CAHC ACCREDITATION MANUAL

PERSONAL CARE SERVICES

AND

IN-HOME SKILLED NURSING SERVICES

Commission on Accreditation for Home Care
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Accreditation Program Overview

Introduction

This manual contains the information needed by home care providers to apply for and maintain accreditation by the Commission on Accreditation for Home Care, Inc. The Commission accredits both Personal Care Services and In-Home Skilled Nursing.

In this manual, the following are used interchangeably:
- Commission on Accreditation for Home Care; CAHC; and the Commission
- Personal Care Services; PCS
- In-Home Skilled Nursing; IHSN.

CAHC’s Mission: The Commission on Accreditation for Home Care seeks to promote the delivery of high quality home care services to the communities in the State of New Jersey:
- by developing standards
- evaluating the implementation of the standards
- accrediting agencies that are in compliance with these standards
- providing industry and consumer education.

CAHC’s Vision: To make CAHC accreditation the standard by which New Jersey home care providers are selected by consumers.

CAHC Accreditation Program

CAHC is a nonprofit, independent accreditation body that operates in the State of New Jersey. Historically, it was founded by the Home Care Council of New Jersey in collaboration with the New Jersey Department of Human Services, the Home Health Assembly of New Jersey, and the Home Health Services and Staffing Association of New Jersey.

The CAHC accreditation program was established in 1986 to meet the growing need for accountability in New Jersey’s rapidly expanding home care industry. The standards for Personal Care Services were implemented at that time. In 1995, the program was expanded to include In-Home Skilled Nursing accreditation.

The Commission is governed by a Board of Trustees that consists of representatives from home care agencies, state government programs, consumers, as well as social service professionals and other relevant professional groups. All decisions regarding the granting or revoking of accreditation are the ultimate responsibility of the Board.
The CAHC staff members assist providers in understanding, achieving, and maintaining compliance with the standards through self-evaluation, consultation, and ongoing educational support. RN field nurse surveyors (surveyors) conduct on-site visits to assess whether the policies, procedures and standards set forth by CAHC are appropriately met by a provider.

**Purpose of CAHC Accreditation**

The purpose of the CAHC accreditation is to ensure that agencies delivering home care services meet established state regulations, industry and best practices guidelines. To achieve this goal, CAHC has developed policies, procedures and standards, known collectively as the accreditation program. CAHC has developed a set of standards for both Personal Care Services and In-Home Skilled Nursing. These standards were developed in collaboration with home care providers and they have undergone field testing and periodic review.
Scope of the Accreditation Program

The scope of the accreditation program includes the geographic area where CAHC accreditation is valid, the type of eligible services, the period of accreditation and the financial costs. The CAHC accreditation program encompasses the contents of the CAHC Accreditation Manual, the signed Memorandum of Agreement, Business Agreement and all CAHC correspondence with the provider.

Geographic

- The jurisdiction of CAHC is the State of New Jersey. For Personal Care Services, the service area for any headquarters/branch office is the geographic area within a fifty (50) mile radius of the office. There is no geographic area restriction for the In-Home Skilled Nursing program.

- For both the PCS and IHSN programs, the service area of a satellite office must remain entirely within the fifty (50) mile service area of its headquarters/branch office.

Types of Services Accredited

- The CAHC accreditation applies to Personal Care Services and/or In-Home Skilled Nursing.

- The accreditation programs for Personal Care Services and In-Home Skilled Nursing are independent of each other. A provider may seek accreditation for one or both services.

- All Personal Care Services and/or In-Home Skilled Nursing are subject to compliance with the accreditation program, regardless of type or source of funding. For example, the surveyor may review both private pay cases, and government funded cases.

- Other services, such as companion, chore worker, baby sitting, transportation, durable medical supplies, laboratory, and therapy services, are not included in the scope of the accreditation program. If these services are provided, they must be marketed and managed separately from the CAHC-accredited Personal Care Services and/or In-Home Skilled Nursing programs. All records pertaining to these services must be clearly labeled and kept separately from the Personal Care Services and/or In-Home Skilled Nursing records. However, the Commission reserves the right to review records to ascertain if services fall under the scope of the CAHC accreditation program.

- A satellite office may only be accredited for those services that are already accredited at its headquarters/branch office.
Only offices that are staffed, deliver patient services and keep personnel and clinical records on site may qualify for accreditation. Recruitment, training and/or in-service sites may not be accredited. However, the Commission reserves the right to survey these sites to ascertain if the activities performed fall under the scope of the CAHC accreditation program.

**Period of Accreditation Approval**

If a provider is determined to be in compliance with the CAHC accreditation program, accreditation is granted for one year. Continued accreditation is contingent on the provider’s ongoing compliance with the accreditation program. Providers are monitored annually to assess compliance or more frequently, if required.

**Fees Charged by CAHC**

As a nonprofit organization, CAHC is supported almost exclusively by the fees generated by the accreditation process. However, payment of applicable fees does not in any way guarantee accreditation.

- All fees and fines are **non-refundable** and are subject to change without prior notice. See attached Fee Schedule.
- The initial application fee and initial processing fee cover the cost of processing the application, including the on-site visit. An additional fee is charged for a revisit, if needed.
- The annual monitoring fee covers the costs associated with the ongoing maintenance of the provider’s accreditation and the monitoring of compliance, including the on-site visit. An additional fee is charged for both announced and unannounced follow-up visits, if needed and in special situations, such as an extension of a site visit.
- Fees may be charged for additional items and services, such as marketing materials, continuing education workshops and copies of the CAHC Accreditation Manual.
- A fee will be incurred when a provider appeals a denial of or revocation of accreditation.

In selected circumstances, CAHC reserves the right to require additional fees related to costs incurred by the Commission. The provider is expected to pay all fees within the time frame specified by CAHC. Also, the provider is expected to submit all required materials to CAHC within the specified time frame. Failure to meet the deadline for the payment of fees or for the submission of documentation may result in the imposition of fines and interest, and may ultimately result in the termination or revocation of the provider’s accreditation.
ACCREDITATION FEE SCHEDULES

All fees are based on service hours provided in the past 12 month period.

To calculate fee for each site:
- Personal Care Services (PCS) accreditation only – use Fee Table 1.
- In-Home Skilled Nursing (IHSN) services accreditation only – use Fee Table 2 on next page.
- Dual accreditation – fee depends upon which service is the primary service as defined by CAHC:
  - PCS is the primary service – use Fee Table 1 below
  - IHSN is the primary service – use Fee Table 2 on next page

### Fee Table 1 – Initial Accreditation/Monitoring

**Step 1 – Find the PCS Fee**

<table>
<thead>
<tr>
<th>Total Hours of PCS Service</th>
<th>Fee</th>
<th>Total Hours of PCS Service</th>
<th>Fee</th>
<th>Total Hours of PCS Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30,000</td>
<td>$1,971.20</td>
<td>500,000 - 549,999</td>
<td>$3,942.40</td>
<td>Under 10,000</td>
<td>$739.20</td>
</tr>
<tr>
<td>30,000 - 54,999</td>
<td>$2,340.80</td>
<td>550,000 - 599,999</td>
<td>$4,065.60</td>
<td>10,000 - 19,999</td>
<td>$985.60</td>
</tr>
<tr>
<td>55,000 - 99,999</td>
<td>$2,710.40</td>
<td>600,000 - 649,999</td>
<td>$4,188.80</td>
<td>20,000 - 29,999</td>
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<td>100,000 - 149,999</td>
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<td>650,000 - 699,999</td>
<td>$4,312.00</td>
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<td>150,000 - 199,999</td>
<td>$3,080.00</td>
<td>700,000 - 749,999</td>
<td>$4,435.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200,000 - 249,999</td>
<td>$3,203.20</td>
<td>750,000 - 799,999</td>
<td>$4,558.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>250,000 - 299,999</td>
<td>$3,326.40</td>
<td>800,000 - 849,999</td>
<td>$4,681.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300,000 - 349,999</td>
<td>$3,449.60</td>
<td>850,000 - 899,999</td>
<td>$4,804.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>350,000 - 399,999</td>
<td>$3,572.80</td>
<td>900,000 - 949,999</td>
<td>$4,928.00</td>
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<td>$3,696.00</td>
<td>950,000 - 999,999</td>
<td>$5,051.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>450,000 - 499,999</td>
<td>$3,819.20</td>
<td>1,000,000 +</td>
<td>$5,174.40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step 2 – For dual accreditation, find the reduced IHSN fee and add it to the PCS fee**

<table>
<thead>
<tr>
<th>Total Hours of IHSN Service</th>
<th>Fee</th>
<th>Total Hours of IHSN Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5,000</td>
<td>$800.80</td>
<td>Under 1,000</td>
<td>$431.20</td>
</tr>
<tr>
<td>5,000 - 9,999</td>
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<td>1,000 - 2,499</td>
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<td>2,500 - 4,999</td>
<td>$677.60</td>
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<tr>
<td>15,000 - 29,999</td>
<td>$1,416.80</td>
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<td></td>
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<td>30,000 - 49,999</td>
<td>$1,601.60</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>75,000 - 99,999</td>
<td>$1,971.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100,000 - 124,999</td>
<td>$2,156.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>125,000 - 149,999</td>
<td>$2,340.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>150,000 +</td>
<td>$2,710.40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All fees and fines are non-refundable and are subject to change without prior notice.
ACCREDITATION FEE SCHEDULES

All fees are based on service hours provided in the past 12 month period.

**Fee Table 2 – Initial Accreditation and Monitoring**

<table>
<thead>
<tr>
<th>Step 1 – Find the IHSN Fee</th>
<th>Step 2 – For dual accreditation, find the reduced PCS fee and add it to the IHSN fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Each Headquarters/Branch Office</strong></td>
<td><strong>Each Satellite Office</strong></td>
</tr>
<tr>
<td>Total Hours IHSN Service</td>
<td>Fee</td>
</tr>
<tr>
<td>Under 5,000</td>
<td>$1,355.20</td>
</tr>
<tr>
<td>5,000 - 9,999</td>
<td>$1,601.60</td>
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<tr>
<td>10,000 - 14,999</td>
<td>$1,848.00</td>
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<tr>
<td>15,000 - 29,999</td>
<td>$2,094.40</td>
</tr>
<tr>
<td>30,000 - 49,999</td>
<td>$2,340.80</td>
</tr>
<tr>
<td>50,000 - 74,999</td>
<td>$2,587.20</td>
</tr>
<tr>
<td>75,000 - 99,999</td>
<td>$2,833.60</td>
</tr>
<tr>
<td>100,000 - 124,999</td>
<td>$3,080.00</td>
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<tr>
<td>125,000 - 149,999</td>
<td>$3,326.40</td>
</tr>
<tr>
<td>150,000 - 174,999</td>
<td>$3,572.80</td>
</tr>
<tr>
<td>175,000 - 199,999</td>
<td>$3,819.20</td>
</tr>
<tr>
<td>200,000 +</td>
<td>$3,942.40</td>
</tr>
</tbody>
</table>

Other Fees:
- Initial Application Processing Fee – $1,000
- Per Diem Rate – $1,500 per day, per surveyor – ONLY charged for follow-up visits, revisits, and extension of site visits
- Appeal of Denial or Revocation of Accreditation – $1,000
- CAHC Accreditation Manual – $300
- Maintain accreditation (no cases) – $500

*All fees and fines are non-refundable and are subject to change without prior notice.*
**Accreditation Cycles and Deferred Survey Policy**

Each agency will be visited during their regularly scheduled monitoring month. The surveyor will not call to schedule specific dates. Instead, the surveyor will perform the unannounced visit anytime during the scheduled month. The Commission will allow the agency to set aside two ‘black-out’ dates, requesting the CAHC surveyor not conduct the on-site survey on those dates. These dates must be requested at least two weeks prior to the regularly scheduled monitoring month.

For good cause and documented hardship, an agency may petition the Commission to defer its annual survey. Such deferrals will only be approved by the Commission on a one-time basis and for no longer than 30 days. Any charges due for annual accreditation must be paid at the time due, unless an installment plan has been approved. Failure to pay fees when due will result in the survey not being conducted at the newly-scheduled date. The agency’s accreditation may then be subject to termination by the Commission without any right to a hearing.

The agency’s accreditation survey cycle will not change as a result of any survey deferral granted by the Commission. All agencies will receive a survey at the conclusion of the existing accreditation cycle, even if this is 11 months from the date of the deferred annual survey, and there is no deferral of annual accreditation fees due from agencies.

**Accreditation Certificates**

If an agency is determined to be in compliance with the CAHC accreditation program, accreditation is granted for one year. A certificate of accreditation will then be furnished with an effective date and an end date, which will not exceed 13 months.

**Maintaining Accreditation**

At the time of the annual monitoring survey, if the provider has had no cases in the past 12 months, it is possible to continue the accreditation by paying an annual maintenance fee of $500. This is limited to 3 years. If the provider still has not serviced a minimum of one patient for that service, the accreditation will be terminated.

**Discount for Accredited Providers**

CAHC may offer a discount to accredited providers for annual monitoring surveys if:
- the Provider Profile and all other requested documents are submitted to the CAHC office on or before the due date, and
- the annual monitoring fee is paid on or before the due date indicated on the invoice.
Installment Payment Plan

For good cause and demonstrated financial hardship, agencies may request an Installment Plan for payment of fees due to the CAHC. Approval of these requests is discretionary on the part of the Commission, and the installment plan may be authorized for 2-4 months of the date due, in equal payments on a monthly basis. The Commission will charge a 5% processing fee in approving any installment plans, which shall be calculated against the total amount due, and payable immediately upon approval. If the full amount of charges due is not paid at the end of the approved installment plan deadline set by the Commission, the agency’s accreditation, as it is a contractual default, will be terminated without any right by the agency to request a hearing before the CAHC Board of Trustees.

Late or Incomplete Documents/Payments Policy

Initial Late Notice: 1-7 days after due date

A courtesy call and/or written notice by fax, email, or letter will be made by the Commission within 7 days of the due date for any CAHC fee or document that is required to be submitted for accreditation purposes. The notice will remind the agency of the overdue fee or document and confirm that it must be submitted immediately. If the Commission does not receive a response from the agency, and irrespective of whether the agency alleges that it has not received the Initial Late Notice, the Commission continues the notice process in accordance with this Policy.

Final Warning Notice: 8-30 days after due date

Upon failure to submit the required fee or document, CAHC will send a formal Final Warning Notice to the Agency via overnight mail or certified mail, providing a final due date for the fee or document. The Final Warning Notice sets the final due date for submission of all missing documents or fees, which is no later than five (5) business days from the confirmed date of receipt. If this date is not met, the CAHC terminates the Memorandum of Agreement without any right of appeal.

Termination Notice: 31 days past due

In all cases where the fee or required documentation is not received within the final Due Date contained in the Final Warning Notice or 31 days past due, whichever is later, the Commission will terminate the agency’s Memorandum of Agreement with the CAHC. Accreditation of the agency will be terminated as of 5 business days from the date of receipt of the Termination Notice in order to allow for an orderly transfer of patients to other accredited agencies. As a contractual default, there is no right of appeal to the Commission Board of Trustees.
CAHC Authority and Other External Authority

The authority of the Commission lies solely within the scope of the accreditation program. The provider is responsible for being knowledgeable about and complying with all federal, state and local laws and contractual requirements. CAHC accreditation does not guarantee compliance with any other external regulatory program.

CAHC and New Jersey Medicaid and other Government Programs

The Commission on Accreditation for Home Care is an accreditation body recognized by the New Jersey Department of Human Services, Divisions of Disability Services and Medical Assistance and Health Services. CAHC has a contractual agreement with the State (Memorandum of Understanding) that includes the monitoring of selected Medicaid requirements as part of the accreditation process.

The Commission has the obligation to inform the following New Jersey State agencies within the Department of Human Services of the on-site visit results; the accreditation status of all accredited providers; and any other information deemed relevant to the accreditation process:

- Division of Disability Services
- Division of Medical Assistance and Health Services.

In addition, the Commission reserves the right to report to the appropriate local, state or federal agencies or departments any suspected unsafe, irregular or illegal procedures, practices and/or conditions that come to the Commission's attention at any time during the application and/or monitoring process or via a complaint or by any other means, whether or not the issue(s) in question are addressed specifically in the accreditation manual or fall within the scope of the accreditation program.
The Application Process

Once a provider determines that its home care program meets all eligibility requirements in the Standards for a period of at least four months, the provider can begin the application process in one of two ways: traditionally (on paper) or electronically. Please keep in mind the following:

- If using the paper application, please check the date on the cover of the CAHC Application for Accreditation. If the date is more than one year old, call the CAHC office at 201-880-9135 for instructions before beginning the application. In addition, the paper copy must be accompanied by a duplicate of pre-selected portions of the application. Please refer to application booklet for details.
- If applying electronically, as with the original paper version, please be sure to include only the information requested in the application. Do not submit additional materials.
- If the provider is already accredited for one service and is applying for accreditation for a second service for the first time, contact the CAHC office for instructions.
- If the applicant has more than one site applying for accreditation at the same time, contact the CAHC office for instructions.
- The average time from submission of the application to the accreditation decision is approximately 6-12 weeks. This time may vary considerably, however, depending on the completeness of the application, the scheduling and the results of the on-site visit.

Application Review by the Commission Staff

Once CAHC receives the complete application with the original signed Business Agreements and accreditation fees, the CAHC staff conducts an initial review to verify the provider’s eligibility for accreditation and completeness of the application. On average, it takes 2 weeks to complete this process. The required 4 months of CAHC compliance, known as the period of accountability, extends back from the date the application is received at the Commission office.

If the application is incomplete or requires clarification, the staff will request the necessary materials which the provider must submit within a specific time frame. The application is put on hold until all required materials are received. Applications will be retained for a period of one year from whom CAHC has received no follow-up response.

If the provider is ineligible, the provider will be notified in writing and the application is considered to be withdrawn. If the application is withdrawn, either voluntarily or by CAHC, and the provider wishes to pursue accreditation in the future, the full application process begins anew. This includes a new application and another initial application and initial application processing fee.
Application Review by the Surveyor

Once an application has passed the initial CAHC staff review, it is sent to the assigned CAHC surveyor. The surveyor conducts a thorough, detailed review to determine if the information is compliant with CAHC standards. This process usually takes four weeks.

If the surveyor’s review indicates that the application is incomplete or needs clarification, the CAHC staff will request the necessary materials which the provider must submit within a specific time frame. The application is put on hold until all required materials are received. Applications will be retained for a period of up to one year for potential Clients from whom CAHC has received no follow up response to its requests for additional information.

There will be a limit of two reviews of the application. The application will then go through the final review process.

If CAHC has determined that the application should be returned to the provider, an extended period of time for re-examination, correction and resubmission is provided. The reapplication process is identical to the initial application process, including all fees.

Initial On-Site Survey

An on-site survey is scheduled once the staff and surveyor have determined that the application is complete and meets the CAHC standards. The provider is contacted directly to schedule an on-site survey. The CAHC staff will provide the provider with a written schedule for the survey if time permits.

If the provider has more than one office applying for accreditation, on-site surveys must be conducted at all sites.

On-site visits average 1-2 days per site. At the conclusion of the survey, the surveyor will provide an exit conference with the provider’s key personnel. The surveyor presents a general overview of the findings of the survey and the provider is given the opportunity to comment on the findings. A tape recording of this conference is permissible, as long as the surveyor is given notice in advance and a copy of the tape is provided on the same day.

Initial Accreditation Visit Report

After the on-site survey is complete, the surveyor completes a written report summarizing all findings of the application review and the on-site survey. A copy of the initial accreditation visit report is sent to the provider for review and the provider is given a specified time frame to comment, in writing, on the findings. The provider’s written comments are incorporated into the survey report, as long as they are relevant to the
findings as of the day of the survey. Comments that include any actions to be taken after the date of the on-site survey or planned for the future are not included.

Accreditation Review Process

The CAHC Accreditation Review process examines the initial accreditation visit report in its entirety. The visit report, including the incorporated provider comments, undergoes a thorough review and a final decision is made by the Commission. Each site applying for accreditation is considered independently, with the exclusion of a satellite. A satellite will not be granted accreditation if its headquarters/branch office fails to gain accreditation.

The provider receives written notification of the final decision within two weeks after a decision is made.

At any time the provider has the option of withdrawing the application. The on-site visit will be considered an educational visit. However, no fees will be refunded.

Accreditation decision is based on the provider’s compliance with the CAHC standards. The decision will be one of the following:

- Full Accreditation - Full Accreditation indicates that the provider was found in compliance with all five (5) accreditation standards.

- Accreditation with Contingencies - Accreditation with Contingencies indicates that the provider has demonstrated substantial (though not complete) compliance with the accreditation standards. The provider will receive this status if they are found in partial compliance with any of CAHC’s five (5) accreditation standards or if they are found to be in non-compliance with Standards II and/or III. The partial or non-compliant areas must be addressed through the submission of additional documentation, a corrective plan of action and/or a follow-up visit.

- Deferral – Deferral indicates that the provider has not met all the essential requirements (Standard I) and/or there were patterns of non-compliance with the accreditation standards. It may also indicate that there was not enough data available to accurately assess compliance. The non-compliant areas must be corrected prior to CAHC granting accreditation and the provider must meet all eligibility requirements. In these cases, the decision is deferred pending another on-site survey which is called a revisit. During the revisit, the surveyor will reassess, at a minimum, eligibility and compliance in all problem areas noted during the previous on-site survey. A fee is charged for a revisit.

- Denial – If the provider is found to be substantially non-compliant, the Board may deny accreditation. Within 30 days of the denial decision, the provider may request an appeal hearing before the Board of Trustees. If the Commission has not received a
written appeal request within 30 days of notification, the provider forfeits the right to an appeal.

The appeal process consists of the following steps:

- The provider submits a written request for an appeal and a hearing. This letter must address in detail any alleged factual errors in the survey findings and/or conclusions it wishes to contest. Actions taken by the provider after the survey should not be included in the appeal and will not be considered.
- The provider must agree to pay the appeal and hearing fee. Full payment must be received at the CAHC office by the due date set by the Commission.
- The Commission has 30 days to review the appeal request. After that time, the hearing will be scheduled for the next regularly scheduled Board of Trustees meeting.
- The CAHC attorney may be present during the hearing of the Board meeting.
- The provider’s oral presentation to the Board is limited to 15 minutes, followed by questions from the Board. If the provider fails to attend the scheduled hearing, the provider forfeits the right to appeal.
- The provider is excused from the hearing and the Board of Trustees makes a formal decision.
- The Commission will notify the provider in writing of the Board’s decision.

If the Board votes to uphold its denial decision, the provider may reapply for accreditation six months after the original denial decision. The reapplication process is identical to the initial application process, including all fees.

Newly Accredited Providers

The Commission notifies the appropriate New Jersey State departments, in writing, of all newly accredited providers within one week of the final decision. Newly accredited providers are mailed an accreditation certificate and marketing materials. If necessary, a follow-up visit, plan of correction and/or documentation is to be submitted within the required time frame.

The provider needs to contact the New Jersey Division of Medical Assistance & Health Services (Medicaid) directly to obtain an application for purposes of having a Medicaid fee-for-service provider number assigned once accreditation is granted by the Commission. This is a separate process and accreditation does not guarantee participation in any government program or insurance plan.

Additionally, as of July 1, 2011 with the start-up of Medicaid’s mandatory managed care initiative, any agency wanting to become a managed care provider of the Medicaid services of Personal Care Assistant (PCA which in CAHC terminology is Personal Care Services) and/or Private-Duty Nursing (PDN which in CAHC terminology is IHSN) under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is required to enter into individual contacts with each State contracted Health Maintenance
Organization (HMO). Again, these are separate processes and accreditation does not guarantee participation in any government program or insurance plan.

**Board of Trustees Notification**

At its next scheduled meeting, the Board of Trustees will be advised of those providers receiving accreditation and is given the opportunity to review the newly accredited provider application and related documentation and discuss further action if needed.
Provider Responsibilities

Memorandum of Agreement

As part of the accreditation process, the provider signs a Memorandum of Agreement with the Commission that is in effect for the duration of the accreditation. In part, the Memorandum of Agreement stipulates that the provider will conduct the operation of the agency and the delivery of services in accordance with all applicable federal, state and local laws and contractual requirements.

Accurate and Truthful Information

The accreditation process and the accreditation decisions rely on the accurate and truthful information and documentation furnished by the provider. It is the provider’s responsibility if misleading or falsified information is given. In addition, the Commission expects the provider to participate in the accreditation process in good faith by completely and accurately portraying the agency operation and delivery of services. Failure to do so may lead to denial of or revocation of accreditation. This includes omitting pertinent or required information and/or providing misleading or false information relevant to accreditation.

Notifying CAHC of Changes

The provider is responsible for notifying the Commission at least 30 days in advance of any of the following changes or of any other relevant changes that would affect the integrity of the provider’s program operations:

- A change in key personnel, such as the administrator or the Director of Nursing
- The provider accepts patients and/or personnel from another agency that has closed or downsized
- An office moves
- An office closes
- Acquisition of the provider by another entity
- Merger of the provider with another entity
- Change in the provider’s agency name.

The Commission reserves the right to conduct an on-site visit to assess ongoing compliance following these changes or require an acquiring entity that is not previously accredited to file a new application. See section “Transferring and Extending Accreditation.”
Updates to Policies, Procedures and Standards

The Commission continuously evaluates and updates its accreditation program. When changes are made, accredited providers will receive written notification and the time frame required to comply with the changes.

One set of updates to the CAHC Accreditation Manual will be sent for each original manual sent to the provider. The provider is responsible for ensuring that all manuals are kept up-to-date.

Designating Responsibility for Functions of Supervisory Personnel

The Director of Nursing and/or Nursing Supervisor may designate another RN to be responsible for specific personnel and/or case management functions, assuming that, in the professional judgment of the Director of Nursing and/or Nursing Supervisor, such designation is appropriate and safe.

Unless noted otherwise, references in the Standards stating that the Director of Nursing and/or Nursing Supervisor must perform certain personnel and/or case management functions, assume that a designated RN may also perform the functions.

Determining Safe Time Frames for Personnel and Case Management Functions

The Director of Nursing and/or Nursing Supervisor responsible for specific personnel and/or case management functions must use professional judgment to determine, on a case-by-case basis, if the time frame specified in the Standards for that function is safe and appropriate. That is, the Director of Nursing and/or Nursing Supervisor may judge that an activity or task needs to be done earlier or more frequently than required by the Standards.

Example:

For a specific patient, the Nursing Supervisor’s professional judgment may be that it is unsafe to wait 60 days for a case monitoring visit. (Refer to Standard V, Intent 16.)
Assessing Compliance

The CAHC accreditation program encompasses the contents of the CAHC Accreditation Manual, the signed Memorandum of Agreement and all CAHC correspondence with the provider. The Commission has the authority to assess whether the provider’s agency operation and documentation comply with the CAHC accreditation program requirements.

In order to obtain or maintain accreditation, a provider must comply with the CAHC standards. The period of accountability in any given review period is defined by the Commission. The burden of proof of compliance rests with the provider. All administrative and service components of the provider’s operation are subject to CAHC review in order to evaluate compliance. CAHC also reserves the right to ensure that all services that appropriately fall under CAHC accreditation are followed according to the standards.

Methods for Assessing Compliance

The methods used to assess compliance with CAHC’s accreditation program may include, but are not limited to:

- Review of a sample of the provider’s operations, policies, procedures, contracts and any other relevant materials

- Interviews with staff members, such as aides, field nurses, coordinators and nursing supervisors

- Interviews with patients and/or family members of patients

- On-site observations by the surveyor

- Review of a random sample of personnel and clinical records

- Written and verbal communication with the provider

- Review of any other information relevant to the delivery of service, such as time sheets, billing records, etc.

The provider must grant CAHC full access to all documentation, materials and staff in order to evaluate compliance with the accreditation program requirements. CAHC reserves the right to inspect and evaluate a provider’s records that the provider asserts is outside the scope of CAHC accreditation in order to verify the provider’s claim of non-applicability.
When a provider's policies, procedures, job descriptions or contractual requirements exceed CAHC standards, the provider will be evaluated in accordance with their own policies or contract.

The surveyor will randomly select personnel and clinical records for review. The surveyor may also request other relevant items in order to cross-check information, such as payroll records or confidential health information.

The surveyor will randomly select staff and patients to interview in order to verify compliance with the standards. CAHC may utilize an interpreting service for these interviews. The interviews shall be conducted in a private area without supervisory staff being present. The Commission also reserves the right to make home visits to interview patients and/or field staff.

The surveyor will observe the physical location of the site to evaluate such areas as the adequacy of the space for competency testing and in-service and/or training programs. Also, the equipment and materials for competency testing will be inspected, as well as the personal protective equipment that is available for field staff.

The purpose of the on-site visit by the surveyor is primarily to assess compliance with the CAHC accreditation program requirements in order to determine an accreditation status. The purpose of the CAHC survey is not to assess the appropriateness of service provision to any specific patient and it is not to verify the provider’s compliance with all applicable laws, regulations and contractual requirements. However, concerns that are identified in these areas may be reported to government agencies.

**Determination of Accreditation**

Accreditation status is based on the extent of compliance with the Commission’s Standards.

**The components for determining accreditation status:**

The process of assigning the accreditation status involves survey visit results, and consideration of other factors/circumstances and input by the Commission staff and Board.

RN field nurse surveyor(s) visits the agency. The information obtained during the survey forms the basis for the accreditation status determination. The surveyor evaluates compliance with the Standards by a variety of methods, which may include documentation reviews, interviews and physical observation. Please refer to details of Assessing Compliance on pages 13 and 14.
Circumstances and factors in determining a provider’s accreditation status:

There are factors that the Commission must consider which may affect a provider’s accreditation status.

These additional circumstances and factors may be considered as sufficient evidence to warrant such action as a probationary or denial status. These include, but are not limited to, the following:

- The history of the provider’s accreditation status shows a pattern of non-compliance or partial compliance, including, but not limited to the following:
  - the submitted corrective plan(s) of action required repeated revisions or they were not implemented effectively based on the result of one or more CAHC survey visits
  - the agency was on Probation previously
  - the particular standard or intent(s) cited in the current survey were non-compliant or in partial compliance on a repeated basis.

- A provider’s non-compliance with CAHC standards or intents has resulted in significant actual harm to one or more patients, or caused immediate jeopardy or risk of serious injury or death to a patient.

- The number of intents that are non-compliant or in partial compliance are substantial and widespread, representing a pattern of poor performance that indicates the provider is not capable of maintaining substantial compliance with the CAHC Accreditation Standards to the extent that it places patients’ safety at risk.

- CAHC has been notified that the agency has had one or more of the following actions taken against it: a) its New Jersey Medicaid provider agreement has been terminated or a notice of termination issued; b) its participation in the Personal Care Assistance Program has been terminated or proposed to be terminated by the Division of Disability Services; c) its Medicaid managed care plan participation agreements are terminated for cause; d) the NJ Division of Consumer Affairs has issued a notice of revocation of the agency’s Health Care Service Firm license or issued other serious enforcement actions for failing to meet regulatory standards of care; or e) a local, state or federal agency has conducted an investigation of the agency for potential fraud, abuse, or criminal activity, resulting in civil or criminal enforcement actions being imposed.

- The Provider has undergone repeated changes in key personnel, such as the Administrator or Director of Nursing, or has had a prolonged vacancy in such key positions which affects the quality of patient care.

- Patients or the provider’s employees have submitted a significant number of complaints that reasonably appear valid and represent a substantial likelihood of non-compliance with one or more Class 1 intents under Standards IV and V.
• A state regulatory or investigative agency has taken enforcement action against the provider for non-compliance with applicable regulations or statutory requirements.

**Final accreditation status:**

Once there has been a review of the survey report and any additional circumstances, a final accreditation status is assigned and a letter is sent to the agency about the accreditation status decision. This letter may also include requests for information, documentation and/or corrective plans of action that are to be submitted to the Commission within a specific time frame.

The documentation, information and/or corrective plans of action will be reviewed by the Commission staff. Additional requests may be made by letter for further information or clarification. If corrective plans are not accepted by the Commission, there may be a request for resubmission.

A decision made by the Commission based on the submitted documents and information may lead to a modification of the accreditation status. This may include an upgrading or downgrading of the accreditation status.

Reports of agencies at risk for revocation are brought to the Accreditation Review Committee for review and a final decision will be made at that time.

**Definition of each accreditation status:**

• **Pending:** Pending indicates that the provider has failed to meet the requirements set forth in Standard I or there is incomplete information in Standards II-V. The accreditation status will remain pending until the issue is corrected or additional information provided.

• **Full Accreditation:** Full Accreditation indicates that the provider was found in compliance with all five (5) accreditation standards.

• **Full Accreditation with Distinction:** Full Accreditation with Distinction is awarded when the provider has achieved Full Accreditation for a minimum of two consecutive annual monitoring surveys.

• **Accreditation with Contingencies:** Accreditation with Contingencies indicates that the provider has demonstrated substantial (though not complete) compliance with the accreditation standards. The provider will receive this status if they are found in partial compliance with any of CAHC’s five (5) accreditation standards or if they are found to be in non-compliance with Standards II and/or III. The partial or non-
compliant areas must be addressed through the submission of additional documentation, a corrective plan of action and/or a follow-up visit.

- **Conditional Accreditation**: Conditional Accreditation indicates that CAHC has temporarily extended or transferred an accreditation for a period of no longer than 6 months. Please refer to Transferring and Extending Accreditation on page 22-23.

- **Probation**: Probation indicates that the provider has demonstrated a pattern of non-compliance with the accreditation standards. The provider will receive this status if they are found to be in non-compliance with Standard IV and/or Standard V. The non-compliant areas must be addressed through the submission of additional documentation, a corrective plan of action and/or a follow-up visit.
The Monitoring Process

In order to maintain accreditation, all accredited sites must undergo an annual monitoring visit. The Commission reserves the right to conduct follow-up visits and additional monitoring visits in special situations. These visits may be announced or unannounced and a fee is charged.

The On-Site Survey

After the initial accreditation is granted, on-site visits are done annually by surveyors. More frequent surveys may be done for other reasons, such as follow-up after an initial or annual survey, follow-up after a complaint to the Commission, a special survey, or follow-up visits after an unsatisfactory survey.

The provider is responsible for submitting updated statistics to the Commission, from which the accreditation fee is based. If the provider has had no cases in the past 12 months, it is possible to continue accreditation by paying an annual maintenance fee. If the provider subsequently receives an active case, the Commission must be notified so that a site visit can be scheduled; a fee will be charged for the visit. The New Jersey Department of Human Services (Division of Disability Services and Division of Medical Assistance & Health Services) will be notified of the agency status.

If the provider has more than one accredited site, on-site surveys will be conducted at each site with a separate monitoring fee for each site.

Survey visits average 1-2 days on-site. The surveyor will assess the provider’s ongoing compliance with the CAHC standards according to the methods described in the above section. At the end of the survey, the surveyor will hold an exit conference with the provider’s key personnel and present a general overview of the findings. The provider is given the opportunity to comment on the findings. A tape recording of the exit interview is permissible, as long as the surveyor is given notice in advance and a copy of the tape is provided on the same day.

There may be certain situations in which an exit conference may not be conducted, such as the investigation of a complaint, or hostile circumstances. It is at the surveyor’s discretion to determine if the exit conference will be held.

Language

All information, documentation and records relevant to accreditation must be in English in order for the surveyor to evaluate them. The only exceptions are advertising materials and materials distributed to the patient. In these cases, the surveyor must have access to an English translation or an interpreter.
Access to Information

All information, documentation and records relevant to accreditation must be on-site and readily available and accessible to the surveyor. Information maintained on a computer must be available in hard copy form or agency personnel must be available to retrieve the information from the computer.

At any given time, a person in authority who can answer questions and provide necessary information must be available in person or by phone. The current organizational chart should reflect this chain of responsibility.

The Commission reserves the right to visit any additional site maintained by the provider, such as a recruitment office or an in-service/training site, in order to evaluate compliance with the CAHC standards.

Surveyor Authority

Surveyors are representatives of CAHC and they have the authority to assess whether or not the provider’s documentation and materials comply with CAHC standards. It is expected that the surveyors will be treated in a professional manner by all provider staff. While the provider may communicate differences to the surveyor, rude or abusive behavior is never appropriate. If a surveyor faces any inappropriate behavior, the survey will be immediately terminated. After a satisfactory resolution, a follow-up visit will be scheduled at the provider’s expense. At any time, the provider may voice concerns regarding the surveyor’s findings, interpretations or professional conduct by contacting the Commission office directly.

All surveyors have photo identification. The provider has the right to inspect the ID and refuse admission to the site if a valid photo ID is not produced.

Extension of Site Visit

The surveyor may find it necessary to extend a site visit beyond the original time estimate. If CAHC determines that this extension is the result of actions on the part of the provider, the provider will be invoiced a per diem fee for the additional time required. Situations that may require an extended visit include, but are not limited to:

- The surveyor was not granted timely and full access to all information, documentation, records and/or personnel needed to perform the survey.
- The provider did not ensure that a person in authority was available on-site or by phone during the site visit.
- The personnel or clinical records were not organized in a standardized fashion or documentation was available, but not filed in the records.
Accreditation Decision

After the on-site survey is concluded, the surveyor completes a written report, summarizing the findings according to each Standard and Intent. The report reviewed by the Commission staff before an accreditation status is determined. Based on this determination, a follow-up visit, a corrective plan of action and/or additional documentation may be requested. The provider will be notified in writing of all visit results.

The provider’s accreditation status will fall into one of the following categories:

- Pending
- Full Accreditation
- Full Accreditation with Distinction
- Accreditation with Contingencies
- Conditional
- Probation

Please refer to pages 16-17 for the definition of each accreditation status.

Provider Comments

A copy of the monitoring report is sent to the provider. If the provider disagrees with or wishes to clarify the surveyor’s findings, written documentation must be submitted to support this position. The Commission will review the documentation and make a decision as to whether or not the provider’s accreditation status will be changed.

Follow-Up Visits

A follow-up visit may be scheduled for a number of reasons including, but not limited to:

- The Commission determines that the provider has not demonstrated full compliance with one or more aspects of the CAHC accreditation program requirements.
- The Commission wants to verify that the provider’s corrective plan of action has been effectively implemented.
- The provider states that a disparity exists between the surveyor’s findings and the actual condition of the agency.
- The previous on-site survey left unresolved questions regarding the provider’s compliance.
- The Commission received a complaint from an outside source that indicates the provider may be noncompliant with CAHC standards.
Follow-up visits may be announced or unannounced and a fee is charged. The exception to this fee policy is in the case when a follow-up visit is initiated by the Commission as a random “spot check” for quality improvement purposes.
Transferring and Extending Accreditation

A CAHC-accredited provider may request that accreditation be transferred or extended to another site, if certain conditions are met. This request must be in writing at least 30 days in advance.

Transferring accreditation may occur if a CAHC-accredited provider either sells the assets of the agency or merges with another agency. The new owner may or may not be a CAHC-accredited agency. Since the Memorandum of Agreement with the Commission was signed under the original ownership, the contract is void once the agency changes ownership. In order for CAHC accreditation to continue, a new Memorandum of Agreement must be executed between the Commission and the new owner/entity. However, CAHC reserves the right to establish the terms under which a new Memorandum of Agreement will be carried out with the new ownership. These terms include, but are not limited to:

- The original CAHC-accredited agency must be in good standing or the acquiring agency must agree to be responsible for ensuring the original agency will achieve full compliance within 90 days or other period as specified by the Commission. If the new agency is also CAHC-accredited, that agency must be in good standing. Good standing includes, but is not limited to: all fees paid in full, all requested documentation submitted on time and an accreditation status of distinction, full, or accreditation with contingencies with no follow-up visit required.

- The accreditation may only be transferred for the same service that is already accredited.

- The new entity has or will obtain upon closing of the transaction, an accurate, current, valid Health Care Service Firm license issued by the New Jersey Division of Consumer Affairs.

- The new entity operates under the same policies and procedures as the CAHC-accredited site.

- The new entity agrees to the terms of the Memorandum of Agreement.

- There is a qualified Director of Nursing.

- Any other conditions required by CAHC.
Extending accreditation may occur if a CAHC-accredited provider wants to extend its existing accreditation to another site. The Commission assumes that if a provider’s home care program operates in compliance with CAHC standards at the accredited site, the provider has the knowledge and experience to do so at another site. The conditions for extension include, but are not limited to:

- The agency must be in good standing at all of their accredited sites. Good standing includes, but is not limited to: all fees paid in full, all requested documentation submitted on time and an accreditation status of distinction, full, or accreditation with contingencies with no follow-up visit required.

- The accreditation may only be extended for the same service that is already accredited.

- The new site has an accurate, current, valid Health Care Service Firm license issued by the New Jersey Division of Consumer Affairs.

- The new site operates under the same policies and procedures as the CAHC-accredited site.

- The new site must agree to follow all of the terms of the Memorandum of Agreement.

- There is a qualified Director of Nursing.

- Any other conditions required by CAHC.

The Commission may grant a transfer or extension of “conditional” accreditation if all of the above conditions are met. The “conditional” accreditation is valid for no longer than six months. Within this six-month period, a field surveyor will conduct an on-site visit to assess the site’s compliance with the CAHC accreditation program and a fee will be charged. Based on the results of this visit, an accreditation decision is made.

**Voluntary Withdrawal from the Accreditation Program**

A CAHC-accredited provider may decide to voluntarily withdraw from the accreditation program by submitting written notification along with the accreditation certificate to the Commission office. All appropriate New Jersey state departments and the CAHC Board of Trustees will be informed of the provider’s withdrawal.
**Revoking or Terminating Accreditation**

The Board of Trustees may revoke an agency’s accreditation in situations such as, but not limited to, the following:

- The provider’s accreditation status is determined to be Probation and the provider has not made the required corrections in the defined time frame.
- The provider has demonstrated unsafe service delivery practices which the Commission has determined is causing immediate and serious threats to patient safety, such that its continued accreditation may put patients at risk. For example, skilled nursing cases are staffed by field nurses who do not have documentation of appropriate licensure or documentation of competency in the relevant areas.

The provider is informed in writing of the Board of Trustee’s decision to revoke accreditation and all appropriate governmental entities are notified of the revocation decision, pending the provider’s right to appeal the decision. Within 30 days of the date of the revocation letter, the provider may request, in writing, an appeal hearing before the Board. The provider’s accreditation remains in effect pending the completion of the hearing process unless suspended for good cause.

If the Commission has not received a written request for an appeal within 30 days, the provider forfeits the right to appeal. In this case, accreditation revocation is effective immediately and all appropriate governmental entities are notified of the effective date of the revocation.

In cases involving immediate and serious threats to patient safety, the Board may reduce the notice period at its sole discretion.

The appeal process consists of the following steps:

- Within 30 days of the revocation decision, CAHC must receive from the provider:
  - A written request for an appeal and a hearing before the Board of Trustees.
  - Written documentation that details any alleged factual errors in the Commission’s findings and/or conclusions with which it disagrees.
  - If the provider wishes the Trustees to review documentation prior to the scheduled Board meeting, the provider must submit the appropriate number of copies for all Trustees and allow sufficient time for mailing and review by the Board members.
- The provider must agree to pay the appeal and hearing fee. Full payment must be received at the CAHC office by the due date set by the Commission.
- The CAHC attorney will be present during the appeal and hearing of the Board meeting.
- The provider may attend the Board of Trustees hearing with any persons they wish to be present, including representation by counsel. However, one week in advance of the meeting, CAHC must be notified of the names and titles of all persons attending the hearing.
- The provider’s oral presentation to the Board is limited to 15 minutes, followed by questions from the Board.
- The provider will be notified if the appeal and hearing will be taped and must grant permission.
- If the provider fails to attend the scheduled appeal and hearing, the provider forfeits the right to appeal and accreditation is revoked.
- After the provider’s presentation and exit from the meeting, the Board will hold a formal vote and decide to either:
  - uphold the original revocation decision or
  - void the original revocation decision, pending a resurvey.
- The provider is informed in writing of the Board’s decision. All relevant governmental entities are notified of the results of the appeal and the Board of Trustee’s decision.
- If the provider’s accreditation is revoked, the decision of the Board is final and not subject to further appeal hearings. The provider may reapply for accreditation one year after the original revocation decision date.

**Terminating Accreditation**

The Board of Trustees may terminate an agency’s accreditation in situations such as, but not limited to, the following:

- The provider has violated the terms of the Memorandum of Agreement with CAHC.
- The provider has not paid its full fees or fines in the defined time frame.
- The provider has not submitted acceptable documentation as requested by CAHC in the defined time frame.

In these situations where accreditation is terminated because of contractual or other reasons not based on an accreditation decision, the provider does not have the right to an appeal.
Performance Improvement, Grievances and Complaints

The Commission on Accreditation for Home Care has a Performance Improvement (PI) program to monitor the quality of services provided. This includes, but is not limited to, a Performance Improvement Committee of the Board of Trustees.

As part of the PI program, CAHC has a formal complaint process. Home care consumers, health care professionals, provider employees, the general public and others may report a complaint to the Commission by telephone or in writing. In order for CAHC to investigate the complaint, certain information is required. The name, address and phone number of the complainant is necessary because anonymous complaints will not be accepted. CAHC will treat the complainant’s identity as confidential information, however, it may be necessary to share this information in the course of the investigation, such as when requested by another regulatory authority or under subpoena. The complaint will be investigated within the jurisdiction and scope of the CAHC accreditation program. CAHC reserves the right to notify the appropriate regulatory body if the complaint falls outside the scope of accreditation, such as allegations of fraud or abuse. A quarterly report of complaints and actions taken will be submitted to the CAHC Board of Trustees.

The Commission requires a provider to have an internal grievance procedure for complaints made by their patients and/or significant others. After that process is exhausted, CAHC will address the grievance or refer it to the appropriate outside entity, if indicated.

Consumer Satisfaction Survey

The New Jersey Division of Disability Services and the New Jersey Division of Medical Assistance and Health Services mandate that an accreditation body conduct periodic formal consumer satisfaction surveys. In addition to this requirement for Medicaid patients, the Commission may conduct a consumer satisfaction survey for patients from all payer sources, including private pay.

The consumer satisfaction survey is available in several languages in addition to English. It is sent directly from and returned to the office of the Commission on Accreditation for Home Care. The aggregate results of an agency’s survey are shared with the specific provider and the above state agencies.

The Commission reserves the right to conduct more frequent consumer satisfaction surveys or to change the manner in which the surveys are conducted in order to obtain relevant feedback about accredited providers’ delivery of home care services.
Response to Serious Adverse Events Policy

**Purpose:** To establish guidelines for agencies to report, analyze and manage serious adverse events to enhance the delivery of safe care to patients and reduce preventable serious adverse events.

**Provider’s Policies:** Providers are required in their risk management policies (Standard III, Intent 7) to define serious adverse events and specify how these events are identified, reported and managed.

**Definition:** The event is:

- Unexpected
- Involves serious physical or psychological injury or death that is not related to the natural course of a patient’s condition or disease
- Requires immediate investigation and a response.

**Examples** include, but are not limited to:

- Unexpected patient death and serious bodily harm requiring a 911 call
- Disability or permanent loss of function associated with a medication error
- Criminal acts or potentially criminal acts that pose a danger to the safety of patients, employees or members of the public, such as homicide, rape, assault, impersonation of a health care worker
- Patient falls, while on service, that result in the death, disability or permanent loss of function
- Suicide of a patient in a home setting.

**Reporting of Serious Events to CAHC by Providers:**

Reporting of serious adverse events by providers to CAHC is voluntary. Early reporting provides an opportunity to the provider to obtain guidance from CAHC in managing the event. It also assists CAHC in its efforts to increase patient safety. Hence, it helps to prevent other events by tracking and maintaining aggregate data on these events.

If CAHC thinks there is immediate or ongoing threat to the safety of patients or employees of the provider, CAHC can make a survey monitoring visit. There will be an associated charge for this visit.

**Procedure for Reporting:**

A report form is available to providers by contacting the CAHC office. Once an event is reported to CAHC, the provider has 30-60 days to submit to CAHC an in-depth root cause analysis of the event. This analysis must focus on systems and processes of the provider, not on individuals. The report shall not identify any patient or employee names. Also, the analysis is to include the following:
• The causes of the incident, including whether they are clinical, organizational, staff-related or external
• A focus on the “why” question, including whether it was avoidable or unavoidable
• An evaluation of whether other patients were or could have been negatively harmed by the cause of the adverse incident
• An analysis of the systems and processes in place and an identification of the changes that could be made through revising current systems and policies or developing new systems and policies
• The identification of risk factors and their contributions to this type of event
• The analysis must be thorough, credible and must include participation by the leadership of the company, as well as the individuals most closely involved in the policies under review.

Along with the root cause analysis, CAHC will require an action plan that identifies strategies for change that have been identified in the root cause analysis. Included in the action plan are:

• The person(s) responsible for implementing the plan
• A time frame for the implementation
• Details of how the effectiveness of the plan will be evaluated.

If CAHC becomes aware of a serious adverse event from other sources, such as employees, patients, families, media or from a survey, the provider will be contacted and required to submit an in-depth root cause analysis and action plan within 30 to 60 days of the CAHC notification.

If CAHC thinks there is an immediate or ongoing threat to the safety of patients or employees of the provider, CAHC can make a survey monitoring visit. There will be an associated charge for this visit.

**Follow-Up Procedures by CAHC:**

1. If the root cause analysis and plan of action are acceptable:

   Once CAHC has received a timely submission of the root cause analysis and plan of action, the Accreditation Review Committee will make a determination of whether or not the analysis and plan are acceptable. If so, the provider will be sent a letter about the continuation or change in accreditation status based on the event and the documentation received. Follow-up activity in six (6) months may include submission of a written progress report or a follow-up monitoring visit, depending on the determination of the Commission. There will be an associated charge for this visit.

   In addition, the provider will submit documentation for the next Accreditation Review Committee meeting or sooner, if necessary. The committee will review the documentation to determine compliance with the plan of action.
2. If the root cause analysis and plan of action are not acceptable:

If the analysis and action plan are not deemed acceptable by the Commission, the provider will be contacted and given guidance regarding the areas for revision. A revised analysis and plan of action will be required in fourteen (14) days from the time of the CAHC notification.

If the provider does not submit the required in-depth analysis and action plan within the assigned time frame, the provider will be given an additional opportunity to submit the documentation within thirty (30) days.

If the provider’s response is not acceptable to CAHC, the information goes to the Accreditation Review Committee for a decision about whether or not to continue accreditation.

A follow-up survey may be conducted, if determined by CAHC. There will be an associated charge for this visit.

**Confidentiality of Documentation:**

Analysis of serious adverse events and corrective plans of action submitted by providers will be maintained by CAHC until the resolution to the Commission’s satisfaction and then they will be destroyed or returned to the provider.
Additional CAHC Policies

Provider’s Confidentiality

Information obtained by the Commission in the application or monitoring process, including but not limited to survey results findings, actions required and recommendations, are given to the provider and to the relevant governmental entities. (Please note that the New Jersey Open Public Records Act allows the public to request state records.)

CAHC may release the following information to the public verbally, in writing, by telephone, via the CAHC website or via any additional method: 1) provider’s legal business name and d/b/a (doing business as), 2) address, phone and fax numbers, website, email address, 3) services accredited and dates of accreditation, 4) whether the provider’s accreditation is in “good standing” or “under review”, and 5) dates of the last CAHC survey.

“Good Standing” means that the provider is in substantial compliance with all Commission standards and is not on probationary status. “Under review” means the provider is either on probation due to significant levels of provider non-compliance or other reasons, or that the Commission has taken action to revoke a provider’s accreditation, but this action is pending because the appeal is in process or because the period of time in which to file an appeal has not expired yet. Consumers seeking names of accredited agencies for referral purposes will not be provided with the names of providers who are under review. In addition, consumers requesting information about providers under review will be directed to request further information from the provider.

The Commission may release any information obtained through the application or monitoring process as required by law, under subpoena, upon receipt of a complaint, when there are findings of actual or suspected fraud or findings of violations of local, state or federal regulations or laws. Upon written request, copies of CAHC survey reports and correspondence related to the accreditation status will be released to governmental agencies with regulatory or legal jurisdiction over the agency or to managed care organizations contracted with an agency for compliance or quality monitoring purposes.

Agencies that are in the application review process and agencies in the enforcement or revocation process are assigned an identification number by the Commission. The provider’s name or other identifying information is not disclosed because only this identification number is used in all reports and in all discussions with the Accreditation Review Committee and the Board of Trustees.

In addition, all references to location, persons and any other information that may identify the provider are deleted from any reports, lists, correspondence, etc. prior to Committee and Board review. This ensures that the provider is treated fairly throughout the application or revocation review process. However, the provider voluntarily forfeits the right to confidentiality during the optional appeal hearing process.
It is understood that the Commission may obtain official records and reports of public or publicly-organized licensing, examining and reviewing bodies.

Compliance with federal HIPAA regulations requires that the Commission keep all personally-identifiable health information obtained during the application and survey process confidential. Upon release of such information, except upon court order, patient names and identifying information will be redacted from the copies that are being released.

**Provider Documentation in Personnel/Clinical Records**

All documentation must be filed in an orderly and timely manner. All documentation must be clearly written and legible.

The purpose of a signature is to verify that the person signing has accepted responsibility for the contents of the document or record. When a signature is required, it must include the first initial, complete last name and credentialing title. A signature stamp is not acceptable. Electronic signatures are acceptable.

It is not acceptable to use correction fluid, to write over or to erase errors in the records or other documentation. The provider must define in policy the procedure for staff to follow to correct errors in documentation.

Documentation of phone calls related to fulfilling the standards must include the following, at minimum:

- Date and time of the call
- Name and signature of the staff person making the call
- Name of the person contacted
- Summary of the conversation.
Additional Services

Certificate

The Commission furnishes a separate certificate of accreditation for Personal Care Services (PCS) and/or In-Home Skilled Nursing (IHSN). The certificate may be copied if the word “COPY” is clearly and conspicuously written or stamped across the face of the copy. Certificates remain the property of the Commission and must be returned upon request.

Accredited Providers List

The Commission encourages consumers to use CAHC-accredited providers. Upon request, the Commission will provide the public with a list of CAHC-accredited providers in good standing for the county requested. This information is also available on CAHC’s website: www.cahcnj.org

Marketing Materials

Once accredited, the provider will receive an accreditation seal and a photostatic copy of the CAHC logo. These may be used on brochures or other marketing materials. The provider must accurately portray the accredited service(s) in all advertising, including brochures, website, business cards, stationery, etc. Also, the Commission has a sample press release that will be furnished upon request.

Note that the Commission reserves the right to determine how the CAHC logo, accreditation seal, accreditation certificate and other references to the Commission shall be used by the provider.

If the provider’s accreditation is revoked, terminated or voluntarily withdrawn, the CAHC logo and all references to CAHC must be removed from all of the provider’s marketing and advertising materials, business cards, websites, stationery, etc. and related materials.

Educational Activities

The Commission periodically conducts and/or co-sponsors workshops on educational topics pertinent to the delivery of home care and the accreditation program.
(Page number 33 reserved for future updates.)
ACCREDITATION STANDARDS LIST

I. THE PROVIDER SHALL HAVE LEGAL AUTHORITY TO OPERATE AND SHALL MEET COMMISSION ELIGIBILITY REQUIREMENTS.

II. THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

III. THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

IV. THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

V. A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.
(Page number 36 reserved for future updates.)
STANDARDS QUICK REFERENCE

STANDARD I.  THE PROVIDER SHALL HAVE LEGAL AUTHORITY TO OPERATE AND SHALL MEET COMMISSION ELIGIBILITY REQUIREMENTS.

Intent 1: Legal Authority
Intent 2: Eligibility for Accreditation – Experience Requirements
Intent 3: Eligibility for Accreditation – Basic Requirements

STANDARD II.  THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

Intent 1: Policy Manual
Intent 2: Job Descriptions
Intent 3: CAHC- Required Policies
Intent 4: CAHC-Required Job Descriptions

STANDARD III.  THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 1: Corporate Structure
Intent 2: Corporate Compliance
Intent 3: Advertising
Intent 4: On-Call
Intent 5: Infection Control
Intent 6: Performance Quality Improvement
Intent 7: Risk Management

STANDARD IV.  THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 1: Personnel Records
Intent 2: Employment Application
Intent 3: Interview
Intent 4: References
Intent 5: Director of Nursing Qualifications
Intent 6: Nursing Supervisor Qualifications
Intent 7: PCS: Nurse Preceptor
Intent 8: PCS: Certified Homemaker-Home Health Aide Qualifications
Intent 9: IHSN: Field Nurse Qualifications
Intent 10: Validation of Credentials
Intent 11: Health Requirements
Intent 12: Agency Orientation
Intent 13: PCS: Clinical Competency
Intent 14: IHSN: Clinical Competency
Intent 15: Performance Evaluations
Intent 16: Certified Homemaker-Home Health Aide In-services
Intent 17: PCS: Training Program
Intent 18: Rehire Requirements
Intent 19: Staffing Cases

STANDARD V. A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 1: Clinical Records
Intent 2: Availability of Service
Intent 3: Intake
Intent 4: PCS: Physician’s Certification of Need for Services
Intent 5: IHSN: Physician’s Orders
Intent 6: Advance Directives
Intent 7: Service Agreement
Intent 8: Patient’s Bill of Rights
Intent 9: Initial Assessment
Intent 10: IHSN: Medications
Intent 11: PCS: Plan of Care
Intent 12: IHSN: Nursing Plan of Care
Intent 13: Orientation to the Case
Intent 14: PCS: Weekly Activity Sheets
Intent 15: IHSN: Nursing Progress Notes
Intent 16: Case Monitoring
Intent 17: Clinical Supervision
Intent 18: Reassessment
Intent 19: Patient Discharge
ACCREDITATION STANDARDS

STANDARD I.  THE PROVIDER SHALL HAVE LEGAL AUTHORITY TO OPERATE AND SHALL MEET COMMISSION ELIGIBILITY REQUIREMENTS.

Intent 1:  Legal Authority
The provider shall demonstrate its legal authority to operate in the State of New Jersey.

Intent 2:  Eligibility for Accreditation – Experience Requirements
The provider shall have experience in providing Personal Care Services/In-Home Skilled Nursing Services in the State of New Jersey.

Intent 3:  Eligibility for Accreditation – Basic Requirements
The Provider shall meet all required eligibility components as a condition of accreditation or continued accreditation.

STANDARD II.  THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

Intent 1:  Policy Manual
The provider shall have written policies and job descriptions to guide its operations.

Intent 2:  Job Descriptions
The provider shall have written job descriptions defining each employee position.

Intent 3:  CAHC-Required Policies
The provider shall include all CAHC-required policies as part of the agency policy manual.

Intent 4:  CAHC-Required Job Descriptions
The provider shall have written job descriptions clearly defining each job position.

STANDARD III.  THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 1:  Corporate Structure
The corporate structure shall clearly define with whom the authority, ultimate responsibility and accountability of operations rest.
Intent 2: **Corporate Compliance**  
The provider shall have a process to ensure compliance with all laws, regulations and agency requirements.

Intent 3: **Advertising**  
All advertising and marketing materials shall accurately portray the provider and its services.

Intent 4: **On-Call**  
All patients and field staff shall have access to a registered nurse for clinical consultation.

Intent 5: **Infection Control**  
The provider shall have written infection control procedures to protect patients and field staff from communicable diseases.

Intent 6: **Performance Quality Improvement**  
The provider shall have a Performance Quality Improvement program to evaluate the quality and appropriateness of services rendered.

Intent 7: **Risk Management**  
The provider shall have a risk management program incorporating prevention, early identification, mitigation and management of risks and occurrences.

Intent 8: **Fiscal Management**  
The provider shall ensure that truthful and accurate financial records are maintained and reviewed at least annually.

**STANDARD IV.**  
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 1: **Personnel Records**  
The provider shall maintain accurate and complete personnel records for all employees.

Intent 2: **Employment Application**  
The provider shall obtain a written application for employment from all prospective employees.

Intent 3: **Interview**  
The provider shall conduct an in-person interview with all prospective employees.

Intent 4: **References**  
The provider shall obtain references for all prospective employees that attest to their qualifications and abilities.

Intent 5: **Director of Nursing Qualifications**  
A qualified Director of Nursing shall provide the clinical oversight of the Personal Care Services/In-Home Skilled Nursing programs.

Intent 6: **Nursing Supervisor Qualifications**  
A qualified Nursing Supervisor shall provide case monitoring for all patients and shall provide supervision for all certified homemaker-home health aides/field nurses.
Intent 7: **PCS: Nurse Preceptor**  
The provider shall have a preceptor program for nursing supervisors who do not have one year of professional experience as a registered nurse.

Intent 8: **PCS: Certified Homemaker-Home Health Aide Qualifications**  
All paraprofessional field staff providing personal care shall be certified as a Homemaker-Home Health Aide by the New Jersey Board of Nursing.

Intent 9: **IHSN: Field Nurse Qualifications**  
All field nurses shall be licensed as an RN or an LPN by the New Jersey Board of Nursing.

Intent 10: **Validation of Credentials**  
The provider shall ensure that all personnel have valid credentials.

Intent 11: **Health Requirements**  
The provider shall ensure that all field staff providing care in a patient’s home meet the health requirements.

Intent 12: **Agency Orientation**  
The provider shall ensure that all newly hired employees receive an orientation to the agency.

Intent 13: **PCS: Clinical Competency**  
The provider shall ensure that each certified homemaker-home health aide is clinically competent to provide the care appropriate to the job description and needs of the assigned patients.

Intent 14: **IHSN: Clinical Competency**  
The provider shall ensure that each field nurse is clinically competent to provide care appropriate to the job description and needs of the assigned patients.

Intent 15: **Performance Evaluations**  
The provider shall ensure that all nursing supervisory staff and all certified homemaker-home health aides/field nurses receive performance evaluations.

Intent 16: **Certified Homemaker-Home Health Aide In-services**  
The provider shall ensure that all certified homemaker-home health aides complete yearly in-service programs relevant to personal care services and the patients served.

Intent 17: **PCS: Training Program**  
If the provider conducts a homemaker–home health aide training program, the program shall be in compliance with the New Jersey Board of Nursing regulations.

Intent 18: **Rehire Requirements**  
The provider shall have a protocol for the rehiring of personnel.

Intent 19: **Staffing Cases**  
The provider shall be responsible for the appropriate assignment and scheduling of qualified field staff.
STANDARD V.  A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 1:  Clinical Records
The provider shall maintain accurate and complete clinical records for each patient serviced.

Intent 2:  Availability of Service
The provider shall have written admission and discharge criteria, servicing only those cases that can be appropriately and safely staffed by the provider.

Intent 3:  Intake
The provider shall ensure that any patient admitted can be serviced appropriately, in accordance with the agency’s Admission policy.

Intent 4:  PCS:  Physician’s Certification of Need for Services
The provider shall provide Personal Care Services following the receipt of a Physician’s Certification of Need for Services for those cases where it’s required by payer source.

Intent 5:  IHSN:  Physician’s Orders
The provider shall provide In-Home Skilled Nursing services in accordance with timely and complete physician’s orders.

Intent 6:  Advance Directives
Patients shall be informed of their right to specify directions concerning their future medical care.

Intent 7:  Service Agreement
Patients shall be informed about service arrangements, including fees and limitations of service, before or at the initiation of service.

Intent 8:  Patient’s Bill of Rights
Patients shall be informed of their rights and responsibilities as a consumer of home care services.

Intent 9:  Initial Assessment
A Nursing Supervisor shall perform a nursing assessment of each patient to establish a baseline of the patient’s physical and functional status.

Intent 10:  IHSN:  Medications
A Nursing Supervisor shall ensure that there is a current and accurate Medication Profile and Medication Administration Record documenting that the medications are given in accordance with the physician’s orders.

Intent 11:  PCS:  Plan of Care
A Nursing Supervisor shall develop an individualized plan of care based on a nursing assessment of each patient receiving services.

Intent 12:  IHSN:  Nursing Plan of Care
A Nursing Supervisor shall develop an individualized nursing plan of care based on a nursing assessment and reflecting the physician’s orders.
Intent 13: **Orientation to the Case**
A Nursing Supervisor shall orient each certified homemaker-home health aide/field nurse to each patient at the time of assignment.

Intent 14: **PCS: Weekly Activity Sheets**
The assigned certified homemaker-home health aides shall render care in accordance with the plan of care.

Intent 15: **IHSN: Nursing Progress Notes**
The assigned field nurses shall render care in accordance with the nursing plan of care.

Intent 16: **Case Monitoring**
A Nursing Supervisor shall evaluate the patient on a regular basis to ensure that the care plan remains consistent with the needs of the patient.

Intent 17: **Clinical Supervision**
A Nursing Supervisor shall directly observe the clinical performance of each certified homemaker-home health aide/field nurse in a patient’s home on a regular basis.

Intent 18: **Reassessment**
A Nursing Supervisor shall perform a nursing reassessment of the patient’s physical and functional status on a regular basis.

Intent 19: **Patient Discharge**
The provider shall ensure the safe and appropriate discharge of patients from service.
STANDARD I
THE PROVIDER SHALL HAVE LEGAL AUTHORITY TO OPERATE AND SHALL MEET COMMISSION ELIGIBILITY REQUIREMENTS.

Intent 1: Legal Authority

The provider shall demonstrate its legal authority to operate in the State of New Jersey.

1 A. The provider shall be currently licensed as a Health Care Service Firm by the Division of Consumer Affairs, New Jersey Department of Law and Public Safety.

1 B. The provider shall have the original copy of the license on-site. It shall be signed by an authorized, designated representative of the provider.

1 C. The name on the license shall include the name the provider uses in its advertising to the public. The address on the license shall be the current address where the provider is offering the accredited services.

NOTE: CAHC accreditation shall only be issued in the exact name of the provider as it is listed on the license.
STANDARD I
THE PROVIDER SHALL HAVE LEGAL AUTHORITY TO OPERATE AND SHALL MEET COMMISSION ELIGIBILITY REQUIREMENTS.

Intent 2: Eligibility for Accreditation – Experience Requirements

The provider shall have experience in providing Personal Care Services/In-Home Skilled Nursing Services in the State of New Jersey.

2 A. The provider shall be licensed as a Health Care Service Firm and operating for approximately six months in the State of New Jersey prior to the date the accreditation application is received in the CAHC office.

2 B. PCS ONLY: Personal Care Services (PCS) applicants shall service at least two to three cases during the four month period prior to the date the accreditation application is received in the CAHC office.

IHSN ONLY: In-Home Skilled Nursing (IHSN) applicants shall service at least one case during the four month period prior to the date the accreditation application is received in the CAHC office.

2 C. The provider shall demonstrate compliance with all CAHC requirements during the four month period prior to the date the accreditation application is received in the CAHC office.
Intent 3: Eligibility for Accreditation – Basic Requirements

The provider shall meet all required eligibility components as a condition of accreditation or continued accreditation.

3 A. The provider shall have current general liability insurance coverage.

3 B. The provider shall directly employ and pay the wages and mandated state and federal employment taxes for all certified homemaker-home health aides and nurses.

3 C. A qualified Director of Nursing shall provide clinical oversight for all Personal Care Services/In-Home Skilled Nursing Services. (See Standard IV, Intent 5 re: qualifications.)

3 D. All Nursing Supervisors, including the Director of Nursing, shall hold a current, valid license as a registered nurse (RN) issued by the New Jersey Board of Nursing.

3 E. PCS ONLY: All paraprofessionals providing personal care services shall be certified homemaker-home health aides. They shall hold a current, valid certificate as a certified homemaker-home health aide issued by the New Jersey Board of Nursing.

NOTE: A companion or certified nurse aide (CNA) shall not be assigned to a patient receiving personal care services in the home.

3 F. IHSN ONLY: All nurses providing home care services shall hold a current, valid license as a registered nurse (RN) or licensed practical nurse (LPN) issued by the New Jersey Board of Nursing.

3 G. The provider shall only provide Personal Care Services within a fifty (50) mile radius of the headquarters/branch. For both PCS and IHSN, the service area of a satellite office shall be entirely encompassed within the fifty (50) mile service area of its headquarters/branch.

3 H. The provider shall agree to and uphold the conditions of the CAHC Memorandum of Agreement which shall be signed and dated by the provider’s authorized, designated representative.

3 I. The provider shall have a Corporate Compliance policy in effect and shall be in compliance with all laws and regulations. (See Standard III, Intent 3 for specific corporate compliance policy requirements.)
STANDARD I
THE PROVIDER SHALL HAVE LEGAL AUTHORITY TO OPERATE AND SHALL MEET COMMISSION ELIGIBILITY REQUIREMENTS.

(Page number 48 reserved for future updates.)
STANDARD II
THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A
CONSISTENT APPROACH TO AGENCY OPERATIONS.

Intent 1: Policy Manual

The provider shall have written policies and job descriptions to guide its operations.

1 A. The provider shall have a policy manual that includes the following components, at
minimum:
   • Administrative policies
   • Personnel policies
   • Clinical policies
   • Job descriptions.

1 B. Each policy shall contain the following components, at minimum:
   • The general policy statement of intent
   • Documentation requirements
   • The procedure to follow for implementation of the policy, such as
     o Who is responsible
     o What steps or actions are to be taken
     o Where the required action is to take place
     o Time frame for the required action.

   For example, the Initial Assessment policy will include the following:  A registered
   nurse is responsible for performing a nursing assessment in the patient’s home by the
   second day of service.

1 C. At least annually, the provider shall review the policies and job descriptions to ensure
compliance with all federal, state and local laws; contractual requirements; and
CAHC standards.  The provider shall document the date of this annual review.

1 D. The provider shall maintain a list of all CAHC-required policies and job descriptions
in the policy manual.  The list shall contain:
   • The implementation date
   • Any revision dates, if applicable
   • The annual review date.

NOTE:  It is acceptable for the dates to be on each separate policy, as long as there is a list
of all policies.
STANDARD II
THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

Intent 2: Job Descriptions

The provider shall have written job descriptions defining each employee position.

2 A. The provider shall have written job descriptions for each position on the organizational chart. Examples include: Director of Nursing, Nursing Supervisor, Certified Homemaker-Home Health Aide and Field Nurse.

2 B. Each job description shall contain the following components, at minimum:

- Qualifications, including:
  - Relevant education requirements
  - Required certification/license, if applicable
- Duties and responsibilities
- Reporting structure.
STANDARD II
THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

Intent 3: CAHC- Required Policies

The provider shall include all CAHC-required policies as part of the agency policy manual.

3 A. The following CAHC-required policies shall be reviewed annually:

Standard III: Administrative Policies
- Corporate Compliance policy
- On-Call policy
- Infection Control policy
- Performance Improvement policy
- Risk Management policy
- Serious Adverse Event policy
- Fiscal Management policy

Standard IV: Personnel Policies
- Personnel Records policy
- Employment Application policy
- Interview policy
- References policy
- Validation of Credentials policy
- Health Requirements policy
- Agency Orientation policy
- PCS: Clinical Competency policy
- IHSN: Clinical Competency policy
- Performance Evaluation policy
- PCS: Certified Homemaker-Home Health Aide In-Service policy
- Rehire policy
- Staffing Cases policy
- PCS: Nurse Preceptor policy, if applicable

Standard V: Clinical Policies
- Clinical Records policy
- Admissions policy
- Interruption of Service policy
- Discharge policy
- Intake policy
- PCS: Physician’s Certification of Need for Services policy
- IHSN: Physician’s Orders policy
- Advance Directives policy
- Service Agreement policy
- Patient’s Bill of Rights policy
  o Grievance policy
STANDARD II
THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

Standard V: Clinical Policies (cont.)
- Initial Assessment policy
  - Pain Management policy
  - Emergency Preparedness policy
- IHSN: Medication policy
- PCS: Plan of Care policy
- IHSN: Nursing Plan of Care policy
- Orientation to the Case policy
- PCS: Weekly Activity Sheet policy
- IHSN: Nursing Progress Notes policy
- Case Monitoring policy
- Clinical Supervision policy
- Reassessment policy
- Patient Discharge Planning policy
- Identification and Reporting Requirements for Child Abuse, Elder Abuse and Domestic Violence
STANDARD II
THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

Intent 4: CAHC-Required Job Descriptions

The provider shall have written job descriptions clearly defining each job position.

4 A. The provider shall have written job descriptions for each position on the organizational chart. It shall include, at minimum:
   - Director of Nursing
   - Nursing Supervisor
   - Certified Homemaker-Home Health Aide, if applicable
   - Field Nurse, if applicable.
STANDARD II
THE PROVIDER SHALL HAVE WRITTEN POLICIES AND JOB DESCRIPTIONS TO ENSURE A CONSISTENT APPROACH TO AGENCY OPERATIONS.

(Page number 54 reserved for future updates.)
STANDARD III

THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 1: Corporate Structure

The corporate structure shall clearly define with whom the authority, ultimate responsibility and accountability of operations rest.

1 A. The provider shall maintain a written statement that clearly defines with whom the authority, ultimate responsibility and accountability of operations rest.

1 B. The provider shall maintain an organizational chart for each site. The organizational chart shall include:
   - The person with ultimate responsibility for operations and the designee in the absence of the responsible person for operational issues. As an alternative, this may be in a separate policy statement or job description.
   - The reporting lines at the site
   - The names and positions of key staff members
   - The number of full-time, part-time and per diem positions
   - The number of persons in each position
   - The designee for clinical issues in the absence of the Director of Nursing. As an alternative, this may be in a separate policy statement or job description.
   - The date.

NOTE: If the organizational chart is missing any of the above components at the time of the on-site survey, it is acceptable for it to be updated during the survey.

1 C. If the provider has a headquarters office that is responsible, in total or in part, for the operation of a branch or satellite site, the provider shall also maintain a written organizational chart for the headquarters office.

   The headquarters office organizational chart shall include:
   - Headquarters office reporting lines to the branch
   - The names and positions of key staff members.
STANDARD III

THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 2: Corporate Compliance

The provider shall have a process to ensure compliance with all laws, regulations and agency requirements.

2 A. The provider shall have a Corporate Compliance policy including the following components, at minimum:
   • a code of conduct and ethics
   • a method for reporting complaints/violations
   • a procedure for responding to reports of alleged misconduct, violation of laws/regulations and unethical practices
   • confidentiality requirements
   • protection for those reporting unethical, fraudulent or illegal activity ("whistleblower" protection)
   • documentation requirements.

2 B. The provider shall appoint a corporate compliance officer who can function in a fair and ethical way. This individual shall report to the entity or person with ultimate responsibility for operations. This individual shall receive and follow-up on all corporate compliance reports, including those that are received internally and externally. The corporate compliance officer is responsible for maintaining the confidentiality of all reports.

2 C. All newly hired employees, both office staff and field staff, shall receive an orientation on corporate compliance. For field staff, this shall be completed prior to the date of first case. This component of the initial agency orientation shall be documented in the personnel record.

2 D. All current employees, both office staff and field staff, shall receive one-time instruction on corporate compliance. This instruction shall be documented in the personnel record.
STANDARD III
THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 3: Advertising

All advertising and marketing materials shall accurately portray the provider and its services.

3 A. The description of the provider and its services shall be accurate in all advertising and marketing materials. This includes, but is not limited to, the following media: print, computer and audio.

3 B. At minimum, the provider shall have a written fact sheet or brochure available for distribution to the community.

3 C. The provider shall have an English translation available for any advertising or marketing conducted in a language other than English.

3 D. The provider shall utilize the CAHC logo for marketing purposes in a way that clearly identifies that only PCS services or IHSN services are accredited by CAHC.
STANDARD III
THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 4: On-Call

All patients and field staff shall have access to a registered nurse for clinical consultation.

4 A. The provider shall have an On-Call policy defining:
   • the process to handle incoming calls in a professional manner during all days and hours of office operation and on-call hours. The agency name must be identified.
   • the criteria and procedure for access to a registered nurse for clinical consultation during all days and hours of office operations and on-call hours.
   • the safe and reasonable response time to the on-call request that shall not exceed 30 minutes.

4 B. The qualifications of the registered nurse who is on-call shall be appropriate to the needs of the patients, for both PCS and IHSN services.

4 C. PCS: The provider shall have on-call nursing consultation available, at minimum, during all hours of service provision.
   IHSN: The provider shall have on-call nursing consultation available 24 hours/day, 7 days/week.

4 D. The registered nurse who is on-call shall be available for in-home visits, as well as telephone consultation.

4 E. The provider shall have a written on-call schedule for each calendar month that includes the names and titles of all on-call personnel, such as the coordinator, registered nurse, etc.

4 F. The provider shall maintain documentation of calls received after office hours and of any follow-up actions required.

4 G. The provider shall have office staff present during all days and hours of office operation. If this is not possible due to an emergency, the provider shall have a process to handle incoming calls. This may involve activating the on-call procedure.
STANDARD III

THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 5: Infection Control

The provider shall have written infection control procedures to protect patients and field staff from communicable diseases.

5 A. The provider shall have an Infection Control policy, applicable to all field staff providing direct care in a patient’s home. The policy shall include the following components, at minimum:
   • an Exposure Control plan
   • mandatory annual in-service requirements
   • guidelines for the use of personal protective equipment (PPE).

5 B. The provider shall have an Exposure Control Plan, applicable to all field staff providing direct care in a patient’s home. The plan shall include the following components, at minimum:
   • Hepatitis B vaccination policy
   • mandatory staff education, including standard precautions, infection control and blood borne pathogens
   • use of personal protective equipment (PPE)
   • method for communicating hazards to field staff
   • housekeeping requirements, such as regulated waste disposal and cleaning procedures
   • engineering and work practice controls
   • evaluating exposure incidents and follow-up actions
   • documentation requirements.

5 C. At minimum, the provider shall provide, at no cost to the employee, the following personal protective equipment (PPE) to all field staff, as needed:
   • soap and/or antibacterial gel for hand washing
   • disposable gloves
   • disposable aprons and gowns
   • disposable eye shields
   • procedure masks
   • ability to obtain respirator masks, if required
   • any other personal protective equipment that may be needed.
STANDARD III

THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 6: Performance Quality Improvement

The provider shall have a Performance Quality Improvement program to evaluate the quality and appropriateness of services rendered.

6 A. The provider shall have a Performance Quality Improvement (PQI) policy that includes:
   - the goals and objectives of the PQI program
   - the components of the PQI program
   - the person(s) responsible for implementation
   - the time frame for evaluation.

6 B. The following components of the PQI program are required, at minimum:
   - clinical record reviews to monitor the quality and appropriateness of care
   - personnel record reviews to monitor the qualifications and performance of personnel
   - patient satisfaction surveys
   - monitoring of CAHC contingencies, if applicable
   - risk management reports
   - at least two indicators chosen by the provider to monitor the quality and appropriateness of care, such as infections, falls or hospitalizations.

6 C. The provider shall implement a written plan of correction for any identified problems.

6 D. Based on the agency PQI policy indicating the time frame for specific components, the monitoring of the PQI program shall be done quarterly, at minimum. This will form the basis of a written annual PQI evaluation report that includes all required components (see 6.B).

Example

First quarter:
A sample of clinical and personnel record reviews, risk management reports and monitoring of CAHC contingencies.

Second quarter:
Patient satisfaction surveys, monitoring of patient falls (indicator) and monitoring of CAHC contingencies.

Third quarter:
A sample of clinical and personnel record reviews, risk management reports and monitoring of patient falls.
STANDARD III

THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Fourth quarter:
*Patient satisfaction surveys and monitoring of patient infections (indicator).*

The annual PQI evaluation will be a summary of the quarterly findings that eventually includes all required components by the end of the year.

6 E. The provider shall maintain appropriate documentation of the PQI monitoring results to support the conclusions of the annual PQI evaluation report.

6 F. If the provider offers both PCS and IHSN services, there shall be a separate quarterly PQI monitoring process for each service and separate findings in the annual PQI evaluation report.
STANDARD III

THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 7: Risk Management

The provider shall have a risk management program incorporating prevention, early identification, mitigation and management of risks and occurrences.

7 A. The provider shall have a Risk Management policy that addresses the prevention, early identification, mitigation and management of risks and occurrences. It shall include:
- the types of occurrences to be reported; the method for reporting occurrences
- the follow-up procedures after an occurrence including reporting of any safety concerns and violations of law to licensing and/or regulatory agencies as required by law, including all criminal or unlawful acts.
- the person(s) responsible for the risk management program.

7 B. The monitoring and follow-up of complaints regarding both service and personnel shall be included as part of the risk management program. The provider’s grievance procedure shall be clearly communicated to patients and their families as part of the Patient’s Bill of Rights documentation. (See Standard V, Intent 8 for Patient Bill of Rights requirements.)

7 C. The provider shall implement a written plan of correction for any identified risks.

7 D. Risk management reports shall be included as part of the quarterly PQI monitoring process.

7 E. The risk management documentation shall be kept confidential and separate from the clinical and personnel records.

7 F. The provider shall have a Serious Adverse Event policy that includes:
- The types of events covered by the policy including reporting of any safety concerns or risk and violations of law to licensing and/or regulatory agencies as required by law, including all criminal or unlawful acts.
- The procedure and methods for reporting a serious adverse event, including which, if any, authorities must be notified.
- The procedure for an in-depth root analysis of the event that focuses on systems and processes of the provider, not on specific individuals.
- The analysis must include:
  - the causes of the event, a focus on the “why” and whether it was avoidable or unavoidable
  - an evaluation of whether patients were or could have been negatively harmed by the cause of the adverse event
  - an analysis of the systems and processes in place and the identification of changes that could be made though revising current policies or developing new systems and policies
  - identification of risk factors and their contribution to this type of event.
STANDARD III
THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY
FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE
SERVICE QUALITY.

The analysis must be thorough, credible and must include participation by the leadership of
the agency, as well as any individuals closely involved in the policies under review.

- development of an action plan identifying strategies for change that have been
  identified in the root cause analysis. The action plan shall include:
  o The person(s) responsible for implementing the plan
  o A time frame for implementation
  o Details about how the effectiveness will be evaluated and monitored.
STANDARD III
THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 8: Fiscal Management

The provider shall ensure that truthful and accurate financial records are maintained and reviewed at least annually.

8 A. The provider shall have a Fiscal Management Policy defining the components of the financial and/or accounting activities of the agency. At minimum this will include a description of the following:
   • A general ledger
   • Balance Sheet
   • Billing records
   • Tax records
   • Accounts Payables
   • Accounts Receivables

8 B. The provider shall have a long range financial plan for future goals of the agency

8 C. The provider shall have a Business and Disaster Recovery Plan.

8 D. A Financial Manager or person responsible for fiscal management will be identified.
STANDARD III
THE PROVIDER SHALL ENSURE THAT THERE IS RESPONSIBILITY AND ACCOUNTABILITY FOR AGENCY OPERATIONS AND THAT THERE IS A FORMAL PROCESS TO ENSURE SERVICE QUALITY.

Intent 1: Personnel Records
The provider shall maintain accurate and complete personnel records for all employees.

1 A. The provider shall have a Personnel Records policy defining the components, requirements and time frame for the maintenance of personnel records. This shall take into account all federal, state, local laws and contractual requirements.

1 B. The personnel records shall be kept confidential and securely locked.

1 C. The confidential health information for each employee shall be kept separate from their personnel record and it shall be kept securely locked.

1 D. The provider shall designate the person(s) approved to have access to the personnel records and the confidential health information.

1 E. The personnel record shall contain, at a minimum:
   • Application for employment
   • Copy of face front photograph
   • Interview documentation
   • References
   • Copy of validated and current certificate/license
   • Copy of annual on-line verification of license/certification status from NJ Division of Consumer Affairs
   • Health attestation form
   • Orientation to agency documentation
   • Clinical competency documentation
   • Performance evaluations
   • Clinical supervision documentation
   • PCS: Certified homemaker-home health aide in-service attendance
   • Other agency requirements, such as malpractice insurance or CPR
   • Date of first case (field staff); date of first day working (nursing supervisory personnel).

 NOTE: As long as it is readily accessible, selected components of the personnel record may be kept separately, such as health attestation forms or in-service attendance.

1 F. The personnel record shall clearly document all hire, rehire and leave of absence dates.

1 G. The following documentation shall remain in the active personnel record: date of first case/first day working, application, validated copy of certificate/license and health attestation form. The following documentation shall be accessible for at least 18 months: interview, references, orientation to the agency, clinical competency, performance evaluations, clinical supervision, in-service education, other agency requirements.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

**Intent 2: Employment Application**

The provider shall obtain a written application for employment from all prospective employees.

2 A. The provider shall have an Employment Application policy defining the application procedure and the components of the application form.

2 B. The written application shall be completed prior to the date of the first case.

2 C. The application shall include, at minimum:
   - Applicant’s name, address and phone numbers
   - Email address, if available
   - Space for Social Security number
   - Names and addresses of all previous employers, including
     - Dates of employment
     - Work experience/title/department
     - Name of Supervisor/title
     - Reasons for leaving each employer
   - Education and training including type of training, name of school, location, degree earned
   - Type of License/certification, issuing authority and number, if applicable
   - License/certification expiration date
   - Malpractice insurance carrier name, policy number, expiration date if applicable
   - Duly executed authorization for background checks*
   - Applicant’s signature and date.

*I, ______________, hereby authorize ____________ to request and receive from all prior employers within ______________ (insert time line; ex: 1 year) of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.*
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 3: Interview

The provider shall conduct an in-person interview with all prospective employees.

3 A. The provider shall have an Interview policy defining the procedure for interviewing prospective employees.

3 B. The provider shall conduct an in-person interview prior to the applicant’s date of first case.

3 C. If the prospective employee is a nurse, the Director of Nursing or Nursing Supervisor shall be involved in the interview process to ensure nursing input into the hiring decision.

3 D. The interview documentation shall include, at minimum:
   - Name of the applicant
   - Position being applied for
   - Specific information about the applicant’s experience, skills and clinical competencies
   - Interviewer’s signature and date.
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 4: References

The provider shall obtain references for all prospective employees that attest to their qualifications and abilities.

4 A. The provider shall have a Reference policy defining the procedure for obtaining references and the required components of the reference.

4 B. The provider shall obtain two references prior to the applicant’s date of first case. If the applicant has worked within the one year period preceding the date of application, the provider is required to request this reference.

4 C. The provider shall obtain written permission from the applicant to contact all references, indicating the position being applied for. The following example of language on a release form is from the New Jersey Division of Consumer Affairs:

\[
I, (applicant) hereby authorize (agency) to request and receive from all prior employers within one year of the date of application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.
\]

4 D. The provider shall obtain written references and/or appropriately documented verbal references. Pre-written letters of recommendation are acceptable if they are verified by the provider with appropriate documentation of the verification.

4 E. For certified homemaker-home health aides: the reference shall be an employment, professional or educational reference.
   - Employment, including an immediate past employer
   - Educational may include the aide training program, high school, etc.

4 F. For RNs and LPNs: Only professional employment or educational references shall be used. At least one reference shall be from an immediate past employer.

4 G. The reference documentation shall include, at minimum:
   - Type of reference
   - Name of the person giving the reference and title/relationship to applicant
   - Dates of employment including job title
   - Written reference: signature/title of the reference and date
   - Verbal reference: Name of person/title giving verbal reference, signature/title of staff member who obtained the reference and date.
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 5: Director of Nursing Qualifications

A qualified Director of Nursing shall provide the clinical oversight of the Personal Care Services/In-Home Skilled Nursing program.

5 A. The Director of Nursing shall hold a current valid license in good standing as a registered nurse issued by the New Jersey Board of Nursing.

5 B. The Director of Nursing shall hold at least a BS degree, with a major in nursing or other health-related field, plus two years of professional experience as an RN in community health and/or home health. In the place of a BS degree, the Director of Nursing shall have three years of professional experience as an RN in community health and/or home health, with progressive nursing responsibilities. The Director of Nursing qualifications shall include experience in providing nursing services in a patient’s home environment, inclusive of an assisted living facility.

NOTE: School nursing, nursing at a medical day care center or nursing in a TB clinic does not meet this requirement.

5 C. The provider shall ensure that the Director of Nursing meets any other qualifications specified in the job description.

NOTE: All Registered Nurses in the state of New Jersey are required to complete 30 continuing education units within a 2 year period, from a NJ Board of Nursing recognized source. This includes the mandatory educational requirement of Organ and Tissue Donation. Evidence of such may be requested at the time of the accreditation survey.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 6: Nursing Supervisor Qualifications

A qualified Nursing Supervisor shall provide case monitoring for all patients and shall provide supervision for all certified homemaker-home health aides/field nurses.

6 A. All nursing supervisors shall hold a current valid license in good standing as a registered nurse issued by the New Jersey Board of Nursing.

6 B. PCS: If the nursing supervisor has less than one year of professional experience as a registered nurse, the following procedure is required. The provider shall follow a written agency protocol for home care orientation, including a preceptorship, and the nursing supervisor shall satisfactorily pass an initial written competency test. (See Standard IV, Intent 7: PCS: Nurse Preceptor.)

6 C. IHSN: All nursing supervisors shall have at least one year of professional experience as a registered nurse *

6 D. The provider shall ensure that all nursing supervisors meet any other qualifications specified in the job description.

*Best Practice:
Experience in Home Care, Education, or Community Nursing with ID/ Criminal Background checks
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 7: PCS: Nurse Preceptor

The provider shall have a preceptor program for nursing supervisors who do not have one year of professional experience as a registered nurse.

7 A. The provider shall have a Nurse Preceptor policy outlining the required components and documentation requirements in those situations where a nursing supervisor employed in the Personal Care Services program does not have one year of professional experience as a registered nurse.

NOTE: One year of experience is defined as commencing from the date of receiving a state license as a registered nurse.

7 B. The components of the Nurse Preceptor program shall include, at minimum:
   - Assignment of an experienced nursing supervisor who will be responsible as the preceptor for the newly employed nursing supervisor.
   - The nursing supervisor shall satisfactorily pass an initial written competency test.
   - The nursing supervisor shall receive an orientation to home care and to the nursing supervisor job description, in addition to receiving the required agency orientation.
   - The nursing supervisor shall initially make home visits with the preceptor to learn first-hand those components of the job description.
   - When the preceptor decides the nursing supervisor is ready, the preceptor shall assign home visits. The preceptor shall review and co-sign all documentation by the nursing supervisor.
   - After the specified time period of preceptorship, the preceptor shall conduct a written evaluation of the nursing supervisor. Based on this evaluation, the nursing supervisor shall begin to work independently or shall receive additional guidance under the preceptor.
   - The newly employed nursing supervisor shall also receive a post-orientation evaluation in the time frame specified in the Performance Evaluation policy.

7 C. The documentation requirements for the preceptor performance evaluation shall include, at minimum:
   - evaluation of the administrative components of the job description, including administrative supervision
   - evaluation of the clinical components of the job description, including clinical supervision and clinical competency testing
   - date and signature of the preceptor
   - date and signature of the nursing supervisor.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 8: PCS: Certified Homemaker-Home Health Aide Qualifications

All paraprofessional field staff providing personal care shall be certified as a Homemaker-Home Health Aide by the New Jersey Board of Nursing.

8 A. All homemaker-home health aides shall hold a current valid certificate in good standing issued by the New Jersey Board of Nursing.

8 B. The provider shall ensure that all certified homemaker-home health aides meet any other qualifications specified in the job description.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 9: IHSN: Field Nurse Qualifications

All field nurses shall be licensed as an RN or an LPN by the New Jersey Board of Nursing.

9 A. All RN and LPN field nurses shall hold a current valid license in good standing issued by the New Jersey Board of Nursing.

9 B. The provider shall ensure that all field nurses meet any other qualifications specified in the job description.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 10: Validation of Credentials

The provider shall ensure that all personnel have valid credentials.

10 A. The provider shall have a Validation of Credentials policy defining the procedure for validating the current certificate/license for all personnel.

10 B. The provider shall validate the current certification/licensure of all personnel at the following times:
- new hire: prior to the date of first case or the first day working
- rehire: prior to the first assignment after returning to work
- when the certificate/license is issued or renewed.

10 C. The provider shall obtain a fax or online verification of the certificate/license from the New Jersey Board of Nursing at the following times:
- prior to the date of first case or the first day working
- rehire: prior to the first assignment after returning to work
- when the certificate/license is issued or renewed.

10 D. In addition, the agency procedure for validating the certificate/license shall include the following:
- The certified homemaker-home health aide/nurse shall present the original certificate/license for visual inspection by the designated agency reviewer.
- The agency reviewer shall then make a copy of the original, current and signed certificate/license. The following notation shall be conspicuously written across the copy of the certificate/license:
  “COPY OF ORIGINAL NOT VALID FOR VERIFYING CURRENT LICENSURE STATUS”
- The person who reviewed the original certificate/license signs and dates the copy.

10 E. PCS: If an aide has recently completed the New Jersey Board of Nursing training course and has not yet received a certificate, the 120 day work permit may be acceptable if verified and as long as the eligibility period does not expire. Once the eligibility period expires, the provider shall obtain a fax or online verification until a copy of the certificate is received and validated.

10 F. PCS: A nursing student may work as a homemaker-home health aide with a written New Jersey Board of Nursing waiver in place of a certificate.

10 G. The provider also shall validate any additional credentials, as required in the employee’s job description, such as CPR, IV or ventilator certifications.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 11: Health Requirements

The provider shall ensure that all field staff providing care in a patient’s home meet the health requirements.

11 A. The provider shall have a Health Requirements policy defining the components and time frame for meeting the health requirements. The components shall include a physical exam, TB screening, rubella and rubeola screening and the status of hepatitis B vaccination. The policy shall include the follow-up procedure for positive tuberculin screening results; sero-negative rubella screening results; and sero-negative rubeola screening results. Also, it shall include whether or not the provider requires periodic health examinations.

NOTE: The CAHC health requirements are based on the Licensing Standards for Home Health Agencies published by the New Jersey Department of Health.

11 B. The provider shall designate the person(s) permitted to have access to employee health information. Whenever possible, this shall be a registered nurse.

11 C. The confidential health information for all field staff shall be kept separate from their personnel record and it shall be kept securely locked.

11 D. A health attestation form, summarizing the dates of all health requirements, shall be maintained in the personnel record of all field staff. It shall include:
   * Date of the post-offer health examination
   * Dates of the periodic health examinations, if required by agency policy
   * Date of initial TB screening
   * Dates of annual TB screening
   * Date of rubella/rubeola screening
   * Dates of Hepatitis B vaccination or declination
   * Signature of the person attesting to the health information and date.

NOTE: Interferon Gamma Release Assays (IGRAs), such as FDA-approved QuantiFERON-TB Gold or T-Spot. TB, are blood tests that may be used instead of the tuberculin skin test (TST) in TB-screening programs for health care workers. In this case, initial two-step testing is not required as with the tuberculin skin test (TST).

The CAHC surveyor shall have the discretion to request specific confidential health information in order to verify the information on the health attestation form.

See sample health attestation form following this intent.
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

11 E. The following health requirements shall be completed prior to the date of first case:
- Post-offer health examination by an MD/DO or Advanced Practice Nurse (APN) completed within 12 months prior to the date of first case.
- Initial TB screening:
  - One of the Interferon Gamma Release Assay (IGRA) blood tests with negative results
  - Two-step tuberculin skin test with negative results within previous 12 months
  - Two negative tuberculin skin tests within the past 12 months
  - An initial TB screening questionnaire is required if there is any documentation of a negative chest X-ray following a positive tuberculin skin test. The questionnaire shall be reviewed by a registered nurse to ensure that the employee is not exhibiting signs and symptoms of TB.

NOTE: See sample alternate assessment – TB Screening Questionnaire form following this intent.
- Rubella screening; the only exceptions are personnel who can document sero-positivity from a previous rubella screening test or who can document inoculation with rubella vaccine, or when medically contraindicated.
- Rubeola screening for all personnel born in 1957 or later; the only exceptions are personnel who can document receipt of live measles vaccine on or after their first birthday, physician-diagnosed measles, or serologic evidence of immunity.
- The provider shall have a follow-up procedure for sero-negative screening results for rubella and rubeola. At minimum, the provider shall inform the employee of his or her screening results and maintain a list identifying each person who is sero-negative and unvaccinated.
- Date that the employee received or declined the Hepatitis B vaccine.

11 F. The following health requirements shall be completed on an ongoing basis:
- Annual TB screening every 12 months (completed by the last day of the calendar month in which it is due):
  - One of the Interferon Gamma Release Assay (IGRA) blood tests
  - Tuberculin skin testing
  - TB screening questionnaire, if the tuberculin skin testing is contraindicated due to prior positive results with a negative chest X-ray.
- Periodic health examinations by an MD/DO or Advanced Practice Nurse (APN), if required by agency policy.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

CAHC SAMPLE
Health Attestation Form

Employee Name: ________________________________
Date of First Case: _________________ (first day worked)

<table>
<thead>
<tr>
<th>Action Completed</th>
<th>Dates</th>
<th>Signature/Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Post-Offer Physical</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ Rubella/Rubeola Screening</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>(born in 1957 or later)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Birth year: _________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Initial TB Screening</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ IGRA blood test OR</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ 2-step Mantoux Screening OR</td>
<td><strong>/</strong>__</td>
<td>________________</td>
</tr>
<tr>
<td>□ Annual Mantoux after initial 2-step</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>(Month due: _______________ ) OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Date of chest x-ray AND</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ TB questionnaire</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ Annual TB Screening Questionnaire</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ Hepatitis B Vaccine: Date accepted/declined</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ Influenza Vaccine, if applicable</td>
<td>___________</td>
<td>________________</td>
</tr>
<tr>
<td>□ Periodic Physicals (if required by agency)</td>
<td>___________</td>
<td>________________</td>
</tr>
</tbody>
</table>

Designated Reviewer
I attest that the above information is truthful and correct pursuant to my review of the health records for the above employee.

Name (Print):______________________________ Title:________________________
Signature:_____________________________ Date:________________________

Name (Print):______________________________ Title:________________________
Signature:_____________________________ Date:________________________

Name (Print):______________________________ Title:________________________
Signature:_____________________________ Date:________________________

Name (Print):______________________________ Title:________________________
Signature:_____________________________ Date:________________________
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

CAHC SAMPLE

Alternate Assessment - TB Screening Questionnaire

Employee Name: ______________________

This form is completed annually for those employees who have documentation of a negative chest x-ray following a positive Mantoux screening test, and whose medical evaluation and chest x-ray indicate that no further Mantoux screening is required.

Do you experience any of the following:  Yes  No

- bad cough that lasts longer than 2 weeks  □  □
- coughing up sputum (phlegm)  □  □
- coughing up blood  □  □
- loss of appetite  □  □
- weakness/fatigue/tiredness  □  □
- night sweats  □  □
- unexplained weight loss  □  □
- fever  □  □
- chills  □  □
- chest pain  □  □

Have you recently spent time with someone who has infectious tuberculosis?  □ Yes  □ No

Any other complaints?  □ Yes  □ No  If yes, explain: ____________________________

__________________________________________________________________________

The above health statements are accurate to the best of my knowledge. I have been inserviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

Employee Signature: ___________________________ Date: ________

Nurse Reviewer Recommendation

□ Refer employee for medical evaluation immediately, before continuing work.
□ No action to be taken at this time.

RN Signature: ___________________________ Date: ________
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 12: Agency Orientation

The provider shall ensure that all newly hired employees receive an orientation to the agency.

12 A. The provider shall have an Agency Orientation policy defining the procedure for orientation to the agency and required components of the orientation.

12 B. The agency orientation shall be completed prior to the date of first case for field staff and completed on or prior to the first day working for supervisory personnel.

12 C. The content of the agency orientation shall include, at minimum:
   - All employees: overview of agency organization and administrative policies, including corporate compliance.
   - All employees: overview of relevant personnel and clinical policies.
   - PCS: patient and environmental changes that a certified homemaker-home health aide is to report immediately to a nurse.
   - PCS: A nursing supervisor with less than one year of professional experience as a registered nurse shall follow a written agency protocol for home care orientation, including a preceptorship. (See Standard IV, Intent 7 Nursing Preceptor)
   - IHSN: process for communicating patient information among field nurses on multiple-shift cases.

NOTE: The above administrative information may be counted towards the total yearly certified homemaker-home health aide in-service requirement, up to a maximum of 2 in-service hours.

- PCS & IHSN: mandatory initial in-services
  - Blood borne pathogens
  - Workforce protection
  - Employee Safety
  - Back Safety
  - Needle stick safety
  - Domestic violence
  - Pain management
  - Handwashing
  - Infection control
  - Standard precautions
  - Child & Elder abuse
  - Fraud and abuse protection
  - Corporate Compliance

The mandatory initial in-service topics shall only be offered as in-office instruction. The actual number of hours awarded shall be determined in accordance with the provider’s Agency Orientation policy.

NOTE: The actual number of hours spent during orientation on these mandatory in-service topics may be counted towards the total yearly aide in-service requirement. (See Standard IV, Intent 16E - Certified Homemaker-Home Health Aide In-Services.)
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

12 D. The agency orientation documentation shall include, at minimum:

- Outline of topics covered
- Length of time for each of the mandatory in-service topics
- Signature of the instructor and date
- Signature of the employee and date
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 13: PCS: Clinical Competency

The provider shall ensure that each certified homemaker-home health aide is clinically competent to provide the care appropriate to the job description and needs of the assigned patients.

13 A. The provider shall have a Clinical Competency policy defining the procedure for appraising certified homemaker-home health aide competency, the required components of the competency appraisal and the time frame.

13 B. A registered nurse shall appraise the clinical competency of all certified homemaker-home health aides.

13 C. The time frames for the appraisal of clinical competency include, at minimum:
   • prior to the date of first case (initial competency testing)
   • whenever a new procedure is assigned
   • annually (annual competency testing).

13 D. Initial competency testing, prior to the date of first case, shall include any task delegated by the RN prior to the start of service in a new patient’s home, regardless of the experience level of the CHHA. This includes the following at minimum:
   • Direct observation of the certified homemaker-home health aide’s performance of the following skills. A mannequin may not be used.
     1) temperature, pulse, respiration
     2) one type of bath (bed, sponge, tub or shower)
     3) shampoo (sink, tub or bed)
     4) nail and skin care
     5) oral hygiene
     6) personal hygiene related to toileting and elimination
     7) safe transfer techniques and ambulation
     8) normal range of motion and positioning
     9) hand washing
   • Written testing, oral testing or direct observation of the certified homemaker-home health aide’s knowledge of:
     1) communication skills
     2) observation, reporting and documentation of patient status, and the care or service furnished
     3) basic infection control procedures
     4) basic elements of body functioning and changes in body function that must be reported to the nursing supervisor
     5) maintenance of a clean, safe and healthy environment
     6) recognizing emergencies and knowledge of emergency procedures
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

7) physical, emotional and developmental needs of and ways to work with the populations served by the agency, including respect for the patient and the patient’s privacy and property
8) adequate nutrition and fluid intake
9) any other task the agency may choose.

13 E. After the initial clinical competency testing, the annual clinical competency testing shall be completed within the calendar month when the annual performance evaluation is due. At minimum, it shall include the direct observation of the certified homemaker-home health aide’s performance of the following skills each year:
1) temperature, pulse, respiration
2) one type of bath (bed, sponge, tub or shower)
3) shampoo (sink, tub or bed)
4) nail and skin care
5) oral hygiene
6) personal hygiene related to toileting and elimination
7) safe transfer techniques and ambulation
8) normal range of motion and positioning
9) hand washing
10) skills in all areas pertinent to the assigned patients throughout the year.

NOTE: Annual competency testing may be performed in a lab setting or by direct observation of the homemaker-home health aide in the patient’s home throughout the year, i.e. during the 60 day clinical supervision. Either way, the annual clinical competency testing is required as part of the annual performance evaluation.

13 F. The clinical competency documentation shall include, at minimum:
• name of the certified homemaker-home health aide
• location of evaluation
• clinical skills that were appraised
• evaluation of the certified homemaker-home health aide’s competency
• signature and title of the registered nurse performing the appraisal followed by the date of evaluation

13 G. The Director of Nursing shall have the discretion to decide whether or not to accept documentation of initial clinical competency testing done at an outside training course. It shall be accepted no more than 60 days after the completion of the training course.

13 H. The provider shall have a defined procedure if a certified homemaker-home health aide does not satisfactorily demonstrate clinical competency.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 14: IHSN: Clinical Competency

The provider shall ensure that each field nurse is clinically competent to provide care appropriate to the job description and needs of the assigned patients.

14 A. The provider shall have a Clinical Competency policy defining the procedure for appraising field nurse competency, the required components of the competency appraisal and the time frame.

14 B. The Director of Nursing or Nursing Supervisor shall appraise the clinical competency of all field nurses.

14 C. The provider shall document proof of the clinical competency of the nursing supervisor who is evaluating the clinical competency of the field nurses. At a minimum, this shall be based on the resume and references of the nursing supervisor.

14 D. The time frames for the appraisal of clinical competency shall include, at minimum:
   • prior to the date of first case (initial competency testing)
   • at the time of orientation to a new case
   • whenever a new procedure is assigned
   • annually (annual competency testing).

14 E. Initial competency testing shall include the following steps, at minimum:

1) Prior to the date of first case, the following steps shall be completed:
   o Self-assessment checklist of skills by the field nurse.
   o Written tests to verify competency in the applicable areas, such as medication administration, ventilator care, and pediatric care.
   o Interview by a registered nurse to verify the field nurse’s competency based on the resume, references, skills checklist, written tests.

2) If needed, the agency shall provide additional training and/or a structured preceptorship program after which the nurse’s competency shall be re-evaluated.

3) During the first shift worked, the nursing supervisor shall provide orientation and supervision in the home. The nursing supervisor shall make additional home visits, if needed, based on the quality of care and the safety of the patient.

14 F. After the initial clinical competency appraisal, the annual clinical competency appraisal shall be completed within the calendar month when the annual performance evaluation is due. At minimum, it shall include skills in all areas pertinent to the assigned patients throughout the year.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

NOTE: Annual competency testing may be a summary of clinical skills observed during the clinical supervision in the home throughout the year. Also, the annual clinical competency testing is required as part of the annual performance evaluation.

14 G. The clinical competency documentation shall include, at minimum:
- name of the field nurse
- clinical skills that were appraised
- evaluation of the field nurse’s competency
- date and signature of the registered nurse performing the appraisal.

14 H. The provider shall have a defined procedure if a field nurse does not satisfactorily demonstrate clinical competency.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 15: Performance Evaluations

The provider shall ensure that all nursing supervisory staff and all certified homemaker-home health aides/field nurses receive performance evaluations.

15 A. The provider shall have a Performance Evaluation policy defining the procedure for evaluating the administrative and clinical performance of the nursing supervisory staff and all certified homemaker-home health aides/field nurses.

15 B. All nursing supervisory staff and all field staff shall receive a post-orientation evaluation within the time frame specified in the agency’s Performance Evaluation policy. The time frame for the post-orientation evaluation shall not exceed 6 months from date of first case.

15 C. All nursing supervisory staff and all field staff shall receive an annual evaluation. The first annual performance evaluation must be one year from the date of first case or the date of hire, not from the post-orientation evaluation.

NOTE: CAHC gives a grace period, allowing the evaluation to be completed by the last day of the calendar month in which it is due.

15 D. The provider shall define who is responsible for evaluating the performance of all field staff and supervisory personnel. A registered nurse shall always evaluate and sign the clinical component of the performance evaluation.

15 E. The documentation requirements shall include, at minimum:
   • evaluation of the administrative components of the job description, including administrative supervision
   • evaluation of the clinical components of the job description, including clinical supervision and annual clinical competency testing, if applicable.
   • date and signature of all evaluators
   • date and signature of the employee.
Intent 16: Certified Homemaker-Home Health Aide In-Services

The provider shall ensure that all certified homemaker-home health aides complete yearly in-service programs relevant to personal care services and the patients served.

16 A. The provider shall have a Certified Homemaker-Home Health Aide In-Service policy defining the procedure, required components and documentation requirements for the in-service program.

16 B. The provider shall offer a minimum 12 hours of in-service education each calendar year. Certified homemaker-home health aides shall obtain, at minimum, 12 hours of in-service each calendar year which shall be documented in the personnel record.

Aides who work only a portion of the calendar year (such as a new hire) or have a documented period of inactivity (such as a leave of absence) shall obtain a pro-rated number of in-service hours based on the number of full months worked. For these aides a minimum of one hour of in-service for each full month of work is required.

NOTE: For example, if an aide is hired in mid-October and works until the end of December, two hours of in-service education are required.

16 C. Certified homemaker-home health aides shall obtain, at minimum, instruction in the following mandatory in-service topics each year:

- blood borne pathogens
- infection control
- standard precautions
- child abuse
- elder abuse
- domestic violence
- pain management
- Workforce protection
- Employee Safety
- Back Safety
- Needle stick safety
- Fraud and abuse protection
- Corporate Compliance
- Corporate Compliance
- Pain management.

16 D. The mode of delivery of the in-service programs shall be in accordance with the provider’s Certified Homemaker-Home Health Aide In-Service policy. Acceptable modes of delivery include, but are not limited to, in-person teacher instruction, self-study materials, take-home education materials, videos, online learning programs and procedures taught by the nursing supervisor in a patient’s home (up to ½ hour per procedure).

If self-study materials, take-home materials, video or online learning programs are used for in-service, there must be an RN available to answer any questions.

NOTE: The Homemaker-Home Health Training program hours may not be counted as in-service.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

16 E. For newly hired certified homemaker-home health aides, the orientation to the agency program requires the above mandatory in-service topics which may be counted towards the yearly total of in-service hours. In addition, up to 2 hours of the administrative components of the orientation to the agency program may be counted towards the yearly total of in-service hours.

NOTE: The mandatory in-service topics required as part of the agency orientation shall only be conducted as in-office instruction. (See Standard IV, Intent 12C – Agency Orientation.)

16 F. The provider shall have an annual written schedule of in-services classes, if in-person instruction is offered. The schedule shall include, at minimum:

- program topics
- dates and times offered
- length of time for each topic
- instructor’s name, if known.

16 G. The provider shall require attendance sign-in sheets for each in-service class taught in-person by an instructor. The attendance sign-in sheet shall include, at minimum:

- location
- instructor’s name
- program topic
- date and time
- length of time
- certified homemaker-home health aide’s signature.

16 H. The provider shall maintain a list of in-service topics that are offered via self-study, take-home materials, video or online programs. The list shall include the hours per topic and the means of evaluating the completion of the educational activity.

16 I. The documentation requirements for in-service topics presented via self-study, take-home materials, video or online programs shall include, at minimum:

- mode of delivery (self-study, video, etc.)
- topic
- in-service hours awarded for each topic
- date of completion of the activity
- certified homemaker-home health aide’s signature
- signature, date and title of agency staff person who has awarded the in-service hours.

16 J. The provider may accept in-service hours furnished by an outside source, such as another home health care agency or nursing facility.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

The provider shall obtain supporting documentation of the certified homemaker-home health aide’s in-service attendance, including at a minimum:

- certified homemaker-home health aide’s name
- instructor’s name
- program topic
- mode of delivery
- date and time
- length of time
- signature, date and title and of the outside instructor or other appropriate personnel verifying the in-service(s)
- Name and location of the outside source, i.e. facility/institution, or agency.
STANDARD IV
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CAHC SAMPLE

For CHHA personnel record

Verification for Self-Study, Take Home, Video, On-Line In-Service

Name of CHHA: ____________________________________________________________

Topic: _____________________________________________________________________

Mode of Delivery:
☐ Self-Study   ☐ Take Home   ☐ Video   ☐ On-Line   ☐ Other__________________

# Hours earned: ___________________________

Date In-service Completed:__________________________________

CHHA Signature: ____________________________________________

__________________________________________________________________________

Signature/Title/Date of Agency staff approving hours
STANDARD IV
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STANDARD IV

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Intent 18: Rehire Requirements

The provider shall have a protocol for the rehiring of personnel.

18 A. The provider shall have a Rehire policy outlining the definition of a rehire and of a new hire after a defined period of not working. The policy shall also include the selected personnel record components that are required for rehiring certified homemaker-home health aides/field nurses and nursing supervisory personnel.

18 B. The following criteria shall be clearly defined in the Rehire policy:
   - the length of time an employee may remain inactive or the length of time since an employee resigned and return as a rehire. This period may not exceed one year.
   - the length of time an employee may remain inactive or the length of time since an employee resigned and return as a new hire.

18 C. The rehire documentation requirements shall include, at minimum:
   - date last worked and date of rehire
   - required components of the rehiring process. This shall include updated health information, competency testing, and other requirements per agency policy
   - visual inspection and validation of the original, certificate/license. The provider shall also obtain a fax or on-line verification of the certificate/license from the New Jersey Board of Nursing

18 D. The new hire documentation requirements for an employee who has remained inactive or who has resigned for a period of time exceeding the rehire time limit shall include all components of the hiring process. This includes an application, interview, references, validation of credentials, health requirements, initial clinical competency and orientation to the agency.
STANDARD IV

THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

Intent 19: Staffing Cases

The provider shall be responsible for the appropriate assignment and scheduling of qualified field staff.

19 A. The provider shall have a Staffing Cases policy defining the criteria and procedure for the assignment and scheduling of qualified field staff.

19 B. The assignment of field staff shall include a consideration of the qualifications, experience and clinical competency of the certified homemaker-home health aide/field nurse appropriate to the needs of the patient.

19 C. PCS: The provider shall define those complex or problematic cases which require nursing input into the assignment of the certified homemaker-home health aide(s).

19 D. IHSN: The provider shall define what additional training and/or certification is needed by the field staff for complex skilled nursing cases.
STANDARD IV
THE PROVIDER SHALL USE A FAIR AND CONSISTENT PROCESS TO SELECT QUALIFIED PERSONNEL AND SHALL REGULARLY MONITOR THE PERFORMANCE OF PERSONNEL.

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STANDARD IV

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STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 1: Clinical Records

The provider shall maintain accurate and complete clinical records for each patient serviced.

1 A. The provider shall have a Clinical Records policy defining the components, requirements and time frame for the maintenance of clinical records. This shall take into account all federal, state and local laws and contractual requirements.

1 B. The clinical records shall be kept confidential and securely locked.

1 C. IHSN: The provider shall have a policy defining the components, requirements and time frame for the maintenance of a home record. The home record shall include, at minimum: initial assessment, reassessments, physician’s orders, advance directives, nursing plan of care, nursing progress notes, medication profile and medication administration records.

1 D. The provider shall designate the person(s) permitted to have access to the clinical records.

1 E. The clinical record shall contain, at minimum:
   - Initial Intake
   - IHSN: Physician’s Orders
   - PCS: Physician’s Certification of Need for Services, if applicable
   - Date service initiated
   - Advance Directives
   - Service Agreement
   - Patient’s Bill of Rights
   - Initial Assessment
   - IHSN: Medication Profile
   - IHSN: Medication Administration Record
   - Plan of Care/Nursing Plan of Care
   - Discharge planning
   - Orientation to the case for each aide/field nurse
   - Clinical supervision of the aide/field nurse
   - Case Monitoring Notes
   - PCS: Weekly Activity Sheets
   - IHSN: Nursing Progress Notes
   - Reassessments
   - Discharge Summary, if applicable.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

1 F. The clinical record shall clearly document all start and end dates of service, such as hospitalization, vacation, readmission, discharge, etc.

1 G. The following documentation shall always remain in the active clinical record:
   - Date service initiated
   - Intake
   - Initial Assessment
   - Discharge Planning
   - Service Agreement
   - Advance Directives
   - Patient’s Bill of Rights.

The following documentation shall be accessible to the surveyor for at least the most recent 18 months:
   - IHSN: Physician’s Orders
   - PCS: Physician’s Certification of Need
   - Plans of Care/Nursing Plans of Care
   - IHSN: Medication Profile
   - IHSN: Medication Administration Record
   - Orientation to the Case
   - Aide Activity Sheets/Nursing Progress Notes
   - Case Monitoring
   - Clinical Supervision
   - Reassessments
   - Discharge Summary.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 2: Availability of Service

The provider shall have written admission and discharge criteria, servicing only those cases that can be appropriately and safely staffed by the provider.

2 A. The provider shall have an Admission policy defining:
   - type of services offered
   - criteria for admission to service
   - service area
   - service hours
   - minimum/maximum hours of service, if applicable
   - fees and insurance coverage
   - on-call availability
   - procedure to follow if a referral is not accepted.

2 B. The provider shall have an Interruption of Service policy defining the procedure for resuming service after a break in service, such as a vacation.

NOTE: The procedure following hospitalization or a stay in a medical facility is addressed in Reassessment. (Standard V, Intent 18)

2 C. The provider shall have a Discharge policy defining:
   - criteria for discharge from service
   - criteria for when an outside source needs to be notified of the discharge
   - procedure to follow if the patient is transferred to another program.

For example, the discharge criteria may include such components as the patient requires more service than the agency can provide; the home environment is unsafe for the certified homemaker-home health aide/field nurse; or the patient moves out of the agency’s service area.

NOTE: The Discharge policy outlines the general reasons why the provider may discontinue service while the Patient Discharge Planning policy (Standard V, Intent 19) addresses the process for discharging a specific patient.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 3: Intake and Job Order

The provider shall ensure that any patient admitted can be serviced appropriately, in accordance with the agency’s Admission policy.

3 A. The provider shall have an Intake policy defining the process of accepting patients for service in accordance with the admission criteria.

3 B. The provider and/or Director of Nursing shall designate the person(s) responsible for obtaining the intake information.

3 C The intake shall be completed prior to or on the date service is initiated.

3 D. The intake documentation shall include, at minimum:
- Date and signature of the person who performed the intake
- Patient name, Date of Birth, gender
- Past medical history, if known
- Medical diagnosis, if known
- Medications, if known
- Referral source
- Pertinent information needed to determine appropriateness of service, according to the admission criteria
- Start of Care date
- Name and phone number of the physician who is primarily responsible for the patient.
- Name and contact information of family member/legal guardian and relationship to patient
- Services in place or needed
- Collateral contacts

3F. The Job Order information shall include:
- Description of setting (residence, school, etc.)
- hours to be worked
- Title/position of staff provided (CHHA, field nurse, Nursing Supervisor, etc.)
- Duties/special skills required
- Special equipment, if applicable
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 4: PCS: Physician’s Certification of Need for Services

The provider shall provide Personal Care Services following the receipt of a Physician’s Certification of Need for Services for those cases where required by payer source.

4 A. The provider shall have a Physician’s Certification of Need for services policy defining the components and time frame for obtaining written confirmation from the patient’s physician for the provision of personal care services for those cases where it is required by payer source, such as Medicaid/PCA.

4 B. The provider shall designate the person(s) responsible for obtaining the physician’s certification of need for services.

4 C. Physician’s certification of need for services shall be obtained prior to or on the date service is initiated and renewed, if required by payer source.

For PCA: If a verbal physician's certification is obtained, this shall be documented in the clinical record with signature of nurse taking the order and date. A faxed certification is also accepted until the physician’s signature is obtained. The physician’s written order with counter signature will be obtained, in conformance with written agency policy.

4 D. The documentation shall include, at minimum:
   • Name of the patient
   • Certification of the need for personal care services
   • Date and signature of the physician.

4 E: An authorized electronic signature is acceptable for the Certificate of Need.

4 F: A Nurse Practitioner may sign the Certificate of Need for the physician if approved by payer source.
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 5: IHSN: Physician’s Orders

The provider shall provide In-Home Skilled Nursing services in accordance with timely and complete physician’s orders.

5 A. The provider shall have a Physician’s Orders policy defining the components and time frame for obtaining physician’s orders. Physician’s orders shall reflect a complete assessment of the patient and provide a basis for nursing care.

5 B. The provider shall obtain a fax or online verification of the physician’s license from the licensing board in the appropriate state prior to the start of care and updated annually. This verification shall be maintained separately, apart from the clinical record.

NOTE: Orders from physicians licensed in a state other than New Jersey are acceptable, unless prohibited by the payer source.

5 C. The Director of Nursing or RN designee shall take physician’s telephone orders

5 D. Physician’s orders shall be obtained prior to or on the date service is initiated. At minimum, they shall be renewed every 90 days and when there is an interruption of service. The physician’s orders shall be updated when required by a change in the patient’s condition.

NOTE: Medicare 485 forms may be used as physician’s orders.

5 E. Verbal physician’s orders: The provider shall obtain an original signed and dated physician’s order within 30 calendar days of receipt of verbal orders.

5 F. Documentation of all conversations with a physician concerning verbal orders shall include, at minimum:
   • Date and signature of the nurse taking the orders
   • Name of the physician
   • Content of the conversation and instructions received.

5 G. Written orders: The provider shall obtain signed and dated written physician’s orders within 30 calendar days. The documentation shall include, at minimum:
   • Name of the patient
   • Specific details regarding medications, treatments, procedures and other skilled nursing care that is required
   • Date and signature of the physician.

NOTE: Certain situations, such as narcotics administration, would necessitate an earlier receipt of the written order. Such situations shall be defined in the provider’s policy.
Intent 6: Advance Directives

Patients shall be informed of their right to specify directions concerning their future medical care.

6 A. The provider shall have an Advance Directives policy defining the procedure for informing the patient/significant other about Advance Directives and providing Advance Directives material to the patient/significant other. The policy shall define the procedure to be followed when a minor patient reaches age 18 or if the patient is not competent.

6 B. The provider shall give written Advance Directives material to the patient/significant other for all patients who are 18 years old or over.

6 C. The Advance Directive material shall be given prior to or on the date service is initiated. They shall clearly state that Advance Directives may be changed at any time and that Advance Directives are not a condition for the provision of care.

6 D. The Advance Directives documentation shall include, at minimum:
   - Date and signature of the patient/significant other or the agency staff person, indicating that the Advance Directives material was given
   - A notation of whether or not the patient has an Advance Directive
   - The location of the Advance Directive, if one has been completed.

*NOTE: See sample verification form following this intent.*
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

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STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

SAMPLE ADVANCE DIRECTIVES VERIFICATION FORM
Patient Self Determination
Verification of Patient Education

NOTE: This form was based on a sample published by the New Jersey Department of Health and Senior Services.

Please check all that are applicable:

_____ The federal and state laws regarding Advance Directives have been explained to me and I have received material about these laws.

_____ I have formulated Advance Directives on _____________.

_____ I have given copies to ____________, ____________, and ____________.

_____ I have not formulated Advance Directives.

_____ I have executed a Power of Attorney with medical decision making authority to:

__________________________
(Name)

_____ I have been advised to give a copy of my Advance Directives to my physician.

_____ I understand that the home health agency does not require that I develop Advance Directives in order to receive care.

_____ I understand that I can make changes to my Advance Directives at any time.

__________________________  ____________________________
(Date)                     (Date)

__________________________  ____________________________
(Patient Signature)        (Nurse Signature)

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

As __________________________ does not have decision making capacity, I

__________________________, as the representative, attest to the above information.

__________________________
(Patient Representative Signature)
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

ADVANCE DIRECTIVE ATTESTATION (to be given on or before start of care)

Client Name: _______________________________________,

_____ Client has an Advanced Directive.

_____ I have been advised to give a copy of my Advance Directives to my physician.

_____ I understand that I can make changes to my Advance Directives at any time.

Copies of the Advanced Directive can be found ____________________________________.

Copies of the Advanced Directive have been given to _______________________________
and ____________________________________,

_____ Client has does not have a Power of Attorney or Health Care Proxy.

_____ Medical decision making authority has been given by Power of Attorney to:

__________________________________________ / ______________________ / ________________.

Name    Relationship    Phone number

_____ A copy of the Power of Attorney document is attached

_____ Client does NOT have an Advanced Directive.

_____ I understand that the home health agency does not require that I develop an
Advanced Directive in order to receive care.

_____ Federal and state laws regarding Advance Directives have been explained
and materials have been provided about these laws by the Nursing Supervisor.

Client Signature: X ____________________________ Date: _____/_____/_____

The Client has given me the responsibility of acting as the Client Representative. By signing
below, I attest to the above information as being true.

Signature Client Representative: ___________________________ Date: _____/_____/_____

Relationship to Client: ________________________________

X ___________________________________________ / _____/_____/_____

(Nurse Signature/Title)     (Date)

Notes:
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 7: Service Agreement

Patients shall be informed about service arrangements, including fees and limitations of service, before or at the initiation of service.

7 A. The provider shall have a Service Agreement policy defining the procedure for obtaining a signed Service Agreement from the patient/significant other. The policy shall define the procedure to be followed when a minor patient reaches age 18 or if the patient is not competent.

7 B. The provider shall obtain a signed Service Agreement from the patient/significant other prior to or on the date service is initiated.

NOTE: For Division of Child Protection and Permanency (DCPP) cases, the provider shall check with the DCPP social worker regarding who is the legal guardian of the minor receiving service.

7 C. The Service Agreement shall include, at minimum:
- Date and signature of the patient/significant other
- Type of service to be provided (PCS and/or IHSN)
- Type of employee to be provided (certified homemaker-home health aide, RN, LPN, etc.)
- Consent for care
- Consent for release of information, including a release applicable for CAHC
- Financial arrangements and a current fee schedule, if applicable. The exception is when prohibited by payer source, such as Medicaid.
- Initial days and hours of service with a statement that these may change, according to the patient’s needs
- Conditions for discharge/transfer.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 8: Patient’s Bill of Rights

Patients shall be informed of their rights and responsibilities as a consumer of home care services.

8 A. The provider shall have a Patient’s Bill of Rights policy defining the procedure for informing the patient/significant other about the Patient’s Bill of Rights and providing Patient’s Bill of Rights material to the patient/significant other. The policy shall define the procedure to be followed when a minor patient reaches age 18 or if the patient is not competent.

8 B. The provider shall give Patient’s Bill of Rights materials to the patient/significant other prior to or on the date service is initiated.

8 C. The Patient’s Bill of Rights materials shall include, at minimum:
- Clear statements about the provider’s responsibilities to the patient
- Clear statements about the responsibilities of the patient/significant other
- Information about the grievance procedure, including the contact information listed in 8 E. below
- Date and signature of the patient/significant other, indicating that the Patient’s Bill of Rights materials were received.

8 D. The provider shall have a Grievance policy defining the grievance procedure a patient/significant other shall follow in the event of a complaint or problem.

8 E. The steps of the grievance procedure shall include, at minimum:
- When a patient complaint or problem is reported, the provider shall first go through an internal grievance procedure.
- If it is not satisfactorily resolved at the provider level, then appropriate outside entities shall be involved.
- Written information on how to contact the following outside entities shall be provided: Division of Consumer Affairs; Division of Disability Services (PCS), if applicable; Division of Medical Assistance and Health Services (IHSN), if applicable; and the Commission on Accreditation for Home Care.
- The provider shall maintain documentation of the complaint and the steps taken to resolve the complaint in accordance with the Grievance policy.
- The response to grievances shall be part of the risk management program and the monitoring of grievances shall be incorporated into the PQI process.

NOTE: Components of the Patient’s Bill of Rights may be contained elsewhere, such as on the Service Agreement.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 9: Initial Assessment

A Nursing Supervisor shall perform a nursing assessment of each patient to establish a baseline of the patient’s physical and functional status.

9 A. The provider shall have an Initial Assessment policy defining the procedure for obtaining a nursing assessment of each patient. The provider shall also have a Pain Management policy which includes, at a minimum, assessing the level of pain and treatment, as applicable.

9 B. The nursing supervisor shall perform an initial nursing assessment in the patient’s home prior to the start of services.

9 C. The initial assessment documentation shall include, at minimum:
   • Past medical history
   • Date of birth
   • Gender
   • Diagnosis
   • Vital signs, including temperature, pulse, respiration, blood pressure, pain assessment
   • Fall assessment
   • Functional status
   • A systems review (respiratory, GI, cardiac, etc.)
   • Psychosocial review relevant to the plan of care
   • Nutritional status, including diet
   • Home safety review
   • An emergency priority code (see 9.D)
   • Significant other information, including name, phone number, and relationship to the patient
   • Services in place, additional services needed and collateral contacts, if applicable
   • IHSN ONLY: educational needs concerning the patient’s care, treatment or medications, if applicable
   • Date and signature of the nursing supervisor.

NOTE: The following required information may be documented anywhere in the clinical record:
   • diagnoses
   • emergency priority code for the patient
   • significant other information.

The assessment of pediatric patients shall include age-appropriate documentation, such as immunizations and developmental milestones.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

9 D. The provider shall have an Emergency Preparedness policy defining the procedure for implementing an agency-wide disaster plan. This shall include establishing case priority and assigning an emergency priority code for all patients. This coding may be based on the system developed by the New Jersey Home Care Association. Preparation of this Patient Classification System for New Jersey home care was supported, in part, by grant funding to the Home Care Foundation of New Jersey from the New Jersey Department of Health and Senior Services, Health Infrastructure Preparedness and Emergency Response, Trenton, New Jersey. (See page 104a – 104b)
September 27, 2005

Dear Home Health Care Administrator:

In 2004, The Home Care Association of NJ received a grant funded by the NJ Department of Health and Senior Services, Office of Emergency Management, to provide emergency preparedness training sessions to home health care agencies throughout the state. Participants in these training sessions determined that our state lacked a reliable patient classification system for emergency management purposes for use by all home health care agencies and health care service firms.

Under the leadership of the Home Care Association of NJ, a volunteer task force accepted the challenge to develop a Patient Classification system and emergency patient admission assessment tool that could be used by agencies in the event of a biological, chemical, nuclear incident or natural disaster. The Task Force recognized that some agencies may have already developed a Patient Classification system; however, having one patient classification system used throughout the state would prevent confusion and discrepancies and enhance patient safety. Understanding of and use of the same classification system by all home care agencies and emergency management officials would provide a clear communication tool to enhance emergency preparedness planning.

We recommend that you review the enclosed materials and consider adopting them into your agency’s disaster/emergency preparedness plan. We also recommend that you encourage and assist your patients to develop their own emergency preparedness plans.

The Task Force determined that the patient’s level of priority classification is based on input from professionals, paraprofessionals and family members. Patient classification is a dynamic entity based on the patients’ changing conditions and should be updated on an ongoing and routine basis, at least weekly, and at the time of an impeding disaster, if time permits.

The examples under the Patient Classification priority levels are not listed in any rank order. These are suggestions for how you may wish to classify your patients. The Task Force has purposely not recommended time frames for the priority levels recognizing that numerous factors may affect each agency’s ability to respond, including the time, type and location of the disaster, available personnel, and the care requirements of the patients. The Task Force also recognizes that it may not be agency staff who are able to access the patient, but local emergency management, fire and safety personnel.

Thank you for taking the time to consider this salient issue. If you have any questions or comments, please feel free to contact Josephine Sienkiewicz, Director of Education and Clinical Practice, at the Home Care Association of NJ, 732-877-1100, email jfs@homecarenj.org.

Sincerely,

The Patient Classification Task Force
Home Care Association of NJ
Quality Network Commit
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

PATIENT CLASSIFICATION TASK FORCE
PATIENT CLASSIFICATION GUIDE FOR EMERGENCY MANAGEMENT/DISASTER PREPAREDNESS

LEVEL 1-Highest Priority

The patient in this priority level needs uninterrupted services. The patient’s condition is highly unstable and deterioration or inpatient admission is highly probable if the patient is not seen. In case of a disaster or emergency, every possible effort must be made for the patient to receive care.

Examples of these may include but are not limited to:

- A patient who is bed bound; paralyzed; ventilator dependent; unable to meet physiologic and safety needs
- A daily insulin dependent diabetic, who is unable to self administer and without support to administer and is not well regulated
- A patient who needs extensive wound care
- An infusion therapy patient who require daily visits
- A patient who needs apnea monitoring
- A psychiatric patient unable to self administer medications
- A cognitively impaired patient with urgent safety issues
- A functionally impaired patient requiring daily assistance to meet physical and nutritional health needs

LEVEL 2-Moderate Priority

The patient in this priority level may have a recent exacerbation of a disease process. The patient requires a moderate level of skilled care that should be provided but may be able to be delayed until the emergency is contained. The patient may have essential untrained family/caregivers not prepared to provide needed care.

Examples may include but are not limited to:

- A patient who uses equipment PRN, i.e. oxygen, suctioning, nebulization, PCA pump
- A diabetic who self administers insulin; requires skilled monitoring of blood glucose less than every 24 hours
- A patient who has extensive wound care needs with support/back-up assistance
- A patient with multiple medication changes in the past 1-2 weeks
- A patient with recent changes in their treatment plan
- A patient who requires medication prefills
- A patient who requires custodial care who could not otherwise be managed

LEVEL 3- Low Priority

The patient in this priority level can safely forego care or a scheduled visit without a high probability of harm or deleterious effects. The patient is able to manage alone for several days or may have significant others or available support systems in place.

Examples may include but are not limited to:

- A patient who is mobile; independent in functioning
- A patient needing uncomplicated routine wound care
- A patient who self manages medications/diet
- A patient who is a low safety risk
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 10: IHSN: Medications

A Nursing Supervisor shall ensure that there is a current and accurate Medication Profile and Medication Administration Record documenting that the medications are given in accordance with the physician’s orders.

10 A. The provider shall have a Medications policy defining the components of and time frame for the review of the medication profile and the medication administration record.

10 B. The medication profile and medication administration record shall be consistent with the current physician’s orders. All prescription and non-prescription medications, whether administered by the field nurse or the patient/significant other, shall be included.

10 C. The nursing supervisor shall complete the medication profile at the time of the initial assessment, by the second day of service. The nursing supervisor shall update the medication profile every time the physician’s orders indicate a medication change.

10 D. The medication administration record shall be maintained as part of the home record as documentation of the medications administered by the field nurse.

10 E. The medication profile and medication administration record shall be reviewed by the nursing supervisor during every case monitoring and reassessment visit, at a minimum.

10 F. The medication profile documentation shall include, at minimum:
   ● Medication name, dosage, frequency, route and side effects
   ● Date and signature of the nursing supervisor.

10 G. Whenever there is a medication change, the documentation shall include, at minimum:
   ● New medication information, including name, dosage, frequency, route and side effect.
   ● Date and signature of the nursing supervisor.

10 H. The documentation of the review of the medication profile shall include, at minimum:
   ● Date of the review and signature of the nursing supervisor conducting the review.

NOTE: It may be included as part of the case monitoring/reassessment documentation.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

10 I. The medication administration record documentation shall include, at minimum:
- Date and time each medication is administered
- Medication name, dosage, frequency, time and route of each medication that is administered
- Signature of the field nurse administering the medication.

10 J. The documentation of the review of the medication administration record shall include, at minimum:
- Signature/title of the nursing supervisor conducting the review and date.

NOTE: It may be included as part of the case monitoring/reassessment documentation.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 11: PCS: Plan of Care

A Nursing Supervisor shall develop an individualized plan of care based on a nursing assessment of each patient receiving services.

11 A. The provider shall have a Plan of Care policy defining the procedure for developing an individualized plan of care by the nursing supervisor.

11 B. The nursing supervisor shall develop a plan of care, based on a nursing assessment, on or before start of service.

11 C. The patient/significant other shall participate in developing the plan of care.

11 D. The plan of care shall include goals as part of the discharge planning process. (For example, maintain an adequate level of functioning in the home.)

11 E. Each aide assigned to the patient shall be oriented to the plan of care by an RN. (See Standard V, Intent 13 – Orientation to the Case)

11 F. The plan of care documentation shall include, at minimum:
   • Days and hours of service
   • Tasks the certified homemaker-home health aide is to perform, including the frequency of the tasks
   • Short-term and long-term goals for patient care and discharge
   • Medical diagnosis, if known
   • Specific changes in patient status that need to be reported to the nursing supervisor
   • Date, signature/title of the nursing supervisor
   • Date, signature of the patient/significant other
   • Date, signature/title of the certified homemaker-home health aide upon assignment, reassessment and whenever a change is made to the Plan of Care

11 G. The RN, patient/significant other and certified homemaker-home health aide shall sign and date the plan of care at the following times:
   ▪ At Initial Assessment or Orientation to the Case
   ▪ Whenever the plan of care is updated to reflect a change in the patient’s status.
   ▪ At the six month reassessment

11 H. A copy of the plan of care shall be in the patient’s home and in the clinical record.

11 I. The RN supervisor or designee will establish contact with the patient and/or family and/or the CHHA at least once every 30 days to ensure that the plan of care is being executed appropriately and that it continues to be consistent with the needs of the patient. All findings will be documented.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 12: IHSN: Nursing Plan of Care

A Nursing Supervisor shall develop an individualized nursing plan of care based on a nursing assessment and reflecting the physician’s orders.

12 A. The provider shall have a Nursing Plan of Care policy defining the procedure for developing an individualized nursing plan of care by the nursing supervisor.

12 B. The nursing supervisor shall develop a nursing plan of care, based on a nursing assessment and reflecting the physician’s orders, by the second day of service.

12 C. The nursing plan of care shall include goals as part of the discharge planning process.

12 D. Each field nurse assigned to the patient shall be oriented to the nursing plan of care by an RN. (See Standard V, Intent 13 – Orientation to the Case)

12 E. The nursing plan of care documentation shall include, at minimum:
   • Days and hours of service
   • Diagnoses and medical conditions identified in the physician’s orders related to the provision of care
   • Care, treatment and procedures identified in the physician’s orders
   • Nursing diagnoses and nursing interventions
   • Frequency of the care, treatment and procedures
   • Short-term and long-term goals for patient care and discharge
   • Change in patient status to be reported to Nursing Supervisor
   • Date and signature of the nursing supervisor
   • Date and signature of each field nurse at time of first assignment, at reassessment and whenever there are changes in the nursing plan of care.

12 F. The Nursing Supervisor will contact the patient/family and Field Nurse at least once every 30 days to ensure that the plan of care is being executed appropriately and that it continues to be consistent with the needs of the patient.

12 G. The nursing supervisor and field nurses who are present shall sign and date the nursing plan of care or nursing care plan attestation form at the following times:
   • At time of assessment/orientation
   • When the nursing plan of care is updated to reflect a change in the patient’s status.
   • At the six month reassessment

12 H. The RN supervisor or designee will establish contact with the patient and/or family and CHHA at least once every 30 days to ensure that the plan of care is being executed appropriately and that it continues to be consistent with the needs of the patient. The copy of the nursing plan of care shall be maintained in both the clinical record and the home record.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 13: Orientation to the Case

A Nursing Supervisor shall orient each certified homemaker-home health aide/field nurse to each patient at the time of assignment.

13 A. The provider shall have an Orientation to the Case policy defining the procedure for ensuring that each certified homemaker-home health aide/field nurse is oriented to each patient by the nursing supervisor.

13 B. The orientation to the case shall include, at minimum, a review of the care plan.

13 C. The nursing supervisor shall use professional judgment to determine the safe and appropriate location for the orientation, even if it is with an ongoing employee.

13 D. Orientation of newly hired certified homemaker-home health aides/field nurses who are placed on their first case, to an already existing case of the provider’s:
   - The orientation shall be performed on or before the first day of placement on the case, prior to start of care during the time the certified homemaker-home health aide/field nurse is in the home.
   - It may be performed either in-person or by telephone.
   - If performed by telephone, the nursing supervisor shall then conduct an in-home orientation on the first day of service.

NOTE: There shall always be an initial clinical supervision along with the initial orientation to the case for homemaker home health aides/field nurses placed on their first case.

13 E. Orientation of certified homemaker-home health aides/field nurses who are ongoing employees on an existing case:
   - The orientation shall be performed at the start of service on the case.
   - It may be conducted either in-home, by telephone, or in the office.

13 F. Orientation of certified homemaker-home health aides/field nurses assigned to a new patient shall always take place in the home at or before the start of service regardless of the experience level of the certified homemaker-home health aide/field nurse.

NOTE: When a new case is opened, there shall always be clinical supervision along with the initial orientation to the case.

13 G. The orientation to the case documentation shall include, at minimum:
   - Where the orientation was performed (home, telephone, office)
   - Name of the certified homemaker-home health aide/field nurse who was oriented
   - Review of the care plan
   - Instructions given to the certified homemaker-home health aide/field nurse
   - Date and signature of the nursing supervisor.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 14: PCS: Weekly Activity Record

The assigned certified homemaker-home health aides shall document rendered care in accordance with the plan of care.

14 A. The provider shall have a Weekly Activity Record policy defining the procedure and time frame for the timely completion and submission of weekly activity sheets.

If the provider uses a telephonic system in lieu of weekly activity sheets, the policy shall define the procedure that includes the following components, at minimum:
- Description of the system used
- Staff orientation and education
- Monitoring of compliance and incorporation into PQI program
- Security
- Computer, Internet and telephone back-up.
- Inclusive

14 B. Certified homemaker-home health aides shall document each patient assignment on a weekly activity record that includes all activities performed for the patient, as indicated on the plan of care.

NOTE: If an activity was not performed as scheduled, a reason must be given as to why it was not done.

14 C. Weekly activity records shall be submitted to the provider office within two calendar weeks of the latest service date of the activity performed. The provider shall date verify the weekly activity information when received. For paperless systems, access to the activity record must be available.

14 D. The weekly activity documentation shall include, at minimum:
- Date and time of each patient assignment
- Documentation of the activities performed
- Any change in the patient’s condition that was reported to the nursing supervisor and documented by the aide and nurse supervisor
- Date and signature of the certified homemaker-home health aide.
- Date and signature of client or designated party
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 15: IHSN Nursing Progress Notes

The assigned field nurses shall render care in accordance with the nursing plan of care.

15 A. The provider shall have a Nursing Progress Notes policy defining the procedure and time frame for the timely completion and submission of nursing progress notes. Nursing progress notes include all nursing documentation, such as nursing flow sheets and medication administration records.

15 B. Field nurses shall complete nursing progress notes for each visit or shift.

15 C. The nursing supervisor shall review the nursing progress notes with the field nurse during each case monitoring and reassessment visit. (See Standard V, Intents 16 & 18)

15 D. Nursing progress notes shall include, at minimum:
  * Date and time of each visit or shift
  * Documentation of the care given in accordance with the nursing plan of care
  * Response to care given
  * Date and signature of the field nurse.

15 E. The documentation of the review of the nursing progress notes shall include, at minimum, the date of the review and signature of the nursing supervisor conducting the review.

NOTE: It may be included as part of the case monitoring/reassessment documentation. If the volume of nursing documentation makes it impractical for all the nursing progress notes to be kept in the clinical record, this documentation may be kept separately as long as it is readily accessible on-site.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 16: Case Monitoring

A Nursing Supervisor shall evaluate the patient within every 60 days to ensure that the care plan remains consistent with the needs of the patient.

16 A. The provider shall have a Case Monitoring policy defining the procedure for timely case monitoring visits by the nursing supervisor.

16 B. The nursing supervisor shall conduct a case monitoring visit in the patient’s home every 60 days or more often, if the patient’s condition warrants it, to re-evaluate the status of the patient and the appropriateness of the plan of care. Case monitoring visits may be conducted more often based on contractual agreements, such as Medicaid or private insurance.

NOTE: IHSN: For Medicaid private duty nursing (PDN) cases, the nursing supervisor shall conduct a case monitoring visit in the patient’s home every 30 days or more often, if the patient’s condition warrants it, to evaluate the status of the patient.

16 C. The case monitoring visit shall be conducted during the time when the certified homemaker-home health aide/field nurse is providing service in the home.

16 D. IHSN: The nursing supervisor shall ensure that the care rendered is consistent with the physician’s orders and the nursing plan of care by reviewing the home record during each case monitoring visit and by reviewing the office clinical record.

16 E. The case monitoring review shall include, at a minimum:
- Functional status
- Change in condition of the patient, including a pain assessment
- Psych/social review relevant to plan of care
- Nutrition and diet
- Fall risk and home safety review
- The emergency plan
- Indication that the Plan of Care continues or does not continue to meet patient care needs
- **PCS**: Temperature, pulse, respirations and blood pressure only if deemed necessary based on the clinical judgment of the nursing supervisor
  - Review of the plan of care with the Certified Home Health Aide and patient
- **IHSN**: Vital signs including pain assessment are required
  - Review of the physician’s orders, nursing plan of care, nursing progress notes, medication profile and medication administration records with the field nurse
- Support services already in place and referrals made, if applicable
- Name of the certified homemaker-home health aide/field nurse present
- Signature, title and date of Nursing Supervisor
- Signature, title and date of CHHA/field nurse
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 17: Clinical Supervision

A Nursing Supervisor shall directly observe the clinical performance of each certified homemaker-home health aide/field nurse in a patient’s home on a regular basis.

17 A. The provider shall have a Clinical Supervision policy defining the procedure for timely supervision home visits by the nursing supervisor.

17 B. The nursing supervisor shall visit the patient’s home during the time when care is rendered to observe the clinical skills of the certified homemaker-home health aide/field nurse at the following times:
- For certified homemaker-home health aides/field nurses who are newly hired: On or before the start of service
- PCS: at least once every 60 days
- IHSN: RN – at least once a year
  LPN – at least once every 6 months
- More frequently, based on the judgment of the nursing supervisor or the patient’s condition
- More frequently, based on payer source requirements, such as Medicaid private duty nursing (PDN), etc.

17 C. The nursing supervisor shall observe the skills of the certified homemaker-home health aide/field nurse in carrying out the plan of care/nursing plan of care to ensure that care is rendered safely and competently.

17 D. The supervision documentation in the Personnel Record shall include, at minimum:
- Name of CHHA/field nurse
- Indication that the plan of care was reviewed with the CHHA/field nurse
- Skill(s) observed in carrying out the care plan
- Indication whether the certified homemaker-home health aide/field nurse is competent to carry out the plan of care/nursing plan of care
- Instructions provided by the nursing supervisor, if applicable
- Date and signature/title of the nursing supervisor.
- Date and signature/title of CHHA/field nurse

17 E. The supervision documentation in the patient’s Clinical Record shall include:
- Name of the certified homemaker-home health aide/field nurse who was supervised during the patient case monitoring visit
- Indication that the plan of care was reviewed with the certified homemaker-home health aide/field nurse
- Skill(s) observed in carrying out the care plan.
- Date and signature/title of the nursing supervisor.
- Date and signature/title of CHHA and/or field nurse

NOTE: The supervision documentation in the personnel record shall not contain protected information about the patient, such as name or vital signs. Likewise, the supervision documentation in the clinical record shall not contain details about employee performance.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

Intent 18: Reassessment

A Nursing Supervisor shall perform a nursing reassessment of the patient’s physical and functional status on a regular basis.

18 A. The provider shall have a Reassessment policy defining the procedure for obtaining a nursing reassessment at least every 6 months.

18 B. The nursing supervisor shall perform a nursing reassessment in the patient’s home during the time when the certified homemaker-home health aide/field nurse is present. The clinical supervision of field staff shall also be completed at this time.

18 C. The reassessment visit shall be conducted at the following times:
   • At least once every six months
   • By the second day of service after a hospitalization or stay in a medical facility, if deemed necessary by the nursing supervisor
   • When service is interrupted, according to the Interruption of Service policy
   • More frequently, based on the judgment of the nursing supervisor or the patient’s condition, including when a patient’s residence changes.

18 D. The reassessment documentation shall include, at minimum:
   • Diagnosis
   • Vital signs, including temperature, pulse, respiration, blood pressure and a pain assessment
   • Functional status
   • A systems review (respiratory, GI, cardiac, etc.)
   • Psychosocial review relevant to the plan of care
   • Nutritional status, including diet
   • Home safety review
   • An emergency priority code
   • Services in place, additional services needed and collateral contacts, if applicable
   • Name of the certified homemaker-home health aide/field nurse who was present
   • Indication that the certified homemaker-home health aide/field nurse was supervised and the skill(s) observed
   • PCS: review of the care plan with the certified homemaker-home health aide and patient
   • IHSN: review of the physician’s orders, nursing plan of care, nursing progress notes, medication profile and medication administration records with the field nurse
   • IHSN: education needs concerning the patient’s care, treatment or medications, if applicable
   • Date and signature of the nursing supervisor.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

NOTE: The following required information may be documented anywhere in the clinical record:

- diagnoses
- emergency priority code of the patient.

The reassessment of pediatric patients shall include age-appropriate documentation, such as immunizations and developmental milestones.

18 E. Post-hospitalization or post-discharge from a medical facility:
- The dates of hospital admission, hospital discharge, and return to service shall be clearly documented in the clinical record.
- A reassessment visit to evaluate a change in status is required, unless it is not deemed necessary by the nursing supervisor. The nursing supervisor shall document who was contacted and what was said in order to support the nursing judgment that a reassessment visit was not needed after discharge.

18 F. Interruption of service:
- The last day of service and the return to service dates shall be clearly documented in the clinical record.
- A reassessment visit to evaluate a change in status is required, unless it is not deemed necessary by the nursing supervisor. The nursing supervisor shall document who was contacted and what was said in order to support the nursing judgment that a reassessment visit was not needed after an interruption of service.
Intent 19: Patient Discharge Planning

The provider shall ensure the safe and appropriate discharge of patients from service.

19 A. The provider shall have a Patient Discharge Planning policy defining the procedure for the safe and appropriate discharge of patients.

19 B. A discharge summary shall be completed by the nursing supervisor within 30 calendar days of the discharge date.

19 C. The discharge procedure shall be in accordance with the criteria of the Discharge policy. *(See Standard V, Intent 2 – Availability of Service.)*

19 D. The documentation of discharge planning shall include, at minimum, a statement of goals on the plan of care.

19 E. The discharge summary documentation shall include, at minimum:

- Patient name and address
- Dates of service
- Summary of services provided
- Functional status of patient at discharge
- Reason for discharge/transfer
- Community referrals, if applicable
- Follow-up instructions, if applicable
- Signature of nursing supervisor
- Date discharge summary completed.
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

(Page numbers 118 – 120 reserved for future updates.)
STANDARD V
A REGISTERED NURSE SHALL PROVIDE CLINICAL OVERSIGHT FOR ALL PATIENT CARE SERVICES.

(Page numbers 118 – 120 reserved for future updates.)
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(Page numbers 118 – 120 reserved for future updates.)
GLOSSARY
As defined by CAHC

Accreditation – official authorization indicating that the provider has met the minimum standards of the home care industry.

Administration – the management of an agency, including fiscal, legal, personnel and policy components.

Admission – acceptance of a patient as an appropriate recipient of services offered by the home care provider.

Assessment – a nursing evaluation of a patient’s physical and functional status, including a medical history, vital signs and a review of systems.

Assignment of Field Staff – the appointment of certified homemaker-home health aides/field nurses to a specific patient, ensuring that the qualifications and clinical competencies of the field staff are appropriate to the needs of the patient.

Attestation – affirming in writing to be true, accurate or genuine; authenticating as a witness.

Branch Office – a site that provides patient services, including the presence of personnel and clinical records; the service area does not exceed a 50 miles radius for PCS services; it may also function as the headquarters office of the company.

Calendar Year – January 1 to December 31.

Case Management – the process of delivering individualized home care services to a patient in the home. This includes, but is not limited to, an initial nursing assessment, development and implementation of a plan of care, ongoing case monitoring of the patient’s status, periodic reassessments, review of the plan of care and referrals to needed services.

Case Monitoring – regularly scheduled home visits by a registered nurse to directly observe conditions in the home, the patient’s status and the patient’s response to the care given.

Case Priority – determination of the appropriate use of available staff based on the ranking of patients’ needs for service.

Certified Homemaker-Home Health Aide (CHHA) – paraprofessional who holds a current, valid homemaker-home health aide certificate from the New Jersey Board of Nursing following the successful completion of a New Jersey Board of Nursing approved training course that follows the Unlicensed Assistive Personnel (UAP) curriculum.

Certified Nurse Aide (CNA) – paraprofessional who has received certification from the New Jersey Department of Health to work in long-term care facilities. This certification can not be substituted for the CHHA certification.
**Clinical Competency** – the ability of a certified homemaker-home health aide/field nurse to perform a given clinical skill with proficiency.

**Clinical Supervision** – home visits by a registered nurse to directly observe the clinical skills performed by a certified homemaker-home health aide/field nurse while carrying out the plan of care/nursing plan of care.

**Collateral Contacts** – communication between the provider and any other person involved with the patient’s care.

**Companion** – unlicensed, uncertified paraprofessional who does not provide any “hands on” or personal care services in the home; the scope of CAHC accreditation does not include companion services.

**Complaint** – a statement of wrong, grievance or injury; to express a sense of ill treatment, or of pain or of grief.

**Contingency** – Accreditation with Contingencies is an accreditation status assigned by CAHC for non-compliance with components of the CAHC Standards requiring a plan of correction and/or a follow-up site visit.

**Contract** – a binding written agreement between the provider and another entity.

**Corporate Compliance** – conducting the affairs of a home care agency in accordance with all laws, regulations and agency requirements, such as abiding by a code of conduct and ethics and responding to reports of alleged misconduct or unethical practice.

**Corrective Plan of Action** – a written explanation of the actions to be taken by the provider to correct identified problems with CAHC compliance and to ensure ongoing compliance with CAHC standards.

**Date of First Case** – date that a newly hired certified homemaker-home health aide or field nurse first works in a patient’s home and receives compensation for this work.

**Date Service Initiated** – date that services are first provided in the home of a newly admitted patient.

**Director of Nursing** – a New Jersey Board of Nursing licensed registered nurse with the required education and community health experience who is responsible for the clinical oversight of the home care program.

**Directly Employed** – employees for whom the provider pays wages and the mandated state and federal employment taxes.

**Discharge** – termination of services in accordance with the provider’s written discharge criteria whereby the provider is no longer responsible for the care of the patient.

**Documentation** – a written record of facts, findings, observations, comments, etc. maintained by the provider.
Field Nurse – a New Jersey Board of Nursing licensed LPN or RN who directly provides skilled nursing services to a patient in the home.

Field Staff – certified homemaker-home health aides and field nurses (LPN, RN) who directly provide service to patients in the home.

Follow-Up Visit – an on-site visit by a CAHC surveyor to monitor compliance following the identification of deficiencies from an earlier on-site visit.

Headquarters Office – a central office that establishes agency policy and provides company-wide administrative services; it may also function as a branch office if patient services are provided from the site.

Health Care Practitioner Supervisor – the name used by the New Jersey Division of Consumer Affairs for the registered nurse who is responsible for the clinical oversight of the home care program. This position is referred to as the Director of Nursing in the CAHC standards.

HIPAA – Health Insurance Portability and Accountability Act pertaining to the protection of confidential health information.

In-Home Skilled Nursing (IHSN) Services – patient services provided by an LPN or RN pertaining to curative, restorative, preventive and palliative aspects of nursing practice; it is ordered by a physician and supervised by an RN nursing supervisor; services may be provided in a patient’s home or in the community, such as a school.

In-Service – education and instruction for certified homemaker-home health aides provided by a qualified person; the content is relevant to the patients served or to the job responsibilities of a CHHA.

Intake – the process whereby a designated person collects relevant information about a prospective recipient of service to determine eligibility for service.

License – current legal authorization to practice in the professional discipline for which an individual has been educated as granted by the licensing authority in the state where the individual intends to practice.

Medication – any therapeutic substance, whether prescription or over-the-counter, that is taken orally, injected, inserted, applied topically or otherwise administered.

Medication Administration Record (MAR) – written record of all medications, whether prescription and over-the-counter, administered by the field nurse in the home; it includes the medication name, dosage, route, date and time of administration, and the nurse’s signature.

Medication Profile – written list of all medications a patient is taking, both prescription and over-the-counter, compiled by the nursing supervisor; it includes the medication name, dosage, route, frequency and potential side effects; it includes medications administered by the patient/family, as well as by the field nurse.
Memorandum of Agreement – binding signed contract between the provider and CAHC.

Nurse Preceptor (PCS) – a registered nurse employed by the provider who is experienced in home care and acts as a mentor to a newly hired nursing supervisor.

Nursing Plan of Care (IHSN) – written summary of the nursing care, treatment and procedures needed by the patient based on a nursing assessment and the physician’s orders. It includes nursing diagnoses, nursing interventions, the frequency of nursing care, as well as goals. The nursing plan of care is developed by the nursing supervisor and revised at periodic intervals based on the patient’s status, identified through assessment.

Nursing Progress Note – the documentation completed by the field nurse for each visit or shift, detailing relevant information about the patient’s response to care, as well as nursing activities performed in accordance with the nursing plan of care. It also includes the date, time and signature of the field nurse. It may be in the form of a flow sheet or narrative.

Nursing Supervisor – a New Jersey Board of Nursing licensed registered nurse with the required professional experience who makes home visits to assess the patient, provide case monitoring of the patient’s status and to supervise the field staff.

Nursing Visits – intermittent home visits by a field nurse to provide nursing care, treatment and procedures in accordance with the physician’s orders and the nursing plan of care.

Occurrence – an unusual event or action that could lead to adverse consequences or that varies from established policies and procedures.

Office Hours – the advertised days and hours that a provider’s office is open for business and staffed with personnel.

On-Call Hours – the advertised days and hours that the provider’s staff is available after regular office hours are over; this includes access to office staff, as well as to a registered nurse for clinical consultation and support.

Orientation to the Agency – the process whereby a newly hired certified homemaker-home health aide or nurse is informed about the provider’s policies, procedures, job descriptions and other relevant information; this takes place before the employee provides service to a patient.

Orientation to the Case – the introduction of the CHHA/field nurse to a patient by the nursing supervisor who reviews the plan of care with the CHHA/field nurse the first time they are assigned to a patient.

OSHA – Occupational Safety and Health Administration, a division of the US Department of Labor that sets standards for the safety and health of workers.

Pain Assessment – the evaluation of the patient’s pain and, if appropriate, the pain relief measures.
Performance Evaluation – a written appraisal by a supervisor of how an employee has carried out his/her job responsibilities.

Performance Quality Improvement (PQI) – the planned process of implementing quality standards and monitoring the attainment of measurable goals to ensure quality in an organization.

Period of Accountability – the time period encompassed in the evaluation of a provider’s compliance with the Commission on Accreditation for Home Care standards:
- applicant agencies – 4 months prior to the date the application is received by CAHC
- accredited agencies – time since the last on-site visit.

Personal Care Services (PCS) – patient services provided by a certified homemaker-home health aide in accordance with a plan of care and carried out under the supervision of a registered nurse; services are aimed at maintaining a patient in his or her home by providing assistance with activities of daily living. In Medicaid terminology, this service is identified as Personal Care Assistant (PCA) services.

Personal Protective Equipment (PPE) – equipment supplied to the field staff free of charge by the provider, in accordance with OSHA standards. Examples include soap, antibacterial gel, disposable gloves, disposable aprons and gowns, disposable eye shields, procedure masks and respirator masks.

Physician’s Certification of Need for Services (PCS) – a Medicaid requirement for any patient wishing to receive the service of a Personal Care Assistant (PCA). Agency must obtain a signed and dated statement from a physician, indicating that the patient needs personal care services; this is required prior to the start of service.

Physician’s Orders (IHSN) – written orders, signed and dated by a physician, authorizing and describing the provision of skilled nursing services to a patient in the home; this is required prior to the start of service and renewed at periodic intervals.

Plan of Care (PCS) – written summary of paraprofessional tasks and activities needed by the patient based on a nursing assessment. It includes the frequency of the tasks, as well as goals. The plan of care is developed by the nursing supervisor.

Plan of Care (IHSN) – see Nursing Plan of Care.

Private Duty Nursing – “Individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to consumers eligible for services through the Division of Disability Services home and community-based waiver programs known as Community Resources for People with Disabilities (CRPD) and the AIDS Community Care Alternatives Program (ACCAP). PDN services are also available to Medicaid eligible individuals between the ages of birth and twenty-one through the Division of Medical Assistance and Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.” (New Jersey Department of Human Services, Division of Medical Assistance and Health Services)
Probation – an accreditation status assigned by CAHC for areas of non-compliance found during a site survey. Due to the significant number non-compliant areas, it requires a plan of correction, a follow-up site visit and may involve a recommendation for further action, such as revocation.

Provider Profile – a CAHC form completed by a provider that furnishes updated agency statistics and other relevant information about the agency program.

Reassessment – a nursing reevaluation of a patient’s physical and functional status, including a medical history, vital signs and a review of systems.

Referral – directing a patient and/or family member for outside services or information.

Reference – a written or properly documented verbal statement of information about an applicant provided by someone familiar with them in the work, educational or personal domain.

Revisit – an on-site visit to an applicant agency by a CAHC surveyor to monitor compliance following the identification of deficiencies from an earlier on-site visit.

Risk Management – the prevention, containment and monitoring of a complaint or occurrence through investigation, documentation and correction in order to improve delivery of service.

Satellite Office – a site that provides patient services, including the presence of personnel and clinical records; the service area is within a 50 miles radius of a branch office and the number of annual service hours is below the service hours threshold that defines a satellite office. (See fee schedule on pages 4a & 4b.)

Scheduling of Field Staff – establishing the work schedule, including the days and hours of service, for a certified homemaker-home health aide/field nurse based on the assignment of cases.

Scope of Service – the written explanation of the services offered by a provider, such as type of service and hours of service availability.

Serious Adverse Event – an unexpected event that involves serious physical or psychological injury or death that is not related to the natural course of a patient’s condition or disease.

Service Area – geographic area served by a provider; it can not exceed a 50 mile radius from the headquarter/branch for PCS services.

Service Hours – the advertised days and hours that a provider is able to provide home care services.

Significant Other – an adult who is the primary caregiver for the patient and/or who accepts responsibility for the patient.
**Staffing Cases** – the process of assigning the appropriately qualified field staff to patients and setting up the work schedule of field staff.

**Standard** – a rule or measure established by an authority for determining practice guidelines.

**Supervisory Personnel** – the Director of Nursing and/or the nursing supervisor.

**Unlicensed Assistive Personnel (UAP) Curriculum** – the training program curriculum required by the New Jersey Board of Nursing to prepare paraprofessionals to become certified homemaker-home health aides.

**Vital Signs** – body temperature, pulse, respiration, blood pressure, pain assessment.

**Weekly Activity Sheets** – documentation completed by certified homemaker-home health aides that details the date, time period and activities performed in accordance with the care plan for each patient serviced.
(Page number 128 reserved for future updates.)