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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-62680 (06/2020) | | | **STATE OF WISCONSIN** Wis. Admin. Code Chapter DHS 133 Page 1 of 3 | | | | |
| **HOME HEALTH AGENCY (HHA) – CLINICAL RECORD REVIEW**  **State-Licensed Only** | | | | | | | |
| Name – Patient | | | | Patient ID No. | | Date – Start of Care | |
| Date – Review | Surveyor No. | HHA License No. | | | Pay Source | | Open  Closed |

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| **Tag** | | **DHS 133** | | **Regulation** | | | | | | | | | | **Yes** | | **No** | | **NA** |
| 141 | | .08(2)(a) | | Patient Rights – Written acknowledgement of acceptance *(waived for federally certified HHAs)* | | | | | | | | | |  | |  | |  |
| 149 | | .08(3) | | Complaint form F-62069 | | | | | | | | | |  | |  | |  |
| 150 | | .09 | | **ACCEPTANCE AND DISCHARGE** | | | | | | | | | |  | |  | |  |
| 152 | | .09(2) | | **SERVICE AGREEMENT** – Signed with services, fees, and charges identified | | | | | | | | | |  | |  | |  |
| 153 | | .09(3)(a)1. | | **DISCHARGE OF PATIENT** – Written notice | | | | | | | | | |  | |  | |  |
| 154 | | .09(3)(a)2.a | | Non-payment | | | | | | | | | |  | |  | |  |
| 155 | | .09(3)(a)2.b | | Unable to provide care | | | | | | | | | |  | |  | |  |
| 156 | | .09(3)(a)3.a | | Staff safety compromised | | | | | | | | | |  | |  | |  |
| 157 | | .09(3)(a)3.b | | Physician orders discharge | | | | | | | | | |  | |  | |  |
| 158 | | .09(3)(a)3.c. | | No longer needs home health care | | | | | | | | | |  | |  | |  |
| 159 | | .09(3)(a)4. | | Copy in patient record | | | | | | | | | |  | |  | |  |
| 160 | | .09(3)(a)5.a | | Reason for discharge | | | | | | | | | |  | |  | |  |
| 161 | | .09(3)(a)5.b | | Patient right to file complaint | | | | | | | | | |  | |  | |  |
| 162 | | .09(3)(b) | | Discharge summary within 30 days | | | | | | | | | |  | |  | |  |
| 168 | | .11 | | **REFERRALS** – Appropriate referrals made | | | | | | | | | |  | |  | |  |
| 169 | | .12 | | **COORDINATION WITH OTHER PROVIDERS** | | | | | | | | | |  | |  | |  |
| Conferences with other agency providers | | | | | | | | | |  | |  | |  |
|  | |  | | Appropriate referrals made | | | | | | | | | |  | |  | |  |
| 231 | | .21 | | **MEDICAL RECORDS** | | | | | | | | | |  | |  | |  |
|  | |  | | CONTENT – Record must include the following: | | | | | | | | | |  | |  | |  |
| 237 | | .21(5)(a) | | * Patient ID information | | | | | | | | | |  | |  | |  |
| 238 | | .21(5)(b) | | * Appropriate (hospital) information | | | | | | | | | |  | |  | |  |
| 239 | | .21(5)(c) | | * Patient evaluation and assessment | | | | | | | | | |  | |  | |  |
| 240 | | .21(5)(d) | | * Plan of Care | | | | | | | | | |  | |  | |  |
| 241 | | .21(5)(e) | | * Physician orders | | | | | | | | | |  | |  | |  |
| 242 | | .21(5)(f) | | * Medication list and patient instructions | | | | | | | | | |  | |  | |  |
| 243 | | .21(5)(g) | | * Progress notes with services, condition, and progress | | | | | | | | | |  | |  | |  |
| 244 | | .21(5)(h) | | * Summaries of review of Plan of Care | | | | | | | | | |  | |  | |  |
| 245 | | .21(5)(i) | | * Discharge summary within 30 days | | | | | | | | | |  | |  | |  |
|  | |  | | * Form of entries | | | | | | | | | |  | |  | |  |
| 246 | | .21(6) | | * Entries are legible. | | | | | | | | | |  | |  | |  |
|  | |  | | * Entries are permanently recorded. | | | | | | | | | |  | |  | |  |
|  | |  | | * Entries are authenticated with name and title. | | | | | | | | | |  | |  | |  |
|  | | .20 | | **PLAN OF CARE** | | | | | | | | | |  | |  | |  |
| 224 | | .20(1) | | Requirement: Plan developed within 72 hours in consultation with physician, patient, and contractual providers. | | | | | | | | | |  | |  | |  |
|  | |  | | Plan signed within 20 working days | | | | | | | | | |  | |  | |  |
| 225 | | .20(2)(a) | | Contents: Goals Measurable – time specific with benchmark dates | | | | | | | | | |  | |  | |  |
| 226 | | .20(2)(b) | | Plan of Care complete and accurate (includes Methods / Discipline) | | | | | | | | | |  | |  | |  |
| 227 | | .20(3) | | Review of plan – MD review at least every 60 days | | | | | | | | | |  | |  | |  |
| **Tag** | | **DHS 133** | | **Regulation** | | | | | | | | | | **Yes** | | **No** | | **NA** |
|  | |  | | MD notified of changes in condition | | | | | | | | | |  | |  | |  |
| 229 | | .20(4) | | Physician Orders – Drugs and treatments provided per order | | | | | | | | | |  | |  | |  |
|  | |  | | T.O. signed by MD within 20 days | | | | | | | | | |  | |  | |  |
|  | | .14(2) | | **SKILLED NURSING** | | | | | | | | | |  | |  | |  |
| 172 | | .14(2)(a) | | Made initial evaluation visit with complete assessment | | | | | | | | | |  | |  | |  |
| 173 | | .14(2)(b) | | Re-evaluations patient needs | | | | | | | | | |  | |  | |  |
| 174 | | .14(2)(c) | | Initiates POT and revisions | | | | | | | | | |  | |  | |  |
| 175 | | .14(2)(d) | | Provides services requiring specialized care | | | | | | | | | |  | |  | |  |
| 176 | | .14(2)(e) | | Initiates preventative and rehab procedures | | | | | | | | | |  | |  | |  |
| 177 | | .14(2)(f) | | Clinical / progress notes present | | | | | | | | | |  | |  | |  |
| 178 | | .14(2)(g) | | Reports changes to MD | | | | | | | | | |  | |  | |  |
| 179 | | .14(2)(h) | | Arranges for counseling | | | | | | | | | |  | |  | |  |
| 180 | | .14(2)(i) | | Participates in in-service programs for agency staff | | | | | | | | | |  | |  | |  |
| 181 | | .14(2)(j) | | Supervises and teaches other personnel | | | | | | | | | |  | |  | |  |
| 184 | | .14(5) | | **COORDINATION OF SERVICE** – Communication w/other disciplines | | | | | | | | | |  | |  | |  |
| 183 | | .14(4) | | **PRACTICAL NURSING** – Duties clearly delegated | | | | | | | | | |  | |  | |  |
| Supervision evident | | | | | | | | | |  | |  | |  |
|  | | .17 | | **HOME HEALTH AIDE SERVICES** | | | | | | | | | |  | |  | |  |
| 192 | | .17(1) | | Services given in accordance with POT | | | | | | | | | |  | |  | |  |
| 200 | | .17(2)(h) | | DUTIES - Reports changes in condition | | | | | | | | | |  | |  | |  |
| 201 | | .17(2)(i) | | Completes appropriate records | | | | | | | | | |  | |  | |  |
| 193-199 | | .17(2)(a-g) | | Duties performed as assigned | | | | | | | | | |  | |  | |  |
| 202 | | .17(3) | | ASSIGNMENTS - Written instructions per RN / therapist | | | | | | | | | |  | |  | |  |
| Updates at least every 60 days | | | | | | | | | |  | |  | |  |
|  | | .18 | | **SUPERVISORY VISITS** | | | | | | | | | |  | |  | |  |
| 214 | | .18(1) | | Evaluation every 60 days | | | | | | | | | |  | |  | |  |
|  | | | | **PT** | | | **ST** | | | **OP** | | | | **MSW** | | | |
| **THERAPY** | | | | 133.15(2)  T187 | | | 133.15(4)  T189 | | | 133.15(3)  T188 | | | | 133.16  T191 | | | |
|  | | | | **Y** | **N** | **NA** | **Y** | **N** | **NA** | **Y** | **N** | **NA** | | **Y** | | **N** | **NA** |
| Evaluation and therapy plan developed in consultation with physician | | | |  |  |  |  |  |  |  |  |  | |  | |  |  |
| Coordination between RN, therapist, MSW | | | |  |  |  |  |  |  |  |  |  | |  | |  |  |
| Progress note after each visit | | | |  |  |  |  |  |  |  |  |  | |  | |  |  |
| Summary report and recertification every 60 days | | | |  |  |  |  |  |  |  |  |  | |  | |  |  |
| **T TAG** | | **COMMENTS** | | | | | | | | | | | | | | | |
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