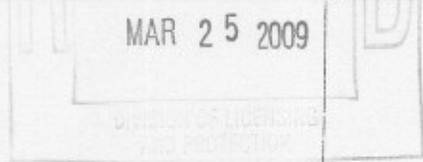


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2009
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NAME OF PROVIDER OR SUPPLIER ADDISON COUNTY HOME HEALTH & HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 754 MIDDLEBURY, VT 05753
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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G 000	INITIAL COMMENTS	G 000		
G 121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>This STANDARD is not met as evidenced by: Per staff interview and record review the agency failed to ensure that all staff complied with acceptable professional standards in the provision of patient services for 1 of 23 patients in the targeted sample. (Patient # 1) Findings include:</p> <p>1. The Personal Care Attendant (PCA) visiting Patient # 1 five days a week to provide personal and homemaking services, failed to communicate to the Registered Nurse (R.N.) providing the supervisory visits, that the PCA was pouring the patients medications into medication boxes for Patient # 1 to self administer. In addition, the PCA was visiting this patient and providing services when not on duty for the agency. During a home visit on the afternoon of 2-9-09, Patient # 1 stated the PCA poured his medications. Per interview on the afternoon of 2-11-09, the PCA confirmed that s/he poured medications for the patient. Per review of the Agency's PCA teaching sheet, it states that PCAs will not pour and/or administer any medications.</p>	G 121		<p>1. a. Because the PCA of note was doing things that she had every reason to know were unacceptable and because she had been cautioned in the past regarding her very porous boundary issues her employment was terminated on February 11, 2009.</p> <p>b. Patient #1 was assigned a new PCA who has been monitored very closely and who clearly understands her obligation to this patient in terms of reporting problems, her boundary goals.</p> <p>All staff members who are involved with this patient have discussed the situation and are proceeding with a heightened awareness of their joint responsibilities regarding timely sharing of pertinent information.</p> <p>2. a. The nurse case manager within the CFC program was cautioned regarding her nonaction relative to her concerns about the behavior/performance issue evidenced by the case manager's statement on 02/11/09.</p> <p>b. For the purpose of identifying any other situations in which the staff member is not reporting properly we have done the following:</p> <p>1. Team leaders have specifically addressed the issue of underreporting and time lag in reporting specific patient problems with each clinician on their team.</p> <p>2. At the 3/4/09 staff conference during which deficiencies were dissected, the clinical director explained the exact course of events outlined in G121 (1b). She encouraged each clinician and program coordinator to review all patients within their caseloads, looking for this specific problem.</p> <p>c. During the 3/12/09 boundaries inservice the Home Health Aide Supervisor and the CFC Coordinator jointly conducted a session at the end of the teleconference which was designed for the purpose of helping HHAs and PCAs to identify any specific patient situations in which a similar set of circumstances (underreporting or withholding of patient information) may be present. There was a long and very productive period of questions and answers at the end that made it clear that the attendees understood the issue.</p> <p><i>In Service re [Signature] POC updated 3-26-09</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon L. Thompson RN</i>	TITLE <i>Clinical Director</i>	(X6) DATE <i>3/24/09</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 121	Continued From page 1 2. The PCA failed to notify the agency in a timely manner that Patient # 1 had expressed suicidal ideations for "a couple of months" prior to telling the R.N. A 12-16-08 nursing note states "PCA states over the last couple of months his moods have been becoming more depressed and that he has talked about killing himself." Per interview on the morning of 2-11-09 the R.N. stated s/he was concerned that the PCA did not report this sooner.	G 121 G141	1. a. Attached please find the personnel policy addressing boundaries for both professional and ancillary staff. This will become a permanent policy on March 27 when approved (if accepted) by the Professional Advisory Committee and then by the Board of Directors at next scheduled board meeting (note in G141d this policy was also shared during the boundaries session). (Reference Attachment #1) b. Also attached please find the customer service guidelines provided for all staff as part of their orientation package since 1999. (Reference Attachment #2) c. On March 12, 2009 all home health aides and personal care attendants will attend a mandatory workshop by teleconference entitled "Appropriate Boundaries". This teleconference will be immediately followed by an interactive teaching session conducted by Cheryl Connor, RN, the Home Health Aide Supervisor. She is also the designer and primary educator within our LNA training program. The teleconference will be taped and used as the foundation of what will become an annual required inservice for all home health aide and personal care attendant staff. This inservice will also be used during the orientation of all newly hired homemakers, personal care attendants and home health aides. d. During professional staff conference on March 4 the clinical director, Sharon Thompson, RN reviewed the deficiency with staff and conducted a teaching session reviewing the following concepts: relationship between ego defense boundaries and professional boundaries, including a discussion of common pitfalls for all health care providers; understanding of the liquidity inherent in the "zone of comfort" model; exploration of the concept of boundary crosses being reviewed as theft of services. The key point of delivery was to examine the ethical and legal responsibility of the professional to recognize and deal constructively with the boundary breaches on the part of other providers of care. i.e. ancillary staff or peers. There is a profound responsibility to confront these issues and yet a strong discomfort with them. In order to prevent further occurrence of this particular problem, an annual agency-wide inservice will be held which will contain a review of the boundaries policy and the confidentiality policy. Review of the concepts contained within these policies will also continue to be a part of the orientation program for all newly hired professional and ancillary staff. The conceptual framework for the presentation is grounded in Spence, Jung, Carl Rogers and a review of nurse/physicians literature and extracts.	
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on record review and staff interview the agency failed to have policies and procedures in place to address boundary issues related to staff/patient relationships. Findings include: 1. Per review of Policy and Procedure Manuals and while addressing professional standards and coordination of patient services (stated in G 121 and G 143), the Director of Choices For Care (CFC) confirmed on the morning of 2-12-09 that there were no policies and procedures that addressed and clarified boundaries as they pertained to staff performance expectations in providing care and services to patients.	G 141		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison	G 143		

3/27/09

3/27/09

3/4/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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G 143	<p>Continued From page 2</p> <p>to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the agency failed to ensure all staff coordinated and communicated efforts to assure optimal patient care for 1 of 23 patients in the targeted sample. (Patient # 1) Findings include:</p> <p>1. The Personal Care Attendant (PCA) visiting Patient # 1 five days a week to provide personal and homemaking services failed to communicate to the Registered Nurse (R.N.) providing the supervisory visits that the PCA was pouring the patients medications into medication boxes for Patient # 1 to self administer. In addition, the PCA was visiting this patient and providing services when not on duty for the agency. During a home visit on the afternoon of 2-9-09, Patient # 1 stated the PCA poured his medications. Per interview on the afternoon of 2-11-09, the PCA confirmed that s/he poured medications for the patient. Review of the Agency's PCA Teaching sheet states that PCAs' will not pour and/or administer any medications.</p> <p>2. The PCA failed to notify the agency in a timely manner that Patient # 1 had expressed suicidal ideations for "a couple of months" prior to telling the R.N. A 12-16-08 nursing note states "PCA states over the last couple of months his moods have been becoming more depressed and that he has talked about killing himself." Per interview on the morning of 2-11-09 the R.N. stated s/he was concerned that the PCA did not report this sooner.</p>	G 143	<p>1. The PCA indicated here was involved in the boundary infringement known as "secret alignment" wherein the staff member and the patient form an "us-against them" alliance. This is a not uncommon variety of boundary cross and would always result in termination of employment upon discovery. In order to better guard our patients against possible problems and to provide ongoing education support to the personal care attendant staff the following performance improvement will take place and be fully operational by March 16, 2009.</p> <p>The quality assurance team will work with the CFC Coordinator and the PCA Supervisor to design a carefully crafted checklist of questions, observations, and scripted statements that will be applied during every face to face interaction with the PCA during a supervisory home visit.</p> <p>This checklist will be designed to assist the supervisor to specifically look for signs that boundary-cross issues have arisen.</p> <p>Examples:</p> <p>Do you understand that you may only provide services or be present in this home when specifically assigned by the agency?</p> <p>Do you understand that you may never dispense, administer, or give advice about any prescribed or OTC medications?</p> <p>The means by which the agency will monitor this activity will be to include a review of the supervisory checklist as part of the record audit tool.</p> <p>If, upon record audit, it is found that the tool is not being properly used, or if there appears to be a problem with performance; the case manager will visit the patient (and the ancillary staff member) to evaluate the situation within 72 hours of the audit.</p> <p>2. Again, we feel that this problem was primarily personnel specific. However, upon review of CFC program policies we feel there is an area requiring attention relative to a written policy → written procedure → specific action track. The coordinator of the CFC program will, by March 16, 2009, complete a set of written policies (with tools for employee use) that clearly outline the scope of responsibility for formal communication between CFC leadership and PCAs regarding expectation for responsible communication; and between PCA and case manager and/or home care clinical staff. In summary by June 1 there will be (specific to the CFC program).</p> <p>a. Policy for coordination of care.</p> <p>b. Policy outlining expectations relative to formal, written, communication to and from personal care attendants.</p> <p>c. Specific tool (form) designed for the use by clinical staff.</p> <p>1. To communicate with PCAs.</p> <p>2. For PCAs to communicate with clinical staff</p>	
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3/16/09

3/16/09

3/16/09

(Attached is the communication tool used by Home Health Aides)

Are accepted for S. Emms 3-26-09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 165	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the R.N. failed to follow physician orders when conducting wound care for 1 of 1 patients in the targeted sample. (Patient # 2) Findings include:</p> <p>1. Per record review, the physician's orders for daily dressing changes for Patient #2 read "cleanse with normal saline, pack with 1/4" nu-form gauze, xeroform, soft Kling and bandage" On the morning of 2-10-09 the nurse surveyors observed the R.N. perform wound care which included cleansing the wound with normal saline, packing the wound with 1/4' nu-form gauze, apply clean gauze pads and tape. During interview on the afternoon of 2-10-09, the R.N. confirmed the written physician's order was not followed.</p>	G 165	<p>1. On interview with the nurse involved in this situation, her team leader learned that she had had a discussion with this patient's physician regarding the inappropriate use of a product which leads to periwound maceration. The physician agreed to drop the use of the xeroform and the nurse neglected to then write a "confirming verbal order" to send to the physician, which is the means this agency uses to incorporate changes into the plan of care.</p> <p>On March 4 during formal staff conference, which is mandatorily attended by all professional staff, the clinical director reviewed the advent and scope of the deficiency and conducted a review of the means by which all verbal orders must be documented and sent to the prescribing physician. It is ONLY after the written order has left the building that the change in protocol, procedure, dose or other item of care is actually instituted. The professional staff unanimously agreed that that is their current standard of practice.</p>	2/12/09
G 236	<p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p>	G 236	<p>for audit 3-26-09 K. Ennos / SRT</p>	3/4/09

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G 236	Continued From page 5 medication allergies.	G 236	<p>For the short term we have made some changes which should successfully decrease opportunities for error once the allergies themselves have been determined. These changes will be fully in place by March 30, 2009 – mostly due to the need for form re-design and reprinting of documents.</p> <p>Changes identified:</p> <ol style="list-style-type: none"> 1. Move allergies to the demographic database so that upon patient admission the allergies would immediately be keyed into our electronic record system. This will cancel out possible opportunity for error in future copying/transcription. 2. Computer to populate the allergy field on the medication flow sheets either directly or by printing allergy labels. 3. In order to prevent further problems and to monitor efficacy of the above changes we are adding allergy specific criteria to our quality audit criteria in addition to our routine mechanical audit criteria. If problems continue to be identified, the QA team will amend the performance improvement plan. <p>c. The changes have been reviewed with the clinical staff on March 4. During our discussions with clinical staff during that March 4 staff conference we urged everyone to use special care until there was a stronger system built to prevent error.</p> <p>d. The performance improvement plan will evolve and change in depth as we continue to carry out our investigation. What we have so far discovered is that there are across the board discrepancies between patient information, doctor's office records, hospital records, hospital discharge summaries and the problem lists found in all these areas.</p> <p><i>Poc vmmv 3-26-09 for S. Egan 1524</i></p>	<p><i>3/20/09</i></p> <p><i>3/4/09</i></p> <p><i>3/4/09 and on-going</i></p>
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Addison County Home Health and Hospice, Inc.

G142 2.)c.

Communication to Clinician

Home Health Aide PCA HMKR

To: _____
(name of case manager)

From: _____
(name of HHA / PCA/ HMKR)

Re: _____

Date: _____

My concerns are the following: _____

Signature: _____

- No changes at this time
- See addendum for changes in plan of care

Signature: _____

Pink ~ Clinician copy

Yellow ~ HHAide/ PCA/ HMKR office copy

02.24.09

G 149 1).

Addison County Home Health and Hospice, Inc.

PCA Supervisory Visit Questionnaire

The Personal Care Attendant (PCA) supervisor is required to ask the PCA these questions on each face to face supervisory visit in the patients' home.

Confidentiality

- | | | |
|-------|--------------------|--|
| | Do you understand, | |
| Yes | No | |
| _____ | _____ | 1. that you may not discuss your patient (their clinical status, family, environment, financial status etc.) with anyone in the community? |
| _____ | _____ | 2. if you meet your patient's family member(s) in public you may not discuss the patient? |
| _____ | _____ | 3. if one patient asks you about another patient you may not discuss the patient in question (their clinical status, family, environment, financial status etc)? |
| _____ | _____ | 4. that you may not share information about another employee with your patients and / or their families? |
| _____ | _____ | 5. that you may not share information about another employee without that person's permission? |

Boundaries

- | | | |
|-------|--------------------|---|
| | Do you understand, | |
| Yes | No | |
| _____ | _____ | 1. that you may not visit the patient outside of assigned times? |
| _____ | _____ | 2. you may not provide care or services outside your assigned role and scheduled times? |
| _____ | _____ | 3. that it is not healthy for you to "take on" the emotions of your patient or try to solve their personal problems? |
| _____ | _____ | 4. that you must notify your direct supervisor if your patient shares information which is effecting their health and well being? It is <u>never</u> acceptable to "keep secrets" from the nurse or CFC case manager. |
| _____ | _____ | 5. that your direct supervisor can assist your patient with appropriate resources? |
| _____ | _____ | 6. you may not share personal information, ask or give advice about life issues? |
| _____ | _____ | 7. you may not ask for support, sympathy or anything that requires the patient to focus on you, your family or your problems? |

Medications

- | | | |
|-------|--------------------|--|
| | Do you understand, | |
| Yes | No | |
| _____ | _____ | 1. that you may never dispense, administer, or give advice about any prescribed or over the counter medications. |

Signature: _____ Date ____/____/____
Personal Care Attendant

Signature: _____ Date ____/____/____
Personal Care Attendant Supervisor or Case Manager

G143 2.) a.

Addison County Home Health & Hospice, Inc.

Coordination of Services

POLICY: Disciplines involved in the individual patient's care document communication and coordinate services and treatments for the patient.

PURPOSE: To provide a logical method for documenting interdisciplinary communication in the provision of patient care.

PROCEDURE:

Clinical Staff:

1. A coordination of services form will be used by staff to document coordination of services such as intra-agency disciplines, physicians, patient family and extra-agency services.
2. Staff will use the form to document discussions with other disciplines involved in the patient's care.
3. The coordination of services form will remain in the patient's travel record to facilitate use by staff.
4. When the coordination of services form has no additional room for documentation it will be removed from the travel chart and filed in the clinical record. A new coordination of services form will then be placed in the travel record.
5. Coordination of services which occurs during a visit to the patient may be documented on the visit sheet.
6. The Coordinator of the Choices for Care Program will provide each clinician involved with a CFC recipient a copy of the monthly case management note. The sharing of these notes will provide the primary crosswalk for the sharing of information between the two separate programs (Clinical home care and CFC).

Ancillary Staff:

1. Home Health Aides, Personal Care Attendants, and Homemakers will use the half page form titled Communication to Clinician. They will document any and all changes, concerns, observations, or ideas for care that they may have. The form is then given to the senior clinician in charge of the patient's care at that time. The form becomes part of the permanent clinical record.

G-143 1)

**Addison County Home Health & Hospice, Inc.
Medicaid Waiver Record Audit**

Patient Name: _____

Auditor: _____

Start of Care Date: _____

Date: _____

Case Management: _____

Home Care Staff: _____

Medicaid Waiver Staff: _____

RECORD AUDIT CRITERIA	AC	YES	NO	N/A	COMMENTS
I. Data Base					
A. Admission Database Sheet					
1. is present	T				
2. appropriate areas are completed	T				
3. directions are readable/logical	T				
4. advance directives info is present	T				
5. DNR	T				
6. Allergies	T				
7. Guardianship paperwork	T				
8. Live-in agreement	T				
9. Emergency contact / back up plan	T				
## POA / if applicable	T				
B. Medicaid Waiver Application					
1. is present	T				
2. is dated, signed by patient/guardian	E				
C. Release of Information					
1. is present	T				
2. is dated, signed by patient/guardian	E				
D. Referral					
1. is present	T				
2. provides appropriate information	A				
II. Patient Assessment					
A. CFC LTCCC Certification					
1. is present	T				
2. is complete	T				
B. CFC Independent Living Assessment					
1. is present	T				
2. is complete	T				
3. provides meaningful descriptive data	A				
4. is consistent with most recent OASIS if followed by Home Care	R				
C. CFC Personal Care Worksheet					
1. is present	T				
2. matches the CFC plan of care, re: number of hours	R				
III. Plan of Care					
A. CFC Plan of Care					
1. is present	T				
2. is dated, signed by patient/guardian	E				

RECORD AUDIT CRITERIA	AC	YES	NO	N/A	COMMENTS
III. Plan of Care cont...					
A. CFC Plan of Care					
3. is dated, signed by CFC utilization reviewer	E				
4. is dated, signed by Agency of Human Services	E				
5. matches the CFC Personal Care Worksheet, re: number of hours or states why it is different	R				
6. the number of hours approved are consistent with the patients needs	A				
B. Agency Plan of Care					
1. is present	T				
2. is complete	T				
3. reflects the patients needs	A				
4. addresses the whole patient	A				
C. PCA Plan of Care					
1. is present	T				
2. is complete	T				
3. shows evidence that the plan has been reviewed with the PCA	A				
4. is reasonable and achievable	R				
5. is consistent with the above agency plan of care	A				
6. shows evidence that there have been intermittent updates/changes	A				
7. if not, is that appropriate	A				
8. action plan; present and complete	A				
9. PCA supervision sheet -- PCA Supervisory Visit Questionnaire present, complete, signatures	A				
D. PCA Flowsheets					
1. are present	T				
2. are complete	T				
3. are consistent with the PCA plan of care	A				
4. if not, is there an explanation	A				
5. if there are variations in the service provided are there explanations why	A				
IV. Case Management					
A. there is evidence that the patient has been contacted on a monthly basis	R				
B. there is evidence that a home visit has been made at least every 60 days	R				
C. there is evidence that the PCA was supervised at least every 60 days	R				
D. the documentation is meaningful and reflects changes in the patients life	A				
E. there is evidence of follow-up, if needed	A				
F. there is evidence of annual reassessment	T				

RECORD AUDIT CRITERIA	AC	YES	NO	N/A	COMMENTS
IV. Case Management cont...					
G. if the assessment reflects changes, the plan of care consistent with those changes	A				
V. Coordination of Services					
A. Coordination of Services clinician / CM					
1. is present	T				
2. there is evidence of communication between Waiver, Home Care, AAA, etc.	A				
3. if follow up is needed is it documented	A				
B. Communication to Clinician Sheet	Clinician	CM	PCA		
1. is present					
2. completed					
3. follow up if needed and documented					

Audit Codes:

T = Thoroughness

R = Reliability

A = Analytical Sense

E = Efficiency

Peer Review Signatures:

<p><u>Recommendations:</u></p>	<p><u>Follow-Up:</u></p>
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Addison County Home Health & Hospice, Inc.

Home Health Aide / Personal Care Attendant Referral

Introductory Visit / POC

Revision

G-236

Frequency _____

Special Times _____

Name: _____

Eps #: _____

Address: _____

Age/D.O.B.: _____ Client #: _____

Lives with: _____

Phone #: _____ Sex: _____

Emergency Contact: _____

Caregivers: _____ Lifeline: Yes No

Diagnosis: _____

Phone #: _____(h) _____(w)

Directions to home: _____

Physician: _____

Phone #: _____

Patient has a DNR: YES NO

ALLERGIES: _____	
MENTAL STATUS: <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Lethargic <input type="checkbox"/> Comatose <input type="checkbox"/> Forgetful	
FUNCTIONAL STATUS: Vision: <input type="checkbox"/> Normal <input type="checkbox"/> Glasses <input type="checkbox"/> Impaired	
Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Aides <input type="checkbox"/> DHOH: <input type="checkbox"/> Left <input type="checkbox"/> Right	
Speech: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired	
REPORTABLE OBSERVATIONS TO NURSE / THERAPIST: Nurse: _____ Therapist: _____	
Reportable Observations: _____	
GOALS: (check all appropriate)	
<input type="checkbox"/> Promotion of Independence	<input type="checkbox"/> Safe ambulation and transfers
<input type="checkbox"/> Improve personal hygiene	<input type="checkbox"/> Promotion of skin integrity
<input type="checkbox"/> Strength / Endurance	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Maintain clean safe environment	
<input type="checkbox"/> Adequate nutritional & fluid intake	
PAIN MANAGEMENT: _____	
PETS: _____	

- Chart Copy

- Home Folder Copy

G 236 CFC program

Addison County Home Health & Hospice, Inc.
Medicaid Waiver Admission Data Base

Initial Assessment Start Date: _____

Patient Name: _____

Patient #: _____

D.O.B. _____

Mailing Address: _____

Phone #: _____

Town of Residence: _____

Marital Status: _____

Sex: M F

Directions to home: _____

Physician: _____

Phone #: _____

Primary Diagnosis: _____

Allergies: _____

Medicaid #:

Case Management by: _____

Personal Care Services by: _____

Hours Allowed: _____

Case Manager: _____

Advance Directives

Have been discussed with client

Yes

No

DPOA Infonation

DNR Information:

a. Is a document in place? Yes No

a. Is a document in place and signed by physician?

b. Does the physician have a copy? Yes No

Yes

No

c. Who is the designated agent?

b. Do the rescue squad and local ER have copies?

Yes

No

Person to call in case of emergency: _____

Work & Home Telephone Numbers: _____

Signature of Admitting Professional: _____

Date: ____/____/____

- Chart Copy

- Billing Office Copy

- Travel Chart Copy

G 236 for CFC program

ADDISON COUNTY HOME HEALTH & HOSPICE, INC.

HOMEMAKER ADMISSION DATA BASE

Regular

Moderate Needs

Better Beginnings

Case Manager: _____

Admission Date: ____ / ____ / ____

Name: _____

D.O.B.: ____ / ____ / ____ Patient# _____

Address: _____

Phone: _____

Marital Status: _____

Town of Residence: _____

Sex: M: F:

Physician: _____

Phone: _____

Principal Diagnosis: _____

Allergies: _____

Referral Source:

MD

Hospital

Choices for Care (CFC)

OTHER: _____

Fee: Full Fee _____; State Program Y N

Patient Pays: \$_____.____ S.S. #: _____

Billing Information: (Other Payor)

Payor Name: _____

Payor Address: _____

Directions to clients home: _____

Signature of admitting professional: _____

Date: __ / __ / __

Person to call in case of emergency: _____

Work & Home Telephone Numbers: _____

Comments: _____

Date 12/18/08

G-236 3) **Addison County Home Health and Hospice, Inc.**
Home Care Quality Record Audit

Trial form

Patient: _____

Date: _____

Clinician: _____

Auditor: _____

The focus of this audit is quality of care. The auditor is expected to review the patient record in depth, and based upon sound clinical judgment provide the clinician with constructive feedback in the areas of the record relating to clinical practice. Each of the areas audited will reflect one of the components of assessment, planning, implementation, or evaluation.

The following process is highly recommended to complete the audit process.

1. Read the record before beginning the actual audit.
2. Thoughtfully consider each question and provide feedback. Yes / no answers are not sufficient, substantive comments, either positive or constructive need to be made.

Areas of Audit	Code	Yes	No	N/A	Comments
Clinical Data Base:					
Review the clinical data base and determine the following:					
Is the data comprehensive?					
Is the initial assessment thorough?	T				
Could you as a covering clinician on visit #2 know what the patient should look like?	R				
What's missing, how can it be strengthened? Give examples.	T/A				
Are patient allergies clearly noted in the demographic database.	T				
And the medication flow sheet					
Is there a discrepancy between these two sources?	R				
If yes, notify the Clinical Director and Quality Assurance Coordinator.	—	—	—	—	
Start of Care / Plan of Care					
Does the initial admission note on the 485 provide an introductory paragraph, which gives a comprehensive description of: the patient, reason for referral, living situation, and patient support system.	T				
Does the note list what the patients problems are and identify why the patient is receiving home health care.	T				
If not, what's missing and how can it be strengthened?	A				
In the SOAP note(s) is there a solid clinical discussion of the patient's primary problems? Are the SOAP notes comprehensive?	T/A				
Is the data presented in an intelligent, organized manner?	A				
What are the strengths of the admission note?	A				

Can the clinical presentation be strengthened? Give examples.	A				
Is subjective / objective information presented appropriately? Are they mixed together?	A				
Can you give constructive suggestions for an admission SOAP note?	T/A				

Areas of Audit	Code	Yes	No	N/A	Comments
Assessment					
Is the assessment for each note analytically sound?	A				
Is it clearly an assessment?	A				
Can you give constructive suggestions in making appropriate assessments?	A				
Outcomes					
Has the clinician written outcomes specific to the patient? Or are they generic? Are they realistically achievable?	A				
Can the outcomes be improved? Give examples	A				
Visit sheets / Flow Sheets					
Is the visit / flow sheet documentation clearly informative?	A				
Are there areas which are presented well?	A				
Are there areas which are weak?					
Can you give suggestions for providing / presenting more informative visit documentation?	T/A				
If you are a covering clinician is there enough information present for you to accurately do your job? What would help you?	A				

<p>If there are multiple clinicians involved, are some clinician's whose documentation is more informative than others? What's the difference?</p>	<p>T/A T/A</p>				
<u>Patient education</u>					
<p>Is patient education a consistent part of each visit?</p>	<p>A</p>				
<p>Are there strengths in the patient education? Are there weaknesses?</p>	<p>T/A</p>				
<p>If there more than one clinician involved, is there a difference in patient education provided / documented? How could that be changed?</p>	<p>T/A</p>				
<p>Can you give constructive suggestions for documenting patient education?</p>					

Areas of Audit	Code	Yes	No	N/A	Comments
<u>Recertification</u>					
<p>Does each recertification present a clear picture of the patient's improvement or decline?</p>	<p>T/A</p>				<input type="checkbox"/> No Recert needed
<p>Are there strengths in the recerts? Are there weaknesses?</p>	<p>A</p>				
<p>Can you give constructive suggestions for writing informative recerts?</p>	<p>T/A</p>				

Acute Care Hospitalization

If the patient was hospitalized while a patient of ACHH&H, did the clinician do the following at start of care (SOC)?

Admit the patient within 24 hours of referral?	E			
Assess for safety hazards in the home?	E			
Assess the patient's support system?	T			
Assess prior hospitalization patterns?	T			
Complete a comprehensive physical assessment?	T			
Teach the patient/caregiver Re; S/S to report?	T/A			
Discuss/teach an emergency plan?	T			
Teach the patient how reach on-call nurses?	T			
Was the patient admitted by the primary nurse / clinician?	E			
What was the frequency of visits ordered for the service being audited?	A			
Are the frequency of visits appropriate based upon the patients clinical presentation?	A			
Did the clinician pick up on changes in the patient prior to hospitalization; and notify the appropriate medical personnel i.e. MD, RN.	A/E			
Did the clinician visit the patient the day after changes occurred?	A/E			
Were there additional referrals based upon the changes?	A/T			
In your audit could you see changes occurring in the patient prior to hospitalization?	A			
Could the hospitalization have been prevented? If yes, how?	A			
What was the reason for the hospitalization?	A			
What was the length of time from SOC (ACHHH) until the patient was hospitalized?	E			
Would you have handled this patient differently? If yes, how?	A			

No Hospitalization occurred while a patient of ACHHH.

Areas of Audit	Code	Yes	No	N/A	Comments
Discharge					
In your opinion was the patient ready for discharge?	A				
Were the outcomes met at a satisfactory level?	T/A				
Were there areas that would have been addressed that were not? Give examples.	T/A				
Does the discharge summary clearly reflect what happened with the patient?	T				
Can the discharge summary be improved? Give examples.	T/A				
Compare the patient's functional status at discharge with his status at start of care using the following OASIS questions.					
OASIS done	SOC	DC	Change		Comments
MO650 – Upper body dressing					
MO660 – Lower body dressing					
MO670 – Bathing					
MO680 – Toileting					
MO690 – Transferring					
MO700 – Ambulation					
MO700 – Oral Medications					
	Code	Yes	No	N/A	Comments
Is the functional status shown here in the OASIS questions consistent with the progress / decline seen in the clinical record?	A				
Is there a discrepancy?					
Why do you think that might be?					
If there is a discrepancy what would you suggest to prevent it?	T/A				

Code: A – Analytical sense
T – Thoroughness
R – Reliability
E – Efficiency

Signatures:
