**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Quality Assurance Page 1 of 2

F-62652 (05/2020)

**HOME HEALTH AGENCY (HHA) – LICENSURE SURVEY HOME VISIT GUIDE**

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| Name – Patient | | | | | | | | | Start of Care and Diagnosis | | | | | | |
| Name – HHA | | | | | | | | | | | Provider No. | | | | License No. |
| Name / No. – Surveyor(s) | | | | | | | Name/Discipline Observed | | | | | | | HHA Supervisor Present  Yes  No | |
| Mileage To and From | | | | | Date – Home Visit | | | Start Time | | | | | End Time | | |
| Type of Residence:  Single family  Apartment  Apartment w/services  Group home  CBRF  Other | | | | | | | | | | | | | | | |
| Observation of Environment and Durable Medical Equipment in the Home | | | | | | | | | | | | | | | |
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| **Family Situation – Caregiver/Patient Interview** | | | | | | | | | | | | | | | |
| 01 | Patient lives:  Alone  With Spouse/Family  Other | | | | | | | | | Primary caregiver:  Self  Family  Agency  Other | | | | | |
| 02 | Alert  Oriented  Responsive  Non responsive  Inappropriate  Forgetful  Depressed  Anxious  Assaultive  Disruptive | | | | | | | | | Family is:  Supportive  Capable as caregiver  Unsupportive  Unavailable | | | | | |
| **Patient Rights / Complaints** | | | | | | | | | | | | | | | |
| 01 | Y  N Did the agency explain your rights on admission? | | | | | | | | | 1. Verbally  2. Written | | | | | |
| 02 | Y  N Is the HHA admission folder in home? | | | | | | | | | 1. Rights statement  2. Current care plan  3. Medication list  4. OASIS privacy notice | | 5, HHA transfer/discharge  6. Resource list  7. HHA visit schedule | | | |
| Folder Contents | | | | | | | | |
| 03 | Y  N Have you been involved/agreed with the planning of your care and/or charges as they occur? | | | | | | | | | 1. Treatment plans  2. Disciplines involved  3. Financial costs | | | | | |
| 04 | Y  N Do you know how and to whom to file a complaint related to concerns regarding your rights, agency staff, or care? | | | | | | | | | 1. Department on Aging  2. Aging and Disability Resource Center  3. QIO agency | | | | | |
| 05 | Y  N Do you have the contact names and number of the federal and state funded entities as resources? | | | | | | | | | 1. HHA administrator contact info  2. State hotline number.  3. LTC Ombudsman | | | | | |
| **Skilled / Aide / PCW Services** | | | | | | | | | | | | | | | |
| 01 | What services does the agency provide for you? | | | | | | | | | Y  N Has staff been prompt?  Y  N Missed visits?  Y  N Changed their schedule? | | | | | |
| RN  LPN | PT  OT | | ST  SW | | HHA  PCW | | | |
| 02 | Y  N Skilled nursing services – RN or LPN? Frequency of Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| 03 | Y  N Home health aide  Y  N Personal care worker (PCW)  Y  N Supervision provided | | | | | | | | | Y  N Bath/shower  Y  N Dress/groom  Y  N Apply creams/salves  Y  N Apply dressings | | | | | |
| 04 | Therapy:  PT  PTA  OTR  COTA  ST | | | | | | | | | Y  N Are you on a special exercise/ROM program? | | | | | |
| 05 | Y  N Are you satisfied with the services being provided?  Y  N Do you feel comfortable and safe when staff cares for you? | | | | | | | | | | | | | | |
| **Infection Control Home Visit Observations** | | | | | | | | | | **Findings** | | | | | |
| 01 | Adherence to standard precautions | | | | | | | | |  | | | | | |
| 02 | Bag technique per agency policy | | | | | | | | |  | | | | | |
| 03 | Hand hygiene adherence | | | | | | | | |  | | | | | |
| 04 | Environmental cleaning and disinfection | | | | | | | | |  | | | | | |
| 05 | Injection and medication safety; minimize potential exposures | | | | | | | | |  | | | | | |
| 06 | Appropriate use of personal protective equipment (PPE) | | | | | | | | |  | | | | | |
| 07 | Reprocessing/cleaning; storage and usage of equipment used during patient care | | | | | | | | |  | | | | | |
| **Summary of Surveyor’s Findings from Observations of Caregiver** | | | | | | | | | | | | | | | |
| Y  N  NA | | | PT teaching appropriate | | | | | | |  | | | | | |
| Y  N  NA | | | Medication list current/reconciled | | | | | | |  | | | | | |
| Y  N  NA | | | Assessment/observations appropriate | | | | | | |  | | | | | |
| Y  N  NA | | | B/P  P  T  POX | | | | | | |  | | | | | |
| Y  N  NA | | | Care plan/treatment plan followed | | | | | | |  | | | | | |
| Y  N  NA | | | Coordination of care/professional mgmt. | | | | | | |  | | | | | |
| Y  N  NA | | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  | | | | | |
| **Surveyor Comments / Observations of Home Visit** | | | | | | | | | | | | | | | |
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