Initial assessments can be tricky—without proper documentation, home health providers could lose earned income or experience payment delays, and publicly reported quality outcomes affected by poor assessment documentation could negatively impact an agency’s reputation.

Ensure that no condition or symptom is overlooked and documentation is as accurate as possible with *Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation*. This indispensable resource provides the ultimate blueprint for accurately assessing patients’ symptoms and conditions to ensure regulatory compliance and proper payment. It will help agencies deliver more accurate assessments and thorough documentation, create better care plans and improve patient outcomes, prepare for surveys, and ensure accurate OASIS reporting.

All of the book’s 75-plus checklists are also available electronically with purchase, facilitating agencywide use and letting home health clinicians and field staff easily access content no matter where they are.

**THIS BOOK WILL HELP HOMECARE PROFESSIONALS:**

- Easily refer to checklists, organized by condition, to properly assess a new patient
- Download and integrate checklists for use in any agency’s system
- Obtain helpful guidance on assessment documentation as it relates to regulatory compliance
- Appropriately collect data for coding and establish assessment skill proficiency
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Brown first became involved with homecare in 1990, eventually moving five years later to Charleston, S.C., where she continues to work in the field. She currently holds the position of patient care coordinator and serves as the infusion nurse specialist for Roper St. Francis Home Care, a hospital-based home health company in Charleston. Brown holds certifications in Certified Registered Nurse Infusion through the Intravenous Nursing Society and received a Certificate for OASIS Specialist-Clinical through the OASIS Certificate and Competency Board in 2010.
Purpose

Documentation has always been a large and important part of homecare. Clinicians are representing their profession and providing the care ordered by the physician, with little back up other than what can be reached by phone. Homecare works in an autonomous fashion, yet is heavily regulated by various organizations due to this very fact. It is imperative to the survival of an agency, that these regulations are followed and evidenced by documentation and outcomes of the patients.

Clinicians must be proficient in their assessment skills so that the plan of care can be developed to meet the patient’s needs and show improvement through the course of care of the patient. Not only the assessment skills must be proficient but also the skill to document patient assessments for support of the plan of care. Review of the documentation must provide a clear picture of the patient’s condition, needs, and interventions provided to meet established goals.

Assessment of the homecare patient not only includes the physical assessment of body systems but also the psychosocial assessment. This includes the patient’s environment, available caregivers, patient/caregiver compliance, safety needs, financial needs, spiritual and/or cultural needs or constraints to name a few. Assessment needs also can vary with the patient. There is no cookie cutter assessment that can be applied to all patients. It is in the assessment skills of the clinician to identify the needs of each patient.

Know your agency’s policy and procedures for documentation requirements. Remember that documentation policy and procedures are there for a purpose and are requirements from regulatory agencies. They help protect you and the agency in a time of tough economic struggles and increased litigation. It is no guarantee against litigation but only with the presence of complete and accurate documentation can protection against litigation be found.

The purpose of this book is to educate the clinician on assessment requirements of regulatory agencies and to provide guidelines for the assessment of the homecare patient. It should be used as an aide for identifying needs of the patient for development of the plan of care. Every patient is an individual with
unique needs and every situation to requiring assessment cannot be listed in a resource, but with the use of an effective assessment tool, we can better identify these unique needs of the patient.
SECTION 1
Assessment and Documentation Guidelines
SECTION 1
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1.1. Medicare Conditions of Participation
1.2. Determination of Coverage Guidelines
1.3. Summary of Assessment Documentation Requirements
1.4. Assessment Documentation for Admission to Agency
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1.11. Resumption of Care Documentation Guidelines
1.12. Recertification Documentation Guidelines
1.13. Discharge Documentation Guidelines
1.1 Medicare Conditions of Participation

Introduction

Medicare Conditions of Participation govern what a homecare agency must document to qualify for Medicare reimbursement. The documentation in the patient's record must support the need for services not only for Medicare but also for Medicaid, the numerous Medicare and Medicaid HMOs, and other insurances. Documentation must show the need for services and that services are skilled and necessary. Documentation must reflect the patient's needs services furnished in the home environment due to homebound status. Some insurances may approve services for the non-homebound patient, but the majority follow Medicare's homebound criteria. Documentation needs to reflect the nursing process, show care provided follows acceptable standards of practice, and follows the physician ordered plan of care. It should be accurate and complete to support care provided and outcomes of the patient. Documentation needs to be able to stand up in a court of law. We all need to remember, “If it is not documented, it was not done.” Unfortunately, we now are in a healthcare society where documentation holds an equal importance to the care provided. It is important to know and understand the Conditions of Participation. It is in understanding the why that helps us with documentation requirements.

Definitions

The following are definitions given in the Medicare Conditions of Participation:

- Clinical note means a notation of contact with a patient that is written and dated by a member of the health team, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition
- Progress note means a written notation, dated and signed by a member of the health team, that summarizes facts about care furnished and the patient's response during a given period of time
- Summary report means the compilation of the pertinent factors of a patient's clinical notes and progress notes that is submitted to the patient's physician
- Supervision means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity
Conditions of Participation

The following are the Conditions of Participation that are related to the documentation required that an agency must adhere to.

**Plan of care**

Must cover the following:
- Pertinent diagnoses
- Mental status
- Types of services
- Equipment required
- Frequency of visits
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications
- Treatments
- Safety measures to protect against injury
- Instructions for timely discharge of referral
- Any other appropriate items

**Periodic review of plan of care**

- Plan of care reviewed as often as the severity of patient’s condition requires, but at least every 60 days
- Physician alerted promptly to any changes that suggest a need to alter plan of care

**Conformance with physician orders**

- Drugs/treatments administered only as ordered by the physician
Duties of registered nurse

- Makes initial evaluation visit
- Regularly re-evaluates
- Initiates the plan of care and necessary revisions
- Furnishes services requiring specialized nursing skill
- Initiates appropriate preventive and rehabilitative nursing procedures
- Prepares clinical and progress notes
- Coordinates services
- Informs physician and other personnel of changes in patient's condition

Clinical records

- Contains pertinent past and current findings
- Contains appropriate identifying information
- Name of physician
- Drug
- Dietary
- Treatment
- Activity orders
- Clinical and progress notes
- Summary reports
- Discharge summary

Comprehensive assessment of patients

- Provides patient-specific, comprehensive assessment
- Reflects patient's current health status
- Includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes
- Identifies the patient's continuing need for homecare
- Meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs
- Verifies homebound status
- Incorporates OASIS-C items
**Initial assessment visit**

- Determines the immediate care and support needs of the patient
- Determines eligibility for the Medicare home health benefit

**Drug regimen review**

- Comprehensive assessment includes a review of all medications to identify any potential adverse effects and drug reactions including:
  - Ineffective drug therapy
  - Significant side effects
  - Significant drug interactions
  - Duplicate drug therapy

**Update of the comprehensive assessment**

- Must be updated and revised as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s condition
- Includes OASIS-C items
- Not less frequently than:
  - Every second calendar month beginning with the start of care date
  - Within 48 hours of the patient’s return to the home from a hospital admission
  - At discharge

**Incorporation of OASIS data items**

- Must be incorporated into the agency’s own assessment
- Includes:
  - Clinical record items
  - Demographics and patient history
  - Living arrangements
  - Supportive assistance
  - Sensory status
  - Integumentary status
- Respiratory status
- Elimination status
- Neuro/emotional/behavioral status
- Activities of daily living
- Medications
- Equipment management
- Emergent care
- Items collected at admission or discharge only
1.2 Determination of Coverage Guidelines

Introduction

Medicare has specific guidelines on determining if a patient qualifies for homecare. Determination of coverage is solely based on documentation, therefore accurate and complete documentation is essential. The decision of coverage is based on the patient’s plan of care, OASIS-C information, and the medical record of the patient. If there is not supporting documentation in these areas to demonstrate care is reasonable and necessary, Medicare can deny coverage for the patient. The following identifies the most important coverage guidelines and how documentation plays a major role. Care must be taken in interpretation of the following guidelines where coverage for the patient is questionable. Consult with supervisors or directors of your agency to determine if the patient qualifies for services under Medicare.

A patient MUST meet these Conditions of Participation to qualify for home health care:
- Confined to home
- Under the care of a physician
- Receiving services under a plan of care established and reviewed by a physician
- Need of skilled nursing care on an intermittent basis

Patient Confined to Residence

- Definition of residence:
  - Private dwelling
  - Apartment
  - Relative’s home
  - Home for the aged
  - Vacation home
  - Caretaker’s home
- The following residences as long as inpatient services are not provided:
  - Personal care home
  - Assisted living facility
  - Group home
A patient may be transported between residence for care if Medicare requirements for homebound status are met.

There exists a normal inability to leave the residence.

Leaving the residence would require a considerable and taxing effort.

Absences from the residence are infrequent or for periods of relatively short duration:
- Absences are attributable to the need to receive healthcare treatment.
- Attendance to adult day centers to receive medical, therapeutic, or psychological care and are licensed or certified by the state.
- Ongoing receipt of outpatient kidney dialysis.
- Receipt of outpatient chemotherapy or radiation.
- Wound care treatment centers.

Other absences that shall not disqualify a patient that are of an infrequent or of relatively short duration:
- Attending a religious service.
- Attendance at a family reunion, funeral, graduation, or other infrequent or unique event.
- Occasional trip to barber or beauty shop.
- Short walk requiring assistance of another person.

Absences must not indicate that the patient has the capacity to obtain healthcare outside rather than in the residence without a taxing effort.

The patient’s condition restricts their ability to leave their place of residence except with the:
- The aide of supportive devices such as crutches, canes, wheelchairs, and walkers.
- The use of special transportation.
- The assistance of another person.
- Or if leaving home is medically contraindicated.

The elderly person who does not leave due to feebleness or insecurity must meet Medicare requirements to be homebound.
Reasonable and Necessary Skilled Nursing Care

The general principles governing reasonable and necessary skilled nursing care include:

1. Service must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse to be safe and effective.

2. To determine if the service requires the skills of a nurse, consider:
   - The inherent complexities of the service
   - The condition of the patient
   - Accepted standards of medical and nursing practice

3. Some services may be skilled based on complexity alone if it was reasonable and necessary:
   - Intravenous injections
   - Intramuscular injections
   - Insertions of catheters

4. In some cases, the service that ordinarily is considered unskilled will be considered skilled if the patient’s condition is such that the service can only be safely and effectively provided by a nurse.

Observation and Assessment

Observations and assessment of the patient’s condition when only the specialized skills of a medical professional can determine patient’s status include:

1. Observation and assessment are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for:
   - Possible modification of treatment
   - Possible initiation of additional medical procedures

2. Observation and assessment are reasonable and necessary only until the patient's treatment regimen is stabilized

3. Must be a reasonable potential of a complication or further acute episode.
4. Services covered for three weeks or so as long as there remains a reasonable potential for such a complication or further acute episode

5. For the patient where services are extended beyond the three-week period, the medical record must support the likelihood of a future complication or acute episode

6. There are other indications that observation and assessment are reasonable and necessary when it is likely they will result in changes to the treatment of the patient:
   - Abnormal/fluctuating vital signs
   - Weight changes
   - Edema
   - Symptoms of drug toxicity
   - Abnormal/fluctuating lab values
   - Respiratory changes

7. Observation and assessment is not reasonable and necessary when these indicators are part of a long standing pattern and there is no attempt to change the treatment to resolve them

Teaching and Training Activities

- Teaching a patient or caregiver how to manage the treatment regimen would constitute skilled nursing services
- Teaching and training activities must be reasonable and necessary to the treatment of the illness or injury
- Whether it is a skilled nursing service, relates to the skill required to teach and not to the nature of what is being taught
- If skilled nursing services are necessary to teach an unskilled service, the teaching may be covered
- If it becomes apparent that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary and the reason why it was unsuccessful must be documented
Teaching and training activities that require skilled nursing services include but are not limited to the following:

- Self-administration of injectable medications or a complex range of medications
- Newly diagnosed diabetic
- Self-administration of medical gases
- Wound care where there is complexity of the wound and the overall condition
- Recent ostomy or reinforcement of ostomy care is needed
- Self-catheterizations
- Self-administration of gastrostomy or enteral feedings
- Care and maintenance of vascular access devices or the administration of intravenous medications
- Bowel or bladder training when dysfunction exists
- Performance ADLs when the uses of special techniques or adaptive devices due to a loss of function are needed
- Transfer techniques
- Positioning and timing techniques of a bed-bound patient
- Prescribed assistive devices needed due to a recent functional loss
- Prosthesis care and gait training
- Use and care of braces, splints and orthotics and associated skin care
- Preparation and maintenance of a therapeutic diet
- Proper administration of oral medication, including signs of side effects and avoidance of interaction with other medications and food
- Proper care and application of special dressings or skin treatments

**Intermittent Skilled Nursing Care**

Intermittent skilled nursing care is defined as skilled nursing care that is either provided or needed on fewer than seven days each week, or less than eight hours each day for periods of 21 days or less and:

- Patient must have a medically predictable recurring need for skilled nursing service at least once every 60 days
- Exception to intermittent requirement is daily skilled nursing services for diabetics unable to administer their insulin when there is no able and willing caregiver
• For skilled nursing services furnished less frequently than once every 60 days, documentation must justify a recurring need for reasonable and necessary, and medically predictable skilled nursing services
  – Indwelling silicone catheter needing change only at 90-day intervals
  – For patient who experiences fecal impactions and must receive care to manually relieve impaction
  – Blind diabetic who self-injects insulin for observation and determination for the need for changes in the level and type of care
  – Exists an extraordinary circumstance of anticipated patient need that is documented, specifically ordered by a physician, considered to be reasonable and necessary, and medically predictable skilled need
• Medicare will cover skilled nursing services seven days a week for short period of time (two to three weeks) if medically reasonable and necessary
• If daily skilled nursing services are extended beyond three weeks, the agency must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services are required
• If full time skilled nursing care is needed over an extended period of time, patient does not qualify for home health benefits
1.3
Summary of Assessment
Documentation Requirements

General Documentation Requirements

- Documentation justifies the need for homecare to provide care, treatment, and services to meet patient specific goals
- Documentation supports patient's condition and listed diagnoses
- Documentation supports care needed on an intermittent basis
- Homebound status is evident within the documentation
- Progress towards goals is routinely evaluated and documented
- Revisions to plan of care are supported by documentation on progress towards goals
- Document shows interdisciplinary care and collaboration among disciplines involved in care of patient
- Communications to physician documented with changes of patient's condition
- Interdisciplinary communications documented with changes of patient's condition
- All communications with patient, physician, interdisciplinary team, organization involved in care, or receiving organization are documented
- Written summaries are completed at least every 60 days
- Documentation records patient's response to care, treatment, and services during course of care and final results at discharge/transfer
- All documentation entries are dated
- Demographic information recorded in medical record include name, age, sex, address, phone number, date of birth, legal representatives, language, and contact persons
- Medical history documented in medical record
- Informed consent and advanced directive wishes are documented in medical record

Plan of Care

Plan of care is based on identified needs and helps to meet the patient's medical, nursing, rehabilitative, social and/or discharge planning needs. The plan of care must be safe and effective, require the skill of a nurse, and be reasonable and necessary.
The following must be included on the plan of care:

- Pertinent diagnoses
- Mental status
- Visit frequency
- Prognosis
- Rehabilitative potential
- Functional limitations
- Permitted activities
- Nutrition requirements
- Medications
- Treatments
- Safety measures
- Instructions for discharge including reason and conditions
- Goals
- Services to be provided
- Supplies and medical equipment

**General assessment requirements**

- Documented assessments:
  - Relevant to care, treatment, and services provided
  - Comprehensive and specific to the patient
  - Reflect the patient’s current status
  - Demonstrate the patient’s progress toward desired goals
  - Support continuing need for care
  - Verify homebound status
  - Done according to visit frequency and changes in condition
- Functional assessments include:
  - Personal hygiene and grooming
  - Oral health as needed
  - Rehabilitation techniques
  - Use of restraints
  - Activity restrictions
  - Abilities in activities of daily living
• Psychosocial assessments include:
  − Cultural or religious practices affecting healthcare
  − Caregivers ability and willingness
  − Assessment for possible abuse or neglect
  − Communication needs
• Pain assessments:
  − Comprehensive assessment completed
  − Methods of assessment consistent for patients
  − Pain is re-assessed and responses made to alteration in pain
  − Management of pain is documented
• Nutritional assessment:
  − Height and weight documented as necessary
  − Diet documented
  − Current nutritional status documented
  − Nutritional needs documented
• Labs/diagnostic/therapeutic tests:
  − Results recorded in medical record
  − Quality controls documented for tests generated
• Equipment:
  − Equipment in home assessment documented
  − Equipment required documented
  − Equipment provided documented
  − Safe and effective use of equipment instructions documented
• Risk assessments:
  − Fall risk assessment documented
  − Education on fall reduction strategies documented
• Oxygen risk assessment documentation includes:
  − Smoking materials in home
  − Other fire safety risks
  − Presence of functioning smoke detectors
• Education documentation requirements include:
  − Causes of fires
  − Precautions to take
− Storage and handling of oxygen
− Any other recommendations
− Assessment on home barriers or other basic/structural risks
− Education on any safety issues documented
− Handling and disposal of hazardous medication or infectious wastes education documented
− All safety measures employed documented

Medication Assessment and Documentation Requirements

• Medical record includes documentation of the following:
  − Allergies
  − Sensitivities
  − Past adverse drug reactions
• Assessment of current medication includes all prescription, non-prescription, vitamin/mineral supplements, and herbal products
• Medications are assessed for the following:
  − Adverse effects
  − Drug reactions
  − Side effects
  − Drug interactions
  − Ineffective treatment
  − Duplicative medications
  − Non-compliance
• Assessments made for updates to medications
• Documentation shows instructions given to patient/caregiver on potential adverse reactions for medications given by staff to the patient
• Documentation for medications include:
  − Name
  − Type
  − Reason for medication
  − Frequency
  − Route
  − Dose
– Side effects
– Anticipated actions
– How to monitor

• When instructing patient/caregiver in administration of a medication, documentation reflects patient/caregiver supervised until safe to administer independently
• Documentation reflects monitoring for side effects, effectiveness, and responsiveness of medications
• Documentation supports management of high-alert medications

**Education Assessment and Documentation Requirements**

• Education assessment includes:
  – Ability to learn
  – Motivation to learn
  – Readiness to learn
  – Learning needs
  – Understanding of education
• Education provided is based on documented needs and abilities
• Coordination of education between disciplines or staff documented
• Education is documented for the following:
  – How to communicate concerns about patient safety issues
  – Plan of care for patient
  – How to manage treatment regimen
  – Procedures for emergency or natural disasters
  – Basic health practices and infection control and prevention measures
  – Any other education provided
• Education provided must be reasonable and necessary as supported through documentation:
  – If patient/caregiver not willing or unable to learn then education is no longer reasonable and necessary
  – Documentation must support why education was unsuccessful
Treatment Assessment and Documentation Requirements

- All treatments provided are documented
- Response/results to treatments provided are documented
- Treatment documented follows plan of care and physician orders

Discharge/Transfer Assessment and Documentation Requirements

- Discharge documentation addresses the patient’s need for any continual care, treatment, or services, including psychosocial and physical needs
- Documentation should reflect that the discharge/transfer was based on patient needs and ability of organization to meet those needs
- Education documentation for discharge/transfer includes:
  - Patient continual needs
  - Follow-up care, treatment, services
  - Why being discharged/transferred
  - Education provided understood
- Documentation sent to physician at discharge/transfer includes:
  - Reason for discharge/transfer
  - Summary of care, treatment, services provided
  - Progress towards goals
  - Resources or referrals made
  - Written summary provided
Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation

Barbara Acello, MS, RN
Lynn Riddle Brown, RN, BSN, CRNI, COS-C

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