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Home Care

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Table of Contents

- Some items in the Table of Contents are indicated as "updated." This means that these policies and procedures (P&Ps) have been updated since the previous edition of *PolicySource*. These changes reflect updates in Joint Commission standards and elements of performance for home care accreditation.
- Those items with a paper clip icon 📎 are not P&Ps themselves but supplementary materials or attachments for a particular P&P. Not every P&P has such attachments, but that does not prohibit someone using *PolicySource* to create their own ancillary materials for any of their own P&Ps.

Individualized Care Plan Development Procedures: Home Health

[Logo]	**TITLE** Individualized Care Plan Development Procedures: Home Health		**IDENTIFICATION NUMBER**
ORGANIZATION(S)	**LEVEL** ☐ System ☐ Organization ☐ Division ☐ Department	**CATEGORY** ☐ Clinical ☐ Management ☐ Regulatory	**POSTING DATE** **EFFECTIVE DATE**
REVIEW CYCLE ☐ 1 year ☐ 3 years **LAST REVIEW DATE:**		**REPLACES** **TITLE:** Individualized Care Plan Development Procedures: Home Health **EFFECTIVE DATE(S):**	

APPLICABILITY

These procedures are applicable to home care organizations and correlate to Joint Commission standards that require written documentation. *See* Applicability Grid for applicable services and settings.

PROCEDURES STATEMENT

Each patient's care, treatment, or services are guided by an individualized plan that addresses individual needs and goals.

PURPOSE

To establish procedures for developing individualized care plans to support coordinated home health care and to provide each patient with appropriate, effective care, treatment, or services.

SCOPE

Applies to all home health care, treatment, or services provided by the organization.

Applies to all staff members who participate in home health care, treatment, or services.

Applies to all patients who receive home health care, treatment, or services at the organization.

DEFINITIONS

Assessment – An objective evaluation or appraisal of an individual's health status, including acute and chronic conditions. The assessment gathers information through collection of data, observation, and physical examination.

Care plan (also called plan of care) – A written plan based on data gathered during assessment that identifies care needs and treatment goals, describes the strategy for meeting those needs and goals, outlines the criteria for terminating any interventions, and documents progress toward meeting the plan's objectives. The plan may include care, treatment, and services; habilitation; and rehabilitation.

Continuing care – Care provided over time in various settings, programs, or services and spanning the illness-to-wellness continuum.

Coordination of care – The process of coordinating care, treatment, or services provided by a health care organization, including referral to appropriate community resources and liaison with others (such as the individual's physician, other health care organizations, or community services involved in care or services) to meet the ongoing identified needs of individuals, to ensure implementation of the plan of care, and to avoid unnecessary duplication of services.

Health information – Any information, oral or recorded, in any form or medium, that is created by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse that relates to past, present, or future physical or mental health or condition; the provision of health care; or payment for the provision of health care to an individual.

Psychosocial – Pertaining to the influence of social factors on an individual's mind or behavior and to the interrelation of behavioral and social factors.

Reassessment – Ongoing data collection, which begins on initial assessment, comparing the most recent data with the data collected at earlier assessments.

RESPONSIBILITIES

Leadership is responsible for the following:

- Overseeing, reviewing, revising, maintaining, and implementing these procedures
- Collecting and analyzing data in compliance with these procedures

Nursing and therapy staff members are responsible for performing assessments and reassessments.

Creating and maintaining a patient's care plan are the responsibilities of all staff members who participate in patient care, treatment, or services.

PROCEDURES

Appropriate nursing and therapy staff does the following:

1. Engages the patient and, if appropriate, family members in performing all assessments and reassessments, whenever possible
2. Performs initial assessment and screenings of the patient, according to organization policies and procedures.
   For home health agencies that elect to use The Joint Commission deemed status option
   - The initial assessment visit must be held within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start-of-care date.
3. Documents all screenings and assessments, as well as the results or outcomes, in the patient record.
4. Identifies the patient's needs, including those related to the following:
   - Clinical needs
   - Pain management needs
   - Emotional and behavioral needs
   - Psychosocial needs
   - Cultural, spiritual, and religious* needs
   - Communication needs
   - Nutritional needs
   - Discharge planning needs

5. Identifies the patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of his or her goals and the measurable outcomes identified by the organization.
6. Identifies the primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, availability, and schedules.
7. Identifies any potential barriers related to the patient's ability to participate in care planning.
    - Implements relevant interventions to address those barriers, as established in organization policies and procedures (for example, interpretive services or translation services, availability of community resources, and so on).

Appropriate staff members who participate in patient care do the following:

1. Engage the patient and, if appropriate, family members and representatives in care planning activities, whenever possible.
2. Review and confirm information from initial assessment and screenings with the patient.
3. Collaborate with the patient to identify goals for care, treatment, and services based on the following:
    - Clinical status
    - Identified needs
    - Evidence-based practice
    - Diagnostic testing and imaging results
4. Collaborate with the patient to prioritize identified goals.
5. Identify the following elements related to each prioritized goal:
    - Interventions, settings, and services needed to meet the goal
    - Time frames for meeting the goal
    - Measurable metrics that will be used to determine progress
    - Potential barriers to meeting the goal and possible strategies to overcome those barriers
    - Resources available to support the patient in meeting the goal (for example, family support services, community agencies, financial assistance)
    - Criteria for deciding the patient has met the goal
    - Discharge planning, including criteria for discharge and plans for continuing care
6. Discuss next steps with the patient.
7. Provide relevant educational materials to the patient in a manner that meets his or her communication needs.
8. Confirm that the patient understands the care plan and related information and education.
9. Document all care planning activities in the patient medical record.

Appropriate nursing and therapy staff does the following:

1. Performs reassessments of the patient periodically, as needed, following hospitalization with significant changes in the patient's condition, at least once every 60 days, and according to time frames described in the care plan.
2. Includes the following in the reassessments:
    - Changes to the patient's clinical status
    - Changes to the patient's pain level or status
    - Any other changes observed or reported by the patient
    - Measurable or reported effects of medications and other interventions
    - Any clinical or other data needed to conduct the reassessment
3. Documents information collected during reassessments in the patient record.

Appropriate staff members who participate in patient care do the following:

1. Review and confirm information from reassessments with the patient.
2. Identify the patient's status with regard to the prioritized goal(s) described in the care plan, based on the measurable metrics described in the care plan.
3. Collaborate with the patient to determine whether any components of the care plan need adjusting, based on the following:
    - Patient's progress toward goal(s)
    - Diagnostic testing and imaging results
    - Continued relevance of the patient's needs and goals
4. Revise the care plan to reflect changes to the patient's clinical status, needs, and/or goals.
5. Document all changes to the care plan in the patient's medical record.

For home health agencies that elect to use The Joint Commission deemed status option
Appropriate staff members who participate in patient care do the following:

1. Address the following elements in the plan of care:
    - All pertinent diagnoses
    - Mental, psychosocial, and cognitive status
    - Types of services, equipment, and supplies required
    - Frequency and duration of visits
    - Prognosis
    - Potential for rehabilitation
    - Functional limitations
    - Permitted activities
    - Nutritional requirements
    - All medications and treatments
    - Safety measures to protect against injury
    - Description of the risk of emergency department visits and hospital readmission
    - All necessary interventions to address underlying risk factors
    - Interventions and education specific to the patient
    - Measurable outcomes and goals
    - Patient and caregiver education and training
    - Information related to any advance directives
    - Disciplines involved in providing care
2. Consult with the certifying physician/nurse practitioner or other practitioners involved in the patient care, as appropriate, regarding additions or modifications to the original care plan.
3. Consider current information when revising the care plan, including information from the following sources:
    - Patient's updated comprehensive assessment
    - Patient's progress toward goals
    - Patient's progress toward measurable outcomes
4. Inform the patient regarding the change in the plan, and document that the patient was informed of and agreed to the change.
5. Communicate any revisions related to the patient's discharge to the patient and the following individuals, as applicable to the patient:
    - Representative
    - Caregiver

- All physicians who issue orders related to the care plan
- Primary care practitioner or other health care professional who will provide care after discharge

REFERENCES

Joint Commission Standard PC.01.03.01, EP 1. The organization plans the patient's care, treatment, and services based on needs identified by the patient's assessment.

Joint Commission Standard PC.01.03.01, EP 5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.

Joint Commission Standard PC.01.03.01, EP 10. **For home health agencies that elect to use The Joint Commission deemed status option:** The individualized plan of care specifies the care and services necessary to meet the needs identified in the comprehensive assessment and addresses the following:

- All pertinent diagnoses
- Mental, psychosocial, and cognitive status
- Types of services, supplies, and equipment required
- The frequency and duration of visits
- The patient's prognosis
- The patient's potential for rehabilitation
- The patient's functional limitations
- The patient's permitted activities
- The patient's nutritional requirements
- All medications and treatments
- Safety measures to protect against injury
- A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors
- Patient-specific interventions and education
- Measurable outcomes and goals identified by the organization and patient as a result of implementing and coordinating the plan of care
- Patient and caregiver education and training to facilitate timely discharge
- Information related to any advance directives
- Identification of the disciplines involved in providing care
- Any other relevant items, including additions, revisions, and deletions that the home health agency, physician, or allowed practitioner may choose to include

Joint Commission Standard PC.01.03.01, EP 23. The organization revises plans and goals for care, treatment, or services based on the patient's needs.
For home health agencies that elect to use The Joint Commission deemed status option: The revised plan of care reflects current information from the patient's updated comprehensive assessment and the patient's progress toward goals and measurable outcomes.

ATTACHMENTS

Abuse, Neglect, and Exploitation Policy
Assessment and Reassessment Policy

APPROVAL

NAME AND CREDENTIALS **TITLE**	**NAME AND CREDENTIALS** **TITLE**	
SIGNATURE		**DATE**
SIGNATURE		**DATE**

* Text shaded yellow is content that goes above and beyond Joint Commission standards and, therefore, is not specifically required.