SUBJECT: JOB DESCRIPTION –LICENSED PRACTICAL NURSE (LPN)

Title: Licensed Practical Nurse
Qualifications: Certification as Licensed Practical Nurse
Duties:

1. The Licensed Practical Nurse shall provide assigned nursing care under the direction of a Registered Nurse, who provides on-site supervision as needed, based upon the severity of patient's medical condition and the nurse's training experience.

2. The Licensed Practical Nurse shall:

   a) Prepare and record clinical notes for the clinical records;
   b) Report any changes in the patient's condition to the Case Manager /Registered Nurse with the reports documented in the clinical record;
   c) Perform assigned tasks, including the administration of treatment and medications, in the care of the patient.

3. Weekly reviews the utilization and progress of the patient with the RN, supervisor and attending physician as necessary.

4. Has knowledge of patient's condition at all times and informs the physician, RN and/or Nursing Supervisor immediately of any change in the patient's condition that warrants attention. Also observes, evaluates and reports to the physician the patient's reaction to drugs or treatments.

5. Interprets to the patient and family the expectations of the diagnosis and the nature of the treatment consistent with the action and wishes of the physician. Interprets to the social and physical factors in the environment that affect patient care, by Registered Nurse supervision.

6. Is responsible for the execution of the physician's orders, supervised by a Registered Nurse, and keeps the physician informed of all pertinent information concerning the patient's condition and response to treatment. Give skills of care to patients.

7. Other duties assigned by the Registered Nurse.

_____ _____
Employee Date

_____ _____
Witness Date

POLICY AND PROCEDURES

FIELD STAFF

POLICY:
All field nurses shall provide quality comprehensive health care services through a coordinated plan of care that will

1. Assist homebound patients to assume full or partial responsibility for their personal and health care needs
2. Facilitate continuity of health care services through a coordinated team approach within the health care system that includes hospitals, nursing homes, rehabilitation centers, clinics, physicians offices and other health care organizations
3. Provide psychological and rehabilitative stimuli for early recovery and maximum rehabilitation of the patients
4. Provide individual client and/or significant other involved in the patient's lifestyle with appropriate education to promote and enhance their health, well being and ability to participate in their health care

The procedures listed below shall be followed to ensure that FHB's goals towards quality service for the homebound patients under our care are met:

Call Office:
- Before 9:00 a.m. daily to verify assignment or if unable to work.
- As soon as sign-up or re-instatement visit is completed to give verbal report.
- By 3:00 – 4:30 p.m. daily to report on patients seen and to receive assignment for next day.
- Whenever you identify a problem with a patient
- Whenever you don see a patient. Give a reason for documentation.
- When beeped – respond as soon as possible (within 15 – 20 minutes)

Call Patients:
- The day before visit to prepare for fasting when lab work has been ordered
- Before visit
- Whenever you will not arrive at expected time

Call Physician:
- When sign-up or reinstatement visit is completed
- Every two weeks for status report
- For any unstable condition
- When patient is discharged

Turn Into Office:

- Notes on a weekly basis, with complete documentation showing reason(s) for visit, homebound status, instructions provided, and elapsed hands-on visit time

  The visit time recorded in the notes shall be equivalent to the actual hands-on time for service. This time does not reflect the travel and documentation time spent on each patient visit.

- Sign-Ups and Reinstatement notes within 24 - 48 hours of the visit

Also:

- Report any change in physician's orders to the Patient Care Supervisor (PCS) on the date received
- Document Aide Supervisory visits every 14 days
- Correct all note deficiencies (as indicated in QA Notice) within one week
- See PCS in office at least once a week to update care plans, discuss problems, and obtain Plans of Care on all your patients
- Participate in Team Conferences, staff and in-service meetings.
- Place appropriate patient teaching tools/indexes in home folder
- Document: patient status on communication sheet and teaching tools/indexes for each visit
- Complete correct lab requisitions and notify lab of pick-up site

I have read and understand the policy and procedures listed.

Employee_____ **Date**_____

Witness_____ **Date**_____

Florida Home Bound MHA, Inc. **Skilled Nursing Proficiency Checklist**

Employee Name: _____

The following is a list of skills that you may or may not have had experience with. It is essential that you answer honestly so that we may determine which skill you are proficient in and which skills you may need assistance with.

Please mark the box that most accurately reflects your experience in the area.

The skills with an asterisk (*) are considered essential for performance of nursing in the home health setting. You will be required to demonstrate your skill in these areas prior to performing them unsupervised. The preceptor will initial the box labeled "competent" or "re-evaluate) during your orientation period. Skills marked "re-evaluate" will have to be repeated prior to performing them unsupervised.

	Self Assessment		Preceptor	
Procedure	Experienced	Needs Review	Experienced	Re-evaluate
Hand washing*				
Bag technique*				
Vital signs*				
Neurological				
Assessment of Neuro signs*				
Assessment of pupils				
Assessment of LOC				
Assessment of CMS				
Patients with:				
Neurotrauma				
Overdose				
Seizure activity				
Spinal cord injury				
Cardiac				
Heart sounds*				
Peripheral pulses*				
Edema*				
Apical pulse*				
Capillary refill time*				
Care of:				
Post-op Cardiovascular patient				
Post-op vascular surgery				
Post-op aneurysm				
Post MI*				
Post CHF*				
Respiratory				
Ascultation of breath sounds*				
Oxygen administration:				
Care of oxygen tanks*				
Nasal Cannula*				
Face mask*				
Tracheotomy				
Tracheotomy site care				
Ventilators				
Establishing an airway*				
Chest tubes				

	Self Assessment		Preceptor	
Procedure	Experienced	Needs Review	Experienced	Re-evaluate
Side-arm nebulizer*				
Suctioning:				
Oral				
Trach				
Naso-pharnyngeal				
Patients with				
COPD*				
Pulmonary edema				
Post thoracic surgery				
Gastrointestinal				
Ascultation of bowel sounds*				
Naso-gastric Tubes:				
Insertion				
Placement verification				
Bolus feedings				
Continuous feedings				
Irrigation				
PEG tubes:				
Placement verification*				
Bolus feedings				
Continuous feedings				
Irrigation				
Site care				
Feeding pumps*				
T-tubes:				
Site care				
G-Tubes:				
Site care				
Care of patients with:				
Iliostomy				
Colostomy				
Ostomy site care*				
Ostomy appliances*				
Administration of Enemas*				
Digital exam with manual disimpaction				
Nutrition				
ADA diet				
Exchange list				
Low Fat diet				
Low sodium diet				
Low cholesterol diet				
Low protein diet				
Genitourinary				
Foley catheter:				
Insertion: male*				
Insertion: female*				
Irrigation				
Care of drainage bag*				

Collection of urine*				

	Self Assessment		Preceptor	
Procedure	Experienced	Needs Review	Experienced	Re-evaluate
Suprapubic Catheter				
Site care				
Care of patients with:				
Nephrectomy tube				
Renal transplant				
Shunts and fistulas				
Gynecology				
Self breast exam				
Care of patients with:				
Hysterectomy				
Mastectomy				
Orthopedic				
Care of patients with:				
Amputations				
Anthroscopy/Arthrotomy				
Crutch walking				
K-wires				
Total hip replacement				
Total knee replacement				
Trauma				
Traction				
Cast care				
Assistive devices				
Hoyer lift				
Foot care*				
Psychiatric				
Assessment of patient*				
Aggressive/combative*				
D.T.s				
Eating disorders				
Manic depressive*				
Obsessive-compulsive				
Schizophrenia*				
Other				
Care of patients with:				
Pressure ulcers*				
Staging*				
Stasis ulcers				
Burns				
Surgical wounds*				
Wound care				
Wound assessment*				
Wound measurement*				
Aseptic technique*				
Wound irrigation*				
Wound packing				
Wet to dry dressings*				
Duodern*				

Unna boots				

	Self Assessment		Preceptor	
Procedure	Experienced	Needs Review	Experienced	Re-evaluate
Additional Skills				
Disposal of biomedical waste				
Disposal of sharps				
Venipuncture				
Culture collection				
Diabetic Management				
Blood glucose monitoring*				
Hyper/hypoglycemia*				
Insulin management*				
Administration of medication via the following routes:				
Oral*				
Subcutaneous*				
Intramuscular*				
Z-Track				
Vaginal				
Rectal				
NG/GT*				
Storage of medications*				

_____ _____

Employee Signature Date

_____ _____

Training and development Date

Florida Home Bound MHA, Inc. **Skilled Nursing On-site Competence Evaluation**

Employee: _____ Date: _____

Sub-contracted Agency _____
Check one: [ ] Probationary [ ] Annual [ ] Other

	Competency	
1. Preparation for Visit	Yes	No
1.1 Uniform dress/identification tag?		
1.2 Calls patient ahead before visit?		
1.3 Provider bag content? Supplies adequate?		
Cleanliness?		
1.4 Organization of materials?		
1.5 Understands Assignment?		
2. Assessment of Skills		
2.1 Vital Signs		
2.2 Neurological		
2.3 Cardiovascular		
2.4 Pulmonary		
2.5 Endocrine		
2.6 Gastrointestinal		
2.7 Genitourinary		
2.8 Integumentary		
2.9 Psychiatric		
2.10 Orthopedic		
2.11 Nutritional		
2.12 Interviews for symptoms related to: Primary diagnosis		
Terminal diagnosis		
2.13 Other:		
3. Treatment Technique		
3.1 Explanation to patient		
3.2 Treatment: Specify		
3.3 Proper draping of patient for privacy		
3.4 Use of Universal Precautions		
3.4.1 Gloves worn for the contact or potential contact of blood/body fluids		
3.4.2 Masks, gowns, goggles (or mask&sheild) are worn for actual or potential splashing or aerosolization of blood or body fluids		
3.4.3 Provider has appropriate personal protective equipment (PPE) to use when a potential for exposure exists.		
3.4.4 Handwashing is performed as outlined in Infection Control and Safety Management Manual.		
3.5 Proper draping of patient for privacy.		
3.6 Follows provider bag technique as outlined in the Infection Control and Safety management manual.		
4. Teaching Technique		
4.1 Provides written instruction to patient and/or family.		
4.2 Provides verbal instruction to patient and/or family.		
4.3 Return demonstration evaluated/verbalized.		
4.4 Able to anticipate needs related to care.		

	Competency	
	Yes	No
5. Evidence of Patient/Family Involvement in Plan of Care		
6. Evaluation of Documentation		
6.1 Nursing clinical note		
6.2 RN: Coordination of services and follow-up		
6.3 Updating field chart		
6.3.1 Patient Summary report		
6.3.2 Medication Profile		
6.3.3 Nursing Care Plan		
6.3.4 HHA Care Plan		
6.3.5 Communication Log		
6.3.6 Client teaching per visit		
6.4 LPN: Evidence of communication of appropriate data to RN		
7. Ability to Perform New Procedure/Technique		
7.1 Demonstrates new procedure/technique appropriately		
7.2 Demonstrates use of equipment/Type of Equipment:		
7.2.1 Safely		
7.2.2 Appropriately		
8. Evaluation of Safety/Environment		
8.1 Home		
8.1.1 Floors		
8.1.2 Electrical		
8.1.3 Phone		
8.1.4 Bathroom		
8.1.5 Stairs		
9. Evaluation of Waste Management		
9.1 Safely		
9.2 Appropriately		

10. Comments _____

_____

_____

_____

Skill Identified	Improvement Plan	Projected Completion	Actual Completion

Employee Signature _____

Training and Development _____ Date _____

Florida Home Bound MHA, Inc. **Licensed Practical/Vocational Nurse Evaluation**

Employee Name:

Performance Responsibilities	Below	Meets	Exceeds
Provides direct skilled nursing care.			
Prepares equipment and materials for treatments, practicing ascepting/sterile techniques as required, and assists the client in learning appropriate self-care techniques.			
Administers medication as prescribed by the Physician and as permitted by law.			
Assists in the evaluation of effectiveness of treatments and monitors client's reactions.			
Contributes to the coordination of services in conjunction with other members of the health care team.			
Maintains accurate records.			
Reports significant findings or changes in the client's condition to the Registered Nurse and to the client's Physician.			
Records clinical/progress notes in the client's clinical record no less often than weekly.			
Documents all client-related activities in a timely manner.			
Reacts to change productively and performs other job-related tasks and duties as assigned.			

Employee Signature _____

Training and Development _____ Date _____

Florida Home Bound MHA, Inc. Home Health Agency

NURSING SCREENING TEST

NAME: _____ DATE: _____

1. **You are in the home situation and your patient has a hospital discharge list of medicines which are different from what is in the home. The patient tells you "The doctor said when I left the hospital that I can resume my old medicines too". You should:**

□ a. Agree with the patient, as doctors often do this on discharge and don't change the orders for the home health referral.
□ b. Tell the patient to go ahead with her old meds and hospital discharge med regimen until you can confirm them with the M.D.
□ c. While in the home, call the doctor to confirm the patient's med regimen.

2. **You are unable to confirm the medications with the M.D. You should:**

□ a. Tell the patient to take only the hospital discharge meds and to hold all old meds. Tell him that you will have the M.D. call the home care agency today with med clarification, and that as soon as we hear from the M.D. we will call the patient to confirm the specific med regimen.
□ b. Tell the patient to follow what the doctor verbally directed on discharge, as it is very common for them to change their minds and decide differently after discharge orders are already written.
□ c. Call the family member who was with the patient at discharge and determine what the M.D. actually ordered.

3. **You are seeing a diabetic patient who has become insulin-dependent. She has reduced vision. She is preparing breakfast and tells you she had her insulin injection about an hour ago when she got up and now she is feeling a little "shaky". You would first:**

□ a. Assess her ability to draw up insulin properly.
□ b. Assess her knowledge of home diabetes regimen.
□ c. Check her blood sugar per glucoscan to assess for hypoglycemia.

4. You realize this same patient had not eaten an adequate dinner the night before and neglected to fix an H.S. snack. This patients needs most for SN to:

□ a. Define diabetes and explain complications.
□ b. Explain the importance of the relationship of insulin to three meals and an H.S. snack daily.
□ c. Administer orange juice with sugar or whatever is quickly available that is sweet in the home.

5. You are now this patient's case manager and are preparing her next lesson plan. You would instruct patient on:

□ a. The importance of checking her weight each visit as well as blood sugar glucoscan levels.
□ b. The importance of foot and skin care and the complications of neglect of checking toes, feet, rashes, etc., daily.
□ c. The relationship of circulation and digestion to injected insulin in the bloodstream and the need for food.

6. You have assessed on the first visit that this patient's vision is not adequate for her own safe insulin preparation. You would:

□ a. Call the doctor and inform him of the problem you have observed.
□ b. Pre-fill an emergency morning insulin syringe even though you plan on seeing her in the A.M.
□ c. Review with the patient s/s of hyperglycemia.

7. A diabetic patient can <u>never</u> have granulated sugar in foods.

True □ False □

8. You are seeing a patient who has a deep L. trochanter pressure decubitus. The wound is draining greenish foul-smelling discharge and has black eschar with yellow string-like portions of flesh over parts of the wound. Your first concern is:

□ a. Wound needs thorough cleansing with hydrogen peroxide, NSS rinse and Betadine to prevent clostridium bacilla (gangrene) formation.
□ b. M.D. will need to be contacted for chemical or mechanical wound debridement order and possibly an order for a wound culture.
□ c. To measure the wound and begin thorough cleansing of wound with acetic acid, NSS rinse and Betadine and get a wound culture.

9. Your patient's abdominal incision appears reddened and the patient reports tenderness at site and there is drainage. You would first:

□ a. Notify M.D. of this change.
□ b. Check vital signs and call M.D.
□ c. Cleanse wound and change dressing as ordered and then call M.D.

10. It is not necessary to bag soiled dressing in the patient's home.

True □ False □

11. Which is the most accurate explanation for why breathing is harder for the patient with emphysema:

□ a. The airways are collapsed during inspiration.
□ b. Fewer alveoli are available for gas exchange.
□ c. Respiratory muscles are paralyzed.
□ d. The $PoCO_2$ level is increased.

12. Dyspnea in a patient with CHF is caused by:

□ a. Decreased CO_2 levels.
□ b. Fluid congestion in lungs.
□ c. Inadequate peripheral circulation.
□ d. Pulmonary infarcts.

13. Which drug is usually given to patients with CHF?

□ a. Aminophylline.
□ b. Digoxin.
□ c. Deltasone.
□ d. Inderal.

14. A patient with recent acute CHF diagnosis would be assessed in which manner by the SN:

□ a. Blood sugar, BP, lung auscultation, edema.
□ b. Apical pulse, wt, lung auscultation, edema.
□ c. Blood sugar, dietary knowledge, weight.

15. The CHF patient is on a 2 gm Na diet. The SN would instruct him to avoid which of the following foods:

□ a. Canned soup, chocolate, ham.
□ b. Frozen vegetables, oranges, cereal.
□ c. Milk, fruit, chicken.

16. Your patient is exhibiting these symptoms: persistent dry cough, orthopnea, shallow aspiration, low BP, 4-lb. weight gain. She probably has:

□ a. Pulmonary edema.
□ b. Pneumonia.
□ c. COPD.

17. You would then:

□ a. Call the M.D. on an emergency basis.
□ b. Call for oxygen.
□ c. Tell the patient to take an extra Lasix.

18. You are unable to reach the patient's M.D. while still in the home. You would then:

□ a. Schedule another visit the next day.
□ b. Tell the patient to take an extra Lasix.
□ c. Have family take the patient immediately to the Emergency Room.

19. You are on call and a patient's spouse calls to report the patient is S.O.B., has pain in his chest/jaw and is sweating. You would:

□ a. Go right out to see patient.
□ b. Have spouse stay with patient while you call the paramedics.
□ c. Have family take patient right to the hospital.

20. If patient teaching is effective, the patient states that Cimetidine (Tagamet):

□ a. Coats the stomach.
□ b. Decreases acid production.
□ c. Changes stomach hormones.
□ d. Neutralizes stomach contents.

21. On an evaluation visit you find the patient in a condition which suggests abuse or neglect. You would:

□ a. Report it and any information about family situation immediately to the Agency, then to Adult Protective Services.
□ b. Tell the family what you suspect and that you expect better conditions on your next visit.
□ c. Call an ambulance and have the patient removed from the home immediately.

22. The most important precautions to teach a patient who has just had a total hip replacement include: Not to cross his legs, not to sit in a low sofa chair and not to sit in a 90 degree angle in bed.

True □ False □

23. Homebound means that the patient is unable to leave his home because:

□ a. He doesn't own a car.
□ b. He doesn't want to.
□ c. It is a taxing effort for him.
□ d. He cannot get a doctor's appointment.

24. On hot, smoggy days, COPD and CHF patients should be instructed to stay inside with their air conditioner on and to conserve energy.

True □ False □

25. Included in the SN's initial assessment of the patient should be how meals are obtained, a phone is in close proximity to patient, support system available, transportation to M.D., and seeing the patient ambulate to access safety in ambulation and transfers.

True □ False □

26. Patients taking Coumadin should be instructed to take this medication at 5:00 p.m. because:

□ a. It is absorbed better at night on an empty stomach.
□ b. The patient is less likely to forget the med at that time.
□ c. Protime results can require a change in the Coumadin dose needed.

27. If your schedule does not allow you to get a lab specimen to the lab within one hour, you should:

□ a. Place the specimen on ice and get to lab ASAP.
□ b. Call a courier service to transport specimen.
□ c. Ask family member to take specimen to the lab for you.

28. If you have a patient who has a "Do Not Resuscitate" order and he expires at home, you should:

□ a. Call the paramedics.
□ b. Initiate CPR.
□ c. Call the physician, proper authorities, and the home health agency.

29. According to universal precautions, syringes and needles should be discarded in a milk container or coffee can that can be closed.

True □ False □

30. Needles are to be recapped or broken before disposition.

True □ False □

The following situations would require prompt notification of the primary physician:

31. True □ False □ Presence of temp over 100 orally or 101 rectally.

32. True □ False □ Systolic B/P of <85 >180.

33. True □ False □ BP under 50 or over 110 diastolically.

34. True □ False □ P. over 50 or under 100.

35. True □ False □ Significant change in mental status.

36. True □ False □ Poor medication compliance.

37. True □ False □ Fasting blood sugar results over 200.

38. When inserting a foley catheter in a male patient, the catheter should be:

□ a. Inserted until urine returns.
□ b. Well-lubricated and inserted 4" with urine return.
□ c. Well-lubricated and inserted to the "Y" with urine return.

39. The patient with O_2 concentrator needs to have a portable O_2 tank close by for emergencies:

True □ False □

40. The peak action of NPH insulin is:

□ a. 2 – 4 hours.
□ b. 10 – 18 hours.
□ c. 4 – 10 hours.

41. The peak action of regular insulin is:

□ a. 1 – 2 hours.
□ b. 2 – 4 hours.
□ c. 8 – 12 hours.

42. A usual daily dose (maintenance) of digoxin is:

□ a. 0.125.
□ b. 0.1260.5 mg
□ c. 1 mg.

43. If a 1000 cc bottle of I.V. fluids is to last 8 hours, it would need to be regulated to show how many drops per minute (15gtts = 1 cc):

□ a. 15.
□ b. 22.
□ c. 31.
□ d. 60.

44. For a patient with emphysema or other chronic lung problems, at what liter flow would you start oxygen through a nasal cannula without specific order from the physician?

□ a. 1 – 2.
□ b. 4 – 5.
□ c. 5 – 6.
□ d. 8 – 10.

45. Insertion of a nasal suction catheter should be done:

□ a. On inspiration.
□ b. On expiration.
□ c. With the patient holding his breath.

46. You are changing a foley catheter and realize the catheter was contaminated by the patient's leg. This was the only catheter in the home and you have no extras in your car supply. You should:

□ a. Have family member drop you a sterile alcohol prep pad and cleanse the contaminated catheter.
□ b. Wipe the catheter off with an extra unused Betadine swab from your catheter kit.
□ c. Insert the catheter despite contamination and call the physician for antibiotic order.
□ d. Go back to office and get new catheter or call scheduling coordinator to see if it can be arranged for another nurse to do the catheter change – if your time schedule will not allow this.

47. The average amount of solution given as a cleansing enema is:

□ a. 4 oz.
□ b. 20 – 500 cc's.
□ c. 750 – 1000 cc's.
□ d. Over 1000 cc's.

48. When inserting a N/G tube, the patient should be:

□ a. Flat on his back with head flat.
□ b. Sitting upright.
□ c. On his right side.
□ d. On his left side.

49. Progressive signs/symptoms of ketoacidosis include:

□ a. Thirst.
□ b. Abdominal pain, headache, hot flushed appearance.
□ c. Kussmaul breathing.
□ d. All of the above.
□ e. a & b.

50. The effects of Coumadin are measured by the lab when blood is drawn for:

□ a. Clotting time.
□ b. Combs test
□ c. Prothrombin time
□ d. Sed rate.

INTERVIEW WORKSHEET
QUESTIONS

1. **Think of a personal or work related stressful situation and how you handled the stress.**

2. **Describe how home care nursing will help you attain your professional goals.**

3. **What do you consider your area of expertise and how do you share with others?**

4. **We strive to maintain the patient's medical record in accordance with agency policy. In an effort to achieve this goal, great emphasis is placed on nurses notes being delivered in a timely manner and documentation deficiencies being kept to a minimum. In the agency, nurses notes are due by 5:00 p.m. on Wednesday; sign-ups are due into the agency within 72 hours. How would you manage your time effectively in order to deliver your notes in a timely manner, with the least number of deficiencies, while still providing quality care to your full patient load?**

SIMULATION A

In the space provided below, note your nursing intervention for Simulation A.

Mr. Perez is a 75-year-old patient with CHF. He lives with his 73-year-old wife who enjoys cooking his favorite meals. Mr. Perez is on a 2 gm NA, low cholesterol diet. Upon entering his home, you interrupt Mr. Perez's breakfast of bacon, 2 fried eggs, bread with butter, and whole milk with café. Upon your initial assessment, his vital signs are 98.6, 98, 26, 190/110. His weight reveals a 2 lb. weight gain since your last home visit 2 days ago. He now had 3+ bilateral pedal edema and states "My shoes are awfully tight".
Mrs. Perez smiles as she remarks, "I'm gonna fatten my man back up".

Applicant's name: _____

Position applied for: _____

Date: _____

QUESTIONS/SIMULATION

REVIEW OUTCOME:

Satisfactory □ Unsatisfactory □

Reviewed by: _____