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HCL / L&C P&P TOC CH Rvd. 040109

MISSION STATEMENT

The mission of Paloma Home Health Agency, Inc. is to participate as an active part of the community, in providing and continuously improving the home health care needs of the patient by delivering value driven, high quality compassionate care.

AGENCY STATEMENT

Paloma Home Health Agency, Inc. hereinafter referred to as "Agency", will participate and be in compliance With federal, state and local laws and regulations.

Agency will also comply with accepted professional standards and principles, as well as disclosure of Ownership and management information.

Agency utilizes the Robyn Rice Manual of Home Health Nursing Procedures for clinical procedures.

Agency does not provide infusion therapy, pediatric services, or psychiatric services.

Agency does not participate in the physician delegation process.

Agency does not utilize volunteers in any capacity.

HCL/Agency Stmt

ADMINISTRATIVE POLICY MANUAL

HOME CARE

GEOGRAPHIC AREA SERVED AND OPERATING HOURS

LD1

1. Agency may provide home health care in the following counties:
COLLIN ,COOKE,DALLAS,DENTON,ELLI5 ,ERATH,FANNIN,GRAYSON, HOOD,HUNT ,JOHNSON,KAUFMAN,NAVARRO,PALO PINTO, PARKER, ROCK WALL, SOMERVELL, TARRANT , and WISE.
2. Agency operating hours are; 9:00 a.m. to 5:00 p.m., Monday through Friday.
3. The Administrator, designated alternate administrator, supervising nurse or designated alternate supervising nurse will perform the following if the agency is closed between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday:
 - Post a notice in a visible location outside the agency that will provide information regarding how to contact the person in charge, and
 - Leave a message on the answering machine or similar electronic mechanism that will provide information regarding how to contact the person in charge.
4. Agency will notify DADS within five (5) days after a change of agency's telephone number and/or agency's operating hours.

HCL LD.1 chap Rvd 060106

SCOPE OF SERVICES

LD2

PURPOSE

To define the services offered by Agency. The agency provides at least one therapeutic service directly with agency employees. A second qualifying service and additional services may be provided under arrangement with

another agency or organization.

POLICY

Agency may offer the following services:

1. Nursing Service: evaluation, direct service, patient teaching, and/or consultation service
2. Physical Therapy: evaluation, direct service, exercise instruction, and/or consultation service
3. Speech Therapy: evaluation, direct service, language instruction, and/or consultation service
4. Occupational Therapy: evaluation, direct service, patient teaching, exercise instruction, and/or consultation service
5. Medical Social Service: direct services, liaison between community agencies, and/or consultation service
6. Nutritional Counseling: direct services provided by an RN or dietician
7. Home Health Aide Service: providing services that are related to personal care of patients and specific services under supervision of a registered nurse; also, providing services that are related to extension of therapy to patients under the supervision of a Registered Therapist
8. Medical Supplies: provision of supplies such as gauze, cotton, band-aids, surgical dressings, catheters, surgical gloves, irrigation solutions, and oxygen when ordered by the physician and considered reasonable and necessary to the plan of care

HCL / LD.2 CHAP Rvd. 063005

ADMINISTRATIVE STRUCTURE

LD3

PURPOSE

To outline Agency administrative structure and establish lines of authority, responsibility and communication.

POLICY

Agency will provide a defined administrative/organizational structure to include:

- Services that Agency provides
- The governing body, the administrator, the supervising nurse, the staff, as appropriate, based on services that are provided by the Agency
- The lines of authority and the delegation of responsibility down to and including the client care level

This document will be either in the form of a chart or a narrative

PROCEDURE

1. Agency will not delegate administrative and/or supervisory functions to another agency/organization.
2. Agency will monitor and control all contractual services.
3. Owner/License holder assumes responsibility for the overall administration and direction of the Agency, including:
 - Adopting, implementing, enforcing, and monitoring adherence to required policies,
 - Ensuring compliance with regulations,
 - Ensuring that safe, professional, quality health care is provided to clients,
 - Ensuring all documents submitted to DADS or maintained by the Agency are accurate and do not misrepresent or conceal material fact,
 - Compliance with an order of the DADS commissioner or other enforcement orders that may be imposed on the Agency in accordance with state regulations.
4. The Board of Directors, whether an individual or a group, will assume ultimate responsibility and legal authority for the management of Agency and for the quality of care provided as defined by state license, charter, Articles of Incorporation, etc.
5. The Board of Directors, in conjunction with Agency leaders, will provide a framework for planning, directing, implementing, coordinating, and improving patient care which is responsive to the patient's and community's needs. Planning will include establishing a mission for Agency and providing the strategic and operational plans and policies to achieve the mission. Planning will address at least all important patient care and Agency-wide functions.
6. Agency's Administrator, appointed by the License holder, will assume overall responsibility and authority for administrative and leadership functions, supervision of the established organizational plan, and responsibility for ongoing communication with the Board of Directors to ensure their awareness and management of quality and

fiscal issues.

7. The License holder will designate, in writing, the appropriate qualified person to perform delegated responsibilities in the absence of the Administrator.

8. The Director of Home Health Services (DHHS/Director of Nurses/Supervising Nurse), appointed by the Administrator, will be responsible for the day-to-day direction, implementation, coordination and improvement of patient care. This person or a qualified alternate will be available in person or via telecommunication. The DHHS/Director of Nurses/Supervising Nurse will monitor all care provided under contract to ensure uniform quality of patient care. The Administrator may also be the DHHS/Director of Nurses/Supervising Nurse.

9. The Administrator will authorize, in writing, a designated Registered Nurse to carry out delegated responsibilities in the absence of the DHHS/Director of Nurses/Supervising Nurse.

10. The Administrator will designate in writing the staff members who may grant entry to the agency by a surveyor.

HCL / LD.3 Rvd. 102507

BOARD OF DIRECTORS

LD.4

PURPOSE

To define the authority and responsibility of the governing body.

POLICY

Agency's Board of Directors, whether an individual, a group or a government agency, will have ultimate responsibility and legal authority (as indicated by state license and/or a charter, Articles of Incorporation, constitution, bylaws or similar documents) for the management of Agency and for the provision of a framework which supports all of the functions carried out by Agency, thereby allowing Agency to fulfill its mission.

PROCEDURE

Agency defines the responsibilities of the Board of Directors to include:

- Communicating systematically with Agency leaders.
- Approving and monitoring long-range, strategic and operational plans.
- Authorizing adequate resource allocation to support the plan.
- Participating annually in the establishment, organization and revision of policies consistent with original mission, to include:
 - Written disclosure of conflict of interest
 - Public disclosure of information
 - Responsibilities of ethical issues review group
 - Rights and responsibilities of clients
 - Internal and external complaint management
 - Exposure control plan
 - Formal safety program
 - Financial policies and procedures
 - Research activities/investigational studies as applicable
- Appointing and annually evaluating a qualified Administrator (reflected in meeting minutes) who manages Agency's framework, directs ongoing Agency functions, and acts as a liaison with the Board of Directors, professional personnel and staff.
- Supporting leadership development to assist fulfillment of Agency mission.
- Adopting written bylaws or an acceptable equivalent.
- Reviewing legal and business documents in light of real or potential changes to the organization on a periodic basis but not less frequently than every thirty-six (36) months:
 - Articles of Incorporation
 - Bylaws
 - Legal Agreements
- Reviewing and approving the annual operating budget and capital expenditures and holding management accountable for the fiscal solvency of the organization and adequacy of the financial resources.
- Providing full disclosure of Agency ownership in compliance with state and federal laws and regulations.

- Reviewing and implementing a written "Conflict of Interest" statement that includes guidelines for disclosure of any actual and/or potential conflict of interest. Annually, the members of the governing body and the executive staff provide written disclosure of all professional or personal relationships or interests, direct or indirect that might present a conflict of interest. Statements are on file in the office.
- Approving the members of the Professional Advisory Committee.
- Participating in Agency Performance Improvement Program.
- Participating in annual Agency evaluation process.
- Participating in the review and revision as indicated, of the philosophy, mission and purpose statements at least every 36 months.
- Arranging for professional advice and support as appropriate.
- Ensuring a safe work environment and maintaining adequate equipment for efficient operation.
- Adopting and supporting the confidentiality policy of Agency.
- Complying with Bylaws and other legal documents.

All Board meetings will be documented in minutes and the Agency will maintain minutes for 5 years.

HCL / LD.4 CHAP Rvd. 120606

BOARD OF DIRECTORS' ORIENTATION

LD.5

PURPOSE

To ensure the Board of Directors participates in an orientation process.

POLICY

All members of the Board of Directors will participate in an orientation program established by Agency.

PROCEDURE

1. Orientation will occur prior to or during a member's first board meeting.
2. Members will be oriented to their responsibilities as defined in policy and educated to the home care industry.
3. The orientation will be documented in the meeting minutes.

HCL LD.5 chap Rvd 050197

RESPONSIBILITIES OF THE ADMINISTRATOR

LD6

PURPOSE

To define the responsibilities of the Administrator to ensure Agency compliance with applicable federal, state and local laws and regulations as appropriate.

POLICY

Agency Administrator will assume overall responsibility and authority for administrative and leadership functions, supervision of the established organizational plan and responsibility for ongoing communication with the Board of Directors, Professional Advisory Committee, as well as the entire Agency staff. Administrator or designee will be available during Agency's operating hours.

PROCEDURE

A. Administrator of a Licensed and Certified Agency

1. Agency defines the responsibilities of the Licensed/Certified Administrator to include, but not be limited to:
 - 1.1 Plan, organize, direct and evaluate operations to ensure the provision of adequate and appropriate care and services
 - 1.2 Ensure Agency is in compliance with all applicable federal, state, and local laws and regulatory agencies
 - 1.3 Be responsible for fiscal planning, budgeting and management of operations in accordance with established fiscal parameters
 - 1.4 Implement governing body directives and ensure that appropriate service policies are developed and implemented
 - 1.5 Recruit, employ and retain qualified personnel to maintain appropriate staffing levels
 - 1.6 Establish and maintain effective channels of communication
 - 1.7 Ensure program personnel have current clinical information and current practices
 - 1.8 Direct and monitor organizational Performance Improvement activities

- 1.9 Ensure staff development including orientation, in-service education, continuing education and evaluation of staff
- 1.10 Assure skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or an RN
- 1.11 Assure appropriate staff supervision during all operating hours
- 1.12 Assure the development and qualifications for professional services and the assignment of personnel
- 1.13 Ensure the accuracy of public information materials and activities
- 1.14 Inform the governing body, staff and professional advisory group of current organizational, community, and industry trends
- 1.15 Take action on reports and recommendations of any authorized planning, regulatory or inspection agencies
- 1.16 Ensure staff education, evaluations and availability of applicable regulations to all Agency staff, including contractual providers
- 1.17 Ensure completion, maintenance and submission of required reports
- 1.18 Ensure documentation of services is accurate and timely
- 1.19 Employs or contracts with qualified personnel.
- 1.20 Maintaining a current organizational chart to show lines of authority down to patient level
- 1.21 Responsibility and authority for the administrative and leadership functions of Agency
- 1.22 Responsible for supervision and evaluation of satisfaction surveys on all patients served.
2. The Administrator, or designee, will prepare a written annual public disclosure statement, in compliance with state and federal laws and regulations, signed by the Administrator.
3. The Administrator will identify resources needed to implement his/her responsibilities and will notify the Board of Directors of these needs.
4. The Administrator will notify the Board of Directors immediately if unable to fulfill his/her responsibilities.
5. The license holder will designate, in writing, the appropriate qualified person to perform the responsibilities of the Administrator's position in his/her absence.
6. The Administrator will designate in writing an agency employee who will provide DADS surveyors entry to the agency in accordance with TAC 97.523 if the Administrator or Alternate Administrator are not available.

HCL / LD.6 CHAP Rvd. 020108

RESPONSIBILITIES OF THE DIRECTOR OF HOME HEALTH SERVICES

LD7

PURPOSE

To define the responsibilities of the Director of Home Health Services to ensure safe, appropriate delivery of patient care.

DEFINITION

Supervising Nurse is the responsible registered nurse for supervising skilled services provided by the agency and who meets qualifications per regulation. This person may also be known as Director of Nurses, Director of Home Health Services or a similar title.

POLICY

Director of Home Health Services, appointed by the Administrator, is responsible for the daily direction of patient care and participates in activities relevant to professional services furnished. The Director of Home Health Services is a registered nurse.

PROCEDURE

1. Agency defines the responsibilities of the Director of Home Health Services to include but not be limited to:
 - 1.1 Ensuring the care offered by Agency is consistently available to all patients.
 - 1.2 Coordinating and integrating care provided by Agency staff, including contractual providers.
 - 1.3 Collaborating on development and implementation of policies and procedures which guide and support the provision of care.
 - 1.4 Recommending resources needed to provide care.
 - 1.5 Collaborating with Agency leadership and appropriate staff to develop the organizational plan as it pertains to patient care.
 - 1.6 Participating in activities relevant to professional services furnished including the development of

qualifications and assignment of agency personnel.

- 1.7 Participating in the development and implementation of the Performance Improvement Plan.
- 1.8 Being available (or designee) at all times in person or via telecommunications.
- 1.9 Assures that a client's Plan of Care is executed as written.
- 1.10 Assures a reassessment of a client's needs is performed by the appropriate healthcare professional:
 - When there is a significant health status change in the patient's condition
 - At the physician's request
 - After hospital discharge

2. The Director of Home Health Services will identify resources needed to implement his/her responsibilities and will notify the Administrator of these needs.

3. The Director of Home Health Services will notify the Administrator immediately if unable to fulfill his/her responsibilities.

4. The Administrator will designate, in writing, the appropriate qualified person to perform the responsibilities of the position in the absence of the Director of Home Health Services.

HCL LD.7 chap Rvd 092104

PROFESSIONAL ADVISORY COMMITTEE (PAC)

LD.8

PURPOSE

To establish Agency advisory group in accordance with applicable laws and regulations.

POLICY

Agency will establish and maintain a group of professional and community members composed of at least:

- One physician;
- One registered nurse;
- Appropriate representation from other professional disciplines;
- One member who is neither an owner nor an Agency employee, and
- Representation from each branch, if applicable.

The PAC functions as the safety committee and ethics committee.

PROCEDURE

1. The governing body (Board of Directors) will appoint appropriate professional individuals and community members to serve as members of the Professional Advisory Committee (PAC).

2. The PAC will meet at least bi-annually and more often as needed.

3. Agency will maintain documentation of PAC activities by dated meeting minutes.

4. The PAC members will be educated regarding Agency mission, Agency vision and patient/Agency confidentiality. Acknowledgment of this will be documented in the PAC minutes/records.

5. The PAC responsibilities will include but not be limited to:

- The establishment and annual review of policies and procedures governing scope of services provided
- Admission and discharge criteria/policies
- Medical supervision and plans of care
- Clinical protocols
- Emergency care
- Clinical records
- Personnel qualifications
- Annual program evaluation that consists of an overall policy review, administrative review, clinical

record review and review of the Patient Bill of Rights

6. The PAC functions as the safety committee, performance improvement committee, ethics committee, and other committees as appropriate.

HCL / LD8 CH Rvd. 030108

AGENCY COMMUNICATION

LD.9

PURPOSE

To establish effective communication mechanisms among Agency staff, Agency leaders and related organizations.

POLICY

Agency staff and leaders, and related organizations when appropriate, will collaborate and systematically communicate to establish and disseminate the organizational plan, performance improvement plan and procedures, and patient care programs.

PROCEDURE

1. The Board of Directors will systematically communicate with Agency leaders as needs arise and at least annually.
2. The Administrator will act as an ongoing liaison between the Board of Directors and Agency staff.
3. The Professional Advisory Committee (PAC) will advise Agency on professional issues, collaborate and assist in the organizational plan, policies and procedures, and the Performance Improvement Plan. It will also assist Agency in maintaining communication with other health care providers in the community.
4. Agency's management/supervisory staff will use formal and informal methods of communication with Agency staff including, but not limited to: staff meetings, in-services, patient care conferences and memos.
5. Agency will communicate with any health care delivery organization that is corporately or functionally related to Agency.

HCL LD.9 chap Org 050197

DEPARTMENTAL RELATIONSHIPS

LD.10

PURPOSE

To enhance continuity of care and to promote positive departmental/staff interactions.

POLICY

Agency leaders facilitate integration of care and services by communication and coordination to enable individuals and areas to work together on activities including operational, financial, and administrative aspects of the organization

PROCEDURE

Examples of coordination of intra-agency activities:

1. THERAPY

- 1.1 Provide in-service programs for Agency.
- 1.2 Consult with Agency.

2. SOCIAL SERVICES

- 2.1 Provide in-service programs for Agency.
- 2.2 Consult with Agency

3. NURSING SERVICES

- 3.1 Provide in-service programs for Agency.
- 3.2 Consult with Agency.
- 3.3 Consult with the Director of agency.

4. PERSONNEL

- 4.1 Recruit and interview Agency personnel.
- 4.2 Administer personnel policies and procedures.
- 4.3 Administer benefits and wage policies and procedures.
- 4.4 Administer employee health benefits.
- 4.5 Educate leadership regarding changes in industry personnel regulations and standards.
- 4.6 Consult with Agency.

5. Billing/Payroll:

- 5.1 Consult with leadership to ensure billing compliance.
- 5.2 Educate leadership on changes in billing procedures.
- 5.3 Educate leadership on changes in the payroll process, and/or regulations.
- 5.4 Consult with Agency.

HCL / LD.10 CHAP Rvd. 110101

FINANCIAL PLAN AND SOLVENCY

LD.11

PURPOSE

To establish guidelines in the preparation and monitoring of the annual budget and capital expenditure plan in a

manner conducive to meeting Agency's financial objectives and goals in accordance with applicable federal and state laws and regulations. To assure that the Agency is able to meet its day to day financial obligations and remains financially solvent.

POLICY

A committee composed of but not limited to Agency leaders, appropriate external resources, a representative of the Board of Directors, and appropriate staff, will develop, implement and monitor an annual operating budget and a long-term capital expenditure plan, as appropriate.

Agency will develop and submit a Medicare cost report annually.

PROCEDURE

1. A written budget and capital expenditure plan will be developed annually by utilizing the following applicable data:

- Measurements to determine patient care/needs
- Agency's staffing plan and benefits
- Performance improvement activities
- Other sources that address the adequacy of fiscal and other resource allocations for provision of patient care
- Budget assumptions
- Expected reimbursements by Medicare, Medicaid, and/or other payor sources

2. The budget review process will consider the appropriateness of Agency's plan for providing health care which meets the patient's needs.

3. The budget and long-term capital expenditure plan, (as appropriate), will be reviewed and approved by the Board of Directors.

4. The budget will be reviewed by Agency leadership to measure the performance of each Agency site and/or aspect of care relative to the approved budget, including measuring and acting upon identified variances under the direction of the Board of Directors.

5. All financial planning meetings and results will be documented and retained in the administrative offices.

6. An annual external financial review will be conducted beginning within one year of agency providing billable services.

SOLVENCY

1. The Agency will have the financial ability to carry out its functions.

- The Agency will not knowingly pay employees with checks from accounts with insufficient funds.
- The Agency will have sufficient funds to meet its payroll.
- The Agency will make available upon request, to the State, financial records relating to its ability to carry out its functions.
- The Agency shall maintain business records in their original state.
- Management staff will identify and obtain external funding sources to support daily operating needs, when needed.

COST REPORT

2. Agency will develop and submit a Medicare cost report annually to CMS, to include:

- Costs based on appropriate and accurate documentation,
- Allocation of costs to various cost centers that are accurate with verified and audited data;
- Properly classified costs;
- Identified related parties on form 339 and all related party charges are reduced to cost

3. Agency will promptly notify the Medicare fiscal intermediary (or other payors e.g. Medicaid, Champus) of errors discovered after submission of the cost report.

4. Clinical and billing records are retained for a minimum of 5 years past the month of filing of the applicable cost report or until the cost report is settled.

HCL / LD.11 CH Rvd. 040908

ESTABLISHMENT, IMPLEMENTATION, AND EVALUATION OF POLICIES AND PROCEDURES

LD.12

PURPOSE

To establish mechanisms that guide Agency leadership in the development, implementation and evaluation of all Agency policies and procedures.

POLICY

Agency leaders, with input from appropriate resources, will participate in policy decision, development and implementation. Policies and procedures will reflect Agency's mission, vision, and organizational plan.

PROCEDURE

A. Development

1. A review of the purposes of Agency's policies and procedures will be performed and guided by Agency's mission, vision, and organizational plan.
2. Agency leaders and staff members, as well as other appropriate individuals, professional committees, and agencies, will be involved in the collection of data and in the development process.
3. The content of the policies and procedures will be:
 - Stated concisely,
 - Described in appropriate language,
 - Written with correct word placement and punctuation,
 - Coordinated with other policies and procedures,
 - Formatted for logical sequence of action and thought,
 - Organized in an accessible and useful manner,
 - In accordance with applicable federal and state laws and regulations,
 - Consistent with all existing Agency policies and procedures.
4. Policies and procedures will be reviewed and approved by Agency leaders, the Board of Directors, and appropriate external resources on an annual basis with documented signatures and dates of review and approval.
5. The approved policies and procedures will be communicated and made available to the appropriate staff by memo, in-service or other appropriate manner.

B. Implementation

1. New or revised policies and procedures will be implemented/incorporated by Agency in a timely manner that is consistent Agency-wide.
2. Agency leaders will attempt to create an understanding environment to accommodate the projected changes.

C. Evaluation

1. The policies and procedures will be assessed and reviewed on an ongoing basis and at least annually, or as required by federal and state laws and regulations.
2. Corrective action and/or policy and procedure revision will be performed as necessary.

HCL LD.12 chap Rvd 050101

CONTRACTUAL AGREEMENTS

LD.13

PURPOSE

To define in a written agreement the nature and scope of care provided through contractual arrangement.

POLICY

Agency may provide care through a contractual arrangement or written agreement. The patient will receive the same level of care/performance from the contracted staff as from Agency staff.

PROCEDURE

Agency contracts and/or written agreements will include the following:

1. The type of care to be provided.
2. The organization or individual who is responsible for:
 - the patient admission process
 - the patient assessment process, including who is responsible for the initial and ongoing patient assessments
 - the development, review and revision of the plan of treatment
 - the coordination, supervision, and evaluation of the patient care provided
 - the scheduling of visits or hours within specified time period
 - the discharge planning
3. The documentation Agency requires and the time frame for completing and submitting the documentation to

Agency.

4. The responsibility of the contracted individual or organization to adhere, as appropriate, to applicable Agency policies, personnel qualifications and professional standards when providing care.
5. The procedures for determining charges and reimbursement.
6. The term of the agreement and conditions for renewal or termination.
7. Designation of full responsibility for Agency control over contracted services.
8. Statement of responsibility of liability and insurance coverage.
9. Date and signature of appropriate authorities.
10. Statement allowing Agency access for periodic review of personnel files of contracted staff for compliance of federal, state and Agency policies as well as maintenance of current licensure and certification.
11. The contracted organization accepting the responsibility of orienting its employees to Agency's policies and procedures. Agency will provide initial orientation to designated person(s) from contractual organization.
12. Specification that patients are accepted for care and discharge only by the Medicare-certified home health agency.
13. A non-discrimination clause pertaining to both the Agency and the Contractor.
14. All contracts will be reviewed annually by the Board of Directors.

HCL LD.13 CHAP Rvd 070105

CHARGE VERIFICATION

LD.14

PURPOSE

To provide guidelines for a method to ensure that all services provided by employees and contracted service/supply providers are charged and to provide accuracy of billing by correcting charge errors before the billing is complete.

POLICY

Each month, charges posted are compared with the individual patient clinical records to ensure that charges for all visits made are entered for billing into the computer system.. Any discrepancies are traced and corrected before the invoices are produced.

PROCEDURE

1. Charges for services are generated from daily time sheets submitted by agency visiting staff and contractors. Daily time sheets have clinical visit notes attached for each visit on the time sheet.
2. Daily time sheets are posted to the computer by the Data Entry staff and attached to an existing order.
3. Clerical staff review and investigate all unconfirmed visits on the patient schedule and remove any change in frequency or missed visits from the patient account.
4. Upon completion of all current month charges and payments, the end-of-month reports are prepared and verified by designated staff. Distributions of month-end reports are made to the Administrator.

HCL LD.14 CHAP Rvd 110101

BILLING AND COLLECTION

LD.15

PURPOSE

To outline the responsibilities of the agency for billing third-party payers, guarantors, or patients for services rendered by the agency or its contractors.

POLICY

1. Billing information is obtained during the referral/intake process and prior to the initiation of service or contracts.
2. The agency, as a service to its patients, routinely bills third-party payers or guarantors for services rendered to the patient.
3. The agency collects these funds and applies them against the appropriate patient account. Amounts not collected from the third party shall be the responsibility of the patient, unless otherwise notified in writing at the time of admission to the agency's service.
4. Services rendered to patients without insurance are the responsibility of the patient or designated guarantor.
5. The patient is notified during admission of his/her financial responsibility, in dollar amounts, for services provided.

PROCEDURE

1. A bill for services rendered will be produced no later than 45 days from the date service was provided.
2. Bills will be produced in accordance with the procedures and protocols defined by the third-party payers, on an agency invoice, advising the payer of its responsibility.
3. Accounts that remain unpaid after 30 days from the date of billing will receive a second statement for payment showing the outstanding receivable balance.
4. Accounts that remain unpaid after 60 days shall receive a third request for payment depicting the outstanding receivable balance. In addition, accounts that are delinquent beyond 60 days will receive a first collection letter requesting payment. The letter will state that failure to remit payment or contact the agency's business office to arrange payment will result in the account being placed with a collection agency.
5. Sixty (60) days after mailing initial bill, if no payment has been received, the staff will send out a first collection letter and will telephone responsible party when account is not paid within 105 days of original bill.
6. Ninety (90) days after mailing the initial bill, if payment has not been received, staff will send out a second collection letter and will telephone responsible party a third time on all accounts not paid within 105 days of original bill.
7. One hundred twenty (120) days after mailing initial bill, if payment has not been received, a final (third) collection letter will be mailed. Before the third collection letter is mailed, staff must bring the account to the Supervisor.
8. Staff will review the account with the Supervisor and, if needed, the Director of Professional Services and/or the Administrator for further direction if payment on the account is not paid in one hundred thirty-five (135) days after mailing the initial bill. The account may be approved for bad debt write-off, or a determination may be made by the staff to forward the account to an outside collection agency. Accounts must be written off or sent to collection before day one hundred fifty (150) days of initial bill.

HCLLDI5 CHAP Rvd 110101

REVIEW AND COLLECTION OF ACCOUNTS RECEIVABLE

LD

PURPOSE

To provide a procedure for reviewing patient accounts and acting on those that are delinquent and to furnish management an accurate picture of accounts receivable.

POLICY

Accounts receivable are properly managed, with prompt collection of amounts due, timely identification of amounts that will not be paid, and timely collection efforts. Accounts considered overdue are acted upon in a consistent manner, dependent on the type of payer and the age of the account. The accounts receivable balance is reviewed monthly to determine effectiveness of all collection efforts.

PROCEDURE

1. The agency's business/billing staff review all open accounts on a monthly basis.
2. Action is initiated dependent upon the type of payer and the length of time payment is overdue.
3. A report of outstanding accounts is prepared by the staff for review with the Administrator.

HCL LD.16 CHAP Rvd 110101

LEADERSHIP'S ROLE IN HUMAN RESOURCES

HR.1

PURPOSE

To ensure Agency staffing is adequate and qualified to meet patient needs.

POLICY

Agency leaders will plan and provide programs that promote the recruitment, retention, and development of all Agency staff.

PROCEDURE

1. Agency leaders will develop, plan and provide programs for the recruitment, retention and development of Agency staff on an ongoing basis by assessing the following factors:
 - Agency's mission/organizational plan
 - The degree and complexity of care required by patients

- The technology used in patient care
- Agency staff's identified learning needs
- Mechanisms utilized to recognize the expertise and performance of Agency staff
- Issues identified or stated by Agency staff that may influence the decision to continue employment with Agency

2. Agency leaders will evaluate staff programs on an ongoing basis and adjust as needed.

3. Agency leaders will provide opportunity for an exit interview with terminating employees, utilizing a specific format. The employee may respond in writing. Validation or declination of interview will be documented in the personnel record. Generic information, relative to recruitment and retention issues will be tracked and trended on an annual basis.

HCL / HR.1 CHAP Rvd. 022805

PERSONNEL CLASSIFICATIONS AND COVERAGE/ BACK-UP STAFFING

HR.2

PURPOSE

To ensure appropriate personnel classifications, recruitment and coverage to fulfill Agency's mission and patient needs. To establish a back-up plan for patient care.

POLICY

Agency will maintain a back-up staffing contract for all disciplines in the event Agency cannot provide the services required.

Agency, with input from external resources, will define the personnel classifications, qualifications and competencies, employee health status and staffing needs of Agency as indicated by the following factors:

- Agency's mission
- The needs of patients served by Agency, the department, or branch, and the degree and complexity of care required by patients/caregivers.
- The scope of care provided by Agency
- The technology utilized in the care of patients
- The expectations of Agency and patient population
- Licensure or certification requirements for each discipline providing care Health requirements for staff as it relates to care responsibilities
- The appropriate number of staff required to provide the level of care required by patients
- The appropriate number and qualifications of individuals supervising care
- Any federal and state laws and regulations

PROCEDURE

1. Agency leaders will define needed personnel classifications.

2. A job description will be written for each classification.

3. Baseline parameters will be established for the number of staff necessary to meet patient care needs.

BACK-UP STAFFING

1. When it is established that staffing is temporarily below the baseline parameters, Agency will initiate one of the following:

- Use of qualified, competent supervisory/administrative staff to provide patient care
- Use of float staff from another Agency branch (if appropriate)
- Use of qualified, competent staff from a Nursing Pool/PRN/Registry agency
- Recruitment efforts
- Referral of patients to another agency
- Declinations of referrals

HCL HR.2 chap Rvd 110101

SUPERVISOR COVERAGE

HR.3

PURPOSE

To define the parameters of supervision coverage based on the scope of care provided and applicable federal and state laws and regulations.

POLICY

Agency will determine baseline parameters to ensure appropriate administrative and clinical supervision of staff in all service areas during all hours of Agency service.

Agency will ensure access to consultation whenever a supervisor does not have the appropriate clinical training and/or clinical specialty experience needed.

PROCEDURE

1. Agency leaders and appropriate Agency staff, with input from external resources, will review supervisory needs on an ongoing basis and at least annually.
2. Agency will define the qualifications for supervisory positions in accordance with applicable federal and state laws and regulations and Agency policy, as well as the needed supervisory and clinical knowledge/experience for the assigned responsibilities. A registered nurse will be responsible for supervising and teaching other nursing personnel and home health aides.
3. Supervisory staff will be selected and oriented to all care that is assigned. Orientation will be documented and maintained in the employee's personnel record.
4. The supervisor will be responsible for notifying their immediate supervisor of new orientation/education/consultative needs.
5. Agency will locate consultative resources when a supervisor identifies a need. The resource should be available prior to providing patient care.

HCL HR.3 chap Rvd 052001

PERSONNEL JOB DESCRIPTIONS

HR.4

PURPOSE

To define the content of personnel job descriptions.

POLICY

Agency will establish written job descriptions for each job classification which will include the following:

- Job qualifications (e.g., licensure, certification, education, training, experience, and competency)
- Job responsibilities
- Line of authority
- Environmental characteristics/health status requirements
- Exposure control/risk category

PROCEDURE

1. Agency will establish and provide written job descriptions for each job classification prior to recruiting for the job.
2. All job descriptions will be reviewed annually for accuracy, completeness and relevancy.
3. Job descriptions will be changed /amended only with written approval from Agency Administrator and with input from external resources.
4. During the personnel selection process, Agency will review the job description with the applicant, answer all questions, and ensure that all content criteria are met.
5. Upon hire, the employee will sign the job description as evidence of understanding the contents.
6. If the job description is changed during employment, it will be reviewed with the employee who will sign the revised job description signifying understanding of the contents.

HCL HR.4 chap Org 050197

SELECTION OF AGENCY STAFF

HR.5

PURPOSE

To ensure a consistent and equitable process for the selection of Agency staff.

POLICY

Agency will establish a process for the recruitment and selection of staff that ensures equal consideration of applicants whose qualifications are commensurate with anticipated job responsibilities.

Agency will not discriminate in provision of services or employment with respect to age, race, color, religion, military status, gender preference, sex, marital status, national origin, disability, or source of payment, and complies with federal and state laws and regulations.

Agency will utilize an equivalent process for selection when utilizing independent contractors or volunteers.

PROCEDURE

1. Agency leaders will review federal and state employment laws and regulations. All regulations will be incorporated into the selection process and/or job descriptions.

2. The appropriate staff will be educated regarding the following personnel selection process:

- Application
- Reference checks (attempt to get minimum of 2)
- Verification of Employability/Criminal History Check
- Verification of qualifications/experience/job history
- Verification of education/training/licensure/certification including contract staff
- Testing (if applicable) to determine if job knowledge requirement(s) are met
- Offer of employment

3. Applicants will be informed of the employment determination.

HCL HR.5 chap Rvd 010406

EMPLOYEE ORIENTATION

HR.6

PURPOSE

To outline orientation and determine job specific proficiency levels in accordance with applicable federal and state laws and regulations.

POLICY

Agency will orient each employee to respective job responsibilities and Agency policies and procedures prior to performing job duties independently. The length of the orientation process will be individually determined by the employee's training and experience, the job category and requirements, and the employee's progress.

New employees will be oriented to agency policies applicable to the employee's position and will sign an acknowledgment of reading, understanding, and complying with the policies.

PROCEDURE

Agency will define the orientation content and proficiency requirements for each job classification.

The orientation will include but not to be limited to:

- ▶ Personnel issues/requirements
- ▶ Agency objectives
- ▶ Policy/procedures specific to the discipline
- ▶ Patient care issues
- ▶ Safety issues
- ▶ Confidentiality regulations, Health Insurance Portability and Accountability Act (HIPAA)

2. The orientation topics, as defined by the job-specific orientation and skills competency, will be presented/reviewed with each new employee and documented in the personnel file.

3. Agency will assign the responsibility for orientation, observation, and proficiency/competency testing to the appropriate qualified Agency staff member.

4. The new employee's knowledge and skill proficiencies will be assessed, as appropriate, for the assigned job responsibility.

HCL HR.6 chap Rvd 032003

STAFF COMPETENCY

HR.7

PURPOSE

To ensure competency of the patient care staff is assessed and improvement needs are identified on an ongoing basis.

POLICY

Agency will provide for competency assessments by qualified individuals. Agency may determine competency in one of the following ways: On hire:

- Successful completion of multiple choice test, specific to specialty, as needed (i.e., Pediatrics, IV, etc) and/or,

- Competency assessment/self competency checklist, accomplished either by demonstration or verbally

Other:

- At least annually on-site in patient's home for all patient care staff
- When introducing new procedures/techniques/equipment
- When an RN delegates a task to an unlicensed person see HR.20 Delegation

Based on competency assessments, staff development needs will be identified.

Care staffs competency will be maintained and improved through:

- Advanced education
- In-service education
- Continuing education
- Participation in appropriate professional associations
- Peer interaction
- Educational resources (e.g., books, journals, articles, etc.)
- Trends and improvement needed identified in quality assurance performance improvement program

PROCEDURE

1. Agency will establish the competency criteria for each job classification. The criteria will be listed on the competency evaluation checklists.
2. Agency will assign a qualified individual to observe the patient care staff during competency evaluations.
3. The competency evaluation checklist will be completed and retained in the employee's personnel file.
4. The employee's supervisor will plan with the employee any follow-up in-service/ educational needs.
5. The employee will be reassessed regarding any additional follow-up/educational needs.

HCL / HR.7 CHAP Rvd. 031003

HOME HEALTH AIDE COMPETENCY EVALUATION

HR.8

PURPOSE

To establish criteria for hiring and utilizing the services of a home health aide.

POLICY

Agency will ensure that each home health aide that provides licensed home health aide services meets state law requirements and performs appropriate services.

PROCEDURE

1. Agency will hire home health aides based on one of the following state requirements:
 - One year full time experience in direct patient care in an institutional setting (hospital or nursing facility); or
 - One year full time experience within the last 5 years indirect care in an agency setting; or
 - Satisfactorily completed a training and competency evaluation program which complies with the state requirements; or
 - An individual who is a nursing student who has demonstrated competency in providing basic nursing skills in accordance with a nursing school curriculum as evidenced by documentation from a director of programs or the dean of a school of nursing; or
 - Is on the Texas Department of Human Services' registry with no finding against the aide relating to patient abuse or neglect or misappropriation of patient property.
2. Tasks are assigned, delegated and supervised by a Registered Nurse/therapist who is responsible for the patient care provided by the home health aide.
3. The home health aide will participate in agency orientation.
4. The home health aide will complete a skills competency demonstration for a qualified RN prior to delivery of services and updated every 12 months.
5. There will be a three month probationary period for all new home health aide staff concluded with a written self-evaluation and evaluation by RN with mutual goals established.

HCL / HR.8 CHAP Rvd. 062907

PERSONNEL PERFORMANCE EVALUATIONS

HR.9

PURPOSE

To establish a consistent process for assessing Agency staff members' demonstrated ability to achieve the expectations stated in the respective job descriptions.

POLICY

Agency will establish a consistent process utilizing objective, measurable criteria for assessing Agency staff members' demonstrated ability to achieve the expectations stated in respective job descriptions, to identify individual growth needs, and to implement an improvement plan, as needed. The process provides an opportunity for active participation and response by employees.

PROCEDURE

Agency's performance evaluation will be continuous and will include input from each employee's direct supervisor, from Agency's staff identified as appropriate by Agency's Administrator, and from each employee. A self evaluation will be completed by the employee.

2. Formal performance evaluations will be performed and documented annually with mutual goal setting by employee and supervisor.

3. The assessment of employee performance will be in accordance with the employee's job description and include review of achievement/progress of previously established goals and new goal setting.

4. The evaluation will show evidence of joint visit of the clinical staff employee by supervisor or designee.

5. All documentation of ongoing performance evaluations (whether positive, negative or progress comments) will be completed and reviewed with the employee, signed by both parties with employee opportunity to document a response and filed in the employee's personnel record.

HCL / HR.9 CH Rvd. 030108

PERSONNEL RECORDS

HR.10

PURPOSE

To define contents and division of the personnel records for Agency employees and contracted employees (contractors).

POLICY

Agency will adhere to federal and state laws and regulations when establishing and maintaining personnel records to ensure the accuracy, completeness and confidentiality of the contents. The contents may be divided into two groups - Personnel and Medical - and the information should be maintained separately.

1. Personnel contents for agency employees may include but not be limited to:

- Employment application/Pre-employment interview
- Job description, signed or statement of acknowledgment of job description
- Copy or verification of Professional/Para-professional License/Certification
- License/certification verification
- Copy of transcripts/diplomas from schools accredited by their respective professional associations for professional staff
- Evidence of two (2) references, with the exception of agency owners
- Certificates (CCC for Speech pathologist, copy of Masters Degree for MSW)
- Competency evaluations - as applicable
- Performance evaluations
- Orientation/skills checklists
- Educational attendance
- Copy or verification of Social Security Card or number
- Copy of Drivers License for employees that drive on the job
- Copy of CPR certification, if required

2. Medical contents for agency employees may include but not be limited to:

- Physical examination results
- Laboratory test results/TB
- Hepatitis B consent/declination
- Post-exposure follow-up reports
- Worker's compensation reports

- Medical work release statements
3. All completed employee 1-9 forms with required documents should be maintained together in a separate file/notebook in a secure location at Agency.
 4. The following items may be kept in a sealed envelope in the personnel or health file or in a separate file folder/notebook in a secure location:
 - Criminal background check
 - Employee Misconduct Registry
 - Nurse Aide Registry
 5. Personnel contents for contracted employees (contractor) may include but not be limited to:
 - Confidentiality Statement License and License Verification
 - Orientation Checklist
 - Competency Skills Checklist, as appropriate
 - Current CPR Certification
 6. Medical contents for contractors may include but not be limited to:
 - Hepatitis B consent/declination
 - Laboratory test results/TB

PROCEDURE

1. Agency will designate an employee to be responsible for maintaining current, accurate Agency personnel/contractor and medical files/records and 1-9 forms.
2. Any Agency employee having access to this information will observe all aspects of confidentiality regarding the Agency personnel/contractor and medical files/records.
3. Agency will maintain all Agency personnel/contractor and medical files/records in locked file cabinets after business hours.
4. Agency will retain employee occupational exposure records for the duration of employment plus thirty (30) years.
5. Agency will retain for a minimum of three (3) years annual training records for exposure prone employees.

HCL / HR.10 CH Rvd. 070109

EMPLOYEE SUPERVISION

HR.11

PURPOSE

To establish employee supervision practices in accordance with applicable federal and state laws and regulations.

POLICY

Agency will provide timely supervision of the following employees by qualified individuals:

Home Health Aides

By a registered nurse every two (2) weeks when skilled nursing or physical, speech, or occupational therapy is performed in addition to home health aide services.

By physical therapist who can initiate a home health aide plan of care and supervise the aide, when the plan of care includes only restorative or maintenance therapy. The plan of care is for the overall care of the patient. [Ref Federal: 42 CFR § 484.36(d)]

Therapy Assistants

By the appropriate discipline's skilled therapist at least every 30 days and as necessary based on patient acuity. Each PT and OT visit note will indicate supervising therapist's name.

Medical Social Services

A Masters prepared social worker will review all social worker assistant documentation and will make recommendations prior to submitting documentation to the physician.

The social worker will review each Plan of Care for every patient visited by a social worker assistant **monthly and prior to discharge.**

Licensed Vocational Nurse (LVN)

By a Registered Nurse at least **every 30 days** and as necessary based on patient acuity.

PROCEDURE

1. Agency will assign the responsibility for employee supervision to the appropriately qualified individual.

2. Supervision will be performed within the time frame defined by the policy.
3. The information required will be defined by the appropriate supervisory area for documentation.
4. Any identified issue that requires follow-up will be directed to the appropriate Agency supervisor.

HCL / HR.11 CHAP Rvd. 062907

AGENCY IN-SERVICES AND EDUCATION

HR.12

PURPOSE

To define the in-service/continuing education requirements for Agency staff.

POLICY

Agency will provide ongoing in-service/continuing education programs which are appropriate to job responsibilities and to the maintenance of necessary skills.

Direct patient care staff are required to attend the following in-services, either internally or externally:

- Risk Management/Safety in the Home Care Environment/Medical Device Act
- Infection Control Program
- Blood borne/Airborne Pathogen Program/HIV
- TB Exposure Control Program
- Advance Directives
- Chemicals in the Workplace
- Abuse, Neglect and Exploitation
- HIPAA
- Emergency Preparedness
- CPR every two (2) years for staff who have direct patient contact and every three years for certified CPR instructors.

All Home Health Aides are required to have at least twelve (12) hours of in-services based on the individual's employment anniversary.

Management staff are required to attend a minimum of two (2) in-services annually to enhance their management skills. Administrator will meet the requirements relating to "Training in Administration of Agencies" in 40 TAC Chapter 97.259.

Agency field staff are required to meet state and federal regulations for maintaining current licensure.

Individually contracted patient care staff will provide evidence of attendance at comparable educational programs as required of Agency patient care staff members.

PROCEDURE

1. Agency will provide in-services to promote staff competency or to meet needs identified through performance improvement activities.
2. Agency will schedule the required in-services for each calendar year and will notify all staff of upcoming in-service.
3. Staff that attend in-services externally are required to provide evidence of attendance for in-service record.
4. Agency will maintain a sign-in sheet for each in-service as verification of employee attendance. A summary of the in-service will accompany the sign-in sheet for verification of content.
5. If an employee is unable to attend a mandatory in-service, Agency will offer an alternative educational opportunity.
6. Agency will collaborate with staff for additional in-service topics to meet their needs.
7. A record of in-service attendance is maintained and is kept in the employee personnel file or in-service manual.

ADMINISTRATOR TRAINING

1. The Administrator and Alternate Administrator will complete a total of **24 clock hours of training** in the administration of the Agency before the end of the 12 months after designation to the position.

1.1 At designation, an Administrator or Alternate Administrator must have 8 clock hours of educational training

within the immediately preceding 12 months in the administration of an Agency that includes:

- Information on the licensing standards for an agency, and
- The state and federal laws applicable to the Agency including:
 - The Texas Health and Safety Code, Chapter 142, Home and Community Support Services, and Chapter 250, Nurse Aide Registry and Criminal Checks of Employees and Applicants for Employment in Certain Facilities Serving the Elderly or Persons with Disabilities;
 - The Texas Human Resources Codes, Chapter 102, Rights of the Elderly;
 - The Americans with Disabilities Act;
 - The Civil Rights Act of 1991;
 - The Rehabilitation Act of 1993;
 - The Family and Medical Leave Act of 1993 as amended January 2009 in response to the National Defense Authorization Act of 2008; and
 - The Occupational Safety and Health Administration requirements.

1.2 The Administrator and Alternate Administrator will complete an additional 16 clock hours of educational training within the first 12 months after designation to the position. Any of the additional 16 clock hours may be completed prior to designation if completed during the 12 months immediately preceding the date of designation to the position. The additional 16 clock hours must include the following subjects and may include other topics related to the duties of an administrator:

- Information regarding fraud and abuse detection and prevention;
- Legal issues regarding advance directives;
- Client rights, including the right to confidentiality;
- Agency responsibilities;
- Complaint investigation and resolution;
- Emergency preparedness planning and implementation; Abuse, neglect, and exploitation;
- Infection control;
- Nutrition (for agencies licensed to provide inpatient hospice services); and
- The Outcome and Assessment Information Set (OASIS) (for agencies licensed to provide licensed and certified home health services).

1.3 After completing the 24 hours of education training within the first 12 months after designation as a first-time administrator and alternate administrator, an administrator and alternate administrator must then complete the continuing education requirements as specified in Section 2 of this policy in each subsequent 12-month period after designation.

2. The Administrator and Alternate Administrator will each complete 12 clock hours of continuing education within 12 months beginning with the date of designation to the position. The continuing education requirements will meet two of the following topics:

- 2.1 Any one of the educational training subjects listed in Section 1.2 of this policy,
- 2.2 Development and interpretation of an agency policy,
- 2.3 Basic principles of management in a licensed health-related setting,
- 2.4 Ethics,
- 2.5 Quality improvement,
- 2.6 Risk assessment and management,
- 2.7 Financial management,
- 2.8 Skills for working with clients, families, and other professional service providers,
- 2.9 Community resources, or
- 2.10 Marketing.

3. The Administrator or Alternate Administrator designated as the Agency Administrator or Alternate Administrator before December 1, 2006, who has not served as an Administrator or Alternate Administrator for 180 days or more will complete 12 clock hours of continuing education within 12 months after designation. At least 8 clock hours of continuing education will include topics listed in Section 1.1 of this policy. The remaining 4 hours must include topics related to the duties of an administrator and may include the topics listed in Section 2.1 of this policy.

4. Educational training will be met through structured, formalized classes, correspondence courses, competency-based computer courses, training videos, distance learning programs, or off-site training courses. Subject matter that deals with the internal affairs of an organization does not qualify for credit. The training will be provided or produced by:

- 4.1 An academic institution,
- 4.2 A recognized state or national organization or association,
- 4.3 An independent contractor who consults with agencies,
- 4.4 An agency.

5. When training is provided by an agency or an independent contractor, the training must be approved by DADS or a recognized state or national organization or association. The agency must maintain documentation of this approval for review by DADS surveyors.

6. Documentation of training includes the following:

- 6.1 Be on file at Agency,
- 6.2 Contain the name of the class or workshop, the course content/curriculum, the hours and date of the training, and the name and contact information of the entity and trainer who provided the training.

7. An administrator or alternate administrator must not apply the pre-survey conference toward the continuing education requirements.

HCL / HR.12 CH Rvd. 070109

PERSONAL APPEARANCE

HR.13

PURPOSE

To establish guidelines for personal hygiene and appearance for Agency staff.

POLICY

Patient care staff will wear Agency-approved uniforms or appropriate street clothes, and/or scrub suits, lab coat and functional shoes. Staff will wear clean clothing at all times. Hair will be clean and well-groomed. Jewelry will be inconspicuous. Fingernails will be clean and supervisors will reserve the right to define nail length. Makeup and perfume will be used conservatively as defined by supervisors. Identification badge will be visible. RNs and LVNs are required to wear identification when providing direct patient care identifying them as an RN or an LVN.

An ID badge worn by an RN cannot contain more than the following information:

- designation,
- name,
- certifications,
- academic degrees,
- practice positions,
- name of employer,
- Picture or other information as authorized by the Texas Board of Nursing (TBON).

2. Office staff/other personnel will wear clothing appropriate to a business setting. Staff is expected to maintain a clean and neat appearance with regard to hair, shoes and stockings. On days approved as business casual dress, jeans may be worn; no shorts or bare shoulder/midriff tops allowed.

HCL HR.13 chap

PATIENT CARE STAFF REIMBURSEMENT

HR.14 (Hourly)

PURPOSE

To establish guidelines that ensure consistent, accurate reimbursement to patient care staff as well as to determine needed reimbursement documentation.

POLICY

Agency will reimburse professional and paraprofessional patient care staff for services rendered in accordance with applicable federal and state laws and regulations.

Reimbursement will be calculated on the individual's hourly rate.

Mileage will be paid for miles traveled in personal vehicle, as part of patient care or other Agency business.

PROCEDURE

1. Upon hire, Agency staff will be educated regarding reimbursement policies and procedures
2. Actual visits made, visit type, and start/stop times will be documented on the Daily Visit Log.
3. This information, along with documentation of all care provided and orders received, will be submitted to the Agency.
4. This information will be entered into the system to generate billing statements to payor sources as well as for staff reimbursement.
5. Agency staff will document any additional hourly reimbursed time on the visit log and submit to the agency by designated date.
6. Agency staff will receive reimbursement according to Agency's pay schedule.

HCL HR.14 (HRLY) chap Org 093004

PATIENT CARE STAFF REIMBURSEMENT

HR.14 (PPV)

PURPOSE

To establish guidelines that ensure consistent, accurate reimbursement to patient care staff as well as determine needed documentation.

POLICY

Agency will reimburse patient care staff for services rendered in accordance with applicable federal and state laws and regulations.

PATIENT CARE STAFF

Reimbursement will be based on a set amount for each visit type. These types are:

- Routine Visit
- Admission Visit
- After-Hours Visit
- Hi-Tech Routine Visit
- Hi-Tech Admission Visit
- Holiday Visit
- Supervisory Visit
- A visit includes all of the following elements:
 - Preparation time for visit
 - Gathering supplies for visit
 - Patient-related phone calls prior to visit
 - Travel time to and from patient's home
 - Actual time in patient's home during visit
 - Documentation time for visit Follow-up phone calls regarding visit
 - Updating care plans
 - Updating medication sheets
 - Writing supplemental physician orders
 - Completing discharge chart and orders
 - At times, supervisory note, QI note, or other forms as directed
 - Mileage

Time spent in the office or other designated location for the purpose of fulfilling the duties of job description is not defined as part of a visit. Therefore, an hourly rate will be paid for the following:

- Orientation
- Case Management Conferences
- Mandatory Staff Meetings
- Personnel Conferences with Supervisor
- Scheduled Conferences with UR Coordinator
- Mandatory In-Services
- Other time as approved by Administration

Reimbursement will be made when all elements of the visit are complete.

PROCEDURE

1. Upon hire, Agency staff will be educated regarding the reimbursement policies and procedures.

2. Actual visits made, the type, and start/stop times will be documented on Daily Itinerary or Daily Visit Log/ Daily Progress Note.
 3. This information, along with documentation of all care provided and orders received, will be submitted to the Agency.
 4. This information will be entered into the system to generate billing statements to payor sources as well as for staff reimbursement.
 5. Agency staff will document any hourly reimbursable time on the appropriate form and submit it to the supervisor as required.
 6. Agency staff will receive reimbursement according to Agency's pay schedule.
- HCL HR.14 (PPV) chap Rvd 093004

OFFICE STAFF REIMBURSEMENT

HR.15

PURPOSE

To establish guidelines to ensure consistent, accurate reimbursement for office staff as well as to determine needed documentation.

POLICY

Agency will reimburse office staff for hours worked in accordance with applicable federal and state laws and regulations.

Reimbursement will be calculated on the individual's hourly rate.

Mileage accrued by employee's personal vehicle used for Agency business may be paid if prior approval by Administration is obtained.

PROCEDURE

1. Office staff will document hours worked and/or vacation/holiday/sick pay hours on the time entry sheet and submit it to the office.
2. Any approved mileage will be documented on an Expense Report and submitted to the office.
3. Agency staff will receive reimbursement/paychecks in a timely manner according to scheduled paydays. Paychecks may be distributed on the nearest workday if the payday falls on the weekend or a holiday.

HCL HR.15 chap Rvd 102405

AMERICANS WITH DISABILITY (ADA) / ACCOMMODATIONS

HR.16

POLICY

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

PROCEDURE

Definitions:

Disabled individual: Any person who has, or who has acquired an impairment, has a record of such impairment, or who is regarded as having an impairment, which limits one or more major life activities on a temporary or permanent basis.

Major life activities: Include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working. An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability.

Major bodily function: A classification of "major life activities" that includes, but is not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Qualified disabled individual: A disabled individual whose experience, education and/or training enables the person with reasonable accommodation to perform the essential functions of the job.

Reasonable accommodation: Any accommodation or adjustment to a job or the work environment that will enable a qualified applicant or employee with a disability to perform essential functions of the job.

Reasonable accommodations can include:

- Existing facilities made accessible
- Acquiring / providing interpreters
- Restructuring a job
- Part-time / modified work schedules
- Reassignment to a vacant position
- Purchasing or modifying equipment or devices

Practices

1. The agency will have job descriptions defining the essential functions or tasks as well as the environment in which the activity occurs.
2. Employment opportunities shall not be denied to anyone because of the need to make reasonable accommodations to the individual's disability.
3. Management has the authority to make reasonable accommodations within the work station or work site of the individual. The accommodation should not create a financial hardship on the Agency.
4. Management and the employee will collaborate on a appropriate and cost effective accommodation.
5. The employee may challenge the decision of the agency by filing a complaint with the Office of Civil Rights at 1-800-368-1019.
6. Management should periodically monitor the effectiveness of the accommodation.

Reasonable Accommodation: The Agency defines "undue hardship" for accommodation as an amount in excess of \$500 per individual.

HCL / HR.16 Rvd. 020109

EMPLOYEE GRIEVANCE/COMPLAINT RESOLUTION

HR.17

PURPOSE,

To establish a procedure for employee grievances.

POLICY

The Agency provides an internal grievance procedure to assist in a prompt and equitable resolution of complaints by employees.

PROCEDURE

1. Employees are encouraged to discuss any concerns or suggestions with supervision immediately. A response should be prompt but no later than forty-eight (48) hours.
2. If the matter is not satisfactorily resolved, the employee may file a complaint either verbally or in writing to the Agency Director. The Agency will initiate an investigation and respond as soon as possible, but no later than ten (10) working days.
3. Unresolved issues should then be brought in writing to the Administrator. A written decision will be issued by the Administrator no later than thirty (30) calendar days after the complaint is filed.
4. If the employee chooses to challenge a decision of the Agency, he/she will have access to the numbers for the Office of Civil Rights, Equal Employment Opportunity Commission and/or CMS/Medicare.

HCL HR.17 chap Rvd. 020102

NURSING PEER REVIEW

HR.18

PURPOSE

To enable the Agency to fulfill the requirements of the Texas Nursing Practice Act for the purpose of evaluating if a nurse (registered nurse or a vocational nurse) has engaged in unacceptable nursing practice.

POLICY

The Agency will implement nurse peer review (NPR) activities through a Nursing Peer Review Committee (NPRC). The Agency will establish a NPRC for vocational nurses, if the agency regularly employs, hires, or contracts for the services of 10 or more nurses; and for professional nurses, if the agency regularly employs, hires, or contracts for the services of 10 or more nurses, at least 5 of whom are registered nurses. The Agency may contract with another entity to conduct the peer review.

The NPRC is not required to submit a report to the Board if the committee determines that the reported conduct was a minor incident that is not required to be reported or the nurse has already been reported to the Board.

The Agency with less than ten (10) nurses will implement the Minor Incident procedure; which will not have to be reported to the Texas Board of Nursing (TBON) unless it is required under Section 301419 of the Occupations Code.

The Agency will permit RNs and LVNs to request Peer Review when s/he is asked to engage in conduct that is believed to be in violation of his/her duty to a patient. The RN or LVN requesting "Safe Harbor" in compliance with Texas Occupations Code Section 303.005 is afforded the protections outlined in Section 303.005. If "Safe Harbor" is invoked, TAC 217.20 Safe Harbor Peer Review regulations will be referenced and followed.

1. Definitions under Sec. 301.401/Sec.303.001 Texas Occupations Code and 22 TAC §217.9(a):

"Board" - Means Texas Board of Nursing

"Chief Nursing Officer (CNO)" - Means the RN who is administratively responsible for the nursing services at a facility

"Conduct Subject to Reporting" - Means conduct by a nurse that:

- A. Violates this chapter or a board rule and contributed to the death or serious injury of a patient;'
- B. Causes a person to suspect that the nurse's practice is impaired by chemical dependency or drug or alcohol abuse;
- C. Constitutes abuse, exploitation, fraud, or a violation of professional boundaries; or
- D. Indicates that the nurse lacks knowledge, skill, judgment, or conscientiousness to such an extent that the nurse's continued practice of nursing could reasonably be expected to pose a risk of harm to a patient or another person, regardless of whether the conduct consists of a single incident or a pattern of behavior.

"Incident-Based Peer Review" - Focuses on determining if a nurse's actions, be it a single event or multiple events (such as in reviewing up to five minor incidents by the same nurse within a year's period of time) should be reported to the Board, or if the nurse's conduct does not require reporting because the conduct constitutes a minor incident that can be remediated. The review includes whether external factors beyond the nurse's control may have contributed to any deficiency in care by the nurse, and to report such findings to a patient safety committee as applicable. (Term used interchangeably with Peer Review in this policy).

"Nurse" - Means a registered nurse or a vocational nurse licensed under Chapter 301 of the Texas Occupations Code

"Nursing" - Has the meaning assigned by Section 301.002 of the Texas Occupations Code

"Nursing Peer Review Committee" – (NPRC) Means a committee established under the authority of the governing body of a national, state, or local nursing association, a school of nursing, the nursing staff of a hospital, health science center, nursing home, home health agency, temporary nursing service, or other health care facility, or state agency or political subdivision for the purpose of conducting peer review. The committee includes an employee or agent of the committee, including an assistant, an investigator, an intervener, an attorney, and any other person who serves the committee in any capacity

"Patient Safety Committee" - Means a committee established by an agency to address issues relating to patient safety. The QAPI Committee could act in this capacity.

"Peer review" - Means the evaluation of nursing services, the qualifications of a nurse, the quality of patient care rendered by a nurse, the merits of a complaint concerning a nurse or nursing care, and a determination or recommendation regarding a complaint. The term includes:

- A. The evaluation of the accuracy of a nursing assessment and observation and the appropriateness and quality of the care rendered by a nurse;
- B. A report made to a nursing peer review committee concerning an activity under the committee's review authority;
- C. A report made by a nursing peer review committee to another committee or to the Board as permitted or required by law; and
- D. Implementation of a duty of a nursing peer review committee by a member, an agent, or an employee of the committee.

"Safe Harbor" means the process that protects a nurse from employer retaliation and licensure sanction when a nurse makes a good faith request for peer review of an assignment or conduct the nurse is requested to perform and that the nurse believes could result in a violation of the NPA or Board rules.

2. Committee Membership

- A. A NPRC must have nurses as three-fourths of its members.
- B. A NPRC that conducts a peer review that involves the practice of vocational nursing, to the extent feasible, must include vocational nurses as members and may have only RNs and LVNs as voting members.
- C. A NPRC that conducts a peer review that involves the practice of professional nursing must have RNs as two-thirds of its members, and may have only RNs as voting members.
- D. The nurses responsible for QAPI shall be members of the Committee.
- E. Management or anyone in the position to discipline nurses shall not be part of the Committee.
- F. Employees of the Agency may participate as members, but only nurses have voting rights..
- G. Preferably, the NPRC shall have at least one nurse familiar with the area of nursing practice in which the nurse is being reviewed.

3. Functions of NPRC:

- A. Evaluation of the accuracy of nursing assessments and observations;
- B. Evaluation of the appropriateness and quality of care rendered by the nurse;
- C. Any reports made to the Committee or reports generated by the Committee
- D. Implementation of the duties of the Committee.

4. Confidentiality:

A. All participants and committee members in the peer review process will sign a confidentiality statement indicating their understanding and agreement to maintaining strict confidentiality of all information presented the NPRC.

B. Breach of confidentiality by a nurse associated with the NPRC may result in disciplinary action by the Agency,

PROCEDURE

1. Anyone who observes a nurse engaging in suspected reportable behavior or is aware of conduct considered reportable shall report that conduct to the appropriate nursing manager, who will forward it to the NPRC. The description of the incident/conduct should be in writing and be limited to factual statements and without accusations or subjective conclusions. The report must be signed.
2. The NPRC Chair or designee will convene the NPRC within ten days for a preliminary review of the situation. Committee members will evaluate the information known and will decide the next steps to take to insure a thorough investigation of the situation.
3. Committee members will schedule subsequent meetings as necessary to ensure that the situation is thoroughly reviewed.
4. The reported nurse will be notified by the NPRC that a complaint has been received and will be informed of the nature of the complaint. The nurse who was reported must receive a copy of the Peer Review Policy and must receive the name and address of a contact.
5. The nurse will be provided with a written notice, either in person or by certified mail at the last known address the nurse has on file with the Agency, that his/her practice is being evaluated and that the NPRC will meet on a specific date not sooner than 21 calendar days and not more than 45 calendar days from the date of the notice unless otherwise agreed upon by the nurse and the NPRC. The notice must include a written copy of the peer review plan, policies and procedures. The notice will also include a description of the event(s) to be evaluated to inform the nurse of the incident, circumstances and conduct including date(s), time(s), location(s), and individual(s) involved. The patient involved will be identified by initials or number to protect confidentiality but the nurse will be provided the name of the patient.
6. The nurse will be given the name, address, and phone number of the contact person to receive his/her response and a copy of Rule 217.19 of the Texas Administrative Code.
7. The nurse may review, in person or by attorney, the documents concerning the event at least 15 calendar days prior to the appearing before the NPRC.
8. The reported nurse will have the opportunity to submit a written statement, call witnesses, question witnesses, and be present when testimony or evidence is being presented. The nurse will have the opportunity to be provided a copy of the witness list and written testimony or evidence at least 48 hours in advance of the meeting.
9. Any witnesses or experts may be called to present facts pertaining to the complaint as deemed necessary by the NPRC. All parties involved in the NPR process shall sign confidentiality statements and be required to adhere to the confidentiality guidelines the same as the members of the NPRC.
10. The nurse will have the opportunity to make an opening statement to the NPRC, ask questions of and respond

to questions from the NPRC, and make a dosing statement to the NPRC after all evidence is presented.

11. The purpose of the NPRC is only to review the appropriateness of the complaint for reporting to the TBON. The NPRC is not a legal proceeding, nor can legal counsel for either the nurse reported or the Agency use it as such. The nurse has a right of representation. The nurse has the right to be accompanied to the NPRC meeting by a nurse peer or an attorney. If either the Agency or nurse will have an attorney or representative present at the NPRC meeting in any capacity, the Agency or the nurse must notify the other at least seven calendar days before the NPRC meeting that they will have an attorney or representative attending and in what capacity, including serving as a member of the NPRC. Representatives must comply with the Agency's NPR policies and procedures regarding participation beyond conferring with the nurse. If an attorney representing the Agency or NPRC is present at the meeting in any capacity, including serving as a member of the NPRC, the nurse is entitled to parity of participation of counsel in that the nurse's attorney is able to participate to the same extent and level as the Agency's attorney, e.g., if the Agency's attorney can question witnesses, the nurse's attorney must have the same right.

12. A final resolution must be completed within 14 calendar days from the meeting.

13. The nurse that is reported must receive a copy of the final outcome of the NPRC meeting in person or by certified mail at the last known address the nurse has on file with the Agency of the findings of the NPRC within at least 10 calendar days of when the NPRC's review has been completed and must have the opportunity to file a written rebuttal statement within 10 calendar days of the notice of the NPRC's findings and make the statement a permanent part of the NPRC record to be included whenever the NPRC's findings are disclosed.

14. Information presented to and/or considered by the NPRC shall be maintained and not disclosed except as provided by Texas Occupations Code 303.006 and 303.007. Disclosure/discussion by a nurse with the nurse's attorney is proper because the attorney is bound to the same confidentiality requirements as the nurse.

15. The NPRC shall review the evidence to determine the extent to which any deficiency in care by the nurse was the result of deficiencies in the nurse's judgment, knowledge, training, or skill rather than other factors beyond the Nurse's control.

HCL / HIR.18 ch Rvd. 050108

15.1 A determination that a deficiency in care is attributable to a nurse must be based on the extent to which the nurse's conduct was the result of deficiency in the nurse's judgment, training, or skill.

15.2 If a determination of a nurse's conduct results in one or more minor incidents then the NPRC must determine if the nurse can be remediated or should be reported to the Board

16. The NPRC shall report a deficiency in care that the committee determines was the result of a factor beyond the nurse's control to a patient safety committee, which may be the QAPI Committee, for evaluation. In addition to the NPRC may also make recommendations for the nurse, up to and including reporting to the Board.

16.1 The patient safety committee shall evaluate the influence of the factors on the conduct of the nurse being evaluated and on the practice of other nurses within the entity that established the committee.

16.2 The committee shall report its findings to the NPRC. The NPRC is not required to withhold its determination of the nurse being peer reviewed, pending patient safety review findings unless the NPRC believes the findings are necessary to determine if the nurse's conduct is reportable.

16.3 The NPRC may extend the time line for completing the peer review process (extending the 45 days by no more than an additional 45 days) if the NPRC believes they need input from a patient safety committee. The NPRC must complete its review of the nurse within this 90-day time frame.

17. A NPRC and a patient safety committee established by the same entity may share information and that information will be protected under Sec. 303.0075 of the Texas Occupations Code.

18. A nurse who knowingly participates in peer review in bad faith is subject to disciplinary action by the TBON. Examples of bad faith are taking action against a nurse without providing the nurse the rights provided by this policy and the Texas Administrative Code rule or taking action based on personal animosity towards the nurse.

19. A nurse whose practice is being evaluated may choose not to participate in the proceeding after being notified of the evaluation. The nurse's rights may not be nullified if s/he chooses not to participate. The nurse retains any right s/he has under the peer review process.

20. The supervising nurse of the Agency is responsible for knowing the requirements of the peer review policy and the rule, as well as for taking reasonable steps to assure that peer review is implemented and conducted in compliance with the policy and rule.

21. If a registered nurse reports a nurse to the NPRC for conduct that nurse has a duty to report to the TBON, report to the NPRC will satisfy the nurse's duty to report to the TBON provided that the NPRC reports the nurse in question engaged in conduct required to be reported to the TBON. The reporting nurse shall be notified of the NPRC findings and shall be subject to Texas Occupations Code 303.006 and shall accept in good faith the findings of the NPRC.

22. The NPRC will submit to the Director of Nurses a detailed summary of the NPRC findings and any written rebuttal statement within five working days of the final committee meeting.

22.1 The Director of Nurses will submit a report on the findings of the NPRC to the TBON when applicable within five working days from receipt of the NPRC report, to include:

22.1.1 The identity of the nurse;

22.1.2 A description of any corrective action taken against the nurse;

22.1.3 A recommendation whether the TBON should take: formal disciplinary action and the basis for the recommendation;

22.1.4 A description of the conduct subject to reporting;

22.1.5 The extent to which any deficiency in care provided by the reported nurse was the result of a factor beyond the nurse's control; and

22.1.6 Any additional information the TBON requires.

22.2 If the NPRC determines that a nurse has not engaged in conduct required to be reported to the TBON, but a member of the Committee feels the NPRC acted in bad faith, s/he can report to the TBON only if s/he had independent knowledge of the conduct. If s/he learned of the conduct only through the peer review, s/he may not report the conduct to the TBON.

23. Any conduct to be reported to the TBON that results in termination, suspension, or substantial disciplinary actions shall be reported to the TBON by the Director of Nursing. The report to the TBON shall include the NPRC's determination of conduct to be reported to the TBON.

24. The grievance process is separate from the Peer Review process. Review by the NPRC does not negate the employee's right to utilize the grievance process.

25. Minor Incidents:

Conduct reported to the Administrator/DON is evaluated to determine if the incident is minor or if it will be reported to the Committee.

A. Determination of a Minor Incident:

"Minor incident" - Means conduct by a nurse that does not indicate that the nurse's continued practice poses a risk of harm to a patient or another person.

B. Administrator/DON will consider:

- Potential risk of physical, emotional or financial harm to the client due to the incident;
- The incident is a onetime event with no pattern of poor practice;
- The nurse exhibits a conscientious approach to and accountability for his/her practice; and,
- The nurse appears to have the knowledge and skill to practice safely.

C. If all the above factors are present, the Administrator/DON need not report the nurse to the Board or the NPR Committee. The Administrator/DON shall document the presence or absence of the above factors and may consider the following additional factors in determining whether the incident is a minor incident:

1. The significance of the event in the particular practice setting;
2. The situation in which the event occurred; and,
3. If these factors are present, the incident shall be referred to the quality assurance committee or quality assurance nurse for investigation into the process.

D. If the decision is made that the incident is minor, the NPRC need not review the incident and the following steps shall be taken:

1. An incident/variance report shall be completed according to Agency's policy;
2. The Administrator/DON shall document and maintain a record of each minor incident involving the nurses under his/her supervision;
3. The Administrator/DON shall assure that the incident / variance report contains a complete description of the incident, patient record number, witnesses, nurse involved and action taken to correct or remediate the problem by the Administrator/DON or Quality Assurance Committee.

E. The Administrator/DON shall report a nurse to the Board if required under Chapter 301.419 of the Texas Occupations Code.

26. A nurse whose practice is impaired or suspected of being impaired due to chemical dependency, drug or alcohol abuse, substance abuse/misuse, "intemperate use", mental illness, or diminished mental capacity, peer review of the nurse shall be suspended. The nurse shall be reported to the Board or to the Texas Peer Assistance Program for Nurses (TPAPN).

Texas Peer Assistance Program for Nurses

PO Box 9877

Austin, Texas 78766

1-800-288-5528

512-467-7027

Texas Board of Nursing

PO Box 140466

Austin, Texas 78714

512-305-7400

26.1 If there is no reasonable factual basis for determining that a practice violation is involved, the nurse shall be reported to the Board or TPAPN.

26.2 If there is a reasonable factual basis for a determination that a practice violation is involved, the nurse shall be reported to the Board.

26.3 Following suspension of peer review of the nurse, the NPRC shall proceed to evaluate external factors to determine if

26.3.1 Any factors beyond the nurse's control contributed to a practice violation; and

26.3.2 Any deficiency in external factors enabled the nurse to engage in unprofessional or illegal conduct

26.4 If the NPRC determines that external factors do exist the committee shall report its findings to a patient safety committee, which shall be the QAPI Committee.

27. A peer review committee's determination to report a nurse to the Board cannot be overruled, changed, or dismissed.

28. Optional Report by Nurse

A. In a written, signed report to the appropriate licensing board or accrediting body, a nurse may report a licensed health care practitioner, agency, or facility that the nurse has reasonable cause to believe has exposed a patient to substantial risk of harm as a result of failing to provide patient care that conforms to:

1. Minimum standards of acceptable and prevailing professional practice, for a report made regarding a practitioner; or

2. Statutory, regulatory, or accreditation standards, for a report made regarding an agency or facility.

B. A nurse may report to the nurse's employer or another entity at which the nurse is authorized to practice any situation that the nurse has reasonable cause to believe exposes a patient to substantial risk of harm as a result of a failure to provide patient care that conforms to minimum standards of acceptable and prevailing professional practice or to statutory, regulatory, or accreditation standards.

C. A person may not, suspend or terminate the employment of, or otherwise discipline or discriminate against, a person who reports, without malice, under Section 301.4025 of the Texas Occupations Code.

HCL / HR.18 ch Rvd. 050108

PROGRESSIVE DISCIPLINE POLICY

HR.19

PURPOSE

To ensure agency discipline is equitable.

POLICY

Agency will utilize an established progressive discipline process in cases of misconduct or unacceptable performance.

PROCEDURE

1. Initial communication regarding problem areas will be verbal, from the employee's supervisor. This will include a clear communication regarding the undesirable behavior or performance, and consequences, if behavior continues. Supervisor will document and keep confidential the communication. (Verbal Warning)
2. A formal documented counseling session which may include an unsatisfactory job evaluation will be retained in the employee file. Supervisory staff may conduct the session. (Written Warning)
3. Second formal counseling session, recorded for employee file, with a warning that continued undesirable behavior may cause termination from the agency. Supervisory and/or Administrative staff will conduct the session. (Final Warning)
4. Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.
5. When an employee refuses to sign a counseling form, management will obtain a signature from a witness.

Reasons for disciplinary action up to and including termination may include:

- Abuse, Neglect or Exploitation of client (Immediate)
- Theft of personal property. (Immediate)
- Theft of company property, including proprietary business information. (Immediate)
- Behavior that demonstrates a lack of respect for following guidelines and rules/authority.
- Unacceptable job performance.
- Excessive absence and/or tardiness.
- Personal use of the internet. (At the discretion of the Director of Services) (Immediate)
- Intoxication (use of alcohol or drugs) (Immediate)
- Use or selling of drugs. (Immediate)
- Harassment of other employees/clients/customers, either verbally or physically.
- Any action in conflict with stated company policies.
- Non compliance with Professional Practice Act
- Sexual Misconduct to include but not limited to: patients, patient's family members or agency employees

HCLHR 19 CH Rvd. 060108

DELEGATION POLICY

HR.20

Registered Nurses employed by Agency, may delegate health-related or nursing tasks in accordance with the Chapter 225 of the Nurse Practice Act (NPA): RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Patients/clients With Stable and Predictable Conditions and in accordance with this policy.

Registered Nurses employed by Agency, do not delegate health-related or nursing tasks in accordance with the Chapter 224 of the Nurse Practice Act: Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments §224.1 - §224.11.

Agency does not participate in the physician delegation process.

DEFINITIONS

Activities of Daily Living - Limited to the following activities: bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer/ambulation, positioning, range of motion, and assistance with self-administered medications. The term does not include more specific tasks defined as health maintenance activities relating to Health Maintenance Activities as defined below.

Administration of Medications - removal of an individual/unit dose from a previously dispensed, properly labeled container; verifying it with the medication order; giving the correct medication and the correct dose to the proper patient/client at the proper time by the proper route; and accurately recording the time and dose given.

Assistance with self-administered medication - any needed ancillary aid provided to a patient/client in the patient/client's self-administered medication or treatment regimen, such as reminding a patient/client to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storage area, and assisting in reordering medications from a pharmacy.

Delegation - authorizing an unlicensed person to provide nursing services while retaining accountability for how the unlicensed person performs the task. It does not include situations in which an unlicensed person is directly assisting an RN by carrying out nursing tasks in the presence of an RN.

Functional Disability - a mental, cognitive, or physical disability that precludes the physical performance of self-care tasks, including health maintenance activities and ADLs.

Health Maintenance Activities (HMAs) - limited to the following tasks that enable the patient/client to remain in an independent living environment and that go beyond ADLs because of the higher skill level required to perform:

- A. Administering oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation;
- B. The administering of a bowel and bladder program, including suppositories, enemas, manual evacuation, intermittent catheterization, digital stimulation associated with a bowel program, tasks related to external stoma care including but not limited to pouch changes, measuring intake and output, and skin care surrounding the stoma area;
- C. Routine care of a Stage 1 decubitus;
- D. Feeding and irrigation through a permanently placed feeding tube inserted in a surgically created orifice or stoma; and
- E. Such other tasks as the Board may designate.

Independent living environment - a patient/client's individual residence which may include a home or homelike setting such as the patient/client's home, an entity licensed or regulated by a state or federal agency or exempt from such licensure or regulation, (such as a group home, foster home, or assisted living facility), and includes where the patient/client works, attends school, or engages in other community activities. The term does not include settings in which nursing services are continuously provided.

Not Requiring Delegation - a determination by an RN that the performance of an ADL or HMA for a particular patient/client does not constitute the practice of professional nursing based on criteria established by the Texas Board of Nursing (TBON) /this Policy.

Patient/client - the individual receiving care.

Patient/client's Responsible Adult - an individual, 18 or older, normally chosen by the patient/client, who is willing and able to participate in decisions about the overall management of the patient/client's health care and to fulfill any other responsibilities required under Chapter 25 of the NPA for care of the patient/client. The term includes but is not limited to parent, foster parent, family member, significant other, or legal guardian.

Stable and predictable - a situation where the patient/client's clinical and behavioral status is determined to be non-fluctuating and consistent. A stable/predictable condition involves long term health care needs which are not recuperative in nature and do not require the regularly scheduled presence of a registered nurse or licensed vocational nurse. Excluded by this definition are situations where the patient/client's clinical and behavioral status is expected to change rapidly or s/he is in need of the continuous/ continual assessment and evaluation of a registered nurse or licensed vocational nurse. The condition of patient/clients receiving hospice care in an independent living environment where deterioration is predictable will be deemed to be stable and predictable.

Unlicensed person - an individual not licensed as a health care provider:

- A. Who is monetarily compensated to provide certain health related tasks and functions in a complementary or assistive role to the RN in providing direct patient/client care or carrying out common nursing functions;
- B. Who provides those tasks and functions as a volunteer but does not qualify as a friend providing gratuitous care for the sick under §301.004(1) of the Nursing Practice Act;
- C. Including, but not limited to, nurse aides, orderlies, assistants, attendants, technicians, home health aides, medication aides permitted by a state agency, and other individuals providing personal care/assistance of health related services; or
- D. Who is a professional nursing student, not licensed as an RN or LVN, providing care for monetary compensation and not as part of their formal educational program will be considered to be unlicensed persons and will provide that care in conformity with the NPA.

DELEGATION
PROCEDURE

1. RN Accountability

1.1 The RN will be responsible for proper performance of the assessment as defined in No. 2 below and for his/her decisions made as a result of that assessment including determining that performance of a particular ADL or HMA for a particular patient/client qualifies as not requiring delegation.

1.2 The RN is not accountable for an unlicensed person's actual performance of ADLs or HMAs not requiring delegation.

1.3 The RN's accountability to the TBON with respect to its taking disciplinary action against the RN's license is met when the RN can verify compliance with the NPA, Chapter 225.

2. RN Assessment of the Patient/Client

2.1 The RN, in consultation with the patient/client if 16 or older, and when appropriate, the patient/client's responsible adult, will make an assessment to determine if the care:

- ▶ Qualifies as an ADL or HMA not requiring delegation;
- ▶ Can be delegated to an unlicensed person; or
- ▶ Should not be delegated

2.2 In making this determination, the RN will consider each of the following elements of assessment to develop an overall picture of the patient/client's health status:

- The ability of the patient/client or patient/client's responsible adult to participate in the health care decision and ability and willingness to participate in the management and direction of the task;
- The adequacy and reliability of support systems available to the patient/client or patient/client's responsible adult;
- The degree of the stability and predictability of the patient/client's health status relative to which the task is performed;
- The knowledge base of the patient/client or patient/client's responsible adult about the patient/client's health status;
- The ability of the patient/client or patient/client's responsible adult to communicate with an unlicensed person in traditional or nontraditional ways; and
- How frequently the patient/client's status will be reassessed.

2.3 While each element will be assessed, strength in one factor may compensate/offset a weakness in another factor. The assessment (under the NPA, Chapter 225) does not require the RN to know either the specific unlicensed person who will perform the tasks or the specific qualifications of the unlicensed person who will perform the tasks, thus the RN is not required to determine the competency of the unlicensed person.

3. Activities of Daily Living Not Requiring Delegation

3.1 Activities of daily living (ADLs) that do not fall within the practice of professional nursing may be performed by an unlicensed person in accordance with the NPA, Chapter 225 without being delegated. The Board has determined that in situations governed by this chapter ADLs do not fall within the practice of professional nursing when:

- A. performed for a person with a functional disability and the patient/client would perform the task(s) but for the functional disability; and
- B. the RN determines, based on an assessment under the NPA §225.6 (relating to RN Assessment of the Patient/Client) that the task(s) is such that it could be performed by any unlicensed person without RN supervision.

3.2 If the above criteria cannot be met, an ADL may still be performed as a delegated task if it meets the criteria relating to Delegation as described below.

4. Health Maintenance Activities Not Requiring Delegation

4.1 Health Maintenance Activities (HMAs), as defined in this chapter that do not fall within the practice of professional nursing, may be performed by an unlicensed person in accordance with the NPA, Chapter 225 without being delegated. The Board has determined that in situations governed by this chapter HMAs do not fall within the practice of professional nursing when:

- A. Performed for a person with a functional disability;
- B. in addition to the patient/client assessment under RN Assessment of the Patient/Client, an RN determines all of the following conditions exist:

- The patient/client would perform the task(s) but for her/his functional disability;
- the task(s) can be directed by the patient/client or patient/client's responsible adult to be performed by an unlicensed person without RN supervision;
- the patient/client or patient/client's responsible adult is able, and has agreed in writing, to participate in directing the unlicensed person's actions in carrying out the HMA; and
- Either
 - The patient/client is willing and able to train the unlicensed person in the proper performance of the HMA, or
 - The patient/client's responsible adult is capable of training the unlicensed person in the proper performance of the task and
 - (I) will be present when the task is performed, or
 - (II) If not present, will have observed the unlicensed person perform the task at least once to assure he/she can competently perform the task and will be immediately accessible in person or by telecommunications to the unlicensed person when the task is performed.

4.2 If the above criteria cannot be met, an HMA may still be performed as a delegated task if it meets the criteria relating to Delegation.

5. Delegation Criteria

5.1 When determining whether to delegate a nursing task or those ADLs or HMAs requiring delegation, the RN, in addition to the assessment relating to RN Assessment of the Patient/Client, will:

- determine that the task does not require the unlicensed person to exercise nursing judgment;
- Verify the experience and competency of the unlicensed person to perform the task, including the unlicensed person's ability to recognize and inform the RN of patient/client changes related to the task. The RN will have either:
 - instructed the unlicensed person in the delegated task; or
 - Verified the unlicensed person's competency to perform the nursing task based on personal knowledge of the training, education, experience, and/or certification/permit of the unlicensed person.
- determine, in consultation with the patient/client or the patient/client's responsible adult, the level of supervision and frequency of supervisory visits required, taking into account:
 - The stability of the patient/client's status;
 - the training, experience and capability of the unlicensed person to whom the nursing task is delegated;
 - the nature of the nursing task being delegated;
 - the proximity and availability of the RN to the unlicensed person when the nursing task will be performed; and
 - The level of participation of patient/client or patient/client's responsible adult.
- Consider whether the five rights of delegation can be met: the right task; the right person to whom the delegation is made; the right circumstances; the right direction and communication by the RN; and the right supervision.

5.2 The RN or another RN qualified to supervise the unlicensed person will be available, in person or by telecommunications when the unlicensed person is performing the task.

5.3 The RN, in consultation with patient/client or patient/client's responsible adult, has the authority to make the final decision to delegate to an unlicensed person.

6. Tasks That May Be Delegated

6.1 The RN may delegate the following tasks unless the RN's assessment determines that the task is not a task a reasonable and prudent nurse would delegate. Tasks include:

- A. an ADL the RN has determined requires delegation (relating to Activities of Daily Living Not Requiring Delegation NPA §225.7);
- B. an HMA the RN has determined requires delegation (relating to Health Maintenance Activities Not Requiring Delegation NPA §225.8);
- C. non-invasive and non-sterile treatments with low risk of infection;

D. the collecting, reporting, and documentation of data including, but not limited to:

- Vital signs, height, weight, intake and output, capillary blood and urine test for sugar and hematest results,
- Environmental situations/living conditions that affect the patient/client's health status,
- Patient/client or significant other's comments relating to the patient/client's care, and
- Behaviors related to the plan of care;
- Reinforcement of health teaching provided by the registered nurse;
- inserting tubes in a body cavity or instilling or inserting substances into an indwelling tube limited to the following:
 - Insertion and/or irrigation of urinary catheters for purpose of intermittent catheterization; and
 - Irrigation of an indwelling tube such as a urinary catheter or permanently placed feeding tube;
- Tracheal care to include instilling normal saline and suctioning of a tracheostomy with routine supplemental oxygen administration;
- Care of broken skin with low risk of infection;
- Sterile procedures involving a wound or an anatomical site that could potentially become infected;
- Administration of medications:
 - Orally or via permanently placed feeding tube inserted in a surgically created orifice or stoma;
 - Sublingually;
 - Topically;
 - Eye and ear drops; nose drops and sprays;
 - Vaginal or rectal suppositories;
 - Unit dose medication administration by way of inhalation for prophylaxis and/or maintenance; and
 - Oxygen administration for the purpose of non-acute respiratory maintenance.
- Administration of oral unit dose medications from the patient/client's daily reminder pill container in accordance with the NPA §225.11(a) relating to Delegation of Administration of Medications from Pill Reminder Container and Administration of Insulin;
- Administration of insulin subcutaneously, nasally, or via insulin pump in accordance with §225.11; and
- Other such tasks as the TBON may designate.

7. Delegation of Administration of Medications from Pill Reminder Container and Administration of Insulin.

7.1 In addition to complying with all previous criteria listed, when delegating the administration of oral unit dose medications from the patient/client's daily pill reminder container, the RN will:

- ensure that the unit dose medication(s) are placed in the patient/client's daily reminder pill container, from properly dispensed prescription bottle(s), by the RN or a person mutually agreed upon by the RN and patient/client or patient/client's responsible adult who has demonstrated the ability to complete the task properly;
- instruct the patient/client or patient/client's responsible adult and the unlicensed person involved in such delegation activity about each medication placed in such a container with regard to distinguishing characteristics of each medication, proper time, dose, route, and adverse effects which may be associated with the medication;
- Provide to the patient/client, patient/client's responsible adult if applicable, and the unlicensed person(s) instructions to contact the RN before the medication is administered when there are questions concerning the medications or changes in the patient/client's status related to the medication being given. An example is when the medications appear to be rearranged or missing.
- make supervisory visits in the event there are changes in the patient/client's status related to the

medication being given and determine the frequency of supervisory visits in consultation with the patient/client or the patient/client's responsible adult to assure that safe and effective services are being provided; and

-Ensure the patient/client or patient/client's responsible adult acknowledges in writing that the administration of medication(s) under this section will be delegated to an unlicensed person.

7.2 In addition to complying with all previous criteria listed, when delegating administration of insulin subcutaneously, nasally, or via insulin pump the RN will:

-Arrange for an RN to be available on call for consultation/ intervention 24 hours each day;

-Provide teaching of all aspects of insulin administration, subcutaneously, nasally, or via insulin pump to the patient/client, patient/client's responsible adult, and the unlicensed person to include, but not limited to, proper technique for determination of the patient/client's blood sugar prior to each administration of insulin, proper injection technique, risks, side effects, and the correct response(s). The RN will leave written instructions for the performance of the administration of insulin subcutaneously, nasally, or via insulin pump, including a copy of the physician's order or instructions, for the unlicensed person, patient/client, or patient/client's responsible adult to use as a reference.

-Delegate the administration of insulin subcutaneously, nasally, or via insulin pump to an unlicensed person, specific to one patient/client. The RN will teach that the administration of insulin subcutaneously, nasally, or via insulin pump is to be performed only for the patient/client for whom the instructions are provided and instruct the unlicensed person that the task is patient/client specific and not transferable to other patient/clients or providers;

-delegate the administration of insulin subcutaneously, nasally, or via insulin pump to additional unlicensed persons providing care to the specific patient/client provided the registered nurse limits the number of unlicensed persons to the number who will remain proficient in performing the task and can be safely supervised by the registered nurse;

-Make supervisory visits to the patient/client's location at least 3 times within the first 60 days (one within the first two weeks, one within the second two weeks, and one in the last 30 days) to evaluate the proper administration of insulin by the unlicensed person(s). After the initial 60 days, the RN, in consultation with the patient/client or patient/client's responsible adult, will determine the frequency for supervisory visits to assure the proper and safe administration of insulin by the unlicensed person(s). Separate visits will be made for each unlicensed person administering insulin;

-Make supervisory visits in the event there are changes in the patient/client's status; and

-Ensure that the patient/client or patient/client's responsible adult acknowledges in writing that the administration of medication(s) under this section will be delegated to an unlicensed person.

8. Tasks Prohibited From Delegation

8.1 The following are nursing tasks that are not within the scope of sound professional nursing judgment to delegate:

- Physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;
- Formulation of the nursing care plan and evaluation of the patient/client's response to the care rendered;
- Specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;
- The responsibility and accountability for health teaching and health counseling to patient/client or patient/client's responsible adult which promotes patient/client or patient/client's responsible adult education and involves the patient/client's responsible adult in accomplishing health goals; and
- The following tasks related to medication administration:

- Calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;
- administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by §225.11(b) relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);
- administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) relating to Task That May Be Delegated;
- Responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and
- administration of the initial dose of a medication that has not been previously administered to the patient/client unless the RN documents in the patient/client's medical record the rationale for authorizing the unlicensed person to administer the initial dose.

9. Supervising Unlicensed Personnel Performing Tasks Delegated by Other Practitioners.

9.1 The following applies to the registered nurse who practices in a collegial relationship with another licensed practitioner who has delegated tasks to an unlicensed person over whom the RN has supervisory responsibilities. The RN's accountability to the TBON, with respect to its taking disciplinary action against the RN's license, is met if the RN:

- verifies the training of the unlicensed person;
- Verifies that the unlicensed person can properly and adequately perform the delegated task without jeopardizing the patient/client's welfare; and
- Adequately supervises the unlicensed person.

9.2 If the RN cannot verify the unlicensed person's capability to perform the delegated task, the RN will communicate this fact to the licensee who delegated the task.

10. Application of Other Laws and Regulations

10.1 Standards of Professional Nursing Practice and Agency require RNs to know and conform to all laws and regulations affecting their area of practice.

10.2 The RN authorizing an unlicensed person to perform tasks in independent living environments should be aware that, in addition to this policy, various laws and regulations may apply including, but not limited to, laws and regulations governing home and community support services agencies and Medicare and Medicaid regulations. In situations where an RN's practice is governed by multiple laws and regulations that impose different requirements, the RN will comply with them all and, if inconsistent, the most restrictive requirement(s) governs. For example, if one regulation requires an RN to make a supervisory visit every 14 days and another leaves it to the RN's professional judgment, the RN would have to visit at least every 14 days or more frequently, if that is what the RN's professional judgment indicated.

HCL HR.20 chap Rvd 090107

PROFESSIONAL PRACTICE ACTS

HR.21

PURPOSE

To establish compliance guidelines and consequences of non compliance with Professional Practice Acts

POLICY

Professional Disciplines will be knowledgeable of and comply with their respective Practice Acts including relating to reporting and peer review.

Failure to comply with the professional's practice act and actions defined as detrimental to the public health and welfare may result in discipline and result in termination from Agency. Agency will report "reportable" non-compliance with a discipline's practice acts to the appropriate Board.

Agency complies with acceptable standards of nursing practice and Rule 217.11 for determining a nurse's scope of practice.

PROCEDURE

1. Agency Registered Nurses will adhere to the Texas Nursing Practice Act and the Rules and Regulation relating

to Professional Nurse Education, licensure and practice/delegation.

2. Agency Vocational Nurses will adhere to the Vocational Nurse Scope of Practice Under Rule 217.11 Standards of Nursing Practice.
3. Agency Physical Therapists and Occupational Therapists will adhere to the Texas Physical Therapy and Occupational Therapy Practice Act
4. Agency Speech Therapists will comply with the Texas Speech Pathologists Practice Act.
5. Agency Medical Social Workers will comply with the Texas Social Work Practice Act.

NURSING SCOPE OF PRACTICE

Definitions

1. **Supervision:** process of directing, guiding, and influencing the outcome of an individual's performance
2. **Healthcare Setting for LVN:** A "structured setting" is defined as a "geological and/or situational environment where policies, procedures, and protocols for provision of healthcare are established in which there is recourse to assistance and support from the full scope of nursing expertise" as defined in the Differentiated Entry Level Competencies (DELC). Also a healthcare practice setting for an LVN may also include a setting where continuous nursing services are provided, or where the LVN has access to the licensed healthcare provider serving as LVN supervisor (such as home care, hospice, assisted living facility, group homes, etc).(definitions taken in part from Texas Board of Nursing (TBON) rules 224.1 and 225.4(9)

3. Focused Assessment vs. Comprehensive (or RN Nursing) Assessment:

217.11(2) (A) (i)

"LVNs conduct focused nursing assessments of the health status of individuals"

A focused assessment is an appraisal of an individual client's status and situation at hand, contributing to comprehensive assessments by registered nurses, supporting ongoing data collection, and deciding who needs to be informed of the information and when to inform.

217.11(3)(A)(i)

Registered nurses conduct "comprehensive nursing assessments of the health status of clients."

A comprehensive nursing assessment is an extensive data collection(initial and ongoing) for individuals, families, groups and communities addressing anticipated changes in client conditions as well as emergent changes in a client's health status; recognizing alterations to previous client conditions; synthesizing the biological, psychological, spiritual and social aspects of the client's condition; evaluating the impact of nursing care; and using this broad and complete analysis to make independent decisions and nursing diagnosis; plan nursing interventions, evaluate need for different interventions, and the need to communicate and consult with other health team members.

PROFESSIONAL PRACTICE ACTS

Vocational Nurse	Registered Nurse
1) Clarification of Practice Parameters Directed Practice under the supervision of an RN, advanced practice nurse, physician assistant, dentist, or podiatrist(Independent practice not permitted)	1) Clarification of Practice Parameters Practice set broadly by NPA, Section 301.002, that precludes RNs from engaging in "acts of medical diagnosis or prescription of therapeutic or corrective measures" RNs are permitted to engage in independent practice within the scope of their license.
2) Provider of Care a) Assist in determination of predictable healthcare needs of clients within structured healthcare settings who are experiencing common, well defined health problems with predictable outcomes. b) Utilize a systematic approach to provide individualized, goal-directed nursing care by: (i) collecting data & performing focused nursing assessments; (ii) Participating in the planning of nursing care needs for the client, and in modifying the nursing care plan for the	2) Provider of Care a) Determine the predictable or unpredictable health status and health needs of clients (individual and family) through interpretation of health data and preventive health practice in collaboration with clients and interdisciplinary health care team members. b) Utilize a systematic approach to provide individualized, goal-directed nursing care by: (i) Performing comprehensive nursing assessments regarding the health status of the client(s); (ii) Formulating a nursing care plan based on determination

<p>assigned clients;</p> <p>(iii) Implementing appropriate aspects of care within the LVN's scope of practice, including compliance with other laws as are applicable to LVN practice setting;</p> <p>(iv) Implementing the teaching plan for clients with common health problems and well defined learning needs;</p> <p>(v) Providing direct basic care assigned to multiple clients in structured settings;</p> <p>(vi) Assist in the evaluation of the client's responses and outcomes to therapeutic interventions; and</p> <p>(vii) Utilize a problem-solving approach as the basis for decision making practice.</p>	<p>of nursing diagnoses;</p> <p>(iii) Implementing nursing care within the RN's scope of practice, including compliance with other laws are applicable to the RN's practice setting;</p> <p>(iv) Developing and implementing teaching plans for clients concerning promotion, maintenance and restoration of health;</p> <p>(v) Providing for the care of multiple clients (individual and family) either through direct care or assignment and/or delegation of care to other members of the health care team;</p> <p>(vi) Evaluate client's (individual and family) responses and outcomes to therapeutic interventions; and</p> <p>(vii) Utilize critical thinking approach to analyze clinical data and current literature as a basis for decision making in nursing practice.</p>
<p>3) Coordinator of Care:</p> <p>Assign specific tasks, activities and functions and maintain appropriate supervision of licensed and unlicensed personnel in structured health settings for clients with predictable health care needs in accordance with designated job descriptions and/or job duties.</p>	<p>3) Coordinator of Care:</p> <p>Make assignments to licensed staff (LVNs, RNs) and delegate to unlicensed staff in compliance with current TBON rules in both structured and unstructured health settings for clients with predictable as well as unpredictable health needs.</p>
<p>4) Member of a Profession:</p> <p>a) Assume accountability and responsibility for the quality of nursing care provided to clients.</p> <p>b) Act as a client advocate to maintain a safe environment for clients.</p> <p>c) Demonstrate behaviors that promote development of positive outcomes in relation to the practice of vocational nursing.</p>	<p>4) Member of a Profession:</p> <p>a) Assume accountability and responsibility for the quality of nursing care provided to clients.</p> <p>b) Act as a client advocate to maintain a safe environment for clients.</p> <p>c) Serve as a healthcare advocate in monitoring and promoting quality of health care and services for client; and</p> <p>d) Participate in activities and act as a leader in promoting best practices within professional nursing.</p>

HCL HR.21 chap Rvd 090107

DRUG FREE WORKPLACE

HR.22

PURPOSE

To establish procedures for a "drug-free workplace.

POLICY

Agency conducts drug testing of its employees when hired and random/for cause.

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

All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on agency paid time. Violation of this policy can result in disciplinary action, up to and including termination of employment.

Employees who have direct contact with clients will be tested on hire. Random/for cause (reasonable-suspicion testing) will be conducted when the Agency or its client has reason to believe that drug or alcohol problem exists, or a violation of the policy has occurred, or post-accident/near-miss accident or an incident where an injury or property damage did or might occur. Agency further reserves the right to perform "random/for cause" drug testing on any employee upon written notice.

In order to implement both the Agency policy and to be in compliance with the Federal Law, employees are notified that:

All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on agency paid time. Violation of this policy can result in disciplinary action, up to and including termination of employment.

Rationale

The Agency and its employees must be alert, responsive and able to perform work in a safe and productive manner. Working "under the influence" of drugs or alcohol creates a risk to the safety and well being of the individual and patient.

PROCEDURE

1. The Agency educates all employees during orientation and patients upon admission regarding the drug testing policy.
2. Employees must sign acknowledgment of receipt of policy. A signed statement will be maintained in the employee personnel file.
3. All employees are responsible to report instances of possible abuse. Reported instances of abuse will be thoroughly and confidentially investigated. Management personnel will terminate the employee, if results of the investigation indicate alcohol/drug use or abuse.
4. The employees are notified of the following:
 - There are substantial dangers of drug and alcohol abuse in the workplace.
 - It is the Agency policy to maintain a workplace free of illegally used drugs and abuse of alcohol.
 - Management and the Human Resources Department are prepared to advise what counseling and rehabilitation programs are available.
 - The Agency may at its sole discretion, require an employee to participate in an appropriate counseling and rehabilitation program as the result of substance abuse violations. Refusal to participate in such program and to periodically submit to "random/for cause" testing during the course of treatment for a reasonable period of time, will be grounds for termination.
 - Employees taking legally prescribed or over-the-counter drugs that might impair mental or physical functions must notify management prior to reporting to work and/or prior to taking after the start of work. A doctor's note may be required.
 - Employees must notify management of drug convictions within five days of such conviction. Management will notify Human Resources immediately.
 - If the employee is performing services under a government contract, the Agency will notify the government contracting officer within ten days of the Agency's receipt of a notice of conviction.
5. The Agency may require an employee to submit to drug and/or alcohol screening under the following circumstances:
 - The Agency will comply with the reasonable contractual requirements of alcohol and/or drug testing of employees.
 - Employees will be subject to "random/for cause" post-accident testing if involved in an on-the-job accident, near-miss accident, or an incident where injury or property damage did occur or might have occurred.
 - Employees will be subject to "random/for cause" (reasonable-suspicion) testing when the problem exists or a violation of the policy has occurred.
 - On-hire drug screening will be required
 - Employees may be required to submit to drug testing when required by state or federal law, regulation or contractual obligation not otherwise anticipated by this policy.

6. Method and Type of drug testing:

Urine drug screening test, SAP-Substance Abuse Panel 5-50 Five Panel with 50ng cutoff for THC W/NIT with nitrates check at Quest diagnostics observed specimen collection.

HCL HR.22 Drug Testing/On Hire-Random/For Cause chap Rvd 071306

UNLAWFUL HARASSMENT

HR. 23

PURPOSE

To ensure a work environment free of unlawful harassment

POLICY

Agency is committed to providing a work environment which is free from all forms of discrimination and unlawful harassment, including sexual harassment.

Management will make every effort to ensure that complaints are investigated promptly and impartially.

PROCEDURE

DEFINITION: sexual harassment is any unwelcome sexual advance either explicit or implicit, as a term or condition of employment. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile or offensive work environment.

Practices:

- An employee who believes that they have been the subject of unlawful harassment by a co-worker, supervisor, resident or individual with a business relationship to the Facility should report the alleged incident immediately and confidentially to management.
- Complaints will be promptly and thoroughly investigated with response within 24 hours.
- Thorough records of complaints, investigations and actions will be maintained confidentially.
- Appropriate follow-up will be conducted to insure the matter has been resolved and proper safeguards are in place.
- When a complaint is found to have merit, the accused will be subject to disciplinary action up to and including termination.
- If an investigation results in a finding that the accuser has maliciously or recklessly made false accusations, the accuser will be subject to appropriate sanctions up to and including termination.

HCL HR.23 chapRvd 092806

BACKGROUND CHECKS

HR. 24

PURPOSE

To establish procedures for verification of employability for unlicensed personnel who provide direct care or services to patients and for Administrator, Alternate Administrator, CFO and owners. Establish guidelines for new hire reporting.

POLICY

Agency will perform background checks for verification of employability on unlicensed personnel who provide direct care or services to patients and on the Administrator, Alternate Administrator, CFO and owner. These checks will occur on every new job offer and on change of ownership of Agency by either the Parent agency or the Branch.

Employees will not have direct contact with patients until the agency has obtained the results of the criminal history record information and has verified employability.

Agency will report new hires per the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which requires employers to report new hires within 20 calendar days.

Criminal History checks and registry searches of employee or applicants for employment will be kept confidential.

PROCEDURE

A. Criminal History Checks for Unlicensed Personnel

1. Agency will request a criminal history check for un-licensed staff that have direct contact with patients in one of the following methods:

- Electronically through a secure web site, or
- Request in writing to the Department of Public Safety (DPS), or
- Through a private entity of Agency's choice.

2. Applicant will sign a Statement of Employability informing them of the Agency's right to no longer employ that person if that person has been convicted of an offense that bars employment as listed in Texas Health and Safety Code §250.006, or that a conviction is a contraindication to employment with clients served by the Agency.
3. A criminal history check will be performed prior to hiring a nurse aide. A nurse aide may not have contact with a patient until the agency has obtained results of the criminal history record, even in an emergency.
4. Agency will maintain a copy of submitted requests in the personnel file or a printed page from online check, to demonstrate that the criminal history check was conducted.

B. Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR) for Unlicensed Personnel

1. Agency will access, prior to hiring, the Employee Misconduct Registry and the Nurse Aide Registry to determine if an individual is eligible for employment in one of the following ways:
 - Reference both EMR and the Nurse Aide Registry at the Department of Aging and Disability Services (1-800-452-3934), or
 - Reference the EMR listing of all unemployable unlicensed individuals on the Department of Aging and Disability Services (DADS) Credentialing Sanctions Database (<http://www.dads.state.tx.us/business/ltr/credentialing/policies.html>).
2. Agency will provide written notification to applicants about EMR/NAR checks prior to performing check, including a statement that a person listed in the EMR is not employable.
3. Agency will deny employment to, or immediately stop using, any person listed on the registries with a finding concerning abuse, neglect, or exploitation, or mistreatment of a patient of an agency or a facility, or misappropriation of a patient's property.
4. Agency will maintain documentation of verification of employability in individual's personnel file.

C. Criminal Background Checks for Administrator, Alternate Administrator, CFO and Owners

1. Agency will complete and submit a criminal history form as designated by the State on every new job offer, with re-licensure application and on change of ownership of Agency, as appropriate.
2. The criminal background check will be performed by DADS on receipt of form.
3. Agency will deny employment to any person listed on the registries as unemployable.
4. Agency will maintain documentation in individual's personnel file to demonstrate that the criminal history check was conducted.

D. Employer New Hire Reporting Program

1. New hires will be reported to the Office of the Attorney General within 20 calendar days of hire.
2. Agency has the option of using the easiest reporting method:
 - Mail paper copy (W-4, printed list or state form) to:
Texas Employer New Hire Reporting
Operations Center
P.O. BOX 149224
Austin, Texas 78714-9224
 - Telephone: 1-800-850-6442
 - Fax: 1-800-732-5015
 - The Internet, including online submission and file uploads
 - An electronic file on compact disk or tape mailed to the agency (specifications required are at <http://employer/oag.state.tx.us>. Go to "New Hires" and select "Electronic Reporting Specifications").

HCL / HR.24 CH Rvd. 080109

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES. RIGHTS OF THE ELDERLY RI.1

PURPOSE

To ensure all patients/caregivers and Agency staff acknowledge, observe and implement the patient's rights and responsibilities.

POLICY

Agency will provide information regarding the Patient Bill of Rights and Responsibilities, and the Rights of the

Elderly (to persons over 60) both verbally and in writing (in a manner that the patient/guardian can understand), to all Agency staff and to each patient or legal guardian in advance of furnishing care or during the initial evaluation visit before the initiation of treatment.

Agency will orient staff regarding patient rights on hire and annually thereafter.

PROCEDURE

1. The Patient Bill of Rights and Responsibilities will be posted in the Agency.
2. Agency staff will be responsible for knowing, observing, and implementing the patient's rights and responsibilities on an ongoing basis.
3. The Patient Bill of Rights and Responsibilities will be given to the patient at the time of the patient's assessment and prior to admission to Agency. The Rights of the Elderly will be given to the patient 60 years of age or older.
4. The patient/caregiver will sign and date an acknowledgment of receipt and understanding after reading and/or having these rights and responsibilities verbally explained in a manner that the patient/caregiver can understand.
5. The patient's/caregiver's signature will be witnessed by an Agency staff member.
6. If the patient cannot sign the form, the person acting on behalf of the patient may do so.
7. The reason why the patient is unable to sign will be stated on the form.

HCL / RL1 CH Rvd. 070109

ADVANCE DIRECTIVES

RI.2

PURPOSE

To ensure that adult patients/legal guardians are informed of patient rights under federal and state law to make and direct decisions concerning medical care; including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives such as a "Living Will", "Medical Power of Attorney", " Out-Of Hospital DNR", or "Declaration of Mental Health Statement".

To guide Agency staff in implementing the provisions of the Patient Self-Determination Act and Texas' Advance Directives Act

To provide for education of staff and the community on issues concerning advance directives and related advance care documents.

Definitions

Artificial Nutrition and Hydration

The provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

Cardiopulmonary Resuscitation (CPR)

Any medical intervention used to restore circulatory or respiratory function that has ceased.

Declarant

Person who has executed or issued a directive.

Health Care or Treatment Decision

Consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual's physical or mental condition, including such a decision on behalf of a minor.

Irreversible Condition

Condition, injury or illness that may be treated but is never cured or eliminated; that leaves the person unable to care for or make decisions for person's own self; and that without life sustaining treatment, is fatal.

Life Sustaining Treatment

Treatment that, based on reasonable medical judgment, sustains life of a patient and without which the patient will die. The term includes life sustaining medications and artificial life support; it does not include pain management medication or a medical procedure that provides comfort care, or palliative care.

Living Will/Directive to Physician

Type of advance directive in which an individual puts in writing their wishes about medical treatment should they

be unable to communicate at the end of life. The Texas Directive permits the withholding or withdrawing of life-sustaining medical treatment in the event of a terminal or an irreversible condition that would result in death without life-support.

Medical Power of Attorney

A document that enables the patient to appoint someone they trust to make decisions about their medical care if they cannot make those decisions them self. This type of advance directive may also be called a "health care proxy" or "appointment of a health care agent." The person appointed may be called the health care agent, surrogate, attorney-in-fact, or proxy.

Qualified Patients

Patient with a terminal or irreversible condition that has been diagnosed and certified in writing by attending physician.

Terminal Condition

Incurable condition that according to reasonable medical judgment will produce death within 6 months, even with available life-sustaining treatment.

Witnesses

Two competent adult witnesses must sign the form acknowledging the signature of the patient or the person acting on the patient's behalf except when signed by two (2) physicians in Section C of OOHDR.

Witness 1 must meet all of the following qualifications and that individual **may not be**:

1. A person designated to make a treatment decision for the patient;
2. Related to the patient by blood or marriage;
3. Entitled to any part of the estate;
4. Be a person who has claim against the estate of the patient;
5. The attending physician or the attending physician's employee;
6. An employee of a health care facility in which that patient is being cared for, if involved in providing direct patient care to the patient; or
7. An officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or any parent organization of the health care facility.

Witness 2 may be any competent adult.

POLICY

Agency recognizes an adult patient's/legal guardian's right under federal and state law to make decisions regarding medical care, including the right to formulate advance directives. The Agency will not withhold care based on whether or not the individual has an advance directive. However, if at any time Agency staff is unable to honor an advance directive elected by the patient, the patient will be notified and, if patient (or designated representative) requests, will be transferred to another appropriate agency/organization.

Agency does not participate in the withdrawal of life sustaining care.

Life sustaining procedures Agency is unable and/or unwilling to withhold in

- Accordance with a patient's advance directive and/or
- As discussed with patient (or designated representative), family, physician, and/or Agency's governing body are:
 1. Artificial Nutrition,
 2. Artificial Hydration,
 3. Mechanical Breathing Machines - (Oxygen, Ventilator, etc.)
 4. Total Parenteral Nutrition,
 5. Blood Transfusions,
 6. Life Sustaining Medications - (All routes),
 7. Dialysis (Agency will not withdraw follow up support services such as assessments and coordination of care because patient is at end of life),
 8. Any other methods recognized as artificial life support,
 9. Surgical Procedures (discussed on an individual basis with patient {or designated representative}, family, physician, and/or Agency's governing body),

10. CPR (Unless patient has a standing DNR or meets other legal criteria for no CPR)

PROCEDURE

1. Agency staff will distribute to and review with the patient/legal guardian written information relating to the patient's right to refuse medical or surgical treatment and the right to formulate advance directives, as well as Agency policies relating to advance directives at the time of the initial assessment, prior to the provision of care to the patient.

2. Agency staff will inquire whether the patient has an advance directive at the time of the initial assessment. If an advance directive is not in place and the patient expresses the desire to establish an advanced directive, then a medical social services referral may be initiated to facilitate the proper execution of documents.

- If an advance directive is in place, Agency staff will request a copy for the patient's medical record and the medical record will be "flagged" appropriately.
- Agency staff will make every effort to obtain a copy of any patient's advance directive and file this copy in the medical record. If the patient does not provide Agency with a copy, this will be documented in the patient's medical record.
- If at the time of notice, the patient is incompetent or otherwise incapacitated and unable to receive the notice, Agency will provide the required written notice in the following order of preference, to:
 - ▶ The individual's legal guardian;
 - ▶ A person responsible for the health care decisions of the patient;
 - ▶ The individual's spouse;
 - ▶ The individual's adult child;
 - ▶ The individual's parent; or
 - ▶ The person admitting the patient.

If Agency is unable, after a diligent search, to locate an individual listed above, Agency is not required to provide notice. Agency will provide notice if at any time the patient becomes able to receive the notice.

3. The patient's advance directive status will be communicated to all staff involved in the patient's care in one of the following ways:

- Identifying the chart(s).
- List in the on call book.
- Verbal and written communication.

4. Agency staff will document in the medical record (i.e. the Consent Form, Plan of Care form), information about any type of advance care directive the patient may have. Agency staff will encourage the patient to forward a copy to his/her physician if the physician does not have a copy.

5. Agency staff will direct the patient/caregiver to the patient's physician, lawyer, MSW or other community resource if the patient requests additional information or wishes to develop an advance directive.

6. Agency staff may complete or witness an advance care document or participate in the decision-making process relating to whether to have an advance care document.

7. If, at any time, a patient refuses medical treatment, Agency staff will discuss the refusal with the physician and document both the refusal and the physician notification in the patient's medical record and complete a verbal order.

8. Agency staff will not provide any medical treatment that the patient has not consented to receive.

9. Agency staff will not withhold treatment or otherwise discriminate against patients based on whether or not the patient has an advance directive.

10. Agency staff will recognize and honor properly executed advance directives as evidence of the patient's desire to have medical treatment withheld or discontinued as specified.

11. Agency will provide functions relating to advance directives such as, but not limited to, educating Agency personnel and the community served on advance directives and other bioethical issues, assisting the patient and family as needed, and aiding in the development of guidelines on advance directives and other bioethical issues.

HCL / R1.2 No Withdrawal Rvd. 060109

CARDIOPULMONARY RESUSCITATION (CPR)

RI.3

PURPOSE

To ensure adherence to the patient's rights to receive resuscitation measures.

POLICY

Agency staff will respond to arrest situations with the initiation of CPR when an Out-of Hospital Do Not Resuscitate (DNR) order does not exist.

PROCEDURE

1. Upon cardiac arrest of any patient that does not have a DNR order, Agency professional and paraprofessional staff trained in CPR will respond to the situation.

2. Witnessed Arrest:

2.1 Agency will initiate emergency services by calling 911 or the service number for first responder of the area.

2.2 Initiation and continuation of resuscitative efforts will be made until one of the following occurs:

- Patient revives,
- Staff becomes too exhausted to continue.
- Help arrives or,

3. Non-Witnessed Arrest:

3.1 Professional and paraprofessional staff will assess the patient's condition and proceed with the initiation of emergency services by calling 911 or first responder of the area when beginning CPR and continue until:

- Patient is revived,
- Help arrives,
- Staff becomes too exhausted to continue.

HCL R1.3 chap Rvd 110101

OUT-OF-HOSPITAL DO NOT RESUSCITATE (OOHDNR)

R14

PURPOSE

To ensure adherence to the patient's right to have resuscitative and life-sustaining procedures withheld in any out of hospital setting.

POLICY

Agency will not initiate resuscitation measures on patients who have implemented and completed an Out-of-Hospital Do Not Resuscitate (OOHDNR) order or a physician executed Do Not Resuscitate Order (DNR).

The state of Texas does not allow an RN to pronounce death when a patient is on a ventilator.

A. Definition:

1. Terminal Condition

Incurable condition that according to reasonable medical judgment will produce death within six months.

2. Irreversible Condition

Condition, injury, or illness that may be treated but never cured; that leaves the person unable to care for or make decisions for person's own self; that without life sustaining treatment, is fatal.

3. Qualified Patients

Patient with a terminal or irreversible condition that has been diagnosed and certified in writing by attending physician. Patients, who are known by the Agency to be pregnant, will not be a qualified patient.

4. Attending Physician

The physician who is selected by or assigned to a patient who has primary responsibility for a person's treatment and care.

5. Qualified Relatives

The patient's spouse, the patient's reasonably available adult children, the patient's parents; or the patient's nearest living relative.

6. Witnesses

Two competent adult witnesses must sign the form acknowledging the signature of the patient or the person acting on the patient's behalf except when signed by two (2) physicians in Section C of OOHDNR.

Witness 1 must meet the following qualifications:

May not be:

- Person designated to make treatment decision for the patient,
- Related to the patient by blood or marriage,

- Entitled to any part of the estate;
- Be a person who has claim against the estate of the patient;
- The attending physician;
- An employee of a health care facility in which the patient is being cared for, if involved in providing direct patient care to the patient; or
- An officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or any parent organization of the health care facility.

Witness 2 may be any competent adult.

PROCEDURE

The procedure for reaching decisions about the withdrawal of life-sustaining care or withholding of resuscitation measures from individual patients is as follows:

1. A patient who is competent and who is an adult may execute a written OOHDNR order at any time or obtain a physician's DNR order.

The Declarant must sign the order in the presence of two witnesses and those witnesses must sign the order except when executed by 2 two physicians. The attending physician must sign the order.

2. A competent person who is an adult may issue an OOHDNR order by non-written communication in the presence of the attending physician and two witnesses. The attending physician and the two witnesses must sign the form.

3. An incompetent person may have the attending physician and the person's legal guardian, agent under Medical Power of Attorney, Managing Conservator, Qualified Relative, or Parent (if a minor) execute and sign an OOHDNR order on behalf of the person.

4. If the patient is incapable of informed consent, and none of the above people are available, the treating physician may execute the order with the consent of a second physician who is not treating the patient or is a member of the ethics committee or other medical committee of the healthcare facility in which the person is a patient.

5. The OOHDNR may be revoked at any time by the Patient or the Patient's legal guardian, agent under Medical Power of Attorney, Managing Conservator, Qualified Relative, Parent (if a minor) or physician, who executed the order. The revocation may involve the communication of wishes to responding health care professionals, destruction of the form, or removal of all or any OOHDNR identification devices the patient may possess.

6. The Agency Director (or designee) will maintain a list of OOHDNR patients. This log should include patient name, attending physician, diagnosis, date of OOHDNR order, date of revocation of OOHDNR (if applicable), and any pertinent specifics related to each patient listed.

7. Agency staff will be continuously apprised of additions or changes to the log/list of OOHDNR patients. Such information will be part of the discussion at case conferences for the respective patient.

8. The OOHDNR form or other identifying device must accompany the person during transport to ensure wishes are conveyed.

9. Agency may accept an OOHDNR order or device that has been executed in other states, if there is no reason to question the authenticity of the order or device.

A. Initiation of Out of Hospital Do Not Resuscitate Orders

1. On admission, Agency will inform the patient/significant other regarding OOHDNR. Agency will inform the patient/significant other that a physician's DNR order will not be honored by Emergency Medical Services personnel.

2. The OOHDNR order will be communicated to all involved Agency providers of care. Nursing personnel will inform the physician of any changes in the patient's condition or attitude towards OOHDNR status.

The OOHDNR will be placed in the patient's home where it can be easily located for verification by other health care providers. A copy of the OOHDNR form may be kept in the patient's chart if available. The chart will be marked to indicate OOHDNR status.

4. Family/significant other will be instructed in importance of maintaining document.

5. A person with a valid OOHDNR may wear an OOHDNR identification device as a necklace or a bracelet to serve as evidence of a valid OOHDNR order.

6. Agency staff may administer palliative care.

B. Conflict Resolution

1. in the event a conflict or dispute occurs regarding an OOHDR issue:

1.1 The attending physician will be contacted. The Medical Advisor/Director may be contacted.

1.2 A phone conference or a live conference may occur. Participants may include members of the Ethics Committee or the Professional Advisory Committee.

HCL / RL4 Rvd. 070109

ILLEGAL REMUNERATION/NON-SOLICITATION OF REFERRALS

RI.5

PURPOSE

To define Agency's compliance with regulation.

POLICY

Agency prohibits the solicitation of referrals, directly or indirectly, overtly or covertly and complies with Occupations Code, Chapter 102 pertaining to the Solicitation of Patients (Clients).

Agency prohibits the payment or receipt of remuneration for securing or soliciting patients to Agency to outside entities.

DEFINITION

Solicitation of Patients: a person who knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency.

PROCEDURE

1. Agency does not reimburse or provide incentives to physicians, medical equipment providers, family, or other referrals entities for patient referrals to the Agency.

2. Agency informs the employees at orientation regarding the non-solicitation policy.

3. Employees may sign a Non-Solicitation Statement.

4. Claims of solicitation and/or remuneration will be thoroughly investigated by management.

5. Employees found in violation of this policy will be subject to discipline up to termination of employment.

RESPONSIBILITY

Ultimate responsibility lies with the Administrator of the Agency.

HCL RI.5 chap Rvd 101106

RESOLUTION OF PATIENT CONFLICTS, GRIEVANCES OR COMPLAINTS

RI.6

PURPOSE

To establish a procedure and ensure the patient's/caregiver's and or guardian's right to voice conflicts, file a complaint, and provide and to make recommendations for resolutions of conflicts without fear of retaliation, coercion, discrimination, reprisal or unreasonable interruption of care.

POLICY

Agency will receive, document, address and resolve conflicts that involve complaints made by a patient, a patient's family or guardian, or a patient's health care provider. Agency will provide a written statement that informs the client of the complaint procedure at time of admission.

Agency will not retaliate against a person for filing a complaint, presenting a grievance, or providing, in good faith, information relating to services provided by Agency. Agency may terminate an employee for a reason involved in the complaint issue other than retaliation.

This grievance procedure is in compliance with Section 504 of the Rehabilitation Act.

PROCEDURE

1. Agency will investigate complaints made by a patient, a patient's family or guardian, or a patient's health care provider regarding:

- Treatment or care that was furnished by Agency
- Treatment or care that Agency failed to furnish

- Lack of respect for the patient's property by anyone furnishing services on behalf of the Agency
2. Agency staff will be furnished educational resources, on an ongoing basis to assist in the evaluation of alternative aspects of patient care.
 3. Agency will inform the patient/caregiver, in writing, at the time of the initial assessment that a complaint against the agency may be directed to the Department of Aging and Disability Services (DADS), DADS' Consumer Rights and Services Division. The DADS' 24-hour hotline number is 1-800-458-9858.
 4. Since the agency is CHAP accredited, the patient and/or family may contact CHAP regarding a complaint. The toll free number is 1-800-656-9656.
 5. Agency will document the receipt of the complaint and initiate a complaint investigation within ten (10) calendar days of Agency's receipt of complaint. Management will be informed of complaint.
 6. Agency will complete the investigation and documentation within 30 days after the receipt of the complaint, unless Agency has and documents reasonable cause for the delay.
 7. Agency will involve the patient/caregiver and/or the patient's physician as appropriate to reach a resolution.
 8. Agency will consider all patient/caregiver recommendations to reach a resolution.
 9. Agency will contact the State Home Health Hotline, the Office of Civil Rights and/or the Equal Employment Opportunity Center to inform them of the situation, as appropriate.
 10. All actions taken and follow-up performed will be documented on the complaint form, as well as reported to the management staff.
 11. Resolution/outcome information is communicated to the complainant.
 12. All abuse, neglect, or exploitation reports will follow agency policy on Abuse, Neglect, and Exploitation (ANE) and will adhere to same time frames as for a complaint.

PROCESS

1. Designated individual(s) responds to and takes action to resolve complaints.
2. Intake information is obtained from the appropriate sources.
3. Documentation of intake information is formalized on Complaint Form.
4. Investigative measures are implemented based on the nature of the complaint.
5. Appropriate authorities are informed.
6. Corrective action is specific and directly related to the complaint.
7. Client and family rights are protected.
8. Complaints are logged, tracked, and trended.
9. Complaint management is incorporated into the Quality Assessment Performance Improvement Program.
10. Resolution/outcome information is communicated to the complainant in writing.

RESPONSIBILITY

The Administrator of the Agency has ultimate responsibility for resolution of patient complaints.

HCL / RL6 CH Rvd. 060109

NON-REIMBURSABLE CARE

RI.7

PURPOSE

To establish consistent guidelines for approval/refusal of care to potential patients with no payment source.

POLICY

Agency will maintain clinical integrity for patient care regardless of financial risk.

Agency will review each request for care when no payment source is available.

PROCEDURE

1. Agency will document each request for non reimbursed care and obtain the following information:
 - Patient name, address, phone number
 - Physician
 - Person initiating request/referral source
 - Estimate of time/number of visits
 - Total dollar amount
2. Each request will be submitted for approval to the Administrator.
3. The referral source will be notified of the decision.
4. If care is to be rendered, the patient will be assigned to the appropriate Agency staff.

DETERMINATION OF CONTINUATION OF CARE

RI.8

PURPOSE

To ensure patient care needs are considered in determining the continuation of care when payment is denied, limited and/or terminated.

POLICY

Agency will consider both the patient's needs and recommendations by payor sources when determining whether to continue the provision of care.

PROCEDURE

1. Agency will review continuation of care recommendations from payor sources which are contrary to the current provision of care.
2. When such conflicts arise, any decision regarding care, services, transfer and/or discharge will be made in response to the care required and ordered by the physician for the patient and not solely in response to the recommendations made by the payor source(s).
3. If Agency agrees with the recommendation/decision, planning for discharge and discharge process policies/procedures will be initiated.
4. If Agency disagrees with the recommendation/decision, Agency will appeal the decision through the appropriate, established channels until all options have been exhausted.
5. If the payor source's final determination remains contrary to the indications for care, Agency's Ethics Committee will review the situation. The committee will seek input from appropriate resources as needed and are responsible for Agency's decision regarding the continuation of care.
6. Documentation of the entire process will be maintained in the administrative office, and a summary of the determination will be retained in the patient's medical record.

HCL RI.8 chap Org 053097

ETHICAL ISSUES

RI.9

PURPOSE

To provide business practices and patient care within an ethical framework established by the profession, Agency's policy and procedure, and the law.

POLICY

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

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

All information concerning ethical issues shall be considered confidential.

Agency educates staff about available alternatives, ethical aspects of care or services, and processes to address ethical issues.

PROCEDURE

1. Ethical issues requiring a decision/resolution may include but are not limited to: the withholding or withdrawal of treatment, informed consent, high technology and medical experimentation, patient safety, standards of care, false advertising, marketing, fraudulent billing practices, admissions/transfers and/or confidentiality.
2. Agency will furnish to its staff the educational resources necessary to assist in the evaluation of available alternatives and ethical aspects of home care.
3. Once an issue has been identified, Agency staff will make every effort to resolve the conflict.
4. The Professional Advisory Committee will act as the Ethics Committee.
5. The purpose of the Committee is to:
 - Review existing and pending Agency policies relating to ethical/ cultural/spiritual issues as needed and at least annually.
 - Serve as an Agency resource (both advisory and consultative).
 - Make decisions using due process on unresolved ethical dilemmas.
6. Committee minutes and all associated documentation will be forwarded to the Board of Directors for review and approval.

7. All activities of the Committee will be documented and maintained in a confidential manner in the administrative office for 5 years.

HCL / RI.9 CH Rvd. 030108

ALTERNATIVE COMMUNICATION

RI.10

PURPOSE

To facilitate effective communication among patients, caregivers and Agency staff.

POLICY

Agency staff will actively address meeting the communication needs of the patient by consistently utilizing a language or a language form that the patient can reasonably understand. Patient will receive effective notice at no cost.

Family members or friends will not be used as a translator unless the patient has been informed that the services of a qualified interpreter are available to him/her at no charge and then chooses the family member or friend to translate.

When the staff cannot meet the patient's communication needs, Agency will arrange access to other resources (interpreters, blind services, etc) to meet the patient's need or refer to another agency.

Agency staff will be oriented upon hire regarding alternative communication needs and to contact the Administrator/DON if a patient is in need of alternative communication assistance.

PROCEDURE

1. Agency, with input from appropriate resources, will assess the patient population periodically to determine the percentages that are non-English speaking. If a significant portion of the non-English speaking patient population is literate in one language, then Agency will provide written material in this language.
2. Agency will assess the ability of its staff to meet needs for alternative communication methods (e.g., who knows sign language, Spanish, etc.).
3. Agency will assess the availability of community resources to meet the need for alternative communication methods (e.g., Blind Services, etc.).
4. An updated list of internal and external resources will be available to all visiting staff that may include but are not limited to the following:
 - Community agencies for outside qualified interpreters (written agreements) and availability
 - Qualified bilingual staff members
 - Auxiliary aids for the sensory impaired
 - Use of a twenty-four hour telecommunication device
5. At the time of the initial patient assessment, Agency staff will assess communication needs, appropriate alternative methods of communication and the availability of caregivers to assist with communication.
6. Agency staff will communicate to the visually impaired in one or more of the following ways:
 - By reading aloud the content of written materials
 - Using written materials that are in large print
 - Communication boards/flash cards
7. Agency staff will communicate to the hearing impaired in one or more of the following ways:
 - Qualified sign-language interpreters, as indicated
 - Texas relay system for the deaf (1-800-855-4000 or 1-800-332-3873)
 - Clear, written materials
8. Agency staff will communicate to the speech impaired in one or more of the following ways:
 - Communication boards
 - Writing materials
9. Agency staff will communicate to the Limited English Proficient (LEP) in one or more of the following ways:
 - Internal or external qualified bilingual interpreters
 - Available written materials in a language form that they can understand
10. Agency will secure and use the appropriate alternative communication method and use it consistently during home visits.
11. Agency will be responsible for the costs incurred as a result of securing the alternative communication and notifies the patient of this.

12. Regardless of the method used, family members or friends will not be used as interpreters unless the patient has been made aware of the availability of qualified language or sign-language interpreters at no charge and, with no coercion, chooses the services of family members or friends.

RESPONSIBILITY

The Director of Nurses or 504 Coordinator is responsible for staff education regarding alternate communication and the maintenance of the list of internal and external resources.

HCL RI.10 chap Rvd 080106

RESPECT FOR PRIVACY, SECURITY, PROPERTY, AND THE RED FLAGS RULE

RI.11

PURPOSE

To ensure the patient/client's right to privacy and security as well as respect for patient/client's property is observed and there is protection against identity theft.

POLICY

Agency will give the Notice of Privacy Practices to the Board of Directors, Professional Advisory Committee, all staff involved in patient/client care, potential employees, health care students, consultants and Business Associates which explains the patient/client's rights regarding confidentiality, privacy, and security.

Agency will give and explain to the patient/client/caregiver the Notice of Privacy Practices regarding privacy rights as mandated by the Privacy Rules of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its revisions, as applicable.

Agency will comply with the HIPAA Security Rules, effective April 21, 2005, (45 CFR Part 164), to protect all of the patients' electronic Protected Health Information (PHI).

If the Agency bills the patient/client for services and accepts credit cards or otherwise defers payments, it follows its established policies and procedures to protect against identity theft as mandated by the Federal Trade Commission's Red Flags Rules 16 CFR §681.2 and the Fair Credit Reporting Act as amended by the Fair and Accurate Credit Transactions Act of 2003, effective November 1, 2009.

Agency will inform the patient/client/caregiver both verbally and in writing on admission, regarding patient/client Privacy Right and Privacy Act Statement pertaining to OASIS data. Agency will obtain acknowledgment of patient/client receipt.

The Board of Directors will be informed of and sign a "Conflict of Interest Statement".

The patient/client/caregiver will be informed on admission regarding confidentiality and the Agency's measures to protect against identity theft.

The patient/client's property will be respected during the provision of patient/client care.

HIPAA Privacy Rules

A. Clinical

1. The Agency shall provide all current employees with training on the HIPAA Privacy Rule.
2. All new employees shall receive privacy training during their orientation.
3. If the Agency changes its policies and procedures, all employees shall receive retraining.
4. All privacy orientation and retraining shall be documented in the employees' personnel files.
 - 4.1 The Privacy Officer shall maintain a record of privacy training given to the employees as defined in the Privacy Rule.
5. On admission, patient/client/caregivers will be informed both verbally and in writing regarding confidentiality, as well as access to, release of and the safeguarding of patient/client records as delineated in the Notice of Privacy Practices.
 - 5.1 This information includes:

- Request to restrict use and disclosure of health information
- Request to receive confidential communications
- Request to access PHI
- Request to amend PHI
- Request for disclosure of PHI

5.2 The need for Authorizations to release information to individuals not covered by HIPAA will be explained.

5.2.1 The patient/client will be instructed to contact the Privacy Officer.

5.3 The patient/client shall be assured that the Agency will:

- Restrict employees to access to the minimum amount of PHI necessary to do their job
- Disclose only the minimum amount of data necessary per the requested purpose
- Request only the minimum amount of PHI needed from other covered entities

5.4 The patient/client will be informed of the option to opt out of receiving fund-raising information per the Notice of Privacy Practices

5.5 The patient/client will be informed of the option to opt out of receiving marketing information per the Notice of Privacy Practices.

6. Agency staff will obtain consent to obtain photographs of patient/client and/or patient/client wounds prior to taking the photograph.

B. Business

1. The Agency restricts the use and disclosure of certain types of information that could be advantageous to other businesses or harmful to the agency, its patients/clients or its employees.

2. Confidential business information is considered agency property.

3. Utilization of confidential information for personal gain is considered by the agency to be improper and/or unlawful.

4. Discussion of confidential information with family, friends or business and professional associates should be avoided.

5. Employees will be educated regarding confidentiality pertaining to use of electronic record/Point of Care device/laptop/personal digital assistants (PDAs)/USB flash drives/computers in the home, information kept in the car, discussions of one patient/client to another and other aspects of potential breach confidentiality. Employee education regarding confidentiality will include, as appropriate, the utilization of Smart Phones, Wireless Access Points (WAPs), Memory Cards, floppy disks; CDs, DVDs, backup media, Smart cards, and Remote Access Devices (including security hardware).

6. Employee data/information requested on hire and periodically, will be required and pertinent to the agency's business.

7. Employees/Board of Directors have a responsibility to have no conflicting interest when they represent Agency in negotiations or make recommendations about a third party. The employees/Board of Directors will work with patient/clients caregivers and other parties doing business with Agency on the basis of what is in Agency's best interest without showing favor or preference to third parties based on personal considerations.

8. An employee/Board of Director who deals with third parties on behalf of the agency or who makes recommendations or approves or rejects them shall not own any interest in or have any personal contact with the third party that could possibly influence the employee in regard to the best interest of the Agency.

9. An employee/Board of Directors shall not directly or indirectly seek or accept payments, loans, services, excessive entertainment, travel, gifts, or other reward from any individual or representative of any business or individual seeking to do business with the agency that might tend to influence the decision of the employee with respect to the agency's business.

C. Business Associates

1. The Agency's Business Associates shall have access to the minimum amount of patient/client PHI needed to accomplish the cited purpose. (See the Professional Services Contract.)

HIPAA Security Rules

The Agency shall appoint an Information Security Officer to oversee compliance with the HIPAA Security Rules.

1.1 This individual may be the Privacy Officer.

2. The Agency shall provide security and awareness training to all of its employees, including management, upon hire and periodically thereafter.
3. The Agency shall perform an initial risk assessment for ePHI to ensure its security measures allow it to reasonably and appropriately comply with the HIPAA Security Rule.
 - 3.1 In deciding if its security measures are adequate, the Agency may consider the following:
 - Its size, complexity, and capabilities
 - Its technical infrastructure, hardware, and software security capabilities
 - The costs of the security measures
 - The probability and criticality of potential risks to electronic PHI
 - 3.2 The Agency shall perform follow-up ePHI risk assessments at periodic intervals including after any event that compromises the Agency's electronic security.
4. The Agency shall ensure the confidentiality, integrity, and availability of all electronic PHI it creates, receives, maintains, or transmits.
5. The Agency shall protect against any reasonably anticipated threats or hazards to the security or integrity of electronic PHI.
6. The Agency shall protect against any reasonably anticipated uses or disclosures of electronic PHI other than those that are permitted by the HIPAA Security Rule.
- 7 The Agency shall obtain assurances in a written contract from its Business Associate(s) that creates, receives, maintains, or transmits electronic PHI on its behalf that the Business Associate will safeguard the information.
8. The Agency shall ensure compliance with the HIPAA Security Rule by all of its employees, including management, and its Business Associate(s).
 - 8.1 The Agency shall institute sanctions against any employee as defined in its progressive discipline policy up to and including termination.
 - 8.2 The Agency shall terminate the contract with the Business Associate(s) if it determines there has been a violation to the HIPAA Security Rule.
9. The Agency shall maintain the policies and procedures implemented to comply with the HIPAA Security Rule in written or electronic form.
 - 9.1 The Agency shall document any action or activity taken and all risk assessments made as required by the HIPAA Security Rule.
 - 9.2 The Agency shall make documentation available to those responsible for implementing the procedures recorded and to appropriate regulatory entities.
 - 9.3 The Agency shall review the documentation periodically and update it as needed in response to environmental or operational changes affecting the security of the patients' electronic PHI.
 - 9.4 The Agency shall retain the required documentation for six years from its creation or the date when it was last in effect, whichever is later.

Red Flags Rules

1. Agency will determine if it is a "creditor" per the Red Flags Rules.
 - 1.1 Agency may be a "creditor" if it defers payments for goods and/or services.
2. Agency will determine if it offers or maintains "covered accounts," which are the extension of credit for goods or services involving a deferred payment.
 - 2.1 A "covered account" is one that is primarily for personal, family, or household purposes that involves or is designed to permit multiple payments or transactions.
 - 2.2 A "covered account" is any other account that the Agency offers or maintains for which there is a reasonably foreseeable risk to the patient/client or to the safety and soundness against identity theft.
3. Agency's Identity Theft Prevention Program (Program) includes, but is not limited to:
 - 3.1 Identifying Red Flags and risks to incorporate into the Program;
 - 3.2 Detecting Red Flags that have been used to perpetrate identity theft;
 - 3.3 Responding appropriately to Red Flags that have been detected to prevent and mitigate identity theft;
 - 3.4 Ensuring the Program is updated periodically to reflect changes in risks to the patient/client and to the Agency's safety and soundness;
 - 3.5 Obtaining approval of the Program from the Board of Directors or Governing Body;
 - 3.6 Involving the Board of Directors or Governing Body or designee from senior management in the

oversight, development, implementation, and administration of the Program;

3.7 Appointing an oversight employee who is responsible for implementing, regularly administering, and annually reporting to the Board of Directors or Governing Body the Agency's compliance with the Red Flags Rule;

3.8 Training relevant staff to effectively implement the Program; and

3.9 Exercising appropriate and effective oversight of the contracts with patients/clients.

4. Red Flags are divided into categories for identification, prevention, and mitigation and include:

4.1 Alerts, notifications, or warnings from a consumer reporting agency

- A fraud or active duty alert is included with a consumer report;
- A consumer reporting agency provides a notice of credit freeze in response to a request for a consumer report;
- A consumer reporting agency provides a notice of address discrepancy;
- A consumer report indicates a pattern of activity that is inconsistent with the history and usual pattern of activity of a patient/client, such as:
 - A recent and significant increase in the volume of inquiries;
 - An unusual number of recently established credit relationships;
 - A material change in the use of credit, especially with respect to recently established credit relationships; or
 - An account that was closed for cause or identified for abuse of account privileges by a financial institution or creditor.

4.2 Suspicious documents

- Documents provided for identification appear to have been altered or forged;
- The photograph or physical description on the identification is not consistent with the appearance of the patient/client presenting the identification;
- Other information on the identification is not consistent with information provided by the patient/client opening a new covered account;
- Other information on the identification is not consistent with readily accessible information that is on file with the Agency, such as a signature card or recent check; or
- An application appears to have been altered or forged or gives the appearance of having been destroyed and reassembled.

4.3 Suspicious personal identifying information

- Personal identifying information provided is inconsistent when compared against external information sources used by the Agency, such as:
 - The address does not match any address in the consumer report or
 - The Social Security Number (SSN) has not been issued or is listed on the Social Security Administration's Death Master File;
- Personal identifying information provided by the patient/ client is not consistent with other personal identifying information provided previously such as SSN or date of birth;
- Personal identifying information provided is associated with known fraudulent activity as indicated by internal or third-party sources used by the Agency, such as:
 - The address on the application is the same as that provided on a fraudulent application or
 - The phone number on an application is the same as that provided on a fraudulent application;
- Personal identifying information provided is of a type commonly associated with fraudulent activity as indicated by internal or third-party sources, such as:
 - The address on an application is fictitious
 - The phone number is invalid or is associated with a pager or answering service;
- The SSN provided is the same as that submitted by other persons applying for services;
- The person applying fails to provide all required personal identifying information on an application or in response to notification the application is incomplete;
- Personal identifying information provided is not consistent with personal identifying information that is on file with the Agency; or
- If the Agency uses challenge questions and the individual cannot provide authenticating information

beyond that which would be available from a wallet or consumer report.

4.4 Unusual use of, or suspicious activity related to, the covered account

- Patient/client fails to make the first payment or makes an initial payment but no subsequent payments or
- The Agency is notified the patient/client is not receiving its statements/invoices in the mail.

4.5 Notice from patients/clients, victims of identity theft, law enforcement authorities, or others regarding possible identity theft in connection with covered accounts held by the Agency.

- The Agency is notified per above that it has opened a fraudulent account for a person engaged in identity theft.

5. Agency will implement processes to detect Red Flags

5.1 Verify the identity of the patient/client applying for services and

5.2 Monitor transactions and verify the validity of change-of-address requests.

6. Agency will respond to, and mitigate instances of, identity theft depending on the degree of risk posed by measures such as:

6.1 Monitoring covered accounts;

6.2 Changing passwords;

6.3 Contacting the patient/client;

6.4 Notifying law enforcement officials as appropriate; or

6.5 Determining that no response is warranted under the particular circumstances.

7. Agency will update the program as technology changes and/or identity thieves change tactics.

7.1 Agency will update program in conjunction with mergers, acquisitions, and change in ownership, alliances, joint ventures, and arrangements with other service providers.

HCL / R1.11 Rvd. 070109

BILLING PROCESS/ADVANCE BENEFICIARY NOTICE/ FALSE CLAIMS

RI.12

PURPOSE

To ensure consistency and accuracy in billing that reflects only the billable care, supplies and/or equipment provided to the patient and ensures detection and prevention of fraud and/or abuse related to billing.

To ensure consistency not only with liability protection requirements under §1879 of the Social Security Act (the Act), but also with the Home Health Conditions of Participation (HH COPs).

To accommodate the Expedited Determination Notices given at the termination of Medicare coverage.

To ensure compliance with requirements of the 2 Circuit's decision in *Lutwin v. Thompson*.

To set forth the guidelines for all Agency officers, managers, employees, contractors, agents, and volunteers to follow relative to the Federal False Claims Act (FCA) and the Texas False Claims Act (TFCA) in the event the Agency receives or makes annual payments of at least \$5,000,000 pursuant to any state Medicaid program.

DEFINITIONS

Abuse

Practices that are not consistent with sound fiscal or clinical practices resulting in unnecessary cost to government programs or practices of seeking reimbursement for goods or services that are not necessary, or not ordered by a physician (if applicable), or that fail to meet professionally acceptable standards for home health care.

FCA

The Federal False Claims Act (FCA) states it is a violation to:

- Knowingly present, or cause to be submitted, a false claim to the government
 1. The term "knowingly" means a person
 - A. Has actual knowledge of the information,
 - B. Acts in deliberate ignorance of the truth or falsity of the information, or
 - C. Acts in reckless disregard of the truth or falsity of the information and no proof of specific intent to defraud is required.

- Knowingly use a false record or statement to obtain payment on a false claim paid by the government.
- Engage in a conspiracy to defraud the government by the improper submission of a false claim for payment.

Damages and penalties for violating the FCA may include but are not limited to:

- Civil penalties of not less than \$5,500 and not more than \$11,000 per violation, plus
- Three times the amount of damages the government sustains because of the Agency's violation.

Qui Tam Provisions

The FCA allows a person to bring an action under the FCA on behalf of the Federal Government and share in any recovery ("whistle-blowing").

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the Agency or him/herself.

TFCA

The Texas False Claims Act (TFCA) states a person commits a violation if s/he presents or causes to be presented a claim that contains a statement or representation the person knows, or should have known, to be false.

The person "should know" or "should have known" information to be false if s/he acts in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information, and proof of the person's specific intent to defraud is not required.

Damages and penalties for violating the TFCA may include, but are not limited to, payment of an administrative penalty of an amount not to exceed twice the amount paid, if any, as a result of the violation, plus an amount:

- Not less than \$5,000 or more than \$15,000 for each violation that results in injury to an elderly person or a person younger than 18 years of age or
- Not more than \$10,000 for each violation that does not result in injury to an elderly person or a person younger than 18 years of age.

POLICY

Based upon information received during the initial assessment, Agency will inform and confirm with the patient the charges for care, supplies, and/or equipment provided to the patient upon and/or after admission to Agency, as well as any changes in charges that may occur thereafter.

Agency will make every effort to reconcile and submit accurate bills to the appropriate payor sources according to contractual, regulatory, and statutory requirements.

Agency will provide Medicare patients/responsible party a written notice (**Home Health Advance Beneficiary Notice**), in advance, of providing physician ordered care that the agency feels is non covered, either at admission, reduction or termination of services.

Agency will prepare and deliver to the Medicare patient/authorized representative, a Home Health Advanced Beneficiary Notice at admission when initiating non-covered care that is "Not a Medicare Benefit", is "Excluded from Coverage under §1862", and/or is "Excluded from Coverage and Subject to Limitation of Liability (LOL) under §1879".

Agency will prepare and deliver to the Medicare patient/authorized representative, a Home Health Advanced Beneficiary Notice (HHABN) when Agency is discontinuing some, not all, care, whether the care ending or continuing care is covered by Medicare or not.

Agency will prepare and deliver to the Medicare patient/authorized representative, a Home Health Advanced Beneficiary Notice (HHABN), in accordance with the requirements of the 2nd Circuit's decision in *Lutwin v. Thompson* and consistent with the Medicare Conditions of Participation, when there is a reduction or termination of home health services. This requirement applies whether the reason for the reduction was a "Medicare coverage determination, lack of physician's certification, a HHA's unwillingness to provide services for business reasons unrelated to coverage or sheer caprice."

PROCEDURE

1. The written Consent Form will be completed at the time of patient admission to the Agency to inform of charges or cost to be incurred by patient.
2. The original copy of the form will be retained in the patient's medical record at Agency and a copy will be retained by the patient.
3. The patient will be informed that the information contained on this form is based upon knowledge of any coverage at the time and could be subject to change at a later date.
4. The patient will be instructed that should any changes occur, he/she will be informed verbally and in writing the date the organization became aware of the changes and prior to the change of care in question is provided, so patient (authorized representative) can make an informed choice of possible beneficiary liability.
5. When preparing bills for any/all payor sources, Agency will ensure that appropriate documentation (including signed Dr. Orders) to substantiate care, supplies, and/or equipment provided to the patient is present in the patient's medical record or may be retrieved upon request from the physician.
6. Individuals preparing bills:
 - 6.1. Will have knowledge of and adherence to the laws, requirements, standards, rules, and regulations pertaining to claims submission and reimbursement under federal, state, and/or other applicable programs.
 - 6.2. Should refer any questions to their supervisor.
 - 6.3. Are prohibited from billing and coding practices that are not true, fair, and correct.
7. All employees have a responsibility to report suspected and actual violations resulting in false claims and/or billing fraud and/or abuse to his/her supervisor immediately.
8. If a billing error is found after the submission of a bill, Agency will submit an adjusted bill to the payor source by the next billing cycle.

9. Home Health Advance Beneficiary Notice (HHABN)

9.1 Agency will prepare and deliver to the Medicare patient/authorized representative, a Home Health Advanced Beneficiary Notice (HHABN):

A. When it is expected that Medicare will not pay for, or will not continue to pay for item(s) and/or service(s) ordered by physicians where "Limitation of Liability" (LOL) protection is afforded based on the following statutory exclusions:

- The patient does not need intermittent skilled nursing care §1879(g)(1)(B)
- The patient is not confined to home §1879(g)(1)(A)
- The services may be denied as "not reasonable and necessary" (medical necessity) § 1862(a)(1)(A)
- Custodial care is the only care delivered §1879(a)(9)

B. In some situations, Agency will prepare and deliver a Home Health Advanced Beneficiary Notice (HHABN) to the Medicare patient/authorized representative when:

- LOL protection is not available when a triggering event occurs, and
- There is not any liability and a triggering event occurs.

9.2 Agency will generally issue HHABNs when it is believed Agency is about to deliver non-covered item(s) and/or service(s) at three "triggering events" or time points - (Initiation, Reduction, and Termination) even if beneficiary (patient) liability is not at issue.

9.3 HHABN Triggering Events - Agency provides HHABN even if beneficiary liability is not at issue:

A. Initiation:

Agency concludes any planned item(s) and/or service(s) do not meet definition of a Medicare covered benefit and will not be covered from the start of a course of treatment given over a spell of illness before the delivery of one-time items or services that Medicare is not expected to cover.

Agency determines any planned item(s) and/or service(s) are excluded from Coverage under §1862 or §1879

Agency plans to charge beneficiary for an assessment that is not followed-up by an admission.

Agency terminates covered care before the initiation of solely non-covered care.

B. Reduction:

Agency reduces or discontinues some, not all, items and/or services during a spell of illness, while continuing others, (includes services during a spell of illness, while continuing others, (includes when one home health discipline ends but others continue) whether the care ending or continuing care is covered by Medicare or not.

Non-covered Care - HHABN is given when there is a reduction in previously non-covered care as listed under "A. Initiations". (i.e.; no longer reasonable or necessary or all care from initiation was uncovered)

Covered or Non-covered Care - HHABN is given when either covered or non-covered care ends because of Financial/Other HHA Reasons (Agency has reasons individual to its business and independent of patient's Medicare coverage for discontinuing some item(s) or service(s).

Covered Care - HHABN is given when a reduction is due to some previously covered care becoming excluded from Coverage and Subject to Limitation of Liability (LOL) under §1879 (i.e., Patient is no longer homebound or no longer has need of intermittent skilled nursing care).

C. Termination:

Agency will provide HHABN when there is a complete cessation of all Medicare covered care (item(s) and/or services) at the end of a course of treatment, but expects to continue delivering other care.

Non-covered Care - Agency will issue HHABN prior to termination of completely non-covered care for reasons under "A. Initiations". Examples:

- (1) Non-covered care terminated is no longer reasonable or necessary. (No LOL protection because care is already non-covered.)
- (2) HHABN given for such termination should also have been given at initiation of non-covered care.

Covered Care - Terminations related to coverage:

*Expedited Determination Notice(s) - Required when all Medicare coverage is terminated. (See Discharge/Expedited Determination Policy)

**There is only one case where both HHABN and generic expedited notice must be given, and that is ONLY if non-covered services will be continuing after covered services end.

(1) Expedited Notice - gives information on right to a quick decision from a QIO affirming or disputing end of all covered care.

(2) HHABN provides information on potential liability for care that would be delivered after coverage ends, and on claim-related appeal rights.

9.4 In keeping with standing Medicare liability notice practices, HHABN must be furnished whenever ongoing continuous non-covered care exceeds a year in duration. (This includes dually eligible clients who are not receiving any Medicare eligible services.)

9.5 Exceptions to HHABN Notification Requirements

A. Increases in Care - Whether under original POC or subsequent orders

B. Transfers - To other covered care, i.e. another HHA or another type of Medicare provider

C. Shortening the Duration of Care - Any change in duration of services included in POC and communicated to patient, i.e., shorter therapy sessions as patient's health status improves

D. Planned Reductions in the Number of Services - Applicable when reductions anticipated in POC are communicated to patient in advance/at admission, i.e., PT 3wk2, then 2wk7

E. Patient Goals Met - All care ending with patient goals met or physician orders completed (Expedited Notice must be given)

F. Beneficiary Choice - Changes in care as a result of patient's decision and are documented in client's

medical record

G. Emergency or Unplanned Situations - Beyond Agency's control, i.e., natural disasters or transportation failures

H. Changes in Caregiver or Personnel - Any changes in caregivers or personnel

I. Changes in Time - Any changes in expected arrival or departure time for HHA

J. Changes in Brand - Any changes in brand of product, i.e., the same item produced by a different manufacturer

9.6 General HHABN Requirements - Instructions Agency will follow when preparing any HHABN:

A. Number of Copies - Minimum of two (Including original - one for patient and one for Agency),

B. Reproduction/Modification/Customization - Agency may reproduce by using self-carbonizing paper, photocopying the HHABN, or other appropriate methods (all reproductions will conform to all applicable instructions).

9.7 Agency will make available to staff HHABNs without pre-printed information to allow for unusual cases that do not conform to pre-printed language for items or services or reasons for non-coverage.

9.8 Agency Completion of HHABN:

A. "Ready to use" HHABNs may be downloaded from RHHL.CMS website. After downloading, Agency may customize identifying information, including Agency name, logo, and billing address (at a minimum) in the "Header Section".

B. Sections of HHABN completed by Agency - Header, Body, and Option Boxes - (See "HHABN Completion and Delivery" for detailed instructions on completion of HHABN form).

9.9 HHABN Delivery:

A. Agency staff is required to explain entire notice and its content and answer all patient (authorized representative) questions orally to the best of the staff's ability.

B. Signature and Date Section - After patient (authorized representative) has reviewed and understands information in HHABN, Agency representative will request patient (authorized representative) to complete Signature and Date Section (Patient's Name, Medicare # - HICN, Signature, and Date). NOTE: Agency representative may complete the "Patient's Name" & "Medicare #" to assist patient (authorized representative).

C. The signature on the HHABN will be obtained either in person, or when this is not possible, via return mail. The patient (authorized representative) must personally sign and enter the date the HHABN is completed.

D. If a patient (authorized representative) refuses to sign the HHABN and/or refuses to choose any option, Agency will annotate HHABN, indicating the circumstances and persons involved and a copy of the annotated HHABN will be provided to patient (authorized representative).

9.10 Retention of HHABN:

A. The patient (authorized representative) will retain a copy of the HHABN and,

B. The original annotated with the date of receipt from the patient will be maintained by Agency and the original will be retained by the Agency in the patient's record.

10. False Claims - In the event the Agency receives or makes annual payments of at least \$5,000,000 pursuant to any state Medicaid program,

10.1 Agency will comply with the educational requirements as directed by Section 6032 of the Federal Deficit Reduction Act (DRA) of 2005:

A. All Agency officers, managers, employees, contractors, agents, and volunteers will follow guidelines be in place relative to the Federal False Claims Act (FCA) and the appropriate State False Claims Act.

B. Agency's officers, managers, employees, contractors, agents, and volunteers will receive training on false claims, upon hire or signing agreements, annually, and in the event of rule changes.

10.2. The Administrator will ensure that all of these individuals understand, support, and follow this policy.

10.3 All employees have a responsibility to report suspected and actual violations resulting in false claims and/or billing fraud and/or abuse to his/her supervisor immediately.

10.4 The Agency will immediately investigate reports of false claims and/or billing fraud and/or abuse and will work with all involved to correct any noncompliance.

Reports may be made to the Texas Waste, Abuse, and Fraud Hotline at 1.800.436.6184 and/or the Texas Health and Human Services Office of Inspector General at www.hhs.state.tx.us/OIG.

10.5 The Agency will cooperate with any Federal or State investigations of false claims and/or billing fraud and/or abuse.

10.6 The Agency will take appropriate disciplinary and enforcement action per its progressive discipline policy against officers, managers, employees, contractors, agents, and volunteers found to have filed a false claim or to have committed an act of billing fraud and/or abuse.

10.7 Employees reporting in good faith incidents of false claim and/or of billing fraud and/or abuse are protected from retaliation or retribution by Agency policy, as well as Federal and State law.

10.8 A signed affidavit with a list of employees who were trained on these policies and procedures will be sent to the appropriate State Medicaid Agency.

For Texas submit to:

Texas Department of Aging and Disability Services

Community Services Contracts Unit (MC W-517)

P. O. Box 149030

Austin, TX 78714-9030

RESOURCES

Centers for Medicare and Medicaid Services Guidance:

False Claims Act

Frequently Asked Questions

State Medicaid Directors Letter #06-025

State Medicaid Directors Letter #07-003

Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a

Deficit Reduction Act of 2005 (Public Law 109-171), Section 6032

False Claims Act, 31 U.S.C. §§3729-3733

Texas Administrative Code, Title 1, Part 15, Chapter 371

Texas Government Code Chapter 531, Subchapter C Texas Human Resources Code Chapter 32 Texas Human Resources Code Chapter 36

HCL RI.12 CHAP Rvd 072507

WRITTEN INFORMATIONAL MATERIALS

R1.13

PURPOSE

To ensure accuracy of written informational materials to patients and the general public.

POLICY

Agency will distribute accurate written informational materials that address the care Agency is capable of providing either directly or through written agreement.

Agency will include a non-discrimination policy to referral sources, community organizations, employees, clients, and potential clients.

PROCEDURE

1. All written informational materials to be distributed to patients and/or the general public will be submitted to Agency leaders for approval prior to distribution for confirmation of accuracy of content.

2. A non-discrimination clause will be included in, but not limited to, the following written documents:

- Agency brochures
- Contracts
- Patient admission packets
- Employee orientation manual

CONFLICT OF INTEREST**RI.14****PURPOSE**

To provide standards of ethical behavior expected of the Agency's governing board, employees and representatives in the disclosure of conflicts of interest related to patient care.

POLICY

Agency will continually be responsible to patients/caregivers and the community for providing a consistent ethical framework for specific business operations.

Agency expects their employees and representatives should make every reasonable effort to avoid situations in which their personal interests or the interests of their relatives may conflict or appear to conflict with the best interest of the patient or Agency.

PROCEDURE

1. The Agency's governing board, employees and representatives will select and deal with suppliers to do business in a completely impartial manner without favor or preference based upon any consideration other than the best interests of the patient or Agency.
2. The Agency's governing board, employees and representatives will not have a significant financial interest, either directly or indirectly, in any supplier, contractor, customer or competitor of Agency without full written disclosure to, and written clearance from, the Board of Directors. (A significant financial interest is five percent (5%) or greater ownership of the company.)
3. Agency employees and representatives will not agree to any business transaction on behalf of Agency or one of its entities with a relative by blood or marriage or with a firm of which such relative is a principal, officer or representative, without prior written disclosure of, and written clearance from, either the president of Agency or the Board of Directors.
4. Agency employees and representatives will not accept nor allow any family member to accept any money, gifts or hospitality of other than nominal value, loans (except from lending institutions in the ordinary course of business), or any other preferential treatment, from any supplier, customer, contractor, or competitor of Agency.
5. In the event that a patient must be referred to another agency, organization, service or individual, the patient will be given options from which to select, if available.
6. Agency will inform patients in writing of referrals or arrangements offered to them which will directly or indirectly benefit Agency, Agency staff, and/or its representatives.
7. The Agency's governing board and executive staff will sign annually a written disclosure / conflict of interest statement .

HCL / RI.14 CHAP Rvd. 010207

STAFF RIGHTS REGARDING PATIENT CARE**RI.15****PURPOSE**

To establish a mechanism to review employee refusal to provide care while ensuring uninterrupted patient care.

POLICY

Agency will implement measures to ensure continuity of patient care when an Agency staff member refuses to or has a conflict providing care.

Personal, cultural, and religious beliefs of Agency staff that conflict with ordered care will be reviewed on a case-by-case basis. Agency will make every effort to accommodate the needs of the employee.

PROCEDURE

1. As soon as the employee is aware of conflict between the ordered care and his/her personal beliefs, the employee will notify his/her supervisor.
2. The supervisor will reassign the patient as soon as possible.
3. The specific conflict will be documented and reviewed in conjunction with the employee's performance appraisal.

HCL RI.15 chap Org 050197

MEDICAL CONSENT FOR TREATMENT**RI.16****PURPOSE**

To provide a process in obtaining a medical treatment consent prior to treatment of patients.

POLICY

An Agency is required to have consent to treat patient as stated in Texas Administrative Code TAC 97.292 (a) (3). As defined in the Health and Safety Code Chapter 313.004(e) an adult surrogate may be used to obtain this signed written agreement under certain patient conditions.

PROCEDURE

1. Agency will obtain signed medical treatment consent prior to treatment of patient.
2. Agency will communicate with an adult surrogate, who may speak for the patient, for any adult patient who is comatose, incapacitated, or otherwise mentally or physically incapable of communication.

2.1 The adult surrogate may be one of the following, "in order of priority, who has decision-making capacity, is available after a reasonably diligent inquiry, and is willing to consent to medical treatment on behalf of the patient":

- "The patient's spouse,
- An adult child who has the consent of all other adult children
- To act as sole decision-maker,
- A majority of reasonably available adult children,
- The patient's parents,
- An individual who has been clearly identified to act for the patient prior to becoming incapacitated,
- The patient's nearest living relative, or
- A member of the clergy."

2.2 If the surrogate decision-maker gives consent by phone, the agency will reduce the consent to writing, sign and obtain a counter-signature from the surrogate decision-maker as soon as possible. The consent will be kept in the medical record.

3. When a surrogate decision-maker is not available, Agency will document demonstrating that the attending physician made a reasonably diligent effort to contact the persons eligible to serve as surrogate decision-makers and will keep this documentation in its clinical record.

4. In order to provide care, the Agency will obtain documentation from the primary physician describing the comatose state, incapacitate state, or mental or physical inability and the proposed medical treatment and will include this in the medical record.

HCL / RI.16 chap Org. 010108

CRITERIA FOR PATIENT ADMISSION AND DISCHARGE

PE.1

PURPOSE

To ensure admission/discharge requests are reviewed for individual appropriateness for home care.

POLICY

Agency will review each request for admission/discharge for appropriate criteria for home care.

Agency will accept a patient for home care based on a reasonable expectation that the patient's medical and social needs can be met adequately in the patient's residence.

Agency will obtain a signed written consent prior to performing services to include:

- Medical Consent for treatment per the Medical Consent For Treatment policy
- Financial authorization
- Release of records
- Services to be provided and estimated frequencies

Agency will complete a discharge summary within 48 hours of discharge from home health.

Agency will not discriminate in provision of services or employment with respect to age, race, color, religion, military status, gender preference, sex, marital status, national origin, disability, or source of payment.

A. Eligibility Criteria for Patient Admission To The Agency:

1. Patient is homebound; or, as required by payor source.
2. Patient is under a physician's care
3. Patient has a specific need for care, as defined by specific payor source (i.e.: Medicare, managed care, private pay).
4. Patient lives in the geographic area served by Agency.
5. Agency is able to provide the level of care needed.
6. The home environment is suitable /safe for providing care.

B. Criteria for Patient Discharge from Agency with 5 Days Prior Notification

1. Patient is no longer homebound.
2. Patient is no longer under a physician's care.
3. The need for care no longer exists (e.g., patient goals are met).
4. Patient no longer lives in the geographic area served by Agency.
5. Agency is no longer able to provide the care needed.
6. The home environment is no longer suitable/ safe for providing care.

C. Criteria for Patient Discharge from Agency without 5 Days Prior Notification

1. upon the client's request;
2. If the client's medical needs require transfer (e.g., a medical emergency); or transfer to an inpatient facility;
3. In the event of a natural disaster where if not transferred, the client's health and safety is at a risk;
4. For the protection of staff or a client after the agency has made a documented reasonable effort to notify the client, the client's family and physician, and appropriate state or local authorities of the agency's concern for staff or client safety, and in accordance with agency policy;
5. According to physician orders; or
6. If the client fails to pay for services, except as prohibited by federal law.

PROCEDURE

1. At time of referral, eligibility criteria will be reviewed to determine acceptance of patient for home care.
2. If patient does not meet eligibility criteria, patient will not be admitted. The referral source, patient and patient's physician will be notified.
3. If Agency determines admission is not appropriate either upon referral or after the initial visit, the patient, patient's physician, and referral source are notified.
4. Patient will be offered alternative care options if not appropriate for home care on admission and through-out the course of care (i.e., Hospice, Assisted Living, Nursing Home, etc.).

HCL / PE.1 chap Rvd. 010108

PATIENT ASSESSMENT GUIDELINES

PE.2

PURPOSE

To provide accurate and consistent patient assessments

POLICY

Agency will utilize and adhere to a defined comprehensive assessment in order to identify the patient's needs for home care and that meets the patient's medical, nursing, rehabilitative, social and discharge planning needs. The Comprehensive Assessment and OASIS data collection will be completed by primary provider - a Registered Nurse, Physical Therapist, Speech Therapist (or Occupational Therapist on recertification).

Other qualified Agency professionals who have the necessary skills and training and comply with all federal and state laws and regulations, will perform applicable assessments per discipline, as ordered by a physician.

PROCEDURE

1. Agency will assign staff to perform patient assessments according to each patient's specific/individualized needs and required level of care.
2. Agency will match staff with patients according to each staff member's skills and training as well as the qualifications defined in Agency's job descriptions. Agency will consider the payor source and physician's orders when determining each discipline's assignment.
3. Each discipline's standards of practice will be referenced for decision-making when assessing for admission.

4. The assessment data/information will be gathered and documented on the appropriate discipline's assessment form(s). The Comprehensive Assessment with OASIS data collection will be performed by primary provider.
5. In the event there is a need to correct a comprehensive assessment, the following will apply:
 - A) The clinician, who completed the assessment, makes the correction on the comprehensive assessment form following the guidelines that include one line, initial and date of correction, OR
 - B) The clinician, available by phone, discusses the need for a change with the appropriate personnel. The correction is documented on an OASIS addendum form that includes the change, the name of the clinician that was consulted and the signature of the individual documenting the change.
6. The scope of each other discipline's assessment will be defined within the appropriate discipline's assessment form(s) according to the specific patient population (e.g., psychiatric nursing, pediatric nursing, PT, OT, ST, etc.).
7. Pertinent data/information will be communicated within the interdisciplinary team, as well as to the patient's physician, verbally and/or in writing.
8. Agency staff will assess the patient environment to identify the need for further assessment.
9. An assessment performed due to an intra-agency referral will be completed as follows:
 - Nursing 48 hours
 - Physical Therapy 5 days
 - Occupational Therapy 5 days
 - Speech Therapy 5 days
 - Medical Social Worker 5 days

HCL / PE.2 CHAP Rvd. 010207

INITIAL PATIENT COMPREHENSIVE ASSESSMENT

PE.3

PURPOSE

To identify data collection needed on multiple aspects of the patient and the environment as a basis for individualized intervention and outcome-oriented care.

POLICY

Each patient will receive a patient specific, comprehensive assessment that incorporates OASIS data set for Medicare/Medicaid patients, completed by a Registered Nurse, Physical Therapist or Speech Therapist. The assessment will accurately reflect the patient's current health status and assist in uniformly and consistently measuring patient outcomes. Medicare patients will be assigned a 60 day Episodic Rate based on the assessment.

PROCEDURE

A. Admission

1. Agency will review referral information to determine if eligibility criteria for admission are met.
2. The initial visit will be conducted within **48 hours of referral** or on the physician ordered start of care date.
3. If Agency determines admission is not appropriate either upon referral or after the initial visit, the patient, patient's physician, and referral source are notified.
4. An RN, PT or ST, whoever is primary, will complete the Initial Comprehensive Assessment that incorporates the OASIS data set, no later than five (5) calendar days after the start of care for all patients in a licensed and certified agency excluding the following patients:
 - Patients under 18 years old
 - Maternity patients
 - Homemaker or chore service only patients
5. The assessment data will be collected utilizing the following methods:
 - Interaction and interview with the patient/family/physician
 - Observation and measurement utilizing the senses and calibrated instruments
6. The Comprehensive Assessment will include but not be limited to the following:
 - Physical assessment/Review of systems
 - OASIS data set for Medicare/Medicaid patients which would include pertinent diagnoses, prognosis, physical findings, medical history, etc.
 - ADL's/Functional status
 - Medication history, including drug allergies, sensitivities and past adverse drug reactions
 - Food and environmental allergies

- Psycho-social status
- Residential environment
- Nutritional requirements
- Agencies or companies supplying Out Patient services and/or medical supplies

7. Screens to identify patients, who may require a more in-depth functional assessment by the appropriate discipline, including:

- Medical history
- Problems/needs/strengths of the patient
- Education needs of patient/family
- Home environment
- Any equipment
- All medications and past medication compliance history
- Patient's family or support system and the care they are capable of providing and willing to provide
- Preventive and periodic health screening
- Identifying patients who are at moderate or high nutritional risk
- Abuse
- Safety

8. The initial comprehensive assessment data/information will be gathered and documented on the following forms:

- Initial Comprehensive Assessment Form
- Medication Record Form
- PT/ST progress note when applicable

9. The Comprehensive Assessment will meet the following criteria:

- Identify the patients continuing need for home care.
- Identify when an additional or more in-depth assessment is needed.
- Meet the patient's medical, nursing, rehabilitative, social and discharge planning needs.
- For Medicare patients, identify eligibility for home health benefit, including homebound status, and
- Incorporate the exact use of the current version of the OASIS data set for Medicare/Medicaid patients.

10. A Registered Nurse and/or other professional disciplines will evaluate data/information gathered at the time of their initial assessment and consult with the patient's physician to determine and approve the Plan of Care.

11. The Comprehensive Assessment data collection will be completed during the initial visit, when possible.

HCL / PE.3 CHAP Rvd.010207

PATIENT REASSESSMENT/RECERTIFICATION/SIGNIFICANT CHANGE IN CONDITION/POST HOSPITAL ASSESSMENT

PE.4

PURPOSE

To establish criteria for reassessment of the patient and revision of the plan of care based on this assessment.

POLICY

Agency will reassess each patient on an ongoing basis to evaluate current problems and needs as well as to adjust the care provided as needed with necessary physician orders obtained.

The Recertification/Follow-Up Comprehensive Assessment which includes OASIS data set will be updated and revised:

- During the last five (5) days of the episode, or
- For a significant change in condition (SCIC) not envisioned in the original Plan of Care

The Start of Care/Resumption of Care Comprehensive Assessment will be completed within 48 hours following a patient's discharge from the hospital.

Pain will be assessed on an ongoing basis as to intensity and quality and reported to the physician for follow-up and/or treatment, as needed.

PROCEDURE

A. Recertification

1. Each patient will be reassessed utilizing the Recertification/Follow-Up Comprehensive Assessment during the

last five (5) days of the episode or for a significant change in condition not envisioned in original Plan of Care.

B. Significant Change in Condition

An RN/Therapist may perform the reassessment for a significant change in condition for, but not limited to, the following:

1.1 A significant change in the clinical status (examples)

- An exacerbation in the patient condition occurs with a resulting primary diagnosis change
- Development of multiple pressure ulcers

1.2 A significant change in the functional status (examples)

- Addition of therapy to the plan of care when not included on the original Plan of Care
- Patient is initially independent and becomes either partially or completely dependent

2. Agency personnel will not complete a Follow-Up Comprehensive Assessment (SCIC) for minor changes that would be an expected part of the original Plan of Care (i.e., no change in the patient's case mix category).

3. The reassessment will be reported to the patient's physician and necessary physician orders obtained reflecting SCIC in diagnosis approach.

C. Post Hospital

1. The RN/Therapist will complete a Start of Care/Resumption of Care Comprehensive Assessment (post hospital) within 48 hours of the patient's discharge from the hospital or other inpatient facility.

2. The Plan of Care will be updated with verbal orders from the physician.

3. The Agency will discharge patients that are still hospitalized or in another inpatient facility on the last day of the 60 day episode. Upon readmission to the Agency post hospitalization, a new Start of Care Comprehensive Assessment and Plan of Care will be completed.

HCL PE.4 chap Rvd 110101

PATIENT TRANSFER/AGENCY DISSOLUTION

PE.5

PURPOSE

To ensure appropriate, timely, and coordinated patient transfers.

DEFINITIONS

Transfer (T) to an inpatient facility - patient is put on hold by the Agency as care will be resumed by the Agency upon dismissal from the inpatient facility/agency.

Transfer and discharge (TD) to community or another facility - patient is transferred and discharged from the Agency.

POLICY

1. Agency will initiate patient transfer or transfer and discharge when:

1.1 Agency must dissolve and no longer be in the business of home care. (TD)

1.2 Agency is no longer capable of providing the needed care at the level of intensity required by the patient's condition; (i.e., Hospital, rehab.). (T)

1.3 When one or more elements of discharge criteria is met and another organization is appropriate to assume care. (Hospice, nursing home). (Tor TD)

2. Agency will consider the following when initiating transfer plans:

- The reason for the transfer or transfer/discharge
- The type of transfer to be initiated (e.g., from one organization to another or from one branch of the agency to another)
- The conditions of the transfer process including responsibility of the patient's care during transfer
- The patient's/family's right to participate in the process

Agency will complete the "OASIS/Transfer to Facility" within 48 hours of notification of the transfer/discharge.

PROCEDURE

A. Inter-Agency

1. The need for patient transfer or transfer/discharge is confirmed and the physician is notified.

2. If indicated, an order for MSW intervention is obtained with the transfer order or transfer/discharge order to facilitate the transfer.

3. Agency intending to transfer a patient will perform the following:

- Provide written notification to the patient's parent, family, spouse, significant other or legal representative;

and

- Notify the patient's attending physician or practitioner if he/she is involved in the Agency's care of the patient.

4. Agency will ensure delivery of the written notification no later than five (5) days before the date on which the patient will be transferred.

5. Agency will deliver the required notice by hand or by mail.

6. When Agency delivers the written notice by mail:

- The notice will be mailed at least eight (8) working days before the date of discharge or transfer; and
- The Agency will speak with the patient by telephone or in person to ensure the patient's knowledge of the transfer or discharge at least five (5) days before the date of transfer or discharge.

7. The patient/caregiver will be notified of any benefits Agency may receive as a result of the transfer.

8. Agency will contact the receiving agency/facility to advise them of the transfer or transfer/discharge, coordinate the transfer date and patient care, and establish any specific transfer conditions.

9. Prior to, but no later than 48 hours after the transfer, Agency will provide the receiving agency with the following:

- Services being rendered
- Specific care
- Medication
- Psychosocial status
- Other organizations involved in care
- Any existing Advance Directives, DNR status and/or Medical Power of Attorney, Directive to Physician

10. The professional staff that is the primary provider of care (RN, PT, OT, ST) at the time of the transfer will complete OASIS and Transfer Form within 48 hours of Agency notification of patient transfer. The Transfer form will be submitted to the transfer facility.

11. Agency will keep the following in the patient's file:

- A copy of the written notification provided to the patient or the patient's parent, family, spouse, significant other, or legal representative;
- Documentation of the personal contact with the patient if the required notice was delivered by mail; and
- Documentation that the patient's attending physician or practitioner was notified of the discharge.

12. The patient transfer is completed.

B. Agency Dissolution/Closure

1. The need for agency closure is decided on by the Board of Directors.

2. Agency will maintain an agreement with an alternate agency to transfer the patients.

3. Patient/family will be informed of right to choose an alternate agency.

4. Patient, physician and alternate agency will be notified in writing of patient discharge and imminent transfer per agency transfer policy.

5. Alternate agency will receive pertinent patient care information from Agency within 24 hours of notification of intent to transfer the patient.

6. Agency will notify the Department of Aging and Disability Services (DADS) of agency closure, in writing, within 5 calendar days prior to cessation of operation of the agency or branch office which will include

- The reason for closing
- The location of the client records (active and inactive)
- And the name and address of the client record custodian

7. Agency will mail or return initial license or renewal license to DADS at end of day that services were terminated.

HCUPE.5 chap Rvd. 120106

PATIENT DISCHARGE

PE.6

PURPOSE

To assess each patient's discharge planning and/or continuing care needs prior to discharge from Agency.

To provide for continuity of care as well as appropriate and timely post-discharge care and documentation.

To provide patients in Original Medicare access to an expedited determination process when their Medicare covered Home Health Agency services are ending.

To allow patients to challenge/appeal their provider's decisions to discharge.

POLICY

Agency will assess each patient's discharge planning and/or continuing care needs on an ongoing basis and will involve the physician, the patient and the caregiver in the planning process.

Agency will discharge patient when the patient meets discharge criteria

Agency will provide appropriate discharge planning and notification, per regulations.

Agency will complete a Discharge Assessment which includes the OASIS data required by CMS, upon discharge, unless patient is transferred to an inpatient facility.

Agency may discharge the patient when transferred to an inpatient facility for more than 24 hours and complete only a "Transfer to Facility" OASIS form and an agency Discharge Summary (see PE.5 Patient Transfer policy)

Agency will provide notice to eligible patients of their right to expedited determinations when their period of covered care ends.

Agency will deliver the generic notice (a prescribed CMS notice) to the patient (or authorized representative), no less than two days prior to the end of the covered period, whenever possible, or as soon as the provider knows coverage has ended.

Agency will deliver a detailed notice to the beneficiary and the appropriate Quality Improvement Organization (QIO) if the beneficiary requests an expedited review by the QIO of the decision that coverage for items and/or services should end.

PROCEDURE

Discharge Assessment and 5 Day Notice

A. Planning For Patient Discharge

1. Planning for discharge will begin after evaluation of the data/information gathered during the Initial Comprehensive Assessment.
2. Changes in patient's needs during the provision of care will be identified and assessed on an ongoing basis through interdisciplinary case conferences, progress notes and comprehensive assessments.
3. The data/information and patient/caregiver participation utilized in planning for discharge may be evident on the following:
 - Initial Comprehensive Assessment form
 - Progress notes
 - Case conference documentation

B. Patient Discharge

1. Agency staff will confirm the need for discharge and identify any remaining discharge planning needs.
2. Agency staff will notify the physician and, as needed, obtain a discharge order.
3. If indicated, an order for Medical Social Services is obtained to complete discharge planning.
4. Agency intending to discharge a patient will perform the following:
 - Provide written notification to the patient's parent, family, spouse, significant other or legal representative; and
 - Notify the patient's attending physician or practitioner if he/she is involved in the Agency's care of the patient.
5. Agency will ensure delivery of the written notification no later than five (5) days before the date on which the patient will be discharged.
6. Agency will deliver the required notice by hand or by mail.

7. When Agency delivers the written notice by mail:

The notice will be mailed at least eight (8) working days before the date of discharge; and

The Agency will speak with the patient by telephone or in person to ensure the patient's knowledge of the discharge at least five (5) days before the date of discharge.

8. The Agency may transfer or discharge a patient without 5 days notice:

- Upon the patient's request;
- If the patient's medical needs require transfer (e.g., a medical emergency);
- In the event of a natural disaster where if not transferred, the patient's health and safety is at a risk;
- For the protection of staff or a patient after the agency has made a documented reasonable effort to notify the patient, the patient's family and physician, and appropriate state or local authorities of the agency's concern for staff or patient safety, and in accordance with agency policy;
- According to physician orders; or
- If the patient fails to pay for services, except as prohibited by federal law.

9. The patient/caregiver will be educated on aspects of post-discharge continuity of care arrangements.

10. All disciplines involved will be notified of the discharge date.

11. Medical record documentation for discharge includes, but is not limited to:

- Progress toward goals/Discharge Summary
- Discharge Comprehensive Assessment (including the OASIS data)
- Discharge orders, if required

12. The Discharge Assessment is completed within 48 hours of knowledge of discharge. The OASIS discharge assessment is completed by the last discipline in the home; (i.e. RN, PT, OT, and ST). In the event the discharge is not planned, the OASIS data is based on the last assessment by the RN, PT, OT, or ST.

13. Agency will keep the following in the patient's file:

- A copy of the written notification provided to the patient or the patient's parent, family, spouse, significant other, or legal representative;
- Documentation of the personal contact with the patient if the required notice was delivered by mail; and
- Documentation that the patient's attending physician or practitioner was notified of the discharge.

Termination Notice and Expedited Review

C. Agency staff will provide valid delivery notice (involves both delivery and completion) of the generic notice to the beneficiary when the end of all covered care is foreseen, even if the beneficiary agrees with the discharge.

1. No later than two (2) days before the proposed end of covered services.

- Agency representative will provide generic notice to patient (or authorized representative) when providing 5 day notice of discharge. In the event a 5 day notice is not needed, per above exceptions, the Generic Notice is still required.
- If Agency fails to give valid notice, patient coverage continues for at least 2 days after notice is received.
- If option for non-covered services exists; Agency will also provide patient with HHABN.

2. If services are fewer than two (2) days in duration, Agency will give notification:

- At the time of admission or
- The next to the last time services are furnished.

3. Agency representative will assure the patient (or authorized representative) understands that the purpose and contents of the notice is to notify the patient that

- End of covered care is imminent and
- Patient (or authorized representative) may appeal the termination decision

4. Agency will have patient (or authorized representative) complete and sign generic notice. Patient or authorized representative should sign and date two copies, keep one, and return a copy to Agency.

D. Telephone or e-mail contact may substitute for an in person visit to deliver notice. If e-mail is used a timely return message must be received. Both must be followed by a written generic notice, which includes information on reconsideration options, and is mailed on same day.

1. The generic notice must be prepared and mailed in duplicate, so patient or authorized representative can sign and date two copies, keep one, and return a copy to Agency.

2. Date of instructions (telephone conversation) is the date of the receipt of the notice.

3. A dated copy of the generic notice will be placed in the patient's medical file and is to include name of

person initiating contact, name of representative contacted, date and time of the contact, and the telephone number.

E. If unable to make direct phone contact

1. Agency will send generic notice to patient (or authorized representative) by certified mail and
2. Request return receipt.
3. The date of receipt is date patient (or authorized representative) signs (or refuses to sign) at patient's address. (Patients or authorized representatives who refuse to sign the generic notice are still entitled to an expedited determination).
4. If notices are returned by post office with no indication of a refusal date, patient liability starts on second working day after Agency's mailing date.
5. Agency will retain a copy of all completed expedited determination notices given to patients in their records and will give completed copies to:
 - Patient (or authorized representative)
 - QIO, if requested, and may give a copy to the patient's physician but, this is not required by regulation.

F. Patient must provide a timely request to State QIO (TMF Health Quality Institute) for expedited determination. The request by patient must be made to QIO (TMF Health Quality Institute) by no later than noon the day before coverage ends or twenty-four hours after the Generic Notice is given when coverage ends abruptly. (If patient or authorized representative requests review without physician's statement, QIO will be responsible for instructing patient or authorized representative to obtain certification).

- •Billing cannot occur until QIO determines if coverage can continue.

G. Agency will provide detailed notice to the patient (or authorized representative) by the close of business the same day the QIO notifies Agency that patient has requested an expedited determination.

1. Patient or authorized representative signature is not required on detailed notice, however, Agency staff should annotate records to reflect this circumstance.
2. Agency will supply copies of the generic and detailed notices to QIO and Agency will be allowed to explain termination decisions to QIO. Phone contact with QIO must be documented in a written record.
3. Determination will be made by QIO no later than 72 hours after receipt of patient's (or authorized representative's) request for expedited determination with notification of patient (or authorized representative), patient's physician, and Agency.
4. Untimely review requests will receive determination "as soon as possible" by QIO, not necessarily within 72 hour limit.
5. Agency will supply patient (or authorized representative) with copies of documentation sent to QIO, if requested, by the close of the first business day after the request (Agency may charge a copying fee).

H. Expedited determinations do not occur if:

1. HHA is acting as a durable medical equipment supplier in one-time situation or sporadic delivery of equipment,
2. Intermittent items or services are covered under Part B since there is no continuous care to end,
3. Discharge is unrelated to coverage, i.e.; unsafe environment.
4. Patient leaves active care so discharge cannot be done in person, i.e.; inpatient hospital admission or readmission, abrupt unforeseen patient departure (should annotate records to reflect this circumstance).

HCL / PE.6 chap Rvd. 120106

STANDARDS OF PRACTICE

TX.1

PURPOSE

To provide patient care within acceptable standards of practice by Agency staff.

POLICY

The Agency will provide patient care in accordance with the professional staffs State Practice Act for acceptable standards of practice and as defined in Agency's policies and procedures.

PROCEDURE

1. Agency will have available for staff the State Practice Acts as well as all Agency policies and procedures.
2. Agency will provide ongoing educational opportunities and updates for Agency staff by means of verbal and/or written communication.

3. Patient care staff will adhere to the respective State Practice Acts, as well as to all policies and procedures established by Agency during patient visits.

HCL TX.1. Chap Rvd 073102

ON CALL FOR PATIENT CARE

TX.2

PURPOSE

To ensure that patient care needs will be met safely and appropriately after Agency office hours, during weekends and on holidays.

POLICY

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

Agency will ensure that an RN is available 24 hours a day, 7 days a week to respond to calls. RN can be contacted through on-call pager or through procedure listed below.

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

PROCEDURE

A. ANSWERING CALLS

1. Agency will either transfer phones directly to the on call Nurse or transfer to an answering service. If using answering service, they will contact the on call nurse immediately.
2. The on call RN will confirm the contact with the answering service.
3. If the on call RN has not confirmed within 20 minutes, then the answering service will contact administrative "on call" designee.

B. ON CALL PREPARATIONS

1. Upon admission, the patient/family will be advised of Agency's 24-hour availability policy and on call phone number. The patient/caregiver will be instructed to leave their name, phone number, and reason for call when calling during hours that office is closed.
2. On call schedules will be prepared on a monthly basis.
3. The on call schedule, as well as a current listing of Agency on call staff with titles and contact numbers, will be provided to the answering service.
4. All changes to the on call schedule must be approved by the appropriate supervisor and then communicated to the answering service by office coordinator.
5. Pertinent patient and plan of care information will be maintained for on call staff in either an on call book, lap tops, pda's, or other portable agency electronic devices utilized for such information. This information will be updated with admissions, discharges, and other information on a weekly basis by supervisor /Patient Care Manger and placed in either an on call book, lap tops, pda's or other portable agency electronic devices utilized for such information. HIPAA compliance will be maintained in all instances.

C. ON CALL ACTIVITIES

1. The on call RN will keep a log of all calls. The RN will document date and time of call, time RN returns the call, patient's name and RN's response to the problem presented. The log will be submitted to the Agency at the completion of the on call rotation.
2. Appropriate activity will be documented on communication notes for the medical record.
3. On call RN will carry a pager or a cellular phone at all times and will remain within range at all time.
4. If the RN needs to be out of range or unable to remain on call, the RN will notify administrative on call designee. The administrative on-call designee will contact the answering service with the on call person's number.
5. The on call RN will respond to all calls and use professional judgment in determining any need to call the administrative on call nurse.
6. Another adult (employee or non-employee) may accompany Agency staff on an on call visit during inclement weather or to ensure staff safety.

HCL TX. 2 chap Rvd 092806

ABUSE, NEGLECT, AND EXPLOITATION

TX.3

PURPOSE

To identify suspected or alleged victims of abuse, neglect, and exploitation (ANE) and establish appropriate protocol for reporting and/or referring abuse, neglect, and/or exploitation of a patient to the appropriate agency. DEFINITIONS (Human Resources Code Chapter 48.401 and 48.002; and Family Code Chapter 261)

A. Definitions

1. "Agency" means an entity licensed under Chapter 142, Health and Safety Code.
2. "Employee" means an individual who:
 - 2.1 Is directly employed by the Agency, a contractor, or a volunteer;
 - 2.2 Provides personal care services, active treatment, or any other personal services to an individual receiving agency services; and
 - 2.3 Is not licensed by the state to perform the services the person performs for the agency.
3. "Employee misconduct registry" means the Employee Misconduct Registry established under Chapter 253, Health and Safety Code.
4. "Executive director" means the executive director of the Department of Family and Protective Services.
5. "Reportable conduct" includes:
 - 5.1 Abuse or neglect that causes or may cause death or harm to an individual receiving agency services;
 - 5.2 Sexual abuse of an individual receiving agency services;
 - 5.3 Financial exploitation of an individual receiving agency services in an amount of \$25 or more; and
 - 5.4 Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services.
 - 5.5 Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services.
6. "Adult Abuse":
 - 6.1 The negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person; or
 - 6.2 Sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense under Section 21.08, Penal Code (indecent exposure) or Chapter 22, Penal Code (assaultive offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.
7. "Adult Exploitation" means the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.
8. "Adult Neglect" means the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.
9. "Child Abuse" includes the following acts or omissions by a person:
 - 9.1 Mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning;
 - 9.2 Causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning;
 - 9.3 Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm;
 - 9.4 Failure to make a reasonable effort to prevent an action by another person that results in substantial harm to the child;
 - 9.5 Sexual conduct harmful to the child's mental, emotional, or physical welfare, including conduct that constitutes the offense of continuous sexual abuse of young child or children under Section 21.02, Penal Code; indecency with a child under Section 21.11, Penal Code; sexual assault under Section 22.001, Penal Code; or aggravated sexual assault under Section 22.021, Penal Code;

- 9.6 Failure to make a reasonable effort to prevent sexual conduct harmful to a child;
- 9.7 Compelling or encouraging the child to engage in sexual conduct as defined by Section 43.01, Penal Code;
- 9.8 Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene as defined by Chapter 481, Health and Safety Code and Section 43.21, Penal Code, or pornographic;
- 9.9 The current use by a person of a controlled substance as defined by Chapter 481, Health and Safety Code, in a manner or to the extent that the use results in physical, mental, or emotional injury to a child;
- 9.10 Causing, expressly permitting, or encouraging a child to use a controlled substance as defined by Chapter 481, Health and Safety Code ; or,
- 9.11 Causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child as defined by Section 43.25, Penal Code.

10. "Child Neglect" includes the following acts or omissions by a person:

10.1 The leaving of a child in a situation where the child would be exposed to a substantial risk of physical or mental harm, without arranging for necessary care for the child, and the demonstration of an intent not to return by a parent, guardian, or managing or possessory conservator of the child;

10.2 The following acts or omissions by a person:

- Placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or a substantial risk of immediate harm to the child;
- Failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child;
- The failure to provide a child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding failure caused primarily by financial inability unless relief services had been offered and refused;
- Placing a child in or failing to remove the child from a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child;
- Placing a child in or failing to remove the child from a situation in which the child would be exposed to acts or omissions that constitute abuse under Subdivision (1) (E), (F), (G), or (K) committed against another child.

10.3 The failure by the person responsible for a child's care, custody, or welfare to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason, including having been in residential placement or having run away.

11. "Child Exploitation" means the illegal or improper use of a child or of the resources of a child for monetary or personal benefit, profit, or gain by an employee, volunteer, or other individual working under the auspices of the agency or program as further described by rule or policy.

12. "Cause to believe" means that an agency or individual knows or suspects, or receives allegation regarding abuse, neglect, or exploitation.

POLICY

Agency employees/contractors will be aware of signs and symptoms indicating possible abuse, neglect, and/or exploitation and upon hire will sign an acknowledgment affirming compliance with Agency policy.

All Agency employees and contractors are required, and have the legal obligation, to report suspected abuse, neglect, and/or exploitation to the Texas Department of Family and Protective Services (TDFPS), the Texas Department of Aging and Disability Services (DADS) and Agency management.

If there is cause to believe abuse, neglect, or exploitation of the patient has occurred by an Agency employee, representative, volunteer or contractor, the incident(s) will be reported to TDFPS and DADS immediately,

meaning within 24 hours, upon witnessing the act or upon receipt of the allegation.

Agency or staff members will not implement retaliatory action against any individual who reports suspected patient abuse, neglect, and/or exploitation.

Patients will be informed of this policy, verbally and in writing, during the admission process.

PROCEDURE

A. Agency staff/contractor/representative will:

1. Immediately report assessment of patient's condition that might indicate abuse/neglect/exploitation to Agency supervisor. Symptoms that may indicate a need for further investigation include the following:

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

2. When appropriate, acquire input from other disciplines providing patient care regarding concerns.

B. Agency Management will:

1. Initiate an investigation of known or alleged acts of ANE immediately upon witnessing the act or upon receipt of the allegation or upon having cause to believe ANE occurred.

Report findings and intentions to report the suspected abuse to the patient's attending physician. Medical Social Services may be ordered by the physician, as appropriate.

3. Report if there is cause to believe abuse, neglect, or exploitation of the patient has occurred by a staff member, representative, volunteer or contractor immediately, meaning within 24 hours to:

- 3.1 Texas Department of Family and Protective Services at 1-800-252-5400, or through the DFPS secure website at www.txabusehotline.org, and
- 3.2 Texas Department of Aging and Disability Services (DADS) at 1-800-458-9858, and
- 3.3 Agency management.

4. Will suspended immediately any Agency employee or contractor suspected of abuse, neglect, or exploitation and an investigation will be conducted by the Agency/State agency. If the investigation validates the claim, the employee or contractor will be terminated and the incident(s) reported to appropriate state department, state licensing board, or law enforcement official.

5. Agency will send a written report, using the Provider Investigation form, of the investigation to DADS Complaint Intake Unit no later than the tenth day after verbally reporting the act to Department of Family and Protective Services and DADS. Documentation will be kept confidential by the Agency to the extent required by state law.

6. File a report of child abuse, child neglect, or child exploitation immediately, meaning within 24 hours, with DFPS, local law or state law enforcement agency, the state agency that operates, licenses, certifies, or registers the Agency in which alleged abuse occurs or other state agency as appropriate.

7. Identify the following, if known in the Child Abuse report:

- 7.1 Name and address of child;
- 7.2 The name and address of person responsible for the care, custody, or welfare of the child;
- 7.3 Any other pertinent information concerning the alleged suspected abuse, neglect, or exploitation.

8. Report any incidents of Family Violence to a local law enforcement agency.

9. Track and keep copies of reports filed with the state or local law enforcement.

HCL/TX.3 Rvd. 070109

PAIN MANAGEMENT

TX.4

PURPOSE

To provide guidelines for pain assessment and appropriate response to patient pain

POLICY

Agency staff is committed to pain prevention and management and will respond quickly to provide effective pain management.

PROCEDURE

1. All patients will be assessed for pain or risk for pain on the initial patient assessment to include:
 - pain character,
 - frequency,
 - location,
 - duration
2. Pain intensity ratings will be recorded utilizing a scale as determined by Agency. Vital signs will also be recorded.
3. Pain will be assessed as part of every patient contact if patient reports pain or is at risk for pain.
4. When Agency determines that pain cannot be adequately managed by Agency in the home, appropriate referrals will be made.

HCL TX.4 chap Rvd 073102

ORDERS FOR CARE

TX.5

PURPOSE

To ensure patient care is provided in accordance with physician's orders and federal and state laws and regulations.

POLICY

Agency will obtain orders and provide care in accordance with physician's orders which are established prior to initiating patient care and reviewed/revised by the physician every 60 days and as needed.

PROCEDURE

1. All orders are kept current and renewed or updated as appropriate to:
 - Changes in patient's condition occurs;
 - The ordered care is ineffective;
 - Changes in diagnosis, treatment (including procedures and medications), and equipment;
 - Desired goals are not being achieved;
 - Applicable law and regulation
2. The data/information/orders will be documented upon initial certification and subsequent recertification as defined by the 485 form.
3. The data/information/orders documented during the interim, on the verbal order form, between certification and recertification(s) should include:
 - Pertinent patient information;
 - Changes in diagnosis and care; and
 - Patient's goals related to care.
 - All changes in orders are communicated to the appropriate Agency staff members.
5. The original order is sent/ faxed to the physician for signature, and a copy is retained in the patient's medical record and/or file. Agency may utilize faxed physician orders (POC and Verbal) as originals. A manual or electronic log is maintained to ensure timely receipt of signed orders. If orders are not returned, the agency may call physician, re-fax order or hand carry a copy of the order to the physician's office.
6. Faxed orders will have a cover sheet identifying agency name and number, who is to be recipient of fax, date sent, a statement that informs recipient that if receive fax in error to notify the agency immediately and a confidentiality clause.
7. Electronic physician's signature is acceptable if Agency maintains patient records by computer rather than hard copy. Authentication by the physician should be available if requested by the Agency.
 - The entry must be dated and indicated as an electronic signature.
 - The entry must be authenticated by the individual who reviewed and approved the entry.
 - Authentication may be by signature, written initials, or computer secure entry by a unique identifier.
8. If utilizing digital signatures, confidentiality/security measures must be taken as well as the signature must not be in an encrypted format.
9. Agency staff will verify upon return of order that the order is complete, accurate, signed with date of order, and final. If changes are made to original order appropriate staff are notified.
10. When received by Agency, the signed order replaces the copy in the patient's medical record.

11. Supplemental verbal orders may be obtained before care is provided and are written within 24 hours of receiving the orders. The verbal orders may be signed by an RN, LVN with co-signature by the RN, a PT, OT, ST, or an MSW. The Plan of Care may be used as the verbal start of care when signed and dated by the RN.
12. Physician signatures are obtained on 485s and supplemental verbal orders within 30 days and all signed orders will be received prior to billing for the service provided.

HCL/TX.5CH Rvd.060108

PLAN OF CARE

TX.6

PURPOSE

To ensure that care provided is appropriately planned in a timely manner to meet the patient's specific needs and problems. Orders will be returned signed within 30 days or prior to billing for the final claim of an episode.

POLICY

Agency will utilize data/information gathered during patient assessments in the care planning process which involves the identification of patient goals, actions or interventions that will resolve or alleviate the patient's problems and/or needs.

The Plan of Care will be signed and dated by a physician at certification and recertification and before the claim for each 60 day episode for services is submitted for the final claim payment.

The patient/caregiver, as well as the patient's physician, will be encouraged to participate in the patient's care planning process to determine mutually agreed upon goals.

PROCEDURE

1. The appropriate licensed professional staff member, with physician participation, is responsible for developing the plan of care within 3 - 5 days of the initial assessment.

1.1 A registered nurse initiates the plan of care for skilled nursing care and for personal hygiene/activities of daily living care. If the skilled nursing care is psychiatric care, then a trained psychiatric nurse initiates the plan of care. If a patient is admitted as part of a specialty program, then a registered nurse with the appropriate specialty training initiates the plan of care.

1.2 A registered physical therapist initiates the plan of care for PT care and for Physical Therapy Assistant care provided as an extension of PT services.

1.3 A Registered Occupational Therapist initiates the plan of care for OT care and for COTA care provided as an extension of OT services

1.4 A Speech Language Pathologist initiates the plan of care for ST care.

1.5 A medical social worker initiates the plan of care for MSW.

2. An RN is responsible for coordinating the plan of care when multi-disciplines are involved, or when more than one agency is involved, to decrease the possibility of duplication/conflict and to identify responsibilities.

3. The 485, which includes the following plan of care elements, is developed in consultation with staff, client, physician and other providers involved in the client's care and will serve as the initial plan of care:

- client's primary and secondary diagnoses/problems
- food or drug allergies
- homebound status, if required by payor
- goals/outcomes to be achieved
- client's mental status
- functional limitations
- activities permitted
- safety measures to protect against injury
- nutritional requirements
- medications and treatment
- specific procedures/treatments to be performed, including amount, frequency and duration
- supplies and equipment required
- discharge or referral plan
- frequency and duration of visits
- prognosis

- rehabilitation potential
- other appropriate items such as precautions and contraindications

4. Modifications to the care plan are indicated by: reassessments, patient condition/needs, changes in orders, and/or achievement of identified goals. These are documented either on discipline progress notes or a physician verbal order. Verbal orders will be signed and dated by the physician within 30 days and will be received prior to the billing of the final claim of an episode.

5. The care plan is reviewed and/or revised, with physician participation, at least every 60 days.

6. If, at any time, a part of the care required by the patient is not provided by Agency, then that portion of the patient's care is referred to an alternative service if available.

7. In the event the care to be provided is not skilled, the RN will prepare an individualized service plan/care plan to include; services rendered, hours of service, problems, method of intervention and projected date of resolution. The non-skilled plan does not require a physician's signature/order. This POC will be updated at least annually.

HCL TX.6 CHAP Rvd. 041706

IMPLEMENTING CARE AND TREATMENT

TX.7

PURPOSE

To ensure patient care and treatment are provided as identified in the care planning process.

POLICY

Agency staff providing patient care and treatment will be competent to the level of care/treatment needed, and the care provided will be within the frequency parameters established on the care planning document(s).

Agency designates a qualified registered nurse who will oversee the following when coordinating the assignments of patient care:

1. The principles of the care to be provided
2. The staff qualifications and proficiency levels
3. The patient population

PROCEDURE

1. Agency will assign appropriate disciplines needed to provide patient care/treatment. When assigning staff, Agency will attempt to limit the number of different staff members within one discipline providing care to one patient.

2. The assigned discipline(s) will be provided with information needed to provide patient care/treatment including, but not limited to, the plan of care.

3. Agency RN will oversee the assignment of a home health aide to a particular patient.

4. The aide will be provided with written instructions for patient care prepared by an RN and/or therapist and which may include but not be limited to:

- Performing simple procedures as an extension of therapy services
- personal care
- ambulation and ROM
- household services essential to the patient's health
- reporting changes in the patient's condition/needs
- completing appropriate documentation

5. If there is a change in the schedule of care, the patient and/or caregiver are notified prior to the scheduled time (if at all possible) by the appropriate discipline.

6. When the provision of care/treatment cannot be implemented as established on the care planning document(s), the patient's physician will be notified. The appropriate documentation will be completed and submitted by discipline/Patient Care Manager.

HCL TX.7 chap Org 050197

MONITORING PATIENT CARE/COORDINATION OF CARE

TX.8

PURPOSE

To ensure coordination of patient care/treatment.

POLICY

Agency will monitor, evaluate and report to the patient's physician regarding the patient's progress toward

achieving goals established on the plan of care. A Sixty Day Summary will be completed and sent to the physician a minimum of every sixty days. Agency will collaborate with other organizations providing services (i.e., medical equipment, other home health agencies, out-patient clinics, etc.), physicians and family/significant others to ensure appropriate coordination of care for the patient.

PROCEDURE

- 1 Effective interchange and reporting, as well as coordination of care will occur between the disciplines providing care. Communication regarding the patient's progress may occur through a formal case conference and/or it may include informal verbal and written communication among all staff members providing care.
2. A written summary report that includes information on the patient's current condition, the outcome and any responses to current treatment and medications will be sent to the patient's physician at least every 60 days, or more frequently if warranted by the patient's condition.
3. The physician's written summary reports may be documented on the "Sixty Day Summary" form or included in the 485.
4. When other organizations are involved in the patient's care, Agency staff members notify them of significant changes in the patient's overall care. This communication is documented in the medical record.
5. Agency staff is expected to contact the agency to inform of patient needs and changes. This will be documented on a communication note and will serve as coordination of care.

HCL TX.8 chap Rvd 060106

REVIEW AND REVISION OF PATIENT CARE

TX.9

PURPOSE

To ensure patient care is reviewed and that appropriate changes are made as necessary.

POLICY

Agency will review and revise patient care in accordance with changes in the patient's condition; psychosocial status and residential environment; lack of achievement of goals within the specified time frame; patient's response to care; and changes that have occurred regarding diagnosis, treatment, medications, precautions and limitations.

PROCEDURE

1. Agency staff will review patient care on each visit.
2. upon identifying that patient care needs have changed (according to Agency policy), adjustments to the care planning documents will be made as follows:

Progress Notes	RN, LVN, PT, OT, ST, HA MSW
MD Interim Orders	RN, LVN with RN co-sign, PT, OT, ST, MSW
Plan of Treatment	RN, PT, OT, ST, MSW
Home Health Aide Care Plan	RN, PT, OT
Medication Profile	RN

3. Each change will be accompanied by the goals and outcome criteria, the tentative date of expected resolution, and specific interventions to achieve goals.

HCL TX. 9 chap Rvd 031604

CARE OF THE DYING PATIENT

TX.10

PURPOSE

To provide appropriate care to meet the needs of the dying patient and caregiver(s).

POLICY

Agency will identify and provide for the special needs of the dying patient, as well as the needs of the patient's caregiver(s) and Agency staff, in order to allow the patient to die with the optimal level of comfort and dignity according to his/her requests concerning death.

PROCEDURE

1. Agency will be aware of the state and community regulations related to death in the home.
2. Agency staff will receive training regarding care of the dying patient as appropriate to the agency services.
3. Agency will be aware of any advance directives and/or Do Not Resuscitate (DNR) orders.
4. The patient/caregiver and physician are included in the care planning process which may include discussion of

advance directives and/or DNR orders.

5. Interventions/care will include but are not limited to:

5.1 Assessments and care to facilitate the management of pain and symptoms as evidenced by documentation of patient's statement of level of pain.

5.2 Assessments and care taken to manage and/or prevent other symptoms of patient problems (e.g., nausea/ vomiting secondary to disease process).

5.3 Care addressing the psychosocial/spiritual concerns of the patient/caregiver

5.4 Appropriate referrals - whether to other Agency disciplines or other organizations - to meet identified needs

5.5 Monitoring of patient response to interventions/care

HCL TX.10 chap Org 010197

EXPECTED/UNEXPECTED PATIENT DEATH

TX.11

PURPOSE

To establish guidelines for Agency staff regarding both expected and unexpected patient deaths in the home.

POLICY

Agency will observe applicable federal/state rules and regulations in the event of a patient death in the home.

A registered nurse will be responsible for responding to emergency phone calls from caregivers requesting instructions related to a patient death.

The RN does not pronounce death of the patient.

PROCEDURE

1. Agency will be aware of the state and community regulations related to death in the home.

2. Agency staff will receive training regarding the procedures associated with death(s) in the home, specific to Agency's service area.

3. Interventions are specific according to the following factors:

- Does an out-of-hospital DNR order exist?
- Is Agency staff present in the home?

3.1 DNR exists and Agency staff is present

3.1.1 Contact primary physician, community authorities and the funeral home

3.1.2 Contact Agency to notify other caregivers

3.2 DNR exists but Agency staff is not present in the home.

3.2.1 Agency staff may go to home and/or offer to contact primary physician, community authorities, and the funeral home.

3.2.2 Notify other Agency caregivers.

3.3 DNR does not exist and Agency staff is present

3.3.1 Contact the Emergency Medical System (EMS) 3.3.2 Initiate CPR

3.3.3 Assist EMS personnel when they arrive 3.3.4 Contact the primary physician and Agency

3.3.5 Implement appropriate follow-up measures (e.g., assist family, contact funeral home, etc).

3.4 DNR order does not exist and Agency staff is not present

3.4.1 RN instructs the caller to contact EMS or offers to contact EMS 3.4.2 Contact the primary physician and other Agency caregivers 3.4.3 Follow-up with patient's outcome

4. Document in the medical record all pertinent aspects of Agency involvement in the event

HCL TX.11 chap Rvd 031598

LABORATORY TESTING

TX.12

PURPOSE

To identify the extent of testing performed by Agency staff and its purpose.

To monitor patient lab values to ensure therapeutic care.

POLICY

Agency will perform only laboratory tests considered as "waived tests" under the Clinical Laboratory

Improvement Amendment (CLIA) of 1988. This will include blood glucose and coagulation monitoring. The results will be used for diagnostic and/or treatment purposes.

PROCEDURE

1. Agency will obtain CLIA waiver for the following test: analysis of blood glucose levels and/or coagulation levels via finger stick.
2. Agency supervisor or a designee will be responsible for reviewing any orders for lab services when it is unclear whether they meet CLIA requirements.
3. Agency will notify the physician and the RN regarding the lab results by fax and/or phone. Critical lab results which are out of the accepted range will be brought to the physician's attention.
4. See policy TX.14 for Glucometer specific requirements.

HCL / TX.12 CHAP Coag Rvd. 121504

LABORATORY SERVICES PROCEDURES

TX.13

PURPOSE

To ensure Agency staff has access to current, accurate clinical policies related to laboratory testing.

POLICY

Agency will maintain current, accurate policy/procedure guidelines related to laboratory testing that include, but are not limited to:

- specimen collection procedures
- specimen preservation
- instrument calibration
- quality control and required follow-up action
- test performance
- the equipment needed
- who may perform the test

Agency staff will have access to this information to perform procedures correctly.

PROCEDURE

1. Agency will provide a Clinical Policy/Procedure Manual for each Agency office.
2. Each Agency office will obtain laboratory-specific procedures and make available to Agency staff.
3. Each Agency office will obtain equipment calibration and maintenance information from the manufacturer and provide it to Agency staff.
4. Agency will only use outside laboratory services that are in compliance with local/state/federal licensing and regulatory standards if the Agency contracts for outside laboratory services.

HCL / TX.13 CHAP Rvd. 050106

GLUCOMETER QUALITY CONTROL TESTING

TX.14

PURPOSE

To ensure accuracy of Glucometer test results for blood sugar testing.

POLICY

Agency staff will conduct quality control on Glucometers utilized by staff, will maintain records of the results, and will provide a procedure for analyzing and correlating the data recorded, according to specific manufacturer's recommendations for the specific brand of Glucometer.

PROCEDURE

1. Agency licensed staff will test the Glucometer for high and low control levels following the manufacturer's procedure.
2. The data recorded is defined on a Glucometer log or on the nurse's note.
3. When utilizing a log, it is turned in monthly to PCM/supervisor for review and analysis of data.
4. If the Glucometer testing is below and/or above the low/high control parameters, then the manufacturer's corrective guidelines are implemented.
5. If these are not effective, then the testing is not performed until a properly functioning Glucometer is available.
6. The physician is notified as indicated.
7. The Glucometer is re-calibrated as indicated by manufacturer's guidelines.

8. Results will be reported as ordered to the physician.

HCL TX.14 CHAP Rvd.020103

MEDICATION ADMINISTRATION

TX.15

PURPOSE

To ensure competent and safe medication administration to patients and maintenance of a current patient medication list.

POLICY

Agency staff will administer and document drugs, biological, and nutritional therapies according to administrative and clinical policies and procedures, and in accordance with all applicable federal and state laws and regulations.

Agency will obtain physician's orders when administering medication with the exception of influenza and pneumococcal polysaccharide vaccines.

Agency may administer influenza and pneumococcal polysaccharide vaccines after assessment of patient for contraindications.

PROCEDURE

1. A written physician's order is obtained for medication administration.
2. Written physician's orders specify:
 - patient name
 - medication name
 - medication dose
 - medication route
 - frequency of medication administration
 - medication start date/time
 - medication stop date/time when appropriate
3. Agency staff will transcribe written physician's medication orders as soon as possible after they are received. These orders will be signed by the physician within 30 days or prior to billing for services.
4. Medications are administered only by:
 - a licensed nurse or physician
 - an employee who has completed a state approved training program in medication administration
 - the patient if the attending physician has granted self-administration
 - Any other individual in accordance with applicable state and local laws/and as specified in the POC: identify the authorized person and the drugs or biologicals to be administered.
5. The individual administering the medication is responsible for knowledge of specific medication:
 - action
 - contraindications
 - usual dose
 - indications
 - route of administration
 - side effects
 - patient allergies
 - special precautions
6. Medications are administered as per Agency's Clinical Procedure Manual and per physician orders.
7. Medication administrations will be documented in the patient's medical record to include:
 - medication name medication dose medication route
 - medication site, as appropriate
 - medication administration date and time
 - nurse's full name

- nurse's professional designation
- patient response

8. The patient's physician and management will be notified if medication is not administered for any reason.
9. Drugs, biologicals, and nutritional therapies are stored and distributed in accordance with acceptable standards, established by the manufacturer including temperature, light and length of time.
10. The attending physician and Agency supervisor will be notified regarding any medication errors as soon as possible.
11. Any medication error or adverse reactions will be documented on the "Occurrence Report" and submitted to management immediately.
12. The first dose of parenteral medication may be administered in the home with the approval of the Director of Home Health and/or Pharmacist or designees with physician specific order.
13. Medications the patient has not previously received intravenously (first dose) may only be given in the home with consent of the Director of Home Health. The Director will consult with a medical team when appropriate. Exceptions will be allowed if administration of the initial dose of medication is approved by the physician, Director and Pharmacist. Lasix is one exception: if the patient has tolerated oral Lasix, they may receive home infusion Lasix. If allergic drug reaction occurs, RN may administer Benadryl and/or Epinephrine as stated in policy/procedure on Adverse Drug Reaction.

Administration of influenza and pneumococcal polysaccharide vaccines

1. Agency staff will assess the patient for potential contraindications prior to administering the vaccine.
2. Patient will sign a consent agreeing to receive vaccine, that they understand the risks involved, and that they have no known allergy to eggs and have not had a serious allergic reaction to a previous dose of flu vaccine. Agency staff will not administer if allergies or reactions have occurred previously.
3. Patient will be instructed to contact physician if they have had a reaction to the vaccine previously.
4. Agency will administer the vaccine according to agency procedure for injection administration and document for patient's record.

HCL / TX. 15 Flu CHAP Rvd 102407

MEDICATION LIST AND MONITORING

TX.16

PURPOSE

To outline a process for ongoing medication monitoring.

POLICY

An Agency RN will be responsible for coordinating the efforts of monitoring the medication regimen by compiling assessment data through a collaborative effort of all Agency staff involved in the patient's care. A medication profile/list will be maintained on all patients.

Medication monitoring will include appropriate date/information to develop an accurate patient medication history and a current, complete medication profile. This data will be available to all Agency staff involved in the patient care.

Assessments of a patient's response to the medication regimen are used when evaluating the continuation of the medication regimen, evaluating patient's compliance, and/or identifying problems.

PROCEDURE

1. Agency will maintain a current, accurate list of all prescription and over-the-counter (OTC) medications taken by the patient (Medication Profile). Oxygen therapy including liters per minute, route and frequency will be documented on the medication profile.
2. A prescription is considered an order from a physician that has been transcribed by the pharmacist. The medication will be documented in the medical record and added to the subsequent Plan of Care.
3. This medication profile will also include:
 - dosage
 - administration schedule
 - route
 - initial order and discontinuation dates where applicable
 - Indication whether the medication is new (N) or changed (C).
4. The Registered Nurse will monitor medications for potential adverse effects and drug reactions including

ineffective drug therapy, significant side effects, significant drug interactions and duplicate drug therapy.

5. Agency nursing staff will assess on an ongoing basis the patient's response to the medication and the patient/caregiver's compliance with the medication regimen.

6. Adverse patient response, lack of patient response, and/or compliance concerns will be communicated to the physician as well as documented in the medical record.

7. Changes in the medication regimen will be documented in the medical record either on the medication profile or on a verbal order, as well as communicated to the patient and/or caregiver. Changes in medication regimen will be documented on the Medication Profile at least every 60 days.

HCL TX.16 chap Rvd 031604

MEDICATION POSSESSION AND TRANSPORT

TX.17

PURPOSE

To establish guidelines for Agency staff members to purchase, store and transport medications, sterile water, saline, and certain vaccines or tuberculin in accordance with state laws/regulations.

POLICY

The Agency or its employees who are registered nurses or licensed vocational nurses may purchase, store or transport medications, sterile water and sterile saline for injection and irrigation, certain for the purposes of administering to their Agency's employees, home health or hospice clients, or client family members under a physician's order or standing order.

The dispensing pharmacy will be responsible for selecting and providing an appropriate container in which to transport the medication. The pharmacy will also provide any additional supplies or instructions needed in the event of an accidental spillage of the container's contents.

Agency employee will transport the item in such a way so as to maintain the identity, integrity and security of the products.

PROCEDURE

1. Agency or its skilled nurses may purchase, store or transport for the purpose of administering to:

a. Home health or hospice clients under physician's order:

- Sterile water for injection and irrigation
- Sterile saline for injection and irrigation

b. Agency's employees, home health, or hospice clients, or client family members under physicians standing orders:

- Hepatitis B vaccine
- Influenza vaccine
- Tuberculin purified protein derivative for TB testing
- Pneumococcal polysaccharide vaccine

NOTE: Criteria for a physician's standing order:

1. Signed and dated by physician

2. Identifies the vaccine or tuberculin covered by the order

3. Indicates that the recipient of the vaccine or tuberculin has been assessed as an appropriate candidate to receive the vaccine or tuberculin and has been assessed for the absence of any contradictions.

4. Indicates that appropriate procedures are established for responding to any negative reaction to the vaccine or tuberculin.

5. Orders that a specific medication or category of medication be administered if the recipient has a negative reaction to the vaccine or tuberculin.

6. Home health or hospice patients under a physician's order:

i. Following items in a sealed portable container of a size determined by the dispensing pharmacist:

- 1,000 milliliters of 0.9% sodium chloride intravenous infusion
- 1,000 milliliters of 5.0% dextrose in water injection sterile saline

ii. Not more than 5 dosage units of any of the following items in an individually sealed, unused portable container:

- Heparin sodium lock flush in a concentration of 10 units per milliliter or 100 units per milliliter

- Epinephrine HCL solutions in a concentration of one to 1000 milligrams per milliliter
 - Diphenhydramine HCL solution in a concentration of 50 per two milliliters
 - Methylprednisolone in a concentration of 125 milligrams per two milliliters vial
 - Naloxone in a concentration of one milligram per milliliter
 - Promethazine in a concentration of 25 milligrams per milliliter
 - Glucagon in a concentration of one milligram per milliliter
 - Furosemide in a concentration of 10 milligrams per milliliter
 - Lidocaine 2.5% and prilocaine 2.5% cream in a five-gram tube
 - Lidocaine HCL solution in a concentration of 1% in a two-milliliter vial
2. The Agency will administer the ordered drug in accordance with a specific treatment protocol for that disease/medication.
 3. The Agency will maintain a written record of the dates and times the container is in the possession of a registered nurse or a licensed vocational nurse.
 4. Physician orders for administration of the above drugs shall be handled in the following manner:
 - a. Verbal Physician orders prior to administering.
 - b. No later than 24 hours after receipt of the order, reduce the order to a written form and send a copy of the order to the dispensing pharmacy and original order to physician for his signature.
 - c. No later than 20 days after receipt of the order, send a copy of the signed physician order to the dispensing pharmacy.
 5. A pharmacist that dispenses a sealed portable container of the above drugs will ensure that the container:
 - a. Is designed to allow access to the contents of the container only if a tamper-proof seal is broken.
 - b. Bears a label that lists the drugs in the container and provides notice of the container's expiration date, which is the earlier of:
 - The date that is six months after the date on which the container is dispensed.
 - The earliest expiration date of any drug in the container.
 - c. Remains in the pharmacy or under the control of a pharmacist, RN or LVN.
 6. When an Agency/employee purchases, stores or transports a sealed portable container of the above drugs, the Agency shall deliver the container to the dispensing pharmacy for verification of drug quality, quantity, integrity, and expiration date not later than the earlier of:
 - a. The seventh day after the date on which the seal on the container is broken, or
 - b. The date for which notice is provided on the container label.
 7. Dispensing pharmacy responsibilities:
 - a. Verification of quality, quantity, integrity, and expiration dates.
 - b. Inventory of drugs used from the container.
 - c. Restock and reseal the container before delivering the container to the Agency for reuse.
 8. Any discrepancies between the pharmacy and Agency data are addressed with the pharmacy prior to delivery.
 9. Other transported drugs:
 - a. The patient's name and address must be included on the delivery container label with a packing list enclosed listing all prescription and nonprescription items.
 10. If medication requires refrigeration for stability, medications must be dispensed for transport by pharmacy /Agency in a cooler with coolant packs.
 11. Cytotoxic drugs should be appropriately labeled as hazardous and cytotoxic agents, and the staff member delivering the medication should have a chemotherapy spill kit for use in transport and know how to use the spill kit.
 12. The employee documents transportation in the clinical record.

HCL TX.17 chap Rvd 050107

DISCONTINUED MEDICATIONS

TX.18

PURPOSE

To establish a process for appropriately handling discontinued drugs to ensure patient safety.

POLICY

Agency nurse will instruct the patient/caregiver in the proper technique for disposal of discontinued medication. Agency recognizes and respects that the medications utilized in the home are the property of the patient.

PROCEDURE

1. Agency will instruct the patient/caregiver on the policy concerning discontinued medication.
2. Agency will notify the patient/caregiver of the medication discontinuation order and will instruct the patient/caregiver on specific disposal techniques as indicated.
3. If a staff member, with patient's/caregiver's approval, participates in the disposal of medication, the method of disposal and amount disposed is documented and witnessed in the medical record.
4. Agency will notify the patient's physician and/or pharmacist if a patient/ caregiver refuses to dispose of a medication and it is suspected that the patient/caregiver and/or home environment indicates one of the following:
 - medication misuse;
 - medication abuse; or
 - Potential improper disposal of a hazardous waste material.

HCL TX.18 chap Org 050197

INVESTIGATIONAL MEDICATIONS/TREATMENTS

TX.19

PURPOSE

To identify the process for Agency participation in investigational medication studies to ensure patient safety and in accordance with applicable federal and state laws and regulations.

POLICY

Agency will individually review each opportunity to participate in investigational medication studies.

Agency administrator, medical director, and an RN will review the study opportunity.

Participation and approval is conditional upon the following:

1. Agency will review and approve the administration and monitoring protocol.
2. Trained, competent staff that is approved by the principal investigator will be available for medication administration as needed.
3. Documentation of the patient's informed consent, either directly or through the principal investigator, will be obtained.
4. The availability of the medication and the provision of its safe delivery to the patient's residence.
5. The ability of Agency's "Information Management System" to retrieve data regarding patient participation.
6. Agency does not handle investigational medications as far as procurement, compounding, and/or dispersing.

PROCEDURE

1. Agency will gather all data/information needed to make an informed decision regarding whether or not to participate in the investigational study.
2. Agency will notify the appropriate individuals involved of the decision.
3. Documentation of the patient's informed consent will be acquired and retained in the patient's medical record.
4. Agency will follow appropriate, approved clinical procedures for administering the treatment and/or disposing of the medication and/or for performing.
5. Medical record documentation adheres to Agency's policy/procedures as well as any additional specific requirements by the primary investigator.
6. Reports will be written and sent as required by the primary investigator.

HCL TX.19 chap Org 050197

REPORTING/FOLLOW-UP OF MEDICATION INCIDENTS

TX.20

PURPOSE

To outline the process for the management of medication incidents.

POLICY

Agency recognizes that two types of medication incidents are possible:

1. Medication errors related to an error in the administration of the medication by staff and/or by patient.
2. Adverse reactions related to the combination of pharmacological properties and the individual patient's

metabolism.

Agency defines medication errors that warrant reporting and possible follow-up as:

1. Any medication omission by a licensed nurse.
2. Any error in route, dosage, or frequency by a licensed nurse.
3. Any incident involving administering the wrong medication by a licensed nurse.
4. Any error involving omission of medication for three or more consecutive doses by the patient.

Agency defines adverse reactions that warrant reporting and possible follow-up as:

1. Any medication which elicits specific signs and symptoms of a reaction not directly associated with that medication.
2. Those adverse reactions which elicit the following signs and symptoms:
 - 2.1 Central Nervous System: headache, tremors, dizziness, muscle spasm, confusion
 - 2.2 Gastrointestinal: nausea, vomiting, diarrhea, cramps, abdominal pain
 - 2.3 Skin: rash, flushing
 - 2.4 Cardiovascular: dizziness, hypotension, dysrhythmia, tachycardia, bradycardia
 - 2.5 Respiratory: shortness of breath, dyspnea on exertion, respiratory depression

PROCEDURE

1. MEDICATION ERRORS

- 1.1 A licensed nurse involved in or discovering a medication error will report it immediately to the Agency supervisor.
- 1.2 If the patient is in immediate danger, the appropriate emergency response is initiated.
- 1.3 The patient's physician will be notified of the medication error.
- 1.4 Internal reporting includes completing an "Occurrence Report" as defined on the "Occurrence Report" form and documentation is completed for medication error as defined in Agency policy.
- 1.5 All occurrences will be reviewed as part of the PI function at least quarterly with trends noted.
- 1.6 Performance improvement activities will be initiated if review of errors indicates the need.
- 1.7 External reporting includes notification of pharmacist, supplier, and/or manufacturer when an error occurs as a result of medication packaging, labeling, delivery, etc.

2. ADVERSE REACTIONS

- 2.1 A licensed nurse involved in or discovering the adverse reaction will report it immediately to the supervisor/ Patient Care Manager.
- 2.2 If an adverse reaction occurs after hours/between visits, the agency staff will report and document upon discovery
- 2.3 If the patient is in immediate danger, the appropriate emergency response will be initiated.
- 2.4 The patient's physician will be notified of the adverse reaction, and any orders obtained at this time from the physician for the administration of medications and/or treatments in response to the adverse reaction will be followed as specified by the physician.
- 2.5 The patient/caregiver will be provided with related instructions as each physician's order and/or circumstance dictates.
- 2.6 All occurrences will be reviewed as part of the PI function at least quarterly with trends noted.
- 2.7 Internal reporting includes completing an "Occurrence Report" and documentation is completed for adverse reactions as defined in the policy.
- 2.8 Performance improvement activities will be initiated if review of adverse reactions indicates the need.
- 2.9 External reporting includes notifying the pharmacist of significant adverse reactions.

HCL TX.20 chap Rvd 020102

AGENCY STORING OF MEDICATION

TX.21

PURPOSE

To outline Agency responsibilities to ensure safe storing of medications in accordance with applicable federal/state laws and regulations.

POLICY

Agency will not store any medication stock for patient use at the Agency's office environment.
Agency staff will not carry as a part of supply stock any medications (i.e., heparin, anaphylaxis kit, etc.).

Emergency drugs will be delivered by IV Company to home per M.D. order, when applicable. Agency staff may carry above in accordance with policy TX 19.

HCL TX.21 chap Rvd 040101

ADMINISTRATION OF BLOOD/BLOOD PRODUCTS POLICY

TX.22

Agency does not administer blood or blood products.

HCL TX.22 chap Rvd 090100

NUTRITIONAL MANAGEMENT PURPOSE

TX.23

To outline the basic principles for nutritional management that are needed to provide nutritional services in an interdisciplinary manner and to meet the patient's unique needs.

POLICY

Agency will obtain from the patient's physician a diet order for specialized diets, enteral therapy, and parenteral nutrition. A diet order comes under the same requirements as a medication order.

When the patient is determined at the initial assessment to be a moderate or high nutrition risk and nutrition care planning is more complex, an interdisciplinary approach to nutrition care planning will occur by telephone conference with physician, an appropriate pharmacist, other RN's, and/or local dietitians or nutritionists at other health care organizations.

PROCEDURE

1. Agency will obtain order in accordance with Agency policy/procedure that are specific to patient diet and nutritional therapy needs.
2. The ordered diet/nutritional therapy will be documented in the patient's medical record and communicated to all staff involved in care of the patient.
3. The patient/caregiver will be assessed for willingness and capability to participate in the diet/nutritional therapy protocols and procedures.
4. The patient/caregiver will be educated to the ordered diet/nutritional therapy protocols and procedures as deemed appropriate.
5. Agency staff will evaluate the patient's progress toward the established goals and document this process in the patient's medical record.
6. This progress, or lack of progress, will be communicated to the appropriate individuals involved in the patient's care.
- 7 The Agency will ensure that any nutritional products in the organizational environment are properly maintained.
8. When Agency staff is responsible for nutrition preparation, Agency will ensure that any food or nutritional products will be safely prepared and stored. This will include but not limited to:
 - Protection of food and nutrition therapy solution from contamination and spoilage.
 - Storage of food and nutrition therapy solutions at proper temperature, using appropriate thermometers and maintained temperature records, when appropriate.
 - Control of lighting, ventilation and humidity to prevent condensation of moisture and the growth of molds, as appropriate.
 - Thorough cleaning and sanitizing all work surfaces, supplies and equipment after each use.
 - Appropriate hand washing before, during and after preparation of food and/or nutritional solutions.
 - Instruction/education to Agency personnel/HHA ordered to assist in meal preparation.

HCL TX 23 chap Rvd 033001

USE OF RESTRAINTS PURPOSE

TX.24

To establish guidelines on the appropriate use of restraints and education in the home care setting.

POLICY

Restraints may be used to protect the patient from injury and/or to prevent the patient from injuring others.

Agency licensed health care personnel will assess the need for use of restraints on admission and on an ongoing basis, and will provide instruction to patient/caregiver on the purpose, risks, application, safety, and care of the restrained patient.

DEFINITIONS

Restraint - A method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body.

Supportive device - A device used to posturally support or assist in maintaining normative bodily functioning and position are not considered restraint interventions. Supportive devices may include vests, belts, table top chairs, or bed rails.

PROCEDURE

1. The licensed health care personnel will assess for the need or use of restraints during the initial assessment and on an ongoing basis. The assessment will include the following about the patient's:

- Physical/mental condition and patient's functional ability
- History of falls
- Safety of residence
- Ability to communicate
- Support systems
- Emotional condition
- Cognitive functioning level
- Age, height, weight

NOTE: The home health aide/homemaker is not allowed to initiate the use of restraints. They may participate in the care of a patient if they have completed appropriate training by the RN with home health experience and have demonstrated competence in caring for a patient with restraints.

2. The guidelines for restraint use in the home are as follows:

2.1 A caregiver who:

- Is present at all times
- Has received instruction on use of the restraint
- Frequently monitors the patient for safety

Discharge notice will be given if patient/caregiver is noncompliant with the Plan of Care in regards to restraints. The physician will be notified.

2.2 A physician order for restraint use in the home. The written order must include:

- Clinical justification for the restraint
- Specific duration

2.3 A determination must be made as to the least restrictive restraint to use.

Document on appropriate form.

- Use the minimal amount of force or pressure that is reasonable and necessary to ensure the safety of the patient and others.
- Safeguard the patient's dignity, privacy, and well-being.

2.4 Alternatives to restraint use will be discussed with patient/caregiver.

2.5 Provide opportunities for questions and address any concerns regarding restraints from the patient/caregiver.

2.6 Restraint reassessment will be ongoing with appropriate documentation determining need for continuing restraint or the possibility of restraint reduction. Physician will be notified if appropriate.

2.7 Restraints will not be used in a manner that:

- ▶ Obstructs the patient's airway, including the placement of anything in, on, or over the patient's mouth or nose;
- ▶ Impairs the patient's breathing by putting pressure on the patient's torso;
- ▶ Interferes with the patient's ability to communicate;
- ▶ Places the patient in a prone or supine position;
- ▶ Extends muscle groups away from each other;
- ▶ Uses hyperextension of joints;

- ▶ Uses pressure points or pain; or
 - ▶ Secures the patient to a stationary object while the patient is in a standing position.
3. The patient/caregiver will be educated regarding the use of physical restraints to include the following:
 - Appropriate indications for the use of restraint
 - Importance of measuring the restraints
 - Potential risk factors/complications associated with restraint use
 - Attention to the needs of the patient in restraints:
 - Observation of the extremity and dependent areas every two hours for position, circulation and skin integrity. Range of motion exercises every two hours to restrained limb, unless contraindicated.
 - Importance of frequent position change.
 - Devices will be released every two hours and reapplied as necessary.
 - Appropriate activities of daily living, such as hygiene, elimination, and nutrition.
 4. The patient/caregiver will be educated regarding the use of chemical restraints to include the following:
 - Purpose of medication
 - Actions and uses of psychoactive drug
 - Side effects
 - Safety issues
 5. Documentation requirements:
 - Justification for use of restraints must be documented in the nursing progress note; to include alternatives to restraints and patient condition that warrants use of restraints.
 - Patient/caregiver instruction will be documented on the appropriate form.
 6. If abuse of restraint is determined, a discharge order will be given and the physician, as well as appropriate authorities, will be notified by the agency.

HCL TX.24 chap Rvd 081006

PHYSICIAN RESPONSIBILITIES POLICY

TX.25

To define the responsibilities of physicians who manage the medical care of Agency patients.

PROCEDURE

1. Agency will provide a written statement of the physician's and Agency's responsibilities regarding the patient care process, as well as any related Agency policies/procedures, to the physician upon receipt of the first referral from the physician.
2. Agency will educate the physician (at least annually, but more frequently if indicated) regarding any changes in these responsibilities and/or related Agency policies/procedures.

PHYSICIAN'S RESPONSIBILITIES

Physician responsibilities in assisting with the provision of medical care by Agency staff include, but are not limited to, the following:

1. To participate in the care planning process upon initial plan, subsequent updated plan and as appropriate when the patient's condition warrants.
2. To provide explicit information and timely home care orders for the benefit of the patient.
3. To define the parameters as to when the physician wants to be contacted with regard to changes in the patient's condition.
4. To inform Agency of the most convenient time for physician contact or the communication alternative in regard to the patient.
5. To make Agency aware of the availability of physician medical coverage for the patient and inform Agency who to contact after hours or in case of an emergency.
6. To inform Agency of any referrals made to other organizations or specialty physicians which may affect the care Agency gives the patient.
7. To answer reasonable requests for any additional patient information pertinent to continuity of care, and designate the hospital to be used in emergency care.
8. To determine the frequency of patient contact.

9. To sign orders on a timely basis in 30 days.
10. To join Agency in observing the Patient's Rights.
11. To receive and review periodic clinical updates at least every 60 days.

HCL. TX.25 CHAP Rvd 030102

PHYSICIAN LICENSURE VERIFICATION

TX.26

PURPOSE

To ensure that all attending physicians have an active license to practice medicine.

POLICY

All physician signing orders for home health care patients must have a current license to practice medicine in accordance with state and federal laws and regulations.

PROCEDURES

Agency will verify physicians' licenses by one of the following methods:

1. Maintaining a current list of active physicians licensed in the state.
2. Obtaining annual verification of active licensure from state licensing boards via internet or written documentation.
3. Maintaining verification from hospitals of staff physicians' licensure status.
4. Contacting the appropriate State Board of Licensure for verification of new physicians.

Agency will mail a copy of Policy TX.25 Physician Responsibilities with a cover letter to all physicians upon initial referral.

HCL TX.26 CHAP Rvd. 010207

G-TUBE FEEDINGS BY UNLICENSED PERSONNEL

TX.27

POLICY

Agency does not permit unlicensed personnel to perform G-tube feedings.

HCL / TX.27 chap Rvd. 020104

AGENCY PHILOSOPHY ON PATIENT EDUCATION

PF.1

PURPOSE

To address the need for a systematic approach to education in relation to the patient's plan of care, level of care, setting in which teaching occurs, and continuity of care.

POLICY

Agency will strive to improve patient health outcomes by promoting recovery, facilitating comfort and return to function, promoting healthy behavior, and involving the patient/caregiver in health care decisions.

PROCEDURE

1. Education to improve health outcomes as appropriate to the care provided by Agency will be accomplished by:
 - Assessing patient/caregiver understanding of the patient's health status, health care options and consequences of selected options;
 - Encouraging patient/caregiver participation in health care decision-making;
 - Assessing patient/caregiver potential to follow the Plan of Care;
 - Assessing patient/caregiver ability to cope with the patient's health status/prognosis/outcome;
 - Encouraging patient/caregiver role in continuing care;
 - Providing patient/caregiver with reference data and educational tools appropriate to patient's health status; and
 - Coordinating patient/caregiver educational needs with all disciplines involved in the Plan of Care and care provided.

HCL PF.1 chap Org 050197

ASSESSMENT FOR PATIENT EDUCATION

PF.2

PURPOSE

To plan, support and coordinate the provision of patient/caregiver education, activities and resources specific to the patient's assessed needs, abilities and readiness to learn as appropriate to the care provided to promote and

maintain health and improve outcomes.

POLICY-

Agency will establish and individualize patient education based on the setting in which the patient is taught, the type of patient requiring education, available education materials, and the various disciplines involved in the patient's care.

PROCEDURE

1. An assessment of patient/caregiver education needs will be accomplished by:
 - Identifying education needs prior to hospital discharge and admission to Agency (if applicable);
 - Providing patient/caregiver with reference data regarding home health care and Agency's scope of services;
 - Identifying the need for community resource involvement; and
 - Identifying patient/caregiver ability to comprehend and implement information taught.
2. The assessment will provide data/information that can be utilized by all disciplines in establishing and coordinating a plan of education which will allow the patient/caregiver to:
 - Learn skills and behaviors that promote recovery and maintain or improve function, or manage disease progression;
 - Gain knowledge to meet ongoing health care needs within the framework provided by Agency;
 - Recognize and use appropriate community resources; and
 - Comprehend and implement information taught.

HCL PF.2 chap Org 050197

CONTINUOUS INTERDISCIPLINARY PATIENT EDUCATION

PF.3

PURPOSE

To provide consistent, standardized information to the patient/caregiver based on a continuous assessment and prioritization of patient/caregiver's learning needs, abilities, and readiness.

POLICY

Agency will provide ongoing assessment and analysis of data/information related to patient/caregiver learning needs and abilities that include cultural and religious practices, emotional barriers, desire and motivation to learn, physical/cognitive limitations, and language barriers.

PROCEDURE

1. All disciplines, whether Agency staff or contracted employees, who are involved in the care of the patient, will plan, prioritize and coordinate the implementation of patient education on an ongoing basis which will include:
 - A formal and/or informal teaching plan appropriate to specific subject/knowledge/skills being taught which meet the ongoing health care needs and interventions of the patient; and
 - Return demonstrations by patient/caregiver.
2. All disciplines involved in the patient's Plan of Care will assess/monitor the patient's/caregiver's knowledge/performance of skills and behaviors and document in the patient's medical record.
3. Re-education and alternative educational tools will be implemented as needed.
4. Continuous patient education will be facilitated by all disciplines involved in the patient's Plan of Care through the following:
 - Coordination of periodic interdisciplinary case conferences (to include contract services);
 - Effective measurement of individual discipline goals;
 - Identifying and prioritizing patient/caregiver learning needs;
 - Appropriate discipline teaching necessary skills and behavior needed to improve patient's health outcomes; and
 - Flexibility of disciplines in teaching based on the patient's/caregiver's choice to comply or not to comply with instruction.
5. Interdisciplinary patient education will reflect consistency of information provided through:
 - Teaching materials used by each discipline;
 - Verbal instruction by each discipline;
 - Community resources used for teaching;

- Aids used to meet specialized needs;
- Expected patient outcomes; and
- Assessment of educational needs.

HCL PF.3 chap Org 050197

PATIENT EDUCATION TO AGENCY AND COMMUNITY RESOURCES

PF.4

PURPOSE

To ensure the patient/caregiver has the information needed to access available Agency/community resources and services to meet the patient's ongoing health care needs.

POLICY

Agency will provide up to date information regarding care provided by Agency as well as other resources/services available throughout the community.

PROCEDURE

1. Agency staff will identify the patient's/caregiver's educational needs.
2. Agency will select and provide appropriate educational resources to meet the patient's/caregiver's needs.
3. Agency will document the patient's/caregiver's response to the educational resources.
4. Educational resources available for Agency staff and patient/caregiver use will include, but are not limited to:
 - Qualified members of the health care team;
 - Various teaching materials;
 - Formal and informal methods of teaching;
 - Use of community resources for teaching; and
 - Use of special devices, interpreters and other written/visual aids to meet specialized needs.

HCL PF.4 chap Org 050197

PATIENT CARE SITE AND PATIENT SAFETY EDUCATION

PF.5

PURPOSE

To ensure the identification of patient/caregiver education needs and the provision of appropriate educational information.

POLICY

Agency will provide the needed education in response to specific identified needs in the following areas:

- Home safety;
- Infection prevention/control; Medications;
- Medical gases;
- Hazardous materials/wastes;
- Rehabilitation; and
- Natural disaster/emergency.

PROCEDURE

1. Agency staff will assess upon admission the patient's environment for the areas defined in policy. Specific elements will include but not be limited to:

1.1 Home Safety:

- Fire response,
- Electrical safety,
- Environmental/mobility safety, and
- Bathroom safety;

1.2 Infection Control Prevention:

- Universal precautions and
- Signs/symptoms to report;

1.3 Medications:

- Name and description of medications,
- Dosage, route of administration, duration of drug therapy,

- Special directions and precautions for preparation, self-administration, and use of medications
- Therapeutic contraindications that may be encountered - including action required if these occur,
- Techniques for self-monitoring of drug therapy,
- Proper storage and expiration dating of medications provided,
- Prescription refill information,
- Action taken in the event of a missed dose,
- Proper disposal of unused or expired medications, especially controlled substances and cytotoxic and hazardous agents,
- Potential drug/food interactions and nutrition counseling/intervention and/or modified diet,
- Use of puncture resistant needle containers (Sharps disposal) and
- Any other information specific to the patient and/or the patient's medication therapy;

1.4 Medical Gases:

- Storage of medical gas cylinders in a stable, protected area (e.g. protected from heat extremes), and
- Response to emergency situations and/or accidents in the patient's place of residence;

1.5 Hazardous Materials/Waste:

- Identification, handling, and disposal of hazardous materials,
- Appropriate use of gloves and protective clothing,
- Use of puncture-resistant needle containers,
- Appropriate bagging of soiled dressings, and
- Proper handling and disposal of containers, supplies, and other materials containing or exposed to cytotoxic or hazardous drugs;

1.6 Rehabilitation:

- Home exercise programs,
- Safe transfers, and
- Activities of daily living;

1.7 Natural Disaster/Emergency Plan:

- Actions and responsibilities of agency staff during/immediately following an emergency;
- Patient's/Family's responsibilities in the agency's Emergency Preparedness and Response Plan;
- List of community disaster resources that can assist a patient during a disaster-related emergency;
- Materials that describe survival tips and plans for evacuation and sheltering in place.

2. The educational needs will be prioritized and incorporated into the patient's Plan of Care.

3. The educational information will be presented, and patient/caregiver response assessed and documented in the patient's medical record.

4. Referrals will be made if needed.

5. After 2 months of instruction, if the patient/caregiver is unwilling to implement the measures to correct or improve the identified hazard, Agency will only be responsible for assessing and documenting the continued presence of the hazard, the educational measures taken, the patient/caregiver's choice, the patient/caregiver's understanding of instructions.

6. The home environment will be re-evaluated for safety issues/hazards on an ongoing basis.

HCL / PF.5 ch Rvd. 040108

AGENCY PHILOSOPHY ON MANAGEMENT OF THE ENVIRONMENT

EC.1

PURPOSE

To address the need for coordination of activities involved in the management of environments.

POLICY

A. Agency will strive to maintain the safety of environments, both patient care sites and Agency site(s).

1. Maintaining safety of environments involves:

- Managing the environments of care, teaching staff and patients;
- Implementing procedures to manage the environment of care;
- Measuring and assessing collected data/information; improving the management of the environment of

- care;
- Reducing and/or controlling environmental hazards and risks associated with care provided to the patient; and
- Preventing accidents and injuries to patients and Agency staff.

HCL EC.1 chap Org 050197

SMOKE-FREE ENVIRONMENT

EC.2

PURPOSE

To establish a smoke-free work environment.

POLICY

Agency employees and visitors will not smoke in any Agency-owned vehicle or at any Agency site except in designated outside areas.

Agency employees will not smoke at any time while providing patient care or in the patient care environment.

PROCEDURE

During orientation, all employees will be educated regarding the smoke-free environment policy.

HCL EC.2 chap Org 050197

MANAGEMENT OF THE ENVIRONMENT PROGRAM

EC.3

PURPOSE

To outline the elements needed in the Management of Environment of Care.

POLICY

Agency recognizes two separate environments in the provision of care:

- The site of patient care, and
- The agency which includes any Agency office or Agency- owned vehicle.

The management of environment will include the following elements specific to each site:

- Safe Environment
- Worker Safety
- Secure Environment
- Hazardous Materials/Waste
- Emergency Preparedness
- Fire
- Equipment/Supply Management
- Utilities Management

PROCEDURE

A. Patient Care Sites

1. Agency staff will assess the patient care environment upon admission, and if patient environment changes, for all elements listed in the policy and will document findings in the patient's medical record.
2. Follow-up educational activities and goals will be established and referrals made when appropriate.
3. Staff interventions and progress toward goals will be documented in the clinical progress notes and/or the case conference notes.
4. When it is determined the patient has chosen not to adhere to Agency teaching, this decision will be documented in the patient's medical record and further interventions will primarily be for assessment.

B. Agency Site(s)

1. Each Agency site will be assessed to identify any environmental hazards and/or unsafe practices, to include ergonomics.
2. The report data will be reviewed by a management/specific committee. Identified areas for review or recommendations for improvement will be reported to the Director of Home Health Services.
3. It is then the responsibility of the Director of Home Health Services to ensure appropriate follow-up measures.

HCL EC.3 chap Rvd 040401

SAFETY AND WORKPLACE VIOLENCE

EC.4

To identify potential safety hazards and educates patients and staff.

POLICY

Agency will promote safety and strive to reduce the potential for patient and/or staff injury in both the home and Agency environments.

Agency will educate the patient regarding safety issues.

The Agency does not tolerate violent behavior or threats in the workplace. Guns and weapons of any kind are not allowed in the workplace.

A. Definition

1. Workplace can be the Home health office, the patient's home, a healthcare facility or anywhere business is conducted.

B. Rationale

1. OSHA has produced voluntary guidelines for healthcare workers in response to the serious problems of violent assaults in healthcare workplaces. Home health providers can be cited for failure to recognize workplace violence.

2. OSHA's guidelines for workplace violence prevention programs for healthcare workers identified three "risk factors" which include:

- Environmental - this risk factor includes the prevalence of hand guns, a decrease in availability of medical attention to the mentally ill, patients right to refuse medication, and sites which contain medication or money and are viewed as a source to rob.
- Administrative and Work Practices - this risk factor includes shortages in staff, reduction of trained regular staff, working alone at night or in a remote area, and poorly lit parking areas.
- Perpetrator and Victim - people with a history of violence, people seeking revenge, gang members, drug or alcohol, social deviants, or individuals who feel threatened and desperate.

PROCEDURE

SAFETY

A. Patient Care Site

1. Agency staff will assess the patient care environment upon admission, and if the patient environment changes, and will document findings in the patient's medical record. These will include:

- Fire response
- Electrical, environmental
- Mobility
- Bathroom safety
- Medication safety risks related to patient care
- Equipment used by the patient within the patient's environment

2. Follow-up educational activities and goals will be established and referrals made when appropriate.

3. Staff interventions and progress toward goals will be documented in the clinical progress notes and/or case conference notes.

4. When it is determined the patient has chosen not to adhere to agency teaching, this decision will be documented in the patient's medical record and further interventions will primarily be for assessment.

B. Agency Sites(s)

1. Agency site will be assessed to identify any environmental hazards and/or unsafe practices.

2. The report data will be reviewed by management. Identified areas for review or recommendations for improvement will be reported to the Director of Home Health Services.

3. It is the responsibility of the Director of Home Health Services to ensure appropriate follow-up measures.

4. The Agency will document all work-related injuries on an "Occurrence Report" and log on the Appropriate OSHA form. Agency will follow OSHA regulations on reporting.

5. If an employee experiences a work-related injury, he/she will choose an approved physician from Agency's panel for evaluation and follow-up.

6. Agency will evaluate the circumstances surrounding the injury for continued potential risks and initiate performance improvement activities as indicated.

WORKPLACE VIOLENCE

A. Agency management should evaluate and implement the appropriate control measures for the agency.

B. These control measures can include, but not be limited to the following:

- To provide some measure of safety and to keep the employee in contact with headquarters or a source of assistance, cellular phones should be provided for official use when the staff must go into private homes and the community.
- All field personnel should carry hand-held alarm or noise devices or other effective alarm devices.
- Protective devices, such as pepper spray, should be evaluated and provided if appropriate. Staff should be trained to use the devices appropriately.
- Employees should be told not to enter any location where they feel threatened or unsafe. The employee must make this decision based upon procedures that have been developed to help them evaluate the relative danger in a given situation.
- Managers should facilitate a "buddy" system or escort services for hazardous situations. Use of this "buddy" system or escort service should be required whenever an employee feels insecure regarding the time of the activity, the location of work, the nature of the client's health problem, patient or family history of aggressive or assaultive behavior, or potential for aggressive acts.
- Field staff should prepare a daily work plan and keep the contact person at the Agency informed as to their location throughout the work day. This work plan would enable supervisors to locate the individual in emergency situations.
- Procedures should be established to reduce the likelihood of assaults and robbery from those seeking drugs, alcohol, or money, as well as procedures to follow in the case of threatening behavior.
- All incidents of threats or other aggression must be reported and logged. Records should be maintained and analyzed in order to prevent future security and safety problems, and to develop appropriate training courses.
- Employers should provide for the field staff a program of personal safety education. At a minimum, this could be a safety seminar offered by local police departments or other agencies. This training should include awareness, avoidance, and action to take in order to prevent mugging, robbery, rapes, and other assaults.
- The employer should respond to incidents of assault promptly and discuss the circumstances with all staff members.
- When agencies provide equipment used in the field, including automobiles, it should be well-maintained.
- Employees should be encouraged to carry only absolutely required identification and money.
- When staff must visit clients who are located in high-rise building that seem to present security hazards, they should exercise special care in elevators, stairwells, and unfamiliar residences.
- Home health service providers should establish policies to provide services in a clearly hazardous situation.

C. Management will treat all threats as serious. A threat assessment should be performed to determine if the purpose of the threat is to intimidate or to actually cause harm. Appropriate measures will be taken to provide protection.

D. If violence is about to occur or is already in progress, call the local law enforcement agency immediately. Contact the Administrator next.

Do not try to handle a violent person.

Resource:

Workplace Violence Coordinator, OSHA, U. S. Department of Labor, 200 Constitution Avenue, N.W., Room N-3107, Washington, D.C. 20210; (202) 219-803 1, ext. 111.

HCL EC.4 chap Rvd 092205

OCCURRENCE REPORTING

EC.5

PURPOSE

To establish a consistent documentation and reporting process, in consideration of all federal/state laws and regulations, and to define those occurrences that require reporting.

POLICY

Agency will document and report all occurrences (accidents, injuries, safety hazards, employee unprofessional and misconduct) that deviate from routine Agency operations and might result in injury or potential harm to a patient/caregiver or Agency staff.

Adverse Events include, but are not limited to:

- provision of care errors, i.e., procedure error which results in trauma and/or injury, attended falls, medication errors, user error related to equipment
- unusual occurrences, i.e., equipment and/or medical device failure, untoward outcome, including drug reactions and intravenous therapy complications
- vehicular crashes/motor vehicle accidents involving a company vehicle or the employee's vehicle while on company business
- other types of accidents or injury, i.e., loss and/or breakage, personal injury from lifting, falling, or transporting equipment
- safety hazards that endanger staff and/or patients
- unprofessional conduct by licensed staff and employee misconduct of unlicensed staff including abuse, neglect and exploitation
- noncompliance and/or refusal of treatment

Serious Adverse Events include, but are not limited to:

- unexpected death not resulting from the patient's medical condition
- loss of body part
- permanent or partial loss of body function
- blindness

No copies will be made of this report and confidentiality of involved individuals will be maintained.

PROCEDURE

1. An Occurrence Report will be completed on all occurrences, as defined in policy, by the staff member involved or the first person to become aware of the incident.
2. The report will be submitted to the immediate supervisor.
3. The supervisor will review the Occurrence Report and will document awareness of the occurrence.
4. The Agency will ensure all applicable federal/state reports/forms are completed (i.e., OSHA No. 200).
5. The Occurrence Report will be forwarded to Management and QAPI Committee for the purposes of reviewing, analyzing, aggregating, trending, and making performance improvement recommendations.
6. Follow-up data needed to resolve the occurrence (e.g., lab reports, physical exams, police reports), will be collected by the supervisor and sent to QAPI Committee.
7. A file will be maintained of all reported Occurrence Reports, as well as any additional data/information pertaining to the Occurrence Report(s).
8. The QAPI Committee will review, analyze, trend the Occurrence Reports on a quarterly and establish performance improvement action plans as needed.

HCL EC.5 CHAP Rvd. 022805

SECURITY

EC.6

PURPOSE

To ensure potential unsafe situations related to the provision of pertinent care and/or Agency sites will be identified, reported and investigated when applicable.

POLICY

Agency recognizes the potential for compromised security in the provision of home care. Agency will strive to decrease this potential and promote the security of both patient and staff.

PROCEDURE

A. Patient Care Sites

1. Upon admission to Agency, and on an ongoing basis, the patient's residence will be assessed for any potential security risks to the patient or the staff.
2. Agency staff will educate the patient/care giver regarding any identified patient security risk.
3. Agency staff will report any noted security risks to the supervisor.

4. This will be documented in the patient's medical record.
5. All staff involved will be notified of any potential security risks and the determined measures to minimize them.
6. The staff will be responsible for following the determined measures, which may include, but not be limited to:
 - A visit made jointly by two (2) staff member;
 - Obtaining an escort if necessary;
 - Making visits during daylight hours;
 - Contacting the physician if no visit is to be made; and/or
 - Holding a case conference to initiate a referral/transfer/discharge if it is determined that the security risk prevents the safe provision of patient care.
7. Any security occurrence will be reported and investigated.

B. Agency Sites

1. Agency site is designed or adapted to maximize the security of the staff (e.g., adequate lighting at entrances).
2. Agency will educate the staff regarding appropriate security measures upon hire and annually thereafter.
3. Agency staff will report any identified potential security risk to Management.
4. Management will be responsible for follow-up of any reported potential risks.
5. Any security occurrence will be reported and investigated.

HCL EC.6 chap Org 050197

HAZARDOUS MATERIALS/WASTE

EC.7

PURPOSE

To provide for the safe, appropriate handling and disposal of hazardous materials/waste.

POLICY

The Agency will comply with federal/state/local laws and regulations regarding the identification, handling, transportation, and disposal of hazardous materials/waste.

The Agency will educate the patient/caregiver, both verbally and in writing, of appropriate disposal of waste in the home.

The Agency will contract for pick-up and disposal of sharps that are returned to the office by staff.

Hazardous materials/waste include but are not limited to:

- Chemotherapy agents
- Blood products and blood-soaked items
- Infectious waste
- Laboratory specimens
- All materials and wastes that require special handling (i.e., sharps)
- Medical gases

PROCEDURE

A. Patient Care Site

1. The staff will assess the patient's Plan of Care for the need to address hazardous material/waste.
2. The patient care site will be assessed for the presence of appropriate supplies and information in the event of an exposure occurrence (e.g., disposal bags and PPE for chemotherapy administration).
3. If needed, Agency staff will communicate the need for hazardous materials/waste disposal supplies to the appropriate agency (e.g., calling the infusion company for chemotherapy disposal containers).
4. Agency will implement appropriate work practice controls, engineering controls, and PPE in provision of patient care. This includes labeling all transportation containers with the "BIOHAZARDOUS" label.
5. Agency will educate the patient/caregiver regarding disposal of hazardous waste in the home to include:
 - Placing all needles and syringes in a hard plastic or metal container with a screw top or re-enforce top with

heavy duty tape.

- Placing soiled bandages, disposable pads/sheets and medical gloves, masks and gowns in securely fastened plastic bags before placing them in the garbage can with other trash.

6. Agency will educate the patient/caregiver regarding medical gases to include:

- Storage of medical gas cylinders in a stable, protected area (e.g. protected from heat extremes).
- Response to emergency situations and/or accidents in the patient's place of residence.

7. In the event of exposure to a hazardous material, Agency will:

- Implement immediate action as indicated by the type of hazardous material (see Material Safety Data Sheet manual, as appropriate),
- Notify the Management,
- Refer to Exposure Control Plan, Blood borne Pathogens Plan, and/or Airborne Pathogens Plan,
- Seek follow-up care as necessary; and
- Complete an Occurrence/Incident Report.

B. Agency Site

1. Agency will assess for the need to safely handle/dispose of hazardous materials waste (e.g., enclosed area for centrifuging blood specimens, arrangements for disposal of sharps).

2. Agency will provide the necessary supplies, environment or services to meet any needs identified in No. 1.

3. Agency will provide in-services to staff upon hire and annually thereafter on all policies/procedures related to the identification, handling, transportation, disposal and exposure to hazardous materials/waste.

4. All areas with hazardous materials/waste within the Agency site are identified with the appropriate signs/labels.

5. In the event of exposure to a hazardous material, the Agency staff will:

- Implement immediate action as indicated by the hazardous material (Material Safety Data Sheet manual),
- Notify the Management,
- Refer to Exposure Control Plan, Blood borne Pathogen Plan and/or Airborne Pathogen Plan
- Complete an Occurrence Report (see Occurrence Reporting policy).

6. Disposal of chemotherapeutic agents:

6.1 Employee will wear latex, non-powdered gloves when cleaning and/or disposing of all materials exposed to chemo-therapeutic agents.

6.2 Do not dispose of unused drug(s) or contaminated solutions in drains or toilets. Use the original vial, intravenous bag/bottle or other closed container for liquid waste.

6.3 Do not clip needles, crush, or disassemble the syringe or intravenous tubing. Dispose of all contaminated equipment intact to prevent aerosolization, leaks and spills.

6.4 Place contaminated materials in a leak-proof, puncture-proof container with a distinctive warning label.

6.5 The leak-proof, puncture-proof container and other contaminated equipment (i.e., gloves, gowns) are placed in a sealable 4-mil polyethylene or 2-mil polypropylene bag that has been labeled with a distinctive warning label.

6.6 Do not use protective clothing that has been contaminated. Gloves should be changed frequently or immediately if torn or punctured. Discard protective clothing in the container used to dispose of other chemotherapy waste.

6.7 Wash hands thoroughly after handling chemotherapeutic agents and equipment.

HCL EC.7 chap Rvd 040101

EMERGENCY PREPAREDNESS and RESPONSE PLAN

PURPOSE

EC.8

To ensure Agency develops, maintains, and implements a written Emergency Preparedness and Response Plan (Plan), based on the Agency's risk assessment.

To establish a plan of action for providing continuous patient care and continuous business operations in the event of a disaster.

To ensure compliance with "Emergency Preparedness Planning and Implementations", Licensing Standards for Home and Community Support Services Agencies, §97.256.

DEFINITIONS

Disaster - The occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or man-made cause, such as fire, flood, earthquake, wind, storm, wave action, oil spill or other water contamination, epidemic, air contamination, infestation, explosion, riot, hostile military or paramilitary action, or energy emergency.

Preparedness - Preparing for the potential of a disaster including, but not limited to: education and training, integration with community resources, developing disaster response plans, organizing response and recovery activities, and conducting exercises are all preparedness efforts.

Mitigation - A process in which sustained actions are taken to reduce or eliminate long-term risk from natural and man-made hazards or disasters. Activities include, but are not limited to coordinating with state agencies, private sector agencies and organizations, and the public following disasters and emergencies.

Response - Actions taken immediately before an impending disaster or during and after a disaster to address the immediate and short-term effects of the disaster. These are the details of the plan given for others to follow in order for the Emergency Preparedness and Response plan to be successful.

Recovery - Activities implemented during and after a disaster designed to return an agency to its normal operations as quickly as possible.

HCL 1 EC.8 Rvd. 080108

EMERGENCY PREPAREDNESS and RESPONSE PLAN POLICY

EC.8

Agency will involve the administrator, supervising nurse, and other agency leaders as appropriate in the development, implementation, and evaluation of the emergency preparedness and response plan.

Agency will designate a Disaster Coordinator, and alternate, by title.

Agency will conduct a risk assessment analysis to identify potential disasters from natural and man-made causes in Agency's service area.

Agency will develop a continuity of operations business plan, based on the risk assessment, to address emergency financial needs, essential functions for patient services, critical personnel, and how to return to normal operations as quickly as possible.

Agency will describe the actions and responsibilities for agency staff in each phase of emergency planning, including mitigation, preparedness, response, and recovery.

Agency will include actions and responsibilities in the response and recovery phases in the event warning of an emergency is not provided.

Agency will initiate a plan for monitoring disaster-related news and information, including after hours, weekends, and holidays, to receive warnings of imminent and occurring disasters.

Agency will utilize an Emergency Preparedness and Response Plan in the event a disaster occurs that could potentially interrupt the provision of patient care.

Agency will maintain a list of emergency contacts by area for utilization in the event of a disaster.

Agency staff (employees, volunteers, and contractors) will be educated regarding their responsibilities in the agency's Emergency Preparedness and Response Plan upon hire and annually thereafter.

EMERGENCY PREPAREDNESS and RESPONSE PLAN

EC.8

Agency will make a good faith effort to comply with the requirements of §97.256(1)(D). If Agency is unable to comply with any of the requirements of this section, it will document in Agency records attempts of staff to follow procedures outlined in Agency's Emergency Preparedness and Response Plan.

Agency will not be required to continue to provide care to clients in emergency situations that are beyond

Agency's control and make it impossible to provide services (i.e., roads impassable - Agency may establish links to local emergency operation centers to determine a mechanism by which to approach specific areas within a disaster area in order for Agency to reach patients).

T

he Agency will develop procedures in accordance with §97.301 (a)(2) related to the release of Client Records and information as allowed by law in the event of a disaster- related emergency.

The effectiveness of the Emergency Preparedness Plan and Response will be evaluated at least annually and after each actual emergency response and will be included in the Agency's Annual program evaluation.

PROCEDURE

RISK ASSESSMENT ANALYSIS -

1. Agency will conduct a risk assessment to identify potential disasters likely to occur in the agency's service area.

CONTINUITY of OPERATIONS BUSINESS PLAN

1. PREPAREDNESS-

A. ADMINISTRATIVE STAFF responsibilities:

Communication -

- Maintain a current listing of staff and all applicable contact numbers (i.e., home phone, cell phone, pager numbers, emergency numbers, special contact numbers of family/friends if employee is unreachable) for use as a communication tree.
- Set up and frequently test a disaster calling tree for patient emergencies.
- Provide administrative call.
- Develop a backup communication plan for staff and patients, in case phone system is not working, i.e., cell phones, walkie-talkies, e-mail-enabled wireless PDAs, meeting at a specific location, etc.
- Meet with local emergency planners to coordinate services and phone numbers, which the Agency will keep readily available.
- Disaster Coordinator will participate in community's disaster planning.

Patient Triage - Disaster Coordinator and clinical staff will maintain a current list of patients prioritized by care needs and based on specific services provided. Criteria for prioritizing may include but are not limited to:

I - Life threatening (or potential) - requires ongoing medical treatment/care. Any equipment dependent upon electricity should be listed with the power company. Oxygen dependent patients should be supplied with a back-up tank from the supplier. Does not have a caregiver capable of providing care. Requires assistance with transportation to hospital or specialized shelter.

II - Not life threatening but patient might suffer severe adverse effects from interruption of services, i.e., daily insulin, IV meds, sterile wound care with large amounts of drainage, symptoms controlled with difficulty, death appears imminent. Capable caregiver present. Will require transportation assistance to hospital or specialized shelter.

III - Visits could be postponed 24-48 hours without adverse effects, i.e., sterile wound care with a minimal amount to no drainage, symptoms need intervention, but are fairly well controlled. Able to care for self or willing and able caregiver. Transportation available from family, friends, or others.

IV - Visits could be postponed 72-96 hours without adverse effects, i.e., symptoms well-controlled. Able to care for self or willing and able caregiver. Transportation available from family, friends, or others.

Secure Office Building -

- Install fire extinguishers and smoke detectors in appropriate places. Fire drills will be conducted at least annually.
- Have exits marked clearly for emergency routes. Post building layouts with exits and fire extinguishers marked, in public places in office.
- Make certain entrances/exits are secure for staff working in agency.
- Mail safety - Make certain staff are able to identify suspect packages and letters, and steps to take such as: Don't open or smell; Isolate package or letter; Wash immediately with soap and water and remove contaminated clothing; Contact Administration and contact local law enforcement authorities,
- Identify equipment that is necessary for keeping business open. Plan how to replace or repair if damaged.
- Store extra supplies that may be needed.
- Review heating/air condition system instructions and know how to shut down if necessary.

Information Technology Systems - Make sure the following are in place:

- Anti-virus software and firewall.
- Make certain staff know not to open email from unknown sources or unexpected email with attachments.
- Use passwords and change frequently.
- Back up computer data (online, back-up disks, CDs, flash drive, etc) on a daily basis, keeping one version in a secure place off-site (example - bank vault - not another office or home) in case of disaster.

Emergency Financial Needs

- Meet with insurance carrier to review coverage for "acts of God" and/or other disasters. Review exclusions based on Disaster Declaration.
- Take inventory, including photos.
- Make plans for paying creditors and meeting payroll.
- Make copies of financial/insurance records to be stored in safe off-site location (example - bank vault - not another office or home) in case of disaster.

Preparation for Utility Disruptions -

- Plan ahead for potential disruptions in utilities, with possible extended disruptions. Speak with service providers.
- Learn where turn-off valves are, and how/when to turn them off.
- Consider purchasing generators, if applicable to agency service area.

Off-Site Location -

- Make plans for meeting site/secondary location for office, to include communication systems, computer systems, and medical records, as applicable.

Media and Information Management -

- In-service all staff for understanding that to ensure accuracy and continuity of information, all Agency specific information directed towards media and any other public outlets, should be directed to the Administrator, or designee.

B. CLINICAL STAFF responsibilities:

Communication -

- Arrange for personal issues to be taken care of, i.e. child care, groceries, medications.
- Keep vehicle full of fuel.
- Make sure Agency has emergency phone list of names and numbers.
- Demonstrate education and understanding of agency's Emergency Preparedness and Response Plan.

Patient Triage -

- Upon admission to Agency and on an ongoing basis, the patient's condition and needs will be assessed for triage prioritization based on specific services provided.
- Upon admission to Agency and on an ongoing basis, the patient's location will be assessed for potential natural and/or man-made industrial disaster.
- Agency will provide patient/family with information on how to handle emergencies in the home related to a disaster. The Patient/family will also be educated on their responsibilities in the agency's emergency preparedness and response plan (Bill of Rights and Responsibilities).
- The patient/family will be assisted with a patient-specific Emergency Preparedness and Response Plan. The patient/family will be educated about this plan. The plan will be documented in the patient's medical record and communicated to Agency staff.
- Staff, volunteers, and contractors will participate in emergency preparedness and response training.
- Staff will rotate on-call per job description as appropriate and per job descriptions.

2. MITIGATION -

A. ADMINISTRATIVE STAFF responsibilities:

Communication -

- The Administrator, or designee, will ensure that the office is adequately staffed.
- Disaster calling trees are utilized for contacting staff, volunteers and contracted staff. Drills are conducted at least annually.
- Training is provided for staff, volunteers and contracted staff for emergency preparedness and response planning in orientation and annually.

Patient Triage -

- Administration will ensure adequate staffing is provided, and back-up staffing plans are in place.
- Contracts will be reviewed for adequate supplies, equipment and medications during times of emergency.
- Disaster Coordinator or designee will be responsible for the monitoring of public information systems 24/7 for disaster related news and information, including after hours, weekends, and holidays. As needed, this information will be communicated to staff for patient access/services.

B. CLINICAL STAFF responsibilities:

Communication -

- The staff members can communicate among themselves and with the office via telephone, cell phones and pagers, walkie-talkies, e-mail-enabled PDAs, or other designated method that has been provided.
- Staff will educate patient/families on emergency planning, and will assist them with information to develop their own emergency plans.
- All patient/family education will be documented in the medical record.
- Staff, volunteers, and contracted staff will attend emergency preparedness and response training.

Patient Triage -

- Coordination of patient care and communication regarding the patient's status will transpire through informal verbal and written communication and a formal case conference among all disciplines providing care. A written summary report will be sent to the patient's physician at least every 60 days, or more frequently if warranted by the patient's condition. Coordination of patient care will include review and update of classification in the triage system when there are significant changes in the patient's condition and at least every 60 days.
- 211 is a special assistance registry for those needing help in a general evacuation. Register patients with special needs in the 211 system in Texas.
- On-call books will be kept up-to-date with patient information.
- On-call reports will be given on all patients.

3. RESPONSE - The Administrator, or designee, will initiate and discontinue the implementation of the Emergency Preparedness and Response Plan.

A. ADMINISTRATIVE STAFF responsibilities:

Communication -

- If communication methods at an Agency site are disrupted, mobile communication systems, email-wireless PDA's, short-wave radios, and e-mail relays may be source utilized by the administrative staff.
- The disaster calling tree will be activated to begin patient triage.
- Back-up staff will be utilized as necessary to make patient contact.
- Volunteers may be used to support office needs, i.e., copying, errands, filing, etc.
- Disaster Coordinator or designee will contact the local emergency medical services and DADS to notify of disaster in progress.
- Disaster Coordinator or designee will be responsible for documenting all aspects of the disaster, to include, names, decisions made, and times of actionable items.

Patient Triage -

- Disaster Coordinator will ensure that the patients are appropriately triaged.
- Agency will make appropriate referrals to assure continuation of care. This will include but not be limited to:
- Life-supporting equipment
- Life-sustaining medication and/or nutrition
- On-call/administrative staff will contact appropriate emergency community support systems, as appropriate to the patient.
- Local radio and/or television stations may be contacted by the Agency as a method of communicating with the patient population, if necessary.

Release of Patient Information -

- In the event of an emergency or severe disaster, protected health information (PHI) as defined by HIPAA can be shared with other healthcare providers without the patient's authorization.
- If a non-health care provider (Le. relative, neighbor, friend) requests PHI for a patient, the Agency must receive a HIPAA compliant authorization to release the PHI. This is unless the individual is the personal representative of the patient..
- The Agency can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care of the patient's location, general condition, or death. In these cases, the Agency should get verbal permission from the patient when possible.
- The Agency can also share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, consistent with applicable law and standards of ethical conduct.

Secure Office Building -

- If an Agency is affected, administrator will determine if the removal of medical, personnel and financial records is necessary.
- Agency staff members will not jeopardize their own safety for the purpose of removing office contents (e.g., medical records, personnel files) when a disaster has occurred at an Agency site.

B.CLINICAL STAFF responsibilities:

Communication -

- If no means of communication is available, then all staff members who can safely travel will report to the office.
- Primary physician, medical advisor/director, and appropriate disciplines involved in patient's care will be advised of patient/family status, as calls and visits are made.
- Patients may contact staff by calling the office number. If the office number is not operational, the call will be handled by the "on call" nurse.
- If the answering service or the paging service is not operational, the agency will call forward to cellular "on call" phone (even if cell phone call won't go through, text messaging may still go through but, privacy isn't protected).
- Staff will maintain contact with the office for updates as possible.

Patient Triage -

- Staff will contact patients according to patient triage prioritization.
- Staff will visit all patients as possible, based on time, disaster, and plan of care.
- Medications, supplies and equipment will be delivered as directed.
- Community emergency support services will be contacted and utilized as necessary, and as authorized by administration.
- Transportation for patients requiring assistance will be coordinated from the office.

C. **Agency Staff** (Administrative and Clinical Staff) responsibilities: Agency will include actions and responsibilities in the response and recovery phases in the event warning of an emergency is not provided.

4. **RECOVERY** - The Administrator, or designee, will be responsible for the Recovery Phase of the Emergency Preparedness and Response Plan.

A. **ADMINISTRATIVE STAFF** responsibilities:

Communication -

- Administrator will receive full briefing of all activities of disaster response, and Disaster Coordinator will develop a Disaster Recovery Plan:
 - Response actions taken
 - Necessary modifications to plans and procedures
 - Training needs
 - Recovery activities to date
- Any incidents that occurred will be documented, with action plans developed.
- Depending on disaster, support groups for staff may be offered, and staff encouraged to participate.
- Review Agency for ongoing care for patients and staff, preventative care, and professional counseling.
- Meet with local emergency response providers to review disaster response and formulate ongoing plans.

Patient Triage

- Review Agency backup staffing plans for effectiveness
- Ensure that patients that were moved are placed back on schedule, and receiving care.
- Follow-up on any transfers or discharges of patients for continuity.
- Review on call logs.

Secure Office Building

- Replenish office supplies and patient supplies.
- Review Agency contracts for effectiveness.
- If agency office is temporarily re-located during a disaster, agency will notify Department of Aging and Disability per regulation, §97.256(5), no later than five (5) working days after move if temporarily:
 - Relocating a place of business,
 - Expanding the service area to provide services during a disaster.
- All notifications to DADS should be made in writing by facsimile, email, or, if unavailable, by telephone to Mary Jo Grassmuck, Manager for HCSSA Program Licensing, at (512) 438-2213 (fax), mary.grassmuck@dads.state.tx.us, or (512)-438-2630 (telephone).
- If records are damaged during the disaster, the records must not be reproduced or recreated except from existing electronic records. Records reproduced from existing electronic records will contain:
 - The date the record was reproduced;
 - The agency staff member who reproduced the record;
 - How the original record was damaged.

Emergency Financial Needs

- Take inventory
- Review costs expended/payors of patients
- Contact insurance carrier

B. **CLINICAL STAFF** responsibilities:

Communication -

- Document any incidents that occurred during disaster.
- Meet with Administration to review activities of disaster response, and provide feedback for

improvement.

Patient Triage

- Contact all patients and notify physician of patient status.
- Meet with all disciplines providing care to patients and re-classify patients for triage.
- Resume visit schedules.
- Assist patient/family with updating their emergency preparedness and response plan.

C. AGENCY STAFF (Administrative and Clinical Staff) responsibilities:

Agency will include actions and responsibilities in the response and recovery phases in the event warning of an emergency is not provided.

PATIENT/FAMILY INFORMATION and HANDOUTS:

Family Emergency Plan from Homeland Security –

http://www.ready.gov/america/downloads/EmergencyPlan_REV6.pdf

Family Emergency Supply Kit from Homeland Security –

www.ready.gov/america/getakit/index.html

Texas Homeland Security and Emergency Management Offices _

www.ready.gov/america/local/tx.html

Texas Evacuation Routes

www.txdps.state.tx.us/dem/hurricane.htm

DADS website

www.dads.state.tx.us/hurricane/index.cfm

211

www.211texas.org/211/

STAFF TRAINING:

National Integration Center Incident Management Systems (NIMS training) for disasters

www.femagov/index.shtm

Community Healthcare Services Foundation - HHA and paraprofessional training

- www.chcforum.org

OTHER:

FEMA

www.fema.gov/

Red Cross

www.redcross.org/index.html

HCL / EC.8 Rvd. 080108

FIRE SAFETY

EC.9

PURPOSE

To define the process to address potential fire hazards and response in both the patient's environment and the Agency's work environment.

POLICY

Agency will evaluate the patient care site for potential fire hazards related to the care provided and will initiate appropriate follow-up.

Agency will establish an office fire safety program that meets all applicable laws and includes:

- Designing an Agency site that allows for adequate fire response.
- Managing staff activities to reduce risk of human injuries.
- Educating staff members about the program.
- Evaluating the program annually.

PROCEDURE

A. Patient Care Site

1. Upon admission to Agency, and on an ongoing basis, the patient care site will be assessed for potential fire hazards and fire safety responses. The assessment will be documented in the patient's medical record.

2. Appropriate referrals/follow-up/education will be initiated as needed.
3. Patient's compliance or noncompliance will be documented in the medical record.

B. Agency Site(s)

1. Agency will identify and meet all applicable laws related to fire safety (e.g., exit doors are clearly marked and are clear escape routes from building; fire extinguishers are present and in proper working order; maintaining all structural features of fire protection).
2. Fire escape routes will be posted in the Agency site(s).
3. Each employee will be educated regarding location of :
 - Fire safety equipment, and
 - Fire escape route for each Agency site at which they will be working.
4. Fire drills may be conducted annually, if deemed necessary by the Board of Directors.
5. Smoke detectors and/or fire alarms will be tested as needed.
6. Management is responsible for maintaining fire safety alarms/equipment.
7. The telephone number of the local fire department will be maintained near each telephone.

HCL EC.9 chap Rvd 110101

MAINTENANCE OF SUPPLIES

EC.10

PURPOSE

To ensure the supplies used by Agency staff and/or patients/caregivers are maintained in a sanitary manner and appropriate for use.

POLICY

Agency will maintain, transport, and deliver supplies according to applicable federal/state laws and regulations.

PROCEDURE

A. Patient Care Site

1. Agency staff will assess the patient care site for an appropriate location for storage of supplies.
2. The staff will request that the patient/caregiver allocate one area (e.g., shelf, drawer, counter top) as the designated storage area.
3. The staff will instruct the patient/caregiver on measures to clean the area and maintain an optimal environment for supplies.
4. The patient/caregiver will be instructed as to storage of items according to vendor's/manufacture's recommendations (e.g., refrigerate after opening).
5. The patient/caregiver will be instructed on principles of maintaining a clean, safe storage environment and the safe handling of clean supplies, equipment, medication and solutions.
6. The patient/caregiver will be instructed on proper disposal and handling of utilized supplies.
7. The staff will document instructions in the patient's medical record and indicate the selected storage area.
8. Agency is responsible for obtaining and delivering only those supplies routinely stocked in the Agency supply room (e.g., dressings, catheter supplies).
9. The patient/caregiver is responsible for obtaining other supplies and medications with the appropriate assistance from Agency staff.

PROCEDURE

A. Agency Site(s)

1. All medical supplies, especially sterile items and drugs, will be properly stored in a clean, dry area and handled in a sanitary manner protected from potential contamination as indicated by the manufacturer.
2. Supplies which can be contaminated will be stored at least six inches off the floor in closed cartons or containers which protect them from contamination.
3. Supply packaging will remain intact while stored. If outer package is damaged or opened, supply shall be removed by vendor.
4. Supplies will be checked for expiration date prior to use. If out of date, the vendor shall be notified to remove them.
5. New medical supplies will be stored behind older supplies to assist in a timely rotation of supplies.
6. Nurses will inspect packages of sterile items for evidence of interruption or exposure to liquid prior to use, and for expiration date if applicable.

7 Nurses using sterile medical supplies will handle items in a manner to protect sterility and prevent contamination.

8. If supplies are transported from Agency to the patient's environment, Agency staff will ensure appropriate and safe delivery of the supplies in a manner which will protect sterility and prevent contamination.

HCL EC.10 chap Org 050197

EQUIPMENT SAFETY / SAFE MEDICAL DEVICE ACT

EC.11

PURPOSE

To ensure safe, appropriate use of equipment by Agency staff in both the patient care and Agency sites.

POLICY

Agency will educate all staff in the safe use of equipment owned and/or utilized by Agency and will notify staff in a timely manner of any identified equipment hazards, defects and recalls.

Agency will comply with the Safe Medical Device Act to identify, report and correct medical device incidents.

PROCEDURE

1. As part of orientation to Agency and on an ongoing basis, staff will be educated on equipment essential to carry out job responsibilities. As part of the orientation and at least annually, staff will be educated on the Safe Medical Device Act.

2. The orientation/education are documented. Return demonstration will be required if appropriate.

3. Agency will access equipment company vendors as educational resources are needed.

4. As Agency is made aware of equipment hazards, defects and/or recalls, staff will be notified.

5. When it has been determined that a medical device has, or may have, caused or contributed to the serious injury of a patient, the organization will make a report to the manufacturer of the device, if known, and to the FDA when the manufacturer is not known.

6. When it has been determined that a medical device has, or may have, caused the death of a patient, the agency will make a report to the manufacturer of the device and to the FDA.

7. The Administrator, or designee, will be responsible for determining when a reportable event has occurred and will complete all required FDA reports.

Medical Device Reporting

Definitions

Medical Device:

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

Serious Injury/Illness: an illness or injury that is either:

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

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

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

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

4. Result of investigation will be documented on the FDA Form 3500A.

Data to report includes:

- Patient information
- Type of adverse event/description of the event
- Relevant laboratory/test data and patient history
- Manufacturer and identification of the suspect device and certain other information about the device as asked on the form
- Initial reporter of the event

- Agency name, address and contact
- Where and when the report was sent

5. Causes may include but are not limited to the following:

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

6. Management staff will report the following:

- Patient deaths within 10 working days to the manufacturer of a device and the FDA;
- Serious illness or injury within 10 working days to manufacturer who will report to the FDA

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

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

8. Reports may be completed online, to <http://www.fda.gov>

Or, may be submitted to:

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

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

10. If an Agency believes that there is a public health emergency, it should contact:

FDA Emergency Operations Branch
Office of Regional Operations
HFC-162
Phone # - 301-443-1240, and send a fax to # 240-276-3454.
HCL / EC.11 CH Rvd. 070109

EQUIPMENT MAINTENANCE

EC.12

PURPOSE

To ensure that the equipment used by agency staff is both safe and accurate.

POLICY

Agency will maintain equipment owned and/or utilized by Agency staff, in accordance with manufacturer's written guidelines. When no written guidelines exist, the agency will establish appropriate procedures or will arrange for another individual/organization to provide equipment maintenance.

PROCEDURE

1. Agency will retain and follow manufacturer's written guidelines for maintenance of equipment that is owned and/or utilized by Agency staff.
2. When no manufacturer's written guidelines for equipment maintenance are available, Agency will provide/establish appropriate written procedures for specific equipment maintenance.
3. When Agency is unable to provide/establish appropriate written procedures for specific equipment maintenance, the management will arrange for another individual/organization to provide the equipment maintenance. Agency will establish and maintain a list of appropriate individuals/organizations to contact.
4. Agency will maintain "Equipment Maintenance Logs" for timeliness of equipment maintenance, as well as serial numbers of equipment.

HCL EC.12 - chap Rvd 050101

COMPANY VEHICLES

EC.13

PURPOSE

To ensure safe, appropriate use and maintenance of company owned vehicles. **POLICY**

Agency staff will observe all applicable laws and regulations when operating a company-owned vehicle.

PROCEDURE

1. Agency will assign responsibility for arranging maintenance, applicable licensure, etc.
2. Beginning and ending mileage will be logged with each use.
3. Maintenance procedures will be logged.
4. Use of a company vehicle for purposes other than business and/or by non-Agency persons must have prior approval by administration.
5. Each vehicle will be stocked with:
 - Jumper cables
 - Weather preparedness supplies
 - Reserve medical supplies
6. Users of the company vehicles will observe the smoke-free environment policy.
7. Seat belts will be worn by all operators and passengers of company vehicles.
8. Company vehicles will be locked when left unattended.
9. Users of company vehicles will consider safety issues when parking (e.g., parking under street lights at night).

HCL EC.13 chap Org 050197

UTILITY SYSTEMS MANAGEMENT

EC.14

PURPOSE

To ensure appropriate utilities management in both the patient care and Agency sites. **POLICY**

Agency will utilize utility systems management at the patient care and Agency sites to promote safe and effective work environments for all Agency staff.

PROCEDURE

A. Patient Care Site

1. Upon admission to the Agency, and on an ongoing basis, the patient's environment will be assessed for appropriate utility systems management related to patient care. This will include but not be limited to: electrical/gas service, water service, waste disposal/pick-up and communication service. The assessment will be documented in the patient's chart.
2. Appropriate referrals/follow-up will be initiated as needed.
3. The patient's compliance or noncompliance will be documented in the medical record.

B. Agency Site(s)

1. Agency will assess for adequate utilities management to include but not be limited to:
 - Electrical/gas service,
 - Water service,
 - Waste disposal pick-up, and
 - Communication service.
2. Identified utilities management needs are reported to the Director.
3. Management will be responsible for ensuring appropriate utilities management.

4. If indicated, identified needs or problems of the inner office other than those listed above will be referred to the performance improvement team.

HCL EC.14 chap Rvd 050101

SAFETY COMMITTEE

EC.15

PURPOSE

To provide an established forum and mechanism to address management of environmental care issues.

POLICY

Agency leaders will establish a group with multi-disciplinary members to review the management of environmental care issues and data. The PAC may serve as the safety committee.

PROCEDURE

1. Agency will establish the Safety Committee/PAC.
2. Agency will confer upon the committee, the authority necessary to carry out responsibilities which include:
 - 2.1 Reviewing all Occurrence Reports.
 - 2.2 Analyzing the aggregated data from the Occurrence Reports.
 - 2.3 Reporting data to the Board of Directors annually or more frequently if deemed necessary.
 - 2.4 Recommending performance improvement opportunities.
 - 2.5 Reviewing the Agency assessments for issues related to environmental hazards and unsafe practices and recommending follow-up actions.
 - 2.6 Documenting all meetings, data, recommendations and follow-up activities.

HCL EC.15 chap Org 050197

INFORMATION MANAGEMENT ASSESSMENT

IM.1

PURPOSE

To outline Agency's assessment of its functions and related information management needs.

POLICY

Agency leaders will be responsible for planning and designing information management processes to meet internal and external needs and for participating in an ongoing monitoring of the effectiveness of the process(es).

PROCEDURE

1. Agency leaders and other appropriate staff will assess Agency's information management needs based on its:
 - Mission,
 - Goals,
 - Care
 - Personnel and their needs,
 - Service delivery environments,
 - Resources, and
 - Access to affordable technology.
2. Agency leaders and other appropriate staff will design, plan, select, and integrate an information management system that is interactive with both patient care and Agency operational information.
3. When designing, planning, and/or selecting an information management system, consideration will be given to:
 - Uniform data definition,
 - Uniform method for collecting data, and
 - Standardization with internal and external sources of minimum data sets, codes, classifications and terminology.

HCL IM.1 chap Org 050197

ACCESSING INFORMATION RESOURCES

IM.2

PURPOSE

To ensure Agency staff has access to internal/external knowledge-based information and databases.

POLICY

Agency leaders will identify and attempt to provide databases and expert knowledge-based resources to all staff on a timely basis in order to meet Agency's information management needs. The needs may include but not be

limited to management/operations, patient care, performance improvement and patients/caregivers. Data bases will be initiated and maintained to ensure the available knowledge-based resources are up-to-date

PROCEDURE

1. Information management needs will be assessed by appropriate Agency staff and prioritized for access.
2. Agency will attempt to provide the resources needed to access the appropriate external database/expert knowledge-based resource.
3. Relationships will be initiated and maintained with external organizations that facilitate information accessibility (e.g., university libraries, professional video/information lending organizations, National Association of Home Care, State Association of Home Care, regional networks, etc).
4. A system for organizing, locating, using and sharing resources utilized by Agency staff will be maintained with current literature.
5. A listing of community resources, including phone numbers, will be initiated and maintained for all Agency staff use.

HCL IM.2 chap Org 050197

INTERFACING STANDARDIZED INFORMATION

IM.3

PURPOSE

To provide for the interfacing of accurate, complete, valid, reliable and consistent standardized information/data Agency-wide.

POLICY

Agency will provide patient care, organizational and management information/data that can be interfaced and utilized throughout all Agency departments and with all patient care providers.

PROCEDURE

1. Each department will identify informational needs and the appropriate staff responsible for generating needed information/data.
2. Agency will develop functions to:
 - Coordinate collection of information
 - Make information available from one system
 - Organize data
 - Analyze data
 - Interpret/clarify the information
 - Provide and access long-term information
3. Agency will identify and define all abbreviations and coding systems (i.e., CPT, ICD-9, etc.) to be used by all Agency staff.
4. Appropriate Agency staff will receive and will be educated regarding Agency's abbreviations and coding systems.
5. Agency's abbreviations will be updated as needed.
6. Agency will maintain current coding system material.
7. Agency will implement the above processes and evaluate for effectiveness.

ACCEPTABLE ABBREVIATIONS

A	Assessment
Abd	Abdomen
ABG	Arterial Blood Gases
ABH	Ativan/Benadryl/Haldol
ABS	Active Bowel Sounds
abx	Antibiotic
a.c.	Before meals
ad lib	As desired
Add	Address
Adeq	Adequate
ADL	Activities of Daily Living

Adm	Admitted, Admission
Alk Phos	Alkaline Phosphatase
AHR	Apical heart rate
a.m.	Morning
AMA	Against Medical Advice
Amb	Ambulatory
Amt	Amount
AP	Anteroposterior
A & P	Anterior and Posterior
Anes	Anesthesia
APGAR	Cry, reflexes, color, respirations of newborn
Approx	Approximately
AODM	Adult Onset Diabetes Mellitus
ASAP	As soon as possible
Asp, ASA	Aspirin
ASHD	Arteriosclerotic Heart Disease
AUR	Acute Urinary Retention
Ax	Axillary
B & B	Bowel and Bladder
Bact	Bacteria
Baso	Basophil
BBB	Bundle Branch Block
BE	Barium Enema
bid	Twice a day
Bilat	Bilateral
Bili	Bilirubin
BKA	Below knee amputation
BLE	Bilateral lower extremity
BM	Bowel movement
BM I	Body Mass Index
BMR	Basal Metabolism Rate
BP	Blood pressure
BPH	Benign prostatic hypertrophy
BR	Bed rest
BRP	Bathroom privileges
BS	Blood sugar
BSC	Bedside commode
BSO	Bilateral salpingo-oophorectomy
BSD	Bedside drainage
BUE	Bilateral upper extremity
BUN	Blood urea nitrogen
Bx	Biopsy
c	With
C	Centigrade or Celsius
CA, ca	Carcinoma
cal	Calorie
CAD	Coronary Artery Disease
Cath	Catheter
CBC	Complete Blood Count
cc	Cubic centimeter
CC	Chief Complaint
CCU	Coronary Care Unit

CDI	Clean, dry, intact
CG	Caregiver
CHF	Congestive Heart Failure
CHO	Carbohydrate
cm	Centimeters
CM	Case Manager
CNA	Certified Nurse Assistant
CNS	Central Nervous System
c/o	Complains of
CO2	Carbon Dioxide
cont	Continue
CPR	Cardiopulmonary resuscitation
CRNA	Certified Registered Nurse Anesthetist
C-Section	Caesarean Section
CSR	Central Service
CVA	Cerebrovascular Accident
CVP	Central Venous Pressure
COPD	Chronic Obstructive Pulmonary Disease
Cysto	Cystoscopy
D & C	Dilation and Curettage
da	Day
d/c	Discontinue
D/C	Discharge
Dec	Decrease
Del	Delivery, Delivered
Delta symbol	Change
Dept	Department
Dk	Dark
DM	Diabetes Mellitus
DNR	Do Not Resuscitate
DOA	Dead On Arrival
DOD	Date of Death
DON	Director of Nurses
DPOA	Durable Power of Attorney
Dr.	Doctor
Drsg.	Dressing
DSD	Dry sterile dressing
Dtr.	Daughter
Dx	Diagnosis
Dx & Rx	Diagnosis and Treatment
EBL	Estimated Blood Loss
ECG, EKG	Electrocardiogram
EDC	Estimated date of confinement
EEG	Electroencephalogram
EENT	Ear, eye, nose and throat
EGD	Esophagogastroduodenostomy
EMS	Emergency Medical Services
ES	Endstage
Eos	Eosinophil
Ep	Epithelial
ER	Emergency Room
etc.	And so forth

Eval	Evaluation
Exc	Excision
Ext	Extremities
Extr	Extraction
F	Female
F°	Fahrenheit degrees
FAST	Functional Assessment Staging Tool
FB	Foreign body
FC	Foley Catheter
FBS	Fasting Blood Sugar
Fe	Iron
FF	Force fluids
FH	Family history
FHT	Fetal heart tone
FHR	Fetal heart rate
FHM	Fetal heart monitor
F/U, f/u	Follow-up
ft	Foot
FUO	Fever of undetermined origin
Fx	Fracture
gal	Gallon
GB	Gallbladder
Gen	General
GI	Gastrointestinal
gm	Gram
gr	Grain
Gray	Gravida
gtts	Drops
GTT	Glucose Tolerance Test
GU	Genitourinary
GYN	Gynecology
GUI	Genitourinary infection
HA	Headache
Hct	Hematocrit
HCVD	Hypertensive Cardiovascular Disease
HBP	High blood pressure
HCO ₃	Bicarbonate
HEENT	Head, ear, eye, nose, throat
Hgb	Hemoglobin
H & H	Hemoglobin and hematocrit
HHA	Home Health Aide
HIPAA	Health Information Portability Accountability Act
H ₂ O ₂	Hydrogen peroxide
H ₂ O	Water
HOB	Head of bed
H & P	History and physical
hr	Hour
HR	Heart rate
HS	Bedtime
Ht	Height
HTN	Hypertension

Hx	History
IADL	Instrumental Activities of Daily Living
ICE	Intermediate Care Facility
ICP	Intracranial pressure
ICU	Intensive Care Unit
ID	Intradermal
IDT	Interdisciplinary Team
I & D	Incision and drainage
IH	Inguinal hernia
IM	Intramuscular
Imp	Impression
Inc	Increase
INH	Isoniazide
Insuff	Insufficiency
Int	Internal
I & O	Intake and Output
IPPB	Intermittent Positive Pressure Breathing
irr	Irregular
Isol	Isolation
IV	Intravenous
IVF	Intravenous fluids
IVP	Intravenous Pyelogram
IVPB	Intravenous fluids piggyback
IVH	Intravenous hyperalimentation
IUD	Intrauterine device
Juv.	Juvenile
K	Potassium
KCL	Potassium Chloride
Kg.	Kilogram
KUB	Kidney, Ureter, Bladder (X-ray)
KVO	Keep vein open
L	Liter
lab	Laboratory
lac	laceration
lap	Laparotomy
lb	Pound
lat	Lateral
LCSW	Licensed Certified Social Worker
LCTA	Lungs clear to auscultation
LDH	Lactic Dehydrogenase
LE	Lupus Erythematosus
Liq	Liquid
Lg	Large
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LP	Lumbar puncture
Ipm	Liters per minute
LPN	Licensed Practical Nurse
LOA	Left Occiput Anterior
LoN	Low sodium
It.	Left

LTCF Long term care facility
 LTL Laparoscopic Tubal Ligation
 LUL Left upper lobe
 LUQ Left upper quadrant
 LVH Left ventricular hypertrophy
 LVN Licensed Vocational Nurse
 Lymph Lymphocyte
 Lytes Electrolytes
 (m) Murmur
 M Male
 MAR Medical administration record
 M.D. Medical Doctor
 meas. Measure
 mec. Meconium
 Med Medication
 Mets Metastatic disease/process
 mg Milligram
 MI Myocardial Infarction
 Min Minute
 ml Milliliter
 mm Millimeter
 MN Midnight
 mo Month
 MOM Milk of magnesia
 Mono Monocyte
 MPOA Medical Power of Attorney
 MR Medical record
 MSW Medical Social Worker
 MSS Medical Social Services
 N/A Not applicable
 Na Sodium
 NaCl Sodium Chloride (salt)
 NC Nasal cannula
 neb Nebulizer
 Neg Negative
 NF Nursing facility
 N/G Nasogastric tube
 NH Nursing home
 NKA No known allergies
 NKDA No known drug allergies
 No. Number
 Noc Night
 NPI National Provider Identifier
 NPO Nothing by mouth
 NR Non-reactive
 NS Normal saline
 Nsg Nursing
 NSR Normal sinus rhythm
 NN Nausea and vomiting
 NN/D Nausea, vomiting and diarrhea
 0 No, none
 O Objective

02	Oxygen
OA	Occiput Anterior
OB	Obstetrics
obt.	Obtained
O/C	On Call
occ	Occasional
od	Daily
O.D.	Right eye
oint	Ointment
Op	Operation
OOB	Out of bed
O.P.	Out patient
OR	Operating Room
O & P	Ova and parasites
O.S.	Left eye
O.T.	Occupational Therapy/Therapist
O.U.	Both eyes
oz.	Ounce
p	After
P	Pulse
PC	After meals
Pap	Papanicolaou Stain Test
PAT	Pre-admission testing
PCG	Primary Caregiver
PCN	Penicillin
PE	Physical examination
Ped.	Pediatrics
PERLA	Pupils equal, reactive to light and accommodation
per	By
PID	Pelvic Inflammatory Disease
p.m.	Evening
PH	Past history
pH	Acidity
PHI	Personal Health Information
PI	Performance Improvement
PMH	Past medical history
PMC	Post Mortem Care
PMS	Pre-menstrual Syndrome
p.o.	By mouth
POA	Power of Attorney
POC	Plan of care
P.O., T.O.	Phone/telephone order
POMR	Problem-oriented medical record
Pos	Positive
Poss	Possible
PP	Post Partum
PPBS	Post prandial blood sugar
PPD	Tuberculin test
PR	Per rectum
Pre op	Before surgery
Preg	Pregnancy
PRN, prn	As necessary or as needed

prob Probable
 PROM Passive range of motion
 Pt Patient
 pt. Pint
 P.T. Physical Therapy
 PT Prothrombin Time
 PTT Partial Prothrombin Time
 PVC Premature ventricular contractions
 q Every
 q am Every morning
 QAPI Quality Assurance Performance Improvement
 q pm Every evening
 qh Every hour
 q3h, q4h Every 3 hours; every 4 hours
 qd Once a day
 qhs At bedtime
 qid Four times a day
 qns Quantity not sufficient
 qs Quantity sufficient
 qt Quart
 R Rectal
 R, Resp Respiration
 Rec Recovery
 Reg Regular
 Rh Rhesus blood factor
 RHV Routine home visit
 RBC Red blood count
 R-L Right to left
 RTH Return to hospital
 RL Ringers Lactate
 RLL Right lower lobe
 RLQ Right lower quadrant
 Rm Room
 RML Right middle lobe
 RN Registered Nurse
 R/O Rule out
 ROM Range of motion
 ROS Review of systems
 RSO Right salpingo oophorectomy
 RSR Regular sinus rhythm
 Rt., rt Right
 r/t Related to
 R.T. Respiratory Therapy
 RTC Return to Clinic
 RUL Right upper lobe
 RUQ Right upper quadrant
 Rx Prescription
 S Without
 S Subjective
 S&A Sugar and Acetone Test
 S&K Sugar and Ketone Test

SB Stillborn
 Seg Segment
 SGOT Transaminase
 SGPT Serum Glumatic Pyruvic Transaminase
 SH Social history
 Sl Sublingual
 Sm Small
 SMA Serum Multiple Analysis
 SN Skilled Nurse
 SNF Skilled Nursing Facility
 S/O Significant Other
 SOB Shortness of Breath
 SOC Start of Care
 Sp Specific
 Spec Specimen
 Sp. gr. Specific gravity
 S/P Status post
 spont Spontaneous
 SQ Subcutaneous
 SR Sustained release/side rails
 s Without
 s/s Signs/symptoms
 SSD Social Security Disability
 SSE Soap suds enema
 SSI Social Security Income
 ST Skin tear
 ss, ss One-half
 SSE Soap suds enema
 Subq Subcutaneous
 Surg Surgery
 T, Temp Temperature
 Tab Tablet
 TAH Total abdominal hysterectomy
 TB, TBC Tuberculosis
 T & A Tonsillectomy and adenoidectomy
 T & C Type and crossmatch
 TCDB Turn, cough, deep breathe
 tid Three times daily
 TIA Transient ischemic attack
 tntc Too numerous to count
 TAO Triple Antibiotic Ointment
 TO Telephone order
 tol Tolerate
 TPN Total parenteral nutrition
 TPR Temperature, pulse, respiration
 tbs Tablespoon
 tsp Teaspoon
 TUR Transurethral Resection
 TURP Transurethral Resection of Prostate
 TW Talked with
 TWE Tap water enema
 Tx Therapy, treatment

U/A, UA Urinalysis
 UD Unit Dose
 UGI Upper gastrointestinal
 umb Umbilicus
 ung Ointment or unguentine
 unk Unknown
 UPIN Unique Physician Identification Number
 URI Upper respiratory infection
 UT Urinary tract
 UTA Unable to assess
 UTI Urinary tract infection
 Vag Vaginal Vaginal
 VC Volunteer Coordinator
 Vd Void
 V.D. Venereal disease
 VDRL Test for venereal disease
 via By way of
 V.O. Verbal order
 Vol Volume
 VS Vital signs
 W White
 WBC White blood count
 we Wound care
 W/C Wheel chair
 WD Well developed
 W/D Warm and dry
 Wk Week
 WN Well Nourished
 WNL Within normal limits
 wt. Weight
 X Times
 yo Year old
 yr year

Symbols

= Equals
 + Positive
 ? Female
 di Male
 > is greater than
 < is less than
 ↓ lowering, decrease
 ↑ rising, increase
 2° secondary
 3 dram
 oz ounce
 # number
 @ at
 + or & and
 ✓ check . degree

Roman Numerals

1. I
2. II

3. III
4. IV
5. V

HCL / IM.3 ch Rvd. 022908

COMPARATIVE USE OF DATABASES

IM.4

PURPOSE

To establish guidelines for use of and contribution to external databases.

POLICY

Agency's information management system will attempt to reference external databases for comparative purposes as well as providing the means for Agency to contribute to databases when required by law or regulation. Throughout these exchanges of information, the system will maintain the confidentiality of patient identity.

PROCEDURE

1. Agency will maintain confidentiality of patient identity throughout information comparison with external reference databases. (May be obtained through National Association of Home Care, Texas Association of Home Care, CMS/OASIS), and other sources for home care data.
2. Agency will assess its scope of care and the availability of external reference databases for comparative data opportunities.
3. Agency will identify appropriate comparative data opportunities for identifying deviations from expected trends and establish a system to access data for performance improvement activities.
4. Agency will identify appropriate comparative data opportunities as well as those required by law or regulation and contribute as indicated.

HCL IM.4 chap Rvd 110101

MEDICAL RECORD INFORMATION CONFIDENTIALITY

IM.5

PURPOSE

To ensure the confidentiality, security and integrity of information in accordance with applicable federal and state laws and regulations.

POLICY

Agency will ensure that all patient identifiable information in the clinical record, including OASIS data, will remain confidential and will be secured and controlled whether in hard copy or in electronic format.

PROCEDURE

ACCESS TO INFORMATION

1. The Agency shall provide all current employees with training on the HIPAA Privacy Rule.
 - 1.1 All new employees shall receive privacy training during their orientation.
 - 1.2 If the Agency changes its policies and procedures related to confidentiality, security and integrity of information, all employees shall receive retraining.
 - 1.3 All privacy orientation and retraining shall be documented in the employees' personnel files.
 - 1.3.1 The Privacy Officer shall maintain a record of privacy training given to the employees as defined in the Privacy Rule.
2. Before assuming job responsibilities, all staff will be educated regarding the confidential nature of medical records and information, either hard copy or electronic format, and be informed of the resulting disciplinary action for willful, unauthorized disclosure of confidential information.
3. Agency staff who have access to active medical records will include:
 - Per-visit staff - access to all information 24 hours a day, 7 days a week.
 - Administrative staff- access to all information 24 hours a day, 7 days a week.
 - Quality assessment/improvement staff - access to all information during office hours.
 - Billing staff - access to information needed to process claims during office hours.
 - Clerical staff responsible for chart maintenance or data entry - access to information for inclusion in medical record and for retrieval to use.
4. Agency staff that have access to inactive medical records will include:

- Quality assessment/improvement staff - access to all information during office hours.
 - Billing staff - at request of administration, access to information needed to process claims during office hours.
 - Administrative staff- access to all information 24 hours a day, 7 days a week.
 - Visiting staff - at request of administration, access to all information during office hours.
 - Clerical staff responsible for chart maintenance - at request of administration, access to information for copying, etc. during office hours.
5. Any discussion involving patient/caregiver information will be conducted discreetly to avoid accidental disclosure to unauthorized staff.
 6. Patient computer data will be accessed, entered or retrieved by authorized persons only,
 7. All employees who have access to the system will be given network and patient database username and passwords. These passwords are not to be shared with any person. Passwords will be changed by the user at least annually, recommend quarterly or following a breach in security. Passwords will be deleted at termination of an employee.
 8. Measures such as locking file cabinets or locking the medical record room will be utilized for protection of records from access and/or retrieval by unauthorized personnel after office hours.
 9. Other sources that may have access, with patient consent, are:
 - Medicare/Medicaid,
 - Fiscal intermediaries,
 - Payor sources,
 - Regulatory agencies, accrediting bodies,
 - Contracted consultants
 10. Any information needing to be faxed will have a cover sheet stating the confidential nature of the information. The following information will not be faxed:
 - Occurrence Reports
 - Employee Drug Screening Reports
 - Employee/Patient HIV testing results
 11. Information collected during performance improvement activities may be shared in statistical reporting formats.
 12. Patient information boards (e.g., schedules will not be displayed in office common areas.)
 13. Agency will secure written contracts that include confidentiality clauses with the following, as applicable:
 - Contracted agents to complete the OASIS regulatory reporting requirements
 - Contracted billing companies who are billing via electronic claims

HCL 1 IM.5 CH Rvd. 060108

SAFEGUARDING MEDICAL RECORD INFORMATION

IM.6

PURPOSE

To define a mechanism for safeguarding medical records/information.

POLICY

Agency will implement measures to safeguard medical records/information against loss, destruction, tampering, and unauthorized use.

PROCEDURE

1. Agency will:

- 1.1 Avoid placing medical records in unattended areas accessible to unauthorized individuals.
 - 1.1.1 Assure medical records on desks or computers can't be read by unauthorized individuals.
- 1.2 Store medical records in a manner that minimizes the possibility of damage from fire and water.
- 1.3 Implement guidelines as to when release/removal of medical records is allowed (see Medical Record Information on Release and Removal, IM.12).
- 1.4 Implement guidelines regarding copying the medical record which include:
 - Consulting with the Privacy Officer before information is disclosed;
 - Which portions of the record may be copied and for what purposes the disclosure is made;

- Documentation of the disclosure;
- Staff accountability for protection of copies in their possession; and
- Control of the destruction of record copies

1.5 Maintain confidentiality during and after normal business hours.

1.6 Educate staff, upon hire and periodically thereafter, on steps to prevent unauthorized disclosure of medical record information.

1.7 Ensure retrievability of baseline data if original medical records are destroyed.

1.8 Implement measures to maintain confidentiality when sending patient information by telecopier (fax) and email. Telecopier (fax) cover sheet will include a statement similar to the following and it shall appear in all email transmissions:

"The information contained in this telefax/email message is legally privileged and confidential information intended only for the use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copy of this telefax/email is strictly prohibited. If you have received this telefax/email in error, please immediately notify us by telephone and return the original message to us at the address listed via the United States Postal Service. Thank you."

1.9 Implement measures to maintain confidentiality/security when utilizing an electronic record/Point of Care device/laptop/personal digital assistants (PDAs)/USB flash drives and memory cards/home computers, including but not limited to:

1.9.1 All employees utilizing an electronic record/Point of Care device/laptop/personal digital assistants (PDAs)/USB flash drives/home computers will sign a confidentiality/security agreement form after being oriented to the electronic record/Point of Care device/laptop device/laptop/personal digital assistants (PDAs)/USB flash drives/home computers process. The form will include the employee's name printed/typed as well as signature.

1.9.2 All persons utilizing an electronic record/Point of Care device/laptop/personal digital assistants (PDAs)/USB flash drives/home computers will be given either network and patient database username and passwords or will password protect the program being utilized. These passwords are not to be shared with any person. Passwords will be changed by the user at least annually (recommended quarterly or following a breach of security).

1.9.3 Access to patient information on an electronic record/Point of Care device/laptop/personal digital assistants (PDAs)/USB flash drives/home computers will be limited to individuals with a legitimate "need to know" in order to effectively perform their specific job duties and responsibilities.

1.9.4 In the event an employee utilizing electronic record/Point of Care device/laptop/personal digital assistants (PDAs)/USB flash drives/home computers is terminated, suspended or has an extended leave of more than 30 days, the user access will be inactivated or, if a laptop, data will be removed to an Agency file. Agency will make every effort to remove confidential information from personal Point of Care device/laptop/personal digital assistants (PDAs)/USB flash drives/home computers. Reactivation will only occur upon notification from the Administrator or supervising nurse.

1.9.5 In the event the electronic record/Point of Care device/laptop is not available, all entries will be made on the appropriate paper documents. Paper records should be carried in locked containers.

1.9.6 If utilizing digital signatures, the above security measures must be taken and the signature must not be in an encrypted format.

1.9.7 Any electronic record/Point of Care device/laptop /personal digital assistants (PDAs)/USB flash drives/home computers issues will be submitted as identified to the QAPI Committee for review with a report of findings submitted to the Board and PAC.

2. Laptop and other portable media/devices security measures to be taken by authorized agency staff may include but, not be limited to:

2.1 Utilization of password management procedures (for changing and safeguarding passwords) for all portable or remote devices that store EPHI;

2.2 Installation of personal firewall software on all laptops that store or access EPHI or connect to networks on which EPHI is accessible;

2.3 Installation, use and regular update of virus-protection software on all portable or remote devices that may access EPHI;

2.4 Use of session termination (time-out), lock-down or other locking mechanisms for inactive or unattended laptops or other inactive portable or remote devices;

2.5 Prohibition of the placement of laptops/other portable media/devices in unattended areas accessible to unauthorized individuals (ex. Never leave in plain view in an unattended vehicle, hotels, public workstations, and Wireless Access Points);

2.6 Prohibition of transmission of EPHI (including email) over open networks, such as the Internet, where appropriate.

3. Preceding training/education and security measures will also be implemented to maintain confidentiality/security when utilizing other kinds of devices and tools such as Smart Phones, Wireless Access Points (WAPs), Memory Cards, floppy disks; CDs, DVDs, backup media, Smart cards, and Remote Access Devices (including security hardware).

4. Contracted Services

4.1 If utilizing electronic documentation, including electronic or digital signatures, the contractor will implement measures to maintain confidentiality/security of patient information and will provide the agency upon request, proof of such.

HCL / IM.6 Rvd.020109

MEDICAL RECORD FORMS AND FORMAT

IM.7

PURPOSE

To establish standardized medical record forms and format.

POLICY

Agency will maintain active and inactive medical records in a format that facilitates easy retrieval of data/information.

Agency will maintain standardized medical record forms as well as a format, for documenting all care provided to patients, which are organized for easy retrieval of data.

PROCEDURE

1. MEDICAL RECORD FORMS

1.1 Each medical record form will be reviewed and adapted to Agency and/or state specifics.

1.2 Forms will be updated as needed to comply with federal/state/CHAP regulations and will be submitted to the Director for final approval.

1.3 Staff will be educated regarding forms.

2. MEDICAL RECORD FORMAT (all filing will be done with the latest dates on top.)

2.1 ACTIVE MEDICAL RECORD:

2.1.1 Admission Information

Admission Data Base

Initial Nursing Assessment(s)

2.1.2 Plans of Treatment

May include 60-day progress/summary notes

2.1.3 Supplemental /verbal Orders

2.1.4 Medication Profiles

2.1.5 Care Plans, Team Conferences

May include 60-day progress/summary notes

2.1.6 Nursing

Visit Notes

Communication Notes

2.1.7 Home Health Aide

Visit Notes

2.1.8 Medical Social Services Visit Notes

Communication Notes

2.1.9 PT

- Visit Notes
- Communication Notes
- 2.1.10 OT
 - Visit Notes
 - Communication Notes
- 2.1.11 ST
 - Visit Notes
 - Communication Notes
- 2.1.12 Lab Reports
- 2.1.13 Miscellaneous
 - Hospital Discharge Summaries
 - Copy of Advance Directive (if applicable)
 - Patient's Bill of Rights and Responsibilities
 - Consent/Authorization
 - Provision of Services Form
 - Reply to Referral
 - Referral Form

2.2 THINNED MEDICAL RECORD:

- 2.2.1 The material which is removed from the active medical record will be compiled into a "thinned medical record."
- 2.2.2 The active medical record will be flagged with the dates thinned.
- 2.2.3 Only the following medical record forms will be considered for thinning from the active medical record:
 - Visit notes (older than 2 months)
 - Communication notes (older than 2 months) plans of treatment (older than 6 months)
 - Supplemental/verbal orders (older than 6 months)
 - Team conferences (older than 6 months)
 - Lab results (older than 6 months unless reports substantiate skill)

2.3 DISCHARGED MEDICAL RECORD:

Medical record contents and all thinned material will be combined into the same order as an active medical record when a patient is discharged from Agency.

HCL / IM.7 CHAP Rvd. 010207

MEDICAL RECORD CONTENT

IM.8

PURPOSE

To ensure each medical record contains complete information which identifies the patient, describes problems and needs of the patient, justifies patient care, and accurately describes care provided, results, significant events and continuity among disciplines.

POLICY

Agency will initiate and maintain an individual and accurate medical record for each patient receiving care in compliance with all federal and state laws and regulations.

PROCEDURE

1. Each medical record will contain the following:

1.1 Patient identification information:

- Name
- Gender
- Address
- Phone number
- Date of birth
- Legal authorized representative (if any)
- Height/weight as appropriate to patient care
- For emergency contact:

- Family member/caregiver's name
- Family member/caregiver's telephone number
- Physician's name

1.2. Patient's needs information, as documented in both initial assessments and ongoing assessments, which reflects:

- Patient history
- Dietary restrictions/nutritional requirements
- Home suitability/adaptability
- Safety measures required to protect the patient from injury
- Care provided by Agency and contracted personnel
- Date care provided
- Staff member who provided care
- An updated medication profile to include medication, allergies, and/or sensitivities
- Actual or potential drug/food interactions
- The dose, time, date, and any adverse drug reactions of every dose of medication administered by Agency staff
- Identification of individual administering the medication
- Patient's mental status

1.3 Justification of care information

- Identity of others known to be involved in patient's care
- Instructions given to patient upon discharge from another facility (if any)
- Transfer summaries/records (if any) received from transferring agencies
- Description of the patient's functional limitations
- Description of the patient's activity restrictions
- A statement of any change in patient's condition
- A statement of the conclusions or impressions drawn from the assessment data
- Primary and secondary diagnoses related to the patient's care as assessed upon admission and updated during the course of care
- Prognosis
- Rehabilitation potential

1.4 Documentation of care provided

- Identification of problems, needs, actions and goals
- Ongoing education of patients/caregivers
- Evidence of consent for care on admission and during the course of care
- Legible, complete, individualized, diagnostic, therapeutic orders, including, but not limited to, types of care and equipment needed, frequency of visits, and instructions for a timely discharge or referral
- Updated orders as obtained
- Actions/interventions/procedures
- Care provided through contracted services

1.5 Documentation/Communication for Continuity of Care

- Conclusions of patient medication monitoring
- Results of all diagnostic and therapeutic procedures and tests performed
- Patient's response to care
- Any referrals to internal or external providers/agencies
- Notification to the prescribing physician of patient discharge
- A discharge summary when patient is discharged from a discipline and/or Agency
- Any summaries of care provided through contracted services

1.6 Written consent from patient/caregiver

- Consent for treatment

- Financial authorization
- Release of records
- Services to be provided and estimated frequencies

HCL IM.8 chapRvd 020102

AUTHORIZATION AND AUTHENTICATION OF MEDICAL RECORD ENTRIES

IM.9

PURPOSE

To identify the authors of medical record entries.

To assure security of the identification of authors of electronic signatures for electronic records/point of care devices.

POLICY

All medical record entries will be made by appropriate staff and authenticated by the author of the entry.

PROCEDURE

1. Medical record entries may be made by Agency health care professionals, para professionals, and/or contracted health care providers.
2. Medical record billing/operation entries may be made by trained Agency staff members responsible for these functions.
3. Medical record entries will be written in ink or typed/computer-generated.
4. Each medical record entry will be dated and signed with the complete name and title of the person making the entry. Initials are acceptable only when requested.
5. Electronic signatures may be used by employees (who have been oriented to the process) for electronic records/point of service devices. Agency will maintain a list of all employees utilizing electronic signatures. Employee will sign a confidentiality/security form that includes the printed/typed name and original signature to facilitate positive identification of the signature per policy and procedure, Safeguarding Medical Record Information.
6. In the case of an alteration needing to be made in the medical record, one line should be made through the entry and then the health care provider should date and initial the change.
7. An original physician order is sent/ faxed to the physician for signature, and a copy is retained in the patient's medical record and/or file. A manual or electronic log is maintained to ensure timely receipt of signed orders. If orders are not returned, the Agency may call physician, re-fax order or hand carry a copy of the order to the physician's office.
8. Agency staff will verify, upon return of physician order that the order is complete, accurate, signed with date of order, and final.

HCL/IM.9ch Rvd. 060108

TIMELINES

IM.10

PURPOSE

To establish timely parameters for all medical record information.

POLICY

Agency will ensure timely provision of care and services to meet the patient's needs in compliance with all federal and state laws and regulations.

PROCEDURE

1. All Agency staff, and physician/physician office staff as appropriate, will be oriented to the following parameters:
 - 1.1 Evaluation visit for admission to Agency is within 48 hours of referral unless otherwise ordered by physician.
 - 1.2 Admission paperwork is completed within 2 days of admission to Agency
 - 1.3 Plan of care is established within 3-5 days of admission to Agency.
 - 1.4 A Registered Nurse will complete the Initial Comprehensive Assessment no later than five (5) calendar days after the start of care (SOC) for all patients in a licensed and certified agency excluding the following patients:
 - Patients under 18 years old

- Maternity patients
- Homemaker or chore service only patients

1.5 Daily progress notes with correlating time sheets are turned in every 7 days.

1.6 Recertification/comprehensive reassessments will be completed at no earlier than 5 days prior to end of cert and no later than one day prior to end of the cert (5 day window).

1.7 Supplemental Verbal Orders may be obtained before care is provided and written within 24 hours of receiving the orders. The 485 may be used as the verbal start of care when signed and dated by the RN.

1.8 Physician signatures are obtained on CMS 485s and supplemental verbal orders within 30 days and prior to billing for the service provided.

1.9 The Discharge Comprehensive Assessment is completed within 48 hours of the discharge/discharge notification or prior to submission of the OASIS data to the state.

1.10 An Admission Medical Record is assembled by the fifth (5th) working day after admission.

1.11 Encoding and submission of OASIS data to the state at least monthly and prior to billing.

1.12 Completed, encoded and locked OASIS data will be transmitted to the state at least monthly or prior to billing.

2. A tracking system will be implemented to track all physician orders.

3. All medical record information will be incorporated into the patient's medical record within 14 business days.

4. The Agency's quality/performance improvement activities may monitor effectiveness of the medical records parameters and will reevaluate the parameters if negative trends are identified.

HCL IM.10 CHAP Rvd. 042507

MEDICAL RECORD REVIEW/UTILIZATION REVIEW

IM.11

PURPOSE

To ensure appropriate documentation through timely medical record review.

POLICY

Qualified Agency individuals will review a representative sample of medical records quarterly in order to ensure that the documentation is complete, accurate and timely.

PROCEDURE

1. At quarterly intervals, a random sampling of home health clinical records is reviewed. Selection includes:

- 10% of each program's annual unduplicated admissions with a maximum of 120 sample records per year
- Representation of all disciplines providing care, diagnostic categories, lengths of stay and discharged records

2. The medical record documentation will be reviewed and analyzed on appropriate forms.

3. The results will be analyzed through the performance improvement procedure, presented to the Board of Directors, PAC, and to all appropriate Agency staff.

HCL / IM.11CHAP Rvd. 010207

MEDICAL RECORD INFORMATION RELEASE AND REMOVAL

IM.12

PURPOSE

To define the process for release or removal of medical record information from Agency's jurisdiction and safekeeping as well as Agency staffs' need for copying medical record information.

POLICY

Agency will observe confidentiality when releasing medical record information and when arranging for record removal from the licensed premises by court order, subpoena, or statute. Agency staff will observe confidentiality when copying and/or removing copied medical record information.

PROCEDURE

RELEASE TO NON-AGENCY ENTITIES

1. All requests for release of information will be submitted in writing.

2. Two copies will be made of the requested information.

2.1 One copy is packaged for hand delivery or pick-up by requesting entity. If it must be mailed, it is mailed by certified mail with "return receipt requested." It is labeled "confidential."

2.2 One copy is for Agency records.

3. The original request and authorization will be filed in the medical record.
4. in situations related to communicable or occupational disease(s) that are reportable to the state health department by law, a signed patient consent form will not be required.
5. The billing department will invoice the requesting entity or expect payment at time of pick-up.
6. Any request to release information to an entity other than the patient's physician, laboratories, contracted entities providing patient care, health care facilities receiving the patient for care, or payor sources, requires authorization in writing specifying the information to be released and the patient's/legal guardian's signature.

PATIENT/CLIENT REQUEST TO AMEND PROTECTED HEALTHCARE INFORMATION

1. Patients/clients must request amending their protected health information in writing, including a reason, and are informed of such upon admission.

a. The request shall be made of the Privacy Officer.

2. The Privacy Officer or designee shall act upon the request:

- within 30 days if the requested information is on site; or,
- Within 60 days if the requested information is off site.

2.1 A 30 days extension is permitted and the Privacy Officer shall notify the patient/client in writing of the reason and the expect date the protected health information will be available for viewing and/or copying.

3. Protected health information is retained by the Agency for six years from the last date it's in effect.

4. The exceptions for information the patient/client cannot amend include:

- that which was not generated by the Agency;
- that which was obtained for criminal, civil and/or administrative actions/proceedings and cannot be amended;
- that which is complete and accurate; or,
- That which is not part to the health or billing record.

5. If the Agency denies the patient's/client's request:

The Agency shall give the patient/client a written explanation in plain language and, if applicable, an explanation on how s/he may review the decision.

5.1 If the patient/client provides a written statement rebutting the denial:

The Agency may rebut that and provide a copy to the patient/client. The original request, denial letter, statement of disagreement and rebuttal shall be included with any disclosures of the disputed health information.

5.2 If the patient/client agrees with the denial, the Agency does not have to include the original request or denial letter with any disclosures of the disputed health information.

6. If the Agency agrees to the patient's/client's request:

- The patient/client is told of the decision and may amend his/her protected health information;
- The Agency shall request identification of and permission to contact other health care entities and/or individuals that need to be told of the amendment; and
- The Agency shall contact those entities as well as its own Business Associates.

7. If the Agency is contacted by another health care provider or plan that the patient's/client's protected health information has been amended:

- The amendment is made part of the medical record; and
- The Agency shall notify any of its Business Associates that use/rely on the information and they shall make changes as required in the written agreement with the Agency.

RELEASE TO AGENCY STAFF

1. Any information in patient's medical record that is pertinent to the planning or delivery of patient care may be copied by designated Agency staff.

Agency retains the right to review and limit the information to be copied in individual patient cases.

2. The following designated staff may utilize copies of medical record information in planning or providing patient care:

- Nursing staff
- Home health aide staff

- Physical therapists
- Occupational therapists
- Speech therapists
- Medical social workers
- Dietitians/nutritionists

3. Agency staff will implement the following measures to ensure confidentiality of copied/original medical record information:

- 3.1 Only information that relates to the patient receiving care will be taken into that residence.
- 3.2 Medical record information will not be left unattended in an unlocked vehicle.
- 3.3 Medical record information with patient identification will not be visible to the public.

RELEASE TO THE PATIENT

1. All patients are entitled to access to their clinical records.
2. Upon request, two copies will be made of the requested information.
 - 2.1 One copy is packaged for hand delivery or pick-up by the patient. If it must be mailed, it is mailed by certified mail with "return receipt requested." It is labeled "confidential."
 - 2.2 One copy is for Agency records.
3. The original request and authorization will be filed in the medical record.

MEDICAL RECORD INFORMATION REMOVAL

1. All requests for removal of information will be submitted in writing.
2. All information to be sent will be copied for Agency and labeled "copy."
3. The original information will be packaged for delivery and labeled "confidential."
4. The information will be delivered in one of the following ways:
 - hand-delivered by Agency staff,
 - picked up by requesting entity, or
 - Certified mail with return receipt requested.
5. The original request and authorization will be filed in the medical record.
6. When the original is returned, the copy will be retained for Agency records.

HCL IM.12 CHAP Rvd. 032003

MEDICAL RECORD INFORMATION RETENTION AND DESTRUCTION

IM.13

PURPOSE

To ensure medical record information retention and destruction is in accordance with federal and state laws and regulations.

POLICY

Agency will maintain all adult medical records for a minimum of five (5) years after discharge of the patient and for any additional time as deemed necessary in the event of an audit, litigation or other dispute until after settlement.

In the case of a child, the medical record will be maintained until the age of maturity (18) years, plus seven (7) years beyond the age of maturity.

If the patient is mentally retarded or mentally handicapped, the medical record will be maintained until the patient reaches the age of maturity (18 years), plus six years, until the patient is 24 years of age.

In the event that Agency ceases to exist, all charts will be maintained in safekeeping for at least six years.

In the case of an employee exposure to communicable diseases, the post exposure records will be retained for 30 years.

The final disposition/responsibility for the patient's medical record will rest with Agency Administrator and Board of Directors.

The State will be notified of closure of the agency, the location of the medical records and the responsible party.

PROCEDURE

PROCESS: RETENTION OF INFORMATION

1. All inactive medical record contents will be combined in chronological order into one document.
2. Inactive patient medical records will be stored in alphabetical order by year of discharge.
3. Medical records will be stored so as to protect them from damage, loss, and/or theft.

4. Inactive medical records will be accessible during normal working hours. If a medical record is removed, the appropriate sign-out form is completed and all medical records are returned by the end of business day.
5. Inactive patient information stored in a computer data system will be protected from accidental deletion and remain accessible to identified staff during normal working hours.

PROCESS: PROTECTION OF PROTECTED HEALTH INFORMATION (PHI) OF DECEASED PATIENTS

1. The Agency shall honor the privacy of a deceased patient's/client's PHI for as long as the information is stored /maintained but at least for six years.
2. The deceased patient's/client's rights regarding his/her PHI may be exercised by someone with legal authority to act on behalf of the patient/client.
3. The Agency shall verify the identity of the individual with legal authority to act on behalf of the deceased patient/client per Agency's protocol.

PROCESS:: DESTRUCTION OF INFORMATION

1. When a patient is discharged from active care, all non-original/copied information carried by Agency staff to facilitate patient care will be returned to the office for destruction.
2. When a patient is discharged from active care, and after final billing, information stored in the computer system will be purged at an appointed time.
3. At the time identified by policy, inactive patient medical records will be removed from storage by Agency staff and destroyed in a manner so as to ensure that information cannot be retrieved.(shredding, contract with disposal company, etc.)

HCL IM.13 CHAP Rvd 030507

PUBLIC DISCLOSURE OF AGENCY INFORMATION

IM.14

PURPOSE

To define the accessibility and availability of public information related to the agency.

POLICY

Agency will prepare and make available to the public upon request a public disclosure statement, in compliance with state and federal laws and regulations.

PROCEDURE

- A. The Administrator, or designee, will prepare a written annual public disclosure statement, in compliance with state and federal laws and regulations, to include but not be limited to ownership information, statement of the organization's mission, and licensure and accreditation status as applicable. The public disclosure statement is to be signed by the Administrator and made available to the public on request and to the clients prior to the start of care or at the time of initiation of care. (May insert policy in Admit Pack and/or may use Public Disclosure Information Form for statement).

HCL / IM.14 L&C CH Rvd. 030108

QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN

QAPI.1

PURPOSE

To develop a Quality Assessment Performance Improvement Plan (QAPI), implemented by the QAPI/Utilization Review (UR) committee that captures significant outcomes that are essential to optimal care and are used in the care planning and coordination of services and events

POLICY

Agency will develop a plan that is reviewed and updated or revised at least once within the calendar year, or more often if needed, by the QAPI/UR Committee.

Agency will strive to improve operational and patient health outcomes by implementing a performance improvement plan that incorporates the following essential processes:

- Designing processes,
- Monitoring performance through data collection,
- Analyzing current performance, and
- Improving and sustaining improved performance over time.

Agency will focus primarily on its processes and/or system performances rather than an individual's performance

yet will recognize the importance of the competence of its staff.

Areas for improvement will be identified through the collection of data for analysis of Agency services. Systems of measures include:

- A representative sample of services furnished to patients contained in both active and discharged charts,
- Issues of unprofessional conduct by licensed staff and misconduct by unlicensed staff,
- Infection control activities,
- Medication administration and errors,
- Services have been performed as outlined in the care plan,
- Patient complaints and satisfaction survey data, including agency response to complaints,
- Patient incidents including agency response to incidents,
- Effectiveness and safety of all services provided, including:
 - ▶ Competency of agency staff,
 - ▶ Promptness of service delivery.

Agency leaders understand performance improvement principles and methods and will be responsible for providing education for staff as needed.

Agency leaders will be responsible for setting expectations, developing plans and managing processes to improve the Agency's performance.

Agency leaders/QAPI committee will choose an approach to performance improvement that is planned, systematic, Agency-wide in scope, collaborative in effort and includes all departments/disciplines.

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

The QAPI committee will consist of, at a minimum, the Administrator, supervising nurse or therapist, and individuals representing the scope of services provided by the agency. The QAPI Committee will meet at least quarterly or more often, if needed.

PROCEDURE

When planning for performance improvement, Agency leaders will consider the following:

1.1 Identifying the role and responsibilities of each level of staff in performance improvement activities.

1.2 Identifying the role of teams and the charting process.

1.3 Identifying the reporting path for all performance improvement activities.

1.4 Identifying the major functions and processes carried out by Agency:

- Scope,
- Functions,
- Staff/patient needs,
- Problems,
- Survey.

1.5 Identifying the performance measures for each function and processes within the function.

1.6 Identifying the data collection methodology (i.e., how and by whom data will be collected and what process will be used to analyze data).

1.7 Identifying the performance improvement problem-solving method to be used.

2. Agency leaders will provide and ensure employee training regarding the performance improvement concept/philosophy by providing an overview during Agency orientation/in-service. Complete training will be provided for employees serving as members on QAPI committee.

3. The QAPI committee will consist of, at a minimum, the Administrator, supervising nurse/therapist, and representation from skilled and unskilled disciplines providing services. The QAPI Committee will meet at least quarterly or more often, if needed.

4. Agency leaders/QAPI Committee will prioritize performance improvement activities. Criteria in setting priorities will include:

- The expected impact on performance;
- Selecting high-risk, high-volume, or problem-prone processes to monitor; Data obtained from Adverse Event reports, as appropriate;
- The relationship of the potential improvement to the dimensions of performance and function; and

- The Agency's resources.
5. Agency leaders will re-prioritize if an unusual or urgent event occurs. The agency will immediately correct identified problems that directly or potentially threaten the client care and safety.
 6. The plan will be communicated to each level of staff.
 7. The performance improvement plan will be implemented.
 8. The program will be evaluated, reviewed and updated or revised at least once within the calendar year, or more often if needed, by the QAPI/PI Committee.
 9. QAPI documents will be kept confidential and be made available to Texas Department of Aging and Disability Services' staff upon request.

HCLQAPI.1 CHAP Rvd. 010207

DESIGNING PROCESSES/PROGRAMS

QAPI.2

PURPOSE

To identify the need for designing/redesigning process/programs and to outline the steps for development and implementation.

POLICY

Agency leaders/QAPI Committee will take the following elements into consideration when designing/redesigning process/programs:

- Agency's mission, vision, values, goals/objectives and strategic plan
- The needs and expectations of patients/caregivers, staff, referral sources and others involved in the Plan of Care
- Up-to-date industry resources
- Reference information when available and appropriate
- High risk, high volume, problem prone processes
- Information from other agencies regarding incidents
- Other significant performance indicators

PROCEDURE

1. Agency leaders will consider the following when identifying potential process/program needs:
 - Agency strategic plan
 - Customer survey results
 - Patient Complaints
 - Staff survey results
 - Industry trends
 - Performance indicators Agency function/processes
 - OBQM/OBQI reports
2. The QAPI Committee, with input from staff, will identify which process(es) or Agency program(s) will be developed/redesigned.
3. Responsibility for developing/redesigning the process/program will be assigned.
4. The responsible staff will include all appropriate internal/external resources during the development/redesign phase.
5. Agency leaders will be involved in the review and approval of any process/program and identifying the pilot phase.
6. The process/program will be piloted.
7. The pilot phase will be evaluated by Agency leaders, QAPI Committee and the staff involved in the development.
8. The QAPI Committee involved in development will determine final implementation and set performance expectations for the new or redesigned process/program.
9. Performance measures will be implemented to determine if the process/program is actually performing according to the performance expectations and the way it was designed.
10. The new/redesigned process/program will continue to be evaluated by the QAPI committee and staffs until expectations are met.

HCL QAPI.2 chap Rvd 103002

PERFORMANCE IMPROVEMENT PROCESS:

QAPI.3

DATA COLLECTION

PURPOSE

Data is collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement, and sustain improvement.

POLICY

The Agency will collect data to monitor performance of areas targeted for study and to determine effectiveness of the change.

Data will be collected in a uniform, systematic way to:

- Establish a performance baseline;
- Describe process performance or stability;
- Describe the dimensions of performance relevant to functions, processes, and outcomes;
- Identify areas for more focused data collection; and
- Sustain improvement.

Agency will collect patient Satisfaction/Perception of Care data to monitor performance (see Policy QAPI.6).

Agency will collect OASIS data on all non-maternity patients age 18 and older (does not include patients that receive only homemaker or chore services).

The Agency will collect data to monitor the performance of processes that involve risks or may result in adverse events/sentinel events to include but not limited to:

- Emergent care for improper medication administration/medication side effect
- Emergent care for wound infection/deteriorating status
- Emergent care for hyperglycemia and hypoglycemia
- Emergent care for fall or accident at home

PERFORMANCE IMPROVEMENT PROCESS:

DATA COLLECTION

- Development of urinary tract infection
- Increase in pressure ulcers
- Unexpected nursing home placement
- Unexpected death
- Discharge to community
 - Needing toileting assistance
 - Needing wound care
 - With behavioral problems
- Substantial decline in:
 - Management of oral medications
 - In 3 or more activities of daily living
- Use of blood and blood components, if provided
- Care or services provided to high-risk populations (i.e., OB, IV, Pediatric)

PROCEDURE

1. Agency leaders will assign appropriate Agency staff to develop the appropriate measurement criteria to outline the data to be collected.

2. Data collection tools will be developed to aid in collection.

3. The appropriate staff to collect the data will be identified and educated regarding Agency expectations.

4. The time frame for data collection will be established.

5. The frequency of data collection will be established for each individual measurement need based on whether it is:

- For a priority issue
- A planned process design/redesign
- For a continuing process

6. The data will be collected and forwarded to the identified person(s).

7. Findings will be presented to the Board of Directors and PAC.

Utilization Review

1. At least quarterly, appropriate health care professionals, representing at the scope of services provided in that quarter, will review a sample of both active and closed clinical records based on Agency's record review criteria.
 - Selection includes 10% of each program's annual unduplicated admissions with a maximum of 120 sample records per year,
 - Record selection includes representative of all disciplines providing care, diagnostic categories, lengths of stay and closed records,
 - Record reviews for clinical services include a random sample of 5% of the current active caseload as applicable.
2. Services, both direct and under contract, will be evaluated to determine the following:
 - Consistency with professional practice standards and Agency policies
 - Compliance with the Plan of Care
 - Appropriateness, adequacy, and effectiveness of services offered
 - Evaluations of anticipated patient outcomes
3. Data collected will be integrated into the QAPI program to assist the Agency in identifying areas needing improvement and in the improvement process.
4. Agency will maintain a written record of the quarterly utilization review process with appropriate signatures.

HCL QAPI.3 CHAP Rvd. 041607

PERFORMANCE IMPROVEMENT PROCESS:

QAPI.4

DATA AGGREGATION AND ANALYSIS

PURPOSE

To define the frame of reference for interpreting the collected data during the measurement phase.

POLICY

Agency will implement a systematic process to analyze collected data on an on-going basis by a QAPI Committee.

Aggregated data are analyzed in order to make judgments about:

- Whether the design specifications for processes were met,
- The level of performance and stability of important existing processes,
- Opportunities for improvement,
- Actions to improve the performance of processes, and
- Whether changes in the processes resulted in improvement.

PROCEDURE

A. The collected data will be organized and displayed using statistical control techniques.

1. The data will be reviewed for the purposes of:

- 1.1 Comparing the processes and outcomes over time for trend analysis of run charts and control charts.
- 1.2 Comparing data to reference databases as appropriate (e.g., State Home Health Licensure Board, State Home Health Association, Inc., National Association For Home Care, OBQI Reports).
- 1.3 Comparing to industry resources (e.g., benchmark with other home care agencies, OBQI reports).
- 1.4 Intensive assessment/analysis when comparisons show that:
 - Important single events, levels of performance, patterns, or trends vary significantly and undesirably from those expected;
 - Performance varies significantly and undesirably from that of other organizations;
 - Performance varies significantly and undesirably from recognized standards; or
- 1.5 Intensive assessment/analysis on all confirmed blood transfusion reactions.
- 1.6 Intensive assessment/analysis on all significant adverse drug reactions.
- 1.7 Intensive assessment/analysis on all significant errors related to medication use.
- 1.8 Identifying the need for actions related to a staff member's competence as a result of performance improvement assessment.
- 1.9 Intensive assessment of unprofessional conduct by licensed staff and misconduct by unlicensed staff.

2. Conclusions will be drawn and recommendations made to the appropriate Agency staff. Recommendations may include but not limited to the following:

- To collect additional data
- To initiate performance improvement activities
- For follow-up with an individual staff member

3. Follow-up with an individual staff member will be documented in the employee's personnel file and may include but is not limited to:

- Educational activities
- Counseling
- Improvement time line

4. All assessment, comparison, and recommendation activities will be documented.

HCL QAPI.4 chap Rvd 103002

PERFORMANCE IMPROVEMENT PROCESS:

QAPI.5

IMPROVED PERFORMANCE

PURPOSE

To establish a standard for achieving improved performance and then sustaining it.

POLICY

Agency leaders/QAPI committee will be responsible for setting the priorities for improvement activities based on Agency functions, the defined measurement factors, the resources required to facilitate the improvement, and the organization's mission.

When developing the improvement activities, Agency will consider the following:

- The expected impact of the improvement
- The expectation level for the improvement activity
- The measures/data needed to evaluate the effectiveness of the improvement activity

PROCEDURE

1. The recommendations for performance improvement activities will be reviewed by the QAPI committee.
2. Activities will be selected and prioritized based on policy elements and will coincide with Agency's mission and strategic plan.
3. The staff members with the greatest working knowledge of the process will be actively involved in the improvement process.
4. The performance improvement activity strategy for change will be designed with appropriate Agency staff and other resources involved.
5. Agency staff affected by the change will be educated.
6. The strategy for change will be tested on a trial basis.
7. Data will be collected to assess if improvement occurred as a result of the strategy for change.
8. If appropriate, the change will be implemented Agency-wide.
9. Performance measures will be used to determine if the improvement is sustained.

HCL QAPI.5 chap Rvd 020102

PATIENT SATISFACTION/PERCEPTION OF CARE DATA

QAPI.6

PURPOSE

To establish a system to obtain feedback and take appropriate action regarding patient/caregiver perception of care provided by the Agency and to evaluate the care provided versus the needs and desires of the patients.

POLICY

Agency will obtain feedback from current and discharged patients to evaluate the care provided by the Agency. This information will be utilized in the planning process to design care which meets the needs and expectations of the patient and utilized in the QAPI Program.

The Administrator will supervise and evaluate the patient satisfaction/perception surveys on all clients served by the Agency.

PROCEDURE

1. The written "Patient Perception of Care Survey" form will be provided to patients within the first month after

discharge.

2. The form will reflect the patient's perception of how well the Agency met their needs and expectations. Focus will be on major clinical care activities and support functions in relation to the appropriateness, availability, continuity, effectiveness, efficiency, respect, compassion, safety, and timeliness of care, as well as what activities/functions are or are not important to the patient.

3. Agency will conduct, as needed, telephone or written surveys to evaluate the effectiveness of performance improvement activities.

4. The survey data will be evaluated and the patient responded to as appropriate.

5. Immediate corrective action will be implemented when necessary.

6. A summary of the survey's data will be compiled quarterly and distributed at least quarterly to appropriate Agency leaders for incorporation, as appropriate, into the planning process for the Agency and for establishing priorities in the Annual Quality Assessment /Performance Improvement Plan.

7. Patient evaluations of Agency care will be communicated to appropriate staff/individuals.

HCL QAPI.6 chap Rvd 103002

AGENCY EVALUATION PROCESS

QAPI.7

PURPOSE

To outline the process for performing an annual agency evaluation and assess Agency's program for appropriateness, adequacy, effectiveness, and efficiency.

POLICY

Agency leaders (including the Board of Directors, managers, PAC, QAPI Committee) will participate in an annual evaluation of the organization's performance in relation to its written organizational plan, mission, vision and philosophy. Findings will be utilized to correct identified problems.

PROCEDURE

A. The evaluation will include an analysis of:

1. Effectiveness of administrative practices to include:

- Policies and procedures
- Organizational structure and system
- Achievement of goals
- Measurable client outcomes
- Programs, including utilization and quality of services and products, appropriateness and adequacy, effectiveness and efficiency (including information about referrals not accepted)
- Personnel/human resources
- Staff development, recruitment and retention
- Performance improvement program to include CASPER Reports, i.e., OBQM Adverse Event Reports, Provider Reports, i.e., Error Summary and Submission Statistics as well as OBQI Reports and outcome measures as appropriate
- Safety, security, fire safety practices
- Emergency preparedness
- Risk management (occurrence reports)
- Financial data and billing practices Information systems
- Benchmarking
- Written service contracts

2. Clinical data collected will include, but not be limited to:

- Demographics of patients served by type of program
- Number of patients served by age, sex, diagnosis, program and discipline of services
- Referral sources
- Number of admissions and re-admissions
- Number of non-accepted patients including rationale for decision
- Number of visits
- Outcomes of care

- Quality indicators
- Lengths of stay
- Discharges and reason for discharge
- Staff productivity by discipline
- Patient complaints and satisfaction surveys
- Services provided under contract or arrangement

3. A written summarization with recommendations for improvement or change will be presented to PAC and the Board of Directors annually for approval and retained at Agency's administrative offices.

4. Agency leaders/QAPI Committee will establish immediate goals for improvement or change and will incorporate recommendations into the organizational plan. The agency will document corrective action to ensure that improvements are sustained over time.

HCL/ QAPI.7 CH Rvd. 070109

INFECTION CONTROL PROGRAM

IC.1

PURPOSE

To outline the policies and procedures for an infection control program which applies to patients, staff and care provided. The program improves patient health outcomes through the identification and reduction of risks of infections in patients and staff.

POLICY*

Agency's infection control program will be based on the following criteria:

- The demographics of the patient population (geographics, number of patients)
- The scope and focus of care provided
- Current scientific methods of surveillance and prevention or control of adverse outcomes related to infections
- CDC guidelines
- Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81 and State List of Notifiable Conditions List (updated annually, Notifiable Conditions may be found under the Texas Department of State Health Services website, Infectious Diseases)
- Current federal/state/local laws and regulations
- A review of current related literature

The Infection Control Program will include:

1. Assignment of responsibilities
2. Definitions of the types of infections to be reported
3. A system that coordinates:
 - 3.1 Surveillance for the occurrence of an infection
 - 3.2 Identification of the occurrence
 - 3.3 Review of the data collected to evaluate for trends, patterns, etc.
 - 3.4 Reporting the data and any identified trends as appropriate
 - 3.5 Implementing appropriate preventive procedures
 - 3.6 Implementing appropriate measures to control infection

4. Educating patients, caregivers and staff on all related policies and procedures. All aspects of the program will be reviewed and revised annually, as needed.

THE INFECTION CONTROL PROGRAM

The geographic area served by Agency.

The patient population is at an increased risk for infections related to HIV, Tuberculosis, and Hepatitis.

The patient population includes a significant number of geriatric patients. By the nature of their age, diagnosis, or the treatment(s) ordered, this population has an increased risk to develop genitourinary, respiratory, and Integumentary infections.

Also, due to these patient population characteristics, caregiver staff could potentially be exposed to airborne and/or blood borne pathogens.

1. ASSIGNMENT OF RESPONSIBILITIES

1.1 Management will be responsible for coordinating all activities related to the Infection Control Program.

1.2 A group composed of representatives of each appropriate discipline will review collected data and submit timely recommendations to the Performance Improvement committee/ PAC.

1.3 Documentation will include at a minimum:

- Date infection was detected
- Client's name
- Primary diagnosis
- Signs/symptoms
- Sources of infection
- Type of infection
- Modes of transmission Pathogen identified, if any Treatment

1.4 Summaries of reviews, trend composites, recommendations, and related performance improvement activities will be maintained by Agency.

2. Process for Reporting Employee Infections

2.1 When an Agency staff member becomes aware that he/she has one of the reportable infections or has been exposed to one, he/she must notify their supervisor before performing any job duties.

2.2 The supervisor will determine if job duties can be performed without risk to co-workers or patients.

2.3 An "Infection Control Report" will be completed within 48 working hours and submitted to Patient Care Manager/QAPI Coordinator.

2.4 If required by law, Agency will report the infection occurrence to the appropriate regulatory agency.

2.5 As needed, exposure follow-up will be initiated as defined in the Exposure Control Program, Blood borne Pathogen Program, Airborne Pathogen Program, or Hazardous Chemical Program.

2.6 The Infection Control Team/QAPI Committee will review all reports and analyze the data, noting trends/patterns. Recommendations needing follow-up will be reported to the Performance Improvement Council.

2.7 A composite of infection control data will be presented to the Board of Directors annually.

3. SYSTEM FOR REPORTING PATIENT/EMPLOYEE INFECTIONS

3.1. All sources of infections, nosocomial, and home acquired and professional exposure will be followed.

3.2. An employee's infection or exposure will be reported and documented as soon as the employee is aware of it.

3.3 The employee's supervisor will determine if the employee can safely perform his/her job duties without exposing coworkers or patients.

3.4 If an employee is aware of his/her infection or exposure and provides patient care without approval from his/her supervisor, the employee will be subject to disciplinary action.

3.5 All reported infections will be documented on the appropriate Agency form for monthly review, analysis, trending, and initiation of performance improvement activities if deemed necessary.

3.6 As mandated by the Occupational Safety and Health Administration (OSHA), tuberculosis will be reported to the local health department.

3.7 Confidentiality of material/information will be maintained as appropriate.

3.8 When trends and significant occurrences are identified, a review will be initiated for appropriate infection prevention or control measures to include identification and investigation of any potential breaks in technique.

4. EDUCATION OF EMPLOYEE

4.1 Upon hire and annually thereafter, all Agency employees will be educated regarding the policies and procedures related to:

- Infection Control Program
- Exposure Control Plan
- Blood borne/Airborne/HIV Pathogen Program
- Hazardous Chemical Program
- Patient care procedures for preventing and/or controlling infections

- Standard precautions

4.2 Patient/Caregiver

When an infection develops or an exposure occurs, the patient's/ caregiver's knowledge base related to infection control policies and procedures will be assessed for the initiation of an appropriate care plan and education will be provided as needed.

Any outbreaks, exotic diseases, and unusual group expressions of disease will be reported. All diseases shall be reported by name, age, sex, race/ethnicity, DOB, address, telephone number, disease, date of onset, method of diagnosis, and name, address, and telephone number of physician. The conditions will be reported per regulation.

Cases or suspected cases of illness considered to be public health emergencies, outbreaks, exotic diseases, and unusual group expressions of disease must be reported to the local health department or TDH immediately. Other diseases for which there must be a quick public health response must be reported within one working day. All other conditions must be reported to the local health department or TDH within one week.

Note that any notifiable condition can be reported by calling 800-705-8868. In case of emergency, calling this number after hours will reach the physician/epidemiologist-on-call. Paper forms can be obtained by calling your local health department, or by calling 512-458-7218.

HCL / IC.1 CH Rvd. 041008

EXPOSURE CONTROL PLAN

IC.2

PURPOSE

To establish Agency programs that includes policies and procedures for the protection of both patients and staff from exposure to blood borne pathogens, airborne pathogens and hazardous materials.

To establish Agency procedures to follow to evaluate and implement new technology to isolate or remove blood borne pathogens hazard from the workplace.

POLICY

The Agency is committed to providing a safe and healthful work environment for the entire staff. In accordance with federal and state laws and regulations, Agency will design, implement and evaluate annually an Exposure Control Plan which will include:

- Identifying which job-related tasks will put an employee at an increased risk for exposure to an airborne or blood borne pathogen.
- Identifying the needed engineering controls and personal protective equipment for each job classification.
- Ensuring that educational needs, exposure follow-up procedure, counseling and documentation needs will be followed as outlined in the Blood borne Pathogen Program, per Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 relating to Blood borne Pathogens, Airborne Pathogen Program, and Hazardous Materials Program.
- Compliance of the agency, employees and contractors with health and safety code, Chapter 85, Subchapter 1, in the prevention of the transmission of human immunodeficiency virus and Hepatitis B virus.

AIRBORNE/BLOOD BORNE PATHOGEN PROGRAM

The purpose of the Airborne/Blood borne Pathogen Program is to define Agency and staff responsibilities, educate Agency staff on all aspects of airborne and blood pathogens, and define available testing for Agency staff, as well as ensure the protection of Agency staff and patients.

A. Agency Responsibilities

1. To provide a system for early identification of individuals with active tuberculosis, or those who are at high risk for active tuberculosis as defined by the Centers for Disease Control (CDC).

2. To provide medical surveillance this will include:

2.1 Tuberculosis

2.1.1 An initial base line screening via the 2 step Mantoux method for all direct patient care staff members on hire. If the employee can provide proof of TB test within the last 12 months then only a one step would

be required.

2.1.2 A negative chest x-ray is required on employees that test positive for TB on hire and/or upon becoming symptomatic during their course of employment.

2.1.3 Annually, the employee will be assessed for the necessity of TB screening.

2.2 Hepatitis B

2.2.1 Direct patient care employees are offered the HBV vaccination series on hire.

2.2.2 Agency is responsible for the series, including cost, at any time the employee elects to receive the vaccination series. The series must be started within 10 days of request.

2.2.3 The employee elects to receive or decline the HBV vaccination series by documenting on the appropriate form.

2.2.4 The vaccinations may be administered by agency management and documented appropriately or by an outside facility.

2.2.5 The employee is responsible for scheduling the series. If the employee does not complete the HBV series, any cost incurred by Agency for the incomplete series will be the responsibility of the employee.

2.3 Hepatitis C

2.3.1 As there is no vaccine against Hepatitis C, and no treatment after an exposure that will prevent infection - orient and in-service staff on infection control procedures to prevent percutaneous injuries.

3. To evaluate and manage employees with a positive skin test, with skin test conversion on repeat testing, or who are exhibiting symptoms of tuberculosis, including work restrictions for infectious employees.

4. To coordinate the home management of patients and control of employee exposure with suspected or confirmed tuberculin infection through engineering and work practice oversight (e.g. Patient with suspected or confirmed tuberculin infection will be the last one seen that day by clinical staff and/or use other measures to decrease risk of patient/employee exposure).

5. To provide training and information related to airborne and blood borne pathogens for all staff upon hire and annually thereafter.

6. To provide training and information related to HIV/AIDS and to the hazards of exposure to TB for all staff upon hire and annually thereafter.

7. To provide appropriate personal protective equipment (PPE) when caring for a suspected/confirmed TB client. Agency will provide disposable, CDC approved masks. (HEPA, Technol), disposal stethoscope/blood pressure cuff, and disposable gown as needed.

8. To maintain staff confidentiality with regard to follow-up testing, record keeping and identification of staff who have experienced needle sticks.

9. To maintain current accurate logs and summaries as required by OSHA.

B. Staff Responsibilities

1. To attend the educational in-service related to airborne and blood borne pathogens upon hire and annually thereafter.

2. To successfully master a cognitive and skill evaluation of the materials.

3. To notify Agency of any special needs related to personal protective equipment (PPE) and/or engineering controls, (e.g., the need for extra large gloves, disposable blood pressure cuff/stethoscope, CDC approved masks, disposable gown, etc.).

4. To appropriately implement the PPE, engineering controls, and work practice oversight to decrease the risk of exposure.

5. To notify Agency of any defaults in PPE or engineering controls, (e.g., self-sheathing needles that do not work, masks that do not properly fit, etc.).

6. To notify the appropriate supervisor of y exposure occurrence.

7. To complete all documentation as required.

8. To participate in selecting safer devices as needs are identified.

C. System for Airborne Pathogen Exposure Protection and Follow-Up

The exposure occurrence will be reported to the supervisor.

2. An "Occurrence Report" form will be completed by the involved individual, and the appropriate OSHA Log will be completed by Agency.

3. Medical follow-up will be initiated at no cost to the worker.

4. The supervisor, with input from appropriate resources, will review the incident and determine what, if any, changes need to be made to engineering controls, work practice controls, personal protective equipment, housekeeping or handling of medical waste to prevent future exposure to patients or staff.

D. System For Blood borne Pathogen Exposure Follow-Up

1. The exposure occurrence will be reported to the supervisor.

2. An "Occurrence Report" form will be completed by the involved individual, and the appropriate OSHA Log will be completed by Agency.

A sharps injury log will be maintained by the Agency to include the type and brand of device involved in the incident, where the exposure incident occurred and explanation of how the incident occurred.

3. The supervisor, with input from appropriate resources, will determine if medical follow-up is indicated. The agency will be responsible for the charges for the medical follow up.

3.1 If medical follow-up is indicated:

3.1.1 The following lab work will be obtained from the employee at the intervals designated below for Hepatitis B Virus, Hepatitis C, and Human Immune Virus

- Within 48 hours of exposure
- 3 months after exposure
- months after exposure
- 12 months after exposure

3.1.2 Employees with suspected/confirmed Tuberculin Disease will receive a chest x-ray to verify active disease. If active disease is confirmed, the employee will receive follow up care per physician's orders. Employee will not see patients until cleared by the physician.

3.1.3 Agency will offer counseling to the employee.

3.1.4 Agency will obtain a physician's order and patient consent to obtain blood samples for the following:

- Hepatitis B Virus
- Hepatitis C Virus
- Human Immune Virus

3.1.5 If the patient refuses to give consent, Agency will document the inability to obtain patient consent.

4. The supervisor, with input from appropriate resources, will review the incident and determine what, if any, changes need to be made to engineering controls, work practice controls, personal protective equipment, housekeeping or handling of medical waste to prevent future exposure to patients or staff.

E. Exposure Determination Statement

1. Classification of Employees

1.1 Employees that have all requirements for occupational exposure risk include the following:

- Registered Nurses
- Licensed Vocational Nurses
- Home Health Aides
- Sitter/Companions

1.2 Employees that have some requirements for occupational exposure risk include the following:

- Physical Therapists
- Occupational Therapists
- Speech Therapists
- Medical Social Workers
- Dieticians

2. Exposure Potential Activities

2.1 Activities that are considered high risk include:

- Blood sugar checks by finger stick;
- All venipunctures;
- Any intravenous procedures: implantable port access or de-access, peripheral or central lines, epidural

catheters, heparin locks;

- Dressing changes of draining wounds;
- Removal of fecal impaction;
- Emptying/changing of any drainage device: urinary drainage collection devices, colostomy bags, Gastrostomy or jejunostomy devices, J-P drains, and wound drainage collection devices; and
- Bathing of patients with excreta on the skin or from draining wounds

3. Exposure Control Plan - Standard Precautions

3.1 All employees will be provided with appropriate equipment and instruction on required guidelines through the use of in-services and written protocols.

3.2 Work Practice Controls / Oversight

- Proper hand washing by health care personnel at the beginning and ending of each visit, and after any procedure considered as occupational risk.
- Gloves must be worn at all times when a reasonable potential for contamination of the employee by blood or body fluids exists.
- Use of face masks, eye protection, disposable blood pressure cuff/stethoscope and disposable gowns are required when the potential for splashing of blood, respiratory droplets, or other infectious materials is possible.
- All health care workers who have cuts, abrasions, puncture wounds or a hangnail of their own hand must wear gloves at all times during patient contact.
- Any surface which has come into contact with blood or other potentially infectious body fluids must be wiped down with a bleach solution, diluted at 1:10 with water, or a commercially prepared disinfectant solution.
- All sharps will be left uncapped and disposed of immediately into properly labeled containers. If a needle must be recapped for safety, the one-handed scoop method is to be utilized. All nurses are to take Biohazard sharps containers into the home for disposal of needles used on venipunctures or when other infrequent procedures are performed. Containers used for collection of sharps must be puncture resistant, closable, opaque, and non-breakable and leak proof.
- A sharps container will be left in the patient's home when venipunctures or other frequent procedures are performed on a continual basis. These containers are to be handled and stored in the home in a safe manner, away from children and pets. When the containers are approximately 2/3 full, the nurse is to transport the container to the office to be disposed of in an approve manner for destruction. The nurse is to transport the filled container with the lid closed and stored upright to prevent spills, and transported in such a manner as to not come into contact with children or others during transport. The patient and/or family shall be taught the correct procedure for the storage and use of the sharps container in the home.
- All contaminated materials are to be placed in a closeable receptacle and labeled as Biohazardous before suitable disposal.

3.3 Engineering Controls

3.3.1 Engineering controls shall be used to eliminate or minimize employee exposure to all airborne/blood borne pathogens. These include:

- Self-sheathing needles
- Sharps with engineered sharps injury protections
- Needleless systems
- Appropriate PPE, such as disposable CDC approved masks (HEPA, Technol), disposable blood pressure cuff/stethoscopes, disposable gowns, etc. when caring for a suspected/confirmed TB client.

3.3.2 Engineering controls shall be examined and maintained or replaced on a regular schedule by the administrator or designee.

3.4 Warning Labels

3.4.1 An approved Biohazard symbol must be affixed to all regulated waste containers.

3.4.2 Refrigerators containing blood or body fluids shall have a Biohazard symbol affixed to the door.

3.4.3 The Biohazard label shall be affixed to all containers used for transport of blood or body fluids, i.e.; ice chests or other containers.

3.4.4 Red bags and or containers marked with the Biohazard symbol may be substituted for the labels.

SHARPS PROTECTION PROGRAM

In accordance with OSHA's regulations, Agency will design, implement and evaluate whenever possible new technology for safer needles and sharps to further prevent needle sticks and cuts.

DEFINITIONS

"Engineering controls" - controls such as sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems, disposable blood pressure cuff/stethoscope, disposable CDC masks, etc. that isolate or remove blood borne pathogens hazard from the workplace.

"Needleless systems" - devices that do not use needles for (1) the collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) the administration of medication or fluids; or (3) any other procedure involving the potential for occupational exposure to blood borne pathogens due to percutaneous injuries from contaminated sharps. Examples include: IV medication systems which administer medication or fluids through a catheter port using non-needle connections; and jet injection systems which deliver liquid medication beneath the skin or through a muscle.

"Sharps with engineered sharps injury protections" - means a non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident. Examples include: syringes with a sliding sheath that shields the attached needle after use; needles that retract into a syringe after use; shielded or retracting catheters; and intravenous medication (IV) delivery systems that use a catheter port with a needle housed in a protective covering.

SHARPS PROTECTION PROCEDURE

1. The Administrator or designee shall review and update information for sharps protection at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

1.1 The review and update shall reflect changes in technology that eliminate or reduce exposure to blood borne pathogens.

1.2 The Administrator or designee shall document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

2. The Agency shall solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice oversight. Employees selected should represent the range of exposure situations encountered in the workplace, such as those in geriatric, pediatric and others involved in direct patient care.

2.1 Employee input will be documented and included with the Exposure Control Plan. Documentation may include:

2.1.1 Listing the employees involved and describing the process by which input was requested; or

2.1.2 Present references to the minutes of meetings, copies of documents used to request employee participation or records of responses received from employees.

3. The Agency shall establish and maintain a sharps injury log for recording percutaneous injuries from contaminated sharps.

3.1 The information in the sharps injury log shall be recorded and maintained in such a manner as to protect the confidentiality of the injured employee.

3.2 The sharps injury log shall contain, at a minimum:

3.2.1 The type and brand of device involved in the incident.

3.2.2 The department or work area where the exposure incident occurred.

3.2.3 An explanation of how the incident occurred.

3.2.4 Additional information the Agency may request as long as the employee's privacy is

protected.

3.3 The sharps injury log shall be maintained by the Administrator or designee.

3.4 The sharps injury log shall be retained for five years following the end of the year to which it relates (OSHA 29 CFR 1904.6).

HCL / IC.2 TB CH Rvd. 070109

HAND HYGIENE

IC.3

PURPOSE

To ensure patient/client care staff practice proper hand hygiene techniques and nail care to aid in the prevention and spread of infection per CDC guidelines.

POLICY

All Agency staff providing patient/client care will observe proper hand hygiene techniques:

- Prior to initial entry into supply bag;
- Before providing direct patient/client care;
- Following each patient/client contact even when gloves are worn;
- After touching bodily excretions on soiled materials;
- Before and after performing any invasive procedure or wound care; and
- Immediately following contact with blood and/or other body fluids.

All Agency staff providing patient/client care will keep fingernails short in length to prevent injury to the patient/client and/or to prevent broken nails and torn cuticles that could provide portals of entry for infection.

All Agency staff providing patient/client care will remove any personal jewelry that may harbor infection or cause injury to the patient/client.

PROCEDURE

1. Hand Hygiene with Soap and Water

- Wet hands and wrists with warm water.
- Apply soap and rub palms together to work up lather. Rub briskly for 15 seconds.
- With hands placed in a downward position, clean all surface areas of hands
 - ▶ Between fingers, around and under nails, wrists and
 - ▶ Rinse thoroughly.
- With hands held upright, dry thoroughly with a clean paper towel.
- While washing, try to prevent clothing (e.g., shirt cuffs) from getting damp or wet. Avoid splashing onto self or surrounding area if possible.

2. If hands are not visibly soiled or in the event adequate facilities are not available for hand washing, Agency staff may use alcohol-based hand rub, except when C-Diff has been identified.

3. Hand Hygiene with Alcohol-based Hand Rub

- Apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry or per manufacturer's guidelines if different.

4. All staff providing patient/client care will be responsible for instructing the patient/client/caregiver in proper hand washing techniques and documenting instructions, response, and compliance.

HCL / IC.3 Rvd. 040109

CLEANING AND MANAGEMENT OF SUPPLIES AND EQUIPMENT

IC.4

PURPOSE

To ensure the proper cleaning and management of supplies and equipment is maintained by Agency staff.

POLICY

Agency staff providing patient care will follow Agency procedure for the cleaning and management of supplies and equipment according to federal/state laws and regulations and appropriate manufacturers' recommendations.

PROCEDURE

The cleaning and management of supplies and equipment will be handled according to, but not exclusive of, the guidelines in the Exposure Control Plan.

HCL / IC.4 ch Rvd. 060108

PROCEDURE FOR: CLEANING AND MANAGEMENT OF SUPPLIES AND EQUIPMENT

ITEM	LEVEL	FREQUENCY	PRODUCT	TIME	NOTES
Nurse/HHA Bag	Non-critical item	Monthly and as needed.	Detergent and tap water	Wipe and allow to air dry.	Prevent contamination by washing hands prior to entering bag and by not placing contaminated supplies back inside bag. Keep sharps container in separate compartment.
Stethoscope	Non-critical item	Ear tips, bell/diaphragm, and tubing between each patient use	Alcohol pad	Wipe and allow to air dry.	Keep individual stethoscope in patient's home when likelihood of non-intact skin in areas where blood pressure cuff would come in contact with non-intact skin or disseminated disease is present (c.g., MSRA).
Blood Pressure Cuff	Non-critical item	Monthly and as needed when Soiled	Detergent and water	Remove cuff cover and wash in detergent and water solution. Rinse and air dry.	Keep individual blood pressure cuff in patient's home when likelihood of non-intact skin in areas where blood pressure cuff would come in contact with non-intact skin (open/draining wound) or disseminated disease is present.
Nail clippers	Semi-critical item	After each use	Clean with detergent and rinse to remove all tissue or blood. Spray or wipe with OSHA Approved solution per instructions.	Spray or wipe with OSHA approved solution per manufacturer's Recommendation. Wipe dry and store in clean Ziploc type bag.	penlight, writing pen, beepers, clipboards, and other work supplies which do not come in contact with patient's blood/body fluids when used for intended Purpose.

Penlight, writing pen, beepers, clipboards, point of care devices (laptop ,etc.) and other work supplies which do not come in contact with patient's blood/ body fluids when used for intended purpose.	Noncritical items	Surface soil should be removed monthly and as needed.	Alcohol wipes or detergent and tap water	Wipe and allow to air dry.	Should accidental contamination with blood or body fluid occur: 1. While wearing gloves, remove gross contamination with paper towel. 2. Wash surface with paper towel containing detergent and water. 3. Rinse with paper towel containing water. 4. Spray or wipe with OSHA approved solution per manufacturer's recommendations. 5. Dry with paper towel. For contamination deep inside equipment that cannot be adequately cleaned, contact Clinical Supervisor for further directions. Such items should be enclosed in a plastic bag and placed in an area of the car which is not occupied by passengers if disinfection on site cannot be done.
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PROCEDURE FOR: CLEANING AND MANAGEMENT OF SUPPLIES AND EQUIPMENT

ITEM	LEVEL	FREQUENCY	PRODUCT	TIME	NOTES
Automatic Lancing Device	Critical 1.Lancing sharp: sterile, one time use 2.Soft touch	One time use only	N/A	N/A	Discard in sharps container. Automatic Lancing Devices that have a non-removable head

	cap: clean (one patient use)				will not be used from one patient to another and may be used on one patient only. Note: Using Automatic lancing Devices that are designed with a non-removable head have a risk of Transmission of HBV and HIV and therefore must not be used.
Nurse Scissors	Semi-critical	After each use	Clean With detergent and rinse to make sure that all possible tissue or blood' is removed. Spray or wipe with OSHA approved solution per the manufacturer's recommendation.	Spray or wipe with OSHA-approved solution per the manufacturer's recommendation .Wipe dry and store in clean Ziploc-type bag.	Sterile scissors from the sterile dressing kit will be used during any procedure which requires contact with wound or tissue.
Tape Measure/Wound Measurer	Critical	After each use	Alcohol pad	Wipe vigorously with alcohol pat and air dry	Single one use only.
Tape Measure: cloth for abdominal girth measurement	Non-critical	N/A	N/A	N/A	One patient use, do not use patient to patient.
Doppler	Non critical	After each use	Alcohol pad	Remove K-Y with paper towel. Wipe diaphragm with alcohol pad and allow to air dry	Clean body of Doppler as needed as outlined in penlight, etc.
Pulse Oximeter	Non-critical	After each use	Alcohol pad	Wipe finger /ear probe with alcohol pad and allow to air dry.	Clean body of Pulse Ox as needed as outlined in penlight etc. section above.
IV . Pole	Non-critical	Weekly when in use and terminal cleaning	Weekly: Any gross soiling should be cleaned with Detergent and water then wipe down with paper towel and an OSHA-approved solution per the manufacturer's recommendations and allow to air dry. Terminal: Same as above	Weekly: wipe and allow to air dry. Terminal cleaning: Spray with an OSHA-approved solution per the manufacturer's Recommendation. Wipe off and allow to air dry,	

PROCEDURE FOR: CLEANING AND MANAGEMENT OF SUPPLIES AND EQUIPMENT

ITEM	LEVEL	FREQUENCY	PRODUCT	TIME	NOTES
Trach Cannula: Single Patient Use	Semi-critical	Daily and as frequently as needed	Peroxide Sterile Water		Wash inner Cannula with brush, pipe cleaner and peroxide. Rinse with sterile water. Shake out excess water (use a face shield or turn head away to avoid contact of fluid with nurse's Mucous membrane). See procedure: Trach Care.
Blood Glucose Monitoring Equipment	Non-critical item	Weekly (except Accu-Easy)	Wipe outside of case with alcohol (see CLIA Program instructions).	Wipe and allow to air dry.	Sec appropriate cleaning procedure in CLIA Program and per manufacturer's Recommendation.
Thermometer	Semi-critical	After each use	Wipe with alcohol, rinse with tap water and pat with paper towel or rinse with soap and water to remove mucous.	N/A	Each patient should have their own thermometer.
Shampoo Board	Non-critical item	After each use with approved solution	Wash with soap and water. Spray or wipe with OSHA approved solution per manufacturer's Recommendation. Rinse and dry.	10 Minutes	Do not store board that contains residual water.
Best Stress Belt back support belt)	Non-critical item	Every month and as needed	Laundry detergent	Wash gentle and line dry.	Keep belt clean, when over clothes, under lab Jacket.
Pocket mask, CPR	Semi-critical				Discard after use. Store in wrapper until need arises for use.
Scales (Adult)	Non-critical item	After each use	Antiseptic	Wipe and allow to	Clean body and

			towelette	air dry.	top part of scale with towelette.
Scales (baby)	Non-critical item	After each use	Antiseptic towelette	Wipe and allow to air dry	Clean body and top part of scale with towelette.
Any PT/Of equipment, i.e., walker, cane, cones	Non-critical item	After each use	Antiseptic towelette	Wipe and allow to air dry	Clean all parts.

PROCEDURE FOR: CLEANING AND MANAGEMENT OF SUPPLIES AND EQUIPMENT

ITEM	LEVEL	FREQUENCY	PRODUCT	TIME	NOTES
Foot Bath: single patient use	Non-critical: Used with intact skin when used for only one patient	After each use	Wash tub with detergent water, rinse with water		After cleaning, position upside down so that unit will not retain water.
	High level disinfection: for terminal cleaning	After each use	Same as above and fill chamber with 1:10 bleach solution, turn unit on. Rinse with tap water and dry.	Run for 10 minutes	Wear plastic apron and clean in area away from carpet, rugs. or fabric that could be damaged by bleach.
	Semi-critical: Non-intact skin use for one patient only	After each use	Same as above and fill chamber with 1:10 bleach solution, turn unit on. Rinse with tap water and dry,	Run for 10 minutes	Bleach must be mixed at the time of use. Do not mix water and bleach and store for future use. Patient must have own foot bath,
Bath Basin: single patient use	Non-critical,	After each use	Wash with soap and rinse with tap water, dry before storage,	N/A	Do not store basin that contains residual water, Do not store bar soap in basin. Store bar soap so that it will dry prior to next use,
Ultrasonic Stimulator single patient use	Non-critical	After each use	Alcohol pad	Remove K-Y with paper towel Wipe diaphragm with alcohol pad and allow to air dry.	Clean body as needed as outlined in penlight, etc
Sterile Single Use Items	Critical	Discard with use	N/A	N/A	Do not re-use sterile, single use items.

Red Rubber Catheter: single patient use	Non-critical item	After each use	Wash with detergent and rinse completely with tap water Allow tap water to flow through inside of catheter.	Air dry	Hang catheter so that they will dry inside and out. Or The patient may use sterile, single use catheters.
Tube Feeding Bag	Non-critical item	Replace with new bag			
Oxygen Cannula	Non-critical item	Daily and as needed	Wipe tips with detergent solution on paper towel. Rinse with tap water and dry.	N/A	Do not allow free water to enter Cannula or tubing.

DISPOSAL OF DRESSINGS

IC.5

PURPOSE

To ensure the safe and appropriate disposal of material/equipment used with/for dressing changes in order to promote the safety of patients, staff and community as well as meet federal/state laws and regulations.

POLICY

Agency will educate staff regarding the appropriate procedure for the disposal of dressings.

PROCEDURE

1. Remove old dressing following standard precautions.
2. Discard soiled/old dressing and gloves in a plastic bag.
3. Plastic bag will be double-bagged and placed in the patient's trash container. If the patient's trash container has a plastic liner, this may serve as the second bag.
4. Staff will educate the patient/caregiver regarding the proper disposal of soiled dressing material(s).
5. Patient/caregiver training, level of understanding and compliance regarding soiled dressing material will be documented in the patient's medical record.

HCL / IC.5 ch Rvd. 030108

BLOOD COLLECTION

IC.6

PURPOSE

To ensure safe and appropriate techniques and precautions are followed during the procedure of blood collection.

POLICY.

Agency staff will be educated regarding the appropriate steps and process to follow for the collection of blood.

PROCEDURE

1. All staff performing a collection of blood samples will wear gloves. Staff may wear masks, goggles, and/or face shields whenever splashes, spray, splatter or droplets of blood may be reasonably anticipated. Also, protective equipment will be worn when eye, nose or mouth contamination can be reasonably anticipated.
2. Blood specimens will be placed in a heavy-duty, zip lock plastic bag. There will be a BIOHAZARD fluorescent orange or orange-red warning label on each Ziploc bag. The bag will then be placed in an approved plastic container which has been labeled with a BIOHAZARD label for transport to the appropriate laboratory per that laboratory's protocol for each specimen.
3. Any refrigerated container used for blood storage will have a BIOHAZARD label on the outside in a conspicuous site.
4. Agency Nursing Procedure Manual may be referenced for complete procedure for blood collection.

HCL IC.6 chap Org 062098

DISPOSAL OF NEEDLES AND SHARPS

IC.7

PURPOSE

To facilitate the safe disposal of sharps in order to protect the nurse, patient and community from the hazards of

inadvertent needle sticks.

POLICY

All staff providing patient care will be educated regarding the appropriate procedure for disposal of needles/sharps and will follow this procedure to ensure conformity with all federal/state laws and regulations. Patient/caregivers will be provided, both in writing and verbally, of proper disposal of sharps.

PROCEDURE

1. Contaminated needles and syringes are not recapped or broken.
2. Individual puncture-resistant Biohazardous waste containers will be provided for the nurse and taken into the patient's home.
3. Needles and syringes used for injections, blood draws, urine aspiration, or wound aspiration will be placed intact in the needle waste container. The contaminated needle and syringe will be placed in the container immediately after use. The Vacutainer needle will be placed in a slot on top of the container and the Vacutainer will be rotated until the needle is dislodged and drops into the container.
4. A single-use Vacutainer which is discarded after one use is recommended. If multi-use Vacutainers are used, the Vacutainer barrel will be cleaned after each draw with alcohol prep.
5. When the biohazard container is two-thirds full, it may be sealed and placed in the designated area in each office to be disposed of by Hazardous Waste Company or disposed of per agency policy. (i.e., delivered to pharmacy/lab, etc)
- 6 Sharps used in conjunction with IV Therapy will also be disposed of in the aforementioned manner.

HCL IC.7 chap Rvd 090199

TRANSPORTATION OF LABORATORY SPECIMENS

IC.8

PURPOSE

To ensure safe and appropriate transportation of laboratory specimens in accordance with federal/state laws and regulations.

POLICY

Agency staff will be educated regarding the process of safely transporting lab specimens, and will be provided with the appropriate supplies/equipment for safely transporting same.

PROCEDURE

1. Laboratory specimens will be placed in a heavy-duty Ziploc plastic bag. There will be a BIOHAZARD fluorescent orange or orange-red warning label on each Ziploc bag. The bag will then be placed in an approved plastic container with a BIOHAZARD label for transport to the appropriate laboratory per that laboratory's protocol for each specimen.
2. The specimen(s) will be transported via the Agency employee's vehicle in a container marked BIOHAZARD MATERIAL.
3. Agency staff will ensure that storage containers and/or bags are properly sealed to avoid spilling or leaking and/or contact with material/equipment/ supplies during transportation.

HCL IC.8 chap Org 050197

ASEPTIC PROCEDURE

IC.9

PURPOSE

To ensure the appropriate aseptic procedure is performed in patient care.

POLICY

Agency staff will be educated regarding and provided with needed supplies to perform proper aseptic procedures.

PROCEDURE

Agency staff will:

1. Verify physician's specific order(s) for aseptic procedures (e.g., dressing change, venipuncture).
2. Wash hands thoroughly and assemble needed supplies.
3. Educate patient/caregiver regarding the procedure that will be followed.
4. Position and drape patient as indicated to provide privacy and adequate access to area.
5. Open any protective wrappers on supplies taking care not to touch and/or contaminate the inner aspect of container.

6. Apply sterile or clean gloves (whichever procedure indicates) prior to performing aseptic procedure.
7. Perform/complete procedure following physician's specific order(s) and/or specific policy/procedure.
8. Document in patient's medical record.

HCL IC.9 chap Org 050197

GUIDELINES FOR PREGNANT HEALTH CARE WORKERS

IC.10

POLICY

Agency will adhere to the following basic principles to observe for protection of the pregnant health care worker and her fetus.

- **Herpes Simplex** No restriction necessary. Transmission does not occur via casual contact or from inanimate objects. Genital herpes requires sexual contact for transmission.
- **Hepatitis B** No restriction necessary. Employees in high risk areas should be urged to receive hepatitis B vaccine. Strict adherence to body substance isolation.

Documented

- Human Parvovirus B19 (fifth Disease) in the immuno-suppressed patient (incl. sickle cell; HIV)

Restrict pregnant staff from caring for patients with a diagnosis of B19 with aplastic crisis or chronic anemia. All Health Care workers are advised of the importance of following good infection control practices. Strict hand washing after patient contact.

- **HIV/AIDS**

No restriction necessary. Strict adherence to Standard Precautions. Transmission does not occur via casual contact.

- **Measles (Rubeola)**

Patient care staff should not care for patients with measles until immunity proved by titer or documentation of vaccination. Employees (regardless of sex) should have documented immunity.

- **Mumps**

Patient care staff should not care for patients with mumps until immunity proved by titer or documentation of vaccination. Employees (regardless of sex) should have documented immunity.

- **Rubella**

Patient care staff should not care for patients with Rubella until immunity is proved by titer or documentation of vaccination. Employees (regardless of sex) should have documented immunity to Rubella. (History of disease is insufficient evidence of immunity.)

- **Syphilis**

No restriction necessary. Transmission occurs through sexual contact with an active (primary stage) case. No risk via casual contact.

- **Varicella or Herpes-zoster (shingles)**

Patient care staff who have not had chicken pox (or who are unsure) should not have contact with patients with chicken pox or herpes zoster; restriction from patient contact is based on history of immunity and not on pregnancy. If exposed to herpes zoster or varicella, employees with negative or unknown history should notify EHS.

- **CMV**

No restriction necessary. Strict adherence to BSI. Studies of HCW's have not shown transmission from patients to personnel.

- **RSV**

Respiratory secretions infective if inoculated onto mucous membranes. Restrict pregnant women from caring for infants receiving ribavirin aerosol.

- **Tuberculosis**

No restrictions necessary; adhere to respiratory precautions. Pregnant women are not at increased risk for tuberculosis.

References:

Association for Practitioners in Infection Control American Journal of Infection Control
Control of Communicable Diseases in Man 15th Edition

HCL / IC.10 ch Rvd. 030108

EMPLOYEE INFECTIONS AND WORK RESTRICTIONS POLICY

IC.11

Agency promotes health/safe working conditions. The commitment to this standard and the commitment to the well-being of the patients we serve results in this policy. Employees who demonstrate symptoms of an infectious condition will adhere to work restrictions as follows.

Disease Problem	Relieve From Direct Patient Contact	Partial Work Restriction	Duration
Conjunctivitis, infectious	Yes		Until discharge ceases
Cytomegalovirus infections	No		
Diarrhea (diarrhea with other symptom)	Yes		Until symptoms resolve
Convelescent state Salmonella (non- typhoidal)	No	Personnel should not take care of high-risk patients	Until stool is free of the infecting organism on 2 consecutive cultures not less than 24 hours apart
Other enteric pathogens	No		
Enteroviral infections	No	Personnel should not take care of infants and newborns	Until symptoms resolve
Group A streptococcal disease	Yes		Until 24 hours after adequate treatment is started

Disease Problem	Relieve From Direct Patient Contact	Partial Work Restriction	Duration
Hepatitis, viral			
Hepatitis A	Yes		Until 7 days after onset of jaundice
Hepatitis B Acute	No	Personnel should wear gloves for procedures that involve trauma to tissues or contact with mucous membranes or non-intact skin	Until antigenemia resolves
Chronic antigenemia	No	Same as acute illness	Until antigenemia resolves
Hepatitis NANB	No	Same as acute Hepatitis B	Period of infectivity has not been determined
Herpes simplex	No		
Genital	No		
Hands (herpetic whitlow)	Yes	(Note: It is not known whether gloves prevent transmission)	Until lesions heal
Orofacial	No	Personnel should not take care of high-risk patients	Until lesions heal
Measles			

Active	Yes		
Post exposure (susceptible personnel)	Yes		From the 5th through the 21st day after exposure and/or 7 days after the rash appears
Disease Problem	Relieve From Direct Patient Contact	Partial Work Restriction	Duration
Mumps Active	Yes		Until 9 days after onset of parotitis
Post exposure	Yes		From the 12th through the 26th day after exposure or until 9 days after onset of parotitis
Pertussis Active	Yes		From the beginning of the catarrhal stage through the 3rd week after onset of paroxysms or until 7 days after start of effective therapy
Postexposure (asymptomatic personnel)	No		
Postexposure (symptomatic personnel)	Yes		Same as active pertussis
Rubella Active	Yes		Until 5 days after the rash appears
Postexposure (susceptible personnel)	Yes		From the 7th through the 21st day after exposure and/or 5 days after rash appears
Scabies	Yes		Until treated
Staphylococcus aureus (skin lesions)	Yes		Until lesions have resolved
Disease Problem	Relieve From Direct Patient Contact	Partial Work Restriction	Duration
Upper respiratory infections (high-risk patients)	Yes	Personnel with upper respiratory infections should not take care of high-risk patients	Until acute symptoms resolve
Zoster (shingles) Active	No	Appropriate barrier desirable; personnel should not take care of high-risk patients	Until lesions dry and crust
Postexposure (susceptible personnel)	Yes		From the 10th through the 21st day after exposure or if varicella occurs until all lesions dry and crust
Varicella (chickenpox)	Yes		Until all lesions dry and crust

Post exposure	Yes		From the 10th through the 21st day after exposure or if varicella occurs until all lesions dry and crust.
Exudative lesions or weeping dermatitis	Yes		Until condition resolves

HCL IC.11 chap Org 050197

BAG TECHNIQUE

IC.12

PURPOSE

To describe the procedure for maintaining a contaminate free home health bag and preventing cross-contamination.

POLICY

The principles in bag technique are developed and utilized to maximize the efficient use of the bag and to assure asepsis and the control of infection.

PROCEDURE

A. Contents of the nursing bag:

1. Hand washing equipment - skin cleanser, paper towels and alcohol gel.
2. Assessment equipment may include-thermometers, stethoscope, equipment to measure wounds, sphygmomanometer, and urine testing equipment.
3. Disposable Supplies, may include - plastic thermometer covers (if applicable), non-sterile gloves, plastic aprons, dressings, tape, alcohol swabs, tongue blades, applicators, lubricant jelly, syringes and needles, vacutainer equipment for venipuncture.
4. The nurse must check the expiration date of any disposable supplies kept in the nursing bag. These supplies should be rotated routinely according to expiration date.

B. Soap and water, alcohol or other cleaning agent may be used in the cleaning process, which is to occur whenever the bag is grossly contaminated and any other time needed.

Bag Technique:

1. The bag is placed on a clean surface in the car and in the home. If this is not possible, a barrier (i.e., newspaper, paper towel, small trash bag, etc.) is to be placed under the bag.
2. Prior to administering care, skin cleanser and paper towels or alcohol gel is removed and hands are washed. These supplies may be left at the sink for hand washing at the end of the visit, if applicable.
3. After hand washing, the supplies and/or equipment needed for the visit are removed from the bag.
4. When the visit is completed, reusable equipment is cleaned using alcohol, disinfectant wipe, and/or soap and water as appropriate and placed on a clean surface, hands are washed, and equipment and supplies are returned to the bag.
 - 4.1. Stethoscope, bell and diaphragm - alcohol and/or disinfectant wipe
 - 4.2. Reusable tourniquet - soap and water, disinfectant wipe, and/or alcohol
 - 4.3. Blood pressure cuff is cleaned in accordance with the manufacturer's guidelines or when the cuff has been soiled with blood, other body fluid or spills - soap and water and/or disinfectant wipe.
5. If paper towels/newspapers/trash bags, etc. are used as a protective barrier for bag placement in the patient's/client's home they will be properly disposed of.

HCL / IC.12 CHAP Rvd. 120107