

DURABLE & HOME MEDICAL EQUIPMENT COMPLIANCE MANUAL

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SUBJECT: ASSESSMENT OF CLIENTS	REFERENCE #1004
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DEPARTMENT: DURABLE & HOME MEDICAL EQUIPMENT	OF: 3
	EFFECTIVE:
APPROVED BY:	REVISED:

TYPE OF DEVICE	ASSESSMENT CRITERIA
<ul style="list-style-type: none"> • Respiratory Care Equipment (continued) 	<ul style="list-style-type: none"> • Has the client recently had lab work which would justify need for the device? • Is the client or caregiver strong enough to carry and/or move the device as required and/or to change cylinders? • Is the client's or caregiver's sight adequate to make the required adjustments to the device and/or administer medications? • Will the client be able to use and operate the device safely? • Is the electrical system of the residence adequate to meet the requirements of the device? • Are grounded outlets available in the room in which the device is to be placed?
<ul style="list-style-type: none"> • Hospital Beds 	<ul style="list-style-type: none"> • Is the client's bed or chair confined? • Does the client have or is he/she susceptible to decubitus ulcers? • Does the client become confused at night or experience falling out of bed? • Does the client require frequent position changes? • Does the client require traction devices and/or side rails? • Is total care required? • Would the client require the variable-height feature? • Does the client need to place feet on the floor while sitting on edge of bed to assist with ambulation? • Is it difficult for client to get in and out of bed? • Will an overbed table be required? • Is there a doctor's order for the device? • For what condition is the bed required?
<ul style="list-style-type: none"> • Traction Equipment 	<ul style="list-style-type: none"> • For what condition will the traction device be used? • Is there a doctor's order for the device? • What weights have been prescribed? • What type of traction device is required? • Does the client have a hospital bed? • Has the client previously used traction devices?
<ul style="list-style-type: none"> • Ambulatory Aids 	<ul style="list-style-type: none"> • What type of aid is required? • For what condition is the aid required? • What is the height and weight of the client? • Does the client have adequate strength to manage the device? • Is the client able to support weight on at least one extremity?

DISCHARGE WORKSHEET

Patient Name: _____ Date of Discharge: _____

SURVEY CLIENT'S FILE TO ENSURE IT CONTAINS THE FOLLOWING COMPLETED AND SIGNED FORMS:

- | | |
|--|---|
| <input type="checkbox"/> Order intake form | <input type="checkbox"/> Plan of care |
| <input type="checkbox"/> Original Invoice | <input type="checkbox"/> Copy of signed pick up invoice |
| <input type="checkbox"/> Equipment instruction checklist | <input type="checkbox"/> Plan of treatment |
| <input type="checkbox"/> Physician's prescription | <input type="checkbox"/> Medication profile |
| <input type="checkbox"/> Physician's telephone order | <input type="checkbox"/> Follow-up visit report(s) |
| <input type="checkbox"/> Authorization to treat | <input type="checkbox"/> Authorization to release medical information |

NOTE REASON FOR DISCHARGE AND PROPER DOCUMENTATION IN HOME CARE RECORD:

CLIENT REQUESTS DISCONTINUATION OF SERVICE:

Discontinuation of equipment and/or service is believed to have a dangerous effect on client; following steps taken:

- Physician contacted; documented in client's home care record.
- Client informed of any adverse consequences which may result from discontinuation of equipment.
- Facility manager consulted.
- Discontinuance of Service Against Medical Advice form completed.
- Protective services notified, if appropriate.

Discontinuation of equipment and/or service does not appear to medically or physically endanger client; following steps taken:

- All pertinent parties (family, physician, etc.) advised of request; documented in client's home care record.
- Client instructed regarding expected consequences, if any.
- Equipment picked up, as required.
- Notation made in client's record regarding reasons for discontinuation of service.

CLIENT EXPIRES:

- Family contacted, condolences expressed and arrangements made to pick up equipment as soon as possible.
- If supplies and/or equipment are nonreturnable, recommendations provided regarding their disposal or removal.
- Notation made in client's home care record regarding reason for discontinuation of service.

CLIENT REQUIRES EQUIPMENT/SERVICES NOT PROVIDED BY THE COMPANY:

- Client/referral notified that required equipment/services not provided by company.
- Client referred to other resources for required equipment/services.
- Transfer/referral coordinated with receiving organization and of any financial benefit to referring organization.
- Rationale for discontinuation of services is documented.

CLIENT MOVES OUT OF SERVICE AREA:

- Facility which services area where client will be moving is notified.
- Copy of client's record submitted to receiving facility, in accordance with record release policy.
- Client informed of ownership of receiving organization and of any financial benefit to referring organization.
- Rationale for discontinuation of services is documented.

SUBJECT: QUALITY IMPROVEMENT PLAN	REFERENCE #3011
DEPARTMENT: DURABLE & HOME MEDICAL EQUIPMENT	PAGE: 1 OF: 5
APPROVED BY:	EFFECTIVE: REVISED:

PURPOSE:

- To identify and implement on an ongoing basis areas for potential improvement in the quality of client care and standard operating procedures. To evaluate, monitor, improve and resolve these identified problems.

QUALITY VISION STATEMENT:

- Ensuring that the company maintains a staff of competent and well-trained personnel dedicated to providing the best service possible to the patients. Improve on facility services through continuous monitoring and evaluation. Provide the employees with training and education in order to maintain their skills at a high level.

OBJECTIVES:

- The Quality Improvement Plan is a continuing process to improve on targeted functions applicable to this home care organization. The Quality Improvement Plan shall be addressed annually with quarterly meetings of the committee to review, monitor and address ways to improve service. The focus of quality efforts shall encompass the following points:
 - Improving organizational performance;
 - Leadership;
 - Education;
 - Rights, responsibilities and ethics;
 - Assessment of patient and environment;
 - Care, treatment and service;
 - Continuum of care;
 - Management of information;
 - Management of personnel;
 - Infection control, prevention and surveillance.

SUBJECT: COMPRESSED MEDICAL GAS COMPLIANCE REGULATIONS	REFERENCE #8001
DEPARTMENT: DURABLE & HOME MEDICAL EQUIPMENT	PAGE: 1 OF: 2
APPROVED BY:	EFFECTIVE: REVISED:

POLICY:

- All _____ facilities, who supply oxygen (liquid and gas) or other medical gases, shall comply with the practices and procedures for Compressed Medical Gas (CMG) suppliers and fillers, which have been defined by the Food and Drug Administration (FDA). All facilities which transfill medical gases shall be registered with the FDA in accordance with the Code of Federal Regulations (CFR) 21 Current Good Manufacturing Practices to provide drug products. _____ shall comply with all rules and regulations set forth by the Department of Transportation (DOT) motor carrier regulations and local fire department standards when transporting CMG.

FDA COMPLIANCE:

- All _____ facilities which transfill or repackage medical oxygen, change the container label or change the container in any way, must comply with all current FDA and CGMP regulations for medical gases and must register with the FDA. Registration is required whether or not the product of the distributor enters interstate commerce. _____ shall register annually on the FDA 2656 form. Please contact the quality improvement department if your registration is not current. A permanent registration number will be assigned to each drug establishment registered in accordance with the FDA. A copy of the form which contains the registrant's registration number as evidence of registration shall be maintained in a file which is accessible. There is no registration fee.
- The information required for registration includes:
 - The name and street address of the facility, with zip code;
 - All trade names used by the establishment;
 - The type of ownership or operation;
 - The name of the owner or operator;
 - The type of business activity.
- The FDA must be notified regarding changes in individual ownership, corporate or partnership structure or street address changes. Notification of changes must be submitted to the FDA within five (5) days of the change. Changes in the names of officers of the corporation do not require submission of a new form but must be shown at the time of the annual registration. Failure to register the facility as a drug establishment may result in a violation of the Food, Drug and Cosmetic Act and is punishable with substantial fees.