**Section 245.205 Services – Home Nursing Agencies**

a) Each home nursing agency shall provide skilled nursing services and may provide home health aide services under the supervision of the registered nurse. Home nursing services may be provided directly by agency staff or through a contractual purchase of services. All services shall be provided:

1) In accordance with the client's health care professional, or under a plan of treatment established by the health care professional; and

2) Under the supervision of agency staff, by a health care professional. If the agency manager is the designated nursing supervisor, the agency shall also have another nurse on staff to provide the direct skilled nursing care.

b) The agency shall state in writing to the client what services will be provided directly by agency staff, and what services will be provided under contractual arrangements with a third party.

c) If the agency provides services under contractual arrangements with a third party, it shall have a written agreement that includes, but is not limited to, the following:

1) A detailed description of the services to be provided;

2) Provisions for adherence to all applicable agency policies and personnel requirements, including requirements for initial health evaluations and employee health policies, and criminal background checks if applicable;

3) Designation of full responsibility for agency control over contracted services;

4) Procedures for submitting clinical and progress notes;

5) Charges for contracted services;

6) A statement of responsibility of liability and insurance coverage (employment, workers' compensation) and taxes, including employment and social security taxes;

7) The period of time the written agreement is in effect;

8) The date and signatures of appropriate authorities; and

9) Provisions for termination of services.

d) Acceptance and Discharge of Patients

Patient acceptance and discharge policies shall include, but not be limited to, the following:

1) Persons shall be accepted for services with a plan of treatment established by the patient's health care professional. This plan shall be promulgated in writing within 30 days after acceptance and shall be signed by the prescribing health care professional within 45 days after acceptance.

2) Prior to acceptance, the person shall be informed of the agency's charges for the various services that it offers.

3) No person shall be refused service because of age, race, color, sex, marital status, national origin or sexual orientation. Patients shall be accepted for treatment on the basis of a reasonable expectation that the patient's nursing needs can be met adequately in the patient's place of residence.

4) When services are to be terminated by the agency, the patient shall be notified seven working days in advance of the date of termination. The notice shall state the reason for termination. This information shall be documented in the clinical record. When any continuing care is indicated, a plan shall be developed or a referral made.

5) Services shall not be terminated until the registered nurse has provided a minimum of seven days' notice to the patient's health care professional. The seven-day notice requirement is not applicable in cases in which the worker's safety is at risk. In these cases, the agency shall notify the client of the timing of the termination of services and the reason for the termination. Documentation of the risk to the worker shall be maintained in the client record.

e) Plan of Treatment

Skilled nursing services shall be in accordance with a plan based on the client's diagnosis, an assessment of the client's immediate and long-range needs and resources, and client participation. The plan is to be established in consultation with the nursing personnel; the client's health care professional; other pertinent members of the agency staff; the client; and client's advocate. The plan shall include:

1) Diagnoses;

2) Client limitations and prognosis;

3) Expected outcomes for the client;

4) The prescribing health care professional's regimen of care designed to address identified client needs, including medications; treatments; activity; diet; specific procedures deemed essential for the health and safety of the client; mental status; and potential for discharge;

5) The types and frequency of services to be provided; and

6) Assessment of need for influenza and pneumococcal vaccination.

f) Consultation with the client's health care professional on any modifications in the plan of treatment deemed necessary shall be documented, and the prescribing health care professional's signature shall be obtained within 45 days after any modification of the plan.

1) The home nursing services team shall review the plan every 90 days, or more often should the patient's condition warrant.

2) An updated plan of treatment shall be given to the client's health care professional for review, for any necessary revisions, and for signature every 90 days, or more often as indicated.

g) Clinical Records

1) The agency shall maintain a clinical record for each client in accordance with accepted professional standards. Clinical records shall contain:

A) Appropriate identifying information for the client, household members and caretakers;

B) A plan of treatment developed by the home nursing agency in accordance with the health care professional's order;

C) A list of medications that the client is taking, updated as needed. The list shall specify the dose, method, route of administration, and frequency of administration of each medication. All potential contraindications, drug interactions, and adverse reactions shall be reported to the health care professional within 24 hours, or sooner as warranted, and documented in the clinical record;

D) Initial and periodic client assessments by the registered nurse;

E) Signed and dated clinical notes for each contact that are written the day of service and incorporated into the client's clinical record at least weekly;

F) Reports on all client conferences;

G) Report of contacts with the client's health care professional by client and staff;

H) Documentation of supervision of services by the supervising nurse, a registered nurse, or other members of the home nursing supervisory/management team;

I) Written and signed confirmation of the client's health care professional's interim verbal orders;

J) A discharge summary giving a brief review of service, client status, reason for discharge, and plans for post-discharge needs of the client. A discharge summary may suffice as documentation to close the client record for one-time visits or short-term services. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary of reports already furnished to the physician or health care professional;

K) A copy of appropriate client transfer information, when requested, if the client is transferred to another health facility or health agency.

2) For record keeping, the agency may utilize hard copies or an electronic format. Each agency shall have written policies and procedures for records maintenance and shall retain records for a minimum of five years beyond the last date of service provided. The procedures may include that the agency will use and maintain faxed copies of records from licensed professionals, rather than original records, provided that the faxed copies will be maintained on non-thermal paper and that the original records will be maintained for a period of five years by the professional who originated the records. If that professional is providing services through a contract with the agency, then the contract shall provide that the professional maintain the original records for a period of five years.

3) Agencies that maintain client records by computer rather than hard copy may use electronic signatures. The agency shall have policies and procedures in place in regard to these entries and the appropriate authentication and dating of those records. Authentication may include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has received and approved the entry. The agency shall have safeguards in place to prevent unauthorized access to the records and a process for reconstruction of the records if the system fails or breaks down.

4) Agencies that are subject to the Local Records Act should note that, *except as otherwise provided by law, no public record shall be disposed of by any officer or agency unless the written approval of the appropriate Local Records Commission is first obtained.* (Section 7 of the Local Records Act)

5) Each agency shall have a written policy and procedure for protecting the confidentiality of client records that explains the use of records, removal of records and release of information.

h) Drugs and Biologicals

The agency shall have written policies governing the supervision and administration of drugs and biologicals, which shall include, but not be limited to, the following:

1) All orders for medications to be given shall be dated and signed by the client's health care professional.

2) All orders for medications shall contain the name of the drug, dosage, frequency, method, and route of administration, and permission from the prescribing health care professional if the client, the client's family, or both are to be taught to give medications.

3) All verbal orders for medication or change in medication orders shall be taken by the nurse, written, and signed by the patient's health care professional within 45 days.

4) When any experimental drug, sera, allergenic desensitizing agent, penicillin or other potentially hazardous drug is administered, the registered nurse administering the drugs shall have an emergency plan and any drugs and devices that may be necessary if a drug reaction occurs.

(Source: Amended at 45 Ill. Reg. 11077, effective August 27, 2021)