Any questions: 305-818-5940 / 786-514-9352
info@pnsystem.com

SKILLED AGENCY

Survey Common Questions

2nd Survey

Supervision

SERVICE	SUPERVISION
Any skilled service (RN, Therapy) + HHA	HHA supervised **Q14D** (every 14 days)
RN opens the case, RPT follow-up visits by LPN, PTA, OTA, STA	Supervised **Q30D** (every 30 days)
Non-skilled service (Personal Care, Homemaker, etc.)	HHA supervised **Q60D** (every 60 days)

Emergency Management

Patient education starts from the 1st day: on Admission, Sign Up day.

- The Admission RN will categorize the patient within 3 main categories (D1, D2, D3). (Please see the Emergency Plan form in the Admission package sample; category explanation on the back of the form.)
- **D1:** patient whose life depends on the service, lives alone, no caregiver. Example: insulin dependent patient with tremors, blind. These are **HIGH RISK** patients and need to go to a special needs shelter or hospital where the service can continue during the emergency.
- **D2:** same patient, their life depends on the service, but during the emergency has a trained caregiver who can take care of the patient (normally for work or distance cannot). **Medium Risk** patients.
- **D3: Low Risk** patient whose service can safely be placed on hold until the emergency situation is stable and streets are safe for work and services. Example: non-skilled care, some physical therapy services, etc.
- Explain that the Agency will maintain a prioritized hard copy list (remember: during a hurricane there is no electricity, computer or internet service) of all active patients by category (D1-D2-D3), with a copy of each patient's Emergency Plan form, Plan of Care, Medications and Shelter Registration attached to the list.
- If the patient needs to go to a shelter (D1 patients), the Agency must help the patient register in the shelter by contacting the DOH Special Needs Registration in the county of the patient's place of residence (data needed is at the end of the CEMP Manual for each county where the Agency is licensed). The doctor must be informed of the Shelter Registration application (usually electronic), and the Agency must share the registration with the MD.
- The Agency must maintain proof of CEMP submission to the DOH and the approval letter (annually).
- Agency staff must educate the patient about emergencies and what to do in an emergency (stay at home, with family, go to a hospital or shelter). Data is collected in the Emergency Plan form included in the admission package.
- If the patient goes to any other place, the Agency must re-establish the services ASAP where the patient is: family home, shelter, etc.
- Every year the Agency must complete (usually in May, before hurricane season begins on June 1st, our most common disaster type): Disaster Drill, Table Top Exercise, staff training, Hazard Communication selection, and all required Emergency Management documentation (included in the website, Safety Minute).
- Explain that the agency executives and all staff will monitor a battery radio (usually the only source of information during a hurricane, because there is no electricity or internet). After an emergency, if it is not possible to contact the patient or family (because phone services are not working), staff will go where we have registered the patient will be: patient's house, family house, shelter, etc.

- The Agency will maintain a Staff Meeting Place (Agency office), explained to all staff during emergency training and drills. Staff are oriented to have a battery radio to monitor community emergency agencies, authorities' bulletins and news; if communication fails, they are oriented to be at our office building at 9 am the day after authorities communicate that streets are safe, to reinstate our services ASAP. If the office is not in working condition, we will meet in the parking lot.
- If our office is totally destroyed, we will temporarily transfer the patients to another Agency with which we have a signed backup contract, until we can operate again.

** At the end of the CEMP Manual there are all Special Needs Registry forms for your counties.*

Staff Records Privacy

All staff files will be in a locked cabinet, accessed only by authorized staff. All in-services for staff are good for 2 years (24 hrs for professional staff: RNs, LPNs, Therapists; aides need 12 hours annually after the initial 75 hours). Office orientation in the office will use cards, manuals, board, etc. Training at https://homecareoffice.com/StaffTraining.htm.

ALL FIELD STAFF MUST BE REGISTERED IN THE AHCA CLEARINGHOUSE (Roster). IDs required. Criminal background and medical results **MUST BE IN A CONFIDENTIAL ENVELOPE**. PHYSICAL EXAM complete (initial TB test required for field staff: RNs, LPNs, aides).

You need at least one staff record completed for each discipline (RN, LPN, HHA, PT, OT, ST, MSW), or a contract with a Staffing Company (for therapy), to be accredited in all disciplines.

IMPORTANT: Agency must provide a full discipline by DIRECT employees, common Nursing (RNs and LPNs), and proof of provide at least one service, every 2 months with that discipline. *THIS IS A CONDITIONAL LEVEL DEFFICIENCY is not in compliance.*

Verifications

License	https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders
eVerify	https://www.e-verify.gov
Sex offender	https://www.nsopw.gov/
OIG	https://homecareoffice.com/hr_duties.htm
Alzheimer's (ADRD)	1 hr initial training within 30 days of hire, then 2 hrs within 7 months (https://elderaffairs.org/adrd-training/#training)

Mandatory Training

Alzheimer's, HIV, CPR up to date (not on-line), Physical Exam. Must have a copy of the rest of the trainings.

How do you evaluate an employee before and after hiring?

On the application date a practical and written test is completed (test results on the last page of the HR manual), verified and evaluated by the RN in charge (the competency test must be completed and signed by another RN). After 90 days the Probation Period evaluation is completed, and then an annual practical competency in the presence of the employee serving a patient.

Aide Services

How do you assign the Aide duties?

After the first nursing visit assessment (SOC), the RN generates the Aide Care Plan and educates and trains the aide in their responsibilities in the care/service of the client, and supervises every 14 or 60 days to verify that the plan is followed. All duties will be detailed; no PRN or as-needed tasks will be used.

Can the Aide assist with patient self-administered medications?

Yes, if ordered, and the aide has completed the 2-hour training and has been educated in the duty by the Admission RN as part of the Aide Care Plan assignment, and the patient is informed/approves. A signed patient consent will be in the patient record (CONSENT, Agency Forms manual, last page).

How do you know if the CNA/HHA is doing what she is supposed to do?

The aide will be supervised every 14 or 60 days (depending on the program and service provided) to verify that the Plan of Care is followed, infection prevention is followed, etc. Also, every 60 days (regular home health episodes): Evaluation of Services, Surveys and the 60 Days Summary Report will be completed.

How do you inform your staff about your policies and procedures?

On the application date, as part of the initial orientation, they are informed about their rights and the availability of the Policy Manual for review, discussion and participation in any needed revisions or updates. A Staff Handbook will also be provided to each applicant.

HIPAA (Privacy)

- The Agency will comply with all HIPAA guidelines and regulations. HIPAA exemptions: **Treatment** (if the patient goes to the hospital, the patient's condition, services provided, etc. can be shared with the hospital), **Billing** (any Program Management Authority like Humana, United Healthcare, etc. has the right to request copies of members' records to verify program guidelines are in compliance), **Regulation** (if AHCA, the healthcare regulatory agency in Florida, visits the agency, they have the right to review records to verify Florida Statutes and Standards are in compliance).
- Explain that all patients' records will be stored in a locked cabinet; only authorized staff will access patients' records; no patient information will be shared with third parties (like lawyers, family members) unless authorized in writing by the patient.
- The Agency will maintain a Visitors Log at the office entrance, which must be signed, to control who visited the office in case a HIPAA breach is detected, to facilitate investigation and solution.
- Staff in the Medical Records department will maintain a Chart Movement Log, to be sure any record requested by staff is returned when the work is finished and that no record is left on a desk outside the locked cabinet.

IV Therapy

The Agency can provide IV therapy services, **yes**, if ordered, a fully documented procedure is received from the patient's physician, and we have qualified staff. An LPN can't complete the 1st/last visit and must have 30 hours of IV training to follow up IV therapy services.

General

COMPLAINTS: A Complaint Log will be maintained (form at https://homecareoffice.com/Logs.htm).

Steps: 1) Receive the complaint 2) Solution 3) Plan to prevent the problem from repeating (always staff training) 4) Follow up on solution satisfaction. Clinical calls and patient-related services must be solved ASAP.

A more complex complaint (like a DC dispute, etc.) should be in writing/phone (LOG completed). Immediately the DON or Administrator shall conduct an investigation to determine its validity, and the Administrator/DON will issue a written decision on the grievance ASAP, but no later than thirty (30) days after its filing. The grievant may appeal the decision within 15 days (30 days to respond). No consequences for any complaints.

Close Agency voluntarily

First step: transfer all patients to another Agency, then complete the AHCA application, return the license, close contracts, providers, etc.

INFORMATION needed on the Agency main entrance door: Agency name, 24 hrs phone, and hours of operation posted. All licenses (AHCA, City, Business) and the Organizational Chart must be framed at the front desk.

Abuse Investigation

During staff initial orientation they are trained that any allegation or expected abuse by anyone, or suspicion of mistreatment, neglect or abuse, should be immediately reported to the employee's supervisor or DON. Employees who suspect or witness an abusive act by a patient's caretaker should notify their supervisor or the Administrator/DON immediately. The Administrator is responsible for coordinating the investigation within 3 days and completing the report and a plan to prevent it from happening again within 30 days (plan: always staff training).

How do you track if a patient falls or there is an incident? How do you know whether the patient's health is declining or it is the staff's fault? When should staff report a change in the patient's health?

As part of staff initial orientation (on the application date), staff are oriented that ANY significant finding, like a decline in the patient's condition, weakness, or safety measures needed in the patient's home (clean pathways, bed rails, etc.) as part of the Aide Care Plan, must be reported to the Agency RN in charge to complete the incident report and take measures to help improve the patient's condition and safety. We will maintain a log of any incident, and the program and the patient's physician will be notified. If the patient's health is affected (like a fall or hospitalization), the care plan will be updated in collaboration with the physician or enrolled health care program. Supervisor reports will be reviewed to verify the assigned aide follows the service plan, infection prevention and safety measures.

Alzheimer's, Offices & Admissions

Do you treat Alzheimer's patients? If so, what is the protocol?

All field staff will complete the 1 hour within 30 days of hire and the 2 hrs ADRD training within 7 months; we will maintain records of the training. New employees have up to 9 months to complete the required training. Any significant finding will be reported to the agency immediately. Training at https://elderaffairs.org/adrd-training/#training.

Do you have other agencies, like remote offices or places where people drop off notes (satellite office)?

NO

If the RN or Administrator worked in other agencies:

They will always be available in case of an emergency or Agency need, and will use any means of communication: emails, texts, phone calls. Always available: **YES**

How do you know the patient received all the proper documents and admission package?

It will be completed by our DON or another qualified admission RN; a supervisor will verify that all admission documentation was completed, discussed with the client/family, and left in the patient's home folder.

QAPI (Quality Assurance Performance Improvement)

All policies are included in the Policy Manual (Evaluation of Agency Program, Section D) and the QAPI Manual.

WHEN	QAPI ACTIVITY
1st Day	QAPI starts on admission, Sign Up day. Your QAPI staff must review all S/U papers, documentation, OASIS or comprehensive assessment to verify that the MD order is reflected in the admission documentation, including medications, orders and evaluations.
Every 2 weeks	At least every 2 weeks: review the quality of progress note documentation for all disciplines (reflecting the Plan of Care and frequency of visits compliance).

WHEN	QAPI ACTIVITY
Every 30 days	A Case Conference Report must be completed with the participation of all disciplines involved in the patient care and the Agency DON or qualified RN, proving coordination of care and assuring our services cover all patient care needs. Field staff complete a progress report (reflecting any progress/deterioration); any adjustment or modification to the plan of care must be authorized by the patient's physician.
Every 60 days	Regular home health episode: service and patient records reviewed and audited, verifying care plan compliance and frequency; Evaluation of Services, Patient Surveys and the 60 Days Summary Report reflecting the patient condition. If goals are met the patient is evaluated for discharge, or recertification if continuing service is documented and approved by the patient's physician (full documentation must be completed).
Quarterly	After we start providing services, a quarterly QAPI / Chart Review meeting is held with all disciplines providing services in the quarter, and a full report about our services is provided to the Board of Directors.

State Licensure Interview Questionnaire: Administrator

Sample questions, with the answers (shown in teal).

QUESTION	ANSWER
How long have you been the administrator?	**APPLICATION DATE**
Do you manage other HHA's? If so, where are they?	**NO**
See H-0217 if the HHA is located in a retirement community.	**NO**
How many patients do you serve? Weekly or monthly.	**N/A, or current number of active patients**
What services do you offer? What services are contracted?	**SN (DIRECT); HHA (CONTRACT)**
How many direct employees do you have? (List # by type, i.e. R.N.)	**2 RN, OFFICE STAFF IF APPLICABLE**
What geographic area do you service? (List the counties)	**DADE**
What are your normal business hours?	**9-5**
How do you handle 24-hour coverage (for skilled)?	**CALL TRANSFER TO ON-CALL PERSON**
Are there other locations?	**NO**
Satellite offices or drop off sites?	**NO**
Does the home health agency have space in an ALF in addition to the main office? If so, is it designated as a satellite office or drop office?	**NO**
Do you advertise that you provide services to patients with Alzheimer's Disease? If so, what information do you have about your services that distinguishes the care as being especially applicable to such persons?	**NO**
Do you provide home health aide training or use the AHCA competency test? If training, who is the primary trainer?	**DON**
How are patients notified of the Abuse Hotline toll-free number?	**LABELS ALL OVER S/U, FOLDER, HANDBOOK, INITIAL VISIT**

QUESTION	ANSWER
What is being done by staff to collect information to assist special needs patients in getting registered with the local emergency management agency? Did you or someone on your staff contact the local emergency management agency to find out what information needs to be submitted?	YES, WE ARE READY WITH ALL FORMS
How is the prioritized list of patients who need continued services compiled & maintained?	YES, WILL BE
If you are in one of the specified counties, was the Emergency Management Plan reviewed by the county health department?	YES, EMAIL
If there was an emergency situation in the counties covered by the HHA, how were patients contacted? Was the plan implemented?	BY ANY WAY OF COMMUNICATION, OR DRIVING TO THE PATIENT'S PLACE OF RESIDENCE. PLAN IMPLEMENTED

Home Health Agency Licensure Survey: Director of Nurses Interview

The following standards should be checked on the initial survey and when there is a new Director of Nursing (DON). Therapy-only HHAs are not required to have a DON, so the relevant questions can be asked of the administrator or the person who oversees the therapists. The asterisked items (*) should be checked on subsequent surveys, at the discretion of the surveyor and as time permits.

STANDARD	REVIEW & DISCUSSION ITEMS
H-0220 Director of Nursing (check if new DON)	Check qualifications if not done on a previous survey. **RESUME** How many HHAs does the DON work for? Is she or he the DON in all HHAs? **ONLY ONE** If the HHA is part of a retirement community, does the DON serve as DON for other facilities on campus? **NO**
H-0222 Alternate DON	Check qualifications if not done on a previous survey or if changed. **RESUME**
H-0223 DON duties	Review procedures for safety, universal precautions and infection control if not done on a previous survey. How are staff informed of the procedures? **ORIENTATION** Does the DON perform duties as listed in this standard? **YES**
H-0224 DON quality assurance program *	Review procedures if not done on a previous survey. **QA STEPS** Discuss whether QA procedures have changed. As time permits, review minutes or other documentation from the DON on QA.
H-0231 RN assign LPN & HH aides *	How does the RN assign portions of patient care to the LPN & home health aide? **PLAN OF CARE ASSIGNMENT, ORIENTATION**
H-0235 Supervision of LPN *	How does the RN supervise the LPN? **Q30D**
H-0240 Home Health Aide & CNA supervision *	How does the RN supervise the Home Health Aide & C.N.A? **SKILLED CASES Q14D, NON-SKILLED Q60D**
H-0250, 251, 252, 254 HH Aide & CNA assist w/ meds: discuss procedure, assessment & training *	What training and oversight is provided to Home Health Aides & C.N.As that provide assistance with medication? Who informs the patient that an unlicensed person will assist? **THE ADMISSION RN, IF THE HHA HAS THAT TRAINING** Who assesses the patient to determine if stable enough and OK for the aide to assist? **THE ADM. RN**

STANDARD	REVIEW & DISCUSSION ITEMS
H-245 HH Aide Competency Test	If the test is used by the HHA, who administers & grades the written test? Who administers & rates the practical portion? **THE DON**
H-390 Lab Test (check on initial visit or if not checked before)	Does the HH agency do any lab tests? **WAIVER ONLY** If so, does it have a license and/or CLIA waiver from AHCA's Lab Unit? **YES, APPLIED (SEE COPY)**
H-0305 Responsibility over contractors *	How does the HHA monitor and manage care provided by contract agencies? **N/A, BUT WE ARE RESPONSIBLE FOR ANY CONTRACT, AND MONITORING/SV Q2WKS**
Other	

10 Skilled Patients Survey: Director of Nurses Interview

The following standards should be checked on the initial survey and when there is a new Director of Nursing (DON). Therapy-only HHAs are not required to have a DON, so the relevant questions can be asked of the administrator or person that oversees the therapists. The asterisked items (*) should be checked on subsequent surveys, at the discretion of the surveyor and as time permits.

Pre-Survey Activity

In preparation for the survey, review documents from the area office file, including:

- Licensure applications.
- Previous survey reports and the results of complaint investigations.
- Check the current license to determine the geographic area.
- Review the resume of the administrator and director of nursing.
- Bring along a list of the personnel, patients and services.
- Review survey instructions, minimum standards and guidelines as needed. Also determine if this home health agency provides specialized services, such as services for Alzheimer's patients (if so, this will be checked in the interview with the administrator).

Survey Length & Staff

It is expected that surveyors will be able to complete the survey within 2-3 days.

Arrival at the Home Health Agency

Upon arrival, talk with the administrator, designated alternate administrator or person left in charge. If the administrator or alternate administrator is not present, they should be reachable by telephone or beeper. Ask the person left in charge to contact the administrator or alternate and advise them that the surveyor has arrived and is beginning the survey. The administrator or his or her alternate is expected to arrive during the survey.

Entrance Conference

The survey can begin with the director of nursing or her alternate if the administrator or alternate administrator has not arrived. In the interview with the administrator or alternate administrator, begin by explaining that the purpose of the survey is to determine if the home health agency is in compliance with state law and rules on home health agency licensure. During the interview, indicate which staff you need to interview and also indicate an approximate time to ensure availability. See the Licensure Home Health Interview Questionnaire for the Administrator for minimum questions that should be asked. Additional questions may be added at the discretion of the surveyor.

Ask the administrator to provide, within the specified time frames, the information listed on the Entrance Conference Checklist.

Once you receive the patient roster, select two to three patients to interview by telephone/visit and notify the administrator. [See the Patient Interviews section below.]

Interview with Director of Nursing

Interview the DON using the review and discussion items on the Home Health Agency Licensure Survey Director of Nursing Interview or another similar list or worksheet.

Record Review

Personnel: Record review activity is required for personnel files and patient records. Select for review the files of all newly hired employees since the last survey. Use the worksheets provided (Personnel Record Review and Certified Nursing Assistant/Home Health Aide Training Review Form) or other similar worksheets to determine compliance with the standards. Use surveyor judgement to determine if other files need to be reviewed.

Patients: When selecting a sample of patient records to review, use the listings of admissions and discharges to pick the sample. It is recommended that the sample include at least 2 new admissions and 2 discharged patients. If there are no skilled services, substitute records for non-skilled services. If the agency has fewer than 8 patients, check all the records. Surveyors should remove the files, or observe the removal of the files from the cabinet by agency staff (secure). Use the Patient Record Review Form, or a similar worksheet that includes at least the same standards, to check the records. If deficiencies are found, use surveyor judgement to determine if more records should be reviewed.

Patient Interviews

As stated above, two telephone/visit interviews need to be scheduled with patients or their family members (or the person that cares for the patient on a daily basis). The surveyor is to select the patients to interview. The surveyor is to call the patient, explain the purpose of the call, and ask permission from the patient or caregiver to be interviewed. If the patient or caregiver refuses, select another patient.

The surveyor may request that the home health agency make the call in their presence and ask permission for the surveyor to interview the patient. The purpose of the interview is to verify that the patient is getting the services as expected, that the services are satisfactory, and that the patient is getting the information required. A home visit should also be arranged, as time permits, if there is an indication of patient care problems in the patient record reviews. Use the Home Visit Consent form for any home visits that are made. It is recommended that the surveyor use the State Licensure Home Health Interview Questionnaire for Patient Home Visit or Telephone Visit. The surveyor may add additional questions at his or her discretion.

The patient interviews/visits do not have to be conducted the same day as the survey and could be done the next day or within the time frames required for completion of the survey report. However, it may be beneficial to conduct the interviews the same day so the findings can be shared in the exit conference.

◆ Patient Home Visit

☐ What services do you receive from [name of HH agency]?
☐ How long have you been receiving home care services?
☐ Has it always been with the same agency?
☐ How often do you receive services?
☐ Do you know when the (nurse, aide, therapist) will come?
☐ Do they ever miss visits? If so, are you called & is the visit ever re-scheduled?
☐ Do they talk to you (or your caregiver) about your care?
☐ If skilled care: did they discuss your plan of care with you & did you get a copy?

☐	Did you get a document that shows what services you will receive and the rates or charges and method of payment? [written agreement]
☐	Did you receive the telephone number to report abuse, neglect or exploitation?
☐	Were you offered information on advance directives?
☐	Do you have the name & telephone number of [name of HH agency]?
☐	Did you get the services you expected to get? Are they satisfactory?
☐	Do you have any comments you would like to make?
☐	Other

Emergency Management Plan

Ask the administrator to see the HHA's emergency management plan. Use the Worksheet for Review of HHA Emergency Management Plans to check for essential required items in the plan. Ask for evidence that the plan has been reviewed by the county health department. **LOG**

Patient Record Review

Does the record contain the following?

☐	Patient identification / name, address, race, sex, etc.	☐	Termination DC summary
☐	Source of referral	☐	Advance directives info offered
☐	Physician verbal orders / prior to start of care	☐	Notified patient of right to take part in plan of care development (skilled)
☐	Treatment orders signed by physician	☐	Special needs registration & evacuation info
☐	Physician contacted if orders must be altered	☐	Plan of care exists for skilled care pts (SN, Therapy)
☐	Assessment of patient needs (skilled care only) (OASIS)	☐	Goals for each skilled service provided
☐	Statement of patient/caregiver problems	☐	Frequency of home visits to provide direct care
☐	Services rendered	☐	Frequency of supervisory visits Q14D skilled
☐	Observations	☐	Changes & updates to the plan (Mod Orders)
☐	Admitting agency responsibilities	☐	RN is the Case Manager if Nursing Services
☐	Reports of case conferences	☐	PT/OT/ST/RD primary case manager
☐	Reports to physicians		

Question

☐	If ALF / copy of contract: duplication of services?	☐	The agreement includes: the services to be provided
☐	Do patients live within the geographic area?	☐	The rates or charges if private pay
☐	Tasks by CNA / HHA are appropriate	☐	The method of payment
☐	Written Agreement		

Conducting a Patient Medication Interview

During the phone call to set up the appointment, ask the patient/caregiver to have all the medication bottles, including vitamins, herbals, over-the-counter medications, eye drops, nebulizers and inhalers, out on the table for viewing. Also

ask them to provide any list of medications they already have or received on discharge from the hospital or doctor's office.

During the visit, as you review the bottles, ask the patient/caregiver open-ended questions:

- How many of the pills or puffs, etc. do they take? This is to validate the dose.
- How do they take the medication? This is to determine their schedule.
- Check if they know what the medication is for.
- What medications do you receive at the doctor's office (i.e. chemotherapy, Vitamin B12 injections) or at dialysis (i.e. Epogen)?

As you examine the patient, include probing questions to help trigger the patient's memory:

- What do you take for your (based on diagnosis) diabetes?
- What meds has your (based on doctors the patient sees) arthritis doctor ordered?
- What do you take when you have a headache?
- Do you take anything for heartburn?
- Do you take anything for your bowels?
- Do you take anything for allergies?
- Do you put any medications on your skin?
- What do you take for sleep?

Following the patient's visit to the doctor's office, ask:

- What did your doctor say?
- Did the doctor make any changes in the medications you are to take?
- Did the doctor make any changes in the dose or frequency of your current meds?

Adapted from the Accreditation Resources and the American Society of Health-System Pharmacists Medication Reconciliation Handbook, Chapter 5: Educating your staff.

The Bag Technique

Our bags have the basic equipment, with supplemental items for specific procedures carried in either the bag or separate containers. Basic items may include:

ITEM	USE
Paper towels	Used to dry hands and create an area to protect the family's environment from the "dirty" outside of the bag, and to protect the bag from environmental microorganisms and/or allergens.
Soap	In a container (or cleansing agent, hand sanitizer). In some instances, disposable pre-treated soap pads or sanitizer may be used if there are no running water facilities in the home.
Aprons & PPE	Aprons (optional, usually disposable); PPE (gloves, mask, etc.).
Antiseptic wipes	Antiseptic wipes or alcohol pads are used as a disinfectant for cleaning items (such as the BP cuff) prior to returning items to the bag.
Waste bags	Paper or plastic bags are used for disposal of waste materials, retrieved/disposed of by the appropriate contracted company. Any infectious materials such as old dressings, disposable catheters, irrigation bags and plastic tubing are handled carefully and discarded into appropriate containers. Syringes must be placed in approved containers for disposal and returned to the office for proper disposal, or disposed of through an approved Biomedical Waste contracted company.

	Needles are never to be recapped.
Thermometers	With disposable sheaths.
Sphygmomanometer	With several sized cuffs for measuring the blood pressure of clients of varying age and size.
Stethoscope	With bell and diaphragm, for measuring blood pressure and auscultation of respiratory, circulatory and other appropriate systems.
Tape measure	Plastic-coated or metal, for assessment of heart, chest and length measurements in children and assessment of limbs and joints.
Penlight	For assessing presence of light reflex in eyes, mouth and nasopharynx; in special instances, transillumination.
Otoscope	Otoscope, ophthalmoscope and tongue blades for assessing head and neck (optional).

Setting Up

The bag is placed on a paper towel, bed pad or Chux on a flat, open and as clean as possible surface. It should be near a sink and kept out of the reach of children and pets. Bags are treated as though the inside is clean, with outside pockets containing paper towels and soap for setting up. The outside of the bag is considered unclean.

If an apron is used, it is put on prior to hand washing. The soap container and several extra paper towels are then removed and placed on the work area. If a paper or plastic bag is to serve for waste, it is opened and set up in a corner of the work area for disposal of used materials. A paper towel is tucked under the arm and soap is placed in one hand. Hands are washed vigorously under running water, rinsed thoroughly and wiped dry with two paper towels, which are then used to turn off the faucets.

Hand washing technique: Wet hands, apply soap, rub palm areas of hands together ten times with fingers intermingled, rotate back and forth ten times. Using a circular motion, go around the anterior and posterior of both hands ten times. Rinse well. Dry thoroughly. Turn off the faucet with paper towels and discard the paper towels. Do not wear fingernail polish, as it chips and can constitute another area of contamination. Clean under nails daily. Keep nails trimmed closely, as they harbor bacteria.

After the hands are washed, set waterless cleanser out on the barrier, and any equipment that is necessary for providing care is removed from the bag. Special procedure sets are set up near the client, and appropriate medical or surgical aseptic techniques are instituted. Any time additional equipment is needed from the bag, hands must be washed again; thus, it is wise to have extra paper towels available on the clean work area in case they are needed.

Assessment and special procedure supplies are placed on the clean or sterile field work areas. After use, they are washed with soap and water, dried, wiped with a disinfectant such as alcohol, and returned to the bag. Equipment in the home is cleaned, disinfected and stored in closed, protected containers for future use. Materials that can be disinfected by soaking in antiseptic solution or boiled for at least 20 minutes in water can be processed in the home. Some materials can be sterilized by placing them in the oven at 350 degrees for 30 minutes.

The type of equipment, its material and its purpose define the procedure used for disinfection or sterilization. Disposable plastic and rubber materials can disintegrate and could produce toxic reactions when processed; thus, it is best to check the manufacturers' instructions and discard questionable disposable materials safely, that is, at our Agency rather than in the home. All syringes and needles are discarded in the contaminated supplies box (Sharps Box).

Equipment such as stethoscopes, tape measures and liquid soap containers is recycled for multi-patient use. Before returning them to the bag, the items are cleaned and, if possible, washed and wiped with alcohol or another disinfectant. If there is suspicion of possible contamination, the item in question is placed in a separate paper or plastic bag and returned to our Agency. The sphygmomanometer is cleaned with antiseptic wipes. It is recommended that every few weeks the cuff is washed in warm soapy water and dried. At this time the Velcro closure is cleansed of any debris such as lint.

Any questions: 305-818-5940 / 786-514-9352
info@pnsystem.com

Patient Care / Assessment Procedure

1. Put the bag on the car seat/floor, over a paper towel or pad.
2. Use hand sanitizer/alcohol rub before entering the patient's home.
3. Greet the patient without kissing or touching him/her.
4. Check for free space to set up the field/place.
5. Prepare the field.
6. Wash your hands and rinse; scrub your hands for at least 20 sec, or use hand sanitizer (DO NOT USE THE PATIENT'S SOAP/TOWEL).
7. Place 2 paper towels in the field, put the bag over them, start to remove the contents and place them over the paper towel (thermometer, glucometer, sphygmomanometer, gloves, hand sanitizer, liquid soap).
8. Look for the patient's insulin/injection/medicine, pen, and nurse/progress note where you will write the V.S., teaching to the patient and all significant findings.
9. Be sure that you have all that you need, because after you put on the gloves you can't go back to the bag to get anything you forgot.
10. Always keep the sharps container in a safe place (where children can't reach it) but accessible for use, not in the same field/place.
11. Wash your hands with liquid soap, scrub for at least 20 sec, and dry with a paper towel (yours, not the patient's), then put it in the garbage (bathroom), or use hand sanitizer.
12. Come back to the nurse field/place and do not touch anything (close the bathroom door with your elbows or with a new paper towel).
13. Put your gloves on.
14. Calibrate the glucometer (yours or the patient's) and check the solution's expiration date. If you are planning to use the patient's glucometer, have yours as a backup.
15. Take the blood sugar result, apply the insulin (verify ID on the med), warm the insulin by rubbing it with your hands, and check for proper color.
16. Discard the needle/lancets in the sharps container.
17. Remove your gloves.
18. Use hand sanitizer, and put new gloves on.
19. Take the vital signs and record them.
20. Do the full assessment from head to toe: respiratory system, lungs (up/down), CV (left/right), bowel movement, check the abdomen (soft), mucous color, mouth, ears, check for edema/adenopathy, check legs (without socks), between fingers, etc.
21. When finished, discard the gloves.
22. Wash your hands, scrubbing for at least 15 sec (CDC guideline), or use hand sanitizer.
23. Keep all things used; paper towels to be discarded.
24. Sanitize your hands.
25. During the patient's assessment, instruct your patient; be sure that he/she understands by asking them to repeat the instructions, and ask for any questions/doubts.
26. Say goodbye to your patient without touching him/her.
27. Before entering your car, sanitize your hands, and put your bag back in the same place using a paper towel.
28. If at any time your gloves are damaged, place new ones over the damaged ones, or remove the damaged gloves and use new ones, sanitizing your hands before wearing them.

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Universal Precautions

Includes blood, body substances containing visible blood, non-intact skin, and mucous membranes.

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Hands should be washed **BEFORE** and **AFTER** patient care.	Gloves should be worn when likely to touch blood and other potentially infectious materials, non-intact skin, and/or mucous membranes. They should also be worn when performing vascular access procedures and when handling contaminated items or surfaces.	A gown should be worn when clothing is likely to become soiled.	A mask and/or protective eyewear should be worn when splashing is likely.	Always place used needles, syringes and/or sharps into a designated disposal container. **DO NOT BREAK, BEND OR RECAP NEEDLES.**