

Patient Rights 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.

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Directions:

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

“Permission to Proceed!” Scenario

During a standard survey, the surveyor observed a home visit that is a Start of Care (SOC) assessment for a Medicare patient, Mrs. Brown, who was discharged from the hospital following a fall at home and fractured right hip with surgical repair. She was to be non-ambulatory for six weeks post discharge. Discharge orders include home health for Physical Therapy (PT) three times per week for strengthening, transfers bed to chair, and conditioning exercises. Mrs. Brown was ambulatory and independent with all aspects of Activities of Daily Living (ADL) prior to her fall. Discharge date is September 21 and the SOC visit is being conducted on September 23.

During the visit, the surveyor observed the following:

- The physical therapist introduced himself to Mrs. Brown and explained the purpose of the visit.
- The physical therapist then performed the initial physical assessment. After the assessment was performed, the therapist checked the home environment for safety hazards and answered Mrs. Brown’s questions regarding level of activity and exercises.
- After completing all of the assessment, including the medication review, the therapist told Mrs. Brown, “We have to make it legal... let’s go over all the paperwork with you, ok?” Mrs. Brown agrees.
- The therapist reviews the patient bill of rights, OASIS data collection, agency procedures, and contact information, and sets up the next visit. Mrs. Brown signs all related consent forms for OASIS data collection and home health care.

Survey Team Questions:

1. As the surveyor, do you have any concerns regarding this observation?

2. If yes, what? What tags would you cite and at what level?

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Preceptor Answer Sheet

1. As the surveyor, do you have any concerns regarding this observation?

For this scenario, the concern is the failure of the physical therapist to explain the OASIS data collection and patient bill of rights before the comprehensive assessment.

2. If yes, what? What tags would you cite and at what level?

Tags: G101, G102 Standard level tags are cited. The patient did not have the full explanation of their rights and the OASIS data collection as required prior to the start of the physical assessment.