CHAP Community Health Accreditation Partner

Virtual HOSPICE/HOME HEALTH Accreditation Intensive Participant Guide

Learning Objectives:

- Outline the CHAP Accreditation process.
- Identify revisions and current version of CHAP standards
- Identify trends in deficient practice based upon site visit results for first two quarters of 2022
- Demonstrate ability to identify areas in need of improvement and develop a performance initiative to address the need.

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 (both days), participation in engagement activities, and completion of the course evaluation.

Hospice CE contact hours – 12.0
Home Health CE contact hours – 13.0
Hospice and Home Health CE contact hours – 18.25

November Virtual Accreditation Intensive Agenda

HSP Day One	
10:00-10:30	Welcome/Housekeeping/Resources
10:30-11:15	Hospice Patient Family Centered Care (HPFC)
11:15 – 12:15	Hospice Assessment, Care Planning and Coordination (HCPC)
12:15-12:30	**Break**
12:30-1:30	Hospice Care Delivery and Treatment (HCDT)
1:30-2:00	**Lunch**
2:00-2:45	Hospice Inpatient Care (HSIC)
2:45-3:30	Care to Residents in a Facility (HSRF)
3:30-3:45	**Break**
3:45-4:15	Hospice Leadership and Governance (HSLG)
4:15-4:45	Hospice Information Management (HSIM)
4:45-5:00	**Closing**

HSP & HH Day Two	
10:00 – 10:30	Welcome to HH and returning Hospice
10:30 -11:30	Infection Control
11:30-12:15	Human Resource Management
12:15-12:45	**Lunch**
12:45-1:45	Quality (small group)
1:45-2:30	Emergency Preparedness
2:30-2:45	**Break**
2:45-4:00	CHAP Application/ Site Visit Process/Action Plan
4:00-4:30	**Closing**
4:30-5:00	**Consultants only**

Home Health Day 3	
10:00-10:30	Welcome and Recap
10:30-11:15	Patient Centered Care (PCC)
11:15-12:15	Assessment, Planning and Coordination (APC)
12:15-12:45	**Lunch**
12:45-01:15	Financial Stewardship (FS)
01:15-02:15	Care Delivery and Treatment (CDT)
02:15-02:30	**Break**
02:30-03:15	Leadership and Governance (LG)
03:15-04:00	Information Management (IM)
04:00-04:15	Closing

*Presented by Bobbie Warner RN, BSN and Linda Lockhart. Curriculum designed in collaboration with Frances Petrella, RN, BSN, and Denise Stanford, MS, SHRM-CP

Introduction:

Ice Breaker: Name, state you are from, and a fun fact about yourself

Housekeeping:

Handouts

Use of Microsoft Teams

Microsoft Poll

How many years has your organization been in existence?

a. Not yet accepting patients
b. 1-5 years
c. 6-10 years
d. 11-15 years
e. 16-20 years
f. Over 20 years.

How long have you been CHAP accredited?

g. Not yet accredited
h. 1-5 years
i. 6-10 years
j. 11-15 years
k. 16-20 years
l. Over 20 years.

Disclosures/Conflict of Interest

Topic: CHAP Hospice Standards of Excellence

Microsoft Poll

Which of the following hospice resources have you utilized?

a. CHAP Standards of Excellence
b. Appendix M (Hospice State Operations Manual)
c. Appendix Z (Emergency Preparedness)
d. MLN Newsletters
e. CHAP eNews

Accessing **CHAP Standards** of Excellence

- Revisions
- Current Version
- Use of evidence guidelines

Additional Resources

- Appendix M
- Appendix Z
- MLN Newsletters
- CHAP eNews
- MAC

CHAP Standards of Excellence Resource tool Packet

DAY ONE

Patient Focus

Topic: Patient Family Centered Care – HPFC

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

_____
_____
_____
_____
_____

Discussion

Elements of Patient Rights

_____
_____
_____
_____
_____

Additional Standard Review

HPFC 3.I - 4.I

_____
_____

HPFC 5.I

_____
_____

HPFC 6.D

_____
_____

HPFC 7.D- 8.D

_____
_____

HPFC 9.D – 10.I

_____
_____

Discussion - Is it enough to provide the verbiage to the patient?

Implementation Steps for Complaint Process

_____

_____

Discussion - Dealing with the various challenges of providing Patient Rights

Top HPFC Findings

Standard	Content	CMS Tag	% OF HPFC
HPFC 10. I	Advance directive provided to patients	L503	36%
HPFC 1. D	Hospice has a written Bill of Rights and patient has right to be informed	L501	12%
HPFC 2. D	Elements to be present in the Patient Bill or Rights	L 502, L518 L519	12%

Patient Rights in writing

_____

_____

Timing of providing patient rights

_____

_____

Advance Directives

_____

_____

Elements of patient rights

_____

_____

Tips for success

_____

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_____

Topic: Assessment, Care Planning and Coordination (HCPC)

Organization information for Angel Wings Hospice

- Initial organization, passed survey through deemed CHAP Accreditation visit four months ago
- Current census – 30
- Has contract in place for short term inpatient care, and respite services. Administrator is non-clinical; Clinical Director is new to hospice but has managerial experience in home health.
- Staff consists of 4 RN case managers, MSW who also fulfills role of volunteer coordinator, Chaplain who also fulfills role of Bereavement Coordinator, 4 hospice aides.
- Medical Director is contracted

Discussion: What key concerns would be your priority?

_____
_____
_____
_____
_____

Standard Summary

HCPC 1.I-3.I

_____
_____
_____

HCPC 4.I-6. I

_____
_____
_____

HCPC 7.I-17.I

_____
_____
_____

Scenario:

Ms. Iris is being discharged from the hospital with a new diagnosis of stage IV pancreatic cancer with metastasis to the liver and has agreed to hospice care upon returning home. The election was signed by Ms. Iris on 8/30/2021. She arrives home and the hospice team makes plans for assessment and development of the plan of care. Due to staffing circumstances a new employee, an RN new to hospice is scheduled to conduct the assessment. The quality director will be reviewing the documentation post assessment.

Comprehensive Assessment Elements	
Nature and condition causing admission	Co-morbid psychiatric history
Presence or lack of objective data and subjective complaints	Complications and risk factors that may affect care planning
Risk for drug diversion	Functional and cognitive status
Ability to participate in own care	Imminence of death
Symptoms and severity of symptoms	Bowel regimen if opioids are prescribed
Patient and family support systems	Patient/family need for counseling and education
Comprehensive pain assessment	Initial bereavement assessment
Patient/family needs for referrals	Comprehensive drug profile and review
Data elements for outcome measurement	

Notes:

_____

_____

_____

_____

Activity

The assessment beginning on the following page was documented from the admission visit. Your role as quality director is to review the assessment and provide feedback to the clinician. Every attendee should review the assessment as a whole and then each group will focus on the assessment component they have been assigned. The group assignments follow the comprehensive assessment.

Attendees will be divided into groups and placed in a breakout room. 20 minutes will be assigned for the breakout room activity.

Upon return one person will represent the group to share:

- An evaluation of the assigned assessment component
- How could the assigned assessment area be improved

Comprehensive Assessment

Patient: Iris Wood
SOC: 9/1/2021
Diagnosis – Pancreatic Cancer with metastasis
Secondary – Congestive Heart Failure
Election of benefit signed 8/30/2021
Discharge – Hospital on 8/31/2021
Level of Care: Routine Hospice Care
Age: 70
Advance Directives – Yes

Vital Signs:
Temp – 97.7
Pulse – 88
Resp – 24
BP – 118/68
Pulse Oximetry - NA

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. Primary caregiver is spouse of 45 years.

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
Husband 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 02

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

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
Drug review completed and no interactions or side effects noted

Patient Name: Iris Wood Diagnosis: Pancreatic Cancer with liver Metastasis	DOB: 3/23/1952 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

Group One – Pain Assessment

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

Discussion
_____
_____
_____

Group Five– Education Conducted

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

Discussion
_____
_____
_____

Group Two– Psycho-social Assessment

Becomes anxious with increasing pain

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. Primary caregiver is spouse of 45 years.

Neurological status
Patient alert and oriented to person, place and time
No issues with vision, smell, taste
Becomes anxious with increasing pain

Activities of Daily Living
Husband 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

Group Three – Medication Assessment

Discussion

_____
_____
_____

Group Five - 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

Discussion

_____
_____
_____

Group Three Medications

See medication list

Drug review completed and no interactions or side effects noted

Patient Name: Iris Wood Diagnosis: Pancreatic Cancer with liver Metastasis	DOB: 3/23/1952 SOC: 9/1/21
Crestor 10 mg PO daily	
Tramadol 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	

Discussion

_____

_____

_____

Plan of Care Elements	
Plan reflects patient and family goals	Planned interventions based on assessments
All services needed for palliation of terminal illness	Pain and symptom management
Scope and frequency of services	Measurable outcomes anticipated
Drugs and treatments	Medical supplies and appliances
Level of patient/representative agreement with the plan	Level of patient/representative involvement with the plan

Activity

The following Plan of Care was documented from the admission visit. Your role as a consultant working with this organization is to review the plan and provide feedback to the clinician. Use the following documentation to write/circle/mark-up to enable participation in a group discussion. You will have 10 minutes for this review.

Patient Name: Iris Wood	DOB 3/23/1952	SOC Date; 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 Usage, Teach s/s respiratory infection
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.

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

Discussion

_____
_____
_____
_____

Coordination

_____
_____
_____
_____

Top Findings for HCPC:

Standard	Content	CMS Tag	% Cited of all
HCPC 21.I	Elements of the Plan of Care	L545, L548	25%
HCPC 15.I	Medication Profile and Drug Review	L530	15%

HCPC 9.I	Assessment within 5 days in accordance with elements of the hospice election statement	L523	13%
HCPC 19.I	Designated RN coordinates care/individualized plan of care in collaboration with physician, patient, primary caregiver	L540, L543	12%
HCPC 22.I	Timely review of the Plan of Care, Revision based on assessment and must note progress	L552, L553	9%

Elements of the Plan of Care:

_____

_____

medication Profile and Drug Review:

_____

_____

Assessment within 5 Days:

_____

_____

Collaboration on the Plan of Care

_____

_____

Timely review and progress

_____

_____

Tips for Success

_____

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Topic: Hospice Care Delivery and Treatment (HCDT)

Standard Summary

HCDT 1.I-4. I

HCDT 5.I-14. I

HCDT 15.I-21. I

HCDT 22.I-28. I

HCDT 29.I-35. I

HCDT 36.D-40. I

HCDT 41. I

Core Services

Non-Core Services

Requirements of all Services

Discussion

Considering the course of Ms. Iris care, what goals and outcomes are important?

Activity Part One

Observe home visit reenactment with patient Iris as if you are conducting a visit for the agency with a clinician. Write down any concerns you identified.

_____
_____
_____
_____
_____

Discussion

What concerns were identified regarding the clinician's visit that you will need to share with leadership?

Activity Part Two

Review IDT meeting minutes in the following pages for the first IDT session that occurs after the visit observation with patient Iris. What concerns are there? Take 10 minutes for this exercise.

_____
_____
_____
_____
_____
_____
_____

Discussion

Share concerns from IDT

Interdisciplinary Note for Iris Wood

Patient: Iris Wood
SOC: 9/1/2021
Diagnosis – Pancreatic Cancer with metastasis
Secondary – Congestive heart Failure
Level of Care: Routine Hospice Care
Age: 76
Advance Directives – Yes
Opioid usage - yes

Date of Meeting: 10/14/2021

Problem overview:
diminished respiratory function
increased weakness
increased pain
decreased mobility
decrease in appetite

Report from Team

Nursing: Patient pain is increasing and becoming difficult to manage at night. Pain medication changes 3 times this week to gain control to the self-identified level of acceptable pain at 4. Patient restlessness increasing and anxiety level escalating. Increasing loss of appetite, eating only small bites with meals. Increased nausea and lack of bowel movement for past three days. Continues oxygen at 2l/min. Caregiver becoming exhausted and unable to get restful sleep. Patient requiring maximum assistance with transfer. Using walker that husband had in storage from his hip surgery.

Recommendations: continued adjustment of pain medication for control of pain. Continued oxygen for comfort level. Continue aide services at 4 times per week, increase nursing visit to five times per week.
Signed: Nurse Julie RN

Social Worker: Has not been able to fit patient into her schedule since patient admission.

Recommendations: Social Worker to schedule immediate visit to discuss anxiety and caregiver ability to meet patient needs.
Signed: Socially Adept MSW

Spiritual Counselor: has not seen patient as patient declined services. Not present at this meeting
Recommendations: None

Volunteer Coordinator: has no ability to schedule volunteer
Recommendations: As soon as a volunteer is available, will let the team know to evaluate the need of the patient/family for volunteer services
Signed: Helping Hand

Physician: Has made multiple changes to medications and will plan on increasing medications as needed and add medication for anxiety.
Recommendations: Orders as follows:
Social worker will increase visits to weekly with first visit to be within 24 hours
RN increase visit to 4xw
No change to aide visits
Chaplain awaiting patient request
Volunteer services to be initiated when available
Adjustments to pain regimen, addition of anxiety med
Orders for Ensure supplement

Signed: Marcus Welby MD
Discussion:

_____
_____
_____
_____

Top Finding in HCDT

Standard	Content	CMS Tag	% Cited Of HCDT
HCDT 16. I	Hospice Aide fulfills responsibilities in the plan of care	L 626	29%
HCDT 15. I	Written aide instructions are prepared by RN	L 625	11%
HCDT 39. I	D/C Summary at time of revocation	L 683	10%
HCDT 18. I	Hospice aide reports changes and documents	L 682	8%
HCDT 38. I	Summary needed for transferred patient	L 682	7%

Hospice Aide Services:

Written Instruction:

Services provided

- Ordered by the Interdisciplinary Group
- Included in the plan of care
- Permitted to be performed under state law and regulation
- Consistent with the hospice aide training.

Reporting Changes

_____
_____

Discharge/Transfer

_____
_____

D/C at time of revocation

_____
_____

Tips for Success

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Topic: Hospice Inpatient Care (HSIC)

Microsoft Poll:

What percent of patients over the past year have utilized GIP services?
0-5%
6-10%
11-15%
16-20%

Today's Hospice Patient

Ms. Iris Wood, a 69-year-old female was admitted to the hospice with a terminal diagnosis of Stage 4 pancreatic cancer with metastasis to the lung four weeks ago.
She lives with her husband of 49 years who is somewhat frail but fully involved in her care. The daughter has been providing some assistance but needs to return to her family.
Over a 3-week period, Ms. Iris has had progressive difficulty in pain management. Shortly after admission, the patient's pain was controlled with Tramadol. Upon admission the use of Dilaudid 2mg for breakthrough pain was added, in week two of her hospice episode, her pain medication plan was changed to oxycontin SR every 12 hours with Dilaudid 8mg for breakthrough pain. In week three Fentanyl patches with Actiq lozenges were unable to provide her acceptable relief.

Discussion

- Is short term inpatient care the right choice for Ms. Iris?
- Is there any other level of care that would be appropriate?
- What level of care would be appropriate if fatigue of the husband was the main issue?

Levels of Care

Routine

_____
_____

Continuous

_____
_____

Respite

_____
_____

General Inpatient

_____
_____

Discussion: Thoughts to Consider when returning home from GIP

_____
_____

Standard Summary

HSIC1.I – HSIC 4.I General inpatient standards:

_____
_____
_____
_____

HSIC 5.D Required elements of the written agreement for inpatient care provided by agreement.

Hospice responsibilities:

- Hospice Plan of Care
- Inpatient clinical record
- Discharge summary
- Training
- Compliance

Facility responsibilities:

- Policies
- Inpatient clinical record
- Designated individual

HSIC 6.I – HSIC 34.I Standards related to directly owned hospice inpatient facility:

- Staffing
- Emergency preparedness
- Life Safety Code
- Facility specifics
- Infection control program
- Medication administration

Specific to Life Safety Code (LSC)

_____
_____
_____
_____
_____

HSIC 35.I – HSIC 46.I Restraint and seclusion in a hospice owned inpatient facility:

- Use of
- Plan of Care
- Policies and procedures

- Responsible staff

- Training

Direct versus Under Arrangement:

_____
_____
_____
_____
_____
_____

Top HSIC Findings

Standard	Content	CMS Tag	% Cited
HSIC 28.I	Preparation/delivery/storage of meals	L736	38%
HSIC 15.I	Participation in testing of the emergency plan	E0039, L724 L726	50%

Tips for Success

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

Microsoft Poll

What percentage of patients that you provide care for are a resident of a facility?

Discussion

What are the challenges that you encounter when providing care to hospice patients in facilities?

Inpatient Care compared to Care provision of a patient in facility

Similarities

- Both require a written agreement with specific elements
- The Hospice maintains financial responsibility
- Hospice directs the care with their plan of care and hospice standards of care

Differences

- Bereavement responsibilities
- Training responsibilities
- Provision of 24-hour nursing

Hospices Responsibilities for care to patient in a facility

- Assessment
- Coordination
- Care provision
- Financial management
- Providing for patient needs
- Determining level of care

Written Agreement

Hospice Responsibilities

- Medical direction and management of the patient
- Nursing/Counseling/Social work
- Provision of medical supplies, durable medical equipment, and drugs

- All other hospice services related to terminal illness
- Reporting of mistreatment or abuse
- Provision of bereavement services

Facility Responsibilities

- 24-hour room and board
- Meeting usual personal care and nursing needs care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home, at the same level of care provided before hospice care was elected by the patient/resident.

Scenario:

Iris has been admitted to a skilled facility for care following her inpatient stay until her daughter is able to arrive and provide care for her mother. The hospice will continue to provide care to Ms. Iris in the facility. The RN is explaining to the facility staff the differences in their roles and has decided to provide examples to reinforce their different responsibilities.

1. Provision of meals
2. Physician call upon worsening of symptoms
3. Providing a chair bath 3 times per week
4. Assisting with incontinence
5. Determining the bowel regimen
6. Implementing the bowel regimen
7. Determines a need for changing the level of care
8. Financial responsibility for long term incontinence supplies
9. Financial responsibility for medications addressing the terminal illness

Activity: Whose Responsibility? A numbers game…. Enter the number of the task in the box it belongs

Hospice
_____
_____
_____
_____

Facility
_____
_____
_____
_____

Discussion: Where do each of the tasks fall?

Top Finding for HSRF

Standard	Content	CMS Tag	% Cited
HSRF 6.I	Hospice plan of care is in place/coordination occurs with facility	L 774	50%
HSRF 9.I	The designated team member provides information to SNF	L781	50%

Tips for Success:

Topic: Hospice Leadership and Governance

HSLG.1 – Compliance with local, state, and federal regulations as licensed as required

_____

_____

HSLG.2-4 – Governance and leadership

_____

_____

HSLG.5-6 – Financial management

_____

_____

HSLG.7 – Volunteers

_____

_____

HSLG.9-13 – DME, drugs and biologicals

_____

_____

HSLG.14-16 – Agreements

_____

_____

HSLG.17-18 – Multiple Location

_____

_____

Organizational Operations

_____

_____

Governance

Appointing of administrator

Overall management and operation

Provision of care and services

- Leadership
- Core
- Non-Core
- Volunteers

Fiscal operations

- Annual operating budget
- Use of inpatient days

Ongoing performance improvement

Administrator

_____

_____

Fiscal Operations

_____

_____

Volunteers

Day to day administrative

Direct patient care

Time equals 5% of total patient care hours

Cost savings is document

Documentation:

- Position held by volunteer
- Work time spent by volunteer
- Dollar estimates if same time spent by paid employee

DME

_____

_____

Drugs and biologicals

_____

_____

Agreements

- Scope of services
- IDG oversight and coordination
- Communication
- Care authorized by hospice
- Qualified personnel
- Safe and effective care
- In accordance with Plan of Care
- Hospice may contract with medical director services
    - Self-employed physician
    - Physician employed by professional entity or physician group

Multiple Locations

- Complies with federal regulation regarding disclosure of ownership and control information
- Ensures hospice multiple locations are approved by Medicare
- Ensures that each location is licensed in accordance with state licensure laws
- Clearly delineates lines of authority
- Shares administration

Standard	Content	CMS Tag	% Cited HSLG
HSLG 3. I	Administrator qualifications and alternate	L 651	43%

Tips for Success

Topic: Hospice Information Management

Standard Summary

HSIM 1.D
Policies and Procedures

_____

_____

HSIM 2.I
Standardized formats

_____

_____

HSIM 3.I
Required elements of the clinical record

_____

_____

HSIM 4.I
Entry Requirements

_____

_____

HSIM 5.I
Protection of the record

_____

_____

HSIM 6.I
Availability of the record

_____

_____

HSIM 7.1
Discontinuation of Operations

_____

_____

Activity: What are the required elements of the clinical record? In two minutes come up with as many as you can think of.

_____

_____

Microsoft Poll:

Which of the required clinical record elements does your staff have the most challenges with?

Clinical Record Elements

- Plans of Care
- Assessments
- Clinical Notes
- Patient Rights
- Hospice Election of Benefit
- Responses to Interventions
- Outcome measure data elements
- Physician Certification
- Advance Directives
- Inpatient Discharge Summary
- Physician orders

Key Components of Information Management

Election of Benefit:

- Hospice Philosophy
- Understanding of effect of election of Hospice benefit
- Explanation of financial responsibility
- Right to request "Patient Notification of Hospice Non-Covered items, services and drugs"
- Right to choose attending
- Acceptance of Hospice Medicare Coverage

Notification of Non-Covered Items

- Diagnosis related to terminal condition and related conditions
- Diagnosis not related to terminal illness and related conditions
- Items, services, and drugs not covered and the reason

Certification of Terminal Illness

- Timeframe
- Certifying Physician
- Contents

Narrative

_____
_____
_____

Face-to-face Encounter:

- Third benefit period and subsequent
- Why clinical findings of face-face encounter support six months or less
- Documentation

Common Errors:

Narrative

- missing
- No attestation statements

Verbal Certification

- If applicable, missing one or both the Medical Director and/or attending

Signature and date

- No physician signatures
- Illegible signature
- Predating physician signature
- Signature not dated
- Lack of both Medical Director and Attending signatures as applicable

Certification Dates

- Not clearly stated

* CMS resource tool: https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf

Top Findings from HSIM

Standard	Content	CMS Tag	% Cited HSIM
HSIM 3.I	Elements of the clinical record	L 678, L 676, L 673	95%

Physician certification and recertification of terminal illness

_____

_____

Signed copies of notice of patient rights and election statement

_____

_____

Physician orders

_____

_____

Tips for Success

DAY TWO

Hospice and Home Health

Administrative/Organizational Focus

Welcome to our Home Health Participants!

Ice Breaker (CHAT BOX): Name, state you are from, and your dream vacation destination.

Microsoft Poll:

Which of the following best reflects your organization…

- We provide home health only
- We provide hospice and home health
- We provide hospice only
- I am a consultant or other attendee not involved with any one organization

How long have you worked in community-based services?

- 0-5 years
- 5-10 years
- 10-15 years
- 15-20
- over 20

Topic: Infection Prevention and Control

Resource Tool Example

Program Goal

Prevention

CDC Healthcare Infection Control Practices Committee

Six Standard Precautions

- Hand Hygiene
- Environmental Cleaning and Disinfection
- Injection and Medication Safety
- Appropriate use of Personal Protective Equipment
- Minimizing Potential Exposures
- Reprocessing of reusable medical equipment between each patient and when soiled.

Control

Coordinated agency-wide program

- Surveillance
- Identification
- Prevention
- Control
- Investigation of infectious and communicable diseases
- Quality

Education

_____

_____

Activity:

Take 5-6 mins to read through the handwashing and bag technique policies.

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

- Handwashing with Water:
- 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.
- Wash hands with a 15 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.

- Use a paper towel to dry hands thoroughly. Turn off the faucet using the paper towel. Discard the towel into regular waste.
- Hand Hygiene Without Water (use 60-70% alcohol-based hand rub):
- Use the solution according to instructions.
- Rub hand cleanser into skin until dry. (If sufficient amount of alcohol-based hand rub is applied, hands will take greater than 10-15 seconds to dry.)
- 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

The bag may have the following contents:

- Hand washing equipment-alcohol based hand rub and skin cleanser, soap, and paper towels
- Assessment equipment (as appropriate to the level of care being provided)-thermometers, stethoscopes, a hem gauge to measure wounds, sphygmomanometer, and urine testing equipment
- 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
- Paper supplies (if applicable)-printed forms and materials necessary to teach patients and family/caregivers and document patient care
- Personnel must regularly check the expiration date of any disposable supplies kept in the nursing bag. Expired supplies should be returned for disposal.
- 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.

Bag Technique Process

- The bag will be placed on a clean surface (i.e., a surface that can be easily disinfected) in the car.
- Once in the home place the bag on an impervious barrier on a flat surface that is not the floor
- 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. The supplies and/or equipment needed for the visit will be removed from the bag.
- 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'shome may be transported in an impermeable sealed plastic bag. Never place used needles, soiled equipment, or dressings in the nursing bag.
- Reusable equipment will be disinfected after each patient.
- 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.

Video

With those in mind, observe the scenario with patient Daisy and identify areas of compliance and non-compliance. ***Take good notes! You'll need them when we get to Quality!***

_____
_____
_____
_____
_____

Discussion:

What breaks in infection control technique did you observe?

_____
_____
_____
_____
_____

IPC Focused Survey Tool

OPERATIONAL ELEMENTS:	MET?
Infection Prevention and Control Plan (IPCP)	
• Is the agency monitoring patients for COVID exposure and/or symptoms?	Y N
• Are staff screened for symptoms routinely?	Y N
• A process is in place to address identified potential positive patients.	Y N
• The agency is aware of staff/patients who are at higher risk and take appropriate action	Y N
• The organization communicates with local/state public health officials	Y N
• The organization has a process for screening of referrals for COVID-19 potential	Y N
Communication	
• A process is in place to provide updates on COVID-19 to all staff	Y N
PPE Availability	
• Internal staff have access to PPE	Y N
• Field Staff have access to PPE	Y N
• Any shortage of PPE has resulted in appropriate steps to obtain supplies ASAP	Y N
• Staff have been taught optimizing measures in instances of PPE shortage	Y N
Staffing in Emergencies	
• Agency has a policy/procedure to ensure staffing to meet patient needs in an emergency	Y N
• The agency has implemented their emergency staffing plan if needed	Y N
Handling Staff Exposure or Illness	
• Agency has a process for staff to report symptoms or potential illness	Y N
• Agency has process for tracing contacts of staff who develop symptoms or test positive	Y N
• Agency follows current CDC/health department guidance regarding return to work	Y N
• Documentation reflects appropriate actions for employees exposed or tested positive	Y N
AGENCY LOCATION PRACTICES	
Screening process for those entering agency	
• Agency conducts screening process for all staff prior to or at the start of their shift	Y N
• Exposure to COVID-19 screening questions	Y N
• Assessment of symptoms	Y N
Internal office staff/visitors' processes	
• Ability to conduct hand hygiene	Y N
• Proper use of mask and social distancing	Y N
• Appropriate disinfection of common areas	Y N
General Standard Precautions	
• Staff perform appropriate respiratory hygiene/cough etiquette	Y N
• Staff perform appropriate environmental cleaning and disinfection	Y N
• Staff appropriately cleanse reusable patient medical equipment	Y N
Transmission Based Precautions	
• Staff wear masks when entering and within agency	Y N
• Staff appropriately social distance	Y N
• Signage posted at agency entrance addresses handwashing, mask use and cough etiquette	Y N

FIELD PRACTICES:	
Screening	
• Staff conduct self-monitoring practices before beginning to see patients each day – symptoms/temperature	Y N
• Staff conduct symptom and exposure screening for each patient and/or family	Y N
• Staff correctly report patients/family who develop symptoms, test positive, or have an exposure	Y N
Hand Hygiene	
• Alcohol-based hand rub (ABHR) is utilized unless hands are visibly soiled	Y N
• In shortages of ABHR, staff use appropriate process for soap and water hand hygiene	Y N
• Hand hygiene is performed	Y N
○ Before and after contact with patients	Y N
○ After contact with blood, body fluids, or visibly contaminated surfaces	Y N
○ After removing PPE (gloves, gown, eye protection, facemask)	Y N
○ Before performing a procedure such as medication preparation or wound care	Y N
• Hand hygiene supplies are readily available	Y N
Use of PPE is appropriate	
• Gloves are work if potential contact with potentially contaminated skin or equipment	Y N
• Gloves are removed following contact with potentially contaminated skin or equipment	Y N
• Gloves are changed & hand hygiene performed in moving from contaminated to clean site	Y N
• Isolation gown is worn for direct patient contact if the patient has uncontained secretions	Y N
• Appropriate mouth, nose and eye protection along with gowns are worn for patient care activities likely to involve splashes or sprays of bodily fluids/secretions	Y N
• Unless additional source control is needed, facemasks are worn by all staff	Y N
• Extended/reuse of PPE is according to national/local guidelines	Y N
• Reused PPE is appropriately cleaned/stored/maintained after and/or between uses	Y N
Aerosol-Generating Procedures	
• Appropriate mask (N95 or higher) is worn, as well as gloves, clothing, eye protection	Y N
• Procedures likely to induce coughing - N95 or higher respirator, eye protection, gloves, and a gown are worn	Y N
• Limit number of people in the room	Y N
• Conduct in private room with door closed	Y N
• Procedure surfaces are disinfected promptly with EPA-registered disinfectant	Y N
Education	
• Have patients/family been educated on mitigating transmission of COVID-19	Y N
• Agency has educated staff on SARS-CoV-2 and COVID-19 (symptoms, transmission, screening criteria, work exclusions)	Y N

Information for tool abstracted from CMS QSO-21-08-NLTC

Staff Vaccination Mandate

Hospice	Home Health	Content Summary
HIPC.11	IPC.15	Who the vaccination requirement applies to
HIPC.12	IPC.16	Process elements defined in policy for those eligible to be fully vaccinated
HIPC.13	IPC.17	Policies related to request for exemption
HIPC.14	IPC.18	Acceptable reasons for delay in vaccination
HIPC.15	IPC.19	Two acceptable job responsibility exemptions
HIPC.16	IPC.20	Policy and procedure addressing process for medical/spiritual exemption
HIPC.17	IPC.21	Documentation evidence
HIPC.18	IPC.22	Requirement to ensure nationally recognized IPC guidelines are followed

100% Compliance expected

Policies and Procedures for those eligible to be fully vaccinated

- Establish who is eligible to be fully vaccinated
- The process for tracking and documenting each individual's receipt of single dose or series prior to the provision of care
- The process for tracking and documenting completion of series;
- The process for tracking and documenting receipt of booster doses
- What vaccination documentation is accepted;
- Who receives, reviews, accepts or rejects vaccination documentation
- How everyone's vaccination information is securely maintained.

Policies and Procedures for those eligible for a delay, exception, or exemption

- The process for an individual to request a temporary delay, an exception due to job responsibilities, or a medical/spiritual exemption
- Who receives and reviews the documentation for above requests
- The process to track the documentation received the acceptance or denial of request
- The contingency plan(s) for an individual not fully vaccinated for COVID-19 and its documentation;

- A process to implement precautions intended to mitigate the transmission of COVID-19
- How each individual's information is securely maintained.

Staff Vaccination Compliance

- Fully vaccinated
- Delay, exception, or exemption

Top HIPC & IPC Findings:

Standard	Hospice Content	Tag	%
HIPC 9.I	Addressing risk for occupational exposure to TB	NONE	25%
HIPC 2.I	Appropriate use of standard precautions	L 579	23%
HIPC.4.I	Bag Technique	L579	11%

Standard	Home Health Content	Tag	%
IPC.3.1.M1	Instances in which the use of hand hygiene is implemented	G 682	31%
IPC.4.1.M1	Bags used to equipment/supplies consistent with policy	G 682	21%
IPC 8.1	TB screening per state local regulation or CDC	G 684	8%

Discussion:

What tips for success have you identified to address infection control practices?

Tips for Success

Topic: Human Resource Management

Discussion

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

Are providers adept at conducting interview?

Are checklists provided for personnel records?

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

Employee Requirements

Position defines:

_____

_____

Hiring Criteria:

_____

_____

All Personnel:

- Are provided orientation
- Demonstrate competency
- Are supervised by qualified staff
- Are evaluated per agency policy and/or state and federal law and regulation
- Participate in ongoing in-service

Microsoft Poll

What word comes to mind when you think of “Hiring Criteria”?

Variable scope of practice for NP

- Full Practice
- Reduced Practice
- Restricted Practice

Microsoft Poll

Do you know the scope of practice for a Nurse Practitioner within the states you work?

Discussion

Use of Nurse Practitioners in Home Health and Hospice:

Web site: https://www.nursepractitionerschools.com/practice-authority/how-does-np-practice-authority-vary-by-state/

Top HSRM & HRM Findings:

Standard	Content	CMS Tag	% Cited
HSRM 16.I	Requirement for criminal background checks	L 795	26%
HSRM 2.D	Requirements for hire and organizational chart	None	22%
HSRM 14.I	Assess skills and competency of all staff/in-services	L 663	12%
HSRM 29.D	Professionals participate in QAPI and in-services	NONE	12%
Standard	Content	CMS Tag	%
HRM.3.I	Hiring criteria is met and OIG List of Excluded Individuals…	G 848	33%
HRM.10.I	Personnel are evaluated per organizational policy	N/A	11%
HRM.7.I	Personnel demonstrate competency	N/A	11%

Tips for success:

Topic: Continuous Quality Improvement

Standard Summary

- Agency wide, data driven, reflects complexity of the organization

_____

_____

Data collection

_____

_____

Data analysis

_____

_____

Action taken

_____

_____

Performance improvement projects

_____

_____

Sustainability (For Home Health only as a standard)

_____

_____

Discussion – What makes an outcome measurable?

S_____

M_____

A_____

R_____

T_____

PDSA

Plan

- Objective
- Predictions
- Plan to carry out the cycle (who, what, where, when)

Do

- Carry out the plan
- Document observations
- Record data

Study

- Analyze data
- Compare results to predictions
- Summarize what was learned

Act

- What changes are to be made
- Next cycle?

Discussion:

What are examples of performance improvement projects your organizations have implemented over the past year?

Group Activity: The purpose of this group activity is two-fold. The first and second scenarios are to validate the importance of a comprehensive team approach to quality improvement rather than working in silos.

Scenario A – Over 3 sequential quarters an agency identified a progressive increase in their Potentially avoidable events for hospitalizations due to wound infections that occurred during an active Plan of Care.

The infections were both surgical and non-surgical.

PIP for wound care

- Group 1A –Develop **SMART** goal **(1 person to report out)**
- Group 2A –Develop a plan to address the deficiency – determine a multifaceted plan **(1 person to report out)**
- Group 3A –Implement corrective steps – what action steps are being implemented **(1 person to report out)**
- Group 4A –Develop performance improvement monitoring of this PIP- What will they monitor; what actions if no improvement **(1 person to report out)**

Scenario B – An agency performs home visits with clinical staff at the time of their annual competency evaluations. The Performance Improvement committee performed an end of year evaluation of the results and discovered infection control violations on 35% of their clinical staff; Nursing and Rehab. The rehab staff were contracted. The Nursing violations were bag technique; the Rehab staff were deficient in hand washing. The Rehab staff were observed using hand gel after obtaining equipment out of their car and before entering the home. The Rehab staff did not utilize hand gel or wash their hands, after entering the home.

PIP for handwashing and bag technique

- Group 1B –Develop **SMART** goal **(1 person to report out)**
- Group 2B –Develop a plan to address the deficiency – determine a multifaceted plan **(1 person to report out)**
- Group 3B –Implement corrective steps – what action steps are being implemented **(1 person to report out)**

- Group 4B –Develop performance improvement monitoring of this PIP- What will they monitor; what actions if no improvement **(1 person to report out)**

Discussion

_____
_____
_____
_____

Determining performance improvement priorities:

_____
_____
_____
_____

Top Findings Quality

Standard	Summary of Content	CMS Tag	% Cited
CQI.1.I.M2	Skilled professionals participate in CQI	G 720	27%
CCQI.2.D.M1	Quality indicators include measures from OASIS	G 644	16%
CQI.3.I.M2	Activities include high-risk, high-volume and problem prone areas	G642	14%
Standard	**Summary of Content**	**CMS Tag**	**% Cited**
HQPI 8.I	Action is taken, success measured, and positive results sustained	L 570	33%
HQPI 1.D	Agency-wide quality program is in place to improve care and safety	L 560	17%
HQPI 2.I	Appointed individual is responsible for QAPI program	L 576	17%

Tips for success

Topic: Emergency Preparedness

Microsoft Poll:

Is your organization currently implementing an emergency preparedness response?

The five components of an Emergency Preparedness Program

Plan

_____
_____
_____

Policies

_____
_____
_____

Communication

_____
_____
_____

Training

_____
_____
_____

Testing

_____
_____
_____

Integrated Healthcare Systems

_____
_____
_____

Top HSEP & EP findings:

Standard	Content	CMS Tag	% Cited
HSEP 3.D	Required policies and procedures of the emergency plan	L16, L13	78%
HSEP 5.D	Elements and updating of the EP training program	L37	14%
Standard	Content	CMS Tag	
EP.3.D.M1	Training program based on EP plan/risk assessment/policies	E37	23%
EP.1.D.M3	Communication Plan required elements	E31	23%
EP.2.D.M1	Policy and Procedure development	E17	18%

_____
_____
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_____

Tips for success

_____
_____
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_____
_____
_____

CHAP Application and Site Visit Process

Accreditation Team

Customer Service

_____
_____
_____
_____

Clinical Support

_____
_____
_____
_____

Steps to Accreditation

Step One_____
Step Two_____
Step Three_____
Step Four_____

Initial Agencies

Creating an Account

_____
_____

Application

_____
_____

Contract Execution

_____
_____

Timing to Prepare

_____
_____

Site Visit Readiness Numbers

_____

_____

LinQ Posting

_____

_____

_____

Condition Level Deficiency Effect

_____

_____

Renewal Visit

Addition of new service/branch/ADS

_____

_____

Grid for Record Review and Home Visits

_____

_____

Renewal Application and Then

_____

_____

Timing to Prepare

_____

_____

Condition Level Deficiency Effect

_____

_____

The Site Visit

Site Visit Preparation

Entrance Conference

_____

_____

Site Visit Activities

_____

_____

Daily Wrap Up

_____

_____

Exit Conference

_____

_____

Action Plan

Time frame

_____

_____

_____

A Successful Plan

- Defines a process for achieving compliance
- Designates responsibility
- Establishes a threshold of compliance to achieve within a designated timeframe
- Provides steps for implementation
- Establishes a timeline for implementation and monitoring
- Outlines activities to assure continued compliance

Determining the Action Plan

Underlying Cause

_____

_____

_____

Responsible Party

_____

_____

_____

Timeline

_____

_____

_____

Ongoing Monitoring

_____

_____

_____

Action Plan Tips

- Don't approach you action steps with generic statements
- This is a blind review. Do not include any identifying information: agency or patient
- The reason for the deficiency will affect your timeline for implementation
- Document
- If at once you don't succeed, try again **
- You have 10 calendar days to respond from the day the Director of Accreditation notified you of the final decision on the deficiencies. NOT from the day you receive the emailed written report of deficiencies
- You will enter your Action Plan directly into CHAPLinQ.

Scenario

It is required that the clinical record retain documentation of coordination of care between disciplines, patients/caregivers.

The standard was not met by clinical record review and interview. 2 of 5 (40%) of the clinical records did not provide evidence of coordination of care.

- Clinical record #1 Patient Plan of Care revealed a diagnosis of a pressure ulcer with orders for Nursing to provide wound care. The clinical record revealed clinical notes from a Registered Nurse and a Licensed Practical Nurse. The RN (agency employee) documented a visit on 3/1/21. The patient had an oral temperature of 101.4 and the pressure ulcer had increased drainage and odor. The physician was contacted, and an antibiotic was ordered. The EMR identified an LPN (contract employee), was also provided the next visit for this patient. The RN did not document contact with the

Clinical Manager or the LPN regarding the patients change in condition and change in orders.

- Clinical record #2- The Physical Therapy Assistant (PTA), an agency employee, documented on 3/5/21 the patient went to the Emergency room on 3/4/21 for disorientation and agitation. The Plan of Care revealed the patient was a diabetic with orders for Physical Therapy only. The clinical record did not reveal communication by the PTA to the Physical Therapist(a contract employee) and/or the Clinical Manager regarding the ER visit.

Site visitor reviewed the clinical record documentation and agency policy on coordination of care with the Clinical Manager on 9/27/21. The Clinical Manager identified in the policies that use of the EMR tab labeled “communications” and the agency internal email system is allowed for coordination of care activities. The Clinical Manager reviewed the clinical record for additional documentation, but none was identified. She called the RN who had called the physician and obtained the verbal orders who indicated she had texted the change to the LPN.

Relieving Anxiety

Constant Preparation

_____
_____
_____

Updated Lists

_____
_____
_____

Site Visit Plan

_____
_____
_____

Communication

_____
_____
_____

Effect of Pandemic on Activities

_____
_____
_____
_____

Handling conflict

_____
_____
_____
_____
_____
_____

Closing Activity:

What is the best thing you learned today? Write your answer below.

DAY THREE

Topic: Patient Centered Care – PCC

CHAT BOX:

Ice Breaker Activity: Name/State/best thing you learned from yesterday

Topic: CHAP Home Health Standards of Excellence

Accessing CHAP Standards of Excellence

- Revisions
- Current Version
- Use of Evidence Guidelines

Additional Resources

- Appendix B
- Appendix Z
- MAC
- MLN Newsletters
- CHAP eNews

Topic: Patient Centered Care

Activity:

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

_____
_____
_____
_____
_____
_____

Element of Patient Bill of Rights

Be informed of and consent to care in advance including

- Mode of care delivery
- Assessments
- Care to be furnished
- Establishment of plan of care
- Disciplines that will furnish care
- Frequency of visits
- Expected outcomes
- Changes in care
- Right to receive all services in POC

Financial

- Advised orally & writing payment liability
- Charges not covered; reduction, termination
- Potential patient payment liability
- Changes related to payment

Complaints

- Right to report grievances
- how to contact state and CHAP hotlines
- Free of neglect/abuse/discrimination

Resources

- Informed of names/addresses/contact for federal and state funded
- Right to access and how to access auxiliary aid aides and language services

Other Patient Rights

PCC.2. _____

PCC.3. _____

PCC.5 _____

PCC.6-7 _____

PCC.8 _____

Implementation of Rights

Complaint Process Example

_____

_____

_____

Discussion

How do you train your organization staff to meet patients where they are at and still provide the required information?

Top Findings in PCC:

Standard	Content	CMS Tag	% Cited
PCC.2.I.M1	Proper Notice regarding potential non-covered care or agency reduction or termination of care	G442	28%
PCC.2.I.M1	Be informed of and participate in care and services	G434	26%
PCC.2.I.M1	Provision of Federal/State Agency Information	G446	20%
PCC.3.I.M3	Written notice of transfer and discharge policies is provided to patients	G412	11%
PCC.3.I.M3	Written notice of rights and responsibilities and transfer/discharge policies provided representative	G422	11%

_____

_____

_____

_____

_____

_____

Tips for success:

Topic: Assessment, Planning and Coordination (APC)

APC.2. I

_____
_____
_____

APC.3. I

_____
_____
_____

APC.5. I

_____

_____

APC.6.I

_____
_____

APC.7.I

_____
_____
_____

APC.8. I

_____
_____
_____

APC.9. I

_____
_____

_____

APC.10. I & 11.I

_____

_____

_____

Comprehensive Assessment Elements

Demographic Information/Medical History/Allergies	Patient's Representative as applicable
Strengths, goals, care preferences, measurable outcomes	Current health/psychosocial/functional and cognitive status
Systems review	Medication review
Activities daily living/need for home care/living arrangements	Emergency care use/data items inpatient facility admit/discharge
Medical equipment	Caregiver availability/willingness, schedules
Medical/nursing/rehab/social and d/c planning needs	Plan in the event of natural disaster

Scenario

Ms. Violet Chap is a 72-year-old female with a recent fall resulting in a shoulder injury. She was admitted 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.

Activity

Review the comprehensive assessment on the next few pages and note concerns that you would want to share with leadership

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

☐ liver disease ☐substance abuse ☐TIA/CVA ☐tobacco use

☒angina ☒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	Regular daytime	Regular nighttime	Occasional or short-term assistance	No assistance available
a. Patient lives alone	☒	O 02	O 03	O 04	O 05
b. Patient lives with other person(s) in the home	O 06	O 07	O 08	O 09	O 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

Other:

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

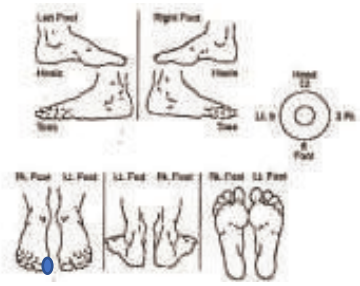
Other: Patient has pain with movement in both knees and right shoulder. States "I just take Tylenol arthritis for the pain" Has pain upon dressing change of diabetic ulcer right great toe"

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

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

Neuro/Emotional/Behavioral:

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:	☐Independent	☒Needs Some Help	☐Dependent
Ambulation:	☐Independent	☒Needs Some Help	☐Dependent
Transfer:	☐Independent	☒Needs Some Help	☐Dependent
Household Tasks:	☐Independent	☒Needs Some Help	☐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:

☐Patient unable to independently take meds

☒Patient requires drug diary or chart for meds

☐Patient med dosages prepared by another person

☒Patient needs prompting/reminding

☒Drug education provided to patient

☐High-risk medication instruction given

☐Patient demonstrates non-compliance

☐Patient meds must be administered

☒Drug regimen review for interactions, Duplicate therapy and potential adverse effects conducted

Comments: Patient medications at home reconciled with discharge medication list. C

Current Medications:

Lantus insulin 30 units at bedtime

Plavix 75 mg once a day

Aspirin 81 mg once a day

Folic Acid 1 mg once a day

Metoprolol tartrate 25 mg twice a day

Glyburide 10 mg twice a day

Simvastatin 40 mg at bedtime

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

☒On Call Availability ☒Fall Precautions

Interventions performed:

Physical Assessment

Teaching as above
Medication review

Plan of Care Collaboration:

Nursing for wound care and me management
Home Health Aide for assistanc 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 as long as 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

Discussion

Notes for comprehensive assessment review

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Plan of Care Elements

All pertinent Diagnosis	Patient care orders, including verbal orders
Mental/psychosocial/cognitive status	Types of services/supplies/equipment required

Frequency and duration of visits	Mode of care delivery including telecommunications
Prognosis and rehabilitation potential	Functional limitations/activities permitted
Nutritional requirements/food and drug allergies	All medications and treatments
Safety measures to protect against injury	Description of risk for emergency department visits
Necessary interventions to address risk factors	Patient and caregiver education to facilitate discharge
Patient-specific interventions and education	Measurable outcomes and goals
Advance directives information	Additional items determined by allowed practitioner

Activity

Review the plan of care on the following page and make note of concerns to share with leadership.

HOME HEALTH CERTIFICATION AND PLAN OF CARE

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

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

11. ICD	Principal Diagnosis: Encounter Fall with Injury	Date: 7/18/2021
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses: Diabetic Ulcer Right Foot; Diabetes Mellitis Type 2	Date: 7/18/2021 long Standing

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

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; 2 ☑ Bowel/Bladder (Incontinance); 3 ☐ Contracture; 4 ☐ Hearing; 5 ☐ Paralysis; 6 ☑ Endurance; 7 ☑ Ambulation; 8 ☐ Speech; 9 ☐ Legally Blind; A ☐ Dyspnea With Minimal Exertion; B ☐ Other (Specify)

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

19. Mental Status: 1 ☑ Oriented; 2 ☐ Comatose; 3 ☑ Forgetful; 4 ☐ Depressed; 5 ☐ Disoriented; 6 ☐ Lethargic; 7 ☐ Agitated; 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 needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the 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, imprisonment, or civil penalty under applicable Federal laws.
Form CMS- 12-) (Formerly HCFA-485) (Print 485 (C-3) (14 Aligned)	

Notes related to Plan of Care Review

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Discussion

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APC Top Findings

Standard	Content	CMS Tag	% Cited
APC.7.I.M2	Required Elements of the Plan of Care	G574	25%
APC.8.I.M3	Provision of written instructions	614/616/618 620/622	22%
APC.11.I.M3	Timely D/C & transfer summary includes all elements	G1022	16%

APC.6.I.M1	Required elements of the Comprehensive Assessment	G536	9%
APC.7.I.M7	Minimum review by physician is 60 days. Includes patient progress	G592/588	9%

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Elements of the Plan of Care

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Written Instructions

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Discharge and Transfer

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Elements of the Comprehensive Assessment

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Tips for Success

Topic: Financial Stewardship

Annual operating budget

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Capital expenditure plan

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Preparation of plan and budget

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Annual review of budget and plan

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Top FS Findings

Standard	Content	CMS Tag	% Cited
FS.2.I	An annual operating budget is present	G988	25%
FS.2.I.M1	Annual operating budget addresses all anticipated income and expenses	G988	25%
FS.2.I.M2	The annual budget is prepared under the guidance of governance	G988	25%
FS.2.I.M3	Annual budget is reviewed and updated at least annually	G988	25%

Tips for Success:

Topic: Care Delivery and Treatment

CDT.2. I – requirements for the provision of services

CDT.3. I – care follows standards of practice within scope of license

CDT.4. D-5. I – physician order requirements

CDT.7. I – care is provided by all disciplines in accordance with plan of care and each discipline fulfills their own responsibilities

CDT.9. I – patient education

CDT.10. I – Supervision, specifically aide supervision

CDT.11. D – Remote monitoring policy requirements

Physician Order Requirements

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_____

Skilled Professionals

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Supervision of Skilled Professionals

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Home Health Aides

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

_____
_____
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Activity: Take a couple of minutes to review the visit note on the following page.

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General Home Health

SKILLED NURSING VISIT NOTE

ASSESSMENT OF SIGNS AND SYMPTOMS: ☐ IF THE FOLLOWING SIGNS AND SYMPTOMS ARE PRESENT

VITAL SIGNS

Temp: 99.2 WT:

HR 76 ☐A ☒R ☐Reg ☒Irreg
RR 22 ☒Regular ☐Irregular

BP	Lying	Sitting	Standing
R			
L		156/86	

PAIN ☐ None at this time
☐ Less often than daily
☒ Daily but not constantly
☐ All the time
Relieved by: ☐ Rest ☒ Medication
Pain Severity Level (Scale of 1/10) 6
Before Intervention 8
After Intervention 6
Location Right Shoulder
Character Throbbing

VISION ☒ No problem Noted
☐ Partially Impaired ☐ R ☐ L
☐ Severely Impaired ☐ R ☐ L

HEARING ☒No observed impairment
☐ W/ min. difficulty ☐ R ☐ L
☐ W/ mod. difficulty ☐ R ☐ L
☐ Unable to hear ☐ R ☐ L

NOSE/THROAT/MOUTH ☒No problem
☐ Congestion ☐ Chewing prob.
☐ Sinusitis ☐ Swallowing prob.
☐ Sore throat ☐ Gingivitis
☐ Hoarseness ☐ Ulceration

MEDICATION ☐ Compliant
☐Non compl. ☒Needs teaching

NUTRITION (DIET) ☒ Followed
☐Not followed ☐Needs teaching

ENDOCRINE ☐ No problem

☐Thyroid abnormality
☐ Hypoglycemia ☐Hyperglycemia
Blood Sugar ☐Fasting ☐ Random
☐ Drowsy ☐ extreme thirst ☐Hunger
☐ Change in vision ☐Lethargic
☐ Asymptomatic

NEUROLOGICAL ☐No problem

☐ Alert ☒ Forgetful ☐Confused
☐Oriented to: ☒T ☒Pe ☒Pl
☐Disoriented to: ☐T ☐Pe ☐Pl
☐Unresponsive
☐Paralysis ☐RUE ☐RLE ☐LUE ☐LLE
☐Weakness ☐RUE ☐RLE ☐LUE ☐LLE
☐Tremors ☐Headache ☐Dizziness
☐Aphasia ☐Express ☐Receptive
Pupil ☐Equal ☐Reactive
Hand Grips ☐Strong ☐Weak ☐Equal ☐Unequal

GASTROINTESTINAL ☐ No problem

Last BM 8/4/2021
Appetite ☐ Good ☒ Fair ☐ Poor
Abdomen ☒ Soft ☐ Distended
Pain ☐ Dull ☐ Sharp ☐Crampy
☐RUQ ☐RLQ ☐LUQ ☐LLQ
☐Ascites ☐Abdominal Girth
Bowel sound ☒ Active ☐ Hyperactive
☐Hypoactive ☐Nausea ☐Diarrhea
☐ Constipation ☐Incontinence
☐ G-Tube ☐ Patent ☐ Obstructed
☐Ostomy: Location
☐Patent ☐Obstructed
Amount of Drainage:

GENITOURINARY ☒ No problem

Urine ☐ Clear ☐Cloudy ☐Bloody
Amount ☐Scant ☐Moderate
Odor ☐None ☐Foul-Smelling
☐Dysuria ☒Nocturia ☐Anuria
☐Urgency ☐Frequency ☒Incontinence
Indwelling Foley Cath.Fr #
Last date changed

MUSCULOSKELETAL ☐ No problem

Gait ☐ Steady ☒Unsteady
☒ROM ☐WNL ☒Limited
☒RUE ☐RLE ☐LUE ☐LLE
☐Contractures ☒Stiffness
☐RUE ☐RLE ☒LUE ☐LLE
Strength ☐ Good ☒Fair ☐Poor
☐ Fracture ☐ Amputation
☐RUE ☐RLE ☐LUE ☐LLE

PSYCHOSOCIAL ☐ No problem

☒ Cooperative ☐ Coping ☒ Anxious
☐ Discourage ☐ Depressed
☐ Agitated ☐ Flat effect
☐ Inappropriate response

INTEGUMENTARY ☐ No problem

☐ Fair ☐ Pale
☐ Cyanotic
☐ Moist ☐ Dry
☐ Warm ☐ Cold
Nail Bed ☐Pink ☐ Blue
☐ Rash ☐ Abrasion
☐ Bruise ☐ Laceration
☐ Pressure Sore
☐ Open Wound
☐ Surgical Incision

RESPIRATORY ☒ No problem

☐Breathing event/Unlabored
☐SOB . ☐At rest ☒On exertion
☐B' Sound ☐Clear ☐Diminished
☒R ☒L ☐Upper ☐Mid ☒Base
☐Wheeze ☒Rales/Crackles
☐R ☐L ☐Upper ☐Mid ☐Base
☐Cough ☐Dry ☐Productive
☐Phlegm ☐Clr/watery ☐Yellow/Green
☐Rust/Bloody ☐Thin ☐Thick
☐Scant ☐Copious ☐Moderate
☐Oxygen use

CARDIOVASCULAR ☒ No problem

☐Chest Pain ☐At rest ☐On exertion
☐ Pressing ☐Dull ☐Burning
☐ Heaviness ☐Tight ☐Stabbing
WITH ☐ Dyspnea ☐Diaphoresis
☐No edema ☐Edema
☐1+ ☐2+ ☐3+ ☐4+
☐ Pitting ☐Non-pitting
☐RUE ☐RLE ☐LUE ☐LLE
Pedal Pulse ☒ RLE ☒LLE
☒ Present ☐ Absent

WOUND ASSESSMENT

Site #	1	2	3	4
Location	R toe			
Stage				
Length				
Width				
Depth				
Tunneling				
Drainage	moderate			
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 reddended, 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

☒ Next or ☐ Last MD Visit date: 9/2/2021
Is there any change in Insurance: ☐ Yes ☒ No If yes, when?

Plan for next visit:

Communication with: ☐ Physician ☐ Pharmacy ☐ Care/Clinical Coordinator ☐ Caregiver ☐ PT ☐ OT ☐ ST ☐ MSW

Discussed:

Resulted to: ☐ New ☐ Changed ☐ No MD Order

Patient Name Violet Chap MR #: SN Name – Title Susie Contract, Ver

Date 8/5/2021 Time In 1000 Time Out 1030 SN Signature Susie Contract

8/5/2121

Discussion: Does the documentation accurately reflect the home visit? What concerns do you have regarding the disciplines fulfilling their responsibilities?

Activity: Take a couple of minutes to review the home health aide plan of care on the following page.

_____
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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 ADA ☐ 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: Keep Dressing Right toe from getting wet	Dates:	Reviewed By:	For Period:
Other: _____			

Prepared By: Paulette Clover LPN Date: 7/23/2021

Patient/Responsible Party Signature: _____

Relationship to Client: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Discussion: What concerns are noted from the home health aide plan of care? How might they be addressed?

CDT. 11 – Remote Monitoring Notes:

Policies and Procedures:

- Type of Equipment
- Patient Eligibility
- Patient/caregiver education
- Process for delivery and set up
- Troubleshooting
- Data collection
- Storage and cleaning

Top CDT Findings:

Standard	Content	CMS Tag	% Cited
CDT.7.I.M2	Skilled professionals follow the plan of care/fulfill duties	G710	44%
CDT.7.I.M7	Home Health Aide fulfills responsibilities	G800	14%
CDT.5.I.M2	Verbal orders authenticated and dated within 30 days.	G584	11%
CDT.4.I.M1	Medication/services treatments administered as ordered	G580	11%

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Tips for Success

Topic: Leadership and Governance

LG.1.I _____

LG.3.I _____

LG.4.I _____

LG.6.I _____

LG.7.I _____

LG.10.I _____

LG.11.D _____

LG.12.D _____

Discussion: In what ways did the pandemic highlight the importance of many of the components of Leadership & Governance?

Governing Body – Full legal authority

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Governing body – Quality oversight

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Leadership

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Administrator

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Contracted Services

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Top FS Findings:

Standard	Content	CMS Tag	% Cited
LG.4.I.M3	Administrator appointed by and reports to governing body	G946	23%
LG.4.I.M1	Governing body assumes full legal authority	G942	15%

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Tips for Success

Topic: Information Management

IM.1. D – Policies addressing collection/sharing/retention of data

IM.2. I – Policies reflecting the time frame to keep personnel/clinical/financial/administrative records

IM.3. I – Appropriate information is shared with government agencies

IM.4. I – access of patient information

IM.5. D – standardized protocols for data collection

IM.6. I – data transmission per regulation

IM.7. I – patient record elements

Discussion Who can name at least one of the requirements of patient clinical record. I will clue you in that there are ten. No peeking in the CHAP standards allowed!

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Microsoft Poll:

Which of the required clinical elements does your staff have the most challenges with?

a. Assessment b. plan of care c. medications d. coordination
e. physician orders f. visit notes

Communicating with Government Officials

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Access of information

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Documentation

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Data transmission

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Required elements of the clinical record

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Top IM Findings:

Standard	Content	CMS Tag	% Cited
IM.7.I.M1	Patient record requirements	G1012, G1014 G1010	34%
IM.5.I.M2	Entries are legible, clear, complete and include signature & title	G1012	27%
IM.4.I.M1	Availability of patient record	G1030	12%

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Tips for success:

References:

https://www.nursepractitionerschools.com/practice-authority/how-does-np-practice-authority-vary-by-state/

THANK YOU!