

Multiple Conditions Case
Home Health Agency Learning Activity

Item	Description
Objective:	Given a scenario, the surveyor will identify areas of concern, potential citations, and related regulatory requirements.
Prior to Class:	Print copies of the scenario. Have the home health regulations available. Have flip charts and markers available.
Total Time for Activity:	60 minutes (The time given is approximate.)
Set-Up:	Set class up for small groups as needed.*

Step:	Preceptor Instructions:	Activity Time:
1.	Divide the class into small groups.*	5 min.
2.	Each group should select someone to take notes on the flip charts and be prepared to report to class. Groups must answer the questions provided.	5 min.
3.	Give the teams time to read and discuss the scenario.	25 min.
4.	As the groups are completing this task, walk around the room and listen to the conversations. Provide direction where appropriate. Warn the class when the time available is down to the last five minutes.	
5.	Debrief each scenario by discussing key points in the Preceptor Answer Sheet.	25 min.

*For individual assignment, provide the worksheet and support where appropriate during the completion of the activity. Once completed, review answers against the answer sheet, and discuss the key points together from the scenario.

Surveyor:

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Directions: Read the scenario and working as a team (if able), document your answers on the flip chart provided.

Major Mismanagement Scenario

Mrs. Smith has been in County Hospital for two weeks following an exacerbation of congestive heart failure. Other conditions include diabetes, arthritis, and hypertension. When discharged on May 1, she was sent home with home health visits ordered three times a week for nursing services for disease and medication management, physical therapy due to deconditioning, home health aide for bathing and dressing, and occupational therapy for activities of daily living (ADL) and energy conservation.

A complaint was received from the patient's family that home health did not come in until May 10. The daughter states, "I thought Mom was going to have to go back to the hospital, she was so sick. She was feeling great when she came home from the hospital."

Survey Team Questions:

1. As the surveyor, what do you ask for at the Entrance Conference? (Document your answers on the flip chart.)

2. Once you obtain the documents, what do you do next? Please note that Mrs. Smith is a current patient at the home health agency. (Document your answers on the flip chart.)

Here are the findings from Mrs. Smith's home visit and record review:

- The occupational therapy assistant and the home health aide visited on May 2.
- The home health aide visited again three times per week starting on May 2.
- The Registered Nurse (RN) visited May 10, completed the initial assessment, and developed the Plan of Care (POC).
- The patient was extremely short of breath, had difficulty performing ADLs, and had to take frequent rest periods during the initial assessment. The nurse documented that the patient's lungs were very congested with inspiratory wheezing.

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- Medication review documented that the patient had a large brown bag full of medications. The nurse asked the patient for her discharge instructions and medication list. Three medications were documented in the nurse's notes: a diuretic, insulin, and blood pressure medication.
- During an interview, the nurse indicated that she copied the medications from the hospital record. She stated that she asked the patient to put away the bag of medications. She also stated that she did not ask the patient what medications she was currently taking and how they were being taken. She did perform medication teaching for the three medications listed.
- At the time of the surveyor visit on May 15, neither the physical therapist nor the occupation therapist had visited.

Findings from other home visits:

- Five total home visits
- Start of Care (SOC) was initiated greater than 48 hours four of the five visits.
- Three of five patients from the home visits required home health aides; all aides started within 24 hours.
- Interview with one aide revealed that the care coordinator gave her the assignment and told her to help patients with ADLs as needed. The aide stated that she asked about written instructions and was told they were being developed and not to worry about it.

Other findings:

- The policy and procedure manuals had not been reviewed or revised since the agency was established in 2007.
- The group of professional personnel meeting minutes and committee list with titles revealed that meetings were conducted quarterly. The committee consisted of two RNs and the Care Coordinator.
- Interview with the administrator regarding review of clinical records reveals that the Director of Nursing (DON) was responsible for choosing a sample for quarterly review.
- The DON stated that the agency had been doing quarterly reviews, but because her assistant went out early on maternity leave, no reviews had been performed. She stated, "We tried to find a replacement, but were unable to do so. She is due back from leave in two weeks." The DON also stated that active records were periodically chosen to "look over." The DON was unable to provide numbers of records or names of patients whose records were reviewed.
- A review of the hospital discharge summary revealed that the patient had received aggressive therapy, was improving with treatment, and at the time of discharge was in stable condition with Shortness of Breath (SOB) on exertion only.

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Survey Team Questions:

1. From the findings, what are your concerns related to each finding? (Document your answers on the flip chart.)
2. Do you need to do further investigation on any of the findings? Why or why not? (Document your answers on the flip chart.)
3. What tags do you think will be cited? (Document your answers on the flip chart.)
4. Do you think any deficient practice will be condition or standard level?
 - a. Defend your answer. (Document your answers on the flip chart.)

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Preceptor Answer Sheet

This is a complex scenario. Discuss and identify each question in the scenario.

1. As the surveyor, what do you ask for at the Entrance Conference?

The items that the surveyor asks for initially are:

- List of the current patients with SOC dates (choose patients for review including the patient who complained)
- Organizational list with names, positions, and phone numbers for contact of key personnel
- Location and availability of policies and procedures
- On-call log for the months of April and May

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2. Once you obtain the documents, what do you do next? Please note that Mrs. Smith is a current patient at the home health agency.

Talk with the new surveyor(s) about the flow of the home health complaint survey. This area is unique as home visits impact the timing of other tasks and the surveyor must be flexible.

- Pick patients for review.
- Schedule home visits, being sure to include Mrs. Smith.
- Set up interviews with team coordinators.

Depending on timing of the home visits:

- Review the on-call log to see if the family called the agency.
- Review policies and procedures related specifically to SOC. Be prepared to ask for other information if findings warrant a partial extended survey (such as group of professional meeting minutes, governing body minutes, bylaws, etc.).
- Conduct interviews.

During home visit:

- Observe the nurse performing assessment and teaching.
- Document the date and time of observations.
- Discuss observations privately with the nurse.

After home visit:

- Complete record reviews and other tasks not yet done. Be sure to interview staff involved in the patient's care.
- Review findings and start decision making process.

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Conduct an Exit Conference with facility staff, explaining areas of concern and the outcome of the complaint investigation.

3. From the findings, what are your concerns related to each finding?

The Occupational Therapy Assistant (OTA) and the Home Health Aide (HHA) visited on May 2.

- Concern: The OTA is performing care without orders.

The HHA visited again three times per week starting on May 2.

- Concern: There is no POC for the patient for over one week. How does the HHA know what to do? The RN has not established the POC and was not present on the first visit to determine if the aide knew what tasks were required and was competent to complete them.

The RN visited May 10 and completed the initial assessment and developed the POC.

- Concern: The RN did not visit within the required 48-hour timeframe.

The patient was extremely short of breath, had difficulty performing ADLs, and had to take frequent rest periods during the initial assessment. The nurse documented that the patient's lungs were very congested with inspiratory wheezing.

- Concern: Did the RN notify the physician of the patient's status?

Medication review documented that the patient had a large brown bag full of medications. The nurse asked the patient for her discharge instructions and medication list. Three medications were documented in the nurse's notes: a diuretic, insulin, and blood pressure medication.

During the interview, the nurse indicated that she copied the medications from the hospital record. She stated that she asked the patient to put away the bag of medications. She also stated that she did not ask the patient what medications she was currently taking and how they were being taken. She stated, "The patient was so short of breath, I didn't want her to get too exhausted. I planned to ask her at a follow-up visit next week." She did perform medication teaching for the three medications listed.

- Concern: The RN did not complete a comprehensive assessment.

At the time of the surveyor visit on May 15, neither the Physical Therapist (PT) nor the Occupational Therapist (OT) had visited the patient.

- Concern: Patient did not receive ordered PT or OT evaluations and/or services.
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4. Do you need to do further investigation on any of the findings? Why or why not?

The surveyor should follow up to determine notification of the physician of the patient's condition and actions taken, if any. This could potentially be an Immediate Jeopardy situation.

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Once the observations, interviews, and record and policy reviews are completed, the surveyor must determine if further investigation is necessary. If not yet done, an interview with the complainant and the patient should be conducted. (Confidentiality must be maintained.)
Correlate all findings.

5. What tags do you think will be cited related to the findings?

G138, G143, G144, G151, G152, G153, G156, G157, G158, G161, G164, G168, G169, G171, G173, G174, G175, G176, G177, G184, G186, G187, G188, G190, G223, G224, G225, G242, G243, G248, G250, G251, G330, G332, G334, G337

6. Do you think the deficient practice will be condition or standard level? Defend your answer.

Acceptance of patients, POC and medical supervision, comprehensive assessment of patients, nursing services, and therapy services may be cited at the condition level.

Write up home health aide service at the condition level per protocol. There is a single deficiency at G224 regarding written instructions by the RN.

Remember to investigate all tags fully before citing.

- Rationale: Patient was put at serious medical risk by the agency's failure to provide skilled nursing services, including a comprehensive assessment, POC development in a timely manner, establishment and definition of home health aide services, and supervision of the aide. Comprehensive assessment is not met due to failure to complete the initial assessment in a timely manner and failure to assess all medications, even with direct observation of a "bag" of medications. Therapy services are not met due to a lack of initial assessment, and an OT assistant performed services without orders or supervision.