ONE YEAR LATER: ASSESSING INDUSTRY OUTCOMES WITH MEDICARE'S NEW CONDITIONS OF PARTICIPATION

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“NEVER ATTACK A PROBLEM WITHOUT ALSO PRESENTING A SOLUTION.”

Jim Rohn
OBJECTIVES

- Discuss challenging conditions and standards
- Review common deficiencies since implementation of the new CoPs
- Discuss strategies to meet compliance and lessen vulnerabilities
- Review how implementing items into QAPI can improve outcomes
COP PHILOSOPHY

- Patient-Centered
- Data-Driven
- Outcome-Oriented
COP PHILOSOPHY

- Process that promotes high quality patient care at all times for all patients
- Continuous, integrated care process across all services, based on patient-centered assessment, care planning, service delivery and QAPI
- Interdisciplinary approach recognizing skills of all of the team
  - Think care management teams
  - Coordination of care
COP PHILOSOPHY

- Outcome-oriented — make quality improvements through QAPI specific to each HHA in order to improve patient outcomes and ensure safety
- Utilize data-driven CASPER reports to improve outcomes
EXAMPLES OF HOME HEALTH DEFICIENCIES SEEN SINCE IMPLEMENTATION OF NEW COPS
§484.50
Patient Rights
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

Many Standard and/or Condition-Level Deficiencies

- §484.50(a)(1) Provide the patient and the patient’s legal representative (if any), the following information during the initial evaluation visit, in advance of furnishing care to the patient:

  - (“In advance” means that HHA staff must complete the task prior to performing any hands-on care or any patient education)

- G 412- (a)(1)(i)
  - Written notice of the patient’s rights and responsibilities under this rule, and the *HHA’s transfer and discharge policies* as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- **G 420 - §484.50(a)(3): Verbal notice of rights and responsibilities**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include verbal notice of the patient’s rights and responsibilities in the individual’s language, free of charge, no later than the completion of the second skilled professional visit.

- **G 422 - §484.50(a)(4): Written notice within four business days**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the written notice to the patient about their right to have a copy of the patient’s rights and responsibilities provided to a patient-selected representative within four business days of the initial evaluation visit.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G 430 - §484.50(c)(2): Be free from abuse
  • Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the patient has the right to be free from verbal, mental, sexual and physical abuse including injuries of unknown source, neglect and misappropriation of property

- G 434 - §484.50(c)(4): Participate in care
  • Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the patient has the right to participate in, be informed about, and consent or refuse care, with respect to completion of all assessments, care to be furnished based on the comprehensive assessment, and expected outcomes
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

**Survey Example:** Eight of 17 records did not have evidence that patient had the right to, participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to all required elements.

- There was no evidence of the patient being informed of the frequency of proposed disciplines
- Consent forms signed at SOC are blank in areas of discipline frequency and no evidence in subsequent documentation of frequency

**Plan of Correction:**

- Revise consent forms in order to include discipline frequency
- Educate all admission clinicians to ensure this is included when doing consent with pt.
- Audit all admission consents to ensure that discipline frequency is in consent
- DPS will review 100% of patient admissions for at least one month to ensure that the patient was informed about the frequency of visits for the disciplines providing care with goal of 100%
- Once threshold is met, will continue to audit 20% of admissions quarterly
- If discipline frequency is added, revised ensure by education and auditing, that it is documented at the time
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G 440 - §484.50(c)(7): Payment from federally funded programs
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the patient has the right to be advised of financial liability changes as soon as possible, in advance of the next home health visit.
  - **Survey Example:** Upon medical record review, 10 of 17 records did not have evidence of documentation in the patient record that before the care was initiated, the HHA informed the patient, orally and in writing, of financial requirements and expectations.
    - There was no evidence patient was informed of charges the individual may have to pay before care was initiated.
    - Consent form signed at SOC is blank in area of patient payment.
  - **Plan of Correction:**
    - Review processes for authorization to ensure complete at initial assessment as well as when changes
    - Educate clinicians to complete financial liability and inform agency if changes
    - Audit to ensure completion as necessary
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G 446 - §484.50(c)(10): Names, addresses and telephone numbers of federally funded and state-funded entities

Survey Example

- Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the names, addresses and telephone numbers of federally funded and state-funded entities.
- The home folders did not include that the patient was advised of the names, addresses and telephone numbers of the Agency on Aging, Center for Independent Living, or the Quality Improvement Organization.
- There was no evidence that the agency provides the patient of the name, address and telephone number for the Agency on Aging.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G 450 - §484.50(c)(12): Access to auxiliary aides and language service
  
  Survey Examples:
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the patient has the right to be informed of the right to access auxiliary aids and how to access these services.

- G 452 - §484.50(d): Transfer and discharge
  
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the agency’s policies for transfer and discharge.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G 454 - §484.50(d)(1): HHA can no longer meet the patient’s needs

Survey Examples:

- Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that the patient and representative (if any) have a right to be informed of the agency’s policies for transfer and discharge when the agency can no longer meet the patient’s needs.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- **G 462 - §484.50(d)(5): Before discharge for cause**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the agency policy for discharge for cause.

- **G 464 - §484.50(d)(5)(i): Advise the patient of discharge for cause**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that the agency must advise the patient or representative (if any), physicians, and healthcare professionals who will be responsible for providing care after discharge, that a discharge for cause is being considered.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- **G 466 - §484.50(d)(5)(ii): Make efforts to resolve problems**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that if the patient is being considered for discharge for cause, the agency must make efforts to resolve the problem.

- **G 468 - §484.50(d)(5)(iii): Provide contact information for other services**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that if the patient is being considered for discharge for cause, the agency must provide the patient or representative (if any) with contact information for other agencies or providers who may be able to provide care after discharge.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G 470 - §484.50(d)(5)(iv): Document efforts to resolve problems
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that the agency must document the problem and efforts made to resolve the problem, if the patient is being considered for discharge for cause

- G 474 - §484.50(d)(5)(7): HHA ceases to operate
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include the patient and representative (if any) have a right to be informed of the agency’s policies for transfer and discharge if the agency ceases to operate
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- **G 480 - §484.50(e)(1)(i)(A): Treatment or care**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that if the patient, the patient’s representative (if any), or the patient’s caregiver or family made a compliant regarding treatment or care that is furnished inconsistently or inappropriately, the agency must investigate the complaint.

- **G 482 - §484.50(e)(1)(i)(B): Mistreat, neglect or abuse**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that the agency must investigate mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- **G 484 - §484.50(e)(1)(ii): Document complaint and resolution**
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that any agency staff in the normal course of providing services to patients, who identifies, notices, or recognizes incidences of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the agency and appropriate authorities in accordance with state law.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G490 - §484.50(f)(1,2): Accessibility
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that information must be provided to patients in a language and in a manner that is accessible and timely to persons with disabilities, include accessible websites and the provision of auxiliary aides services are at no cost to the individual and must be provided to persons with limited English proficiency, at no cost to the individual including oral interpretation and written translations.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G 530 - §484.50(e)(1)(ii): Document complaint and resolution
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that any agency staff in the normal course of providing services to patients, who identifies, notices, or recognizes incidences of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the agency and appropriate authorities in accordance with state law.
DEFICIENCIES SEEN — PATIENT RIGHTS: §484.50

- G490 - §484.50(f)(1,2): Accessibility
  - Based on review of the agency’s current patient rights information and interview, the agency failed to update the written notice of patient rights to include that information must be provided to patients in a language and in a manner that is accessible and timely to persons with disabilities, include accessible web sites and the provision of auxiliary aides services are at no cost to the individual and must be provided to persons with limited English proficiency, at no cost to the individual including oral interpretation and written translations.
ACTION ITEMS: PATIENT RIGHTS

- Review admission packets/home folders to ensure they are updated and have ALL of the required information from the new CoPs
- Review and update agency transfer/discharge policies — make specific to CoPs and be Sure that These are given In Advance to care
- Ensure your agency has auxiliary aid services in place
  - Educate staff on the use of these services and how to implement, if necessary
- Review patient consents and update as needed
  - Educate clinicians on filling consents out in their entirety
PLAN OF CORRECTION

Names, addresses and telephone numbers of federally-funded and state-funded entities

- Deficiency
  - Upon observation the home folders did not include the patient was advised of the names, addresses and telephone numbers of the Agency on Aging, Center for Independent Living, or the Quality Improvement Organization (QIO)

- Plan of Correction
  - Five home observation visits will be made by the clinical manager/designee to assess the patient handbook to ensure the address and phone numbers are included for the Agency on Aging, Center for Independent Living and the QIO
  - Goal — 100%
  - Once threshold is met, five home observation visits will be conducted biannually

*Note: This same template can be used with any of the patient rights deficiencies mentioned previously*
§484.55
Comprehensive Assessment of Patients
Consistent with the principles of patient-centered care, the intent in identifying patient strengths is to empower the patient to take an active role in his or her care.

The HHA must ask the patient to identify her or his own strengths and must also independently identify the patient’s strengths to inform the plan of care and to set patient goals and measurable outcomes.

Examples of patient strengths identified by HHAs through observation and by patient self-identification may include: awareness of disease status, knowledge of medications, motivation and readiness for change, motivation/ability to perform self-care and/or implement a therapeutic exercise program, understanding of a dietary regimen for disease management, vocational interests/hobbies, interpersonal relationships and supports, and financial stability.
G530 - §484.55 (C)(2): STRENGTHS, GOALS, AND CARE PREFERENCES

- The intent of assessing patient care preferences is to engage the patient to the greatest degree possible to take an active role in their home care rather than placing the patient in a passive recipient role by informing the patient what will be done for them and when.

- **Survey Example:** Upon medical record review, 5 of 6 patient records did not have the patient’s strengths, goals, and care preferences, including information that may be used to demonstrate the patient’s progress toward achievement of the goals identified by the patient
  - The RN failed to assess/document specific patient-identified strengths, goals, care preferences

- **Plan of Correction**
  - Education including the info in IG re Care Preferences and Patient Goals
  - Coordination of care in order to obtain pt goals and care preferences
  - QAPI- clinical manager will review 25% of patient admissions for a minimum of one month to ensure documentation of the specific patient-identified strengths, goals and care preferences with a goal of 95%. Once threshold is met, will continue to audit 20% of admissions quarterly
G536 - §484.55 (C)(5): REVIEW OF ALL MEDICATIONS

Identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

Survey Examples:

- Upon medical record review, 9 of 17 clinical records did not have evidence of a review of all medications that the patient was currently using.

- Examples: Profile included:
  - Normal Saline flush two to three times a day IVP without including dose.
  - Heparin Flush 100u/ml, 5000 units every day IVP, Dosage was ordered 500 units.
  - Tylenol every four to six hours PRN without a qualifier for PRN.
  - Loratadine, Lyrica, Neurontin, Prochlorperazine, Santyl, Senna, Senna without including a dose, frequency or route.
  - Insulin Lispro 1-16 units SQ before meals without defining the dosage parameters.
ACTION ITEMS: REVIEW OF MEDICATIONS

- Ensure an **ongoing** medication review is completed for all patients by an RN
  - Have ALL disciplines ask patient / caregiver if there are any new or revised meds, stressing that OTC, herbal and supplements are part of medications as well

- Have a process in place for therapy-only cases — RN must document medication review

- Educate clinicians that ALL PRN medications need to include the reason as to why the medication should be taken, as well as dosage and frequency.

- Educate clinicians that the following should be included in the medication profile:
  - All prescription and over the counter (OTC) medications
  - Oxygen

- Have a process in place for physician notification of any medication discrepancies, side effects, problems, or reactions

- Ensure the patient has a medication list that is consistent with the list in the clinical record — At SOC and Updated Ongoing
PLAN OF CORRECTION — REVIEW OF ALL MEDICATIONS

- QAPI Coordinator will review 100% of patient admissions for a minimum of one month to ensure a comprehensive review of medications was completed, documented and notification to physician was made for any discrepancies and/or clarifications, if warranted. Threshold — 100%. Once threshold is met, will continue to audit 20% of admissions quarterly.
- Medication education to Clinicians for role required for each discipline.
- Ensure tight process for having accurate patient med list in home on SOC and updated as necessary.
- IV Cases – very vulnerable in home health agencies
  - Ensure IV competency and frequent in-services.
  - Consider QAPI indicator for IV therapy.
- If medications are problematic within your agency consider a PIP.
§484.60
Care Planning, Coordination of Services, and Quality of Care
DEFICIENCIES SEEN — CARE PLANNING / COORDINATION OF CARE: §484.60

Many Standard and/or Condition-Level Deficiencies Seen
Immediate Jeopardy Situations Have Risen Under this CoP

G574 - §484.60(a)(1): Individualized plan of care

- Upon medical record review, 17 of 17 did not have evidence of an individualized plan of care
- Examples: Canned interventions and goals on numerous patients
- PRN
  - Order for SN to assess for following risk factors at SOC and/or PRN... did not include a PRN qualifier
  - Order for SN to assess patient/caregiver knowledge of diabetic management at first visit and review PRN did not include a PRN qualifier
  - Order for sacrum wound care daily and PRN did not include a PRN qualifier
  - Orders for current certification period starting x/x were not included on ROC POC
  - Order for therapy to instruct use of ice for pain/edema control did not include location, duration and frequency for ice
Upon medical record review, 6 of 6 patient records did not include a description of the patient’s risk for emergency department visits and hospital re-admission, and information related to any advanced directives on the plan of care

Individualized Plan of Care

Plan of Correction

Agency DON/designee will review 100% of patient POC/485’s for new admissions and patients being recertified for a minimum of one month to ensure the plan of care is individualized, has complete physician orders, includes information related to advanced directives and includes the risk for emergency department visits and hospital re-admission

- Threshold is 100%
- Once threshold is met, will continue to audit 20% of admission/recertification POC/485s quarterly
G578 - §484.60(B): CONFORMANCE WITH PHYSICIAN ORDERS

Upon medical record review, 4 of 6 patient records did not follow physician ordered visit frequencies

- Initial PT orders were for 2x week for four weeks
  - The PT saw patient 3x week for one week, 2x week for two weeks, and 1x week for the fourth week
    - There was no change in orders and no documentation of notification to the physician
- Order for MSW evaluation was obtained from physician by SN
  - There was no documentation of the MSW evaluation or an order to discontinue the evaluation prior to the patient discharged
PLAN OF CORRECTION

Conformance with Physician Orders

- **Plan of Correction**
  - Educate all staff to the necessity of following physician orders for frequency
    - If Missed visit, attempt to reschedule within the week; if not, notify patient care team and/or physician as necessary
  - QAPI coordinator will review 100% of patient records for a minimum of one month to ensure that physician ordered visit frequencies are being followed with goal 100%
    Once threshold is met, will continue to audit 20% of patient records quarterly
  - Ensure that there is a tight process to ensure all visits are scheduled and made to physician orders
G578 - §484.60(B): CONFORMANCE WITH PHYSICIAN ORDERS

Survey Example:

- Plan of care/485 had order for SN to change wound vac every three days and set to 125mm
  - No documentation that the wound vac was changed every three days,
  - No documentation that the wound vac was set at 125mm or monitored that it was at 125mm
  - No change in orders noted in record from physician or wound care clinic

- POC had orders to monitor blood glucose and blood pressure (Parameters of when to notify the physician were identified for both)
  - The SN documented at several visits results of blood sugars and/or blood pressure readings that were out of the parameters given in the POC
    - There was no documentation that the physician was notified

Continued on next slide......
Plan of care had orders to:

- Have patient’s new colostomy site and three surgical wounds monitored and dressings changed
- Teach the patient/caregiver about the care of the ostomy site
- The SN failed to document an initial assessment of the colostomy site
  - Failed to document an initial assessment of the three surgical sites
  - Failed to provide and/or document the colostomy/wound care and assessment at each visit
  - Failed to provide and/or document that education was given to patient and caregiver at any visit (Over a three-week time period)

Outcome:

- Patient was hospitalized for sepsis
  - Infection being from GI tract
PLAN OF CORRECTION SURVEY EXAMPLE: CONFORMANCE WITH PHYSICIAN ORDERS

- Education/Counseling to clinicians involved in example. Discover the “WHY?” that orders are not being followed
  - Is it documentation-related, or care issues, or both?

- Education to ALL clinicians to review this case study and ensure all understand conformance to physician orders

- Design processes to ensure clinical manager and team are coordinating care in order to avoid negative patient outcomes

- QAPI designee will review 100% of patient records for a minimum one month to ensure that all physician orders are being followed and that there is appropriate documentation of the orders/interventions with goal of 100%
  - Once threshold is met, will continue to audit 20% of patient records monthly for six months, then decrease to 20% quarterly.
  - PIP can be utilized if multiple processes, disciplines, etc., are involved
DEFICIENCIES SEEN — CARE PLANNING / COORDINATION OF CARE: §484.60 (CONT.)

- G580 - §484.60(b)(1): Only as ordered by a physician
  - Upon medical record review, three of six did not ensure drugs and treatments were administered only as ordered by a physician
    - Missing medications/wound orders
    - Medications/wound orders not being implemented per the orders
    - Medications/wound orders not being discontinued per the orders
G590 - §484.60(C)(1): ALERTING PHYSICIAN(S) TO ANY CHANGES IN THE PATIENT’S CONDITION

Upon medical record review, eight of 17 charts did not have evidence that the agency promptly alerted the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

- PTA noted patient has new increased edema, fatigue and coughing during visit
- Blood sugar of 462 documented by SN
  - Parameter to notify physician for blood sugar above 450
- Pain at level 6-8 for four visits without notification to physician
- Patient taking new OTC that is not reported
- Patient wound is larger by measurements with more drainage
- Frequencies not following orders and no documentation of notification to physician
ACTION ITEMS: PHYSICIAN NOTIFICATION

- Ensure that the care team is communicating patient issues to each other ongoing and reporting to the physician, with return communication
- Document all of the team coordination and physician notification along with follow-up
  - Keep in mind, if it is not documented it wasn’t done
- Early and frequent physician notification is also instrumental in improving patient and agency outcomes for emergent care and hospitalization
- Ensure that the relevant physician(s) are notified of patient issues, including the HH responsible physician, and appropriate consulting physicians approved
- If issues with reaching physicians, have Administrator communicate the need to have physicians respond timely and/or pre-designated other physicians
14 of 17 records did not have evidence in the patient record of coordination of care by the HHA
  • No evidence that the disciplines talked to each other or the physician about the care the patient was receiving and coordinating services for maximum benefit to the patient

Upon medical record review, 9 of 17 did not show evidence of coordination of care by the agency

Examples:
  • The RN documented the plan for the next visit included filling the med planner. There was no evidence of care coordination between the RN and the LPN prior to the LPN visit and the LPN visit note did not show evidence of filling the med planner
  • The MSW visit note included the caregiver planned to meet with the home health aide regarding helping the patient put on and take off her brace. The MSW did not communicate this information to the RN or the Aide, instead instructed the caregiver to contact the office to schedule training with the aide
ACTION ITEMS G600 - §484.60(D): COORDINATION OF CARE

- Have written processes for coordination of care guidelines for patient care teams
- Ensure that team works together towards improving patient outcomes
- Team “Reports” to each other when see any adverse, s/s, or new issues
- Team is each other’s eyes and ears
DEFICIENCIES SEEN — WRITTEN INFORMATION TO PATIENT

- **G614 - §484.60(e)(1): Visit schedule**
  - Upon home visit observations that were conducted, 3 out of 3 home folders failed to contain written instructions outlining the visit schedule, including frequency of visits for all disciplines providing care to the patient.

- **G616 - §484.60(e)(2): Patient medication schedule/instructions**
  - Upon home visit observations that were conducted, 3 out of 6 home folders failed to contain a medication list and 3 out of 6 home folders do not have updated medication lists matching the clinical record.
DEFICIENCIES SEEN — WRITTEN INFORMATION TO PATIENT

- G 618 - §484.60(e)(3): Treatments and therapy services
  - Upon home visit observation, review of patient’s home folder, clinical record review and interview, the agency failed to provide the patient and/or caregiver a copy of written instructions outlining treatments to be administered
    - Upon home visit observations that were conducted, 3 out of 3 patients failed to show that both verbal and written information regarding the therapy home program plan was given
DEFICIENCIES SEEN — WRITTEN INFORMATION TO PATIENT

- G622 - §484.60(e)(5): Name and contact information of the HHA clinical manager
  - Upon home visit observation, review of patient’s home folder, clinical record review and interview, the agency failed to ensure the patient was aware of the name and contact information of the clinical manager
    - Upon home visit observations that were conducted, 5 out of 5 patient home folders failed to contain written information regarding the name and contact number of the clinical manager
ACTION ITEMS: WRITTEN INFORMATION TO PATIENT

- Ensure calendar for patient visits is done by all disciplines at SOC and ongoing throughout HH. Do not change schedules for agency convenience (per IG’s). Report to team any physician visits and put on schedule.

- Medications — Clinicians must be aware of current med list in home and update to be consistent with the clinical records.

- All disciplines ask pt on every visit about changed or new meds.

- Ensure process for updating plan of care treatments and procedures for patients — ex paper form or EMR updates in home folder.
Three Standards

- Prevention: §484.70(a) – G682
- Control: §484.70(b)(1)(2) – G684
- Education: §484.70(c) – G686

§484.70

Infection Prevention and Control
DEFICIENCIES SEEN — INFECTION CONTROL AND PREVENTION: §484.70

- Agency did not have infection reports compiled in order to analyze trends and improve potential infection control and prevention procedures
  - Individual infection event reports were placed in QAPI folder with no further information or follow-up
- Agency did not have evidence that 100% of the staff were educated on infection prevention and transmission of communicable disease
- Other heavily cited areas:
  - Handwashing
  - Bag technique
  - Cleaning of equipment
Examples Seen from Home Visits During Mock Surveys:

Trach Patient:

- Patient had a tracheostomy and mostly independent
  - Nurse holds mirror for patient and hands supplies during
- While the SN was handing the patient the clean trach, it slipped off SN hand and fell to the floor
- SN picked it up and took to the kitchen
  - Cleaning was not observed but did hear tap water ran but only for a short period of time
- SN handed the trach to the patient and the patient inserted it into her trachea
  - No other cleaning technique was completed

Continued…
DEFICIENCIES SEEN — INFECTION CONTROL AND PREVENTION: §484.70

Other Examples:

- While changing the PICC dressing, there was no dirty bag or field set up and the SN put the initial dirty supplies on the medication table
- Handwashing not performed before or after performing wound care
- SN stopped setting up a medication planner to put hair into a pony tail without sanitizing hands prior to setting backup
- PT did not clean laptop per policy before placing it back into bag
- PT did not sanitize hands prior to leaving patient’s home
- SN did not sanitize after the removal of gloves
- SN placed bag on floor without a barrier
ACTION ITEMS: INFECTION CONTROL AND PREVENTION

- Perform supervisory visits frequently
  - Often infection control breaks in home
  - Ensure the supervisor doing the visit knows what is compliant!

- Patients state that they were not taught specifics about infection control/prevention
  - Ensure staff has education tools, such as “teach back” tools
  - Ensure all staff teach infection control each visit

- Integrate infection control into QAPI:
  - Utilize data driven such as development of UTI
  - Surveillance: Ensure process that all clinicians understand and complete
  - Trend data quarterly
§484.75
Skilled Professional Services
DEFICIENCIES SEEN — SKILLED PROFESSIONAL SERVICES: G704 - §484.75

Responsibilities of skilled professionals

- Upon medical record review, 4 of 7 patients did not have services provided that were ordered by the physician as indicated in the plan of care
  - Discrepancies with visit frequencies
- Upon medical record review, 7 of 17 clinical records did not show evidence that skilled professionals prepared clinical and progress notes and provided services that were ordered by the physician as indicated in the plan of care
  - POC included SN to perform diabetic nail care monthly, but no diabetic nail care had been performed or discussed by the due date

Continued…
POC included the SN to instruct the patient about a low-sodium diet, and to weigh daily and document on a calendar
  • There was no SN clinical documentation that these instructions were provided, and no weights were documented
SN noted that patient on a NAS diet at SOC; however, POC had that diet was regular
Medication planner was not filled as ordered on the plan of care
  • POC had to instruct patient to weigh self daily and document in a diary
No instruction or weights were documented in any visit note
DEFICIENCIES SEEN — SKILLED PROFESSIONAL SERVICES: §484.75

- **G706 - §484.75(b)(1): Ongoing interdisciplinary assessment of the patient**
  
  Upon medical record review the agency failed to ensure effective ongoing interdisciplinary assessment of the patient.

- In 3 of 3 patient records reviewed, the physical therapist failed to adequately assess/document the patient’s pain status.

- In 1 of 3 patient records reviewed the physical therapist failed to perform an evaluation in a timely manner and failed to coordinate care with the physician and agency.
  - PT was ordered and an evaluation was not performed by the PT for 10 days — there was not communication between PT and RN or PT and physician.
PLAN OF CORRECTION — SKILLED PROFESSIONAL SERVICES

Education:
- One-on-one in-service will be provided to affected staff and a staff meeting will be conducted for clinical staff who are responsible for completing the pain assessment to include all elements that need to be present in a pain assessment and physician notification for pain.
- Ensure tight scheduling processes in order to have timely visits by all disciplines.

Monitor:
- QAPI Coordinator will review 100% of pain assessments for a minimum of four weeks to ensure that the pain assessment is being completed accurately and physician notification has occurred when applicable, then 20% per quarter with 100% goal.
- Audit timeliness of all therapy evals after ordered for three months with 100% compliance in time frame required by HH policies and/or physician orders.
§484.80
Home Health Aide Services
Upon record review, 2 of 3 records did not show evidence of thorough written patient care instructions for the Home Health Aide:

- Patient required placement of a cast for a fractured vertebrae following her bath from the home health aide
  - The aide care plan did not include instructions for this required cast placement, as was evidenced during a surveyor home visit
  - Patient had been consistently receiving aide services, but the aide care plan was last updated at SOC, eight weeks prior

- There was no evidence of a competency given by RN to the Aide for this procedure
  - Crosses over to other aide standards

- There was no order for this procedure by the physician
  - Crosses over to other standards
HOME HEALTH AIDE — G798 - §484.80(G)(3) G802 — DUTIES OF HOME HEALTH AIDES

- Upon medical record review, 2 of 2 records did not have evidence the Home Health Aide provides services that are:
  - Ordered by a physician
  - Included in the plan of care
  - Permitted to be performed under state law
  - Are consistent with the home health aide training

- All aide visits documented the completion of the following tasks that were not on the aide care plan:
  - Assist with transfer
  - Assist with Medications
  - Make light meal
  - Laundry
1 of 4 patients receiving home health aide services had no evidence of ensuring aide followed the patient's plan of care for completion of tasks assigned to them by the Registered Nurse

- On every visit the aide marked three or more tasks N/A or No

The following elements were not in evidence for all aide supervisory visits in 4 of 4 records receiving aide services:

- Ensuring open communication with patient/family
- Ensuring aide honored patient rights
- Ensuring aide followed infection control and prevention policy and procedure
- Ensuring aide reported changes in patient’s condition
PLAN OF CORRECTION

Home Health Aide Supervisory

- Educate supervising clinicians on the frequency and components of aide supervision
- Clinical Manager/designee will review 100% of patient records having an aide for a minimum of one month to ensure that the supervisory assessments include:
  - Ensuring open communication with patient/family
  - Ensuring aide honored patient rights
  - Ensuring aide followed infection control and prevention policy and procedure
  - Ensuring aide reported changes in patient’s condition
- Threshold is 100%
- Once threshold is met, will continue to audit 20% of patient records quarterly
ACTION ITEMS: HOME HEALTH AIDE

- Although aides do not have to be on site for supervisory patient visits every 14 days, ensure the RN or therapist is talking to the aide to review the assignment sheet/care plan, as well as all elements in the supervisory visit
  - In this manner, the aide assignment sheet can be updated at all times
- Ensure aides understand that they must do ALL tasks on the aide assignment sheet and CANNOT DO anything NOT on the assignment sheet
  - Ex: Aide to contact RN if any task the patient/caregiver is requesting is not on assignment sheet
- Educate all aides on reporting all changes in patient condition to the RN immediately and documenting it
ACTION ITEMS: HOME HEALTH AIDE

- When completing the aide assignment sheet, ensure that all tasks are clearly explained, and are specific
  - No PRNs or per patient request, as aides cannot have discretion
- Be sure that aides assigned to patient have a competency completed for all tasks assigned
  - Aide competencies should be a working document for clinical managers to view prior to assigning aides
- Consider a quality indicator for aide services
  - So vulnerable to multiple deficiencies, which can quickly lead to condition-level
§484.102 Emergency Preparedness
DEFICIENCIES SEEN — EMERGENCY PREPAREDNESS: §484.102

- E0006 - §484.102(a)(1)(2): Emergency preparedness plan based on all hazards risk assessment
  - Risk assessment not individualized to agency
    - Generic from sources and/or done by agency system
  - Not customized for risks:
    - Hurricane, blizzards, tornado, etc., depending on agency location
  - Strategies not developed to address the specific risks
## EXAMPLE: HAZARD VULNERABILITY TABLE

### Emergency Operations Plan - Hazard Vulnerability Table

<table>
<thead>
<tr>
<th>Event</th>
<th>PROBABILITY</th>
<th>RISK</th>
<th>PREPAREDNESS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Med</td>
<td>Low</td>
<td>None</td>
</tr>
<tr>
<td>SCORE</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>NATURAL EVENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hurricane</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tornado</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEFICIENCIES SEEN — EMERGENCY PREPAREDNESS: §484.102 (CONT.)

- E0037 - §484.102(d)(1): Emergency preparedness training and testing
  - All staff and contracted staff are not receiving annual training in emergency preparedness
    - Evidence of in-services and sign-in sheets, but not 100% of all staff and contractors
  - Staff not knowing the home health agency emergency preparedness procedures
    - When interviewing staff, they do not know their role in an emergency
E0037 - §484.102(d)(1): Emergency preparedness training and testing

- Upon personnel record review, 11 out of 11 records did not show evidence of emergency preparedness training
  - The xx/xx/17 staff meeting minutes stated "Handouts given on step-by-step for completion of emergency preparedness profile as far as contact person"
  - The meeting attendance was 24 out of 74 listed staff, contract, and office personnel — No other training documentation was observed
- There was no evidence of training of the contracted staff
PLAN OF CORRECTION

Emergency Preparedness Training and Testing

Plan of Correction

- Implement a process for in which all employees are trained to agency’s emergency preparedness policies and procedures upon hire/initiation of contract
- Ensure a process is in place for yearly education on emergency preparedness for ALL employees and document
  - Include contracted staff
- All employee files, including contracted staff, will be audited annually to ensure documentation of emergency preparedness policies and procedures in each
- Threshold is 100% compliance
§484.65 QAPI
QI / QAPI PROGRAM

Ensure that program is designed to help you!

- Choose activities to monitor from your deficiencies and action plan
- Focus on activities to ensure that you have no vulnerabilities to getting a condition out
- Focus on high-risk, high-volume, and problem-prone areas
  - Consider incidence, prevalence and severity
- Have an immediate correction of any identified problem(s) that directly OR potentially threaten the health and safety of patients
QI / QAPI PROGRAM CHART REVIEWS

Reviews should be ongoing:

- Recommend at least quarterly
  - May increase prior to survey

How many?

- Recommend 20% each quarter
  - If deficient with an indicator
    - Recommend 50% until 90% compliance is reached

Who?

- Clinical manager/QA nurse/RN/etc.
  - Recommend training more than one person
    - Ensure consistencies
QI / QAPI PROGRAM CUSTOMER SATISFACTION

Review HHCAHPS report:

- Choose indicators to focus on that are low to benchmarks and cross over to outcome reports
  - Medication management, pain
- Develop an indicator and add criteria were the HHCAHPS score is poor
  - Informed when providers would arrive
  - Agency explained care and services
QI / QAPI PROGRAM OUTCOME MEASUREMENTS

CASPER reports:
- Critical to review these each time they are updated
- Determine indicators that need improvement
  - Add to QI program

Potentially Avoidable Events:
- Be proactive in identifying adverse events
- When events are identified audit patient record

Outcomes:
- Choose ones that affect all disciplines
  - ADLs, ambulation, pain, etc.
- Choose clinically significant ones
  - Dyspnea, pain, medications, etc.
QI / QAPI PROGRAM OTHER AREAS TO INCLUDE

Incorporate:

- Incident reports
  - Fall reduction tracking
- Complaints
- Medication errors and/or adverse events
- Infections
QI / QAPI PROGRAM ACTION PLAN

Specifics found:

- Example: In 3 of 8 charts reviewed, physician orders for wound care were not followed
  - State for each chart what was not followed

Action items:

- Include monitoring
  - Review 20% of records a quarter to focus on following wound care orders with a goal of 90% compliance
    - Ensure audit tool is designed for this particular area
COMPLIANCE WITH COPS AND THE RELATION TO OUTCOMES

- Coordination of Care
- Team works together to Improve patient outcomes
  - Pain
  - Medication
  - Functional areas
- Will decrease ER / Hospitalization use
- Improve patient adherence and compliance
- Improve HHCAHPS scores
  - Patients involved in their care
  - Patients seeing the team communicate
CONCLUSION: TIPS TO COMPLY WITH COPS

Frequent Mock Surveys
- Have an objective qualified person in your agency or an outside qualified entity
  - Perform the way a surveyor would
  - Determines your vulnerabilities

QAPI Program That Can Help You
- Base on high volume, high risk, problem prone areas you find on mock survey, past near-misses, past survey deficiencies, CASPER Outcome Reports, etc.

Frequent Supervisory Home Visits
- Ensure person doing these knows what to look for
CONCLUSION: TIPS TO COMPLY WITH COPS

Ongoing Concurrent Clinical Record Reviews

- Essential as it allows for:
  - Action to be taken for physician notification
  - Improvement in patient / agency outcomes
  - Prevention of emergent care visits
  - Documentation to be in compliance

Include 100% of your staff and contractors – Key to being in compliance!

- If there is a lack of understanding of the rules, the rules will not be followed
- Have task forces for key vulnerable areas
- Have staff involved in QAPI - rotate so have all staff
- Utilize your best performers to assist with home visits, record reviews, etc.

*EDUCATE, EDUCATE, EDUCATE!*
KEY COMPONENTS TO AVOID COP DEFICIENCIES

- Investigate the issue causing non compliance
- Revise policies and procedure to be compliant
- Develop processes that are specific for staff / agency
- Education — Frequent and Fresh!
- QAPI monitoring — Can ensure Continuous Survey Readiness
- Reevaluate to ensure compliant practices continue
- Involve All Staff!
ANY QUESTIONS?

THANKS!

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