This document, “Best Practices for Health Care Service Firms,” is advisory only, though it may serve as the basis for regulation development in the future.

Personal care services, though frequently characterized as "nonmedical" services, may require touch or physical contact to support a client with activities of daily living such as feeding, toileting, bathing, dressing, grooming, transferring, ambulating, etc. The "Best Practices for Health Care Service Firms" has been developed as a supplemental resource to administrators and employees of Health Care Service Firms in the State of New Jersey for the delivery of personal care services.

This document incorporates statutory and regulatory provisions and provides non-binding, optional best practices to aid Health Care Service Firms in the delivery of these services. To the extent, if any, that this document conflicts with or exceeds the requirements of N.J.S.A. 34:8-43 et seq. or N.J.A.C. 13:45B-13.1 et seq., such laws and regulations govern the conduct of HCSFs. Notwithstanding use of the terms “shall” or “required" in the “Best Practices,” the contents remain aspirational only.

Best Practices for Health Care Service Firms

April 15, 2014

I. Definitions

1. “Date” means day, month and year.

2. “Licensed” means holding a valid, current New Jersey license, certification or registration, required by law as a precondition to the practice of a regulated profession or occupation.

3. “Director of Nursing/Health Care Services Supervisor” (DON/HCSS) means a New Jersey Board of Nursing licensed registered nurse with education and community health nursing experience and progressive management experience in community health nursing, who is responsible for the clinical oversight of a Health Care Services Firm’s (HCSF) health care services program.

4. “Nurse Supervisor” means a New Jersey Board of Nursing licensed registered nurse with education and community health nursing experience with progressive responsibilities in community health nursing. The Nurse Supervisor is assigned by the Director of Nursing/Health Care Services Supervisor to oversee services rendered by employees, including other registered nurses (RNs), licensed practical nurses (LPNs), certified homemaker home health aides (CHHAs). The Nurse Supervisor or a registered nurse designee shall be available on call during all hours of service. The Nursing Supervisor and the Director of Nursing may be one and the same person.

5. “Signature” means at least the full name (first and last) and title (for example, RN, LPN, CHHA) of a person, legibly written either with his or her own hand , generated by computer with authorization safeguards, or communicated by a facsimile communication system. If the signature is not legible, the individual’s full name shall be printed in an

adjacent space. When a signature is required, it shall be followed by a title (for example, RN, LPN, CHHA), which may be pre-printed on a form.

6. "Health care services" means those tasks performed for the purpose of maintaining or restoring a patient's physical or mental health, for which the individual performing the task must be licensed and/or certified**.** Personal care services are included in health care services.

7. "Personal care services" means those tasks for the purpose of assisting a patient with the activities of daily living, including assisting with feeding, toileting, bathing, dressing, grooming, transferring, ambulation, exercise or other aspects of personal hygiene. These services are a subset of health care services. "Personal care services" do not include tasks relating to housekeeping, meal preparation, shopping, laundry, cleaning or transportation services which may be performed by unlicensed persons.

8. "Community health nursing" means professional nursing practice emphasizing health promotion, health maintenance, primary prevention, health education and management, coordination of health care services, and continuity of care for individuals, families, and groups in the community. It includes, but is not limited to, home visits to assess, plan for, and provide nursing services; health guidance and direct care; and coordination of services with community resources, families and other health professionals and paraprofessionals.

9. "On call" means available to respond to questions concerning services via electronic communication or telephone, but does not require that the on-call individual be available to personally visit the patient.

II. Clinical Policies

Intake Interview and Initial Assessment

The HCSF, by or through its DON/HCSS, assigns a nurse, office manager or other responsible staff member the task of conducting an intake interview with the patient and/or family/significant-other.

Patient-care assignments may be initiated for patients who are discharged from a health care facility, in those situations where a nurse case manager assessed the immediate care needs of the discharged patient and communicated those needs to the HCSF through the DON/HCSS or the RN on call. Based on this communication, the DON/HCSS or RN on call assumes responsibility for appropriately delegating health care and personal care services during the first 24 to 48 hours pending the patient's in-person nursing assessment by the designated RN.

Prior to starting all other patient-care assignments (not initiated immediately following discharge from a health care facility), an in-person nursing assessment of each patient, by an RN, should be conducted to establish a baseline of the patient's physical and functional status and identification of the level of services needed to meet the patient's needs.

Required Intake Interview Documentation:

The HCSF shall maintain documentation that includes, at a minimum:

1. Full name of patient
2. Date of birth
3. Gender
4. Primary Care Provider and/or other health care professional contact information, including name and phone number
5. Past medical history, if known
6. Nursing and medical diagnosis(es) or problem(s), if known
7. List of medications, if known
8. Functional status, if known
9. Family/Significant-Other contact information, including name, phone number and relationship to the patient

10. Identification of services in place, additional services needed, and collateral contacts, if applicable, and
11. Name, date and signature of person conducting intake.

If the patient's medical history, diagnoses, medications and functional status are not known, the documentation should reflect that an attempt was made to obtain that information.

Required In-Person Assessment Documentation:

The HCSF, by the DON/HCSS, or a Nurse Supervisor assigned to the task by the DON/HCSS, shall conduct an in-person nursing assessment of the patient to determine the tasks that are to be delegated to an assigned CHHA, prior to the start of service, or in the case of a patient discharged from a health care facility within 24 to 48 hours of the start of service. The HCSF shall maintain documentation that includes, at a minimum:

1. Vital signs, including temperature, pulse, respiration, blood pressure, and a pain assessment
2. Past medical history
3. Nursing and medical diagnosis(es) or problem(s)
4. List of medications
5. Functional status
6. Psycho-social review relevant to the Plan of Care
7. A systems review (neurologic, musculo-skeletal, integumentary, cardiovascular, pulmonary, gastro-intestinal, genito-urinary)
8. Nutritional status, including diet
9. Home safety review, including fall risk assessment
10. Emergency plan
11. Advance directives
12. Primary Care Provider's Certification of Need for Services, if applicable, and
13. Date and signature of the Nurse Supervisor conducting the assessment.

Plan of Care

The HCSF, by and through its DON/HCSS, or a Nurse Supervisor assigned to the task by the DON/HCSS, shall develop a Plan of Care based on the in-person nursing assessment, prior to the start of service, or in the case of a patient discharged from a health care facility within 24 to 48 hours of the start of service. The HCSF shall maintain the Plan of Care, which shall include the following documentation, at a minimum:

1. Days and hours of service to be provided to the patient
2. Nursing and medical diagnosis(es) or problem(s)
3. Tasks to be performed by employees and licensure/registration status of the assigned employees – RNs, LPNs, CHHAs, unlicensed assistive personnel, and therapists
4. The frequency at which the tasks are to be performed
5. Short-term and long-term goals for patient care and discharge
6. Specific changes in patient status that need to be reported to the Nurse Supervisor

7. Date and signature of the nurse who assessed the patient and developed or modified the Plan of Care
8. Date and signature of the patient and/or family/significant-other
9. Date and signature of the employee who is assigned at the start of service, and
10. Date and signature of the employee who is assigned at reassessment and whenever there are changes in the Plan of Care.

The HCSF shall ensure that a copy of the Plan of Care is maintained in the office and at the patient's residence and available to the patient, the patient's family/significant others, and agency employees.

Competency Evaluation of Assigned CHHAs Prior to the Start of Services

The HCSF, by the DON/HCSS, or a Nurse Supervisor assigned to the task by the DON/HCSS, shall ensure that CHHAs assigned to perform personal care services in a new patient's home have an in-person description and/or demonstration of the tasks being delegated by the RN, prior to the start of services in a new patient's home, regardless of the experience level of the CHHA. If the plan of care is available, the Nurse Supervisor should review that plan with the assigned CHHA. If the tasks required are complex or involve specialized equipment not available in the HCSF office, the RN, in the exercise of professional judgment, may determine to conduct the in-person description and/or demonstration of tasks in the home of the patient.

With respect to the initial assignment and all subsequent assignments of CHHAs to any patient, the RN shall assure that the CHHA has the requisite skills to perform the delegated tasks and that all subsequently assigned CHHAs are provided with a description of tasks being delegated and, in the exercise of delegating nurse's professional judgment, demonstration as needed. The RN has the duty to refuse to delegate nursing tasks to an assigned CHHA determined not to possess the requisite competencies to care for the patient. A CHHA has the duty to refuse to accept a delegation that he/she does not possess the competency to carry out.

Weekly CHHA Activity Records

The HCSF shall ensure that the assigned CHHA prepares and files with the HCSF a weekly activity sheet. The HCSF shall maintain weekly activity records, which shall include, at a minimum:

1. Date and time of each patient assignment
2. Documentation of the activities performed, as well as those activities identified in the Plan of Care that were not performed and the reasons why those activities were not performed
3. Any change in the patient's condition that was reported to the Nursing Supervisor and documented by both the CHHA and nurse
4. Date and signature of the CHHA, and
5. Date and signature of patient, family member, significant other or designated party.

The HCSF shall maintain these records along with the patient's medical record in the office for a minimum of seven (7) years for an adult and twenty-one (21) years for a pediatric patient, or as required by law.

Periodic Patient Review and Re-Evaluation and Documentation Requirements

The HCSF shall ensure that a Nurse Supervisor evaluates records relating to the care provided to the patient on a regular basis, and contacts the patient and/or significant other at least every 30 days, to determine if the Plan of Care continues to meet the needs of the patient. The patient's clinical record shall reflect that this evaluation was conducted.

The HCSF shall ensure that a Nurse Supervisor conducts an in-person re-evaluation of the patient and the continued appropriateness of the patient's plan of care every 60 days (or 2 months), or more often if the patient's condition warrants it, or when there has been an interruption of service, or a hospitalization or stay in a medical facility, if deemed necessary, or a change in the patient's condition or functional status, or, if consistent with a service agreement.

The HCSF, through the Nurse Supervisor, shall make and maintain documentation relating to these re-evaluations in the patient's clinical record. If, based on the nurse's clinical judgment, there are any changes that should be made to the plan of care resulting from the review of any of the following, the documentation shall reflect the reasons for the changes:

1. Nursing and medical diagnosis(es) or problem(s)
2. Changes in vital signs, including temperature, pulse, respiration, blood pressure and a pain assessment
3. Changes in functional status
4. Psycho-social review relevant to the Plan of Care
5. Nutritional status, including diet
6. Home safety review, including fall risk assessment, and
7. The emergency plan.

The documentation shall also include:

1. Name of any employees present, their licensure status, and the skill(s) observed
2. A confirmation that the plan of care has been reviewed with the CHHA
3. Any communication with patient, family, significant other, or designated party regarding complaints, problems, etc.
4. Date and signature of the Nurse Supervisor.

Documentation Requirement Relating to the Clinical Performance of the CHHA

Whenever the Nurse Supervisor has an opportunity to directly observe the skills of a CHHA, at the start of services, during the in-person evaluation or other patient monitoring visit, documentation should be included in the CHHA's employee file, reflecting :

1. The skills directly observed
2. An evaluation of how well those skills were performed

3. Any demonstrations/instructions provided by the Nurse Supervisor, if applicable
4. The date of the observation
5. The signature of the employee being evaluated, and
6. The signature of the Nurse Supervisor.

III. Personnel Policies

Employment Application

The HCSF shall require every applicant for employment involving the provision of health care services to patients to complete a written application, which shall include, at a minimum:

1. Applicant's name (including any nicknames), address, telephone number and e-mail address, if available
2. Applicant's New Jersey license or certificate number, as applicable, the type of license, the licensing authority and the expiration date of the license
3. Applicant's date of birth
4. Applicant's Social Security number
5. Names, addresses and telephone numbers of all employers during at least the year preceding the application, including:
   a. Names of supervisors
   b. Dates of employment
   c. Work experience
   d. Reasons for leaving each employer
6. Education and training, including the dates of training, and the location where the training was obtained, any degrees obtained or certificates received, including attainment of training in CPR, and the dates of issue and expiration, if applicable.
7. Date and signature of applicant, and
8. Authorization to conduct a criminal background check.

Interview Documentation

The HCSF shall require every applicant for employment to be interviewed. The HCSF shall maintain documentation relating to the interview, including the name and title of the interviewer and the date on which the interview took place.

References

The HCSF shall obtain written references, and/or appropriately documented verbal references from at least two individuals, at least one of whom shall be:

1. An employer, including an immediate past employer, or
2. An educator, including an instructor from a CHHA training program, if applicable. References shall **not** include family members or friends.

Documentation in the applicant's file shall include the following:

1. Name and relationship to the applicant of the person giving the reference

2. Dates of the applicant's employment
3. Content of the reference, including documentation relating to the reasons for the employee having left employment.
4. As to written references: the signature and title of the reference and date signed, and
5. As to verbal references: the signature of the HCSF staff member who obtained the reference and date of the call.

Pre-written letters of recommendation are acceptable if they are verified by the HCSF.

Verification of Credentials and Content of Personnel Record

Prior to referral or placement of a licensed, certified or registered individual, the HCSF, after a personal examination of the original or other reliable verification sources, shall maintain a copy of every employee's current license, registration or certificate, as applicable, as well as a copy of documentation obtained from the Division of Consumer Affairs' online verification page, verifying current status. In addition, the HCSF shall maintain within the personnel record, or other retrievable and printable file:

1. Health attestation form, reflecting the results of tests for Mantoux tuberculin skin test as well as rubella and rubeola immunization or serologic evidence of immunity
2. Clinical competency documentation
3. Performance evaluations
4. Clinical supervision documentation
5. In-service attendance records
6. Malpractice insurance policy number, if applicable to the individual
7. Date of hire
8. Annual verification of licensure status as reflected by the New Jersey Division of Consumer Affairs' online verification page printout. The agency shall establish the yearly date for credentials verification; and
9. A photograph of the employee, in which the face of the employee is clearly visible, like those required for a passport, matching the photograph used for the employee's identification badge.

Agency Orientation

The HCSF shall provide an orientation program on a quarterly basis to all newly hired CHHAs within three months of employment, or sooner, based on the CHHA's documented level of expertise. The agency shall include, at a minimum, instruction on the following topics:

1. Infection control
2. Blood-borne pathogens
3. Child abuse
4. Elder abuse
5. Domestic violence
6. Pain management
7. Patient rights
8. HIPAA

9. Corporate compliance
10. Ethical considerations in home care delivery, including issues involving receipt of gifts and money from clients and other financial transactions
11. Employee safety
12. Emergency procedures, and
13. Agency administrative and clinical policies and procedures.

The HCSF shall maintain documentation pertaining to the content of the orientation program, which shall include, at a minimum:

1. Outline of topics covered
2. Length of time for each of the mandatory in-service topics
3. Date and signature of instructor, and
4. Name, date and signature of employees on an agency sign-in sheet.

Records of attendance at the orientation program shall be maintained. Those records may be maintained electronically, as long as they are readily retrievable and printable.

Agency Mandatory In-Service

The HCSF shall provide an in-service program at least once each year, or over the course of a year, for all CHHAs, which shall include, at a minimum, instruction on the following topics:

1. Blood-borne pathogens
2. Infection control
3. Standard precautions
4. Child abuse
5. Elder abuse
6. Domestic violence
7. Pain management
8. Workforce protection
9. Employee safety issues
10. Back safety
11. How to handle needle sticks
12. Fraud and abuse prevention, and
13. Corporate compliance.

A HCSF may accept documentation from another HCSF that verifies a CHHA has met a portion of or all of the above-required Agency Mandatory In-Service topics. Records of attendance at in-service programs shall be maintained. Those records may be maintained electronically, as long as they are readily retrievable and printable.

Clinical Competency: Prior to or on the date of the first Assignment

The HCSF shall ensure that all CHHAs shall undergo a clinical competency testing by a Nurse Supervisor, prior to, or on the first date of assignment, which shall include the following:

1. Direct observation of the CHHA's performance of delegated personal care services related to:

    a. the musculo-skeletal system, including exercise, activity and positioning, range of motion, transferring, ambulation and assistive devices
    b. the integumentary system, including personal hygiene (nail and skin care, bathing, shampooing, etc.) and positioning
    c. the upper and lower gastrointestinal system (i.e. oral hygiene, feeding, toileting and elimination)
    d. the urinary system (personal hygiene related to toileting and elimination)
    e. the cardiovascular and respiratory systems, specifically, vital signs (temperature, pulse, respiration), applying antiembolic stockings, assisting the client to use oxygen, and positioning the client for circulatory and respiratory comfort
    f. the neurological system, specifically, care needs of a client with cognitive impairment, care of a client with a seizure disorder, care of a client following a stroke and rehabilitation or restorative care
    g. the endocrine system, specifically foot care, skin care and nutrition for a client with diabetes, and
    h. the promotion of sleep.

If the direct observation of such skills involved is impractical or would represent an intrusion of the patient's privacy, the Nurse Supervisor, in the exercise of professional judgment, may ask the CHHA to provide a description of how the task would be performed.

2. Written testing, oral testing or direct observation of the CHHA's knowledge and communication skills, in the following areas:

    a. Observation, reporting and documentation of patient status, and the care or service furnished
    b. Basic infection control procedures
    c. Basic elements of body mechanics and functioning, and changes in body function that must be reported to the Nurse Supervisor
    d. Maintenance of a clean, safe and healthy environment
    e. Recognizing emergencies and knowledge of emergency procedures
    f. 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, and
    g. Adequate nutrition and fluid intake.

Clinical Competency: Testing or assessment throughout the year

The HCSF shall also ensure that the clinical competency of every CHHA is tested or assessed throughout the year, through direct observation of the performance of skills as demonstrated with respect to assigned patients and/or through written or oral testing as set forth in 1 and 2 above.

Clinical Competency: Recordkeeping

The HCSF shall ensure that the documentation concerning clinical competency is maintained in the employee file and includes, at a minimum:

1. Name of the CHHA
2. Clinical skills tested, as well as the date and location where the testing took place
3. An evaluation of the CHHA's competency, and
4. Date and signature of the Nurse Supervisor performing the testing.

At a minimum, there shall be an assessment of competency recorded by the end of each year of employment. Those records may be maintained electronically, as long as they are readily retrievable and printable.

IV. Administrative Policies

Corporate Compliance Policy

The HCSF shall ensure that there are policies and procedures relating to:

1. Assignment of individuals, for the appropriate level of care, authorized to provide required service, assuring that Certified Nurse Assistants (CNAs) and unlicensed assistive personnel are not assigned to perform in-home, personal care services.
2. The requirement for licensed and certified personnel to provide proof of New Jersey licensure or certification (out-of-state certifications are not valid for New Jersey in-home personal care).
3. Reporting of patient complaints to the agency
4. Agency's response to alleged reports of misconduct, violation of laws/regulations and unethical practices
5. Confidentiality requirements
6. Protection for those reporting unethical, fraudulent or illegal activity ("whistle-blower" protection), and
7. Reporting of safety concerns and violations of law to licensing and/or regulatory agencies, as required by law.

Clinical On-Call Policy

The HCSF shall ensure that there is a procedure by which an RN, LPN, CHHA or other clinical staff can reach a RN for clinical questions at all times, in no less than one hour, and that there is a RN on call during all hours of service.

Service Agreement Policy

The HCSF shall ensure that the patients and family/significant others are provided with full and truthful disclosure of all information concerning fees and billing policies