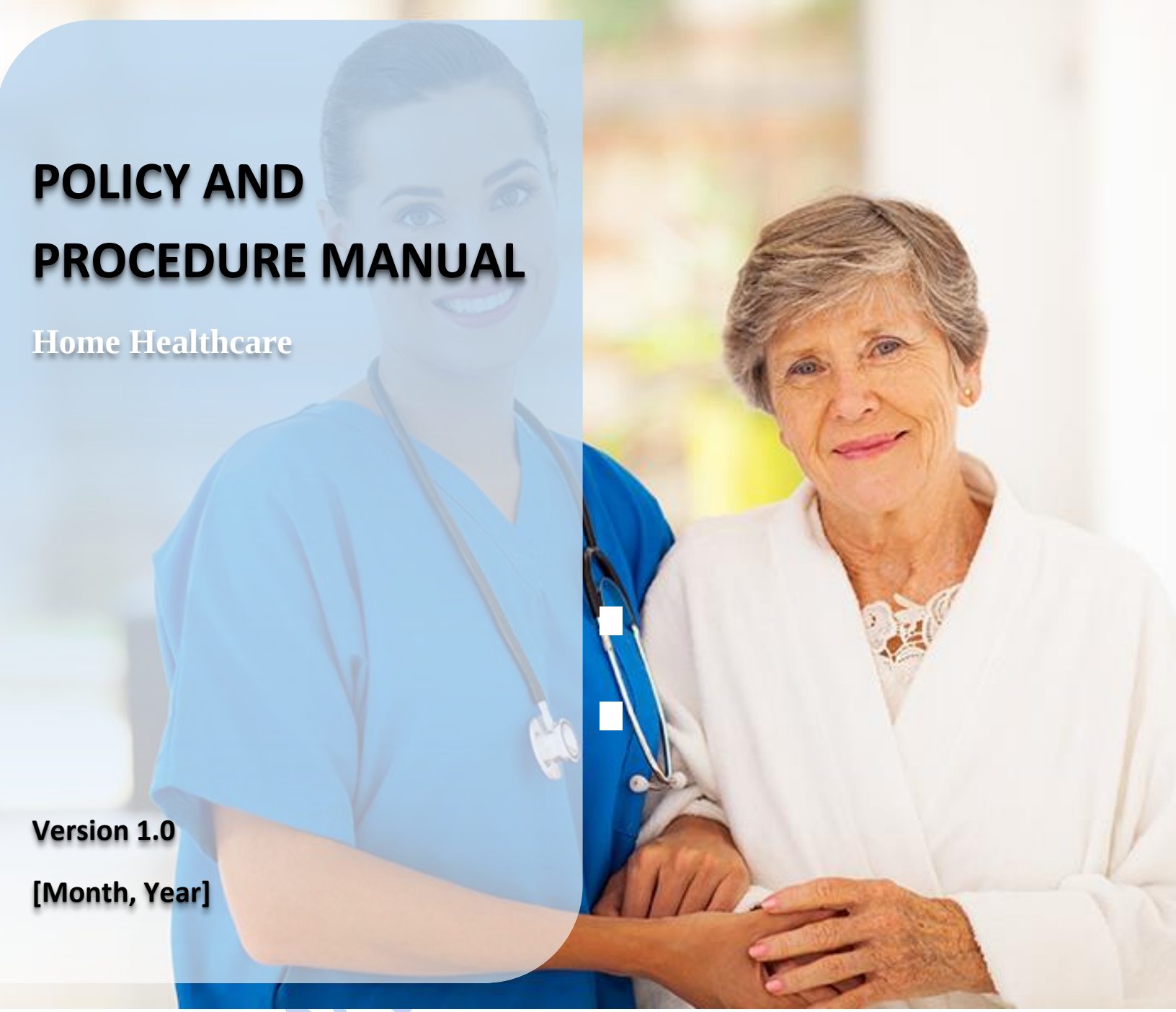


POLICY AND PROCEDURE MANUAL

Home Healthcare

Version 1.0

[Month, Year]

YOUR LOGO HERE

[Agency Name]
[Agency Address]
[Contact Number]
[Email Address]
[Website]

TABLE OF CONTENTS

INTRODUCTION

[Agency Name] is a home health agency located in Virginia that is dedicated to providing high-quality and compassionate care to individuals in the comfort of their own homes. Our team of skilled healthcare professionals is committed to improving the health and well-being of our patients by delivering personalized care that meets their unique needs.

At [Agency Name], we understand that each patient has their own set of health challenges and goals, and we strive to create individualized care plans that address those specific needs.

We believe that home-based care offers a more personalized and comprehensive approach to healthcare that can lead to better health outcomes and improved quality of life for our patients. Our mission is to provide exceptional care and support to our patients and their families, and to empower them to live as independently and comfortably as possible.

OUR VALUES

- **Service**: providing a helping hand that allows our residents to feel valued and cared for by upholding their sense of dignity.
- **Trust**: maintaining honest lines of communication with safe and competent care that protects privacy.
- **Integrity**: fostering an undivided attitude directed towards doing the right thing the first time around, every time.
- **Respect**: promoting esteem and acceptance for and towards everyone we come in contact with

STATEMENT OF PURPOSE

The purpose of this policy is to define organization-wide processes and activities that maximize the coordination of quality home services to clients at [Agency Name]. The goal of this plan is to coordinate resident care in a manner that is seamless from the resident's perspective. This policy shall be made available for review, upon request, to clients and their designated representatives and shall be readily available for staff use at all times within [Agency Name].

STATEMENT OF POLICY

[Agency Name] prohibits discrimination in all its activities on the basis of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, gender identity, genetic information, and any political beliefs

[Agency Name] is consistent with the:

- Needs of our clients and the community we serve;
- Policies and procedures;

We strongly adhere to compliance requirements stated by Virginia Law, Department of Health and follow the best practices implemented in terms of policies and procedures within [Agency Name].

DOCUMENT CONTROL & APPROVALS

Document Revisions shall be recorded in the table below;

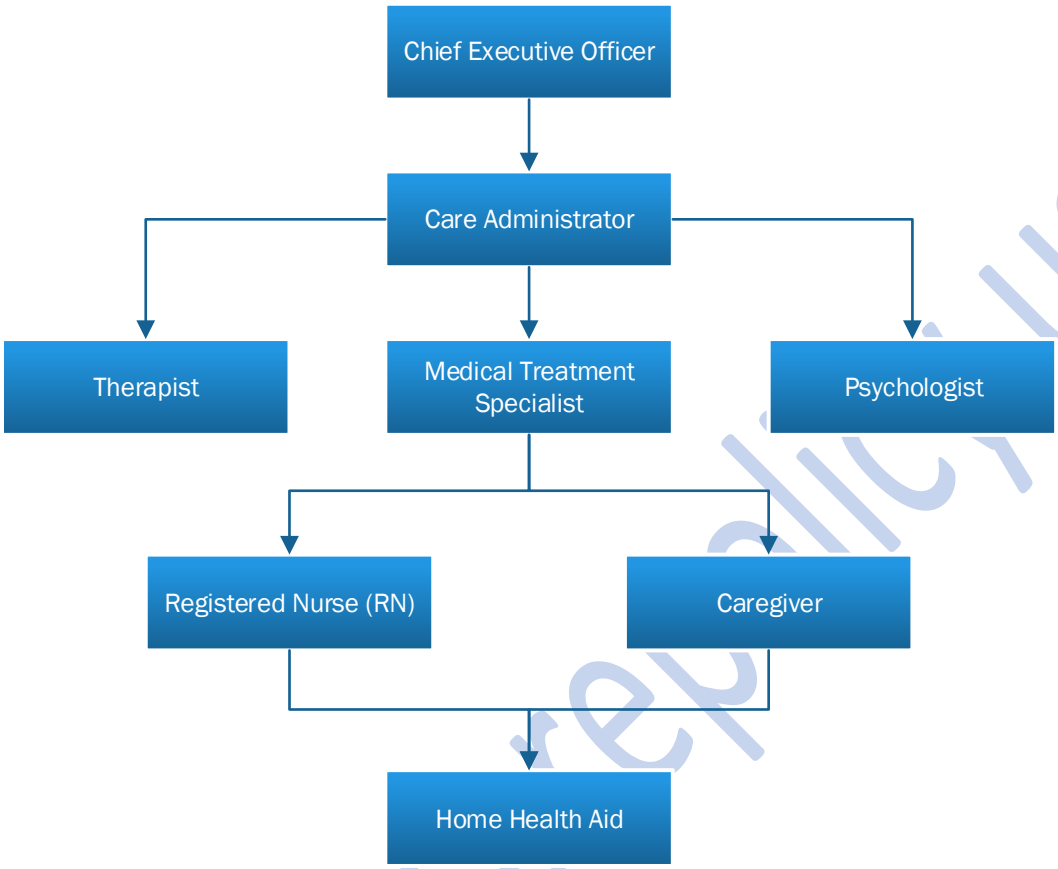
Ver. No.	Rev. No.	Page No.	Description of Amendment	Approved By	Date

Document review and approvals shall be recorded in the table below;

Description	Title	Signature	Date
Prepared By			
Reviewed By			
Approved By			

Note: All policies and procedures shall be reviewed at least annually, with recommended changes submitted to the governing body for approval, as necessary.

ORGANIZATIONAL CHART



SERVICE DESCRIPTIONS

Service Descriptions

1. Unskilled Work: [Agency Name] offers unskilled services to individuals who require assistance with their activities of daily living (ADLs). Our caregivers provide support with tasks such as bathing, dressing, grooming, toileting, and mobility. Our goal is to ensure that our clients are able to live as independently and comfortably as possible in the comfort of their own homes.
2. Skilled Work: Our skilled services are performed by licensed RNs and include G-tube feedings, medication administration, and wound care. Our skilled services are provided in accordance with a physician's orders and are designed to help our clients manage complex medical conditions and maintain their health at home.
3. Mobile IV Therapy: [Agency Name] also offers mobile intravenous (IV) therapy services to individuals who require medication or fluid therapy outside of a hospital setting. Our licensed nurses are trained to safely administer IV medications and fluids in the comfort of our clients' homes.

Policy and Procedures

1. Unskilled Work: [Agency Name] provides unskilled services to individuals who require assistance with their activities of daily living (ADLs). Our caregivers are trained and experienced in providing assistance with tasks such as bathing, dressing, grooming, toileting, and mobility. Our policies and procedures for unskilled work include:

- Conducting an initial assessment to determine the client's needs and developing a care plan in collaboration with the client, family, and healthcare provider
- Providing assistance with ADLs in a respectful and dignified manner
- Monitoring and documenting the client's condition and reporting any changes to the healthcare provider
- Following infection control practices to prevent the spread of illness
- Providing ongoing training and supervision to caregivers to ensure that they are providing safe and effective care.

2. Skilled Work: [Agency Name] provides skilled services, including G-tube feedings, medication administration, and wound care, that require a licensed RN. Our policies and procedures for skilled work include:

- Obtaining a physician's order for the skilled service and developing a care plan in collaboration with the client, family, and healthcare provider
- Ensuring that the RN providing the service is licensed and trained to perform the procedure
- Following infection control practices to prevent the spread of illness
- Monitoring and documenting the client's condition and reporting any changes to the healthcare provider
- Providing ongoing training and supervision to RNs to ensure that they are providing safe and effective care.

3. Mobile IV Therapy: [Agency Name] provides mobile intravenous (IV) therapy services to individuals who require medication or fluid therapy outside of a hospital setting. Our policies and procedures for mobile IV therapy include:

- Obtaining a physician's order for the IV therapy and developing a care plan in collaboration with the client, family, and healthcare provider
- Ensuring that the nurse providing the IV therapy is licensed and trained to safely administer IV medications and fluids
- Following infection control practices to prevent the spread of illness
- Monitoring and documenting the client's condition and reporting any changes to the healthcare provider
- Providing ongoing training and supervision to nurses to ensure that they are providing safe and effective care.

ADMINISTRATIVE AND OPERATIONAL POLICIES AND PROCEDURES

ADMINISTRATIVE RECORDS

A medical record is considered a legal document used to protect the legal interest of a resident as well as the [Agency Name]. Information maintained within the record serves as a basis for review, study and evaluation of the care rendered to the resident. It is essential that medical records are neat, legible, accurate and readily accessible for purposes of service delivery, audit and possible litigation proceedings. The medical record shall be locked in a container and handled and transported in a manner that ensures the security and confidentiality of the record at all times.

Clinical record entries must be complete, legible and accurate. Inaccurate documentation can lead to errors in the treatment of the resident, which could put the resident at significant risk of harm. [Agency Name] shall strive for complete, legible and accurate documentation on all resident records and will follow specific guidelines to ensure accurate documentation.

All employees of [Agency Name] shall not disclose or knowingly permit the disclosure of any information in a client record except to appropriate provider staff, the client, responsible party (if applicable), or other health care providers, the department, other individual authorized by the client in writing.

All clients are to be treated with consideration, respect, and dignity, including the provision of privacy during care. [Agency Name] will maintain confidentiality of clinical records in accordance with legal requirements and we will release information only with client authorization or as required by law.

To assure the maintenance and security of all client/resident records, the following will take place:

- The Administrator will supervise the maintenance of all records
- Records will be maintained in a locked file cabinet located at the office of [Agency Name] to assure protection.
- The Administrator has total custody of all records.
- The records may be released to the client/responsible party by request (if applicable) and other members of the health care field authorized by the client or by subpoena.

- Confidentiality will be enforced during all staff meetings.
- Records will be retained with full protection for a minimum of 5 years after services are discontinued (the last date of service).

Record Procedures

- All entries will be dated and signed. Signatures/initials in the clinical records will be recorded in accordance with the agency's legal signature list. No alterations will be permitted. If an Interpreter is used for resident interaction the interpreter must sign the entry along with the provider of the service.
- Narrative notes are to be numbered with the most recent pages on the top progressing to earliest entry on the bottom.
- Each page in the chart is to include name (last, first, middle/maiden), date of birth and resident number.
- All resident/client encounters are documented in the medical record noting the type of contact.
- Entries are to be made within the margins and to the end of the line. If unable to fill the line, draw a line to the end. There is to be no crowding or writing in the margins, and no unfilled lines between entries. All unused lines will be crossed out between documentation.
- All telephone encounters (if any) will be documented in the client's clinical record on the note sheet in chronological order.
- Each personal health program is responsible for providing program specific documentation guidelines and monitoring/reviewing those guidelines according to Quality Assurance.
- The employee who provided the service will document all resident data collection and service provided. Provider must initial and date on the laboratory reports when reviewed.
- The Medical Records Policy adheres to guidelines regarding content, access, storage, removal and retention of medical records to ensure that the agency abides by statutes and regulations pertaining to legality, privacy and security.
- Late entries made out of chronological order must be recorded as soon as possible in the next available chart space, as a "note out of sequence". The late entries should have time of entry and must have two dates, the date the entry was made and date of the encounter along with the reason for the late entry.
- Clinical records will be reviewed periodically by an audit review committee to determine compliance with policies and procedures.
- Records found to be incomplete or in need of clarification will be returned to the appropriate staff member.

Correction of documentation

- Documentation error will be corrected by drawing a single line through the incorrect documentation, initialing and dating the mistake and continuing with the note. The error will remain legible.
- The reader must be able to discern what the incorrect entry states.
- The person who documents the original information corrects the documentation. At no time should another discipline correct documentation or strike through documentation made by the original author.
- Correction fluid or erasers will not be used to correct documentation in the resident's record.

Records

- Chart Maintenance – Central Filing: The central files must be kept up-to-date at all times in order to serve its purpose.
    - Ragged or damaged folders will be replaced with new ones.
    - Include these steps in preparing for filing:
        - All charts are placed in alphabetical order.
        - Remove all paper clips or notes (review and remove if not required).
- All charting to be completed on day of client visit and returned to central filing or pending file by 4:45 p.m.
- The staff is not allowed to keep charts in their own personal filing cabinets or offices.

Filing of Records

- Medical records are first filed alphabetically following a color-coded system based on the first two letters of the resident's last name. All active records will be maintained in the medical records area when not needed for delivery service. All in-active records are kept in locked files in the conference room; which is locked at closing. All records must be returned to medical records area after the delivery of service or by the end of the workday to ensure security of medical information. When a medical record is outside the medical records area it must be handled in a secure manner to protect the medical information from being disclosed to unauthorized persons.

- Notes, reports, medical forms, etc. will be secured inside each individual resident's folder according to the order specified by the agency. All note and problem pages in the medical record will be sequentially numbered and each page will have resident identification information.

Security of Records

- As legal custodians of medical records generated in our agency, proper care will be exercised to assure that the records themselves and their contents are properly safeguarded and secure at all times. All of these individuals shall be made aware that access is allowed only to those records pertinent to official function or service delivery. Intrusion into a record for curiosity purposes at no time will be tolerated and appropriate disciplinary action will result or termination of access to records.
- All records must be properly signed out using out-guides with a label reflecting the resident's name, name of person or clinic needing records and date retrieved. Authorized personnel who signed out record(s) will be responsible for returning the record (s) when finished working with them or at the end of the workday. Records will not be left available for public viewing at any time and records must be secured to prevent accessibility to unauthorized persons.
- Ordinarily medical records will not be removed from the unless it is deemed necessary to provide resident care. Records will not be removed from the building except by authorized personnel who can transport records according to agency transportation procedure for use at other sites, for court proceedings or for agency related activities.

SERVICE CRITERIA

Admission Criteria

[Agency Name] who admits a client into services must maintain written policies, procedures and criteria for accepting members referred by the care coordinator/ Veterans Administration care coordinator or Private Pay Client's Rep.

The client must meet eligibility criteria, which is based on the level of care (LOC). Eligibility includes elderly and/or functional impairment caused by physical limitations, unmet need for care, and approval of care by the RN. Eligible persons are those who: have been determined Medicaid eligible or potentially Medicaid eligible, have been assessed appropriate the care

coordinator, are certified for the level of care appropriate for placement in an intermediate care facility, and are in need of services which can be provided at less cost than the Medicaid cost of nursing facility care.

- When the resident has limitations, which make it difficult to perform normal daily living activities and live independently
- Qualify for the level of care provided by a nursing home
- Have health needs that can be met in the community with services offered by the program and established individual cost guidelines. The individual cast is estimated based on projected care plan

Note: Residents on a property shall be limited to a maximum of 7-8 residents and a maximum of 2-4 staff/per day shall be within the property. License/Registered nurse shall be on site during all times.

Admission can be granted as long as health and safety needs can be met by [Agency Name]. The criteria for clients admitted to service may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, or handicap, in accordance with the Civil Rights Acts.

Discharged/ Termination Criteria

[Agency Name] may discharge a client if the care coordinator or utilization review analyst recommends a reduction or termination of service(s). If the member chooses to appeal the adverse action decision, and request a continuation of service(s), he/she has 10 days after notice of termination to appeal. If the member does not appeal, discharge from services occurs in 10 days from the member's receipt of the adverse action notice.

Except in an emergency, or when a client leaves of his or her own accord or against program advice, no client shall be transferred or discharged unless a written plan has been developed by the facility staff in conjunction with the client and his or her primary counselor.

Discharge or termination occurs for the member when one of the following occurs:

- The care coordinator determines that the member is no longer appropriate or eligible for services.
- Utilization Review (UR) staff recommends in writing that a member be discharged from services.

- The enrolled member has not received services for 60 consecutive calendar days.
- A member fails to pay cost share in accordance with the agreement.
- Member/Member's representative repeatedly refuses services.
- Member enters a nursing facility. [Agency Name] must send discharge notice immediately upon the member's facility placement. Services may continue for up to 2 months or 62 days if member is expected to return home
- Member allows or exhibits illegal behavior in the home or there has been bodily harm threats inflicted by member or others living in the home to another person within the past 30 calendar days.
- Member/representative or care coordinator requests immediate termination of services.
- Member relocates outside of the planning service area to an area not served by the [Agency Name].
- Member expires
- Provider can no longer provide services ordered on the comprehensive care plan.

INFORMED CONSENT

- "Informed consent" means the knowing and voluntary agreement, without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion, of a person who is capable of exercising free power of choice. For the purposes of human research, the basic elements of information necessary to determine the existence of such consent shall include the following:
    - A reasonable and comprehensible explanation to the person of the proposed procedures or protocols to be followed, their purposes, including descriptions of any attendant discomforts, and risks and benefits reasonably to be expected, how the results of the human research are disseminated, and how the identity of the person is protected;
    - A disclosure of any appropriate alternative procedures or therapies that might be advantageous for the person, together with their side effects, risks, and benefits;
    - A description of any adverse consequences and risks to be expected and an indication of whether there may be other significant risks not yet identified;

- An instruction that the person may withdraw his consent and discontinue participation in the human research at any time without prejudice to him or fear of reprisal;
- An explanation of any costs or compensation that may accrue to the person and, if applicable, the availability of third-party reimbursement for the proposed procedures or protocols or any medical care that may be available if an injury occurs;
- An offer to answer any inquiries by the person or, if applicable, his legally authorized representative concerning the procedures and protocols and a description of the ways in which concerns may be raised or questions asked;
- A statement that the study involves research, and an explanation that includes identification of any procedures that are experimental; the expected duration of the person's participation; a statement describing the extent, if any, to which confidentiality of records identifying the participant will be maintained; and if any data from this study are published, the person will not be identified without his written permission;
- A disclosure of any appropriate alternative procedures or therapies that might be advantageous for the person;
- A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the person is otherwise entitled, and the person may discontinue participation at any time without penalty or loss of benefits to which he is otherwise entitled;
- An explanation of whom to contact for answers to pertinent questions about the research and research participants' rights, and whom to contact in the event of a research-related injury; and
- For research involving more than minimal risk, an explanation as to whether any compensation or medical care is available if injury occurs and, if so, what is included or where further information may be obtained

- All information concerning an individual client is confidential.
- Home care staff, and Ministry of Health staff in Virginia have access to confidential information for program purposes only (i.e. on a “need to know” basis).

- [Agency Name] must obtain and document informed verbal or informed written consent from the client as follows:
  - to assess the client;
  - to release the client's personal health information to anyone other than internal staff and Virginia Ministry of Health personnel; and,
  - to provide service to the client.
- [Agency Name] must obtain and document informed verbal consent. To obtain informed verbal consent, the [Agency Name] must ensure that the client has full knowledge of the specific actions for which the consent has been requested.
- To obtain informed written consent, the [Agency Name] must ensure that the client has full knowledge of the specific actions for which the consent has been requested, and that those actions are specified in the consent document signed by the client. A witness must certify the client's signature.
- When applicable, [Agency Name] shall discuss Health Care Directives and communicate this to appropriate team members.
- [Agency Name] must have a policy regarding disclosure of health information with consent or as otherwise specifically authorized in *The Health Information Protection Act*.