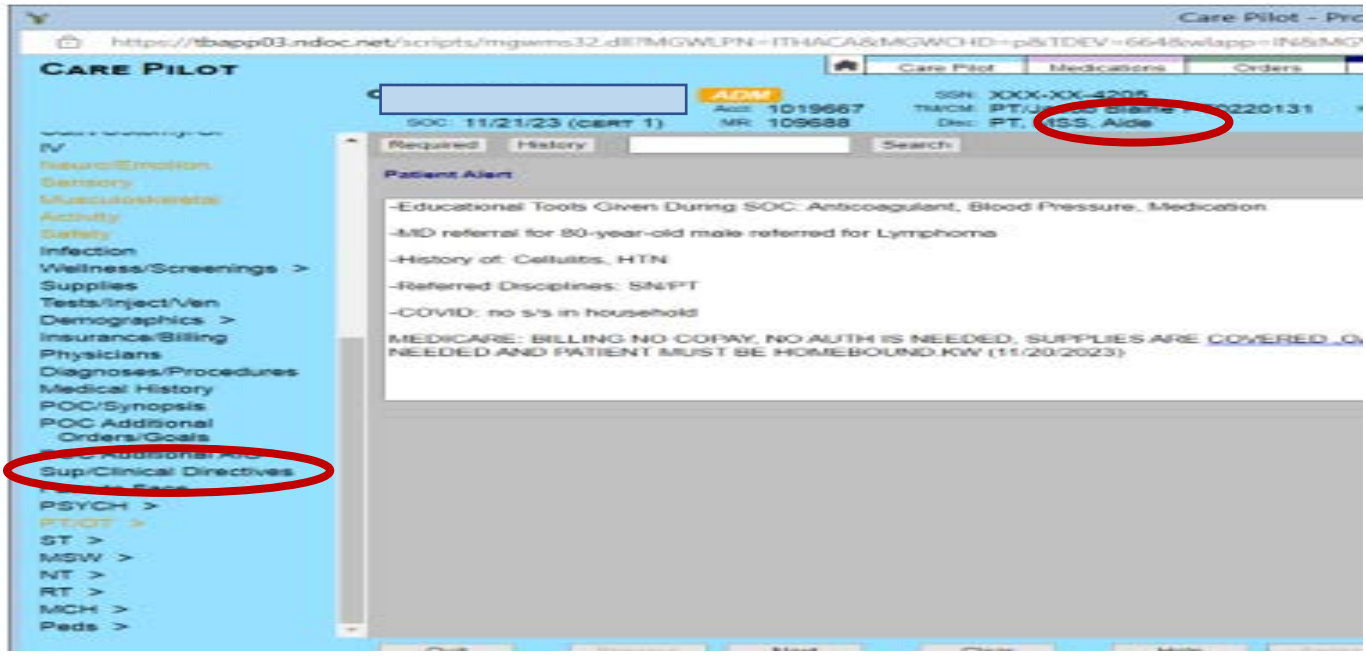
Survey findings:

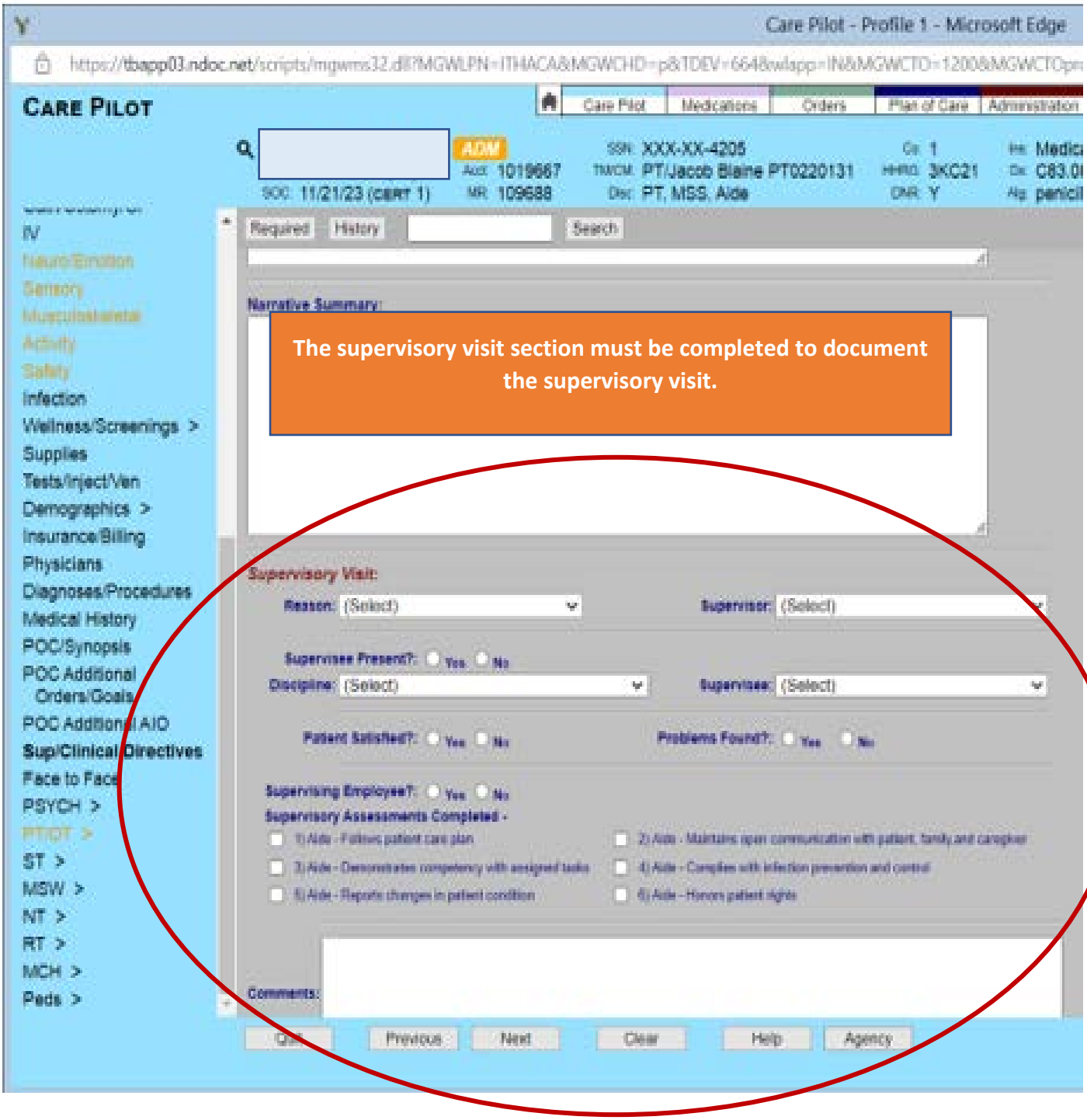
- Based on reviews of 4 clinical records for patients receiving home health aide service, in 2 out of 4 records, the skilled nurse failed to ensure that all home health aides providing services to patients receiving skilled services are supervised no less frequently than every two weeks.
- Failure to ensure that home health aide supervision is conducted every fourteen 14 days, has the potential for negative patient outcomes.

Correction Needed:

- Follow VNS policy and regulations regarding HHA Supervision.
- Document the supervisory visit **within charting section** (SUP/Clinical Directives), designed to demonstrate supervision was completed. This section only appears when Aide is added to disciplines for the patient. Charting in the summary note is not sufficient.
- Coordinate disciplines to ensure regulation is met– RN/PT/OT/SP can provide supervision.

NDoc Screen Shots of HHA Supervisory section for charting




Care Pilot - Profile 1 - Microsoft Edge
CARE PILOT
Care Pilot
Medications
Orders
Plan of Care
Administration
ADM
Narrative Summary:
The supervisory visit section must be completed to document the supervisory visit.
Supervisory Visit:
Reason:
Supervisor:
Supervisee Present?:
Discipline:
Supervisee:
Patient Satisfied?:
Problems Found?:
Supervising Employee?:
Supervisory Assessments Completed -
Comments:
Previous
Next
Clear
Help
Agency

Attestation:

I have read and understand my responsibility regarding developing a complete care plan and requirements of supervising the HHAs.

_____Discipline _____

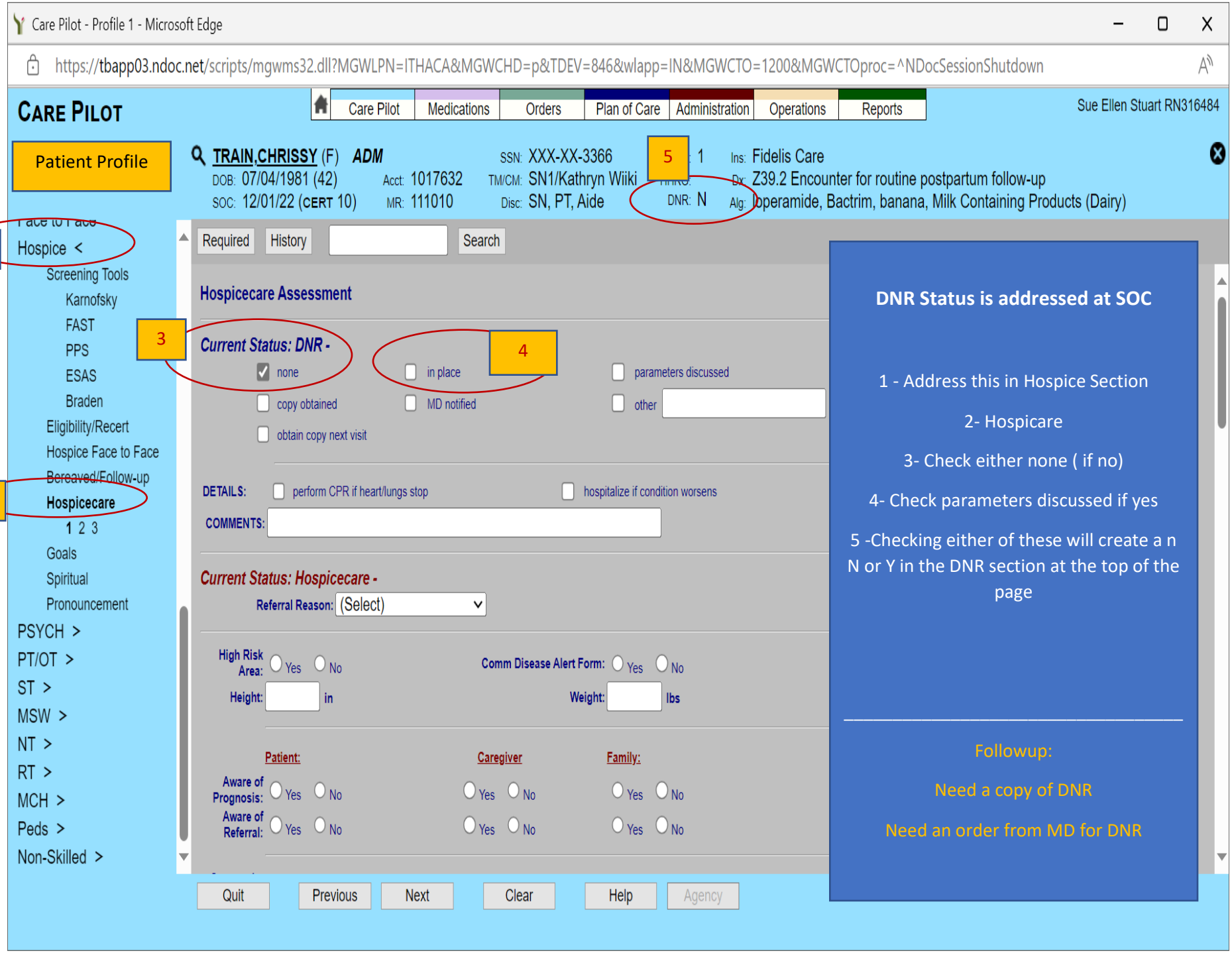
Name (please print on line above)

_____Date_____

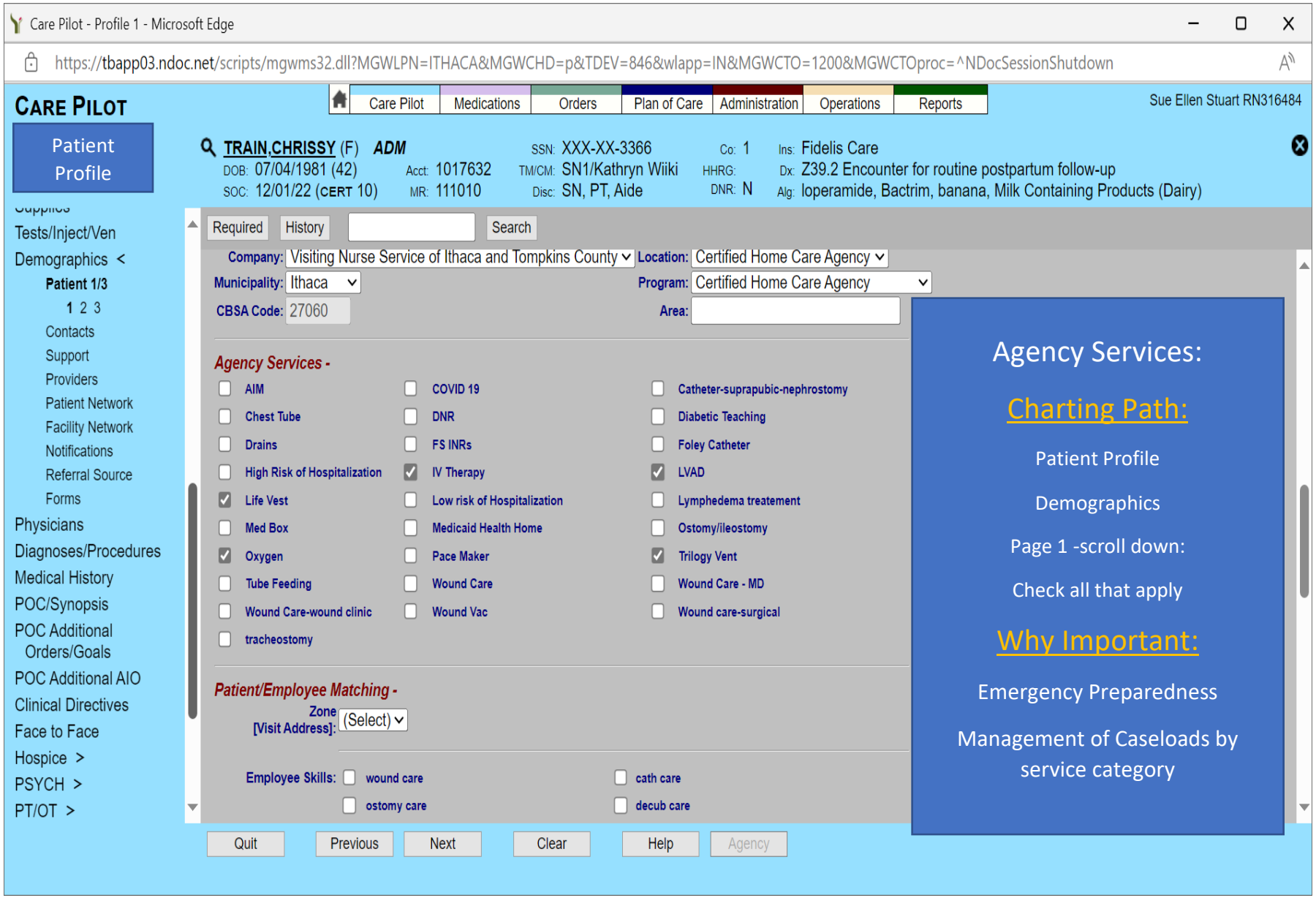
Signature

Submit to HR – place in mailbox on door or send back to your supervisor.

DNR NEEDS TO BE DOCUMENTED



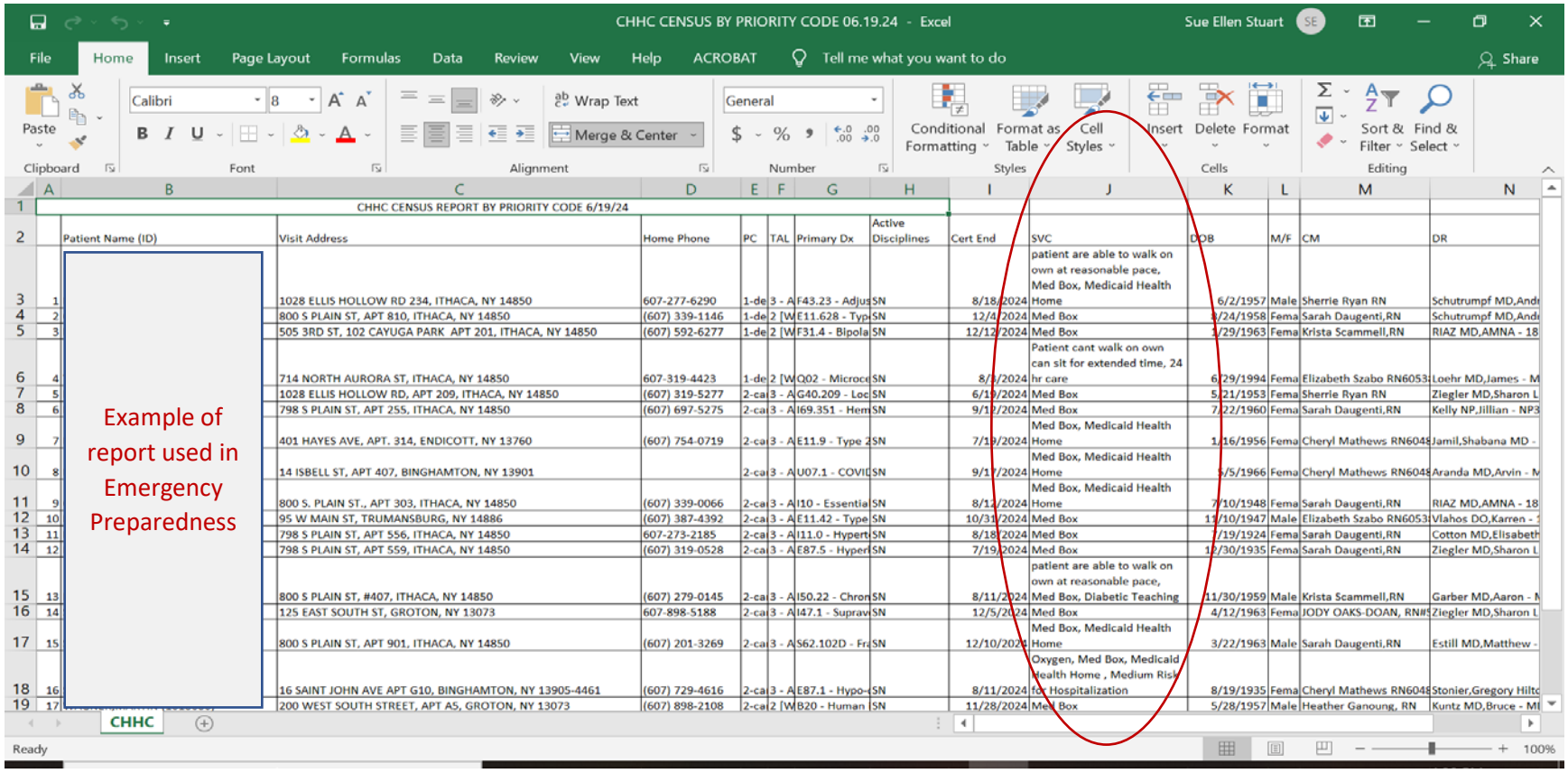
AGENCY SERVICE BUTTON



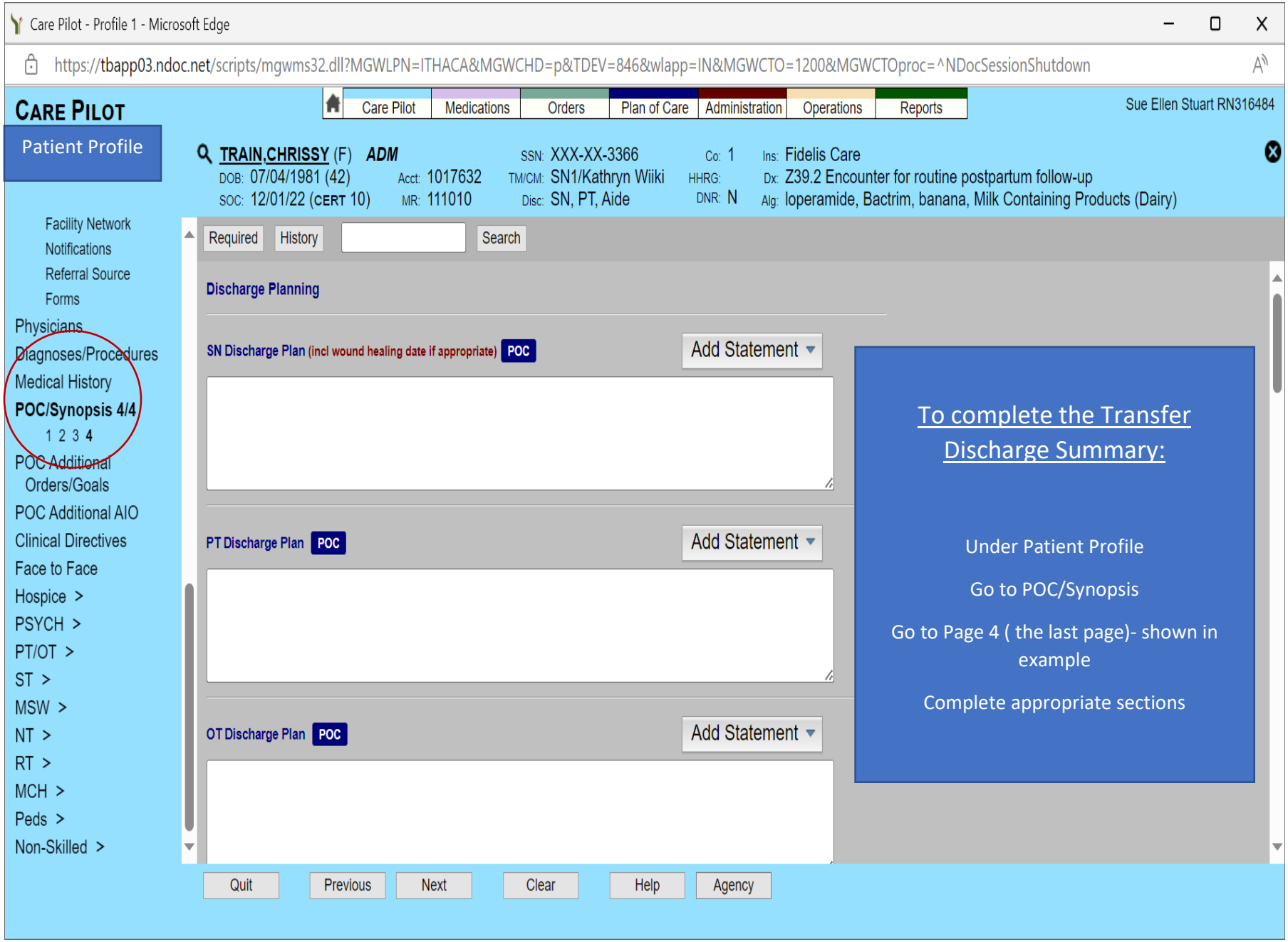
AGENCY SERVICE BUTTON

WHY ARE THE AGENCY SERVICE BUTTONS IMPORTANT?

1. Emergency Preparedness – our census reports that we use for emergency preparedness indicate the service provided. It is a regulation for us to be able to determine patients that have life sustaining services, like oxygen , in an emergency.
2. Management of caseloads – reports can be pulled by the services so we can determine, for example, all of our patients that have med boxes or all of our patients that have wounds or wound vacs.



TRANSFER OR DISCHARGE SUMMARY



4.8 PLAN OF CARE

Policy

Every patient that is receiving home health services, must receive a written, individualized plan of care. The plan of care must identify the services necessary to meet the patient's home care needs and the care to be provided to achieve the patient's measurable outcomes and goals. The plan of care will identify the responsible discipline(s) and be periodically reviewed and signed by a doctor of medicine, osteopathy or Podiatry, in accordance with his or her state license, certification or registration.

Purpose

To outline the agency expectations with regard to the patients care and to ensure the agency is following federal, state and local regulations and accepted standards of practice as to the plan of care for a patient.

Reference

Medicare COP §484.60, §484.60 (a)(1), §484.60 (a)(2), §484.60 (a)(3), §484.60 (c)(1), §484.60 (c)(2), §484.60 (c)(3)

Policy

1. Each discipline, i.e. nursing, therapies, social work including contracted services, develops a plan of care based on the assessment of patient needs and clinical status at the time of the initial/admission visit.
2. The Care Manager responsible for the patient receives a verbal summary of the plan of care the day of the initial assessment visit.
3. When the agency receives a general referral from a physician that requests agency services but does not provide actual treatments and observations for the patient, the agency will not be able to create the plan of care until a home visit is done and sufficient information is obtained to communicate with and receive approval from the physician.
    a. Patient-specific interventions and education; measurable outcomes and goals identified by the agency and the patient;
    b. Information related to any advanced directives; and
    c. Any additional items the agency or physician may choose to include.
    d. All pertinent diagnoses.
    e. All patient care orders
4. The signed original plan of care is submitted to the agency office electronically within 24 hours of visit.
5. The designated agency person is responsible for overseeing the care planning process. The plan will be appropriate and realistic based on the patient's needs and clinical status. The plan of care must promote positive outcomes and avoids duplication of services.

6. In the event of potential or actual duplication of services, the Care Manager will contact the disciplines involved and conduct a case conference to correct the situation. The case conference may be conducted via telephone. The results of the case conference are documented and become a permanent part of the patient's medical record.
7. Each member of the healthcare team reviews the plan of care at least every 60 days and more often if necessary, based on patient needs and clinical status to evaluate the appropriateness of the plan and the patient's progress toward goals.
8. The healthcare team member updates the plan of care as necessary.
9. The plan of care is dated and signed by the appropriate discipline whenever it is reviewed.
10. Verbal care conferences conducted on an impromptu, as-needed basis should be documented in the visit notes of each of the disciplines involved.
11. Multidisciplinary care conferences are held on selected patients at least monthly and more frequently if needed to promote coordination and continuity of care. The results are documented, and a copy is retained in the patient's medical record.
12. All disciplines involved in the patient's care including contracted services, are encouraged to attend the monthly conferences.
13. A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward measurable outcomes and goals identified.
14. Any revision to the plan of care due to a change in patient health status must be communicated to the patient/representative, caregiver and any physician's issues orders for the agency plan of care. This communication must be documented in the clinical record.
15. Any revision to the plan for the patient's discharge must be communicated to the patient/representative, caregiver, all physicians issuing orders for the plan of care and the patient's primary care practitioner or health care professional who will be responsible for providing care and services to the patient after discharge. These communications must be documented in the patient record.

4.9 PHYSICIAN PLAN OF CARE ORDERS

Policy

The agency will provide care, treatment and/or services according to a state licensed physician or licensed practitioner's orders or prescriptions in compliance with applicable laws and regulations.

Purpose

To ensure agency staff follow physician's orders and follow all regulations when obtaining, recording and implementing physician's orders.

Reference

Medicare COP §484.60 (b) (1), §484.60 (b) (3), §484.60 (b)(4), §484.60 (c)(1)

Procedure

1. The agency accepts verbal/telephone/facsimile and/or written orders from physicians or licensed independent practitioners whose licenses have been verified according to agency policy.
2. A nurse (RN or LPN) or licensed therapist may accept physician verbal/telephone orders.
3. All orders for medical care, treatment and/or services are reviewed/evaluated for appropriateness and accuracy by an appropriately licensed individual (i.e. registered nurse, licensed therapist) prior to providing care, treatment and/or services.
4. Verbal/telephone orders that are received:
    a. Must be accepted only by personnel authorized to do so by applicable state laws and regulations and/or agency policy.
    b. Must be transcribed into one of the following forms:
        i. Referral Sheet
        ii. Physician Order/Prescription Form
        iii. Electronically
    c. Must be communicated to the Care Manager and appropriate members of the healthcare team.
    d. The staff member who accepts the order must reduce the order to writing, ensures the appropriateness, accuracy and completeness of the order and signs, dates and times the order.
    e. Must be authenticated, signed and dated by the physician in accordance with applicable regulations.
    f. The written order must be placed in the patient's clinical records.
5. All orders are renewed or updated to reflect
    a. Changes in the care, treatment and/or services being provided
    b. Changes in the patient's physical or psychosocial condition
    c. The patient's response to care, treatment and/or services

d. The patient's outcome related to care, treatment and/or services
e. Changes in diagnosis, treatment (including procedures and medications) and equipment

6. The plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care as frequently as the patient's condition or need require, but not less frequently than once every 60 days beginning with the start of care date.
7. Drugs, services, and treatments are administered only as ordered by a physician that establishes and periodically reviews the plan of care.

Orders/Care Plans/Medications

These must be reviewed at every visit .

Ask these question:

- **Do I have orders for everything I am providing for the patient?**
  Remember this is a requirement by regulation!

- **Examples:**
  - Wound Care
  - All medications
  - Orders for all treatments
  - Teaching the patient about disease management
  - Parameters to report to MD if outside of what has been set for that patient