RTP Home Healthcare Services

Name:_____ MR# _____

	YES	NO	N/A	COMMENTS
I. THE 485				
1. Is the 485 current and signed by the M.D.?				
2. Is there a date stamped when the 485 was returned?				
3. Are all meds listed with route, dose, frequency, and indicated as new or changed with 'N' or 'C'?				
4. Are the supplies listed on the 485?				
5. Are the goals specific, mesurable, achieveble, realistic and timed?				
6. Is there an END IN SIGHT for daily SN visits in field 22 of the 485?				
7. Is there a letter of medical necessity for SN visits 5 times a week or greate?				
8. Was the recert 485 signed and returned before the recert period began?				
II. ORDERS				
1. Is there an M.D. order for admission and/or recert for home health care?				
2. Is the frequency based on assessment of client's needs?				
3. Are there signed supplemental orders to reflect any changes to the plan of care?				
4. Is there an order for all supporting services that are caring for the client?				
5. Are all orders signed/cosigned bye the RN and the Physician?				
6. Are all orders signed timely within 30 days?				
7. Are telephone orders updated with new goals when changes occur in the plan of care?				
III. CASE CONFERENCE				
1. Are there interdiciplinary case conferences in the chart every 60 days?				
2. Is there a date stamped when the 60 day summary was sent to the physician?				
3. Do the case conferences reflect the status of the patient, plan modalities, summary, and prognosis?				
4. Does the case conference form indicate that the chart was updated/reviewed?				
IV. SAFETY GUIDELINES				
1. Was home safety checklist implemented and completed?				
2. Was safety-teaching guidelines implemented on admission and completed within 2 visits?				
V. NUTRITIONAL SCREENING				
1. Is the nutritional screening completed on admission and with each recert?				
2. Has an M.D. order been obtained for a dietician's evaluation when > 60?				
3. If not, is there an explanation (communication record or visit note) as to why not?				
4. Has the Dietician been notified (if indicated)?				
VI. NURSING ASSESSMENT / OASIS / ADMISSION CRITERIA				
1. Is OASIS completed, signed and dated by nurse doing assessment?				
2. Do the diagnosis' match the 485?				
3. Are there dates of onset or exacerbation with each diagnosis?				
4. Is there an OASIS for each required occurrence, admission, recert, post-hospital, SCIC, transfer, and discharge?				
5. Does the 485 reflect the assessment?				
6. Does the client meet criteria for admission?				
7. Is there a copy of the Infusion Patient Admissions and Acceptance Criteria (if applicable)?				
VII. NURSE'S NOTES				
1. Were the visits made at ordered frequency?				
2. Do the notes reflect the plan of care?				
3. Is each note billable / skilled per orders?				
4. Is the patient and/or caregiver's response to interventions/teaching noted/				
5. Is the homebound status documented consistently?				
6. Does the homebound status documented agree with the 485?				
7. Are there orders for all skills performed and information taught, etc.				
8. Was the M.D. notified of any change in condition?				
9. Was the RN manager notified of any change in condition?				

10. If the client receives daily care, does the documentation support it?				
11. Is there coordination of care between services?				
12. Is there documentation of the desired goal on each note, does it relate to goals on 485 and to primary or secondary diagnosis?				
13. Is there documentation of progress or lack of progress towards goals?				
14. Are all medications administered by agency staff charted to include med, time, route, dose, client, effects, and absence of adverse reaction in the nurse's note?				
15. Are notes legible and written in permanent black ink?				
16. Are corrections done according to agency policy no write overs?				
17. Do notes contain only agency-approved abbreviations?				
18. Are the notes signed and dated by the nurse?				
19. Does each note stand-alone?				
20. Is there a weekly wound sheet (when applicable)?				
21. Do the notes correspond with the Clinical Pathway?				
22. Are all notes filed within 14 days?				
23. Is the time in and out of the home designated AM or PM or military time?				
VIII. MEDICATION PROFILE				
1. Does the med profile agree with the 485?				
2. Is there a new med profile in the chart with every recertification?				
3. Are there start and DC dates for each medication?				
4. Is the classification indicated in the space provided an ALL meds?				
5. Is the form dated and signed and updated as needed and at least every 60 days?				
6. Is there an I.V. flow sheet and/or High Tech med profile (if applicable)?				
7. Are meds indicated as new "N" or changed "C"				
8. Does the medication profile reflect all changes to the plan of care?				
IX. THERAPY SERVICES				
1. Is there a written order for therapy services?				
2. Is the therapy evaluation signed and dated by the M.D.?				
3. Is there an evaluation every 30 days?				
4. Does the evaluation have ordered frequency and does it address pt's problems, goals, interventions, and re-evaluation?				
5. Are the visits made according to the ordered frequency?				
6. Do notes reflect skilled care?				
7. Do notes reflect client's response to interventions?				
8. Are notes signed and appropriately dated?				
9. Is the care plan appropriate to diagnosis and care provided?				
10. Is there a supervisory visit of therapy assistants every 30 days in the home?				
11. Is there a therapy-related diagnosis on the 485?				
12. Are corrections done according to agency policy?				
13. Do note contain only agency-approved abbreviations?				
14. Are notes legible and written only in permanent black ink?				
15. Are all notes filed within 7 days?				
X. SOCIAL SERVICES				
1. Is there are written order for MSW Services?				
2. Is there an evaluation that is signed by M.D. and have ordered frequency and doe is address pt's problems, goals, interventions, and re-evaluations?				
3. Are visits made according to ordered frequency?				
4. Do notes reflect skilled care?				
5. Do notes reflect patient's response to interventions?				
6. Is the care plan appropriate to diagnosis and care provided?				
7. Are corrections done according to agency policy? No write overs				
8. Do notes contain only agency-approved abbreviations?				
9. Are notes filed timely within 7 days?				
XI. HOME HEALTH AIDE NOTES				
1. Is there a plan of care for this cert. period and with each change in the POC?				
2. If visits are ordered BID is there a plan of care for both AM and PM visits?				
3. Are visits made according to ordered frequency?				

4. Is the aide given an accurate description of client needs/ condition?				
5. Is the care plan signed and dated by all Aides caring for the patient?				
6. Are parameters listed on the plan of care?				
7. Do the home health aide notes reflect the assignment sheet?				
8. Are all notes signed and dated by aide and patient?				
9. Is the home health aide supervised every 2 weeks (14 days)?				
10. If the aide notified the RN of a problem is there follow up documentation?				
11. Are corrections done according to agency policy? No write-over.				
12. Do the notes contain only agency-approved abbreviations?				
13. Do the days and dates match?				
14. Is the time in and out designated as AM or PM or military time?				
XII. LAB AND SPECIAL REPORTS				
1. Are there copies of all ordered lab results in the chart?				
2. Have physicians been notified of lab results?				
XIII. CONSENT FORMS				
1. Is the financial agreement in the chart, complete and without blanks?				
2. Is the Beneficiary/ Medicare Verification in the chart?				
3. Is the ADVANCE DIRECTIVE notification signed, if so is there a copy of the Advanced Directive in the chart?				
4. Is the Acknowledgement of Forms in the chart and signed?				
5. Is the Emergency Preparedness form in the chart?				
6. Is the Medicare Secondary Payer Questionnaire in the chart?				
7. Is the Rights of Home Health Patient form signed and in the chart?				
XIV MISCELLANEOUS				
1. Does the patient continue to meet homebound criteria?				
2. Is there a need for continued services?				
3. Is there an available caregiver identified on the chart? 1. Willing 2. Unwilling				
4. Are the documented outcomes on each goal?				
5. Are there communication records to support when changes occurs, with appropriate disciplines notified? Was the patient notified?				
XV. DISCHARGE				
1. Is there a completed discharge summary by each discipline?				
2. Is there a completed discharge Oasis?				
3. Is there a signed discharge order from the M.D. in the chart?				
4. Had the patient and/ or caregiver been given 5-day notice prior to DC?				
5. Are all visit notes present in the chart per ordered frequency?				
6. Have all orders been signed and received with original signatures?				
7. Is there documentation to support discharge planning to include client's needs after discharge?				
8. Has the client/ caregiver given verbal acknowledgement of the discharge?				
9. Have all disciplines been discharged?				
10. Is the client discharge instruction from complete?				