In-Home Aides

Partners in Quality Care

HOME CARE ALLIANCE of MASSACHUSETTS
www.thinkhomecare.org

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Reflective Questions:

*Did you learn anything new that will help you in your documentation of client care?
*Is there a main point from the newsletter that you found interesting?
*Will you be more in tune to client observations based on the newsletter information?

OBSERVATION

Objective- The objective method of observation means that you are using one or more of the body senses to gather information (sight, sound, smell, touch) and facts

Subjective- Someone tells you information that you cannot observe (client tells you he/she has pain, client says he/she is dizzy, family member tells you the client has been depressed).

Documentation and Observe, Record, Report (ORR)

A plan of care is the written description of the authorized home care services and tasks to be provided to a client. Documentation is a record of the care you provided to the client and provides the basis for your agency to bill for the services provided. It shows how your time was spent in the client's home performing the tasks which are assigned on the plan of care/ assignment sheet. The plan of care for a home care client is developed by the appropriate professional required for the service such as a Registered Nurse. The plan of care is developed based on an assessment of the client to determine the type of care and services needed. The plan of care is reviewed periodically and changed or updated as needed as the client's need for care and services change. The client and or responsible party should be an active participant in development of and in agreement with the plan of care. The type of information you will typically find on a home care client plan of care includes:

(1) type of service(s) and care to be delivered - (the services to be provided on each visit, such as assisting with Activities of Daily Living (ADL's) - mobility, eating, bathing, dressing, and toileting, other
(2) frequency and duration of service (what days and amount of time each day for services)
(3) activity restrictions (such as restrictions due to recovery after surgery, or due to shortness of breath with lung or heart conditions)
(4) safety measures (such as risk of falls, home oxygen safety, other)
(5) service objectives and goals (such as client needs for ADL assistance will be met safely and according to the plan of care)
(6) equipment required (such as a walker, wheelchair, cane, beside commode, other)
(7) functional limitations (such as problems using arms, or legs, or hands, other).
(8) other client information according to the assessment such as dementia care needs

Home care agencies are held to strict documentation requirements by their state licensing agencies, accreditation agencies and their payer sources (some examples are Medicaid, Medicare, VA, aging services, and private insurance). Your documentation should show the care you provided to the client. If your client refuses a task, this should be noted in the documentation and your supervisor notified. Also, if your client or client's family asks you to perform tasks that are not on the plan of care (assignment sheet), you should check with your supervisor to determine if the plan of care can be changed to allow the task. Your responsibility as an In-home aide professional is to document clearly and to ask for assistance when you are unclear about performing tasks or how to document according to your agency specific requirements. Different agencies will have different forms or flow sheets for documentation. Be sure to know your agency policies regarding documentation requirements such as your signature requirements, time in /out, dates, documenting deviations, client signature, notifying your supervisor for changes and when your documentation is due back to the agency. Many states now require certain agencies to use Electronic Visit Verification (EVV) and your agency may use an Electronic Health Record (EHR) for documentation rather than a paper time sheet. Whatever the form of documentation used as a record of your visit, be sure it is accurate and meets your agency specific guidelines.

Documentation and Observe, Record, Report (ORR)

An important task of an In-home aide is to accurately report on the client's care and progress daily. It is imperative that the In-home aide follow his or her agency's guidelines for communication, including reporting and recording. The In-home aide will also report observations and changes in a client. As noted above regarding documentation for state home care licensing or payer requirements, your agency can be cited as having a deficiency by a state or federal audit, accreditation audit, or a payer source audit for inaccurate and missing documentation. If a payer source conducts an audit and finds documentation missing or not according to the payer source requirements, the payer can take back the money paid to the agency for the services provided (a recoupment). Remember, the client's record is a legal document so all documentation must be in legible, clear and accurate language so that there is no misunderstanding of the meaning. Never falsify documentation or turn in false time sheets/ service notes to your agency. Always check with your agency for policies on specific documentation requirements for your agency.

As an In-home aide you may spend more time with a client than any other health care worker. You are a valuable part of the care team. By noticing changes in the client's condition that could signal increasing illness, a worsening of the client's physical or mental condition and/or a change in the client's disease process, you can provide valuable information to help get needed care and treatment to a client in a timely manner. As an In-home aide you should note what you *observe* while providing care to and while spending time with client's according to your agency policies and procedures and as assigned by your supervisor.

Observe, Record, Report-:

- ❖ Observe- For example, if you are assisting a client with a bath, and you saw (observed) reddened skin areas that could become pressure sores. You can observe the client for changes as you are providing care.
- ❖ Record- Document what you observe using your agency's paper or electronic forms and according to your agency policies and procedures.
- ❖ Report- Use the telephone, cell phone, or other reporting method per your agency policy to notify your supervisor (or who you are to report to) about what you observed. There may be specific instructions in the client's plan of care and your assignment sheet on reportable observations. If you are unsure of what you should report, ask your supervisor for guidance.

- ✓ The word ***observe*** means to watch carefully and attentively. This is a way of gathering information about something.
- ✓ People communicate in various ways: verbal, nonverbal, and written.
- ✓ Just as communication is a continuous process, observation also must be a process that is constantly in use.
- ✓ During the first visit, you will be gathering new information about your client, the client's family, and the home environment. Then, with each visit, you will build on this information by observing any changes in your client, the client's family, and the home environment.
- ✓ If you have a concern about a client or if you feel like your question or concern requires immediate attention – don't just put it in your documentation – contact your supervisor or other person according to the guidelines you are given on the client's plan of care and instructions.

- ➔ **Remember, the client's record is a legal document so all documentation whether written or electronic must be in legible, clear and accurate language so that there is no misunderstanding of the meaning. Never falsify documentation or turn in false time sheets/ service notes/ electronic notes to your agency!!**
- ➔ **Always check with your agency for policies on specific documentation requirements for your agency.**

Documentation and Observe, Record, Report (ORR)

Visit Documentation:

- When documenting client care, all information must be completely accurate and up to date.
- Each home care client is unique, and you will need to follow the plan of care to know how to record and what and to whom to report regarding observations specific to your clients.
- Document observations and the care you provided. Only document the care you provided, not what another team member may have completed. It is unethical and illegal to document things that you intend to do in the future, in other words, things that you have not yet completed.
- It is important to describe what you observe, and not your personal judgment. For example, instead of writing, "Susan is very sick today," write what you observe, for example, "Susan expressed feeling tired and achy, and she also has a temperature of 101.1 degrees." Stick to facts, observations, and quotes from the client. Documented reports must also be completed in a timely manner. Other people may need the information that you will provide, and memories are always the freshest right after an event happens. Your agency will need proof of services provided by your documentation to file a claim with the payer source.
- It is also important to know your agency policies regarding incident reporting and how to report signs of possible client abuse, neglect, or exploitation. It is important for the In-home aide to be aware of what is happening in the client's home that may be affecting the client' well-being and care. If an In-home aide feels that some sort of abuse is happening in the client's home, the first step is to talk to a supervisor. In most cases, the local Adult Protective Services (APS) or Child Protective Services (CPS) department will be called. Talk to your supervisor about your agency policies for reporting client concerns, what to look for, and when and to whom to report.

Recording and Reporting Observations Key Points:

➔ Different agencies will have different forms and formats (paper and/or electronic) that they want you to use for documentation. There is a specific law in place that protects a person's protected health information (PHI) and the information collected that is used in computer interactions, and the security of that information, and it is called the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your agency will have policies related to any electronic documentation that you must follow.

➔ You would document the tasks completed, any deviations from the plan of care such as a client refusing care, notifications of reportable observations and who was given the information. Whatever form of documentation is used by your agency, you would sign and date or authenticate your documentation and note the time your arrived, and the time your left the client's home. Many states required Electronic Visit Verification (EVV) for their Medicaid program payment of services. Whatever form of record keeping, confidentiality is vital, in paper or electronic format.

➔ Depending on your agency policies and regulations that must be followed, you may need to obtain the client or responsible party signature verifying the visit note.

➔ Be sure to know your agency specific policies on what, how and to who to report client information. If you are assigned to assist a client with blood pressure monitoring (or other vital signs such as pulse rate, temperature, respiratory rate) be sure to know what, how, and to whom to report readings outside of normal ranges. If assisting a client with vital signs or blood sugar monitoring, having set parameters (set limits or ranges) are important for you to know when and to whom to report readings outside of set parameters. Reporting timely is important in case the client needs medical attention. Each agency will have different guidelines on reporting, be sure to obtain this information from your agency.