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Tip sheet

Staff orientation in home health

Guidance for preparing new staff to join your team

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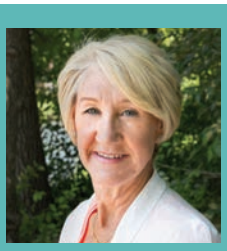


About the author

Jill Dyer, BSN, RN, HCS-D, HCS-O is a senior-level home health executive with more than 30 years of progressive management experience. An accomplished nurse, Jill has fulfilled a wide variety of roles that inform her expertise as an industry consultant, including home health administrator, home health director of nursing, and nurse consultant for home health. Jill is also certified as a Home Care Coding and OASIS Specialist. Through her clinical knowledge as a nurse and extensive management experience, Jill brings a comprehensive and well-rounded perspective to her work as a consultant and educator.

Introduction

This tip sheet will provide you with ideas to incorporate into your agency's staff orientation process. Every agency will have their own unique outline to get new staff ready to care for patients. You can incorporate some of these ideas into your orientation process. This list is not meant to be exhaustive, but is intended as a guide to the key concepts to consider when orienting new staff. Orientation should also include an assessment and education on clinical skills.

Orientation guidance:

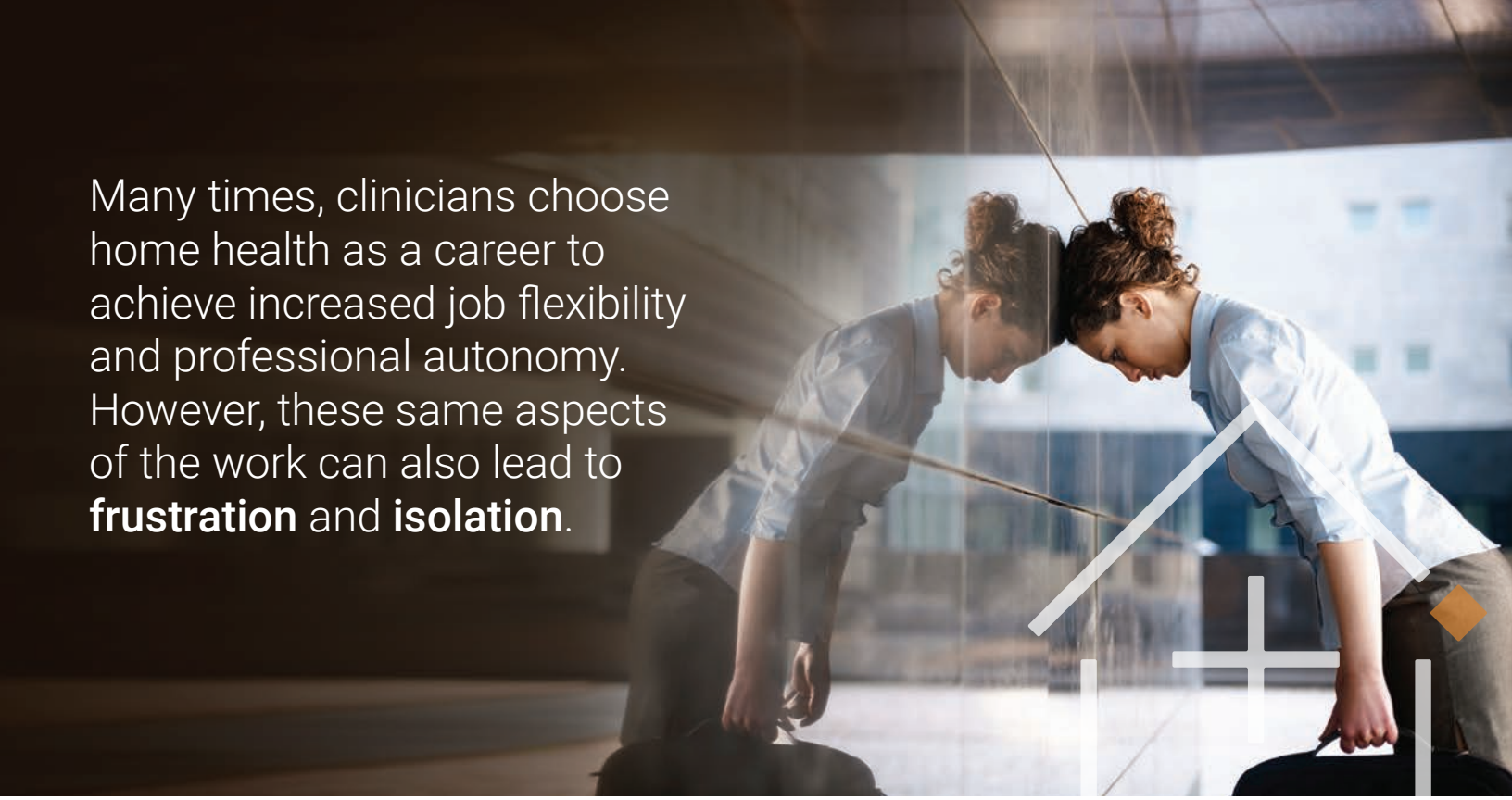
The essentials of home health

Understanding the philosophy of home health takes experience and education. Many times, clinicians choose home health as a career to achieve increased job flexibility and professional autonomy. However, these same aspects of the work can also lead to frustration and isolation. Acknowledging the challenges and rewards of home health during the orientation phase may help to prepare your clinicians for the hurdles ahead.

Admission process

Your agency has policies and procedures for admitting patients. New staff will need to know that process. You want your staff to be able to identify the principles of admission to home health, including the required paperwork. When you explain your process, be sure to include these points:

- ☑ How will staff be informed of new admissions? Will it be a call, a text, or an alert on their schedule?
- ☑ What does your admission packet contain? What is the importance of each document in the packet?
- ☑ Make sure all staff members understand the importance of consents, patient rights, and advance directives.
- ☑ How are your non-admits processed? Who gets notified and how do you document that notification?



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Home safety

Education on safety is important for both your staff and patients. It is also essential for your staff to understand their responsibility for reporting any confirmed or suspected abuse. Each state has laws relating to reporting, so be sure you include your state's requirements in the orientation. Cover concepts such as:

☑ **Poison control**
The American Association of Poison Control Centers [aapcc.org] has information and handouts you may find helpful in educating staff on poison prevention.

☑ **Fall prevention**
The Center for Disease Control and Prevention (CDC) says that 3 million people are treated for fall injuries in emergency departments every year. Educating staff on your fall prevention program is essential. If you do not have a fall prevention program, a program is available through the CDC called *STEADI* which stands for "Stopping Elderly Accidents, Deaths, and Injuries." STEADI includes materials for providers and patients.

☑ **Medication related problems**
Medication related problems affect the overall health of all patients. The importance of safety through focused assessment of the home environment and self/caregiver management of medications must be discussed in safety orientation.

☑ **Oxygen safety**
Oxygen safety should be discussed during your orientation. Also be sure to review the tools you provide the patient and caregiver regarding O2 safety.

☑ **Personal safety**
Personal staff safety depends on accurate, timely reporting from clinicians regarding safety concerns in patients' homes. Agencies should promote a culture of open dialog between clinicians, managers, and administrators when safety concerns arise.

Reportable incidents in the home might include:

- Threats, harassment or violence
- Existing or history of drug or alcohol abuse
- Weapons in the home or discussion of weapons
- Dangerous animals
- Potential for socio-cultural misunderstandings
- Dangers in accessing the home (e.g. inadequate lighting, broken steps, parking challenges, etc.)

Time management

Time management in home health is unlike other health care settings. The nature of home health requires clinicians to plan for both travel and documentation time.

- ☑ Discuss visit planning the day or night before
- ☑ Require documentation be submitted within 24 hours of the visit with most of the documentation being completed in the home.
- ☑ Encourage staff to add 15-20 minutes to each scheduled visit to allow for documentation and coordination of care time. For Start of Care OASIS visits, add 60-90 minutes. This will allow your staff to complete their documentation.
- ☑ Stress to clinicians that home health encompasses a wide range of roles with a broad scope of practice including assessment, clinical decision making, clinical practice, coordinating care, educating patients and caregivers, acting as patient advocates, supervising aides, as well as helping to financially manage the cost of care.
- ☑ Also stress to your team that home health clinicians have the great satisfaction of providing *personalized care* to patients and families. They can implement individualized care plans, improve outcomes for patients, and assist patients in achieving their highest-level health in a holistic manner.

Orientation guidance:

Medicare guidelines

If your agency is accredited, you should discuss the accreditation during your orientation and review the differences of your accreditation from Medicare. Stress that *all* regulations – state, Medicare, and accrediting organizations – must be followed by everyone.

1. Eligibility requirements for Medicare patients

All staff need to have a good understanding of the Medicare requirements of skilled services. These requirements include the following:

- Homebound status
- Skilled care
- Face-to-Face requirements
- A physician to manage the home health episode

Clinicians must know whom in the agency they should call with any questions about patient eligibility.

2. OASIS

During your orientation, be sure to provide extensive education on completing an OASIS accurately. Remind staff that Medicare/CMS provides us with guidance on how to answer questions on the OASIS. The OASIS is used for data gathering and outcomes, therefore we need to answer consistently – as the OASIS guidance manual instructs. The comprehensive assessment that is completed at the same time as the OASIS data allows us to more completely document the status of the patient.

Patient goals should be SMART:

Specific
Measurable
Attainable
Relevant
Time-defined

Download the OASIS guidance manual

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D-Guidance-Manual-final.pdf

3. Plan of care

The plan of care for home health must include several items as outlined in the Conditions of Participation for Home Health, Section 484.60(a)(2). Clinicians should know where they need to document the information and how this information transfers to the plan of care.

4. Writing frequencies

Writing a frequency can be a difficult concept for clinicians new to home health. To help them understand how to write frequencies correctly, give clinicians several examples and have them write a few on their own.

5. Writing goals and outcomes

Goals and outcomes are established by the clinician, patient, and family/caregiver. They are a result of the assessment. As needs are identified from the assessment, the clinician guides the patient and family/caregiver to identify goals and outcomes. Interventions are then put in place to achieve the outcome. Teach your clinicians to create goals that are SMART – *Specific, Measurable, Attainable, Relevant, Time-defined*. Both short- and long-term goals should be identified.

6. Documentation

Medicare expects documentation to be completed in a timely manner and to address the goals and interventions identified. There should be clear documentation on the patient's progress toward the goals identified in the plan of care.

During orientation, clinicians should be informed of your agency's expectation of timely documentation. The importance of timely documentation – and the consequences of not following the expectation – should be clearly understood by your entire team.

7. Reimbursement

Staff need a solid understanding of how your agency is reimbursed for the care provided. Knowing that your initial payment (RAP) cannot be billed until the OASIS and plan of care are completed helps clinicians understand the necessity of timely documentation.

During your orientation, inform your team that final billing is done only after all orders are signed by the physician, so any verbal orders of a change to the plan of care must be completed at the time the change occurs. When your staff understands the pivotal role that the OASIS responses play in reimbursement, they will appreciate your emphasis on accurate, complete, timely OASIS submission.

8. Medicare vs. Medicare replacements and managed care

Knowing the coverage differences between Medicare and Medicare replacement insurances will help your staff understand the specific benefits for which patients are eligible. If a patient does not have Traditional Medicare, authorizations, reimbursement, and documentation may be somewhat different.

9. Care coordination

Medicare expects home health agencies to coordinate care to meet patient needs. It is expected that there will be communication between clinicians regarding management of schedules, patient status, home safety, and progress towards goals. During orientation, clinicians should be made aware of the need to document the communication between staff and physicians to provide evidence of the coordination.

Staff orientation in home health

Infection control

Infection control has always been a priority in the home health setting. And with the new Conditions of Participation (CoPs), it has become a regulatory requirement.

Your orientation process must include your agency's infection control program. Written information on infection prevention must be based on current standards of practice, fully up-to-date, and readily available to your staff.

The interpretive guidelines for the CoPs state that staff should have job-specific education prior to performing their duties and a process that ensures they understand and are competent in infection prevention.

"Standard precautions must be used to prevent transmission of infectious agents. *Standard precautions* are a group of infection practices that apply to all patients regardless of suspected or confirmed infection status at the time health care is delivered. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions, may contain transmissible infectious agents."
- **Interpretive Guidelines §484.70(a)**

6 key elements of infection control identified by the Centers for Disease Control and Prevention

1 Hand hygiene

Must be performed at a minimum...

- Before contact with a patient;
- Before performing an aseptic task (e.g., insertion of IV, preparing an injection, performing wound care);
- After contact with the patient or objects in the immediate vicinity of the patient;
- After contact with blood, body fluids or contaminated surfaces;
- Moving from a contaminated body site to a clean body site during patient care; and
- After removal of personal protective equipment (PPE).

The term "hand hygiene" includes both handwashing with either plain or antiseptic-containing soap and water, and use of alcohol-based products (gels, rinses, foams) that do not require the use of water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbiocidal activity, reduced drying of the skin, and convenience.

2 Environmental cleaning and disinfection

Clinicians must maintain clean equipment and supplies during the home visit and during transport of reusable patient care items in a carrying case in the staff vehicle.

3 Injection and medication safety

All HHA staff must adhere to safe injection practices, which include, but are not limited to:

- Use of aseptic technique when preparing and administering medications;
- Not reusing needles, lancets, or syringes for more than one use on one patient; using single-dose vials for parenteral medications whenever possible;
- Not administering medications from a single-dose vial or ampule to multiple patients;
- Use of fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and disposal appropriately after use;
- Considering a syringe or needle/cannula contaminated once it has been used to enter or connect to patient's intravenous infusion bag or administration set;
- Entering medication containers with a new needle and a new syringe even when obtaining additional doses for the same patient;
- Insulin pens must be dedicated for a single patient and never shared even if the needle is changed; and,
- Sharps disposal is in compliance with applicable state and local laws and regulations.

6 key elements of infection control *(continued)*

4 Appropriate use of personal protective equipment

Appropriate use of personal protective equipment (PPE) is the use of specialized clothing or equipment worn for protection and as a barrier against infectious materials or any potential infectious disease exposure. PPE protects the caregiver's skin, hands, face, respiratory tract, and/or clothing from exposure. Examples of PPE include: gloves, gowns, face masks, and eye protections if there is the potential for exposure to blood or body fluids of any patient. The selection of PPE is determined by the expected amount of exposure to the infectious materials, durability of the PPE, and suitability of the PPE to the task.

5 Minimizing potential exposures

Minimizing potential exposures in the home health setting focuses on preventing exposure of other family members and visitors and preventing transmission by the HHA staff while transporting medical specimens and medical waste, such as sharps.

6 Reprocessing of reusable medical equipment between each patient and when soiled

Cleaning and disinfecting of reusable medical equipment is essential. Reusable medical equipment (e.g. devices such as, blood pressure cuffs, oximeter probes) must be cleaned/disinfected prior to use on another patient and when soiled. The HHA must ensure that HHA staff are trained to: (1) maintain separation between clean and soiled equipment to prevent cross contamination; and (2) follow the manufacturer's instructions for use and current standards of practice for patient care equipment transport, storage, and cleaning/disinfecting.

Bag technique

All home health clinicians use some type of bag to transport supplies, personal protective equipment, vital sign equipment, and tablets/computers. The bags may be backpacks, shoulder or hand-carry bags, or wheeled rolling bags. Your agency may have bags you provide and require your staff to use. Orientation education should be based on your policies.

The principles of "bag technique" should include:

- ☑ Hand Hygiene
- ☑ Bag Placement during visits
- ☑ Bag storage between visits and when not seeing patients (car storage)
- ☑ Cleaning the surfaces of the bag (internal and external)
- ☑ Maintenance of supplies and equipment stored in the bag
- ☑ Management of equipment and supplies removed from the bag

Medication management

Management and education of medications is one of the most important jobs of the home health clinician.

The home setting presents a different need for assessment and education than an inpatient setting. Studies show that the elderly in the community using home health care continue to have medication errors with both under and over adherence of medications. Education provided during orientation should include the tools your agency uses for medication management.

Educating new staff on medication management may include the following:

Assessment and medication reconciliation
A key of medication management is medication reconciliation and a comprehensive assessment of all medications at admission and as new medications are ordered. Special attention should be given to adherence, financial concerns, side effects, and interactions with other medications. Tips on assessment include:

- Observe patient gathering their medication supplies and the area where medications are stored. Consider... is the process organized? What compliance aids are used? Are there functional / cognitive limitations?
- Observe patient opening medication containers. Is assistance needed or used?
- Ask the patient to state the proper dosage, time and frequency for each medication. How does the patient's response compare to the medication directions? Are there cognitive/mental limitations?

- Check the medication bottles for instructions and compare dosage and frequency with any medication list the patient utilizes.
- Ask probing questions such as, “What do you do if you are having trouble sleeping?” and “How often do you take your pain medication?”
- Ask the patient to demonstrate how they take their medications. Observe the patient/caregiver opening, dispensing, and reading medication labels. Check pill bottles to assess compliance.
- Always compare the list of medications from the discharge/referral information to what the patient is taking at home.
- Instruct that the medication reconciliation should include ALL medications the patient is taking, including over-the-counter, supplements, vitamins, and herbs.
- Assess for any financial concerns regarding medications.

Guiding patients toward medication adherence

The plan of care should include interventions to assist the patient/caregiver in proper medication administration. The following are ideas on assisting patients/caregivers to achieve the best outcomes.

- Establish habits and routines and incorporate medications into existing routines.
- Be aware of low vision patients and make needed adjustments.
- Use easy open pill containers and med planners.
- For memory deficits use pill alerts, timed dispensing aids, and habitual activities.
- Make a referral for a medical social worker if financial concerns are found.

Medication simplification steps

Discuss the following with pharmacists, physicians, or patient/caregivers if appropriate.

- Remove/discard unnecessary or expired drugs to prevent confusion.
- Encourage use of a single pharmacy to enhance regimen review and collaboration with pharmacist.Consider non-pharmacologic alternatives.
- Coordinate administration times with established sleep and activity patterns/routines.
- Decrease administration frequency, using sustained-release or long acting products.
- Reduce multiple medications to treat a single condition, unless combination therapy is intentional.

All team members shoud be aware that if they identify potential interactions or find duplicate drugs, they should **contact the physician** with this information and request a call back same day if at all possible. They must follow up until **acknowledgement is received** that the physician is aware and either changes the medication orders or decides to continue the medication. **Document the physician contact, discussion, and outcome.**