

MECHANICAL VENTILATOR DEPENDENT WAIVER  
SCOPE OF SERVICES  
FOR  
IN-HOME RESPITE

A. Objective

The objective of In-home Respite Services is to provide temporary care in the home for mechanical ventilator dependent clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary relief for the primary caregivers and maintain the client at home. This service is necessary to avoid institutionalization.

B. Description of Services to be Provided

1. The unit of service will be a twenty-four hour period.
2. The number of units and services provided to each client will be dependent upon the individual client's needs as established or approved by the Case Manager and set forth in the client's Service Plan. In-home respite services may be provided for a period not to exceed fourteen (14) days per State fiscal year (July 1-June 30) in accordance with the provider contracting period.
3. In-home respite services will provide skilled medical services as ordered by the physician and will be performed by a Registered Nurse, or Licensed Practical Nurse, who will perform their duties in compliance with the Nurse Practice Act and S. C. Code of Laws, Regulations, Chapter 91, State Board of Nursing.
4. In-home respite services will include, but are not limited to, any household care, meal preparation and personal care services as needed by the client during the in-home respite period. All other waiver services will be discontinued during the in-home respite period.

C. Staffing

1. A licensed practical nurse or registered nurse who meets the following requirements:
  - a. Currently licensed by the state of South Carolina to practice nursing.
  - b. At least one year experience in public health, hospital, or long term care nursing.
  - c. No more than ninety (90) days prior to employment, all staff having direct client contact shall have a PPD tuberculin skin test, unless a previously positive reaction can be documented. The two-step procedure is advisable for initial testing in those who are new

employees in order to establish a reliable baseline. [If the reaction to the first test is classified as negative, a second test should be given a week later. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10mm) in such a person within the next few years, is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected.]

In lieu of a PPD tuberculin test no more than 90 days prior to employment, a new employee may provide certification of a negative tuberculin skin test within the 12 months preceding the date of employment and certification from a licensed physician or local health department TB staff that s/he is free of the disease.

Employees with reactions of 10mm and over to the pre-employment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment should be given, and the person must not be allowed to work until declared noncontagious by a licensed physician.

Routine chest radiographs are not required on employees who are asymptomatic with negative tuberculin skin tests.

Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.

New employees who have a history of tuberculosis disease shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared noncontagious.

Preventive treatment should be considered for all infected employees having direct client contact who are skin test positive but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventive treatment. Employees who complete treatment, either for disease or infection, may be exempt from further routine radiographic screening, unless they develop symptoms of tuberculosis. Employees who do not complete adequate preventive therapy should have an annual assessment for symptoms of tuberculosis.

Post exposure skin tests should be provided for tuberculin negative

employees within twelve (12) weeks after termination of contact to a documented case of infection.

Providers needing additional information should contact the Tuberculosis Control Branch, Department of Health and Environmental Control, 2600 Bull Street, Columbia, S.C. 29201 (phone (803) 898-0558).

2. Minimum training for licensed practical nurses and registered nurses:
  - a. The Provider assures CLTC that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician including the care required by an individual requiring mechanical ventilator assistance.
  - b. The Provider will provide for a minimum of six (6) hours relevant in-service training per year (based on date of employment) for each nurse.

D. Conduct of Service

1. The name of a designated person(s) and telephone number(s) will be furnished to CLTC in order to provide CLTC seven (7) day twenty-four (24) hour accessibility.
2. An individual client record must be maintained.
3. The Provider will be responsible for procuring the skilled nursing orders from the physician.
4. In-home Respite Services must begin on the date negotiated by the Case Manager and the Provider.
5. The Provider must send a plan of care to the Case Manager which includes goals, after completion of the first in-home respite nursing visit. If applicable, recommendations to change the service schedule from that on the initial Service Provision Form may be sent to the Case Manager at that time.
6. The In-home Respite Service must not be provided prior to the authorized start date as stated on the Service Provision Form.
7. The Provider will notify the Case Manager within two (2) working days of the following client changes:
  - a. Client's condition has changed and the Service Plan no longer meets the client's needs or the client no longer needs In-home Respite Services.
  - b. Client dies or moves out of the Service area.

- c. Client no longer wishes to receive the In-home Respite Service.
  - d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.
8. A record keeping system will be maintained which establishes an eligible client profile in support of units of In-home Respite Services. A daily log will reflect the services provided by the nurse and the time expended for this service.
  9. The Provider must develop and maintain a state approved Policy and Procedure Manual which describes how it will perform its activities in accordance with the terms of the contract.
  10. The Case Manager will authorize In-home Respite Services by designating the amount, frequency, and duration of service for clients in accordance with the client's Service Plan. This documentation will be maintained in the client's file.
  11. The Case Manager will obtain the initial physician's order for In-home Respite Services. A copy will be sent to the Provider to be placed in the client's file.
  12. The provider will obtain the direct care physician's orders.
  13. The Case Manager will review the client's Service Plan within three (3) days of receipt of the Provider's request to modify the plan.
  14. The Case Manager or CLTC will notify the Provider immediately if a client becomes medically ineligible for CLTC services. CLTC will make every effort to verify Medicaid eligibility on a monthly basis. However, the Provider should refer to the language in the Community Long Term Care Services Provider Manual on page 1-5 regarding the Provider's responsibility in checking the client's Medicaid card.

E. Administrative Requirements

1. The Provider agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the Provider agency. The Provider agency shall notify DHHS within three (3) working days in the event of a change in the agency Administrator, address, or phone number.
2. The organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. This shall be readily accessible to all staff and shall

include an organizational chart. A copy of this shall be forwarded to DHHS at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the Provider agency and to DHHS.

3. The Provider agency must have written bylaws or equivalent which are defined as "a set of rules adopted by the Provider agency for governing the agency's operations." Such bylaws or equivalent shall be made readily available to staff of the Provider agency and shall be provided to DHHS upon request.
4. Administrative and supervisory functions shall not be delegated to another agency or organization.
5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the Provider agency. A listing of the members of the governing body shall be made available to DHHS upon request.
6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to DHHS prior to the signing of the initial contract with DHHS. The Provider agency must maintain an annual operating budget which shall be made available to DHHS upon request.
7. The Provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance to protect all paid and volunteer staff, including board members, from liability and/or injury incurred while acting on behalf of the agency. The Provider agency shall furnish annually a copy of the insurance policies to SCDHHS.

**Effective July 1, 2005**