

**HealthSystems of Mississippi – HOME HEALTH CARE QUALITY INDICATORS**

INDICATOR	APPLICATION OF SCREEN	EXPLANATORY NOTES/EXAMPLES
H.1 Adequate assessment of patient before or at time of entry to determine the patient meets requisites for home care.	<p>If there is indication that an inadequate assessment of the patient was conducted or that the assessment did not indicate that the patient's needs met the requisites (i.e, homebound, etc.) for home care, this indicator is failed.</p> <p>Look at the HHA admission assessment form, plan of care, nurses notes, hospital or SNF discharge record, physician orders.</p>	<p>Was an adequate assessment of the patient done so that the HHA was aware of all of the patient's needs?</p> <p>Did the patient meet the requisites for home health services?</p>
H.2 Adequacy of HHA's capacity to provide the services.	<p>If there is indication that the Home Health Agency does not have the capacity to provide the services, i.e., staff resources, etc., this indicator is failed.</p> <p>Look at the HHA admission assessment form, plan of care, nurses notes, physician's orders, hospital or SNF transfer information, social service notes.</p>	<p>Review for appropriateness of the level of care, i.e., is the HHA capable of providing the care required for the patient. Did the recipient require a higher level of care?</p>
H.3 Adequate assessment of physical environment and capability of caregiver to provide care in home.	<p>If there is indication that the physical environment and capability of the caregiver are in question or not appropriate, this indicator is failed.</p>	<p>Review home environment to determine if any changes were required (i.e., open stairway, exposed electrical cords, etc.). Were solutions to the problems identified, discussed &amp; appropriate resolutions agreed on?</p>
H.4 The plan of care (care plan) reflects measurable goals specific to the areas of care needed by the patient.	<p>If the plan of care does not have measurable goals to be achieved prior to discharge for all areas of care needed by the patient, this indicator is failed.</p> <p>This screen applies to skilled nursing services, speech and physical therapy services only.</p>	<p>Does the care plan address the goals to be achieved and are they measurable?</p>
H.5 The plan of care was followed exactly or documentation was provided for any deviations from the plan of care.	<p>If the plan of care has not been followed, i.e., the home aid performed tasks other than those outlined in the plan of care and there is no documentation to explain the deviation, this indicator is failed. Another example would be that skilled nursing services were outlined in the plan of care but documentation reveals that skilled services were not rendered.</p>	<p>For each type of service (skilled nursing, physical /speech therapy, nursing aide) outlined in the plan of care as needed, did the actual care follow the plan?</p>
H.6 Care plan and interventions modified appropriately according to the ongoing/periodic reassessment of patient need.		
H.7 Documentation shows patient/patient care giver participation in care planning.		

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H.8 The following indicators relate to the appropriate and timely intervention by the HHA for changes in the patient's medical condition which would warrant timely intervention (i.e., physician notification, possible change in treatment, etc.). Timely intervention, at a minimum, would be an attempt to notify the physician within 4 hours from the time of detection. Intervention may include change in treatment, ordering of diagnostic tests, treatment changes based on abnormal diagnostic results, etc.		
H.8.1 Presence of temperature elevation (100 degrees oral, 101 rectal) or hypothermia noted and acted on.	Latitude is permitted for the nurse reviewer to use judgment when there is a physician's order which covers the situation identified by this indicator. If the HHA identifies a temperature elevation or hypothermia and there is no documentation to indicate that the HHA attempted to notify the physician within 4 hours, this indicator is failed.	Hyperthermia, as well as hypothermia may be a problem. Therefore, a minus 2 degree change from patient's normal temperature requires intervention.
H.8.2 Presence of BP reading < 85 or > 180 systolic or < 50 or > 110 diastolic noted and acted on.	If the HHA identified this event and there is no documentation to indicate that an attempt was made to notify the physician within 4 hours, this indicator is failed.	If the HHA attempted to notify the physician and there is a delay in ordering treatment, this indicator is failed, however, the physician would be the source of problem.
H.8.3 Presence of pulse < 50 or > 120 noted and acted on.	Same as above.	
H.8.4 Presence of other significant changes in signs or symptoms noted and acted on.	Same as above.	Temperature elevation > 2 degrees after 72 hours of start of care or from an invasive procedure.
H.8.5 Presence of incident with resultant injury or untoward effect noted and acted on.	If the incident occurred while the HHA was onsite, and there is no documentation that the physician was notified, this indicator is failed. An incident that takes place when HHA is not present in the home would cause indicator failure only if the HHA was remiss in providing education which could have prevented the incident.	Injury or untoward effect includes fracture, dislocation, concussion, laceration.
H.8.6 Presence of a decubitus ulcer noted and acted on.	Failure of this indicator includes situations where a previous decubitus ulcer becomes worse while the patient is under the care of the HHA.	Decubitus ulcer is defined as a break in the skin not present on admission regardless of the site and depth.
H.8.7 Adverse drug reaction or medication error noted and acted on.	An error or reaction that takes place when HHA is not present in the home would cause this indicator to be failed only if the HHA was remiss in providing education which could have prevented the incident.	Physician error in prescribing medications is also included in this indicator.
H.8.8 Appropriate reporting of abuse/neglect.		
H.8.9 Timely reporting to the physician of family and/or patient non-compliance.	A benchmark of 3 consecutive, professional visits where non-compliance is noted without physician contact is sufficient to fail this indicator.	Non-compliance is defined as refusal rather than an inability to comply.

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H.9 Presence of a patient education plan and evidence of patient learning.	Look for documentation that the patient was provided the instructions/education required for his/her condition, and the patient learning as evidenced by verbal feedback and/or return demonstration.	Patient verbal feedback and/or return demonstration - i.e., taking his/her own pulse, diabetic monitoring and/or therapy, exercises, etc.
H.10 Adequate documentation of coordination of services,	This indicator looks at the coordination of all disciplines required to carry out the care plan for the patient.	Documentation in the care plan should include coordination of services (interdisciplinary follow-up and reinforcement)
H.11 Evidence of ongoing discharge planning.	Review documentation for evidence of screening for appropriate time of discharge, i.e., when patient no longer meets home health criteria or does not require ongoing skilled care at home.	