



CHAP

Community
Health
Accreditation
Partner

Home Health & Hospice Accreditation Intensive Activity Guide

Learning Objectives:

- Demonstrate knowledge of the CHAP Home Health and/or Hospice Standards of Excellence.
- Identify the revisions within the CHAP Home Health Standards and CMS Conditions of Participation.
- Demonstrate knowledge of the revised CMS Hospice Survey process.
- Identify trends in deficient practice based upon site visit results for calendar year 2022.
- Demonstrate ability to identify areas in need of improvement and develop a performance initiative to address the need.
- Outline the CHAP Accreditation process.

Disclosures/ Conflict of Interest:

This nursing continuing professional development activity was approved by the Virginia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

There are no conflicts of interest for any individual in a position to control content for this activity.

How to obtain CE contact hours:

Criteria for successful completion includes attendance at the entire event (service applicable days), participation in engagement activities, and completion of an evaluation.

Home Health Only Attendees – 11.25 Contact Hours

Hospice Only Attendees – 12.5 Contact Hours

Home Health and Hospice Attendees – 18.50 Contact Hours

Hospice Day One (All times in EST)

10:00-10:30	Welcome and Housekeeping/ Get to Know Each Other
10:30-10:45	CHAP Standards & Resources
10:45-11:30	Hospice Patient Family Centered Care (HPFC)
11:30-11:45	Break
11:45-12:45	Hospice Assessment, Care Planning and Coordination (HCPC)
12:45-1:45	Hospice Care Delivery and Treatment (HCDT)
1:45-2:15	Lunch
2:15-3:00	Hospice Inpatient Care (HSIC)
3:00-3:45	Care to Residents in a Facility (HSRF)
3:45-4:00	Break
4:00-4:30	Hospice Leadership and Governance (HSLG)
4:30-5:00	Hospice Information Management (HSIM)
5:00-5:30	New Hospice Survey Process

Hospice & Home Health Day Two (All times in EST)

10:00–10:45	Welcome to Home Health and returning Hospice
10:45-11:45	Infection control
11:45-12:00	Break
12:00-12:30	Human Resource Management
12:30-1:45	QAPI
1:45-2:15	Lunch
2:15-3:00	Emergency Preparedness
3:00-3:15	Break
3:15-4:15	Accreditation Process
4:15-4:30	The CHAP Consultant
4:30-5:00	Question and Answer

Home Health Day Three (All times in EST)

10:00-10:45	Welcome and Recap/CHAP Standards & Resources
10:45-11:30	Patient Centered Care (PCC)
11:30-11:45	Break
11:45-1:00	Assessment, Planning and Coordination (APC)
1:00-1:30	Financial Stewardship (FS)
1:30-2:00	Lunch
2:00-3:00	Care Delivery and Treatment (CDT)
3:00 – 3:30	Leadership and Governance (LG)
3:30-3:35	Bio Break
3:35-4:05	Information Management (IM)
04:05-04:15	Final Q and A

DAY ONE

Hospice

Topic: CHAP Standards of Excellence

Accessing **CHAP Standards** of Excellence: from the CHAP Education webpage

Revisions

Current Version

Evidence Guidelines

Key Performance Areas

Patient Centered Care

Safe Care Delivery

Sustainable Organizational Structure

Additional Resources (see slides)

Complaint Handling Discussion

Patient MRN	Complaint
465382	The patient's husband called and stated they haven't seen or heard from their social worker in almost 2 months.
465932	The daughter of the patient called to state that when she pulled up to her mother's house the hospice aide was standing on the driveway finishing her cigarette and she watched her flick it to the street curb prior to entering the house.
465962	The patient called complaining that when her hospice aide is giving her a bed bath, she is rough and last time she was there she was so rough she caused a skin tear to her left shin.
457363	The patient's son reported to his mother's nurse that the Chaplain never arrives when he says he will arrive, and it throws off his mother's routine.

Thoughts to Consider...

What would be your first step in addressing these complaints?

Who might you want to interview or speak with?

What policy/policies might you want to review?

What type of education might you want to conduct with staff?

Topic: Assessment, Care Planning and Coordination (HCPC)

Ms. Iris' Hospice Journey...

Ms. Iris is being discharged from the hospital to home with initial hospice care. Her primary diagnosis is stage IV pancreatic cancer with liver metastasis. Her primary caregiver is her husband of 50 years who is struggling with COPD. The next closest relative is a daughter living 500 miles away. Both Ms. Iris and her husband are very anxious about this next step. Due to staffing circumstances a new employee, an RN new to hospice, is scheduled to conduct the assessment. As the consultant/Administrator, you are evaluating the admission documentation and process.

Group Activity – 15 mins

Attendees will be divided into breakout rooms. Each group assigns one spokesperson to share their thoughts.

- Each participant should conduct a high-level overview of the entire assessment.
- Each group will be assigned key elements of the assessment for in-depth review. For your specific assigned assessment components do the following:
 - Evaluate the assessment of your assigned areas and what was documented.
 - How should the assessment be improved?

Groups

- Group one – focus on pain assessment and vitals
- Group Two – focus psychosocial aspects
- Group Three - focus on functional aspects
- Group Four – focus on medications
- Group Five – focus on coordination aspects

Group Responses & Discussion

Comprehensive Assessment Example

Patient: Iris Wood

SOC: 7/22/2021

Diagnosis – Pancreatic Cancer with metastasis

Secondary – Congestive Heart Failure

Skilled Facility Transfer 10/1/2021

Election of benefit signed 9/1/2021

Level of Care: Routine Hospice Care

Age: 76

Advance Directives – Yes

Vital Signs:

Temp – 97.7

Pulse – 88

Resp – 24

BP – 118/68

Pain Assessment

Intensity of 4 current and frequently

Acceptable level to patient is 4

Description of pain – sharp abdominal pain with movement, becomes dull after medication taken.

Current medication effective “usually” “better than before I went into the hospital

Patient’s Primary Concern/Goal

Relief of pain and to enjoy her remaining days

Caregiver’s primary concern/goal

Patient is free from pain per spouse. Daughter is now primary care provider.

Neurological status

Patient alert and oriented to person, place and time

No issues with vision, smell, taste

Becomes anxious with increasing pain

Cardiac status

Pulse regular, patient with +2 edema both lower extremities (pedal and ankle) No complaints of chest pain

Respiratory

Respirations even, slightly labored when patients “catches her breathe” due to pain.

Oxygen is in place at 2 liters per minute, nasal cannula. Breath sounds bilateral diminished in bases.

Gastrointestinal

Abdomen distended and firm, patient complains of occasional nausea, last bowel movement three days ago. Patient states this is normal for her. Minimal bowel sounds noted in all quadrants.

Genitourinary

Patient incontinent of urine on occasion. Urine observed to be clear and dark yellow. No complaints of burning or pain with urination. Utilizing urinary pads for incontinence.

Musculoskeletal

Patient able to move all extremities. States “I am feeling weaker and am afraid of falling.” Husband assists with transfer to chair and patient walking 15 steps with moderate shortness of breath. Patient not willing to use bedside commode at this point.

Activities of Daily Living

The daughter is assisting with cleaning, shopping, cooking and assisting with medication administration. Assists patient with bath using shower chair in the shower. Patient independent in feeding self.

Fall Risk Assessment

Standardized fall risk completed, and patient scored as high risk due to the following factors:

- Over age of 65
- Increased anxiety
- Unable to ambulate independently.
- Initial admission to hospice
- Attached equipment in relation to O2.

Skin Integrity

Poor turgor, skin slightly jaundiced and dry, warm to touch. No rashes, skin tear right leg upon discharge from SNF

Endocrine

No issues

Coping

Patient coping better with diagnosis but is worried about being a burden for her daughter.

Medical supplies

Oxygen in place

Patient needs: hospital bed, walker

Medications

See medication list below.

Drug review completed and no interactions or side effects noted

Patient Name: Iris Wood	DOB: 3/23/1952
Diagnosis: Pancreatic Cancer with liver Metastasis	SOC: 9/1/21
Crestor 10 mg PO daily	
MS Contin 15 mg every 12 hours	
Ativan 0.5mg PO PRN	
Tylenol 325 mg PO PRN	
Atenolol 25 mg PO daily; hold heart rate <50	
Digoxin .25 mg daily	
Albuterol 2.5mg via nebulizer q 6-hour PRN for shortness of breath/wheezing	
Comfort Kit	
DME	
Walker	
10 L concentrator	
Hospital bed	
Overbed table	
Nebulizer	

Comprehensive assessment needs:

- Nursing
- Social work
- Spiritual care – refused.
- Physician
- Bereavement –

Teaching completed:

- Disease process and signs of disease progression
- Plan of care review
- Safety during ambulation/transfer
- On call number

Coordination:

- Physician call for update on patient and orders obtained.
- DME call for hospital bed.
- Social Work notified of patient admission and summary given.
- Volunteer – unable to provide assistance at this time.
- Spiritual counselor – not called as patient refused.

Signed: Nurse Rose RN 7/22/2021

Pause and Consider...

Based on the assessment information provided, the admitting RN did not conduct the initial bereavement assessment during their visit. The spiritual counselor was refused as the patient prefers to talk with her priest. The interdisciplinary team was informed of the admission on day two following the election of benefit. The social worker called on day two and the family requested a visit for next week. By day six following the election of benefit, there has been no initial bereavement assessment completed.

Is this a compliance issue?

If so, what is the issue?

How could this issue have been handled differently to ensure compliance with the standard?

Individual Activity

- Review the Plan of Care in your participant guide on pages 14-15 to evaluate the abilities of the clinician to develop a comprehensive Plan of Care
 - The activity will be allowed 10 minutes
 - Discussion will follow related to the comprehensive nature of the plan of care
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Plan of Care Example

Patient Name:	DOB	SOC Date;
Iris Wood	3/23/1945	9/1/2021
Level of Care: Routine Hospice Care Primary Hospice Diagnosis: Primary Pancreatic Cancer Secondary Diagnosis: Congestive Heart Failure	Referral physician: Attending physician: Name/Address Hospice Medical Director: Name/Address	
Address: 45 Apple Blossom Road, Pineville GA		
Visit frequency: RN 2w9, MSW 1m3, Chaplain – declined, Hospice Aide 2 w 10		
DNR: Yes/No Advance Directive: Yes/No Medical Power of Attorney (POA)Name: Contact phone number Language Preference: English Equipment: Oxygen concentrator, Portable Oxygen cylinders, hospital bed, overhead table, Shower chair etc. Medical Supplies/Appliances: Depends Special Precautions: Example, fall, oxygen, bleeding Allergies:		
Problem	Alteration in respiratory status	
Intervention	Assess vital signs, Assess respiratory status; Assess adequate oxygen to patient comfort level; Teach oxygen tory infection Usage, Teach s/s respira	
Goal Patient will	exhibit adequate oxygenation within 1 week as noted by normal respiratory rate and depth.	
PATIENT/FAMILY GOAL:		
Problem	Alteration in Pain Management	
Intervention	Teach Pt/PCG appropriate use of pain control medications. Teach use of medications per comfort box; assess effectiveness of medication for pain control; assess availability of pain medications; if opiates are prescribed patient placed on stool softener, teach Pt/PCG s/s to report to agency	
Goal	Patient’s pain will be managed to patient acceptable level of 4	
PATIENT /FAMILY GOAL		
Problem	Alteration in urinary status as evidenced by incontinence	
Intervention	Assess skin for potential breakdown; Teach Pt/PCG of need to ensure dry clothing/linen;	
Goal	Patient will be free from skin breakdown related to incontinence	
PATIENT/FAMILY		
Problem	Alteration in nutritional status	
Intervention	Assess nutritional status of patient; Teach Pt/PCG use of small frequent meals rather than large meals; Teach use of high protein supplements	
Goal	Patient will be able to enjoy small amounts of food that are appetizing to her. Nutritional status will assist maintenance of skin integrity.	
PATIENT/FAMILY		

Problem	Alteration in ability to care for personal care needs
Intervention	Assess patient need for assistance with ADL. Teach Pt/PCG measures for safety during transfer and ambulation; Aide to provide care to patient 2 times per week for shower with use of shower chair; shampoo each visit, assist with transfer and ambulation; to inform RN of changes in the patient condition
Goal	Patient's personal care needs will be met safely and effectively.
Problem	
Intervention	
Goal/PATIENT/FAMILY	

SPECIFIC PHYSICIAN ORDERS AS FOLLOWS:

OXYGEN 2 LITERS VIA NASAL CANNULA CONTINUOUS.

Foley: Size 14 fr Balloon 5cc to drainage bag PRN Yes /No /prn for urinary retention

Routine comfort pack

Patient/Caregiver participated in plan of care and agree to care being provided. Date:

Signed and dated by the following physician. Marcus Welby MD

Top 2022 HCPC Findings

Tips for Success

Topic: Hospice Care Delivery and Treatment (HCDT)

Activity/Home Visit Observation

Observe the home visit with Ms. Iris and write down any concerns you might have about the visit as you watch. We will discuss it as a group once completed.

Pause and Consider...

If you had observed this visit and overheard Ms. Iris state the aide had provided a bed bath instead of a shower, what are some follow-up actions you would take?

Activity...

Take a few moments to read through the nurses' comprehensive assessment documentation again on pages 9-12.

What tasks would be appropriate for the RN to assign the aide to complete when providing care for Ms. Iris?

What instructions or precautions should the aide be aware of when providing care for Ms. Iris that should be included on the aide plan of care?

Knowledge Check: Can you think of what components make up a completed discharge/transfer summary?

Top 2022 HCDT Findings

Tips for Success

Topic: Hospice Inpatient Care (HSIC)

Ms. Iris' hospice journey continues...

Over a 3-week period, Ms. Iris has had progressive difficulty with pain management. When admitted, the patient's pain was controlled with MS Contin 15mg BID and the use of MSIR for breakthrough pain.

In week two of her hospice certification period, her pain medication plan was changed to MS Contin 30mg BID with an increase in MSIR dosage and frequency.

In week three her medication regimen was changed to Fentanyl patches with Actiq lozenges; however, her pain continued and was not effectively managed. This has caused an increase in lack of sleep and anxiety, with additional medication changes needed.

GIP Decision

The decision was made to admit her to GIP for pain management. This decision was very difficult for the husband to agree to but after discussion with the social worker, he admitted he felt hopeful that his wife may be able to get some pain relief. It was noted by members of the IDT that the husband appeared exhausted and had not had a good night's sleep in 3 weeks.

In addition, the personal care needs of his wife were growing more complex each day and without his daughter's help, he was overwhelmed with his wife's needs.

Ms. Iris was admitted to a Medicare Certified Skilled Nursing Facility that the hospice had contracted with for their provision of GIP services.

Thoughts to Consider...

Was short-term inpatient care the right choice for Ms. Iris?

What other options could be considered?

What interventions might need to occur for Ms. Iris to come back home?

What level of care would be appropriate if fatigue of the husband was the main issue?

Top 2022 HSIC Findings

Tips for Success

Knowledge Check: Short-term inpatient care is for what 3 purposes?

Topic: Hospice Care to Residents in a Facility (HSRF)

Ms. Iris' story continues...

Following her GIP stay, Iris is admitted as a custodial patient to the skilled nursing facility on routine level of care until her daughter can return and provide care for her mother.

The RN is explaining to the facility staff the differences in their roles and has decided to provide examples to reinforce their different responsibilities.

- Provision of meals
- Physician call upon worsening of symptoms
- Providing a chair bath 3 times per week
- Assisting with incontinence
- Determining the bowel regimen
- Implementing the bowel regimen
- Determines a need for changing the level of care
- Financial responsibility for long-term incontinence supplies
- Financial responsibility for medications addressing the terminal illness

Activity: Whose Responsibility? A numbers game....Which tasks are the responsibilities of the hospice, and which are the responsibilities of the facility? Are there any that are shared?

Hospice (1)

Facility (2)

Top 2022 HSRF Findings

Tips for Success

Topic: Hospice Leadership and Governance

Top 2022 HSLG Findings

Tips for Success

Knowledge Check: Does attending IDG count towards volunteer patient care hours?

Topic: Hospice Information Management (HSIM)

Knowledge Check: What are the required elements of the clinical record?

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Pause to Consider... which of the required clinical record elements do your organizations have the most challenges with?

Top 2022 HSIM Findings

Tips for Success



Topic: CMS Revised Hospice Survey Process

Knowledge Check: Name one (or all) of the four core CoPs.

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What is your “Golden Nugget” from today’s sessions?



DAY TWO

Home Health & Hospice

Welcome Back to Hospice Participants & Welcome to our Home Health Participants

Topic: Infection Prevention and Control

Activity: Take a few mins to read through the two policies below. With these in mind, observe the scenario and identify areas of compliance and non-compliance.

Handwashing Policy:

PURPOSE

To prevent cross contamination and home care-acquired infections and to promote hand hygiene thereby reducing and/or preventing health care acquired infections.

POLICY

Personnel providing care/service in the home setting will wash their hands using either an agency approved alcohol-based hand rub or soap and water:

- Upon entering and before leaving the home
- When hands are obviously soiled, wash with soap and water
- Before entering the clean section of visit bag (if applicable)
- After handling household pets
- Before and after contact with each patient
- After handling bed pans, urinals, catheters, linens and contact with body fluids
- Before and after gloves and other personal protective equipment are used
- Before and after eating
- After use of the toilet
- After blowing nose, sneezing, or coughing

PROCEDURE

- 1.0 Handwashing with Water:
- 1.1 Wet hands and apply the soap working into a heavy lather using friction, covering, the entire hand, top and bottom. Pay special attention to the nails, between the fingers and back of the hands.
- 1.2 Wash hands with a 20 second vigorous rubbing together of all lathered surfaces, followed by thoroughly rinsing under a flowing stream of water. If hands are visibly soiled, a longer handwashing time is required.
- 1.3 Use a paper towel to dry hands thoroughly. Turn off the faucet using the paper towel. Discard the towel into regular waste.

- 2.0 Hand Hygiene Without Water (use 60-70% alcohol-based hand rub):
 - 2.1 Use the solution according to instructions.
 - 2.2 Rub hand cleanser into skin until dry. (If enough alcohol-based hand rub is applied, hands will take greater than 10-15 seconds to dry.)
 - 2.3 Pay special attention to the nails and between the fingers.

Bag Technique Policy:

PURPOSE

To describe the procedure for maintaining a clean nursing bag and preventing cross-contamination.

POLICY

As part of the infection/exposure control plan, Agency personnel will consistently implement principles to maximize efficient use of the patient's care supply bag when used in caring for patients.

Staff will use a bag supplied by the agency, or one that has been approved for use.

PROCEDURE

- 1.0 The bag may have the following contents:
 - 1.1 Hand washing equipment-alcohol based hand rub and skin cleanser, soap, and paper towels
 - 1.2 Assessment equipment (as appropriate to the level of care being provided)- thermometers, stethoscopes, a hem gauge to measure wounds, sphygmomanometer, and urine testing equipment
 - 1.3 Disposable supplies (as appropriate to the level of care being provided)-plastic thermometer covers (if applicable), sterile and non-sterile gloves, plastic aprons, dressings, adhesive tape, alcohol swabs, tongue blades, applicators, lubricant jelly, scissors, bandages, syringes and needles, vacutainer equipment for venipuncture, skin cleanser, paper towels, and a CPR mask
 - 1.4 Paper supplies (if applicable)-printed forms and materials necessary to teach patients and family/caregivers and document patient care
- 2.0 Personnel must regularly check the expiration date of any disposable supplies kept in the nursing bag. Expired supplies should be returned for disposal.
- 3.0 The bag will be cleaned as soon as feasible when it is grossly contaminated or dirty. Antiseptic wipes, alcohol, or another approved cleaning agent will be used.
- 4.0 Bag Technique
 - 4.1 The bag will be placed on a clean surface (i.e., a surface that can be easily disinfected) in the car.
 - 4.2 Once in the home place the bag on an impervious barrier on a flat surface that is not the floor
 - 4.3 Prior to administering care, alcohol-based hand rub or soap and paper towels will be removed, and hands will be washed. These supplies will be left at the sink for hand washing at the end of the visit.
 - 4.4 The supplies and/or equipment needed for the visit will be removed from the bag.
 - 4.5 When the visit is completed, discard disposable personal protective equipment in an impermeable plastic trash bag. Contaminated equipment that cannot be cleaned in the patient's home may be transported in an impermeable sealed plastic bag. Never place used needles, soiled equipment, or dressings in the nursing bag.
 - 4.6 Reusable equipment will be disinfected after each patient.
 - 4.7 Hands will be washed prior to returning clean equipment and/or unused clean supplies to bag. Return cleaning supplies, e.g., liquid soap, to the bag.

Discussion: What deficient practices did you take note of? Did you note any compliance in her infection control practices?

Top 2022 IPC Findings

Top 2022 HIPC Findings

Tips for Success

Topic – Human Resource Management

Hiring Criteria Discussion...

What are some hiring criteria that may differ from state to state?

Is training provided on how to conduct an interview?

Are certain disciplines more difficult to hire than others?

CHAP standards are less restrictive than in the past, do you find that providers understand how to conduct the hiring process?

Top 2022 HRM Findings

Top 2022 HSRM Findings

Tips for Success

Topic: Continuous Quality Improvement

Knowledge Check: What are some possible quality indicators for data collection?

Group Activity: Each group will be provided an area in need of improvement. One person should be given the role of reporter of your results. The group will be placed in individual breakout rooms and have 20 minutes for this activity. Remember to be specific, comprehensive, and measurable.

Address the following in your performance improvement plan:

Smart Goal

Plan

Actions to be taken

How will effectiveness be monitored

Thoughts to Consider...

How extensive is the non-compliance?

Does the non-compliance affect quality of patient care?

Is one clinician involved or several? New or tenured?

Does the organization have the resources to address the issue?

Top 2022 CQI Findings

Top 2022 HQPI Findings

Tips for Success

Topic: Emergency Preparedness

Top 2022 EP Findings

Top 2022 HSEP Findings

Tips for Success

Knowledge Check: If an actual event occurs requiring activation of the plan, the agency is exempt from the next required community-based facility based functional exercise. (True or False)

CHAP Accreditation Process

Knowledge Check: CHAP offers accreditation and/or certification for which service lines?

Knowledge Check: A home health organization seeking initial accreditation with deemed status must provide which disciplines?

Knowledge Check: Organizations seeking _____ accreditation need to submit readiness.

The Site Visit

Knowledge Check: Name one activity the Site Visitor will conduct during a site visit.

What is your “Golden Nugget” from today’s sessions?

DAY THREE

Home Health

Topic: CHAP Home Health Standards of Excellence

Accessing **CHAP Standards** of Excellence: from the CHAP Education webpage

Revisions

Current Version

Evidence Guidelines

Key Performance Areas

Patient Centered Care

Safe Care Delivery

Sustainable Organizational Structure

Additional Resources (see slides)

Topic - Patient Centered Care (PCC)

Individual Activity: Write down all the elements you can think of that need to be included in the Patient Bill of Rights

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Knowledge Check: Is it acceptable to provide the patients with their bill of rights only verbally and document the conversation?

Top 2022 PCC Findings

Tips for Success

Complaint Handling Discussion

Patient MRN	Complaint
465382	The patient's husband called and stated they haven't seen or heard from their physician therapist in almost 2 weeks, and they are supposed by seeing them weekly.
465932	The daughter of the patient called to state that her mother is almost out of wound supplies and per the nurse, the shipment was due to arrive two days ago, and they still have not received the supplies.
465962	The patient called complaining that when her home health aide was helping her into the shower, the aide was rushing her and almost caused her to slip and fall.

Thoughts to Consider...

What would be your first step in addressing these complaints?

Who might you want to interview or speak with?

What policy/policies might you want to review?

What type of education might you want to conduct with staff?

Topic: Assessment, Planning and Coordination (APC)

Ms. Violet's home health journey...

Ms. Violet Chap is a 72-year-old female with a recent fall resulting in an acute care hospitalization due to a shoulder injury. She was admitted to home health approximately one month prior to her fall with a primary diagnosis of Diabetes. She also has a history of hypertension and during the hospital stay developed a diabetic ulcer on her right toe. She is scheduled to be discharged today and an RN just out of orientation is scheduled to conduct the Resumption of care.

Group Activity – 20 mins

Attendees will be divided into breakout rooms. Each group assigns one spokesperson to share their thoughts.

- Each participant should conduct a high-level overview of the entire assessment.
- Each group will be assigned key elements of the assessment for in-depth review. For your specific assigned assessment components do the following:
 - Evaluate the assessment of your assigned areas and what was documented.
 - How should the assessment be improved?

Groups

- Group one – focus on integumentary and diabetes
- Group Two – focus functional status
- Group Three - focus on cognitive status
- Group Four – focus on medications
- Group Five – focus on nutrition and pain
- Group Six – focus on safety

Group Responses & Discussion

Comprehensive Assessment

Patient Name: Violet Chap

Visit Date: 7/22/2021

Start of Care Date: 6/29/2021 **Resumption of**

Care Date: 7/22/2021

Allergies:

Vital Signs:

Temperature: 99.2

Pulse Apical: 82

Reg

Irreg

Resp: 22

Pulse Radial: 82

Reg

Irreg

B/P: 146/85 Left Arm – Unable to take in right arm due to shoulder pain with movement

Health Screening/Immunization

Not Assessed

Facility Discharge Date: 7/21/2021 Facility:

Short term acute hospital

inpatient rehabilitation

Skilled nursing facility

other

Long term care hospital

Inpatient Facility Diagnosis

Unspecified Fall

Type 2 Diabetes

Diabetic Ulcer lower extremity

History of Hypertension

Medical history:

- None
 Diabetes
 Asthma
 Falls
 dementia
 arthritis
 angina
 liver disease
 substance abuse
 TIA/CVA
 tobacco use
 hypertension

Orders:

Comments: Skilled Nursing, Home Health Aide, Physical therapy to evaluate and treat. Wound care to right toe. Continue prior medications.

Spiritual/Cultural

- Not Assessed

Spiritual/Religious Affiliation

Spiritual/Religious Contact

Living Arrangement	Availability of Assistance				
	Around the clock every day	Regular daytime	Regular nighttime	Occasional or short - term assistance	No assistance available
a. Patient lives alone	<input type="radio"/>	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input checked="" type="radio"/> 05
b. Patient lives with other person(s) in the home	<input type="radio"/> 06	<input type="radio"/> 07	<input type="radio"/> 08	<input type="radio"/> 09	<input type="radio"/> 10

Safety Measures include:

- Standard precautions
 Fall Precautions
 ADL Safety
 Safe Disposal of Sharps
 Airborne Infection Control Precautions
 Contact Infection Control Precautions

Body Systems

Range of Motion: **limited range in right arm. Patient states "frozen right shoulder" since the fall.**

Functional Limitations: **slow to move, uses arms of chair to be able to get out of chair**

Assistive Devices: **use of a cane for ambulation**

Swollen Joints: **Arthritis both knees**

Pain Assessment:

Standardized validated assessment conducted: Yes No

Pain Frequency interfering with activity:

- No Pain Pain does not interfere with activity Daily but not constant
 All the time

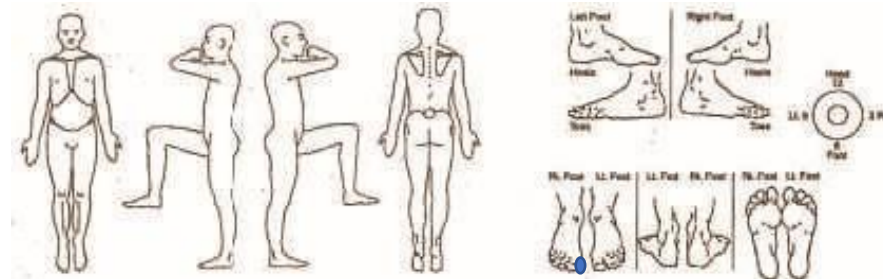
Other: Patient has pain with movement in both knees and right shoulder. States "I just take Tylenol arthritis for the pain" Has pain upon dressing change of diabetic ulcer right great toe"

Integumentary: Skin Warm and Dry,

Wound: Yes No

Location: Right great toe

Type of Wound: Vascular Diabetic Surgical Trauma Pressure



Wound Care: per patient, in the hospital they changed the dressing every day but he did not know what was being used.

Respiratory:

Wheezes Dyspnea CPAP Rales Rhonchi Cough

Breath Sounds: RR- 22 Bilateral lung sounds with rales in lower right lobe. Patient coughs upon taking a deep breathe. States she gets "winded" going up the stairs to the bedroom at night.

Endocrine:

WNL Excessive Hunger/thirst Excessive bleeding Thyroid Issue
 Diabetic

Blood Glucose Performed: Result:

FSBS Range: Per patient 120-185 although lately she has had fasting sugars over 200

Foot lesions Foot care taught foot care performed

Cardiac:

WNL Syncope Angina Chest Pain Varicosities
 Pacemaker Orthopnea (# of pillows) 3 pillows at night Edema
 Other: B/P – 146/85 P- 82 irregular – slight non-pitting edema at bilateral ankles. Patient states ankle swelling increases throughout the day.

Elimination Status:

Urinary:

WNL Urinary incontinence Frequency Burning
 Nocturia

Bowel: WNL

Gastrointestinal: Abdomen soft/non-tender. Bowel sounds present in all four quadrants. Patient states daily bowel movements without difficulty if she takes her MiraLAX in the morning.

Nutritional Assessment:

WNL Pain Nausea Vomiting Diarrhea Constipation

Standardized nutritional assessment Completed: Yes No

Diet: 1500 calorie diet

Neuro/Emotional/Behavioral:

Oriented: Time Place Person
 Alert Forgetful Dizziness Pupils equal/reactive
 Slurred Speech Abnormal speech Insomnia Anxious
 Headache Depressed Uncooperative Memory deficit

Comments: Patient is anxious that she may lose her foot. Ms. Violet had a close friend who began with a diabetic ulcer on the toe and went on to lose her foot. In discussion regarding consistency with blood sugar monitoring and medication compliance, the patient revealed that she often forgets to take her blood sugar and to take her medications on time, sometimes missing several doses.

ADL/IADL

Self-Care:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent
Ambulation:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent
Transfer:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent
Household Tasks:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent

Comment: Prior to fall requiring hospitalization Ms. Violet was independent in all daily activities. Following the fall, her right shoulder has limited mobility and is painful upon movement which limits her ability to fulfill all activities of daily living independently.

Assistive Devices: Walker Cane Shower Chair Reacher

Medications:

- | | |
|---|--|
| <input type="checkbox"/> Patient unable to independently take meds | <input checked="" type="checkbox"/> Drug education provided to patient |
| <input checked="" type="checkbox"/> Patient requires drug diary or chart for meds | <input type="checkbox"/> High-risk medication instruction given |
| <input type="checkbox"/> Patient med dosages prepared by another person | <input type="checkbox"/> Patient demonstrates non-compliance |
| <input checked="" type="checkbox"/> Patient needs prompting/reminding | <input type="checkbox"/> Patient meds must be administered |
| <input checked="" type="checkbox"/> Drug regimen review for interactions, duplicate therapy | |

potential adverse effects conducted

Comments: Patient medications at home reconciled with

discharge medication list. **C Current Medications:**

Lantus insulin 30 units at bedtime

Metoprolol tartrate 25 mg twice a day

Plavix 75 mg once a day

Glyburide 10 mg twice a day

Aspirin 81 mg once a day

Simvastatin 40 mg at bedtime

Folic Acid 1 mg once a day

Medication Management:

Oral Medications: Independent Need some Help Dependent N/A

Injectable : Independent Need some Help Dependent N/A

Comments: Ms. Violet has difficulty remembering to take her medications, including her evening insulin. She lives alone but has a family friend who lives two doors down who might help. A daughter lives 150 miles away but comes to see her mother once per month. Currently the patient has no other forms of assistance.

Plan of care/Teaching or Teaching Interventions Performed this visit.

Education performed:

- Medication management
- Emergency Plan
- Hand Hygiene
- Fall Precautions
- On Call Availability

Interventions performed: Physical Assessment

Teaching as above
Medication review

Plan of Care Collaboration:

Nursing for wound care and medication management
Home Health Aide for assistance with ADL
Physical therapy to evaluate patient

Assessment Summary:

Comments: 82-year-old female with recent fall requiring hospitalization due to shoulder injury. During hospital stay, diabetic ulcer noted on right great toe. Patient is alert and oriented with self-identified times of forgetfulness. Ms. Violet informed nurse that she has at times forgotten to take her medicine. Patient uses Lantus injectable pen but also at times forgets to take her evening insulin. Discussion with patient about use of pill organizer and the setting of an alarm as a reminder for her insulin. Also discussed the availability of a close neighbor for assistance and that daughter may be able to call her each night as a reminder. Vital signs were stable. Respirations easy with rales noted in right lower lobe. Patient with no bowel difficulties if she takes her Miralax. Infrequent urinary incontinence due to difficulty in getting up quickly from her chair. Patient having pain in her right shoulder since the fall and

has limited range of motion which affects her ability to conduct ADL/IADL easily. Dressing not removed during this visit as the wound had been redressed prior to **discharge**.

Physician contacted regarding plan of care:

Comments: None

Homebound Status:

Residual weakness dependent upon adaptive device confusion, unable to leave alone

Medical restriction severe SOB upon exertion requires assistance to ambulate

Pause and Consider...

Take a few moments to review Violet's plan of care below. Remember, the comprehensive assessment is the starting point for developing the plan of care. Keep in mind the issues you identified when in your groups and how those impact the plan of care.

What issues are you identifying as you review?

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. **123456** 2. Start Of Care Date **7/22/2021** 3. Certification Period From **7/22/2021** To **9/22/2021** 4. Medical Record No. **12589** 5. Provider No.

6. Patient's Name and Address
Violet Chap
2300 Chappy Lane, Chapster, MA 23568

7. Provider's Name, Address and Telephone Number
Dr. Guthrie
Physician Drive
Hospital, IN 23657

8. Date of Birth
 9. Sex M F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Lantus insulin 30 units at bedtime
Metoprolol tartrate 25 mg twice a day
Plavix 75 mg once a day
Glyburide 10 mg twice a day
Aspirin 81 mg once a day S
imvastatin 40 mg at bedtime
Folic Acid 1 mg once a day

11. ICD Principal Diagnosis **Encounter Fall with Injury** Date **7/18/2021**

12. ICD Surgical Procedure

13. ICD Other Pertinent Diagnoses **Diabetic Ulcer Right Foot** Date **7/18/2021**
Diabetes Mellitus Type 2 long Standing

14. DME and Supplies
Glucometer, cane

15. Safety Measures
Fall Risk

16. Nutritional Req. 1500 Cal Diet

17. Allergies No Drug or food allergies

18.A. Functional Limitations
 1 Amputation 5 Paralysis 9 Legally Blind
 2 Bowel/Bladder (Incontinence) 6 Endurance A Dyspnea With Minimal Exertion
 3 Contracture 7 Ambulation B Other (Specify)
 4 Hearing 8 Speech

18.B. Activities Permitted
 1 Complete Bedrest 6 Partial Weight Bearing A Wheelchair
 2 Bedrest BRP 7 Independent At Home B Walker
 3 Up As Tolerated 8 Crutches C No Restrictions
 4 Transfer Bed/Chair 9 Cane D Other (Specify)
 5 Exercises Prescribed

19. Mental Status
 1 Oriented 3 Forgetful 5 Disoriented 7 Agitated
 2 Comatose 4 Depressed 6 Lethargic 8 Other

20. Prognosis
 1 Poor 2 Guarded 3 Fair 4 Good 5 Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) OMB No. 0938-0357

SN 3W4, 2W3, 1W2; HHA 2-3 times per week for personal care; PT to evaluate and treat;

Skilled Nursing to assess wound R great toe each visit. Wound care as ordered. Teach medication compliance, s/s of infection; S/S of hypo/hyperglycemia, fall safety. Maintain foot elevation. Supervision of HHA.

HHA personal care 2-3 times per week - bathing, hair shampoo, assist with ambulation and transfer, meal preparation, clean bedroom and bath. Notify RN of change in patient condition.

22. Goals/Rehabilitation Potential/Discharge Plans **Patient desires to be independent and able to walk without cane.**

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Nurse Patsy Cline

25. Date of HHA Received Signed POT

24. Physician's Name and Address
Dr Guthrie
Physician Drive
Hospital, IN 23657

26. I certify/recertify that this patient is confined to his/her home and need intermittent skilled nursing care, physical therapy and/or speech therapy continues to need occupational therapy. The patient is under my care, and have authorized services on this plan of care and will periodically review plan.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine.

Top 2022 APC Findings

Tips for Success

Knowledge Check: How many days do you have to send the DC summary and who is it going to?

Topic: Financial Stewardship

Top 2022 FS Findings

Tips for Success

Knowledge Check: How often should the budget be reviewed and updated?

Topic: Care Delivery and Treatment

Ms. Violet's nursing visit

Activity/Discussion: Observe home visit reenactment with patient Violet. Write down all your concerns and be prepared to discuss:

Next...

Review the visit note on the next page and compare it with information you obtained from the reenactment. What concerns do you have regarding the documentation?



General Home Health

SKILLED NURSING VISIT NOTE

ASSESSMENT OF SIGNS AND SYMPTOMS: <input type="checkbox"/> IF THE FOLLOWING SIGNS AND SYMPTOMS ARE PRESENT													
VITAL SIGNS			ENDOCRINE <input type="checkbox"/> No problem			GENITOURINARY <input checked="" type="checkbox"/> No problem			RESPIRATORY <input checked="" type="checkbox"/> No problem				
Temp: 99.2	WT:		<input type="checkbox"/> Thyroid abnormality			Urine <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Bloody			<input type="checkbox"/> Breathing event/Unlabored				
HR 78	<input type="checkbox"/> A <input checked="" type="checkbox"/> R <input type="checkbox"/> Reg <input checked="" type="checkbox"/> Irreg		<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperglycemia			Amount <input type="checkbox"/> Scant <input type="checkbox"/> Moderate			<input type="checkbox"/> SOB <input type="checkbox"/> At rest <input checked="" type="checkbox"/> On exertion				
RR 22	<input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular		Blood Sugar <input type="checkbox"/> Fasting <input type="checkbox"/> Random			Odor <input type="checkbox"/> None <input type="checkbox"/> Foul-Smelling			<input type="checkbox"/> B' Sound <input type="checkbox"/> Clear <input type="checkbox"/> Diminished				
BP	Lying	Sitting	Standing	<input type="checkbox"/> Drowsy <input type="checkbox"/> extreme thirst <input type="checkbox"/> Hunger			<input type="checkbox"/> Dysuria <input checked="" type="checkbox"/> Nocturia <input type="checkbox"/> Anuria			<input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> L <input type="checkbox"/> Upper <input type="checkbox"/> Mid <input checked="" type="checkbox"/> Base			
R				<input type="checkbox"/> Change in vision <input type="checkbox"/> Lethargic			<input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input checked="" type="checkbox"/> Incontinence			<input type="checkbox"/> Wheeze <input checked="" type="checkbox"/> Rales/Crackles			
L		156/86		<input type="checkbox"/> Asymptomatic			Indwelling Foley Cath. Fr #			<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Upper <input type="checkbox"/> Mid <input type="checkbox"/> Base			
PAIN <input type="checkbox"/> None at this time			NEUROLOGICAL <input type="checkbox"/> No problem			Last date changed			<input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive				
<input type="checkbox"/> Less often than daily			<input type="checkbox"/> Alert <input checked="" type="checkbox"/> Forgetful <input type="checkbox"/> Confused			MUSCULOSKELETAL <input type="checkbox"/> No problem			<input type="checkbox"/> Phlegm <input type="checkbox"/> Clear/watery <input type="checkbox"/> Yellow/Green				
<input checked="" type="checkbox"/> Daily but not constantly			<input type="checkbox"/> Oriented to: <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> Pe <input checked="" type="checkbox"/> Pi			Gait <input type="checkbox"/> Steady <input checked="" type="checkbox"/> Unsteady			<input type="checkbox"/> Rust/Bloody <input type="checkbox"/> Thin <input type="checkbox"/> Thick				
<input type="checkbox"/> All the time			<input type="checkbox"/> Disoriented to: <input type="checkbox"/> T <input type="checkbox"/> Pe <input type="checkbox"/> Pi			<input checked="" type="checkbox"/> ROM <input type="checkbox"/> WNL <input checked="" type="checkbox"/> Limited			<input type="checkbox"/> Scant <input type="checkbox"/> Copious <input type="checkbox"/> Moderate				
Relieved by: <input type="checkbox"/> Rest <input checked="" type="checkbox"/> Medication			<input type="checkbox"/> Unresponsive			<input checked="" type="checkbox"/> RUE <input type="checkbox"/> RLE <input type="checkbox"/> LUE <input type="checkbox"/> LLE			<input type="checkbox"/> Oxygen use				
Pain Severity Level (Scale of 1/10) 6			<input type="checkbox"/> Paralysis <input type="checkbox"/> RUE <input type="checkbox"/> RLE <input type="checkbox"/> LUE <input type="checkbox"/> LLE			<input type="checkbox"/> Contractures <input checked="" type="checkbox"/> Stiffness			CARDIOVASCULAR <input checked="" type="checkbox"/> No problem				
Before Intervention 8			<input type="checkbox"/> Weakness <input type="checkbox"/> RUE <input type="checkbox"/> RLE <input type="checkbox"/> LUE <input type="checkbox"/> LLE			<input type="checkbox"/> RUE <input type="checkbox"/> RLE <input checked="" type="checkbox"/> LUE <input type="checkbox"/> LLE			<input type="checkbox"/> Chest Pain <input type="checkbox"/> At rest <input type="checkbox"/> On exertion				
After Intervention 6			<input type="checkbox"/> Tremors <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness			Strength <input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor			<input type="checkbox"/> Pressing <input type="checkbox"/> Dull <input type="checkbox"/> Burning				
Location Right Shoulder			<input type="checkbox"/> Aphasia <input type="checkbox"/> Express <input type="checkbox"/> Receptive			<input type="checkbox"/> Fracture <input type="checkbox"/> Amputation			<input type="checkbox"/> Heaviness <input type="checkbox"/> Tight <input type="checkbox"/> Stabbing				
Character Throbbing			Pupil <input type="checkbox"/> Equal <input type="checkbox"/> Reactive			<input type="checkbox"/> RUE <input type="checkbox"/> RLE <input type="checkbox"/> LUE <input type="checkbox"/> LLE			WITH <input type="checkbox"/> Dyspnea <input type="checkbox"/> Diaphoresis				
VISION <input checked="" type="checkbox"/> No problem Noted			Hand Grips <input type="checkbox"/> Strong <input type="checkbox"/> Weak			PSYCHOSOCIAL <input type="checkbox"/> No problem			<input type="checkbox"/> No edema <input type="checkbox"/> Edema				
<input type="checkbox"/> Partially Impaired <input type="checkbox"/> R <input type="checkbox"/> L			<input type="checkbox"/> Equal <input type="checkbox"/> Unequal			<input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Coping <input checked="" type="checkbox"/> Anxious			<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+				
<input type="checkbox"/> Severely Impaired <input type="checkbox"/> R <input type="checkbox"/> L			GASTROINTESTINAL <input type="checkbox"/> No problem			<input type="checkbox"/> Discourage <input type="checkbox"/> Depressed			<input type="checkbox"/> Pitting <input type="checkbox"/> Non-pitting				
HEARING <input checked="" type="checkbox"/> No observed/impairment			Last BM 8/4/2021			<input type="checkbox"/> Agitated <input type="checkbox"/> Flat effect			<input type="checkbox"/> RUE <input type="checkbox"/> RLE <input type="checkbox"/> LUE <input type="checkbox"/> LLE				
<input type="checkbox"/> W/ min. difficulty <input type="checkbox"/> R <input type="checkbox"/> L			Appetite <input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor			<input type="checkbox"/> Inappropriate response			Pedal Pulse <input checked="" type="checkbox"/> RLE <input checked="" type="checkbox"/> LLE				
<input type="checkbox"/> W/ mod. difficulty <input type="checkbox"/> R <input type="checkbox"/> L			Abdomen <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Distended			INTEGUMENTARY <input type="checkbox"/> No problem			<input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent				
<input type="checkbox"/> Unable to hear <input type="checkbox"/> R <input type="checkbox"/> L			Pain <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Crampy			<input type="checkbox"/> Fair <input type="checkbox"/> Pale			WOUND ASSESSMENT				
NOSE/THROAT/MOUTH <input checked="" type="checkbox"/> No problem			<input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ			<input type="checkbox"/> Cyanotic			Site #	1	2	3	4
<input type="checkbox"/> Congestion <input type="checkbox"/> Chewing prob.			<input type="checkbox"/> Ascites <input type="checkbox"/> Abdominal Girth			<input type="checkbox"/> Moist <input type="checkbox"/> Dry			Location	R toe			
<input type="checkbox"/> Sinusitis <input type="checkbox"/> Swallowing prob.			Bowel sound <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hyperactive			<input type="checkbox"/> Warm <input type="checkbox"/> Cold			Stage				
<input type="checkbox"/> Sore throat <input type="checkbox"/> Gingivitis			<input type="checkbox"/> Hypoactive <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea			Nail Bed <input type="checkbox"/> Pink <input type="checkbox"/> Blue			Length				
<input type="checkbox"/> Hoarseness <input type="checkbox"/> Ulceration			<input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence			<input type="checkbox"/> Rash <input type="checkbox"/> Abrasion			Width				
MEDICATION <input type="checkbox"/> Compliant			<input type="checkbox"/> G-Tube <input type="checkbox"/> Patent <input type="checkbox"/> Obstructed			<input type="checkbox"/> Bruise <input type="checkbox"/> Laceration			Depth				
<input type="checkbox"/> Non compl. <input checked="" type="checkbox"/> Needs teaching			<input type="checkbox"/> Ostomy: Location			<input type="checkbox"/> Pressure Sore			Tunneling				
NUTRITION (DIET) <input checked="" type="checkbox"/> Followed			<input type="checkbox"/> Patent <input type="checkbox"/> Obstructed			<input type="checkbox"/> Open Wound			Drainage	moderate			
<input type="checkbox"/> Not followed <input type="checkbox"/> Needs teaching			Amount of Drainage:			<input type="checkbox"/> Surgical Incision			Odor	slight			
Homebound Reason Diminished endurance, use of cane for ambulation, unable to leave home without assistance													
Nursing Diagnosis/Problems: wound, diabetic, urinary incontinence													
Interventions/Skilled Care Performed													
Upon arrival aide was providing personal care, assisting Ms. Violet out of the shower. Cane found to be in living room on first floor. Physical assessment as above. Patient has not been monitoring glucose. Glucometer found to not be working. Wound care done per patient direction. Orders needed to clarify wound care. Dressing removed, cleansed with saline, applied silvadene and redressed. Skin surrounding wound reddened, slight edema in toe and faint odor noted. Patient to be evaluated by Physical Therapy. Upon interview, patient states she forgot her medication in the morning yesterday. She has been taking Tylenol Arthritis for her right shoulder. She states this also helps her throbbing in her right toe. Patient educated to keep toe elevated, to call nurse if increased pain or temperature.													
Response to Care/Instruction: good						<input checked="" type="checkbox"/> Next or <input type="checkbox"/> Last MD Visit date: 8/2/2021							
						Is there any change in Insurance: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, when?							
Plan for next visit:													
Communication with: <input type="checkbox"/> Physician <input type="checkbox"/> Pharmacy <input type="checkbox"/> Care/Clinical Coordinator <input type="checkbox"/> Caregiver <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW													
Discussed:													
Resulted to: <input type="checkbox"/> New <input type="checkbox"/> Changed <input type="checkbox"/> No MD Order													
Patient Name Violet Chap						MR #:			SN Name - Title Susie Contract				
Date 8/5/2021						Time In 1000		Time Out 1030		SN Signature Susie Contract			
8/5/2021													

Home Health Aide Activity

Take a few moments to review Violet's home health aide visit note below. What issues are you identifying as you review?

HOME HEALTH CARE

Name of Patient/Client: Violet CHAP Male Female Age: 72

Goals of Care: Patient will be free from injury Patient will receive assistance with ADLs/IADLs
 Other: _____

(Check appropriate interventions, write specifics as needed)

Nutrition Type of Diet: 1500 PDA Plan /Prepare Meals/Snacks Serve Meals
 Assist with Eating Offer Fluids Fluid Restriction Thicken Fluids

Body Mechanics/Mobility
Transfer: Assist Stand/Pivot Sliding Board Bedrest Hoyer
Ambulation: Assist Cane Wheelchair Walker Crutches
 ROM/HEP Apply Orthopedic Device
 Other _____

Personal Care/Assistance with ADLs
Bathing: Tub Shower Bed Chair Shower Bench
 Hand Held Shower Other _____
Hair: Comb/Brush Shampoo Condition
General: Dress Shave Skin Care/Grooming
Oral Hygiene: Clean Dentures Brush Teeth Mouthwash Oral Swabs

Toileting: Assist to Commode/Toilet Assist with Bedpan/Urinal Catheter Care
 Empty Catheter/Drainage Bag Diapers/Depends Other _____

Homemaking: Shop Straighten Clean Bathroom after use Clean Kitchen after Meal Prep
 Make Bed Change Bed Linen Personal Laundry Medication Reminder Assistance
 Other _____

Other/Record: Temp A/O Intake/Output Pulse B/P Respiration Observe Universal Precautions
 Call office immediately for any fall, loss of consciousness, injury, oral temp above _____, pulse above _____ or below _____

Safety Instructions: Recent Fall Right Shoulder Injury

Infection Control Instructions: _____

Special Instructions: <u>Keep Dressing Right toe From getting wet</u>	Dates:	Reviewed By:	For Period:
Other: _____			

Prepared By: Paula Clover LPK Date: 7/23/2021

Patient/Responsible Party Signature: _____

Relationship to Client: _____

Physician Name: _____

Physician Signature: _____ Date: _____

9/08 WHITE: Clinical Record YELLOW: Patient Copy Page 1 of 1

Top 2022 CDT Findings

Tips for Success

Knowledge Check: Physician orders should be signed according to what timeframe?

Topic: Leadership and Governance

Thoughts to Consider...

In what ways did the pandemic highlight the importance of several of the standards in the Leadership and Governance chapter?

What deficiencies, if any, did you observe within your organization or organizations you work with?

What “wins” did you observe?

Top 2022 LG Findings

Tips for Success

Knowledge Check: Name one of the responsibilities the governing body assumes?

Topic: Information Management

Knowledge Check: What are the required elements of the clinical record?

Pause to Consider... which of the required clinical record elements do your organizations have the most challenges with?

Top 2022 HSIM Findings

Tips for Success



What is your “Golden Nugget” from today’s sessions?

THANK YOU!!