### PURPOSE

To define the process for the communication of patient information and assignment of responsibilities to paraprofessional personnel caring for the patient.

### POLICY

When making patient care assignments, consideration will be given to the needs of the patient, the home health aides’ competencies, and the specific care that is to be provided.

Home health aides will receive patient information in the form of an aide assignment prior to caring for the patient. This will include information about the physical, psychosocial, and environmental aspects of care.

Patient care communication may include verbal or written instruction and demonstration. The communication about assigned responsibilities may include on-site orientation when appropriate, and/or telephone contact prior to caring for the patient.

### PROCEDURE

1. The personal care and support services provided will be based on the initial and ongoing assessments of patient needs as conducted by a nurse or therapist in the patient’s home.
   1. The nurse or therapist will be responsible for the initial assessment and assignment of the home health aide. Assessments are reviewed and/or revised every 60 days and as the patient’s condition changes.
   2. The functional status, psychological status, availability of support, and the patient’s goals will be considered in determining the frequency of visits and plan of care.
2. The home health aide will review the duties to be performed and the arrangements for providing services as stated in the plan of care, and he/she will discuss this with the nurse or therapist as needed.
   1. An orientation or placement visit is scheduled in the patient’s home by the clinician, whenever feasible.
3. Each patient receives care in accordance with the plan of care and related instructions.
   1. The home health aide visit documentation note correlates with the orders on the plan of care.
   2. The aide will complete an aide clinical note in the electronic medical record on each patient at every visit. In the event that the clinical documentation is not feasible, as approved by the Clinical Supervisor, a paper clinical note with be completed at the time of the visit and will be scanned into the electronic medical record.
   3. When a health or care concern is identified or a significant change in a patient’s physical condition is noted, the aide will immediately report this information to the Clinical Supervisor or patient’s case manager.