Nursing Department Handbook

"To impact the lives of everyone we touch in a very meaningful, sincere and deliberate way, every single day."

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Introduction

Congratulations on joining Harmony's Nursing Team! We welcome you and hope that over the next several weeks you will begin to feel a part of our professional family.

Harmony's Core Values include compassion, teamwork, quality, trust, enthusiasm, honesty, and innovation. The Nursing Team adds to these values with the acronym C.A.R.E, to help distinguish the services that patients, their families and referrals sources should expect from Harmony's Nursing Staff.

Communication Harmony's Nursing Team understands that nurse case managers are the coordinators and planners of patient care. With this comes great responsibility; our nurses are expected to ensure great communication with physicians, therapists, patients, families, and office staff. In doing so patients will be properly cared for and our goal of providing excellent care will be achieved.

Attitude Our employees understand that positive thinking and team work can produce great results. When seeing patients or while in the office personal feelings and frustrations must be left at the door. Positive attitudes are contagious and we want it to start with you!

Respect Harmony's Nursing Department understands as nurses you will encounter many different people that believe many different things. Treating people with the upmost respect and dignity regardless of race, nationality, gender, religion will lead to happy patients, coworkers and will always produce positive outcomes.

Exceptional care is what harmony nurses strive to provide. We make every effort to be the best in our industry and we believe it starts with our nursing staff. The little things do matter; asking if we can do anything before leaving a visit, bringing in patients mail, taking time to look at pictures of grandkids, thanking them for allowing us to come into their homes makes the difference.

We look forward to our future with you as part of our team, as we continue to grow and set the standard for patient care in the Home Health Industry.

Disclaimer

This Nursing Department Handbook is meant to be used as a supplement to the Harmony Home Health & Hospice Employee Handbook, and not to take its place or the place of any company policies. Please read both carefully, become familiar with their contents and continue to use them as valuable references. If the Handbook, and/or any policy which has been explained to you by a Supervisor, appear to be in conflict with Harmony's Employee Handbook or company policies, please address those points directly with your Supervisor and/or Director of Nursing Services as soon as possible. When in doubt, it is always better to ask for clarification.

Harmony Home Health & Hospice reserves the rights to modify, revoke, suspend, terminate or change any or all contents of this Handbook, in whole or in part, at any time, with or without notice. The language used in this Nursing Department Handbook is not intended to create, nor is it to be construed to constitute, a contract, whether express or implied, between Harmony and any one or all of its employees. Harmony Home Health & Hospice is an at-will employer, meaning that either the employee or the Company may terminate the employment relationship at any time, with or without cause or notice.

Hiring Process & Organizational Orientation

Once a job candidate has been offered a conditional offer of employment, he or she will be asked to attend new employee general orientation and department orientation. New employee general orientations are typically held every Tuesday at Harmony's corporate office in Murray, UT or by the Office Manager in Albuquerque, NM office. For RN's and LPN's orientation starts at 0800 and typically continues until 1700. The following is a list of documents that a job candidate will be asked to bring to the general orientation:

- ❖ Professional State License for pertinent field*
- ❖ Driver's License*
- ❖ Auto Insurance Card*
- ❖ TB test results (if taken within the last 2 weeks)◊
- ❖ Current CPR certification*
- ❖ Original Social Security Card
- ❖ Copy of School Transcripts or Diploma

PAF

Towards the end of the general orientation, the job candidate will be presented with and asked to review a Personal Action Form (PAF), which represents the mutually agreed upon compensation to be provided to the New Employee for their services (e.g. per visit rate, trip fee, administrative pay rate and any pertinent full-time employee benefits). If everything represented on the PAF is as the job candidate understood and expected them to be, they will be asked to sign the form.

Competency Assessment

The job candidate will also be asked to complete Competency Assessment Skills Checklists during the general orientation. The candidate should understand that by indicating that they are not experienced or competent with any particular skill, they are not inevitably putting their job candidacy at risk; however, Harmony may help the professional to receive additional training and experience in the area. We want to help even our best professionals become better at what they do!

- * The employee will be expected to maintain these items and keep them up-to-date with the Human Resource Department. The compliance pay portion of the employee's per visit rate is partially dependent on their ability to do so. Employee will not be scheduled for any visits until all compliance items have been received and accepted by the Human Resources Department.

- ◊ If the job candidate does not have recent TB test results, a Harmony Home Health nurse will be available to administer the test, at no cost to the job candidate, at some point during the orientation. It will then be the responsibility of the job candidate to have the TB test checked, and the associated form signed, by a licensed nurse within 48 and 72 hours after its administration (the nurse does not have to be a Harmony Home Health employee.

Department Orientation

The department orientation is an ongoing process, and Harmony will be sure to help provide sufficient training and mentoring for all New Employees. The initial introduction to Harmony's Nursing Team policies and procedures is presented from the supervisor and other team members. The orientation will include the following:

- On-Line Systems
    - Harmonyhomehealth.com website for charting
    - E-mail

- The Patient Admit Process (To be performed by RN only)
    - Receiving a Referral
    - Making Initial Contact
    - Acceptance criteria
    - Performing the SOC
    - Completing the SOC paperwork
    - Reporting SOC's to the Nurse Clinical Liaison

- Patient Nursing Visits
    - Scheduling
    - Universal Precautions and Cross-Contamination Prevention
    - Building Patient Rapport
    - Patient & Caregiver Safety
    - Providing Skill
    - Completing Visit Documentation
    - Other Do's and Don'ts

- Services offered through the agency
    - SN, PT, OT, SLP, SW, CNA, RT, PCA, HK

- Regulations pertaining to Home Health, including what is a skilled visit and Home Health Aide Supervisory Visits.

- Documentation

- Communication

- Line of Authority

Online System & e-Mail

Harmonyhomehealth.com (On-line Documentation and Scheduling System)

To access past or present documentation for a Harmony patient on your caseload, go to www.harmonyhomehealth.com, click on the "Secure Login" link in the upper right-hand corner and enter your Harmony username and password. During the first time that you log-on to the system, click on "Account Maintenance" and then "Change Password"; once you have entered your new password you can begin using the system. The EMR link on the left hand side (or top if using mobile site) will allow you to access the patients chart.

EMR

The EMR allows you to access patient referrals, assessments, orders, visits (SN, PT, OT, HHA, etc.), labs, medication profiles, communication notes, and the patients POC.

Schedules and Confirming Visits

One key area is the "Clients" section on the right side, where you can review your confirmed visits by going to "Print My Schedule." After you have selected a date range, you will see buttons to view Admin, Clinical, Meetings, and On Call times. The system will also show you if visits are paid or unpaid, and if they are payable. If a visit shows that it is not payable, please contact your Care Coordination Representative to discuss the issue

Harmony E-Mail

To access your Harmony e-mail account you must be at a Harmony location (for your first time login). Go to the company's website at www.harmonyhomehealth.com, click on the "Secure Login" link in the upper right-hand corner and- instead of logging in directly- click on the blue hyperlink that reads "Mail"; then enter your Harmony username and password (typically provided within 48 hours of completing new-employee orientation). You will need to log onto your Harmony e-mail within 5 days of receiving your temporary password, to change the password. If you fail to take this step, you will be temporarily locked out of the system and need to contact the Harmony I.T. Department directly by calling (801) 743-4238 or e-mailing support@harmonyhomehealth.com. **It is a requirement that nurses check their e-mails daily.**

Harmony Company Calendar

To access the primary calendar of events you log into the harmony website and select company calendar in the list of items to choose from it is at the top. The calendar will open in Google and it will default to select all departments and events, you may customize the items you would like to view by using the drop down box under agenda to the top right hand side of the calendar.

Managing your visit Calendar

You will be required to manage your visit calendar weekly by logging into the Harmony Home Health secure website. Your visit calendar must be completed no later than Thursday of every week for the following week. Please move all required/scheduled visits for the upcoming week from the right side of the screen on to your calendar and assign each visit a specific time. Having your visit calendar/schedule set up each week lessens the amount of missed visits, keeps you organized and also allows your supervisor to assign any additional visits that need to be done that day. Your supervisor will check your visit calendar to ensure it is set up by Thursday each week. *You will also complete a "Managing Your Visit Calendar" training via Mindflash to assist with managing your visit schedule and documenting your regular skilled nursing notes.

Scope of Services Offered

Skilled Nursing (SN)- IM/Sub Q injections, Central line/IV management, Parenteral Nutrition management and education, Catheter care, Wound and Ostomy care, Manage chest tubes/catheters, Rehabilitative nursing procedures (bowel & bladder), teaching and training activities, Home Safety, Edema management, Medication management, Disease management, Comprehensive patient assessments, Develop and customize the POC with the patient and physician, Provide patient/family/caregiver education and support, coordinate care with all other services, telemedicine as needed, measure outcomes of care.

Physical Therapy (PT) - Strength; ROM/Flexibility; Balance; Coordination; Posture and Body Mechanics; Endurance and Energy Conservation; General mobility (walking, stair climbing, getting in and out of bed or chairs); Recommendations for Adaptive Mobility and other equipment, and training in its use (e.g. wheelchairs, crutches, canes, walkers, T.E.N.S. for pain control, splints/braces, orthotics and

prosthetics); Wound Care; Edema Management; Home Safety Evaluations; Positioning programs to help prevent contracture and pressure sore formation or progression; Home Exercise Programs

Occupational Therapy (OT) - ADL's; Strengthening; ROM; Coordination; Upper Extremity Splint/Brace and Prosthetic Use; Edema Management; Home Safety Evaluations; Positioning programs to help prevent contracture progression of the Upper Extremities; Recommendations for Adaptive Equipment and Training in its Use (Bath Aids, Adaptive Graspers, Meal Preparation/Feeding Aids, Handwriting Aids, etc.); Recommendations for Assistive Technology and Training in its Use (Adaptive Switches, Modified Home Appliances, Visual Schedules, Computer Programs and Mobile Apps); Body Image (e.g. post stroke hemispheric neglect); Sensory Motor Deficits (hyper or hypo-sensitivity to sensory input and pathologic responses); Low-vision (safety/functional training, adaptations and assistive aids)

Speech Language Pathology (SLP) - Receptive Language (Comprehension); Expressive Language; Pragmatic Language (Social Skills); Articulation (Pronunciation of Words) and Fluency (Stuttering); Voice; Oral Motor Skills and Chewing/Swallowing; Memory and Attention; Problem Solving; Fluid Intelligence; Recommendations for Assistive Technology and Training in its Use (Hearing Aids, Cochlear Implants, FM Systems, Visual Schedules and Aids, Computer Programs and Mobile Apps); Instruction in Sign Language

Respiratory Therapy (RT) – This is used for patients with advanced pulmonary diseases only. This is used sparingly as this is not a reimbursed discipline. These therapists will help the patient/family/caregivers understand the proper steps to preventing continued exacerbation (dilate, treat, prevent) and gain a better understanding of their numerous/complex medication regimen.

Aides (CNA/HHA) – Scheduled visits should be decreased as the patient improves with therapy. OT should be ordered with any patient that receives a CNA.

Personal Care Assistant (PCA) -

Housekeeping (HK)

Social Work (SW/MSW/CSW) – Assess psychosocial status of patient, family dynamics, and caregiver status, assist with alternate living arrangements if necessary (SNF/ALF), set up Meals on Wheels, Assist nursing staff with potential situations that may need to be referred to APS/CPS, Assistance with Advance directives/living wills, etc., Help set up alternate financial assistance, Enrollment in other medical benefits (Medicaid, VA, County services, etc.), Set up senior companions/transportation

Outpatient Therapy (OPT) – PT is offered in each branch, OT & SLP are temporarily branch specific until the program is expanded. If you go out to evaluate a therapy patient and they are not homebound but still would like therapy, this service may be offered. Contact the appropriate CCR or Intake coordinator.

Back on Your Feet – Harmony offers this program to help reduce re-hospitalization. The goal for our agency is to keep patients referred to our care out of the hospital by helping them become as independent as possible, look for ways to reduce or eliminate factors that lead to reoccurrence or injury, and educate patient/family/caregivers in proper care.

Patient Admit Process

There's a reason why there are so many clichés about the importance of making a good first impression. If the RN who makes initial contact with a patient is attentive to their care and goes the extra mile to make sure that they have a good experience during the start of care, the proper groundwork will be laid for a positive healing experience.

Receiving a Referral

- Nurses will receive notification of a new patient (SOC) via a phone call from the assigned Care Coordination Representative (CCR). Once the case manager has accepted the SOC an e-mail will be sent to the nurse's phone. The e-mail will contain the patient's referral information which includes the patient's orders. The nurse may also come into the office if she/he chooses to pick up a hard copy of the SOC referral packet.

- The CCR will also load the appropriate SOC forms to the nurse's To-Do-List.

Making Initial Contact

- It is Harmony goal that a new patient be contacted by the assigned Nurse Case Manger within 2 hours of receiving the referral. It is also Harmony policy that the SOC visit takes place within the first 48 hours of receiving the referral; however it is Harmony's goal that every admission takes place within 24 hours of referral, unless otherwise specified by the physician.

    - Any new referrals that are received on Friday for Friday after 1700, Saturday or Sunday admission will be given to the on call nurse.

- In the case that a patient is not reachable by phone within the first 24 hours, the nurse should first attempt to contact the emergency reference listed on the patient Face Sheet. If all else fails the Nurse should attempt to drive-by the patient's home by the end of the 48 period since receiving the referral.

- If a patient is not reachable within the first 48 hours, or if the patient was contacted, but was for some reason unavailable for the SOC within 48 hours of the initial referral the Nurse should:

    1. Notify physician for approval of the delay and then notify intake so the referral source can be contacted
    2. Contact the Branch Clinical Manager and CCR with an update; and
    3. Complete a Case Communication Form describing the attempts at contact that have been made and the reason why the patient would not be seen during the first 48 hours.

Telephone Etiquette

- General Guidelines for all calls to patients, caregivers, or physicians
    1. Identify yourself and Harmony Home Health
    2. State the reason for the call
    3. Be courteous

4. Take notes if applicable
5. Always thank the representative you speak with and get there name
6. Leave contact information if appropriate

- Examples for Making the Start of Care phone call

1. Identify yourself to the patient or caregiver. “Hi my name is ____, and I am calling from Harmony Home Health. How are you?”
2. Let the patient or caregiver know the reason for the call. “I received orders from the hospital/rehab/clinic for nursing, physical therapy, home health aide, etc. I would like to come to your home to get these services set up for you.”
3. Schedule a time to complete the Start of Care visit. “What time tomorrow is convenient for you?”
4. End the phone call and leave contact information. “Excellent, I look forward to seeing you at ___ tomorrow. If you need anything before then please call Harmony Home Health at____, thanks.”

- Tips & Points to remember

1. At the SOC it is not clear how healthcare literate your patient is going to be, please use laymen’s terms to describe care since patients typically will not understand clinical language such as “SOC, PT, OT, SN, etc.” One example of this is when talking to your patient regarding Hypertension be clear that this is the term used for high blood pressure.
2. With patients who are resistant to letting a nurse complete the start of care visit remind the patient the doctor has requested that the nurse come out to see how they are doing. Help them to understand the benefits of the service you are going to provide.
3. If a patient refuses services all together inform them the doctor will be contacted to report services have been declined.
4. Listen: patients may be apprehensive about care. Be sure to hear them and adjust the call accordingly.

Performing the Start of Care (SOC) Visit

- More often than not a patient will be overwhelmed, tired, and frequently in pain after returning home from the hospital, rehab, or care center. The SOC requires the nurse to gather a lot of information which can be overwhelming to complete in one visit. The most vital tasks that should be completed in the first visit are the legal documentation including obtaining signatures, review/education of all medications, and some education in regards to safety. Remember for the visit to be billable there must be a skilled service performed and documented. Assessment alone is not considered a skill. If the skilled service is medication reconciliation and education you need to be sure to document that clearly on your visit note. The OASIS may be completed on the second visit if needed.

- SN visits including SOC, ROC, Recerts, and Discharges must almost always be at least 30 minutes in length in order to be payable to a RN. However, these visits should typically last 40-60 minutes. Only in exceptional cases should a nursing visit last an hour or longer, due to the risk of over-staying our welcome and/or overwhelming the patient.

- Do your best to be punctual for the appointment. If you are running more than 5 minutes late to a scheduled evaluation, call the patient to let them know where you are, and provide them with an estimated time of arrival. It is recommended that when giving patients a time of arrival a two

hour window time frame is observed (e.g. between 1200-1400). Obey all local laws and ordinances when driving. It's better to arrive late, but safe, to a patient's home then not to arrive at all.

- It is the case manager's repositionability to complete all of their own SOC's. If a nurse is overloaded with visits and a SOC comes across the nurse case manager must give away regular visits to the field staff and take their own SOC's.

Completing the 1st Visit

- Upon completing the SOC, the RN should be sure to perform the following actions:
    - Ask if the patient has any preferences or conflicts regarding the days of the week or time of day when they will be seen for nursing visits. Although a Nurse should respectfully consider a patient's scheduling requests, it may be necessary to explain that availability is dependent on other assignments and on the location of other patients on a given day.
    - Schedule the next appointment- Please inform the patient that they will also receive a separate phone call from the Therapist/s or HHA scheduler to set up evaluation/appointments (if applicable).
    - Thank the patient for their time, and ask if they have any questions or if there is anything that you can get for them (e.g. a drink of water, blanket or remote control). Be sure that they are safe and comfortable when you leave the home.
    - SOC paperwork consists of: the paper SN Assessment/OASIS, Medication Profile, 485 (order), SOC Summary, HHA POC (if applicable), SOC nurses note (found in the back of the OASIS paper packet), Billing Agreement, Consent for Treatment, Advanced Directives, Emergency Plan and the SOC check off list.
    - The SOC Assessment/OASIS and nursing note are to be filled out on paper while you are in the patient's home performing your assessment. After the medication reconciliation is completed the medication profile for the patient is to be left in the patient's home.
    - The rest of the SOC paperwork: Medication Profile, 485 (order), SOC Summary, and HHA POC (if applicable) will be completed by the nurse calling the nurse clinical liaison. The nurse is responsible to call the clinical liaison directly after completing the SOC. The main number for the clinical liaisons: 801-743-1412
    - You must then report the needed services to CCR directly following the phone call to the clinical liaison so they can inform the correct disciplines to go out and see the patient
    - The clinical liaisons use the following form and you will be expected to know the answers for the following questions:

Clinical Liaison Report ☐SOC ☐ROC ☐ Recert Date:

Client:

If the nurse needed to obtain the patient's SS # enter:

Payer:

Nurse: Clinical Liaison:

Date of referral: Date of Admit: If >48 hrs need verbal order/reason ☐ New SOC Needed From M.D.

Reason for delay in admit:

Frequencies entered: ☐ M.D. Notified: ☐

Orders requested: ☐ PT ☐ OT ☐ ST ☐ SW ☐ HHA ☐ Nursing

MEDICATIONS ☐ Medications entered on the 485
Oxygen ☐ No ☐ Yes

Primary Reason for Home Care:

Co- Morbidities:
Event:
Evaluated in:
Newly Diagnosed with:
Procedure:
New Diagnoses:
New Tx:

Wound/Incision: Source/Size/Treatment:

Type:	Location:	Size	Treatment

Nursing Care/Objectives: Must be skilled care for Medicare. New Medication monitoring is good for 3 wks but the medication must be documented on each visit. ☐ Assessments ☐ Medication teaching of
☐ Observation/assessment of
☐ wound care ☐ IV site care - ☐Administering of
☐ Education of
☐ Catheter care size Changed: weeks+ PRN

Fall Risk: ☐ low ☐moderate ☐high **Braden Score: ☐ <18 ☐ >18**

Functional Summary: The patient is a year old . The patient is alert and oriented X The patient's lungs and . The patient . The patient . The patient's skin is . The patient , , and The patient reports The patient is their ADLs. The patient lives Other observations are that the patient , .

Additional information:

SN Visits

Home Health provides a unique opportunity to work with patients in their *own* environment. Think of what home means to you. For most, home is a haven a sanctuary from the stressors of the outside world. We must be respectful of the patient's refuge, and take care not to bring anything harmful inside of it (whether it is a cold virus or a negative attitude). Nurses should treat patients the same way that they would like themselves or a family member to be taken care of.

Scheduling Nursing Visits

- Patients should be asked if they have any preferences or conflicts regarding the days of the week or time of day when they will be seen for treatment sessions. Although a nurse should respectfully consider a patient's scheduling requests, it may be necessary to explain that availability is dependent on other assignments and on the location of other patients on a given day.

- Whenever possible, try and schedule an entire week's worth of appointments for a patient, rather than scheduling on an appointment-by-appointment basis. It is also recommended that consistent appointment times be established when possible.

- In the case that a nurse knows or suspects ahead of time that they will be unable to complete visits in a given week, due to illness, vacation or any other personal reason, the employee's immediate supervisor* should be notified as soon as possible. It is the case manager's responsibility to find coverage for their patients; however your nurse manager is available to assist in finding coverage if needed. Patient report is required all on patients being seen by an alternate nurse. It is *NOT* alright to simply skip or miss a day without trying to make other arrangements for the patient.

- When you know that you are going to be taking time off you will be required to complete a "day off scheduled sheet". This sheet is shown below:

Time	Date:
	Day of the Week:
0800	Patient: Diagnosis: Skill: **Covering Nurse**:

- This must be completed for every patient that needs to be seen while you are off. This will be turned in directly to your supervisor.
- All nurses must turn in a schedule showing patient visits to be done by that particular nurse each week to the Clinical lead or Manager on a weekly basis.

Nursing Frequencies

- The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services. (MBPM 30.2.2)
  A Home Care week is defined as Sunday through Saturday. When writing an order the nurse must take in to consideration the day of the week the start of care takes place. For instance a nurse is doing a start of care for a traditional Medicare patient on Friday. The 3 consecutive nursing visits would be scheduled as such: 2wk1 and then 1wk1, due to the week ending Saturday and beginning Sunday. This includes frequencies for PT, OT, ST and SW. For example if a patient is admitted on Friday and requires Physical Therapy; however the patient doesn't want therapy to start until Monday the order would read PT 1wk1 effective: wk 2 (meaning 1 visit during the second week of care. 0 (zero) is not considered a frequency. Another example of specific frequencies is SN 7wk1; 3wk4; 2wk3, (SN 7 times per week for 1 week; 3 times per week for 4 weeks; and 2 times per week for 3 weeks) for skilled observation and evaluation of a surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile dressing change consists of (detail procedure here).
- **WHEN CREATING YOUR SCHEDULE KEEP IN MIND LPN'S ARE NOT ALLOWED TO SEE VA PATIENTS.**

All Traditional Medicare patients must be seen for 3 consecutive SN visits following SOC/ROC/Recert

Nursing Frequency Guidelines

Diagnosis	Frequency	Interventions/Teaching
CHF	3 wk2, 2wk1, 1wk 2 and possibly through cert period depending on severity.	Weights, edema, leg measurements, medication education/monitoring, B/P log. Medicare and other insurance companies are auditing for BP checks and tracking on most patients with a Cardiovascular/heart related diagnosis.
COPD	3 wk2, & Respiratory therapist consult, 2wk1, 1wk2	Medication education/compliance, s/s of exacerbation, deep breathing, IS, what to do if symptoms occur, oxygen safety, precautions, and use
TKA/THA	3 wk1, 2wk1, 1wk1	Incision care/assessment, anti-coagulation monitoring/education, pain control, transfer techniques
Pneumonia/ infections	3 wk1, 2 wk1, 1 visit on last day of antibiotics to ensure patient is not symptomatic and 3 days following to ensure infection has not returned	Medication education/effectiveness, medication side effects, s/s of infection, oxygen safety, precautions, and use
Weakness/ Therapy	3 wk1, 1 wk2	Medications, f/u to ensure therapy has gone out, Pain, Depression

*These are guidelines only, and understand every patient is different. However these guidelines should be the minimum amount of nursing visits made. It is up to the admitting nurse as to what the actual frequencies will be.

Line of Authority

- The immediate supervisor for LPN's and Nurse Case Managers is the Branch Clinical Lead (where applicable) or the Branch Clinical Manager. If for any reason the Branch Clinical Manager is unavailable the Clinical Administrator should be contacted.

Administrator: Mike Garza
Clinical Administrator: Ashley Mack

Clinical Mangers:
Albuquerque- Kim Nicholson
Provo: Kim McCormick
Murray- Whitney Lopez

Definition of Skilled Nursing Visit

A skilled nursing visit is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, the reviewer considers both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice. Some services may be classified as a skilled nursing service on the basis of complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters, and if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on this basis. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse.

Please contact your supervisor or reference the Medicare Benefit Policy Manual Chapter 7 Section 40.1 when whether or not the service is considered a skill.

What is Considered a Skilled Nursing Visit

- **Injections**-must be a medical reason med can't be taken orally
- **Tube feedings**-replacement, adjustment, stabilization, and suctioning
- **Nasopharyngeal and Tracheostomy aspiration**
- **Catheters**
- **Wound Care**
- **Ostomy Care**-during the post-operative period and in the presence of associated complications
- **Medical Gases**-initial phases of a regimen involving the administration of medical gases that are necessary to the treatment of the patient's illness or injury.
- **Rehabilitation nursing procedures**-including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs)

- **<u>Teaching and training activities (Education)</u>** that require the skills of a licensed nurse include, but are not limited to, the following:

    1. Teaching the self-administration of injectable medications, or a complex range of medications;
    2. Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;
    3. Teaching self-administration of medical gases;
    4. Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;
    5. Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;
    6. Teaching self-catheterization;
    7. Teaching self-administration of gastrostomy or enteral feedings;
    8. Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;
    9. Teaching bowel or bladder training when bowel or bladder dysfunction exists;
    10. Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;
    11. Teaching transfer techniques, e.g., from bed to chair, that are needed for safe transfer;
    12. Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;
    13. Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;
    14. Teaching prosthesis care and gait training;
    15. Teaching the use and care of braces, splints and orthotics and associated skin care;
    16. Teaching the preparation and maintenance of a therapeutic diet; and
    17. Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.
    18. Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis, eczema, or due to skin deterioration due to radiation treatments)

Universal Precautions and Cross-Contamination Prevention

- Upon entering the patient's home and before touching anything, sanitize your hands (in the presence of the patient if possible). If you or the patient has sensitivity to the alcohol in hand sanitizer, or if a more thorough cleansing is needed, you may wash your hands with soap and warm water instead, using disposable paper towels to dry in place of a hand towel.

- Nursing bags or other items brought into the patient's home should be placed on top of a disposable pad, paper or plastic sheet and not directly onto the floor or furniture.

    - If questioned or concerned that the action may be misinterpreted as offensive, gently explain that it is State policy to use a barrier between our bags and other items brought into the house in order to help prevent the risk of bringing anything into their home that shouldn't be there.

- Remove any equipment from your nursing bag which you will be using during the visit (e.g. pulse-oximeter, blood pressure cuff, and thermometer), sanitize and place on the protective barrier; assure that the equipment is not in contact with the treatment bag.

- When finished with the visit, re-sanitize the equipment and return it to the nursing bag, throw away the disposable barrier inside of the patient's home, and re-sanitize your hands immediately upon leaving the patient's home- or beforehand if you are using soap and water- and before re-entering your vehicle.

- Wear disposable gloves if you or the patient has any open skin lesions

- If you are infectious, stay home and make arrangements for someone else to see your patients(s) until you are feeling better and no longer contagious.

Building Patient Rapport

- Take a few moments at the beginning of the visit to ask how the patient is doing. Ask about their family or recent events that you are aware of (e.g. MD appointment, Birthday or Grandson's Graduation). If it is your first time in the patient's home, pay particular attention to the environment (photos, magazines, art work, etc.) for potential shared interests that you can build a relationship of trust on, while maintaining professional boundaries.

- You may continue social conversation during the visit, but don't allow the conversation to control the session or the quality of care.

- Several guidelines regarding conversation:

    - Be careful not to share too much personal information about yourself or your family with the patient.

    - Always observe HIPAA policy; never discuss other patients or share any identifiable information. Keep all patient confidential information covered or in the trunk at all times. The nurse is responsible to keep patient information secure.

    - Do not complain to a patient about another Harmony employee or contracted staff's behavior, or about the company or any of the companies with whom Harmony does business. If a patient has a complaint, tell them that you would be happy to report it to your supervisor and have someone from Harmony follow-up on the issue. Do not make any other guarantees or share any opinions with the patient regarding the matter.

    - Never discuss the personal lives of another Harmony or Staffing Agency employee. This includes not sharing the nature of an employee's own health condition that may be keeping them from being able to see the patient.

    - Avoid the use of any questionable language, humor, or subject matter.

    - Avoid overt discussion regarding politics or religion, and the sharing of opinions regarding subjects that could be deemed controversial.

- If you notice that the patient is a Veteran, thank them for their service, but be careful not to ask many questions about their service unless the information is offered. For many of our patients, memories of war can still cause significant anxiety.

Except in cases of emergency, or when you are expecting a phone call from a Physician, Do Not answer your cell phone, text or send/read e-mail when you are with a patient. If you do need to receive a phone call, excuse yourself politely from the patient, making sure that they are safe before you leave them, and either step outside or to another part of the home so that the conversation is private and you don't run the risk of confidential information being overheard. Keep the phone call as short as possible

Patient & Caregiver Safety

- When in doubt about the safety of a transfer or other activity, trust your better judgment. It is better to wait until you are confident that the patient will be safe with the activity, given the physical support that is available to them.

- Observe established medical precautions and restrictions (e.g. post-operative limitations on hip flexion, adduction, etc. after a hip replacement)

- Use proper body mechanics and teach the patient to do the same.

- Consider using a gait/transfer belt with the patient during transfers and weight-bearing activities and/or a back brace for yourself

Hands on Care

- Performing skilled nursing care should be based on Best Practice principles. Don't ever be afraid to ask for additional training, or to let your supervisor know if you are uncomfortable performing a particular treatment/skill.

*****DO NOT ATTEMPT TO PERFORM TREATMENT ON A PAITENT THAT YOU ARE NOT COMFORTABLE WITH, THIS MAY CAUSE POTENTIAL HARM.*****

- In the same spirit of Best Practice, Nursing Professionals should maintain an atmosphere that encourages open, two-way communication between Nurses, CCR's, and across disciplines. Ideas and insight regarding patient treatment should be shared appropriately with other members of the Care Team without fear of judgment.

- A nursing visit must almost always be at least 30 minutes in length in order to be payable. However, these visits should typically last 40-45 minutes, to ensure a thorough assessment, proper treatment and education. Only in exceptional cases should a nursing visit last longer than an hour, due to the risk of over-staying our welcome and/or exhausting the patient.

- Harmony's Nursing Staff are expected to follow and perform any treatment or skill directly as ordered.

- A large portion of a nurse's time is spent on education. Harmony encourages (this is a Medicare requirement) nursing staff to involve patients/caregivers when possible, and to leave visual

depictions and/or teaching aids for the activities when appropriate (only use programs that are either non-copyright protected, or for which you, Harmony or the Staffing Agency you work for has a license or other documented permission to use).

Patient Care Report Card

- We are interested in feedback from our patients and caregivers. We have a Patient Care Report Card, which is part of the start of care packet. The nurse or therapist will review the patient satisfaction and the Patient Care Report Card between the first 14 and 30 days of care. If the patient prefers not to discuss their care to the nurse or therapist they can fill out the Patient Care Report Card and give it in a sealed envelope to a team member or mail it into the office with the addressed envelope provided.

Completing the Visit

- Upon completing a nursing visit, the nurse should be sure to perform the following actions:
    - Ensure the patient has Harmony's on call/contact information
    - Confirm the next appointment
    - Thank the patient for their time, and ask if they have any questions or if there is anything that you can get for them (e.g. a drink of water, blanket or remote control). Be sure that they are safe and comfortable when you leave the home.
    - Report should then be given to the nurse case manager if applicable and the MD should be notified if any significant changes were identified.

Documentation

Nursing Visit Note

- The skilled nursing notes are documented and completed using tablets that are connected to the internet utilizing your work phones as a hot spot. The documentation is done through the Harmony Home Health secure website.

- Due on Mondays, Wednesdays and Fridays (unless otherwise specified in a separate agreement with Harmony). For example, if a patient visit is completed on a Monday or Tuesday, the completed visit note is due in the system by the end of the day on Wednesday (i.e. 11:59 p.m.). If the visit is completed on a Wednesday or Thursday, it is due by the end of the day on Friday; and if completed on a Friday Saturday or Sunday, it is due by the end of the day on Monday.

- Scanning OASIS Assessments and SOC Notes
    - Place papers on top of printer in the feeder, select "image send" located in the middle top portion of the screen. Then select "2-sided booklet" at bottom left of screen, click okay after selecting proceed to selecting "address book" and choose the correct address (each

branch will have different address). Then hit the big round green button at the bottom of the printer and images will be sent. Place nursing notes in the appropriate basket.

Missed Visit Report

- Missed visits, regardless of the reason, should be documented as a missed visit note. If a nursing visit can be re-scheduled during the same week, then a missed visit report does not need to be generated. The exception to this would be if an order for a specific date has been missed, a missed visit note must be generated and the physician contacted. If the visit was done on another day, a new ordered is needed.

- If a cancellation, "no show" or refusal occurs once you arrive at the patient's home or after you have travelled at least 50% of the way to the patient's home from your last appointment, the company will compensate your mileage.

- Due on Mondays, Wednesdays and Fridays (unless otherwise specified in a separate agreement with Harmony).

- Missed visit reports are to be documented online

Case Communications Form

- Use the case communication form for anything that may be questioned or could prove to be a potential liability later. For example: Repeated attempts to schedule an appointment with a patient, when you are either not able to make contact, or the patient is not making time for the appointment; Consecutive missed visits (you should also complete a Cancelled Visit note); evidence or reason to suspect illegal and/or dangerous activity in the home; significant changes in patient condition whether they are observed or reported by a patient, family member, caregiver, or medical professional. If it is a reportable Incident (e.g. fall and/or injury), an Incident Report should also be completed. If the fall is reported to a field/visit nurse it needs to then be reported to the nurse case manager; who then needs to notify the pts Primary Care Provider.

NEVER DOCUMENT IN A PATIENT CHART THAT AN INCIDENT REPORT HAS BEEN COMPLETED**

- Be sure to indicate on the form who you ***communicated*** with. If you aren't sure who you should be contacting, call the Branch Clinical Manager.

- Submit by sending to your assigned CCR

Incident Report

- Complete report and contact the physician, whether or not you were present for the incident (be sure to indicate on the form whether or not you were). Document the name of the physician that was notified of incident.

- A copy of the incident report should be turned-in to the Branch Clinical Manager/Lead and your assigned CCR within 24 hours of the incident.

- All deaths in home care must be reported to the clinical manager within knowledge of the death.

Medication Error Report

- Complete medication error report if nurse administered any medications in error and document name of MD contacted.

- A copy of the medication error report should be turned in to the Branch Clinical Manager/Lead within 24 hours of the error.

- If it is a substantial error, notify emergent personnel as needed and notify your Clinical Manger/Lead immediately after patient has stabilized.

Patient Complaint Form

Simple Complaints

- Promptly complete and return the Patient Complain Form, regardless of the nature of the complaint (e.g. a complaint about a Home Health Aid), to your immediate Clinical Manager for review and evaluation. In addition, you should notify the Case Manager of the situation if applicable.

- If the complaint/grievance is within your ability and/or authority to correct, and the solution does not violate company policies or procedures, then you should take the appropriate steps to resolve the issue.

- The client/patient and/or caregiver should be involved during this process as necessary to reach a mutually beneficial resolution.

- The Patient Complaint Forms are located in the branches and should be filled out upon knowledge of complaint and turned into the Branch Clinical Manager within 24 hours.

Serious Complaints

- Promptly complete and return the Patient Complain Form, regardless of the nature of the complaint, to your immediate Clinical Manager for review and evaluation. In addition, you should notify the Case Manager of the situation.

- The Clinical Branch Manager will respond to the complainant either verbally or in writing. This communication will document that the complaint/grievance has been received and an investigation is taking place if applicable. A notation of this action will be added to the Complaint/Grievance Form.

- The Branch Clinical Manager will investigate the issue and attempt to resolve it if it is within his or her ability/scope of knowledge or authority to do so. The Branch Clinical Manager will document his or her investigation and outcome on the Complaint/Grievance Form and report the findings to his or her Administrator. The Branch Clinical Manager will then inform the complainant of the resolution if appropriate.

- If there is no resolution and/or the concerned party is not satisfied, the complaint/grievance may be referred to the QA Coordinator or the next highest level of management for investigation/resolution.

- Throughout the complaint/grievance procedure, the client/patient and/or caregiver should be involved as necessary.

Notice of Medicare Non-Coverage (NOMNC)

- Any patient who is covered by Medicare or a Medicare enhanced/alternative plan, whether it be as their primary or as a secondary insurance, should be given a 'Notice of Medicare Non-Coverage' form for their review and signature at least two days prior to their planned discharge from services. If a patient is not receiving any skilled nursing services, the responsibility falls upon therapy staff (a Therapist or Assistant) to take time to explain the significance of the form and the patient's right to appeal the decision to discontinue therapy services. By signing the form, the patient is not necessarily agreeing to the decision, but a signature is required to indicate that they have received and understood the notice. If the patient or their legal caregiver asks for a copy of the form, complete two forms with the exact same information at the time of signing or, if a machine is available, take a photocopy of the original.
- If the patient refuses to sign the NOMNC, make a clear notation on the form that the patient refused to sign, and if known the reason why.
- The dates and information needs to be filled out appropriately, at least two days prior to discharge. If this form is not completed properly or the notice of non-coverage is not given timely in advance the agency may be liable to cover additional care free of charge.
- The form is found in the SOC packet. Once a patient signature has been obtained, the form should be given to the appropriate CCR.

Home Health Change of Care Notice (HHCCN)

- This form is required to notify the patient when a triggering event changes the beneficiary's POC. Triggering events are reduction or termination in the patients care either due to a physician order or other home health agency reasons.
  1. Examples of HHCCN triggering events due to physician or provider orders:
     a. Reduction= the plan of care lists wound care every day. The physician writes a new order to decrease wound care to every other day.
     b. Termination=the plan of care lists wound care 3x's a week. The physician writes a new order discontinuing all wound care.
- Examples of HHCCN triggering events due to home health agency reasons.
  a. Reduction=PT services are ordered 4 times per week in the POC. The Home Health Agency has an unexpected staffing shortage and can only provide PT services 2 times a week.

b. Termination=PT services are ordered 4 times per week in the POC. The home health agency has lost PT staff and can no longer provide any PT services.

Advance Beneficiary Notice (ABN)

- This form is a notice given to beneficiaries with Medicare Insurance, to convey that Medicare is not likely to provide coverage for a certain item, service, lab test, test, procedure, care or equipment.

Supervisory Visits

- Supervisory visits of Aide's should be performed by the RN at least every 14 days. If the 14 day supervisory visit is due and there is no scheduled **skilled** visit a separate supervisory visit note should be completed (this is payable to the nurse, but not a billable nursing visit). In the instance the nurse is seeing the patient for a skilled visit and completing an Aide SV the regular SN note may be completed with the Aide Supervisory section filled out. If the patient you are completing the Aide supervisory visit for is a non-skilled patient the supervisory visit is due every 55-60 days. This type of patient requires the nurse to supervise the aide while in the patient's home.

- The CCR's will print you two of the most previous Aide visit notes and you must take those out to compare to the POC that is in the patient home.

- **Every patient that is receiving Aide services must have a CNA POC in their home at all times**

- **USE THE SUPERVISORY VISIT AS AN OPPOURTUNITY TO COMMUNICATE WITH THE AIDE, YOU WILL RECEIVE A HHA PHONE LIST.**

- Supervisory visits for LPN's need to be performed at least every 30 days.

Qualifications for Home Health Aide

**Reminder when creating CNA POC we need to justify why the Aides are needed. ** Home Health Aides must perform 3 personal cares per visit to ensure the visit is billable.
Personal Cares include:

- Shower/Bed Bath
- Washing Hair
- Comb Hair
- Oral Care
- Assist with Dressing
- Elastic Stockings
- Clean File Nails
- Moisturize Skin
- Shave

Acute skilled patients who require assistance from Aides need to have the visits tapered. As the patient progresses with Physical and/or Occupational Therapy the need for assistance should decrease.

Discharges

- A discharge visit (discharge nursing note) is required for all home care patients unless otherwise specified which would need to be approved by the Administrator or Clinical Administrator.

- A discharge OASIS (in addition to discharge nursing note) must then be completed along with a discharge summary, noting resources the nurse has discussed with the patient

- Discharge packet should be used for all discharges and medication teaching sheets should be used and left with the patients for at least two (2) of the patient's medications.

    - Who will manage pts medications and resources (leave updated medication list)
    - Time and date of follow up appointment with physician
    - Document any educational material left with patient/caregiver
    - Ask "was there anything we could have done different to enhance their experience with Harmony Home Health?"
    - Leave name and business card

- Documentation of physician notification of discharge must be noted including who you spoke with.

- Submit via Harmony Home Health secure

- If there is an unplanned discharge the last skilled visit in the home is the discharge date and all discharge OASIS answers must be based on the physical assessment performed at that visit. If the last skill in the home was therapy you may need to talk with the therapist to complete the discharge.

Interim Orders

- Used to make corrections or request changes to frequencies and/or Plan of Care such as new INR orders, new wound care orders, etc.

- Interim orders should be emailed to the clinical liaisons to input into the system at: Cl@Harmonyhomehealth.com

- Be specific about what should be included in an interim order
    1. Date
    2. Time
    3. Physician name
    4. If writing a medication interim order include: Drug name, dose, route, frequency and start date and end date if applicable. An example of an interim order: Coumadin 5mg PO every Monday, Wednesday, and Friday, Coumadin 2 mg PO every Tuesday, Thursday, Saturday, and hold Sunday starting MM/DD/YY (date). RN to re-check INR on MM/DD/YY.

5. When writing an order for skilled care indicate the type of professional that will be providing service, the frequency and duration of the service ordered, the details of the treatment needed, wound care will require specific details on the dressing change each time the physician orders different products to be used.
6. Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

Additional Forms

Case Conference Notes

- Case Conference notes are required on every patient at least once a month. Case Conference notes are documented on every other week and are broken up by the alphabet. Patients to be discussed are alternated by last name; A-M/N-Z depending on week of conference.

- Case conference notes are completed when report is called into the Case Conference. The coordinator will set up a day and time of the week that the call will take place. The type of information that needs to be documented in a case conference note includes: report on the patient's progress (is function improving or declining); is the patient experiencing shortness of breath, an inappropriate HR/BP response, etc.; if there have been any falls or other reportable incidents; and upcoming plans to D/C or re-cert the patient, with as much anticipation as possible.

- Once your report has been taken the coordinator will then contact each appropriate discipline (PT, OT, ST, HHA, MSW, etc.) caring for the patient. After report is taken from each discipline in the patient's home the case conference note will be put on your to-do-list to be reviewed and signed. Once signed it will be faxed out to the patients PCP.

Administrative Time Sheet

- Administrative time is entered in directly on the Harmony Home Health website by at least by the 1st and 16th day of each month.

- Employees who request Administrative Time, which is in addition to whatever time/tasks have been pre-authorized, must obtain authorization from the Clinical Manager.

- You don't need to fill out an admin time sheet if you have signed a roll sheet for a meeting.

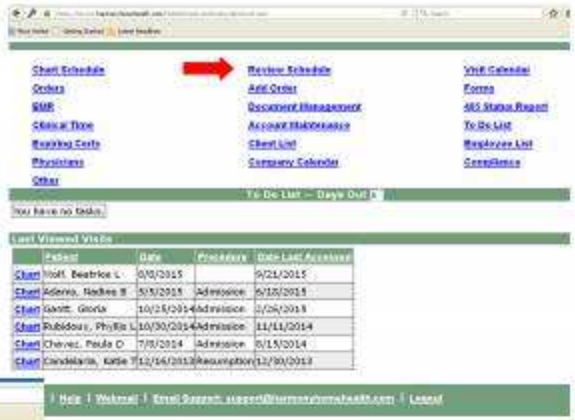
PDO Request Form

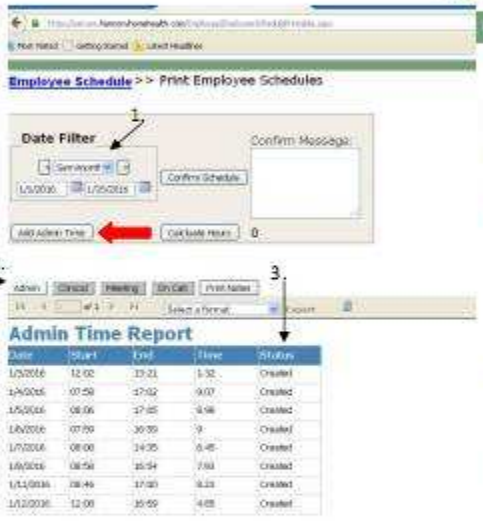
- PDO Request Forms must be submitted via the Harmony Home Health website by the 1st or 16th of every month depending on when the time off is scheduled.

- PDO Request Forms need to be filled out anytime you are requesting time off (including time off that without pay). All PDO requests must be approved by your supervisor and an employee must give at least a 14 day notice when planning on taking time off.

- Please see the instructions below for a step-by-step guide in entering your admin time and PDO requests.

Once you login to Harmony's Secure Site you will see this screen. Click on the blue *Review Schedule* button.





The following screen has a couple of great features.

1. Date filter – you can set this to daily or for the entire pay period
2. You can see the type of time you want such as Admin, Clinical, Meetings and On-call.
3. You can see the status of the time: Created, confirmed, approved, paid, unpaid, not payable, etc.
4. Clicking on the *Add Admin Time* button will allow you to enter your Admin Time electronically!

Simply enter the type of Admin Time you completed, the date, start and end time and a description, then click **SAVE**
You can go back to the previous screen to see your entry. Be careful as you will not be able to delete your entries! Be as detailed as possible in your description so your supervisor can approve your time.

Mileage Log

- If a Nurse needs to take blood work to a lab, or is requested to travel outside of their normally assigned geographical region for a training or in-service they may record their mileage and turn-in the form for reimbursement at the company's current mileage rate.

- Submit to the Clinical Manager at the end of the pay period.

Documentation Abbreviations

Nurses should only use abbreviations which are commonly accepted for medical documentation. When communicating between disciplines or other parties (e.g. insurance companies, patients and their families and even Physician's), it is best to limit the abbreviations that are used, or not use them at all. Though abbreviations can be extremely helpful for increasing the efficiency of documentation, they can also cause confusion for the reader if they are not familiar with its meaning.

Protecting Documentation

Nurses must keep all documentation it is not recommended that patient records be kept on a computer hard drive or external storage media. If external media is used, a Flash Drive (a.k.a. USB or Jump Drive) with encryption/password capability is the preferred method. Patient records or otherwise confidential or sensitive material, including electronic devices that contain such information, should never be left behind in a car (even for a moment). All electronic devices are required to be password protected. Any paper documentation with confidential or sensitive material should be disposed of appropriately via a paper shredder. It should not be reused or recycled under any circumstances.

Communication

"Communication works for those who work at it."
-John Powell

Good communication is the key to providing exceptional holistic patient care. The greatest problems often emerge from the smallest of miss-communications (or the absence of communication), while great success in any organization requires a collaborative effort.

Harmony encourages professional communication between its office and field staff, patients, patient caregivers and outside healthcare providers. Nevertheless, it is important that all communication, whether it is in-person, written, electronic or by phone, adheres to the following guidelines:

- Communication should follow the proper chain.

    - For LPN's and field/visit nurses, concerns regarding a patient should be communicated to the supervising Nurse Case Manager or, in situations when the Case Manager is not readily

available and the concern requires immediate attention, contact the Clinical Manager/Lead. Regardless of who receives the initial communication, it should be documented and the information still relayed to the Nurse Case Manager; who should then contact the physician if applicable.

- Nurse Case Managers should communicate patient concerns regarding therapy directly to the Therapist. In some instances, communication with the Director of Therapy may also be warranted.

- Concerns regarding documentation should first be addressed with the assigned Care Coordination Representative. When the communication is sent via e-mail, in unresolved cases, the Nurse Clinical Manager/Lead should also be included in the communication.

- Concerns regarding payroll should first be addressed with the assigned representative. Assigned representative for the Murray office is the CCR Team Lead. Ogden, Provo and Tooele would contact the office manager.

- Concerns involving another Harmony staff member that may not, or should not be resolved directly with the other party, should be discussed with your immediate supervisor. If the concern involves your immediate supervisor, and cannot be resolved appropriately by speaking with them, it should be addressed with the administrator who directly oversees that supervisor. For example, if a LPN has a concern with the supervising Nurse Case Manager, they should discuss the matter with the Branch Clinical Manager/Lead. If there is a concern with the Branch Clinical Manager/Lead that cannot be resolved without assistance, it should be discussed with the Clinical Administrator. You may also involve HR at any point in this process.

- Communication should always follow HIPAA standards for privacy.

  - Use discretion when discussing patients in the workplace, and never share information that would reveal the patient's identity to non-concerned parties.

  - Never share the identity or any confidential information about a patient with your family, friends or other parties, including any unauthorized family and friends of the patient.

  - Your Harmony e-mail account should not be used for non-work-related correspondences, nor should your private or other non-Harmony e-mail accounts be used for Harmony related communication. Whenever referring to a patient through your Harmony e-mail, it is best to include as little information as is necessary in order for the receiver to positively establish the identity of the patient you are referring to. For example, if a patient's name were Wilhelm Funkymeister, you could use "Mr. W.Funkymeister" to refer to the patient in your e-mail. In the-unlikely- case that there were several W. Funkymeister's in the Harmony database, it is appropriate to use a date of birth (i.e. W.Funkymeister DOB: 04/01/1913). Remember, for security reasons, only use the Harmony e-mail system. Using other domain names to e-mail patient information is a HIPAA breach.

  - Do not use text messaging to send a patient's name or other identifying information.

  - Protect your electronic devices, including cell phones, with a password, "swipe code," or finger print entry.

- Communication should be reliable

    - If you don't know the answer to a question posed by a patient, co-worker or other party, don't guess or make it up! It's always better to say that you don't know, but that you will either find the answer yourself, or find someone else who can help.

    - Big problems can be caused by providing the wrong guidance. Care must be taken even when expressing an opinion, because to a patient, a professional opinion is oftentimes as good as the "gospel truth." Never provide direction in response to a question that falls outside of your area of expertise and/or which is not covered by your professional practice act.

    - Communication should occur in a timely manner, especially when a response is expected within a given timeframe. Harmony Therapy Staff are asked to check their e-mail at least two times a day, and text messages and voicemail should be checked approximately every two hours during the workday. When a new patient is referred to your caseload, a confirmation e-mail should be sent to the referring party (i.e. supervising Therapist or Case Manager Assistant).

- Communication should be appropriate

    - Unprofessional communication, even during "private conversations," has an uncanny way of coming full circle. Think twice before hitting the 'send' button on an e-mail or before saying something inappropriate. Use only professional language when representing Harmony, regardless of where you are.

    - Gossip and backbiting spread like wildfire. Don't be the one holding the match, or fanning the flames.

    - We do our best to create a professional family at Harmony, and all families have their up's and down's. As important as it is to appropriately communicate concerns, it's just as important to share the kudos!

Meetings and Training Sessions

- Full-time employees may be asked to attend a weekly or semi-monthly nursing team meeting at their branch. The presence of part-time employees at both of these events is always encouraged, but not typically required if the employee has other obligations. When a part-time employee is unable to attend a nursing staff meeting, they must be sure to communicate any agenda items to the branch clinical manager and the assigned CCR.

- Harmony will occasionally schedule special trainings for employees and agency staff (online documentation system; Medicare/Medicaid regulation changes, etc.). Although these are required trainings, Harmony will try to accommodate schedules in making the sessions as convenient and as flexible as possible.

- Harmony encourages its employees to be actively engaged in continuing education, and will strive to create and advise employees of opportunities that are of particular interest and benefit to our industry.

Departmental Administrative Directory

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Departmental Calendar

1st & 16th of each month Admin Time and Mileage Due for Employees

13th & 28th Pay Day for Harmony Employees (if it falls on a Saturday or Sunday, it will be the Friday before)

Case Conferences

- All Branches alternate call in times for case conference notes every other Tuesday. Times will be set up individually with the case conference note coordinator**.**

Nursing Department Meetings

- **Murray** Every Thursday at 8:00 a.m.
- **Albuquerque** Every Thursday at 8:00 am