Orientation Packet
Section VI
Clinical Information

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Professional Boundaries

What Are Professional Boundaries?

- Clearly established limits that allow for safe connections between service providers and their clients
- "Being with" the client, not becoming the client
- Being friendly, not friends
- The ability to know where you end and the client begins
- A clear understanding of the limits and responsibilities of your role as a service provider

The Importance of Boundaries

- Role modeling to the client healthy communication and professional relationships
- Avoiding the "rescuer" role
- Staying focused on one's responsibilities to the client & the provision of helpful and appropriate services to the client
- Avoiding burn-out ("compassion fatigue")
- If working in conjunction with other services providers: maintaining a healthy, open, communicating and functioning team
- Maintaining one's physical and emotional safety

Consequences of Having Loose/Poor Boundaries

- Compassion fatigue – the service provider's role may not feel sustainable
- Potential for "splitting" on teams
- Client may not be given appropriate or helpful services, which could affect his/her willingness to accept future services
- Client may feel betrayed, abandoned, and/or poorly served
- Service provider may act unethically
- The reputation of the service provider's agency and/or profession may be compromised
- Service provider and/or client may be emotionally traumatized and/or put in physical danger
- Techniques for Creating & Maintaining

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Healthy Professional Boundaries

□ As early as possible in the relationship (ideally at your initial meeting/intake/ assessment), establish clear agreements with the client regarding your role as a service provider, your availability, best ways to communicate with you, and what to do if you see one another in public.

□ When boundary issues or warning signs appear, address these issues with the client quickly. Be sensitive to their feelings when doing this; emphasize the importance of and your commitment to maintaining healthy boundaries.

□ Self-disclosure: if you do decide to tell a client something personal about yourself, ensure that the information is related to the client's goals. Too much self-disclosure shifts the focus from the client to the service provider and can confuse the client in terms of roles and expectations of the relationship.

□ Realize that how a client interprets your words and actions might not match what you were trying to communicate. With these sensitive relationships, you may need to frequently clarify your role and boundaries and ask the client to repeat back what you said to ensure that he/she understands. This will also give the client an opportunity to ask clarifying questions.

□ Use your supervisor, professional colleagues and/or a mental health professional as a sounding board when you have questions or concerns regarding boundaries, and especially when boundary issues are impacting your ability to provide objective, compassionate care. Also consult with your supervisor or professional colleagues if you are feeling uncomfortable about talking with your clients about boundaries.

□ Dual relationships: If you had a personal relationship with a client before becoming the client's service provider, realize that you must use your professional judgment when interacting with the client in social settings. Pay particular attention to the client's confidentiality as well as his/her physical and emotional security. Situations in which one person is in a position to hold power over the other person must be avoided if at all possible

□ For supervisors: Recognize that questioning someone's boundaries can create defensiveness. Rather than instructing someone to "have better boundaries", use open-ended questions to help the service provider identify for him/herself that his/her work would benefit from the establishment of clearer boundaries.

□ If you are working with a team of service providers, remember to promote and role model positive, open communication and respectful sharing of

information. Trust that team members are fulfilling their roles as service providers, and remember that you can't (and shouldn't) "do and be everything" for your client.

□ Take care of yourself! Make sure you are getting enough sleep, eating well, spending time with friends and family, exercising, seeking supervision as needed, and "leaving work at work" to the greatest extent possible.

Performance Improvement Plan

Purpose: To provide for the objective and systematic monitoring, evaluation and coordination of the quality, appropriateness and cost-effectiveness of patient care, resolve identified problems and improve the Agency's performance.

Policy: The Agency will establish and maintain an ongoing Quality Assessment and Performance Improvement Program composed of a system of measures that captures significant outcomes that are essential to optimal care, and are used in the care planning and coordination of services and events. The QAPI committee is appointed by the Administrator and approved by the governing board.

Please reference Policy 8.001.1 for procedural specifics.

Insert list of accepted medical abbreviations

DOCUMENTATION

Documentation is a critical aspect of patient care delivery. Staff must effectively and accurately document pertinent information regarding our patients.

Documentation must include:

- Assessments
- Nurses Notes
- Orders

- Communication Reports with any change in patient condition including call in reports from field staff
- Case Conferences
- 60-day summaries
- Discharge summaries
- Discharge Oasis
- Complaints
- MD Reports such as BP and BS logs
- Supervisory Visits
- New or Changed Medications- doc. on med profile and nurses notes
- Modifications to the Plan of Care

Orders have to be filed on the chart for the following:

- Admission orders
- SOC
- Orders for all disciplines
- Orders for all visits, if the nursing frequency changes, then a new order must be written
- Order for all supplies
- Wound Care
- New Medications
- Skills, procedure, and education
- Discharge

Orders must be signed and placed on the chart within 30 days. All nurses' notes must mirror the physician's orders

HOME RECORD

At the time of Admission, the admitting nurse will leave a folder in the patient's home.
The folder will consist of a patient calendar and vital sign log, as well as safety handouts, information on patient rights, and advance directive information. There will also be a patient education folder for each patient that will be left in

the client's home for their reference. For patients that are on daily logs such as weight, BP, or FSBS, please place the logs into their folders so all disciplines can access the information.

PATIENT EDUCATION

Patient education is an essential component of nursing. The nurse must provide the patient and/or caregiver adequate information about the patient's conditions, medications, and all other care that is pertinent to their needs. We will provide the patient with an education folder at the SOC that contains all pertinent information and medication information for the patient. An extra copy will be placed in the folder for the nurse's documentation. Please initial and date the education material that you cover to ensure that
all necessary material is reviewed with the patient. Document the teaching and the patient /caregiver's
response to the education on the nurse's notes.

If the patient has had a change in condition, new diagnosis, or new medication, then educate the patient on the new material as well as other material that needs to be reviewed.

CARE PLANS

If a care plan needs to be updated as a result of a new or changed diagnosis or problem, then add the new nursing diagnosis to the POC using the nurses notes.

MEDICATION ADMINISTRATION

The SN can administer medications to the patient as ordered by the physician. Most patients do not require that a nurse administer the medications, but may need medication set-up by the RN. Medication set-up must be ordered at the SOC by the MD.

ADMINISTERING MEDICATIONS

Refer to the nursing policy and procedure manual for correct technique for medication administration.

All Medications that are given by the nurse must be documented in the nurse's notes. Documentation must include medication given, route, dose, and patient response to the medication.

OFFICE SCHEDULING

It is the nurse's responsibility to inform the case manager if anything changes with a patient's POC. If a frequency change is imminent, then the employee must notify the case manager so we can better prepare to meet the needs of the client.

FORMS

Nurses Notes/PT Therapy Notes
Missed Visit Reports- to be filled out by all staff if a visit is not made Physician Orders- can be written by LPN but must be cosigned by RN
Fax Communication Sheets- used as a cover sheet to fax confidential information.
Communication Forms- used to document any pertinent information regarding patient care delivery. Time Sheet- used to document mileage and daily visits for payroll
Referral Forms- used to document new patient information
Oasis- comprehensive assessment performed by RN at SOC, Recert, Change of Condition, and DC for each patient.
New admit pack- taken to home for new patient admissions.
Case Conference- documentation that is sent to the MD at least q 60 days on each patient Supervisory Visit reports- done by RN q 60 days on each LPN working with each patient and every 14 days for HHA.
Complaint Forms- form to be filled out by administration for all verbal and written complaints.

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Sec. 484.18 Condition of participation: Acceptance of patients, plan of care, and medical supervision.
Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

(a) Standard: Plan of care. The plan of care developed in consultation with the agency staff covers all pertinent diagnosis, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.
(b) Standard: Periodic review of plan of care. The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.
(c) Standard: Conformance with physician orders. Drugs and treatments are administered by agency staff only as ordered by the physician. Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in Sec. 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Verbal orders are only accepted by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies.

[54 FR 33367, August 14, 1989, as amended at 56 FR 32974, July 18, 1991; 64 FR 3784, Jan. 25, 1999]

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Sec. 484.36 Condition of participation: Home health aide services.
Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1990, the HHA must use individuals who meet the personnel qualifications specified in Sec.
484.4 for ``home health aide''.

(a) Standard: Home health aide training--(1) Content and duration of training. The aide training program must address each of the following subject areas through classroom and supervised practical training totaling at least 75 hours, with at least 16 hours devoted to supervised practical training. The individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training.
(i) Communication skills.
(ii) Observation, reporting and documentation of patient status and the care or service furnished.
(iii) Reading and recording temperature, pulse, and respiration.
(iv) Basic infection control procedures.
(v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.
(vi) Maintenance of a clean, safe, and healthy environment.
(vii) Recognizing emergencies and knowledge of emergency procedures.
(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy and his or her property.
(ix) Appropriate and safe techniques in personal hygiene and grooming that include--
(A) Bed bath.
(B) Sponge, tub, or shower bath.
(C) Shampoo, sink, tub, or bed.
(D) Nail and skin care.

(E) Oral hygiene.
(F) Toileting and elimination.
(x) Safe transfer techniques and ambulation.
(xi) Normal range of motion and positioning.
(xii) Adequate nutrition and fluid intake.
(xiii) Any other task that the HHA may choose to have the home health aide perform.
``Supervised practical training'' means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse.
(2) Conduct of training--(i) Organizations. A home health aide training program may be offered by any organization except an HHA that, within the previous 2 years has been found--
(A) Out of compliance with requirements of this paragraph (a) or paragraph (b) of this section;
(B) To permit an individual that does not meet the definition of ``home health aide'' as specified in Sec.
484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);
(C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of the HCFA or the State);
(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;
(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA;
(F) Has had all or part of its Medicare payments suspended; or
(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--
(1) Has had its participation in the Medicare program terminated;
(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;
(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;

(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients; or

(5) Was closed or had its residents transferred by the State.

(ii) Qualifications for instructors. The training of home health aides and the supervision of home health aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of home health care. Other individuals may be used to provide instruction under the supervision of a qualified registered nurse.

(3) Documentation of training. The HHA must maintain sufficient documentation to demonstrate that the requirements of this standard are met.

(b) Standard: Competency evaluation and in-service training--(1) Applicability. An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph. The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.

(2) Content and frequency of evaluations and amount of in-service training.

(i) The competency evaluation must address each of the subjects listed in paragraph (a)(1) (ii) through (xiii) of this section.

(ii) The HHA must complete a performance review of each home health aide no less frequently than every 12 months.

(iii) The home health aide must receive at least 12 hours of in-service training during each 12-month period. The in-service training may be furnished while the aide is furnishing care to the patient.

(3) Conduct of evaluation and training--(i) Organizations. A home health aide competency evaluation program may be offered by any organization except as specified in paragraph (a)(2)(i) of this section.

The in-service training may be offered by any organization.

(ii) Evaluators and instructors. The competency evaluation must be performed by a registered nurse. The in-service training generally must be supervised by a registered nurse who possesses a minimum of 2 years of nursing experience at least 1 year of which must be in the provision of home health care.

(iii) Subject areas. The subject areas listed at paragraphs (a)(1)

(iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aide's performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.

(4) Competency determination. (i) A home health aide is not considered competent in any task for which he or she is evaluated as ``unsatisfactory''. The aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated as
``unsatisfactory'' and passes a subsequent evaluation with ``satisfactory''.

(ii) A home health aide is not considered to have successfully passed a competency evaluation if the aide has an ``unsatisfactory'' rating in more than one of the required areas.

(5) Documentation of competency evaluation. The HHA must maintain documentation which demonstrates that the requirements of this standard are met.

(6) Effective date. The HHA must implement a competency evaluation program that meets the requirements of this paragraph before February 14, 1990. The HHA must provide the preparation necessary for the individual to successfully complete the competency evaluation program. After August 14, 1990, the HHA may use only those aides that have been found to be competent in accordance with Sec. 484.36(b).

(c) Standard: Assignment and duties of the home health aide--(1) Assignment. The home health aide is assigned to a specific patient by the registered nurse. Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.

(2) Duties. The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under State law. The duties of a home health aide include the provision of hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered. Any home health aide services offered by an HHA must be provided by a qualified home health aide.

(d) Standard: Supervision. (1) If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.

(2) The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.

(3) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.

(4) If home health aide services are provided by an individual who is not employed directly by the HHA (or hospice), the services of the home health aide must be provided under arrangements, as defined in section 1861(w)(1) of the Act. If the HHA (or hospice) chooses to provide home health aide services under arrangements with another organization, the HHA's (or hospice's) responsibilities include, but are not limited to--

(i) Ensuring the overall quality of the care provided by the aide;

(ii) Supervision of the aide's services as described in paragraphs (d)(1) and (d)(2) of this section; and

(iii) Ensuring that home health aides providing services under arrangements have met the training requirements of paragraphs (a) and (b) of this section.

(e) Personal care attendant: Evaluation requirements--(1) Applicability. This paragraph applies to individuals who are employed by HHAs exclusively to furnish personal care attendant services under a Medicaid personal care benefit.

(2) Rule. An individual may furnish personal care services, as defined in Sec. 440.170 of this chapter, on behalf of an HHA after the individual has been found competent by the State to furnish those services for which a competency evaluation is required by paragraph (b) of this section and which the individual is required to perform. The individual need not be determined competent in

those services listed in paragraph (a) of this section that the individual is not required to furnish.

[54 FR 33367, August 14, 1989, as amended at 56 FR 32974, July 18, 1991; 56 FR 51334, Oct. 11, 1991; 59 FR 65498, Dec. 20, 1994; 60 FR 39123, Aug. 1, 1995]

Sec. 484.48 Condition of participation: Clinical records.
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. The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.

(a) Standards: Retention of records. Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinued operations. If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.
(b) Standards: Protection of records. Clinical record information is safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and the conditions for release of information. Patient's written consent is required for release of information not authorized by law.

[54 FR 33367, Aug. 14, 1989, as amended at 60 FR 65498, Dec. 20, 1994]

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Sec. 484.30 Condition of participation: Skilled nursing services.

The HHA furnishes skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care.

(a) Standard: Duties of the registered nurse. The registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions, furnishes those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.
(b) Standard: Duties of the licensed practical nurse. The licensed practical nurse furnishes services in accordance with agency policies, prepares clinical and progress notes, assists the physician and registered nurse in performing specialized procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the patient in learning appropriate self-care techniques.

[54 FR 33367, August 14, 1989, as amended at 56 FR 32974, July 18, 1991]