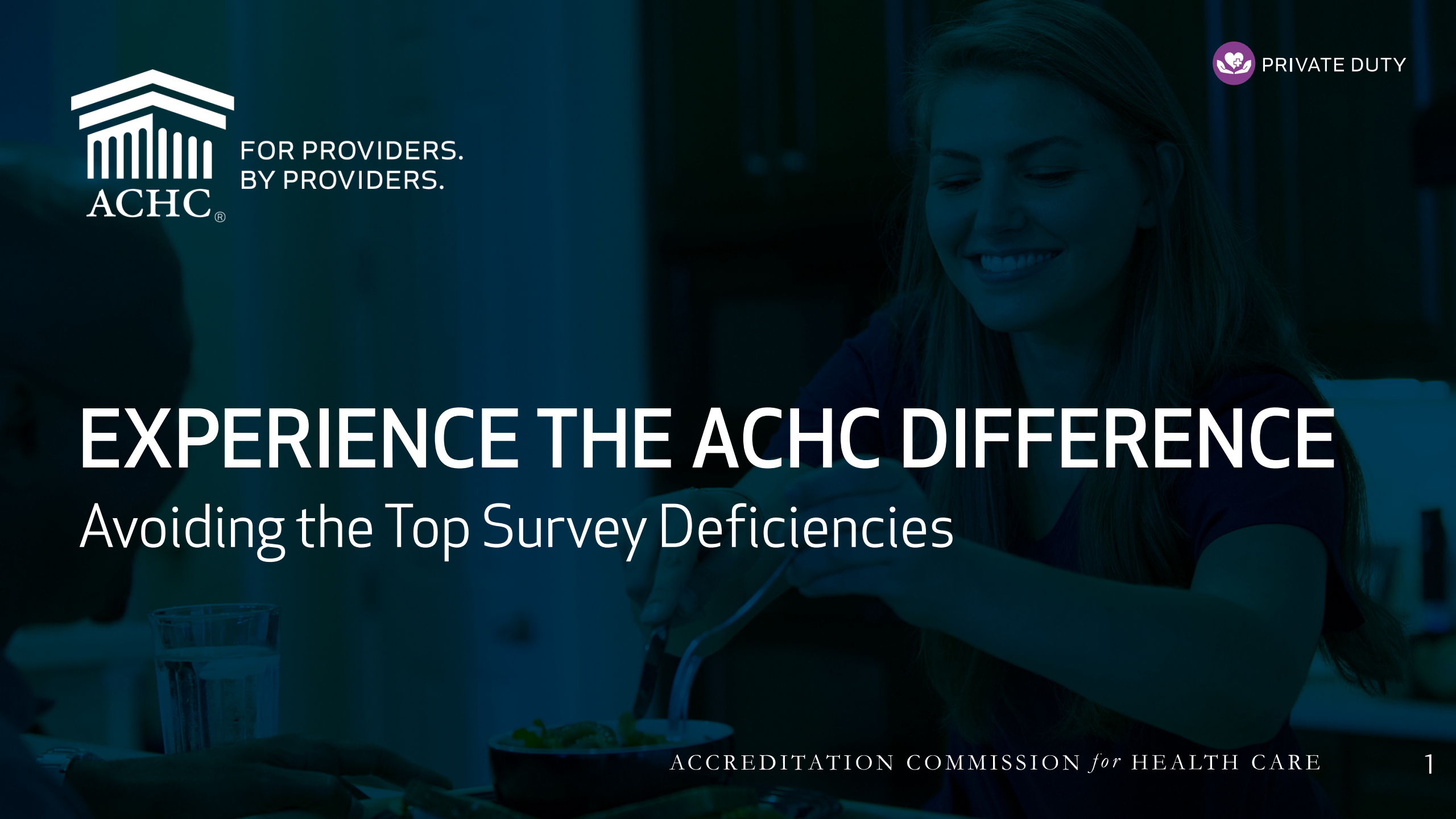

ACHC®

FOR PROVIDERS.
BY PROVIDERS.

PRIVATE DUTY

EXPERIENCE THE ACHC DIFFERENCE

Avoiding the Top Survey Deficiencies

VIRTUAL SURVEYS

- Initial and renewal PD accreditation
- Available in all states except CA, IN, OH, and TX
- FL: must remain unannounced for providers who offer PDN
- CA: licensure surveys allowed
- Covers the same scope, quality, and review of standards as on-site surveys
- Contact your AA to best determine which survey process is right for your agency

TOP SURVEY DEFICIENCIES

- Top survey deficiencies are primarily from Section 5
  - Audit medical/client records

PROGRAMS AND SERVICES

Standard PD2-1A: Written policies and procedures are established and implemented in regard to the Agency's descriptions of care/services and the distribution to personnel, clients/patients, and the community.

Written policies and procedures include, but are not limited to:

- Types of care/service available
- Care/service limitations
- Charges or client/patient responsibility for care/service
- Eligibility criteria
- Hours of operation, including on call availability
- Contact information and referral procedures

PROGRAMS AND SERVICES

Standard PD2-2A: Written policies and procedures are established and implemented by the Agency in regard to the creation and distribution of the Client/Patient Rights and Responsibilities statement.

- Agency develops a Rights and Responsibilities statement that is provided to the client/patient in advance of furnishing care/service or during the initial evaluation visit before the initiation of care/service
- If client/patient cannot read the statement, it is read, and a copy given to the client/patient in a language the client/patient understands
- Documentation of receipt and understanding of the information is signed, dated, and maintained in the client/patient record
- Agency protects and promotes the exercise of these rights
- Personnel provided training during orientation and at least annually

FISCAL MANAGEMENT

Standard PD3-6B: The client/patient is advised orally and in writing of the charges for care/service at, or prior to, the receipt of services. The client/patient also has the right to be informed of changes in payment information, as soon as possible but no later than 30 days after the agency becomes aware of the change.

- Client/patient provided written information concerning the charges for care/service at or prior to the receipt of care/service.
- Client/patient record contains written documentation that the client/patient was informed of the charges, the expected reimbursement for third-party payors, and the financial responsibility of the client/patient.

PROVISION OF CARE AND RECORD MANAGEMENT

Standard PD5-1A: Written policies and procedures are established and implemented relating to the required content of the client/patient record. An accurate record is maintained for each client/patient.

The content includes, but is not limited to:

- Identification data
- Names of family/legal guardian/emergency contact
- Name of primary caregiver(s)
- Source of referral
- Name of physician responsible for care
- Diagnosis
- Physician's orders that include medications, dietary, treatment and activity orders, (as appropriate to the level of care/service the client/patient is receiving)
- Signed release of information and other documents for Protected Health Information (PHI)
- Admission and informed consent documents
- Initial assessments
- Signed and dated clinical and progress notes
- Signed notice of receipt of Client/Patient Rights and Responsibilities statement
- Initial plan of care
- Updated plan of care
- Evidence of coordination of care/service provided by the Agency with others who may be providing care/service, if applicable
- Ongoing assessments, if applicable
- Assessment of the home, if applicable
- Copies of summary reports sent to physicians, if applicable
- Client/patient response to care/service provided
- A discharge summary, if applicable
- Advance Directives, if applicable
- Admission and discharge dates from a hospital or other institution, if applicable

PROVISION OF CARE AND RECORD MANAGEMENT

Standard PD5-1C: Client/patient records contain documentation of all care/services provided. All entries are legible, clear, complete, appropriately authenticated and dated in accordance with policies and procedures and currently accepted standards of practice.

- **Client/patient record contains documentation of each home visit, treatment, or care/service provided, directly or by contract, and has entries dated and signed by the appropriate personnel**
- **Signatures are legible, legal, and include the proper designation of any credentials**

PROVISION OF CARE AND RECORD MANAGEMENT

Standard PD5-3D: All clients/patients referred for Aide Services have an assessment. The initial assessment is conducted and care/service implemented within seven days of the referral or on the date requested by the client/patient. (PDA only)

- **Assessments and reassessments are conducted by a Registered Nurse (RN) or a qualified professional, per state licensure rules or regulations**
- **The assessment includes, but is not limited to:**
  - Client/patient demographics
  - Social component
  - Environmental component
  - Economic component
  - Functional limitations
  - Physical health component
  - Mental component

PROVISION OF CARE AND RECORD MANAGEMENT

Standard PD5-3F: There is a written plan of care for each client/patient accepted to services. (PDN only)

The initial plan of care includes, but is not limited to:

- Start of care date
- Certification period
- Client/patient demographics
- Principle diagnoses and other pertinent diagnoses
- Medications: dose/frequency/route
- Allergies
- Orders for specific clinical services, treatments, procedures (specify amount/frequency/duration)
- Equipment and supply needs
- Caregiver needs
- Functional limitations
- Diet and nutritional needs
- Safety measures
- Measurable goals

PROVISION OF CARE AND RECORD MANAGEMENT

Standard PD5-3G: There is a written plan of care for each client/patient accepted for Aide Services. (PDA only)

The written plan of care shall be based upon assessment data and specify:

- Problems/needs
- Interventions
- Services
- Expected client/patient outcomes/goals
- Treatments/orders

PROVISION OF CARE AND RECORD MANAGEMENT

Standard PD5-3K: Care/services are delivered in accordance with the written plan of care.

The client/patient record reflects that the care is delivered in accordance with the plan of care and is directed at achieving established goals.

QUALITY OUTCOMES/PERFORMANCE IMPROVEMENT

Standard PD6-2C: Each Performance Improvement (PI) activity or study contains the required items.

Each PI activity/study includes the following items:

- A description of indicator(s) to be monitored/activities to be conducted
- Frequency of activities
- Designation of who is responsible for conducting the activities
- Methods of data collection
- Acceptable limits for findings/threshold
- Written plan of correction when thresholds are not met
- Plans to re-evaluate if findings fail to meet acceptable limits
- Any other activities required under state or federal laws or regulations

EVIDENCE FOR COMPLIANCE

- Documented evidence that is readily available
- If it's not documented, it's not done!

AFTER ACCREDITATION

- Once your Account Advisor emails you with the survey decision, there will be a link to the Private Duty After Survey Webinar which will tell you how to complete a Plan of Correction as well as review resources to help you maintain compliance.

ACHC®

FOR PROVIDERS.
BY PROVIDERS.

PRIVATE DUTY

THANK YOU

Accreditation Commission for Health Care

139 Weston Oaks Ct., Cary, NC 27513

(855) 937-2242 | **achc.org**