**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Quality Assurance Page 1 of 2

F- 62652A (06/10)

**PERSONAL CARE AGENCY HOME VISIT GUIDE**

|  |  |
| --- | --- |
| Name – Patient      | Agency Approval Number      |
| Name – Agency      |
| Name of Personal Care Worker 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 | Client 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 |       |
| **Client 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 / changes 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? |       |
| 06 | Were you able to choose your personal care worker? [ ]  Yes [ ]  No |  |
| **PCW Services** |
| 01 | How often do they come?  |       |
| 02 | Has staff been prompt? [ ]  Yes [ ]  NoMissed visits? [ ]  Yes [ ]  No Changed their schedule? [ ]  Yes [ ]  NoMeeting your needs? [ ]  Yes [ ]  No |       |
| **PROBES** (Complete applicable areas only) | **OBSERVATIONS / COMMENTS** |
| 03  | Who comes from the agency to supervise your PCW?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_ |       |
| 04 | Does \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ review your care with you? [ ]  Yes [ ]  No |       |
| 05 | Does someone: *(Use comment section.)*Set up your medications? [ ]  Yes [ ]  NoHand you your medications? [ ]  Yes [ ]  NoHelp obtain your medications? [ ]  Yes [ ]  NoApply creams, salves, etc.? [ ]  Yes [ ]  NoApply dressings? [ ]  Yes [ ]  NoIf so, what does \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do for you? |       |
| 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 |       |
| 11 | Do you feel comfortable and safe when staff cares for you? [ ]  Yes [ ]  No |       |
| **Summary of Surveyor’s Findings from Observations of Personal Care Worker (PCW)** |
| **Yes** | **No** | **N/A** | **Cite** | **Outcome** | **Comments** |
| [ ]  | [ ]  | [ ]  |       | Procedure/care plan followed |       |
| [ ]  | [ ]  | [ ]  |       | Standard precautions followed |       |
| [ ]  | [ ]  | [ ]  |       | Client rights respected |       |
| [ ]  | [ ]  | [ ]  |       | Assessment / observations appropriate |       |
| [ ]  | [ ]  | [ ]  |       | Supervision appropriate |       |
| [ ]  | [ ]  | [ ]  |       | Changes in condition identified and reported appropriately |       |
| [ ]  | [ ]  | [ ]  |       | Other: |       |
| **Surveyor Comments** |