HOME HEALTH AGENCY LICENSURE SURVEY HOME VISIT GUIDE

(OPTIONAL)

Name – Patient	Agency License Number

Name – Agency

Name and Discipline Observed	Date Observed	Agency Supervisor Present ☐ Yes ☐ No

Name – Surveyor(s)	Surveyor Number

Violation(s) Noted ☐ Yes ☐ No	Mileage To and From	Date – Home Visit	Start Time	End Time

List Applicable Cites

	PROBES *(Complete applicable areas only.)*	**OBSERVATIONS / COMMENTS**
Family Situation		
01	Patient lives: ☐ Alone ☐ With Spouse / Family ☐ Other	
02	Primary caregiver Is: ☐ Self ☐ Family ☐ Agency ☐ Other	
03	Family is: ☐ Supportive ☐ Unsupportive ☐ Capable as caregiver ☐ Unavailable	
Behavior / Mental Status		
	☐ Alert ☐ Oriented ☐ Responsive ☐ Non responsive ☐ Inappropriate ☐ Forgetful ☐ Depressed ☐ Anxious ☐ Assaultive ☐ Disruptive	
Patient Rights		
01	Did the agency explain your rights on admission? ☐ Yes ☐ No	
02	Do you know who is paying for your care? ☐ Yes ☐ No	
03	Have you been involved with the planning of your care / charges as they occur? ☐ Yes ☐ No	
04	Do your caregivers treat you and your property with respect and provide for your privacy? If appropriate, ☐ Yes ☐ No	
05	If you had a problem or concern about your care or caregivers, what would you do?	
Skilled, Aide, PCW Services		
01	What services does the agency provide for you? *(Circle.)* RN LPN PT OT ST SW AIDE PCW How often do they come?	
02	Has staff been prompt? ☐ Yes ☐ No Missed visits? ☐ Yes ☐ No Changed their schedule? ☐ Yes ☐ No Meeting your needs? ☐ Yes ☐ No	

	PROBES (Complete applicable areas only.)	OBSERVATIONS / COMMENTS
03	Who comes from the agency to supervise your aide / PCW? _____ How often? _____	
04	Does _____ review your care with you? ☐ Yes ☐ No	
05	Does someone: *(Use comment section.)* Set up your medications? ☐ Yes ☐ No Hand you your medications? ☐ Yes ☐ No Help obtain your medications? ☐ Yes ☐ No Apply creams, salves, etc.? ☐ Yes ☐ No Apply dressings? ☐ Yes ☐ No If so, what does _____ do for you?	
06	Are you on a special exercise / ROM program? ☐ Yes ☐ No	
07	Who developed that for you? _____ Who helps you to do this program? _____	
08	Do you feel the agency services have made a difference in the way you feel? *(Explain.)* ☐ Yes ☐ No	
09	Are you on a special diet? *(Describe.)* ☐ Yes ☐ No	
10	If your doctor orders more services or new services, e.g., PT, has the agency been able to respond quickly? ☐ Yes ☐ No	
11	Do you feel comfortable and safe when staff cares for you? ☐ Yes ☐ No	

Summary of Surveyor's Findings from Observations of Caregiver

Yes	No	N/A	Cite	Outcome	Comments
☐	☐	☐		Procedure/care plan followed	
☐	☐	☐		Standard precautions followed	
☐	☐	☐		Patient rights respected	
☐	☐	☐		Teaching appropriate	
☐	☐	☐		Medication list current	
☐	☐	☐		Medications checked and/or assisted/administered correctly	
☐	☐	☐		Assessment / observations appropriate	
☐	☐	☐		B/P P T R	
☐	☐	☐		Supervision appropriate	
☐	☐	☐		Changes in condition identified and reported appropriately	
☐	☐	☐		Other:	

Surveyor Comments: