AVEANNA HOME HEALTH THERAPY ORIENTATION

HOME VISIT TRAINING

Home Visit Training-Agenda

- Home Visit Expectations-prior to visit, during visit, conclusion of visit, discharge
- Aveanna Patient Booklet
- Bag Technique
- Hand Hygiene
- Discipline Specific Competencies

aveanna healthcare

Home Visit Expectations

Prior to visit

1. ALWAYS review medical records or the prior clinical notes to be informed of the patient's status and focus for visit.
2. ALWAYS call to confirm the appointment the night before.
3. ALWAYS call the patient if you are running late.

During the visit

1. ALWAYS be pleasant.
2. ALWAYS enter your start time to prevent overlap with other clinicians.
3. ALWAYS sanitize your hands prior to engaging with the patient. Be aware of company policies if new community risks are present e.g. Covid precautions with N95 masks and gloves
4. ALWAYS take vital signs.
5. ALWAYS ask if there has been any medication changes (prescribed or over the counter). Update in home and in HCHB.

aveanna healthcare

Home Visit Expectations

Conclusion of the visit:

1. ALWAYS enter the end time prior to leaving.
2. ALWAYS return a patient's home to the same state prior to your arrival e.g. if you had to use a chair for exercises, put it back in place.
3. ALWAYS have the patient sign the tablet or paper form.
4. ALWAYS ask, "Is there anything else I can do for you before I leave?".
5. ALWAYS complete calendar in admission book and inform patient when you plan to return for your next visit.
6. ALWAYS place note in saved status (complete/incomplete) to indicate visit was completed.

If patient's plan of care is ending within a week:

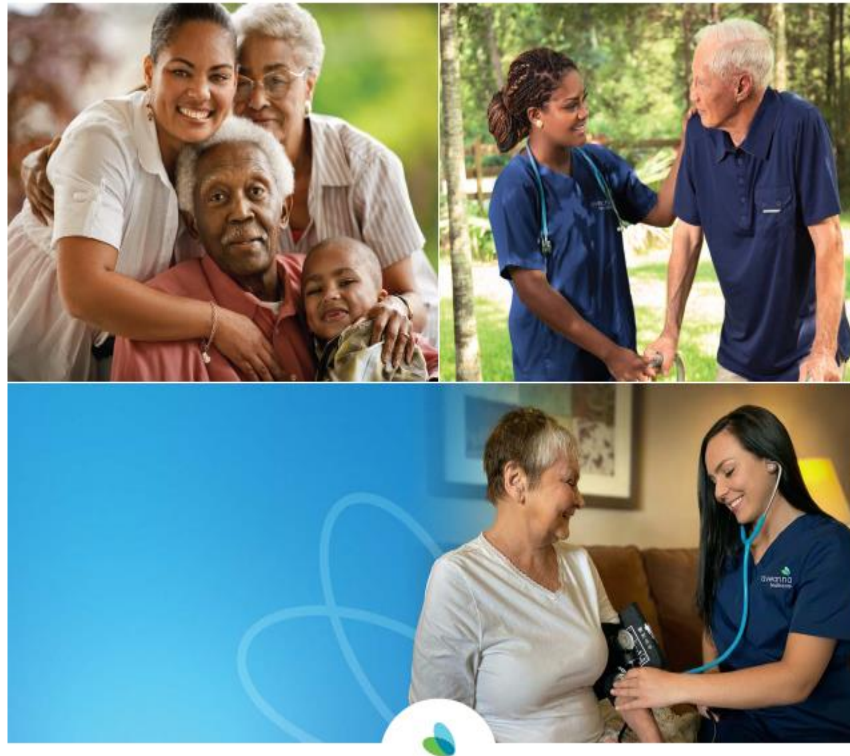
1. ALWAYS make sure patient is aware of pending discharge. If Medicare or Medicare Advantage plan is the payor, issue a Notice of Non-Medicare Coverage form (NONMC).

Discharge visit:

1. ALWAYS provide final written instructions.
2. ALWAYS obtain NONMC form if it was not taken prior to visit.

Home Visit Expectations

Patient Booklet



Committed to comprehensive homecare, quality, and innovation.

Home Visit Expectations

aveanna
home health

Home Health Consent

Patient Rights and Responsibilities:
I acknowledge I have read and have received a verbal explanation and a written copy of the Client's Rights and Responsibilities under the State and Federal provisions in the Home Care Bill of Rights, and I understand them. I have received a copy of the Aveanna Home Health Admission Booklet containing information regarding its policies and Health Care Directives, the Outcome and Assessment Information Set ("OASIS") rights, agency Administrator's name, and contact information; Discharge, Transfer, and Referral policies; and how to contact local resources. The applicable state home health hotline number, its purpose, and hours of operation have been provided and explained to me. I understand that I have the right to choose my provider of services and acknowledge that I have chosen this agency as my provider of choice for my care. No employee of this agency has solicited or coerced my decision in selecting a home health agency.

Consent for Treatment:
I hereby give my permission for authorized personnel of Aveanna Home Health to perform all necessary assessments, procedures, and treatments as prescribed by my physician for the delivery of home health care, including telehealth services. I understand that services provided by telehealth will not replace needed in-person visits as ordered by my physician in my plan of care. I understand that the agency will supervise the services provided. I may refuse treatment or terminate services at any time, and the agency may terminate their services to me as outlined in the Admission Booklet.

I agree and consent to the home care plan and payment as outlined in the Admission Booklet. I understand my initial Plan of Care and subsequent Plans of Care may change based on medically necessary determinations made by my physician. I will be notified by the agency in advance of any change made to my plan of care.

Authorization for Payment:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I consent to the release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payer be made on my behalf to Aveanna Home Health.

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full, and I have no financial liability. Should service(s) not be covered by Medicare and I wish to receive care or service, the Agency will notify me in writing. I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. If I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me, or my supplier and I will be responsible for the total cost.

Services	Proposed Frequency	Payor	Estimated Financial Responsibility
☐ Skilled Nursing			
☐ Physical Therapy			
☐ Speech Therapy			
☐ Pediatric Nursing			
☐ Social Worker			
☐ Occupational Therapy			
☐ Home Health Aide			
☐ Homemaker			

The Aveanna family of companies includes Aveanna Healthcare, LLC, its wholly-owned subsidiaries and affiliates, any other entity or organization in which Aveanna Healthcare or an affiliate owns a direct or indirect equity interest of greater than 50%, and any other healthcare entity in which an affiliate either manages or controls the day-to-day operations of the entity. Aveanna Healthcare, LLC does not discriminate on the basis of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, disability, or any other basis prohibited by federal, state, or local law.
© 2021 Aveanna Healthcare, LLC. The Aveanna Heart Logo is a registered trademark of Aveanna Healthcare LLC and its subsidiaries. AVA-950 HH Rev 11/19/2021

aveanna
home health

If I have other insurance, I may be responsible for the co-payment, deductible, and any charges that my insurance will not cover. I will refer to my payer's explanation of benefits for maximum amount that I may be required to pay for services provided to me by Aveanna. I understand that I am responsible for amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the agency at Aveanna's usual and customary rate at the time the service was provided to me.

Authorization for Release of Information:
I acknowledge receipt of the **Notice of Privacy Practices** and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information (PHI) about me to carry out treatment, payment, or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing, quality assurance, and risk management; any hospital, nursing home or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and any other health care providers in order to initiate treatment.

I agree that the agency may share my PHI with emergency officials or others involved in my care to assist in disaster relief efforts.

Consent to Film or Record:
I hereby consent for the agency to record or film my care, treatment, and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition, or for insurance providers to document my condition for payment purposes. This consent includes the recording or filming of my image or voice.

Advance Directives:
I have been made aware of my right to make health care decisions for myself in accordance with state law and that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I authorize Aveanna Home Health to receive a copy of my Advance Directive for their records. I understand if a copy of my Advance Directive is **not provided** to Aveanna Home Health within a reasonable period of time, the agency will continue to provide all care as ordered by my physician, which in the event of an adverse event and/or healthcare emergency, includes life sustaining and stabilizing measures consistent with standard and accepted medical practices.

aveanna
home health

I have read and understand the following policies and/or procedures as described in the Aveanna Home Health Admission Booklet:

1. Rights and Responsibilities
2. Notice of Nondiscrimination
3. Notice of Privacy Practice
4. Discharge, Transfer, Referral and Corresponding Summary
5. Notice of OASIS Rights and Responsibilities
6. High Alert Medication Side Effects
7. Beneficiary and Family Centered Care (BFCC) and Quality Improvement Organizations (QIO) Directory
8. Administrator Notification
9. Patient Individualized Emergency Plan
10. Patient Safety Tips
11. Cover Your Cough
12. State Specific Addendum(s)

Include the following additional forms if applicable:

____
____
____
____
____

By signing this consent, I acknowledge receipt of the Aveanna Home Health Admission Booklet and confirm my understanding and agreement with its contents. I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

By signing, I certify that I have received and read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may achieve a copy of this document upon request.

Document signed electronically, digital signature on file. For reference only.

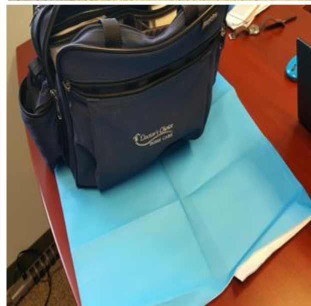
aveanna℠
healthcare

Bag Technique

Make sure there is a protective barrier between any equipment and the clinical bag that you bring into the house. There must be a clean and dirty side to your bag. Have sanitizer available to clean your equipment. All your equipment should be cleaned in between each patient use.

Zipper all portions of the bag completely during visit.

At all times, make sure that you have PPE with you including CPR barrier/mask, blood pressure cuff, pulse ox, universal protection kit, masks, and gloves. If you are missing any of these items, ask your branch to replenish your supplies. This includes N95 masks.



aveanna healthcare

Hand Hygiene

- Hand hygiene is a basic component of safe patient care.
- It is the most important infection control practice to reduce and/or eliminate the source of infections.
- Direct patient contact and respiratory-tract care are the highest risk patient care activities that contaminate hands.
- Hand hygiene theory and practices must be understood and correctly performed by all employees who enter the family home, have any patient contact, or will come into contact with any inanimate objects in the home.
- Hand hygiene does not take the place of wearing gloves, nor does wearing gloves imply that hand hygiene is unnecessary.
- Gloves are to be worn according to the CDC recommendations for standard precautions, but they are not reliable to prevent hand contamination during patient care activities.

aveanna healthcare

Hand Hygiene

Hand hygiene is performed in the following circumstances:

-Upon entering and prior to leaving the patient's home

-Before any contact is made with anyone in the work environment. i.e. shaking hands

-Before and after having direct contact with the patient's intact or non-intact skin

-Before putting on gloves

-After removing gloves

-If there is visible dirt, blood or body fluids on the hands

-After contact with body fluids or excretions, or if contact is possible with mucous membranes, broken or intact skin, or wound dressings even if hands are not visibly soiled

-Before handling an invasive device (regardless of whether or not gloves are used) for patient care, e.g., suction catheters, urinary catheters, gastrostomy tubes

aveanna healthcare

Hand Hygiene

Hand hygiene is performed in the following circumstances:

-Before moving from a contaminated body site to a clean body site during patient care, e.g., when moving from the perineal area to tracheostomy stoma care

-After contact with equipment and inanimate objects in the immediate vicinity of the patient.

-During or after a potential exposure to the organisms C. Difficile, norovirus, or enterovirus

-Prior to handling or preparing medications

-Prior to preparing food

-Before and after eating

-After using the toilet

aveanna healthcare

Hand Hygiene-Using sanitizer

Using an alcohol-based sanitizer:

1. Check the expiration date on the alcohol-based hand hygiene product. Use a new bottle if it has expired or if the date is illegible. A product with emollients is preferred.

2. Apply the product to the palm in one hand using the amount recommended by the manufacturer, or the amount necessary to thoroughly wet all surfaces of the hands including the palms, back of hands, fingers, between fingers/webs, fingertips, and fingernails. Amounts to consider are 3-5 mL of a liquid, the size of a dime for a gel, or the size of an egg for a foam product.

3. Continuously rub the hands until they are dry, which should equal approximately 20 seconds if the appropriate amount of product was used. The alcohol must dry to provide effective antimicrobial action and to decrease irritation. Hands should be dry before donning gloves.

4. Apply a compatible lotion or cream with emollients as needed to prevent skin irritation or breakdown

Hand Hygiene-Using soap and water

Hand hygiene with soap and water:

1. Wet the hands and wrists with warm water.
2. Apply soap to hands and lather thoroughly. Liquid soap is preferred. Do not use bar soap unless that is the only soap available.
3. Vigorously rub the hands together for a minimum of 20 seconds. Interlace fingers and rub all surfaces of the hands, including the palms, back of hands, fingers, between fingers/webs, fingertips and fingernails using a circular motion. Keep the fingertips down to facilitate the removal of microorganisms.
4. Rinse the hands with warm water and do not turn off the faucet with your hands.
5. Thoroughly and gently dry from fingers to wrists with a paper towel, or with a paper towel that has not previously been used.
6. Turn off the faucet with another paper towel.
7. Throw away the paper towel.

Discipline specific competency

- Prior to initiating patient visits, all therapists will be competencied by a Registered Therapist of the same discipline.
- Clinical competency includes core abilities that are required for fulfilling one's role as a clinician. The Company assesses staff competence in a systematic, measurable, and objective manner.
- Competency assessments measure an individual's professional judgement, knowledge skills, which demonstrate critical thinking skills appropriate to job responsibilities.
- Competency is evaluated through but not limited to direct observation, return demonstration, review of process, LMS modules, review of documentation in medical records, testing, and/or verbal discussion.

aveanna™
healthcare

Discipline specific competency

Physical Therapist or Physical Therapy Assistant (PTA) Skills Competency Assessment

Physical Therapist or PTA Name: ____________________________ ☐ Initial ☐ Annual

Clinician Self Rating

A = I can perform well	B = I need to review	C = I have no experience

Competency Verification Method

DO = Direct Observation / Return Demonstration	LMS = Learning Management Modules
V = Verbal Question and Answer	MRR = Medical Record Review

Core Skills	Self-Rating	Qualified Observer (Physical Therapist)		
		Verification Method	Completion Date	Assessor Initials
Vital Signs (BP, HR, O2 Sat, RR, Temp	A, B, or C			
ROM testing with goniometer	A, B, or C			
Manual muscle testing	A, B, or C			
Therapeutic exercise	A, B, or C			
Transfer training	A, B, or C			
Bed mobility	A, B, or C			
Gait training	A, B, or C			
Stair training	A, B, or C			
Prosthetic training and management	A, B, or C			
Assist. device management and fitting	A, B, or C			
Wound Care/Incision Management	A, B, or C			
Pain assessment	A, B, or C			
Application of gait belt	A, B, or C			
Edema management	A, B, or C			
Timed Up and Go	A, B, or C			
MAHC – 10 (__) NA for PTA	A, B, or C			

aveanna healthcare

Welcome to Aveanna Home Health!

aveanna healthcare