TOP 10 **HOME HEALTH** DEFICIENCIES

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CHAP Community Health Accreditation Partner

	Standard	G Tag	Standard Content	Tips for Compliance
1	APC.10	G574	Content of the individualized plan of care	• Educate all disciplines on including problems, interventions and goals based on the completed comprehensive assessment and on-going clinical assessments • Ensure goals are SMART (Specific, Measurable, Achievable, Realistic, Timely) • Focus on individualization of the plan of care specific to each patient's unique needs • Perform final review of Plan of Care for accuracy including allergies, interventions, medications, emergent care and hospitalization risk • QAPI indicator or PIP to achieve and sustain compliance with problems, interventions, goals
2	APC.14	G614, G616, G618	The organization provides the patient and caregiver(s) with a copy of written instructions including a visit schedule, including frequency of visits by HHA personnel and contractors; patient medication schedule/instructions, including medication name, dosage, and frequency; and any treatments to be administered	• Educate all disciplines, including contractors, that they must complete the visit schedule in the home at SOC and continuing through discharge • Educate clinicians on the importance of ensuring a medication list is left in the home that is accurate and complete • Provide education to clinicians regarding providing documentation to the patient/caregiver regarding any treatments to be administered • Perform home observation visits to ensure visit schedule is current and complete, a medication list is present and accurate/complete, and information regarding treatments is provided (if applicable)
3	APC.8	G536	The comprehensive assessment includes a medication regimen review	• Conduct medication reconciliation during home visits • Educate all disciplines to communicate any medication changes to the physician • Perform record audits to verify all medications are present on medication profile
4	APC.23	G1022	Clinical record includes transfer and/or discharge summaries within the required time frame with evidence of date sent	• Develop process for tracking days to ensure timeliness • Educate clinicians on elements to include in the summary and time frame for sending • Audit to ensure timeliness
5	PCC.2	G434, G440, G442	The patient has the right to: 1. Participate in, be informed about, and consent or refuse care in advance of and during treatment 2. Be informed of the extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA; the charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA: the charges the individual may have to pay before care is initiated 3. Patient's have the right to receive written notice in advance of care being furnished, if there is possibility of not-covered care, or in advance of reducing or terminating ongoing care	• Ensure the bill of rights document is complete and includes all required components • Audit patient bill of rights documents in the clinical record to ensure the patient and/or representative were provided with a complete list of their rights as a home health patient • Ensure that staff provide patients with information related to potential payment liability at time of admission • Audit discharge processes to ensure patients were informed of reduction or termination of services
6	CDT.9	G710	Skilled professionals follow plan of care including following physician orders	• Ensure a process is in place to audit visit frequencies against actual visits completed • Ensure a process is in place to audit clinical documentation against the plan of care to ensure all disciplines are following the plan care as established by the physician
7	APC.12	G588, G590, G592	The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days. The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition. A revised plan of care must reflect current information from the patient's updated comprehensive assessment and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.	• Educate clinicians on the requirements of the standard • Perform clinical record review audits to ensure the plan of care is reviewed and revised at least once every 60 days, there is documentation in the record to support the physician or allowed practitioner was notified of any changes in the patient's condition, and the revised plan of care is in line with the patient's updated comprehensive assessment
8	IPC.6	G682	Hand hygiene performed when indicated	• Conduct ongoing education and training related to standard precautions • Conduct routine field observation visits with staff to validate their ability to comply with infection control processes
9	IPC.8	G682	Bags used to carry equipment or supplies into patient's homes follows agency's policy to prevent the spread of infections and communicable diseases	• Provide frequent education to field staff on Bag Technique policies and procedures and evaluate competency • Perform frequent home supervisory visits to observe staff in the home in order to assess compliance
10	CDT.12	G800	Home Health aides provide services ordered by the IDG and included in the plan of care	• Educate Aides on following the Aide Care Plan and communicating with the RN if changes needed • Educate RNs on collaboration with Aide and to revise Aide Care Plan as needed • Perform home supervisory visits to observe Aide and identify if following Aide Care Plan • Educate RNs to compare Aide documentation to the Aide Care Plan during the supervisory process to ensure compliance