SECTION 11. GENERAL REQUIREMENTS

A. Operational Policies

1. The agency shall have a written plan of operation including:

   (a) Organizational chart showing ownership and lines of authority down to the patient care level;

   (b) The services offered, including hours of operation and lines of delegation of responsibility down to the patient care level;

   (c) Criteria for patient acceptance, referral, transfer and termination;

   (d) Evidence of direct administrative and supervisory control and responsibility for all services including services provided by branch offices;

   (e) An annual operating budget approved by the governing body;

   (f) Written contingency plan in the event of dissolution of the agency.

2. Policies shall be developed and enforced by the agency and include the following:

   (a) Orientation of all personnel to the policies and objectives of the agency;

   (b) Participation by all personnel in appropriate employee development programs, including a specific policy on the number of inservice hours that will be required for registered nurses, licensed practical nurses and aides;

   (c) Periodic evaluation of employee performance;

   (d) Personnel policies;

   (e) Patient care policies;

   (f) Disciplinary actions and procedures;

   (g) Job description (statement of those functions which constitute job requirements) and job qualifications (specific education and training necessary to perform the job) for each position with the agency; and

(h) Infection control policies including the prevention of the spread of infectious and communicable diseases from agency personnel to clients.

3. (a) A personnel record shall be maintained for each employee. A personnel record shall include, but not be limited to, the following:

i. job description;

ii. qualification;

iii. application for employment;

iv. criminal history check as required by Ark. Code Ann. § 20-38-101 et. seq.

v. verification of licensure, permits, references, job experience, and educational requirements as appropriate;

vi. performance evaluations and disciplinary actions; and

vii. letters of commendation.

(b) All information shall be kept current. In lieu of the job description and qualifications for employment, the personnel record may include a statement signed by the employee that the employee has read the job description and qualifications for the position accepted.

4. It shall be the responsibility of the administration to establish written policies concerning pre-employment physicals and employee health. The policies shall include but not be limited to:

(a) Each employee shall have an up-to-date health file;

(b) At a minimum, each employee shall be tested or evaluated annually for tuberculosis in accordance with the applicable section of the Tuberculosis Manual of the Arkansas Department of Health;

(c) Work restrictions shall be placed on home health personnel who are known to be affected with any disease in a communicable stage or to be a carrier of such disease, to be afflicted with boils, jaundice, infected wounds, diarrhea or acute respiratory infections. Such individuals shall not work in any area in any capacity in which there is the likelihood of transmitting disease to patients, agency

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personnel or other individuals within the home or a potential of contaminating food, food contact surfaces, supplies or any surface with pathogenic organisms;

(d) Other test shall be performed as required by agency policy.

B. Governing Body

1. The governing body, or a committee designated by the governing body, of the agency shall establish a mechanism to:

(a) Approve a quality assurance plan whereby problems are identified, monitored and corrected;

(b) Adopt and periodically review written bylaws or an acceptable equivalent;

(c) Approve written policies and procedures related to safe adequate services and operation of the agency with annual or more frequent review by administrative or supervisory personnel;

(d) Appoint an administrator and approve a plan for an alternate in the absence of the administrator;

(e) Oversee the management and fiscal affairs of the agency;

(f) Approve a method of obtaining regular reports on participant satisfaction.

2. The governing board shall insure the agency has an administrator who is an employee of the agency or related institution to:

(a) Organize and direct the agency's ongoing functions;

(b) Maintain an ongoing liaison between the governing body and the personnel;

(c) Employ qualified personnel and ensure appropriate ongoing education and supervision of personnel and volunteers;

(d) Ensure the accuracy of public information materials and activities;

(e) Implement a budgeting and accounting system; and

(f) Ensure the presence of an alternate administrator to act in the administrator's absence.

3. The governing board shall be responsible for ensuring the agency has a full-time supervising registered nurse to supervise clinical services. Full-time shall be according to established business hours of the agency. The administrator and supervising nurse may be the same individual.

4. If a licensed agency contracts with another entity for services, the governing body shall ensure that administration, patient management and supervision down to the patient care level are ultimately the responsibility of the licensed agency.

C. Services Provided by Contractors

1. An Arkansas licensed home health agency may contract to provide services in the licensed agency's service area provided that administration, patient management and supervision down to the patient care level are ultimately the responsibility of the licensed agency.

2. A written contract is required and must specify the following:

(a) All referrals are through the primary agency and patients are accepted for care only by the primary agency;

(b) The services to be provided;

(c) The contracted entity conforms to all applicable agency policies, including personnel qualifications;

(d) The primary agency is responsible for reviewing, approving and assuring the implementation of the plan of treatment;

(e) The manner in which services will be controlled, coordinated and evaluated by the primary agency;

(f) The procedures for submitting medical record documentation and scheduling of staff;

(g) The procedure for how changes in the plan of treatment will be communicated between the two agencies; and

(h) The procedures for determining charges and reimbursement.

D. Quality Improvement

1. An agency shall adopt, implement and enforce a policy on a quality improvement program which provides for accountability and desired

outcomes.

2. Those responsible for the quality improvement program shall:

   (a) Implement and report on activities and mechanisms for monitoring the quality of care;

   (b) Identify, and when possible, resolve problems; and

   (c) Make suggestions for improving care.

3. As part of the quality improvement program a clinical record review shall be conducted at least quarterly by appropriate professionals. A minimum of ten percent of both active and closed records shall be reviewed or a minimum of ten records per quarter if the case load is less than 99. The purpose of the clinical record review is to evaluate all services provided for consistency with professional practice standards for home health agencies and the agency's policies and procedures, compliance with the plan of care, the appropriateness, effectiveness and adequacy of the services offered, and evaluations of anticipated patient outcomes. Evaluations shall be based on specific record review criteria that are consistent with the agency's admission policies and other agency specific care policies and procedures.

E. Patient Rights

1. The agency shall provide each patient and family with a copy of the Bill of Rights affirming the patient's right to:

   (a) Be informed of the services offered by the agency and those being provided to the patient;

   (b) Participate in the development of the plan of care and to be informed of the dates and approximate time of service;

   (c) Receive an explanation of any responsibilities the participant may have in the care process;

   (d) Be informed of the name of agency and how to contact that agency during all hours of operation;

   (e) Be informed of the process for submitting and addressing complaints to the agency and be notified of the State Home Health Hotline number;

   (f) Be informed orally and in writing of any charges which insurance

might not cover and for which the patient would be responsible;

(g) Courteous and respectful treatment, privacy and freedom from abuse and discrimination;

(h) Confidential management of participant records and information;

(i) Access information in the participant's own record upon request; and

(j) Receive prior notice and an explanation for the reasons of termination, referral, transfer, discontinuance of service or change in the plan of care.

(k) Be informed of the right to voice grievances regarding treatment of care that is (or fails to be) furnished, and the lack of respect for property by anyone who is furnishing services on behalf of the agency and the right not to be subjected to discrimination or reprisal for doing so.

2. The agency shall provide each patient and family with a written list of responsibilities affirming the patient's responsibility to:

(a) Assist in developing and maintaining a safe environment;

(b) Treat all agency staff with courtesy and respect;

(c) Participate in the development and update of the plan of care;

(d) Adhere to the plan of care or services as developed by the agency and to assist in the care as necessary.

F. Advance Directives

1. The agency shall have written policies and procedures regarding advance directives.

2. The agency shall inform and distribute written information to each patient on the initial evaluation visit concerning its policies on advance directives. Written information shall include notifying patients of their right to:

(a) Make decisions about their medical care;

(b) Accept or refuse medical or surgical treatment; and

(c) Formulate, at the individual's option, an advance directive.

(d) The agency shall document in the patient's medical record whether the or she has executed an advance directive.

G. Services Provided

1. All services shall be rendered and supervised by qualified personnel. An agency shall provide at least one of the following:

(a) If nursing service is provided, a registered nurse shall be employed by the agency to supervise nursing care. A licensed practical nurse may only provide services under the supervision of a registered nurse. The administrator shall designate a registered nurse to serve as an alternate supervisor;

(b) If physical therapy is provided, a registered physical therapist shall be employed by or under contract with the agency to provide services and/or supervision. A licensed physical therapy assistant may only provide services under the supervision of a registered physical therapist.

(c) If occupational therapy service is provided, a licensed occupational therapist shall be employed by or under contract with the agency to provide services. A licensed occupational therapy assistant may only provide services under the supervision of a registered occupational therapist;

(d) If speech-language pathology services are provided, a licensed speech language pathologist shall be employed by or under contract with the agency to provide services and/or supervision;

(e) If medical social work is provided, a licensed medical social worker shall be employed by or under contract with the agency. A social work assistant may only provide social services under the supervision of a licensed medical social worker;

(f) If home health/personal care aide service is provided, a home health/personal care aide shall be employed by or under contract to provide home health aide services. The aide shall be supervised by a registered nurse at least every 62 days.

H. Nursing Services

1. A registered nurse shall make the initial evaluation visit and initiate the plan of care and necessary revisions. The initial evaluation routinely must be performed within 72 hours of the initial referral or discharge from an

inpatient facility.

2. A registered nurse shall regularly re-evaluate the patient's nursing needs. A visit to the patient's home by the registered nurse shall be conducted at least every 62 days and after each hospitalization.

3. The registered nurse and the licensed practical nurse shall prepare clinical notes and furnish services according to agency policy.

4. If a patient is under a psychiatric plan of care, a psychiatric nurse shall be available to make the initial evaluation visit, re-evaluate the patient's nursing needs at least every 30 days and complete clinical notes.

I. Physical Therapy Services

1. The registered physical therapist shall assist the physician or licensed practitioner in evaluating the level of function and help develop the plan of care (revising it as necessary). The initial evaluation shall be conducted within five working days of the referral or sooner if medical necessity dictates.

2. If a licensed physical therapy assistant is used, the registered physical therapist shall conduct a visit to the patient's home at least every 62 days to re-evaluate the patient's condition and supervise the licensed physical therapy assistant.

3. The registered physical therapist is responsible for discharge planning from physical therapy services and for communicating this plan to the patient.

4. The registered physical therapist and licensed physical therapy assistant shall prepare clinical notes and furnish services according to agency policy.

J. Occupational Therapy Services

1. The registered occupational therapist shall assist the physician or licensed practitioner in evaluating the level of function and help develop the plan of care (revising it as necessary). The initial evaluation shall be conducted within five working days of the referral or sooner if medical necessity dictates.

2. If a licensed occupational therapy assistant is used, the registered occupational therapist shall conduct a visit to the patient's home at least every 62 days to re-evaluate the patient's condition and supervise the licensed occupational therapy assistant.

3. The registered occupational therapist is responsible for discharge planning from occupational therapy services and for communicating this plan to the patient.

4. The registered occupational therapist and the licensed occupational therapy assistant shall prepare clinical notes and furnish services according to agency policy.

K. Speech-Language Pathology Services

1. The licensed speech-language pathologist shall assist the physician or licensed practitioner in evaluating the level of function and help develop the plan of care (revising it as necessary). The initial evaluation visit shall occur within five working days of the referral or sooner if medical necessity dictates.

2. The licensed speech-language pathologist shall prepare clinical notes and furnish services according to agency policy.

L. Medical Social Services

1. The licensed medical social worker shall participate in evaluating the patient's need for services and in the development of the plan of care.

2. The licensed medical social worker shall supervise the social work assistant according to agency policy.

3. The licensed medical social worker and social work assistant shall prepare clinical notes and provide services according to agency policy.

M. Home Health Aide Services/Personal Care Aide Services

1. Each home health/personal care aide shall meet at least one of the following requirements:

(a) Have at least one year of experience in an institutional setting (home health agency, hospital, hospice, or long-term care facility). This experience shall be verified by a previous employer;

(b) Have a certificate issued by the State of Arkansas for working in longterm care facilities. A copy of this certificate shall be available for review;

(c) Have completed a 40 hour aide training course that meets the requirements set forth in these regulations.

NOTE: In lieu of the requirement for completion of the home health aide training course, a nursing student may qualify as a home health aide by submitting documentation from Health Facility Services of programs and/or the Dean of a School of Nursing that states that the nursing student has demonstrated competency in providing basic nursing care in accordance with the school's curriculum.

2. The agency is responsible for evaluating the competency of any aide who has not been employed as an aide in an institutional setting in the last 24 months. At a minimum, the aide shall be observed by a registered nurse performing the skills required to care for a patient including bathing, transferring, range of motion exercises, toileting, dressing, nail care and skin care. The registered nurse shall observe the aide performing these skills on a person. Any other tasks or duties for which the aide may be responsible may be evaluated by written test, oral test or observation. There shall be documentation by the agency to show evidence of this evaluation.

3. A registered nurse shall complete an aide assignment sheet for each patient receiving aide services. Each aide caring for the patient shall receive a copy of the assignment sheet and provide services as assigned. A copy of the assignment sheet shall be left in the patient's home.

4. Each aide assignment sheet shall be individualized and specific according to the patient's needs.

5. The registered nurse shall conduct a visit to the patient's place of residence at least every 62 days to supervise the aide and update the aide assignment sheet.

6. In no event shall a home health aide be assigned to receive or reduce to writing orders from a physician or licensed practitioner. A home health aide shall not perform any sterile procedure or any procedure requiring the application of medication requiring a prescription.

7. Upon a request by a patient and/or family member for assistance with medications, the registered nurse may assign a home health aide to assist with oral medications which are normally self-administered. Assistance shall be limited to reminding a patient to take a medication at a prescribed time, opening and closing a medication container and returning a medication to a proper storage area.

8. Except as otherwise provided in these rules, duties of the home health aide may include:

(a) Personal care: bathing, grooming, feeding, ambulation, exercise, oral hygiene, and skin care;

(b) Assistance with medications ordinarily self-administered as assigned;

(c) Household services essential to health care in the home;

(d) Completion of records and reporting to appropriate supervisor;

(e) Taking and charting vital signs;

(f) Charting intake and output;

(g) Extension of therapy services; and

(h) Any duty consistent with the State Board of Nursing Regulations on Delegation of Duties may be assigned by a registered nurse to meet the individual needs of the patient.

9. If the training is provided by the agency, the training program for home health aides shall be conducted under the supervision of a registered nurse. The training program may contain other aspects of learning, but shall include the following:

(a) A minimum of 40 hours of classroom and clinical instruction related particularly to the home health setting;

(b) Written course objectives with expected outcomes and methods of evaluation; and

(c) An assessment that the student knows how to read and write English and to carry out directions.

10. Course and clinical work content shall include, but not be limited to, bathing, ambulation and exercise, personal grooming, principles of nutrition and meal preparation, health conditions, developmental stages and mental status, household services essential to health care at home, assistance with medication, safety in the home, completion of appropriate records and reporting changes to appropriate supervisor.

11. Aides shall receive a minimum of 12 hours of inservice training per 12 months. The inservices provided shall address areas that directly relate to the patient care aspects of the aide's job.

N. Records and Documentation

1. The home health agency shall maintain records which are orderly, intact, legibly written and available and retrievable either in the agency or by electronic means and suitable for photocopying or printing.

2. Records shall be stored in a manner which:

   (a) Prevents loss or manipulation of information;

   (b) Protects the record from damage; and

   (c) Prevents access by unauthorized persons.

3. Records shall be retained for a minimum of five years after discharge of the patient or two years after the age of majority.

4. Each record shall include:

   (a) Appropriate identifying information;

   (b) Initial assessment (performed by a registered nurse or therapist). If the agency is unable to perform the initial evaluation for physical therapy, occupational therapy or speech-language pathology in the required time frame, the reason for the delay shall be documented. If delays are due to the agency not having the staff to perform the initial evaluation and/or provide services, there shall be documentation to show the patient and the physician or licensed practitioner were notified of the delay and were given an estimated date when services would begin. The patient, physician or licensed practitioner shall also be informed of other agencies in the area available to provide the ordered services.

   (c) Plan of care (which shall include as applicable, medication, dietary, treatment, activities).

   (d) Clinical notes; and

   (e) Acknowledgment of receiving information regarding advance directives.

5. The following shall be included, if applicable;

   (a) Physician, podiatrist and/or licensed practitioner order;

   (b) Records of supervisory visits;

(c) Medication administration records;

(d) Records of case conferences; and

(e) Discharge summary.

6. Clinical notes are to be written the day the service is rendered and incorporated into the record no less often than every 14 days.

7. Provisions shall be made for the protection of records in the event an agency ceases operation.

O. Discharge Planning

1. There shall be a specific plan for discharge in the clinical record and there must be ongoing discharge planning with the patient.

P. Complaints

1. Each agency shall keep a record of complaints received. Documentation shall be kept on each complaint regarding the name of the complainant, the relationship to the patient (if applicable), the nature of the complaint, and the action taken to resolve the complaint.