Guidance Document: Professional Activities and Standards for Nursing Aides and Caregivers: December 2016

Collington Resident Association

PURPOSE: The purpose of this Guidance Document is to suggest standards and procedures a Resident or their Healthcare Agent/Power of Attorney collectively known as "the Resident" (family or healthcare agent) might seek from a Nursing Aides/Caregiver. For those Nursing Aides/Caregivers who are part of a company, the company will be responsible for the daily professional conduct of their employees.

When an individual Resident desires to have a personal nursing aide or caregiver the following activities and documentation are suggested which should be monitored by the Resident.

1. CLIENT ASSESSMENT. The initial Clinical Notation of the Resident should be written in collaboration with the Resident as part of the Intake Interview to include, at the minimum, the following:

a. A list of the relevant areas/issues/ADL's for which the Caregiver will have responsibility.
b. Statement of Resident's baseline mobility. *
c. Resident's special nutritional requirements. *
d. Description of Resident's potential or actual behavioral issues. *
e. Summary of Resident's psychosocial issues. *
f. Document allergies or drug sensitivities. *
g. Obtain and review Advanced Directives.
h. Obtain and review the Resident's MOLST document if available.
i. Additional documentation may be available from a clinical discharge summary from the Creighton Center, or from a hospital. Clinical summaries may also be available from Collington's Clinic, the Resident's PCP and/or the responsible family member.
j. List of current medications.
k. List names and phone numbers of current doctors.
l. Document to be signed and dated
m. Updates to Clinical Notation to be carried out every 90 days and more frequently if clinically indicated.

(* Please note: In Maryland, these Assessments and associated Care Plans must be made by a Registered Nurse (RN).

2. **DAILY PROGRESS DOCUMENTATION.** (Time sheets and clinical log.) A Communications Log should be maintained in the home to document progress changes in the Client at the end of Caregiver's shift to include at least the following:

a. Name of Caregiver.
b. Sign-in date and time.
c. Sign-out date and time.
d. Change of any physical diagnosis since last visit of a Caregiver.
e. Change in mobility issues since last visit of a Caregiver.
f. Summary of nutrition consumed.
g. Record of any behavioral issues.
h. Record of any social issues.
i. Record blood pressure, pulse, heart, and lung examination when required.
j. Any other general comments.
k. A copy of these items will be maintained in the resident's home.

3. NOTIFICATION BY PHONE TO AGENCY'S RN SUPERVISOR.

a. Significant change of any physical diagnosis or health status, including any falls, visits to ER, hospitalizations since last visit of a Caregiver.
b. Change in mobility or stability issues since last visit or during current visit.

4. DOCUMENT MANAGEMENT.

a. The documents to be kept in the Resident's home in appropriately labeled folders.
b. The documents to be monitored at the discretion of the Resident or a representative of the Healthcare Services Committee at the request of the Resident.
c. Documentation to be recorded as follows:
  i. Service Request Form and/or Intake Form
  ii. Initial baseline Clinical Notation
  iii. Daily progress notation
  iv. Weekly time sheets

5. ACTIONS TO BE TAKEN IN ANY SITUATION THOUGHT TO BE AN EMERGENCY BY NURSING AIDE OR COMPANION

a. Call 911 and describe the following:
  i) The immediate reason for calling
  ii) Breathing: (none/shallow/heavy).
  iii) Pulse: (none/palpable/fast).
  iv) Resident moving: (yes/no).
  v) Level of consciousness: (coma/normal/diminished/agitated).
b. Follow 911 operator instructions until EMT or trained Collington staff arrive.
c. Call Collington Security to inform them of the occurrence: phone extension # 2020
d. Adhere to Advanced Directives, MOLST instructions and/or Living Will directives.
e. When time allows, call your employment company to inform it about the occurrence.

6. "HAND-OVER" PROCESSES.

a. In the absence of a knowledgeable live-in caretaker, a company supervisor will be present to introduce any new Caregiver who might be scheduled for the Resident.

b. It will be preferable for the knowledgeable Caregiver with prior experience with this resident to be present for a hand-over process.

c. The clinical notation features listed in Paragraph 1 and 2 (discussed above) will be reviewed with the new Caregiver. Once all questions have been answered the new Caregiver will date and sign the Clinical Intake Form, or Nursing Aide Assignment sheet.

7. RESPONSIBILITY FOR ALL DOCUMENTATION.

a. This responsibility will lie with the registered company or private Caregiver.

b. The Resident maintains the right to review these documents at any time.

c. All documents will remain in the residence of the Resident.

8. FAILURE TO DOCUMENT.

Failure to maintain these records in a concurrent and timely fashion may jeopardize the relationship between the Company or private Caregiver with the Resident.

9. INCIDENT REPORTS, SENTINEL EVENTS AND ROOT CAUSE ANALYSES

a. In the agreement between the Resident and the Caregiver Company or private Caregiver, the Resident's access to external review processes for incident reports or sentinel events (including Root Cause Analysis, when needed) with the active collaboration of the company will be made clear.

b. The company will provide a signature of understanding for these commitments.

10. SERVICES PROVIDED.

a. When a Company provides the staffing for private duty Caregivers, they will be employees and under the general supervision of the Company.

b. Services provided by the Company to be billed as appropriate to Medicare or Medicaid or the Resident will pay privately as agreed.

c. Assure coverage of all shifts when needed.

11. FEES.

a. Company will invoice/collect fees for caregiving directly to the Resident or their agent.

b. Billing issues will be discussed between the Company and the Resident or their agent.

12. DUE DILIGENCE.

When using Independent Caregivers, Residents are advised to carry out due diligence on the following: (a) Verify work history. (b) Carry out background checks. (c) See proof of liability insurance. (d) See proof of licensure and certifications.

The Health Services Committee will consider the development of a set of generic forms to assist in the above processes which might be of assistance to Independent Nursing Aide contractors.

LPF for Health Services Committee.
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