

How to Meet Revised Home Health CoPs with Joint Commission Accreditation

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How We're Different

Customers choose to work with us for many reasons, but most highlight the following:

- **Solution-focused surveyors** are a practical, solutions-oriented resource
- **Trusted readiness resources** help you prepare or stay ready for accreditation
- **Timely support** helps you stay on track pre- and post-survey
- **Hands-on, patient-centered review** through observations of care in real time and under typical business conditions
- **Active leadership** helps you stay ahead of changing regulations, and educates your care partners on the importance of working with accredited providers

Quick Poll: Are you currently accredited by The Joint Commission?

Objectives

- Identify the most challenging CoPs for home health organizations to meet
- Describe ways to promote compliance with these challenging requirements

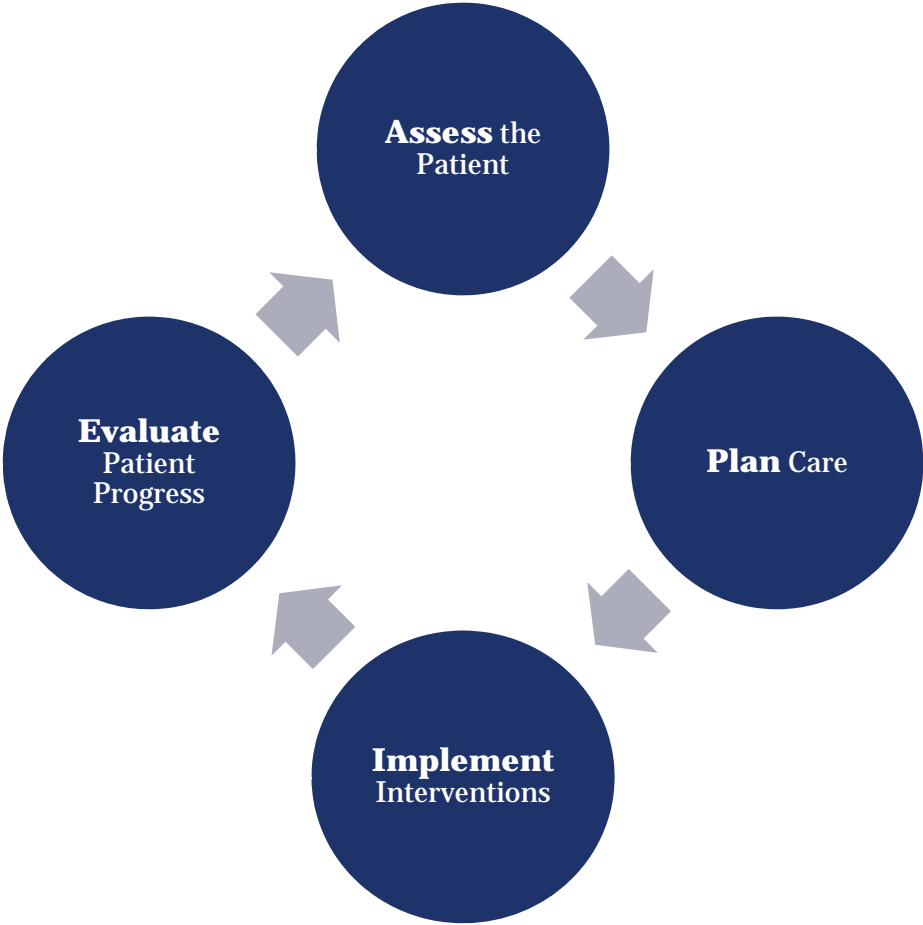
What is SAFER™?

- The **Survey Analysis for Evaluating Risk™ (SAFER™)** is a transformative approach for identifying and communicating risk levels associated with deficiencies cited during surveys. The additional information related to risk provided by the SAFER Matrix helps organizations prioritize and focus corrective actions.
- The **SAFER Matrix™** provides one, comprehensive visual representation of survey findings in which all Requirements for Improvement (RFIs) are plotted on the SAFER matrix™ according to the likelihood of the issue to cause harm to patients, staff or visitors, in addition to how widespread the problem is, based on the surveyor's observations.
- The **SAFER Matrix** replaces the current scoring methodology, which is based on pre-determined categorizations of elements of performance (such as direct and indirect impact) – instead allowing surveyors to perform real-time, on-site evaluations of deficiencies. Placement of RFIs within the matrix will determine the level of detail required within each RFI's Evidence of Standards Compliance follow-up.

SAFER Matrix

		Immediate Threat to Life (a threat that represents immediate risk or may potentially have serious adverse effects on the health of the patient, resident, or individual served)		
LIKELIHOOD TO HARM A PATIENT/STAFF/VISITOR	HIGH (harm could happen at any time)			
	MODERATE (harm could happen occasionally)			
	LOW (harm could happen, but would be rare)			
		LIMITED (unique occurrence that is not representative of routine/regular practice)	PATTERN (multiple occurrences with potential to impact few/some patients, visitors, staff and/or settings)	WIDESPREAD (multiple occurrences with potential to impact most/all patients, visitors, staff and/or settings)

The Care Planning Process in Home Care



Assess

Assess

- The comprehensive assessment must accurately reflect the patient’s status and include at a minimum, the following patient information:

PC.01.02.01 EP#25
G536 484.55(c)(5)

Comprehensive Medication Review

- A review of all current medications in order to identify potential medication related problems

In 2 of 4 home visits conducted organization failed to assess and reassess its patients as evidenced by absence of a review of all current medications for HV#1 and HV#3.

#1 Assess

– Action Items

- Medication Management
 - High risk during care transitions
 - Medication reconciliation orientation
 - The home care nurse **owns** medication reconciliation!
 - Every skilled nursing visit
 - Verify, Clarify, and Reconcile

#1 Assess

– Action Items

- Review your agency's top admitting diagnoses
- Offer nursing education on assessment techniques specific to these diagnoses
- Build OASIS questions into assessment education

Plan

Plan

- The Plan of Care specifies the care and services necessary to meet the needs identified in the comprehensive assessment and addresses the following:

PC.01.03.01 EP#10
G574 484.60(a)(2)(xiv)

Measurable Outcomes and Goals

- Measurable outcomes and goals identified by the organization and patient as a result of implementing and coordinating the plan of care

In 3 of 3 patient records reviewed the organization did have patient specific interventions and education, measurable outcomes and goals.

Sample Survey Finding

In 17 of 17 patient records reviewed During record review for HHV#5, 6 and 7, the surveyor observed that patient goals were frequently not measurable, did not have appropriate time frames, or were not patient focused. For example, in HHHV#5, in box 22 in the plan of care, " Patient/cg will verbaliza/demonstrate appropriate measures to promote safety and prevent injury by end of certification period," is a goal that is not measurable. "Respiratory exacerbation will be identified and interventions initiated to minimize risk" is not patient goal. In this same record "PT plan of care will be ordered by the physician and provided by PT," is not a patient goal. In record review for HHHV#6, the patient goal, "ability to care for HTN by end of cert" is vague and not measurable. In the same record, the goal "patient will verbalize understanding of pharmacological and non-pharmacological measures to maintain effective anticoagulant therapy by end of certification period would require evaluation earlier than the end of the certification period, due to the danger of hemorrhage associated with anticoagulant therapy. On the discharge summary for this patient, four goals were discontinued and labelled "not applicable." In HHRR#9, on the discharge summary, 27 goals were labelled "not applicable," indicating staff should be more accurate in goal setting at SOC and select goals based on the clinical assessment.

Plan of Care

Order Number: _____

HOME HEALTH CERTIFICATION AND PLAN OF CARE					
1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____		4. Medical Record No.	
5. Provider No.					
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
8. Date of Birth		9. Sex	<input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD-10	Principal Diagnosis		Date		
12. ICD-10	Surgical Procedure		Date		
13. ICD-10	Other Pertinent Diagnoses		Date		
14. DME and Supplies			15. Safety Measures:		
16. Nutritional Req.			17. Allergies:		
18.A. Functional Limitations			18.B. Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest B/P	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Cane	D <input type="checkbox"/> Other (Specify)
			5 <input type="checkbox"/> Exercises Prescribed		
19. Mental Status:			5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated	
1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful		6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other	
2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed				
20. Prognosis:			3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)					

#2 Plan

– Action Items:

- Make patient goals a priority
- Goals should be specific, measurable, timed
- Developed based on diagnoses for cert period
 - Over-used goals
- New or revised goals

Implement

Implement

- The organization provides the patient with written instructions outlining the following:

PC.02.03.01 EP#33

Written Information

- Patient medication schedule and instructions, including the medication name, dosage, and frequency and which medications will be administered by home health staff

G616 484.60(e)(2)

In 6 of 7 home visits conducted It was observed that the organization did not provide the patient with a medication schedule and instructions, including medication name, dosage, and frequency.organization failed to provide the patient and caregiver with a copy of the written medication instructions, including medication name, dosage, and frequency for which medications will be administered, as evidenced by the absence of a medication list in the home. Discussed and verified by the Nursing Supervisor.

Written Information cont'd

- Visit schedule, including frequency of visits by home health staff

G614 484.60(e)(1)

- Any treatments to be administered by home health staff and staff acting on behalf of the organization, including therapy services

G618 484.60(e)(3)

In 3 of 3 home visits conducted the surveyor noted the organization did not provide the patient, in writing, any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. The organization had not developed a process to provide this information. the surveyor noted the organization did not provide the patient, in writing, visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. . The organization had not developed a process to provide this information.

Physician Orders

- The organization follows physician orders when administering medications or providing care, treatment or services. PC.02.01.03 EP#8
G580 484.60(b)(1)

In 6 of 7 home visits conducted It was observed that the organization did not provide the patient with a medication schedule and instructions, including medication name, dosage, and frequency.organization failed to provide the patient and caregiver with a copy of the written medication instructions, including medication name, dosage, and frequency for which medications will be administered, as evidenced by the absence of a medication list in the home. Discussed and verified by the Nursing Supervisor.

Sample Survey Finding

In 12 of 17 patient records reviewed During record review of HHHV#2, the Surveyor noted that the organization had not followed physician orders when providing care, treatment, or services. For example, the wound care order was: Cleanse Stage 2 pressure ulcer to R buttocks with wound cleanser, pat dry, apply triple antibiotic ointment and cover w 4x4 gauze daily. The Surveyor observed the RN cleanse the wound with wound cleanser and then apply a gauze dressing with Silvasorb gel and cover with a secondary foam dressing. During record review of HHHV#6, the Surveyor noted that the organization had not followed physician orders when providing care, treatment, or services. For example, the Speech Therapist evaluated the patient and did not include orders for subsequent visits yet visited the patient six days later. The patient was then hospitalized and the Speech Therapist performed a re-evaluation when care had been resumed. A frequency of three times a week for four weeks was written and all three visits were missed in the second week without documentation of the reason for the missed visits. This finding was verified by the Clinical Manager. the organization did not obtain orders prior to providing care and did not follow physician orders when providing care.

#3 Implement

– Action Items:

- Implementation of interventions direct care to meet patient goals
- Interventions should have rationale. Ask...
 - Why is the nurse planning this intervention?
 - How will it help the patient to meet goals?
- Provide examples and guidance to nurses

#3 Implement

– Action Items

- Implementing disease management
 - More than tasks listed in the POC
 - Requires critical thinking and effective nursing judgement
 - Collaborating
 - Advocating
 - Communicating
 - Reporting

Evaluate

Evaluate

- A completed discharge summary is sent to the primary care physician...

In 2 of 2 patient records reviewed The organization did not send a completed written discharge summary to the primary care practitioner or other health care professional within 5 business days. The surveyor noted in D/C RR # 1 and DC RR # 2 that the physician order for patient discharge documented "that "all Goals Met and Discharge Summary available upon MD's request" This was confirmed by the Director of Nursing"

PC.04.02.01 EP#3
G1022 484.110(a)(6)(i)

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Discharge Summary

- Within 5 business days of the patient's discharge a summary of the care provided is sent to the physician

In 2 of 2 patient records reviewed for discharged patients, the agency failed to document that a discharge summary was sent to the primary physician within 5 business days of the patient's discharge. In RR#6 the patient chart did include a discharge summary but it was sent to the physician 13 days after discharge. In RR#7 there was no discharge summary documented in the record. This was validate with the Administrator.

#4 Evaluate

– Action Items

- Nurse case managers should be evaluating the patient at every visit and determining if the POC needs revision
 - Revisions should be documented in real time
 - Document changes with rationale
 - Revise goals as appropriate
- 60-day case conferences should be interdisciplinary
 - Reflect a comprehensive review of the POC
 - Include input by all active team members

#4 Evaluate

– Action Items

- Directors/managers – review 4-5 POCs from different referral sources and different treatments and diagnosis
 - Do they all have the same frequency?
 - Do the goals all look alike?
 - Are the interventions eerily similar, but the diagnosis very different?

Other Challenging Areas

- Risk

Equipment cleaning IC.02.01.01 EP#2

G682 484.70(a)

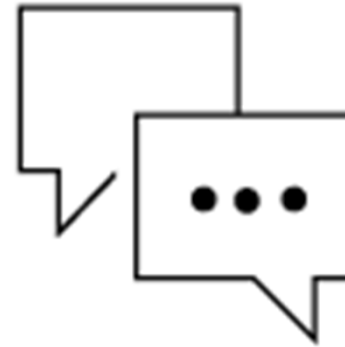
- Pattern

“All entries are...timed” RC.01.02.01 EP#9

G1024 484.110(b)

As we conclude...

- A recording and PDF of today's Webinar will be emailed to all attendees
- Please complete a brief survey upon exit from today's presentation
- For information on accreditation:
 - 630-792-5070
 - homecare@jointcommission.org
 - Visit our [web site](#)



Thank you!