Standards of Home Health Nursing Practice

The purpose of Standards of Home Health Nursing Practice is to fulfill the profession's obligation to provide a means of improving the quality of care provided to consumers. Standards reflect the current state of knowledge in the field and are therefore provisional, dynamic, and subject to testing and subsequent change. Since standards represent agreed-upon levels of practice, they have been developed to characterize, to measure, and to provide guidance in achieving excellence in care.

Within these home health standards are criteria that address professional performance, such as use of theory, professional development, interdisciplinary collaboration, and research. Implicit throughout the standards are the nurse's accountability to the patient, respect for the patient's rights, and advocacy for the patient.

Nurses who work with home health patients encounter situations in which human rights and freedom are in jeopardy. Therefore, it is important for the rights of patients as well as nurses to be acknowledged.

Patient's rights include the right to be autonomous, the right to make an informed decision, and the right to one's domain, including one's body, life, property and privacy.

After a clear explanation, due consideration and an opportunity to question, a competent patient has the right to make decisions about care without coercion. Competent patients have the right to refrain from home health care recommendation when their decisions do not affect the health and well being of others.

When the patient is a child or an adult whose competence is questionable, an evaluation must be made of the patient's or the caregiver's ability to make informed decisions about care. In the case of the infant or very young child, the parent(s) or guardian(s) should make informed decisions about care, provided the child's rights are not violated. Conflicts will arise between rights of individuals and rights of families- for example, in cases of domestic violence or neglect- and between rights of individuals and the public's right to protection. In such instances, the home health nurse should seek consultation with the Administrator, who may, in turn, seek legal and/or ethical consultation to determine the best course of action.

**Standard I. Organization of Home Health Services**

All home health services are planned, organized and directed by a professional nurse with experience in community health and administration.

**Rationale:**

The nurse executive with community health experience builds from the resources of the community, using administrative knowledge to plan and direct services to meet the complex
needs of individuals and families within their homes and communities.

**Outcome Criteria:**

1. The Agency is in compliance with all licensing and regulatory requirements.

2. The established quality improvement program is used to revise and improve services.

**Standard II. Theory**

The nurse applies theoretical concepts as a basis for decisions in practice.

**Rationale:**

The theoretical concepts for home health nursing are derived from nursing and other related disciplines; the resulting insights are integrated into a foundation for practice. The actions of the nurse are based on theoretical concepts.

**Outcome Criteria:**

1. Nursing actions are consistent with recognized nursing theories and established knowledge.

2. Recognized nursing theories and knowledge are evaluated and tested within the practice setting.

**Standard III. Data Collection**

The nurse continuously collects and records data that are comprehensive, accurate and systematic.

**Rationale:**

Data collection is an essential prerequisite to assessment of the individual, family, and community. The process allows the nurse to reach sound conclusions and plan interventions based on both scientific and social theories. Data collection reflects reality and is the basis upon which the nurse repeatedly evaluates care.

**Outcome Criteria:**

1. Nursing information is synthesized and recorded in a standardized and retrievable format.

2. The data base is kept current and accurately reflects the individual's or family's present clinical status.

3. The data base is complete.
Standard IV. Diagnosis

The nurse uses health assessment data to determine nursing diagnosis.

Rationale:

Nursing diagnosis is an integral part of the assessment process. Nursing diagnosis is the nurse's identification (by independent judgement) of the individual's or family's actual or potential health problem needs. Nursing's logical basis for intervention rests on the identification of those diagnoses that flow from nursing theories and scientific knowledge.

Outcome Criteria:

1. The diagnoses are recorded in a manner that facilitates planning, evaluation and research.
2. Evidence exists that nursing diagnoses are used by other health care team members in planning care.
3. Nursing diagnoses are validated with colleagues, individuals and families as appropriate.

Standard V. Planning

The nurse develops care plans that establish goals. The care plan is based on nursing diagnoses and incorporates therapeutic, preventative and rehabilitative nursing actions.

Rationale:

Planning guides nursing interventions and facilitates desired outcomes. Care plans, specifying goals and interventions, are based on nursing, diagnoses, and the medical treatment plan. The patient and family participate in the planning process.

Outcome Criteria:

1. The patient, family, physician, and other health providers participate in the planning process as appropriate.
2. The plan is initiated prior to the patient's admission to home health services.
3. The plan exists in a concise, standardized, and retrievable format.
4. The plan evidences revision and delegation of actions as goals and objectives are achieved or changed.
Standard VI. Intervention

The nurse, guided by the care plan, intervenes to provide comfort, to restore, improve and promote health, to prevent complications and sequelae of illness, and to affect rehabilitation.

Rationale:

The nurse implements the care plan to achieve the desired goals and objectives. The nurse provides direct care, incorporates preventative measures in the patient's care, teaches the family and nonprofessional caregivers methods to promote the patient's recovery and provides comfort and support during a terminal illness.

Outcome Criteria:

1. The patient and family demonstrate self-care to the extent of their ability.

2. There is a measurable evidence of progress toward goal achievement.

3. The patient and family use community resources appropriately.

4. Problems, interventions and responses of the patient and family are recorded in a systematic, retrievable and timely manner.

5. There is documented evidence that interdisciplinary services are in accord with patient needs and capability.

Standard VII. Evaluation

The nurse continually evaluates the patient's and family's responses to interventions in order to determine progress toward goal attainment and to revise the data base, nursing diagnoses, and plan of care.

Rationale:

Nursing practice is a dynamic process that responds to alterations in data, diagnoses, or plans previously made. Evaluation of the quality of care is an essential part of all health services. The effectiveness of nursing care depends on the continuing reassessment of the patient's and family's health needs and appropriate revision of the plan of care.

Outcome Criteria:
1. There is evidence that the data base, diagnosis and plan of care are revised in accord with continuing evaluation.

2. There is evidence that the patient and family participate in the evaluation and revision of the plan of care.

3. There is evidence that program evaluation is used to make program decisions.

4. Evaluation of intervention is documented in a manner that contributes to the effectiveness of nursing actions and to research.

**Standard VIII. Continuity of Care**

The nurse is responsible for the patient's appropriate and uninterrupted care along the health care continuum, and therefore uses discharge planning, case management, and coordination of community resources.

**Rationale:**

Without specific nursing interventions, gaps and fragmentation occur in the delivery of health care services, causing the patient's condition to be compromised.

**Outcome Criteria:**

1. There is evidence that coordinated and appropriate home health services are provided.

2. There is evidence of appropriate interdisciplinary coordination including case conferences and ongoing communication.

3. There is documented exchange of information between referral sources.

4. The patient has a written plan for discharge from the home health agency.

5. There is documented evidence in the patient record of appropriate and coordinated use of community resources.

**Standard IX. Interdisciplinary Collaboration**

The nurse initiates and maintains a liaison relationship with all appropriate health care providers to assure that all efforts effectively complement one another.

**Rationale:**

The complexity of home health care delivery systems requires a multi disciplinary approach to
delivery of services, necessitating the strong support and active participation of all the health professions. Nurses must actively promote the collaboration, planning and interventions required to ensure high-quality home health services.

Outcome Criteria:
1. There is evidence that the nurse is an integral member of the interdisciplinary team.

2. There is documented evidence that interdisciplinary collaboration exists.

**Standard X. Professional Development**

The nurse assumes responsibility for professional development and contributes to the professional growth of others.

Rationale:

Scientific, cultural, social and political changes in society require a commitment from the nurse to the continuing pursuit of knowledge to enhance professional growth to facilitate patient care.

Outcome Criteria:

1. Evidence exists that the nurse participates in the peer review process and continuing education programs.

2. Evidence exists that the nurse incorporates new information and methods into practice.

3. Evidence exists that the nurse meets continuing education requirements for relicensure and for certification as appropriate.

**Standard XI. Research**

The nurse participates in research activities that contribute to the profession's continuing development of knowledge of home health care.

Rationale:

Improvement of the practice of home health nursing depends upon a commitment of the nurse to participate in research activities, to disseminate research findings and to use research findings in practice.

Outcome Criteria:
1. Research activities occur within the practice setting, and evidence exists that this is true.

2. Evidence exists that the knowledge base of home health nursing is continuously augmented and updated by the findings of relevant research activities.

**Standard XII. Ethics**

The nurse uses the code for nurses established by the American Nurse's Association as a guide for ethical decision making in practice.

**Rationale:**

The nurse is responsible for providing health care to individuals in a setting where the patient must trust the nurse to make significant judgements about health care. The nurse must assure that the home is an appropriate setting for the care provided and that the nurse and care providers are prepared by education and experience to provide the care needed by the patient. The Code of Nurses provided the parameters which the nurse makes ethical judgements.

**Outcome Criteria:**

Evidence exists that nurses adhere to the Code for Nurses established by the American Nurse's Association.

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