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Agency: ______________________________________________

## OASIS TRANSMISSION LOG CONTROL

*(Per regulation all OASIS assessment must be transmitted monthly)*

Year:____________

| **Month** | **Dates of Transmission** | **Troubles in connection** | **Printed Initial Feedback Report** | | **Printed Final Feedback Report** | | **OBQI (Casper) Report Printed** | | **Transmission Successful** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No | Yes | No | Yes | No |
| January | | | | | | | | | | |
| February | | | | | | | | | | |
| March | | | | | | | | | | |
| April | | | | | | | | | | |
| May | | | | | | | | | | |
| June | | | | | | | | | | |
| July | | | | | | | | | | |
| August | | | | | | | | | | |
| September | | | | | | | | | | |
| October | | | | | | | | | | |
| November | | | | | | | | | | |
| December | | | | | | | | | | |

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Comments: ______________________________________________________________

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# FALL PREVENTION LOG

Month: __________ Year: __________

| DATE | PATIENT NAME/MR # | WHY PRONE TO FALL | FALLS HISTORY | PLAN TO PREVENT FALLS | PHYSICIAN NAME | MD Notified (Y-N-N/A) |
|---|---|---|---|---|---|---|
| | | | | ☐ Inservice to Staff<br>☐ Patient/S.O. training<br>☐ In Home Safety checked<br>☐ Other, explain: | | |
| | | | | ☐ Inservice to Staff<br>☐ Patient/S.O. training<br>☐ In Home Safety checked<br>☐ Other, explain: | | |
| | | | | ☐ Inservice to Staff<br>☐ Patient/S.O. training<br>☐ In Home Safety checked<br>☐ Other, explain: | | |
| | | | | ☐ Inservice to Staff<br>☐ Patient/S.O. training<br>☐ In Home Safety checked<br>☐ Other, explain: | | |
| | | | | ☐ Inservice to Staff<br>☐ Patient/S.O. training<br>☐ In Home Safety checked<br>☐ Other, explain: | | |
| | | | | ☐ Inservice to Staff<br>☐ Patient/S.O. training<br>☐ In Home Safety checked<br>☐ Other, explain: | | |

Additional Comments: ____________________________________________________________________________________

____________________________________________________________________________________________________

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# CRITICAL TEST RESULT REPORTING

Year: __________

| DATE | TIME | PATIENT NAME/MR # | WHO'S TAKE REPORT/RESULT | CRITICAL TEST RESULT | ACTION | COMMENTS | MD Notified (Y-N-N/A) |
|---|---|---|---|---|---|---|---|
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Additional Comments: ______________________________________________________________

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## Patients on Anticoagulation

| MR # | **Patient's Name** | **Lab work** | **Date** | **Physician Communication** |
|---|---|---|---|---|
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Comments: ______________________________________________________________________

________________________________________________________________________________

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# HOSPITALIZATION LOG

| MR | Pt's Name | Hospitalization Date | Hospital/Phone | Hospital's D/C |
|---|---|---|---|---|
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Observations:

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ON-CALL REPORT / COMPLAINT REPORT

Date: ______________________ Time: __________________

Employee: _________________________________________________________________

Report related Patient: _____________________________ MR:________________

Incident:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Action taken:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

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MD reported: ____ Yes ____ No Comment:_______________________________

________________________________________

Signature

# ON-CALL LOG

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| Emp:<br>ph:<br>Date: | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
| **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** | **Emp:**<br>**ph:**<br>**Date:** |
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Observation:______________________________________________________________

_________________________________________________________________________

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# QA CLINICAL RECORDS REVIEW LOG

| Review Date | Patient/Comment | Improvement Needs |
|---|---|---|
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Comments: ____________________________________________________________________

Reviewer Name & Title: _________________________________________________________

Signature: _______________________________________ Date: _____________________

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# GRIEVANCE/COMPLAINTS LOG

| Complaint Date | Patient's Name | Complaint/Grievance | Answer/Response | Answer Date |
|---|---|---|---|---|
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Comments: ____________________________________________________________

## Patient Grievance Form

Date of Notification of the Grievance: ____/____/______

Name of the person reporting the Grievance: ___________________________________

Relationship to Patient: _____________________________________________________

Name of the Patient for Grievance: ___________________________________________

Address: _________________________________________________________________

Telephone #: (_____) ______ - ___________ Insurance #:_______________________

Date in which Grievance was Noted: _____/_____/ ________

Describe Nature of the Grievance in detail: _____________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
_____________________________________________________________________

Resolutions and/or Actions taken to address the Grievance: ______________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
_______________________________________________________________________

Was a copy of this grievance provided to the Q & I Compliance Officer: Y / N

This Grievance Case was closed and Solved by: ________________________________

On ____/____/ ______ Sign: _______________________________ Title: ________

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# Patient COMPLAINT/CONCERN Form

Date of Notification of the Complaint/Concern: ____/____/ _______

Name of the person reporting the Complaint: _________________________________

Relationship to Patient: __________________________________________________

Name of the Patient for Complaint: __________________________________________

Address: ______________________________________________________________

Telephone #: (_____) _______ - ______________ Insurance ID#: _______________

Date in which Complaint was Noted: ____/____/ ________

Describe Nature of the Complaint: ___________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
________________________________________________________________

Resolutions and/or Actions taken to address the Complaint: _____________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
__________________________________________________________________

Was a copy of this Complaint provided to the Q & I Compliance Officer? Y / N

This complaint Case was Closed and Solved by: ______________________________

On ____/____/ ______ Sign: _____________________________ Title __________

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## BIO-MEDICAL WASTE / SHARP CONTAINER CONTROL LOG

**Contract Company:** ______________________ **Contact:** ______________________ **Phone:** ______________________

| MR # | Patient's Name | CONTROL # | Address | Phone | Delivery Date | Removed Date |
|---|---|---|---|---|---|---|
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**Comment:** ______________________________________________________________

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# PHYSICIAN'S ORDER: POC, MODIFY, REINSTATEMENT, DC, ADMISSION, RECERT ORDERS MOVEMENT LOG

Month: ___________________ Year: _____________________

| MR # | Patient's Name | Type of Order (See above) | Physician's Name | MD Phone | Send by Mail-Courier-Person-Fax | Date Out | Date In |
|---|---|---|---|---|---|---|---|
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Comments: ________________________________________________________________________________

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**QUALITY ASSURANCE EVALUATION FORM**
**PATIENT / FAMILY QUESTIONNAIRE**

DATE OF EVALUATION:

NAME OF STAFF RECORDING THE EVALUATION: ______________________________

NAME OF PATIENT:

NAME OF PERSON MAKING RESPONSES:
(person being interviewed) *Rating from 1 "Disagree" - 5 "Strongly Agree"*

| QUESTIONS | ALWAYS/Good 4 - 5 | SOMETIMES 2 - 3 | NEVER 1 |
|---|---|---|---|
| 1. Did you like your nurse/aide/therapist? | | | |
| 2. Was your nurse/aide/therapist always there when she was expected to be there? | | | |
| 3. Did your nurse/aide/therapist always wear a clean uniform? | | | |
| 4. Did your nurse/aide/therapist appear to know her job? | | | |
| 5. Was your nurse/aide/therapist punctual? | | | |
| 6. Would you say the nurse/aide/therapist took good care of you? | | | |
| 7. Was your nurse/aide/therapist a good listener? | | | |
| 8. Perception of effectiveness of Care Provided: Care Plan Management, Disease Management, Pain Management, Patient's Safety, Medication Management, Infection Prevention, Fall prevention. | | | |
| 9. Your nurse/aide/therapist were always available to communicate with you? | | | |
| Other Comments | | | |

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______________________________ ______________________________
Signature of Staff Patient's Signature (optional)

**C U E S T I O N A R I O** ***(Spanish version)***

Fecha de la evaluación: _____________

Nombre del empleado haciendo la encuesta: _______________________________________

Nombre del Paciente: _________________________________________________________

Nombre de la persona dando respuesta: __________________________________________
*(Persona intervenida)*

Escala desde 1 "No estoy de acuerdo" - 5 "Estoy completamente de acuerdo"

| **Preguntas** | **Siempre/Bien 4 - 5** | **Algunas Veces 2 - 3** | **Nunca 1** |
|---|---|---|---|
| 1. Le gusto el empleado (enfermera(o), ayudante, therapista?) | | | |
| 2. Estuvo nuestro empleado siempre con usted cuando era ersperado? | | | |
| **3. Nuestros empleados siempre usaron uniformes limpios?** | | | |
| 4. Conocian nuestros empleados su trabajo? | | | |
| **5. Nuestros empleados fueron puntuales?** | | | |
| 6. Diria que nuestros empleados le dieron un buen cuidado? | | | |
| **7. Nuestros empleados oian sus opiniones?** | | | |
| 8. Evaluación del Cuidado recibido: Manejo del Plan de Cuidado, Manejo de la Enfermedad, Manejo del Dolor, Seguridad del Paciente, Manejo de los Medicamentos, Prevención de Infecciones, Prevención de Caidas. | | | |
| 9. Nuestros empleados estuvieron siempre disponible para comunicarse con usted? | | | |
| Otros comentarios | | | |

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________________________________ ________________________________
Firma de empleado Firma del paciente (opcional)

CUSTOMER SERVICE PHONE MONTHLY QUESTIONNAIRE

NAME: ____________________________ PHONE:___________________________

DATE OF CALL____________________ COORDINATOR #: ________________

SN: _______________________________ HHA:_______________________________

OTHER:___________________________  ___________________________________

1. Is the service you are receiving to your satisfaction?
   El servicio que recibe es satisfactorio?
   Yes / No   Comments : _________________________________________________
   _________________________________________________________________
   _________________________________________________________________

2A. How many times has the ______ gone this week? ____________
   Cuantas veces la _____ ha ido esta semana? __________
   (Should have gone ____________times)
   (Debe haber ido _______veces)

   B. How many times has the ______ gone this week? ___________
   Cuantas veces la _______ ha ido esta semana? __________
   (Should have gone ___________ times?
   (Debe haber ido __________ veces?
   C. How many times has the _______ gone this week? _________
   Cuantas veces la _______ ha ido esta semana? __________
   (Should have gone ____________ times)
   (Debe haber ido _________ veces

Comments :_______________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

3.Is there anything we can do to improve the service you are receiving? Yes / No
  Que pudieras hacer para mejorar el servicio que recibe? Comments: __________
  ___________________________________________________________________
  ___________________________________________________________________

************************************************************************
For official use:
Does any action need to be taken? Yes / No Comments:_________________________
_________________________________________________________________________

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QUALITY ASSURANCE FORM
PHYSICIAN QUESTIONNAIRE

Dear Dr.

We are conducting a survey on our Quality Assurance Standard. Please check the appropriate box in the questionnaire form below:

Thanks.

| ITEMS PHYSICIAN | RESPONSE | | | |
|---|---|---|---|---|
| | EXCELLENT | ABOVE AVERAGE | AVERAGE | BELOW AVERAGE |
| 1. Did agency staff display adequate knowledge and professionalism in maintaining patient records? | | | | |
| 2. Did agency staff make themselves accessible to physician when applicable? | | | | |
| 3. Were agency staff members able to communicate adequately with patient's family and to the physician? | | | | |
| 4. How would you rate overall quality of nursing care toward patients as performed by the staff of this agency? | | | | |
| 5. Other | | | | |

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Date:

Physician's signature:

## EMPLOYEE SATISFACTION SURVEY

**Circle One:** Home Health Aide LPN RN Therapy Office / Clerical Administration / Management

**Rate the areas below by marking the category that is closest to correct about your job.**

| Categories | Very Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied |
|---|---|---|---|---|---|
| **Your Job** | | | | | |
| Opportunities to use your skills and abilities | | | | | |
| Opportunities for interesting, challenging work | | | | | |
| Recognition for work well done | | | | | |
| Amount of responsibility given to you | | | | | |
| Pay in relation to job duties | | | | | |
| **Patient Care** | | | | | |
| Your daily work load | | | | | |
| Effectiveness of team approach | | | | | |
| Effectiveness of team leaders | | | | | |
| Rotation of areas | | | | | |
| Daily scheduling process | | | | | |
| Accessibility of medical supplies | | | | | |
| distribution of medical supplies | | | | | |
| number of miles driven each day | | | | | |
| frequency of after hours visits | | | | | |
| compensation for after hours visits | | | | | |
| **Communication** | | | | | |
| Opportunities to talk with administration | | | | | |
| Responses from administration | | | | | |
| Amount and quality of information received re: daily personal performance | | | | | |
| Amount and quality of information received re: annual evaluation and salary review | | | | | |
| Amount and quality of information received re: changes in personnel policies | | | | | |
| Amount and quality of information received re: Medicare regulations-changes and effect on your job | | | | | |
| Amount and quality of information received re: agency financial issues | | | | | |
| Response from administration re: suggestions/concerns | | | | | |

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| Categories | Very Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied |
|---|---|---|---|---|---|
| Amount and quality of information received re: employee benefits (vacation, sick leave, mileage reimbursement, educational opportunities, health insurance, retirement plan) | | | | | |
| **Working Conditions and Benefits** | | | | | |
| Mileage reimbursement | | | | | |
| Number of Agency in-services | | | | | |
| Physical working conditions within your work area | | | | | |
| Number of educational opportunities outside the Agency | | | | | |
| Quality of educational opportunities outside the Agency | | | | | |
| Employee suggestion/concerns procedure | | | | | |
| **On Call System** | | | | | |
| Scheduling procedure | | | | | |
| Pager system | | | | | |
| Backup system | | | | | |
| Timeframe for being on call (length) | | | | | |
| Compensation for accepting ""call"" | | | | | |
| Available of other staff to make visits | | | | | |

**Would you be interested in additional health insurance coverage for dental/vision/disability? Yes No**

Would you be interested if the premiums for this additional coverage were your responsibility? Yes No

**Do you feel that an employee Suggestion Box would be beneficial for the Agency? Yes No**

**Additional Comments:** ___________________________________________________________________________

_______________________________________________________________________________________________

**Signature (optional)** _____________________________________ **Date** ____________________

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Period from: ________________ to ______________ (Every Quarter)

**Rating** from **1** "Disagree" - **5** "Strongly Agree"      Summarize Total Patient in each Question

| Question | Always/Good | | | Sometimes | | | Never | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | 4 - 5 | % | Total | 2 - 3 | % | Total | 1 | % |
| 1. Did you like your nurse/aide/therapist? | | | | | | | | | |
| 3. Did your nurse/aide/therapist always wear a clean uniform? | | | | | | | | | |
| 4. Did your nurse/aide/therapist appear to know her job? | | | | | | | | | |
| 5. Was your nurse/aide/therapist punctual? | | | | | | | | | |
| 6. Would you say the nurse/aide/therapist took good care of you? | | | | | | | | | |
| 7. Was your nurse/aide/therapist a good listener? | | | | | | | | | |
| 8**.** Perception of effectiveness of Care Provided: Care Plan Management, Disease Management, Pain Management, Patient's Safety, Medication Management, Infection Prevention, Fall prevention**.** | | | | | | | | | |
| 9. Your nurse/aide/therapist were always available to communicate with you? | | | | | | | | | |
| 10. Other | | | | | | | | | |
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| | | | | | | | | | |
| Goals: | 90 - 100 % of Customers | | | | | | | 0 % | |

**Action Plan** if **Goals not Met**: (Indicate Responsible party, and due date)

□ Inservice to our Employees requesting reinforced in areas with problems: ______________________

□ Reinforced Punctuality and frequency ________________________________________________

□ Patient Care, Safety, Treatment need improvement ________________________________________

□ Interdisciplinary, Physician, Family/Patients Communication need improvement __________________

□ Other ___________________________________________________________________________

Evaluator/Title Name: ______________________________ Signature: _________________________

Date:___________________

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## HOME HEALTH CARE AGENCY
## STAFF CONCERN

**I. General information**

1. Date of incident ______________________________
2. Time of incident ______________________________
3. Place of incident ______________________________
4. Name of individual(s) involved in incident _________________________________
5. Date this staff concern form completed _____________
6. Time this staff concern form completed _____________

**II. Objective narrative description of incident**

________________________________________________________________________
________________________________________________________________________

**III. Description of identified problems resulting from incident**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**IV. Corrective action implemented __ Yes __ No (Explain)**

________________________________________________________________________

**V. Date corrective action implemented ________________**

**VI. Description of implemented corrective action**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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**FOLLOWING SECTION TO BE COMPLETED BY DIRECTOR OF NURSING**

**VII. Review of incident documentation**

**Review date of this completed Staff Concern form _____________**

**Review time of this completed Staff Concern form _____________**

**VIII. Description of incident investigation:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

**IX. Additional corrective action implemented __ Yes __ No (Explain)**

**X. Description of implemented additional corrective action:**

**Signature of individual completing this form** **Date**

**Signature of Director of Nursing** **Date**

**Signature of Administrator** **Date**

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# TRAINING ATTENDANCE RECORD

Date: ____________________ Inservice Title: ______________________________________

Instructor Name & Title: _______________________________________________________

Instructor Signature: ____________________________

| EMPLOYEE NAME & TITLE | SIGNATURE | COMMENT |
|---|---|---|
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Staff Collecting Attendance: _____________________________________

Signature: ________________________________ Date: ________________

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# YEARLY BLOOD PRESSURE GAUGES CHECKED
**Year: __________**

| Employee Name | Title | Checking Date | Observation Problem Detected | Correction Action if needed | Correction Date | RN Supervisor Name checking gauge | Signature |
|---|---|---|---|---|---|---|---|
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Comment: ______________________________________________________________________________

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***INFECTIOUS DISEASE REPORT FORM***

| DATE | PATIENT/EMPLOYEE ***ID NUMBER AND NAME*** | ***SOC*** | ***TYPE OF DISEASE SUSPECTED ORG.*** | ***ONSET DATE*** |
|---|---|---|---|---|
| | | | | |
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***INVESTIGATION:***

***Signature of person doing the Investigation*** ***Date***

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**PATIENT: ACQUIRE INFECTION TRACKING** **Month: ________ Year: _______**

| Med.Rec. | Pt. Name | Hospitalization | | Type Infx | Onset Date | C&S Results | Temp | Treatment | Hosp Due to current Infx | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Hospital | D/C Date | | | | | | Hospital | Doctor |
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**Observation:** ______________________________________________________________________

______________________________________________________________________

**EMPLOYEE: ACQUIRE INFECTION TRACKING** **Month: ________ Year: _______**

| Type | Emp. Name | Discipl ine | Dr. Visit (Y/N) | Medication | Other Tx | Follow required | Days Missed |
|---|---|---|---|---|---|---|---|
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**Observation:** ______________________________________________________________________________

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## *INFECTION TRACKING SUMMARY* ***Month: ______ Year: ______***

***Patient at SOC:***

**Totals: Wound _________ Respiratory _______ UTI with Foley ________**
**UTI without Foley _____ Others __________**

**Trends (same Hospital, physician, etc) ________________________________________**

________________________________________________________________________________

________________________________________________________________________________

***Patient acquired:***

**Totals: Wound _________ Respiratory _______ UTI with Foley ________**
**UTI without Foley _____ Others __________**

**Trends (same Hospital, physician, etc) ________________________________________**

________________________________________________________________________________

________________________________________________________________________________

***Employees:***

**Totals: Respiratory _______ Cold/Flu ___________ GI ___________**
**Other _____________________________________**

**Trends (same Nurse, Aide, therapist, MSW, etc) _______________________________**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

***Employee <-> Patient Trends (ie: pt with resp. infection passed to aide, then passed to secretary of team, etc):***

________________________________________________________________________________

________________________________________________________________________________

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## DISCHARGE PLANNING CONTROL LOG

Month: ___________________ Year: ___________

| MR # | Patient's Name (Active) | Assessment of Discharge Potential | | Case Conf. Discuss DC Potential / Plans for continuity of Care | POC Update Plan of Care Update | Family/Pt discussion of DC planning | AFTER DISCHARGE | | | | DISCHARGE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nursing Assessment and Care plans | POC | | | | Referral for follow support | Contac t with Pt Family after DC | Full DC - Transfer Documented MD Informed Pt Instructed | Report DON Agency any DC process problem | Date | Reason (Rehab to Pot, Hospital, etc) |
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Comments: ______________________________________________________________________________

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# PATIENT DISCHARGE FORMS ARE CHRONOLOGICALLY KEPT IN LOG

**Patient Discharge**

**Patient Name:** ____________________________________________________

**Address:** ________________________________________________________

**Phone #:** (_____) _______ - ___________

**Discharge Date:** ____/____/ _______

**SERVICES/ITEMS Discharge:** ____________________________________________

**Reasons for Discharge:**

_____ Patient Died - Date of Death if known: ____/____/____
_____ Patient Moved
_____ Patient Transferred to another HHA Provider
_____ Doctor has ordered this Discharge
_____ Non-Renewal of Services
_____ Patient Requested discharge due to Non-Satisfaction of Service - Report to Q & I Compliance Officer
_____ Patient joined HMO
_____ (Other) Specify: _________________________________

**Discharge Process by Employee:** ____________________________________ **Print**

____________________________________ **Sign**

**(Attached to the Discharge Planning, QA Manual)**

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# ANNUAL PERFORMANCE IMPROVEMENT (PI) REPORT

Year: ___________

□ Data collected as Part of the QI/PI activities including Services, Assessment, Outcomes monitoring, surveys, audits reports, etc during the year analyzed.

________________________________________________________________________________

________________________________________________________________________________

Explain the effectiveness of our PI program: ______________________________________________

□ Gather data needed for performing the analysis □ all of our staff received a performance evaluation annually

□ the number of employees involved in PI program, receive a full year Orientation/Training to improve our services/care ________________________________________________________________

□ Effectiveness, quality and appropriateness of care/services provided to the patients, according Agency's QA program, Accreditation standard ________________________________________________________

________________________________________________________________________________

□ Care/service areas and community served, including cultural diverse population ____________________

____________________________________________________ □ all staff trained in cultural diverse population

□ Any service provided under contractual arrangements (explain) ________________________________

the effectiveness was analyzed, and follow our QA/PI program ___________________________________

________________________________________________________________________________

□ Personnel utilization, staff recruitment as needed, ongoing activities __________________________

________________________________________________________________________________

□ Annually review of Policy and Procedures, update as needed following new State, Federal regulation and Accreditation Standards. Last revision: _______________________

□ Revision of the Agency Forms as needed, including the Adequate documentation under new requirements in all of our services including □ Nursing □ Therapy □ Aides □ Social Services

□ Summary of all PI Activities, data collection, findings and corrective actions

________________________________________________________________________________

________________________________________________________________________________

□ Agency Annual Evaluation done on time, approved by PAC/Board of Director

Report submitted by: _______________________________________ □ Submitted to PAC

Director of Nursing

Date: ______________________

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**PERFORMANCE IMPROVEMENT MONITORING/EVAL PLAN TRACKING SHEET** Month: ___________ Year: _________

| Priority Focus Area | Performance Meassurance/Outcome | Related Functions | Benchmark Goals | Data Collection | | | | | | PAC Informed (Y/N) Date |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Weekly Data | | | | Total Month | Significant finding | |
| Assessment and Care/Services Management of CHF | Diuresing/Weight<br>Response to diuretic Meds (Lab work)<br>Lung sounds/Edema<br>Understand Disease/Tx, response teaching<br>D/C inst./level underst. | | | | | | | | | |
| Assessment and Care/Services Pain Management | Pain level assessed in Adm.(scale)<br>Effectiveness of pain Meds<br>Effect. Of Pain management techniques<br>Communication with MD, and other team members | | | | | | | | | |
| Assessment and Care/Services Open Wound | Open wound assessed and measured in Admission<br>Open wound assessed on each visit<br>Wound care followed MD orders<br>Asseptic/clean techn. Followed. Standard Prec.<br>Documented patient/S.O. understanding wound care management | | | | | | | | | |
| Assessment and Care/Services Education, training nneds | Patient/S.O. education needs and level of understanding assessed in each visit<br>Education materials appropriate to the level of understanding | | | | | | | | | |
| Assessment and Care/Services Other: | | | | | | | | | | |

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# PERFORMANCE IMPROVEMENT OUTCOME EVALUATION

Department: Home Health

Person Making Report: ____________________

Month/Quarter Reviewed: ____________________

| Priority Focus Area (PFA) | Conclusions | Action | Evaluation of Effectiveness and Collaboration with Other Services |
|---|---|---|---|
| Assessment and Care/Service | | | |
| Patient Safety | | | |
| Communication | | | |
| Infection Control | | | |
| Management of Information | | | |
| Orientation and Training | | | |
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# PERFORMANCE IMPROVEMENT TRENDING SHEET

**Department/Committee:** ______________________________ **Date:** ____________

*PFA = Priority Focus Area

| Performance Measures/Outcomes | Interdepartmental Collaboration | Benchmark Goal | Function | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PFA:**<br>- | | | | | | | | | | | | | | | | |
| - | | | | | | | | | | | | | | | | |
| - | | | | | | | | | | | | | | | | |
| **PFA:**<br>- | | | | | | | | | | | | | | | | |
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| **PFA:**<br>- | | | | | | | | | | | | | | | | |
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| **PFA:**<br>- | | | | | | | | | | | | | | | | |
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# PERFORMANCE IMPROVEMENT

**Department/Committee:** Home Health **Year:** ____________

| Volume Measures/Statistics | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # of completed Plans of Care/Treatment sent to physician within ten (10) days of the start of care visit | | | | | | | | | | | | | |
| # of physician verbal orders signed and returned to Agency office within 30 days of receipt of the order | | | | | | | | | | | | | |
| # of patients admitted within 48 hours of referral/patient's return home/physician ordered start of care | | | | | | | | | | | | | |
| # of patients readmitted | | | | | | | | | | | | | |
| # of patients readmitted for exacerbation of diagnosis | | | | | | | | | | | | | |
| # of medication errors | | | | | | | | | | | | | |
| # of medication adverse reactions | | | | | | | | | | | | | |
| # of patient falls | | | | | | | | | | | | | |
| # of patients assessed at risk of falls due to medications | | | | | | | | | | | | | |
| # of patients assessed at risk of falls not due to medications | | | | | | | | | | | | | |
| # of patients assessed as being at nutritional risk are provided a referral to a Registered Dietitian | | | | | | | | | | | | | |

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# PERFORMANCE IMPROVEMENT

**Department/Committee:** Home Health **Year:** ____________

| Volume Measures/Statistics | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # of infections acquired following admission to Agency | | | | | | | | | | | | | |
| # of patients admitted for therapy | | | | | | | | | | | | | |
| # of patients with improved ambulation | | | | | | | | | | | | | |
| # of patients recertified | | | | | | | | | | | | | |
| # of visits | | | | | | | | | | | | | |
| # of scheduled visits (all disciplines) | | | | | | | | | | | | | |
| # of missed visits | | | | | | | | | | | | | |
| # of unscheduled (extra) visits | | | | | | | | | | | | | |
| # of visits by Agency staff (all disciplines) | | | | | | | | | | | | | |
| # of visits by contracted staff | | | | | | | | | | | | | |
| # of staff sick calls | | | | | | | | | | | | | |
| # of days per diem staff used | | | | | | | | | | | | | |
| # of patient complaints | | | | | | | | | | | | | |
| # of admissions to Agency | | | | | | | | | | | | | |

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# PERFORMANCE IMPROVEMENT

**Department/Committee:** Home Health **Year:** ____________

| **Volume Measures/Statistics** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Totals** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # of total discharges from Agency with all goals met | | | | | | | | | | | | | |
| # of patients assessed for pain | | | | | | | | | | | | | |
| # of patients requiring pain management modalities | | | | | | | | | | | | | |
| # of acquired wound infections following admission to Agency | | | | | | | | | | | | | |
| # of wound care patients | | | | | | | | | | | | | |
| # of Medication Profiles completed according to Agency policy | | | | | | | | | | | | | |
| # of supervisory visits completed within appropriate time frames | | | | | | | | | | | | | |
| # of staff competence evaluations completed during probationary period | | | | | | | | | | | | | |
| # of staff annual competency evaluations completed | | | | | | | | | | | | | |
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# PERFORMANCE IMPROVEMENT OUTCOME MONITORING

**Patient Safety Goal:** Accurately and Completely Reconcile Medications Across the Continuum of Care **Date:**

| Performance Measures/Outcomes | Method | Volume Measure/ Numerator | Benchmark / Goal | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - # of patient admission forms/ medication reconciliation forms sent to Medical Record without complete list of current patient/resident/ client medications | QA Department review of medical record and patient drug profile | # of admissions per month | 0/# of admissions<br>0% | | | | | | | | | | | | | |
| - # of Discharge Instruction Sheets without complete listing of medications upon discharge | Random medical record review | 20 records per month | 0/20<br>0% | | | | | | | | | | | | | |
| - # of Transfer Summaries without complete listing of medications at time of patient/resident/ client transfer | Random medical record review | 20 records per month | 0/20<br>0% | | | | | | | | | | | | | |
| - # of medication errors related to lack of information about patient's current medication regimen | QA/PI Reporting<br>(incident reporting) | # of errors related to lack of patient information per total # of errors reported | 0/# of incidents<br>0% | | | | | | | | | | | | | |
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# PERFORMANCE IMPROVEMENT OUTCOME MONITORING

**Patient Safety Goal:** Reduce the Risk of Healthcare-Associated Infections **Date:** ____________

| Performance Measures/Outcomes | Method | Volume Measure/ Numerator | Benchmark / Goal | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - # of times random observation identified staff member not following hand hygiene protocol | Random physical observation of clinical staff members<br><br>Total = total observations per month<br><br>Observations conducted by supervisor or designee | # of times protocol breached/ # of observations | 0/# of observations<br><br>0% | | | | | | | | | | | | | |
| - # of hand rub solution dispensers noted to be empty during random inspection | Random physical inspection of hand washing tech<br><br>Total = total inspections per month<br><br>Observations conducted by supervisor or designee | # of follow techniques<br><br># of inspections | 0/# of inspections | | | | | | | | | | | | | |
| - Volume of hand rub solution usage measurements are above baseline | Monthly solution volume measurement<br><br>Total solution volume per patients/visit | # of times volume above baseline | 0/1000 patient/visit | | | | | | | | | | | | | |
| - # of clinical staff members identified with natural nails over one-quarter (1/4) inch in length | Random observation of clinical staff per month<br><br>Observations conducted by supervisor or designee | # of staff members with nails over one-quarter (1/4) inch in length | 0/# of observations | | | | | | | | | | | | | |

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# PERFORMANCE IMPROVEMENT OUTCOME MONITORING

**Patient Safety Goal:** Reduce the Risk of Healthcare-Associated Infections **Date:** ______________

| Performance Measures/Outcomes | Method | Volume Measure/ Numerator | Benchmark / Goal | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - # of staff with artificial nails in high-risk patients (Infection disease patients, bloodborne, other) | Random observation of clinical staff per month<br><br>Observations conducted by supervisor or designee | # of staff members with artificial nails | 0/# of observations | | | | | | | | | | | | | |
| - # of healthcare associated-infections | Infection Control Surveillance reporting monthly per unit | # of discharges<br>+<br># of clean cases | 0/total volume | | | | | | | | | | | | | |
| - # of sentinel events related to healthcare associated-infection | Cases reported<br><br>(incident reporting)<br><br>Infection Control reporting | # of sentinel events/<br><br>discharges | | | | | | | | | | | | | | |

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# PERFORMANCE IMPROVEMENT OUTCOME MONITORING

**Patient Safety Goal:** The Organization Identifies Safety Risks Inherent in its Patient Population
Home Fires Associated with Use of Long Term Oxygen Therapy

**Date:** ____________

| Performance Measures/Outcomes | Method | Volume Measure/ Numerator | Benchmark Goal | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - # of home fires related to oxygen therapy | Incident Reports | # of home fires/total volume | 0% | | | | | | | | | | | | | |
| - # of times physicians notified for patients who are noncompliant with fire safety measures | Incident Reports | # of physician notified/total volume | 0% | | | | | | | | | | | | | |
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# Quality Improvement & Assurance Forms & Adverse Events

**Q & I Indicator Project Name & Process: ________________________________**

1. **Problem Statement: Will we get positive referrals from our existing patients?**
2. **Hypothesis: We anticipate an overall favorable opinion.**
3. **Experiment: Send to ALL Patients by a satisfaction survey form along with letter of explanation and self addressed stamped envelope.**
4. **Process: This Q & I evaluation for the indicator of "customer service survey" will be conducted during a 90 day period and then a conclusion will be determined based on ratio-percentages according to the total response from the received patent letters.**
5. **Results: This study will be presented to the Governing Body by the Q & I Compliance Officer and if necessary the implementation of new policies and procedures will be adopted.**

---

**Process In Detail:**

**Letters Sent: ________**
**30 day follow up for unanswered letters: _______**
**60 day follow up for unanswered letters: _______**
**80 day follow up for unanswered letters: _______**
**85 day mark begin totaling responses received**
**90 day mark schedule meeting with Governing Body for Results**
**Implement new policies & procedures if applicable**

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# CLINICAL RECORD AUDIT RESULTS AND TREND

Clinical audit is about measuring the quality of care we provide against relevant standards. If we are failing to meet these standards, the audit should help us understand the factors that are causing us to fail, so that we can set priorities and make improvements.

**Instructions:** Auditing forms part of a cycle of activities:

Selecting standards (setting our own or adopting existing standards or guidelines), Doing the audit (or analyzing the results of ongoing monitoring) and identifying where we are failing to meet standards, Identifying the factors causing us to fail, setting priorities, and taking actions to improve what we do. Checking whether we have improved (by doing a full re-audit or by monitoring one or two indicators, for example, visual outcome or patient numbers) and finding other solutions if we have not improved. If we have improved, repeating the cycle to identify and address the next set of problems or to measure ourselves against a new set of standards.

Every time an audit cycle is completed, there should be further improvement in patient care.

**Clinical Audit results: Quarter: ____________________ Year: _______________**

| STANDARD | Analyzing the results Ongoing Monitoring | Fail reason, Priorities | Action taking to improving | Results of audition Trends/Outcomes |
|---|---|---|---|---|
| Assessment on time/Quality | | | | |
| Plan of Care compliance for all disciplines (Nursing, Therapy, Aides) | | | | |
| Safety issues, Fall prevention | | | | |
| Infection Control/Handwashing | | | | |
| Disease / Pain Management | | | | |
| Patient response to instructions, teaching | | | | |
| Diabetes Management | | | | |
| Agency Clinical Records State/Federal/Accreditation standards compliance | | | | |
| Discharge Planning | | | | |
| Patient complaints, feedback, follow up care referrals | | | | |

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Director of Nursing signature/Date: ____________________________________________

Discussed in Clinical Record Review Committee on: __________________ Discussed in the PAC meeting on: ___________________

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# INCIDENT - ACCIDENT REPORT

Date Reported: ____/____/ __________ Incident Date: ____/____/ __ ___

Report Number: _________________ Report Taken By: _________________________

Person making the report: ___________________________________________________

Patient Name: _____________________________________________________________

Address: _________________________________________________________________

Phone Number: (_____) ______ - ___________ Insurance ID#: _______________

Description of Incident: _____________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

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________________________________________________________________

Action Plan:

1. ______________________________________________________________________

2. ______________________________________________________________________

3. ______________________________________________________________________

4. ______________________________________________________________________

This Incident / Accident was reported to Compliance Officer on:

____/____/ ______ Name of C/O: __________________________________________

Compliance Officer Notes: ____________________________________________________

_________________________________________________________________________

_________________________________________________________________________

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# INCIDENT REPORT

**CONFIDENTIAL:** Place into sealed envelope and route to Director of Patient Care Services within 24 hours. **Note:** Employee Injuries sent to Human Resources Dept.

Patient/Person Involved: ___________________________________________
MR#: _______________ DOB: _____________________ Sex: ______

Address: ______________________________ City/State/Zip: ________________

Date of Occurrence: ___________________________ Time of Occurrence: ______

Person Completing Report: ______________________ Date Report Filed: _________

☐ Patient ☐ Employee ☐ Family Member ☐ Other: ______________________

**Check Applicable Event:**

☐ Hospital Admission
☐ AMA
☐ Cardiopulmonary Arrest
☐ Abusive Behavior:
- ☐ Patient
- ☐ Family Member

☐ Medication Problem:
- ☐ Missed Dose
- ☐ Incorrect Dose
- ☐ Incorrect Medication

☐ Equipment Failure
Lot # _______ Tracking # ________
☐ Fall ☐ Staff in home ☐ No staff present
☐ Infusion Equipment Problems
☐ Employee Injury
☐ Employee Property Missing/Damaged
☐ Patient Injury
☐ Patient Property Missing/Damaged
☐ Untoward Reaction to Treatment/Procedure
☐ Wound Disruption
☐ Other: _____________________________

Describe the event, effects, outcome and potential risk issue (name equipment, drug, procedure, treatment, etc. if applicable)

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_________________________________________________________________

**For PI Director Use Only:** Date Received: _____________

Effect:
☐ Trending
Medical Lega: Date Field ___________
☐ Inconsequential ☐ Consequential ☐ Non-existing/Unknown

Comments: _________________________________________________________
_____________________________________________________________________
___________________________________________________________________

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# ETHICAL INCIDENT REPORT

**Date Reported: ____/____/ ______** **Ethical Incident Date: ____/____/ ______**

**Report Number: ________________** **Report Taken By: _______________________**

**Person making the report:_________________________________________________**

**Patient name: ____________________________________________________________**

**Address: ________________________________________________________________**

**Phone Number: (_____) _______ - _________** **Insurance ID #: ______________**

**Description of Ethical Incident:**

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
_________________________________________________________________

**Action Plan:**

**1.** ______________________________________________________________________

**2.** ______________________________________________________________________

**3.** ______________________________________________________________________

**4.** ______________________________________________________________________

**This Ethical Incident was reported to Compliance Officer on:**

**____/____/ ______ Name of C/O: ___________________________________________**

**Compliance Officer Notes: _______________________________________________**

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# INFECTION CONTROL INCIDENT REPORTING FORM

**Date Reported: ____/____/ ______**

**INFECTION CONTROL Incident Date: ____/____/ ________**

**Report Number: ______________ Report Taken By: ________________________**

**Person making the report: __________________________________________________**

**Patient Name: ______________________________________________________________**

**Address: __________________________________________________________________**

**Phone Number: (____) ______ - ______________ Insurance ID #: ______________**

**Description of Infection Control Incident:**

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
______________________________________________________________________

**Action Plan:**

**1.** ________________________________________________________________________

**2.** ________________________________________________________________________

**3.** ________________________________________________________________________

**4.** ________________________________________________________________________

**This Infection Control Incident was reported to Compliance Officer on:**

**____/____/ ______ Name of C/O: ______________________________________**

**Compliance Officer Notes: __________________________________________________**

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**EMPLOYEE EXPOSURE INCIDENT**

NAME OF EMPLOYEE: ____________________________________________________________

JOB CATEGORY: _________________________________________________________________

DATE OF EXPOSURE INCIDENT: _____________________________________________________

ROUTE OF EXPOSURE: ____________________________________________________________

_______________________________________________________________________________

CIRCUMSTANCES OF EXPOSURE INCIDENT: __________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

SOURCE INDIVIDUAL:

1. Name: _____________________________________________________________________

2. Address: __________________________________________________________________

   __________________________________________________________________

3. Telephone #: _______________________________________________________________

4. _____ Client

5. _____ Other (explain) ______________________________________________________

_______________________________________________________________________________

6. Known to be infected:
   HBV _____ Yes _____ No _____ Not Known

7. Blood Test obtained (Not needed if source individual is known to be infected.)
   _____ Yes
   _____ No/legally required consent cannot be obtained

8. If blood test obtained - results of the test:
   HBV ___________________________________________________________
   HIV ___________________________________________________________

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**INCIDENT/OCCURRENCE REPORT**
(Use Additional Pages if Needed)

___ PATIENT OCCURRENCE ____ EMPLOYEE OCCURRENCE

EMPLOYEE NAME/SOC. SEC.# ______________________________________________________
PATIENT NAME/ADDRESS __________________________________________________________
OTHERS ASSIGNED ________________________________________________________________
DATE OF OCCURRENCE _____________________________________________________________
NOTIFICATION DATE ______________________________________________________________
LOCATION OF OCCURRENCE _________________________________________________________
WITNESSES ______________________________________________________________________

TYPE OF OCCURRENCE: Describe the occurrence and how it occurred. List all people involved or aware of the occurrence.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

INTERVENTION: Describe in detail how the Agency handled this occurrence i.e. MD referral, treatments, medications, referrals, police notification, etc. List reports which were filed.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

FOLLOW-UP: Describe in detail the follow-up, medical treatment. Agency or police action provided.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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______________________________________________________________________________
______________________________________________________________________________

DISPOSITION: Describe in detail how this case has been resolved. If indicated, state when/if employee can return to work.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

DATE OF RESOLUTION _____________________ DATE CASE CLOSED _____________________

EMPLOYEE SIGNATURE/DATE ___________________________________________________________

SUPERVISOR SIGNATURE/DATE _________________________________________________________

ACTION TO PREVENT SIMILAR OCCURRENCE:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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## MEDICAL DEVICE INCIDENT REPORT FORM:

**Device Description:** ____________________________________________________

**Brand Name/Model:** __________________________ **Serial No. Lot:** _____________

**Is the Device or package available for Inspection:** __ **Yes** __ **No**

**Company Supplier Information:** ___________________________________________

**Contact Person:** ______________________________ **Phone:** __________________

**Have the patient report the problem to other parties:** ___ **Yes** ___ **No**

**If yes, Provide the Name of the Company/Persons:**___________________________

______________________________________________________________________

______________________________________________________________________

**Phone:** ________________________ **Date of Report:** __________________________

**Problem Description:** ____________________________________________________

______________________________________________________________________

______________________________________________________________________

**Consequences of the Problem:** ____________________________________________

______________________________________________________________________

______________________________________________________________________

**Person taking the Report:** ________________________________________________

**Signature:** _____________________________ **Date:** _________________________

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INCIDENT REPORT (Risk Management)

**Incident Description:**________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

☐ **Negligence** ☐ **Abandonment** ☐ **Work Delegation Problem** ☐ **Staffing Level**

☐ **Staff Competency** ☐ **Documentation Problem** ☐ **Other** ____________________________

______________________________________________________________________________

**Patient Name:** _________________________________ **Med. Record:** ____________________

**Agency/MD Notified:** __ **Yes** __ **No, if Yes, Date:** _________________ **Time:** ______________

**Physician Name:** _______________________________________ **Ph:** ______________________

**Agency Staff notified:** ___________________________________ **Date:** ____________________

**Have the patient report the problem to other parties:** ___ **Yes** ___ **No**

**If yes, Provide the Name of the Company/Persons:**______________________________________

______________________________________________________________________________

______________________________________________________________________________

**Phone:** _________________________________ **Date of Report:** __________________________

**Problem Description:** ___________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Consequences of the Problem:** _____________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Action Taking:** _________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Person/Title making the Report:** ____________________________________________________

**Signature:** ______________________________________ **Date:** _________________________

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**INCIDENT REPORT - FALLS**

Patient ___________________________________ Date of Fall _______________________

Number of falls in past 3 months: ________________ Witnessed by Agency staff? Yes No

Location of fall: Bathroom Bedroom Other:___________________________________________

Contributing Factors:

Transferring Lost Balance Fell out of bed Fell out of chair

Dizzy Did not use assistive device Mental Status changes

Clutter in fall area Throw rug/loose rug Lack of adaptive equipment

Water on floor Improper foot wear Trip hazard - wires, catheter, etc.

Describe the fall and situation surrounding the fall:_____________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Ortho BP check done Sitting/Lying_______________ Standing __________________________

Injury: _________________________________________________________________________

None Noted Possible Fracture Altered level of consciousness

Bruising Soreness Pain

Skin tear/laceration Abuse/neglect suspected?

Describe injury and treatment: _____________________________________________________

Dr. notified? Yes No Response ____________________________________________________

Education Provided _____________________________________________________________

Need for use of assistive device and/or supervision Request for PT Referral

_______________________________________________________________________________

Orthostatic hypotension precautions Request for OT Referral

_______________________________________________________________________________

Environmental Changes Needed Request for SW Referral

_______________________________________________________________________________

Request for Dietician Referral _____________________________________________________

Other:__________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Staff member signature: ______________________________________ Date: ______________

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# MEDICATION ERROR/INCIDENT REPORT

Patient: ____________________________________________ Date of Birth___/___/___

Staff/Services: ________________________________________ Med. Rec.#:____________

Medications_________________________________________ Dosage_______________

Medications_________________________________________ Dosage_______________

Time Medication to be administered___________________________________________________

Date of Incident____________________________________________________________________

Reason for Report: Missed medication, wrong medication, etc. Give a detailed report as to how incident happened:

_____________________________________________________________________________________

_____________________________________________________________________________________

_______________ ___________________________________________________________________

Action Taken/Intervention: ___________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Describe how this incident could be avoided in the future: __________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Name of caregiver/guardian who was notified:___________________________________________

Time/date of notification:____________________________________________________________

Name of Patient's Physician who was notified:__________________________________________

Time/date of notification:____________________________________________________________

Printed name of person preparing report_______________________________________________

Signature of person preparing report__________________________________________________

Follow up contact/care:______________________________________________________________

_____________________________________________________________________________________

Agency's Director of Nursing/Administrator signature_____________________________________

Date: _____________

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# UTILITY SYSTEMS TESTING VERIFICATION TRACKING FORM

______ Computer Back Up System
______ Fire Extinguisher & Expiration Date
______ Smoke Detectors
______ Burglar Alarm (if applicable)
______ Emergency Exits
______ Lighting for Exits
______ Lighting within Office & Warehouse
______ Telephone back up (non powered direct line phone)
______ Back up Energy (Generator if applicable)
______ Other: ______________________________________________

**Fire Drill: Date ____/____/ _______** **Time of Drill: _______________**

**Drill Sergeant: ______________________________** **Time to exit: _________**

**Notes and observations:**
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
____________________________________________________________________

**Q & I Officer Sign: ___________________________________ Date: ___/____/ _____**

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## OUT GOING REFERRALS ARE DOCUMENTED IN CHRONOLOGICAL ORDER IN LOG

| Ref. Date | Patient Name | Reason for Referral | Referred to: | Initials |
| --- | --- | --- | --- | --- |

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# PATIENT TRANSFERS ARE CHRONOLOGICALLY KEPT IN LOG

| Date of Transfer | Patient Name | Attending Physician | Transferred to: |
|---|---|---|---|
| | | | |

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# LICENSURE VERIFICATION FOR STATE LICENSED PROFESSIONALS

https://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP

| DATE | NAME OF EMPLOYEE VERIFYING INFO | NAME OF LICENSE | TYPE LIC | STATUS |
| --- | --- | --- | --- | --- |
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# INCOMING NEW INVENTORY

| DATE | ITEM DESCRIPTION | MFG | SERIAL # | LOT # | EXP. DATE | PURCHASED FROM |
|---|---|---|---|---|---|---|

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# INCOMING NEW MEDICAL SUPPLY INVENTORY

| DATE | ITEM DESCRIPTION | MFG | SERIAL # | LOT # | EXP. DATE | PURCHASED FROM |
|---|---|---|---|---|---|---|

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# EMPLOYEE TRAINING FORM FOR EQUIPMENT CLEANING & MAINTENANCE

| EMPLOYEE NAME | SIGNATURE | DATE TRAINED | INSTRUCTOR |
| --- | --- | --- | --- |
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**NOTES: ITEMS(S) DISCUSSED IN TRAINING:**

# OFFICE STORAGE AREA WEEKLY CLEANING & MAINTENANCE RECORD

| EMPLOYEE | DATE CLEANED | AREA | SOLUTION USED | PROCEDURE |
|---|---|---|---|---|

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APPENDIX C: SUPPORT MATERIAL

## *PATIENTS WHO NEED CONTINUED SERVICES DURING AN EMERGENCY* (Prioritized List)

| Med. Rec. | Patient's Name and Address | Phone | Actual Main Services | How services will continue | Special needs shelter (Y/N) Name/ Address / Phone | Medication Equipment list updated (Y/N) | Pt needs to be transferred (Y/N) | Receive Skilled Care (Y/N) |
|---|---|---|---|---|---|---|---|---|
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Category: _________

Observation:________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

AHCA Form 3110-1022 Revised 6/24/2009 to conform to Law changes in 381.0303 F.S. 7/1/2008
Revised 7/1/2009 to conform to Law changes in 408.821 F.S.
Form Available at: http://ahca.myflorida.com

## EMERGENCY MANAGEMENT: HAZARD VULNERABILITY ANALYSIS WORKSHEET

Rate on scale of 5-1
5 being the highest possibility of occurrence or the weakest resources
1 being the least likely to occur or the strongest resources
See www.fema.gov for explanation of categories

| Type of Emergency/Disaster | Probability of Emergency Occurring | Human Impact | Impact on Property | Impact on Business | Internal Resources Available | External Resources Available | Total |
|---|---|---|---|---|---|---|---|
| Acts of terrorism (includes extensive physical damage and loss of life) | | | | | | | |
| Bioterrorism | | | | | | | |
| Blizzard | | | | | | | |
| Bomb Threat | | | | | | | |
| Chemical Terrorism | | | | | | | |
| Civil Disorder Incident (riot,strike) | | | | | | | |
| Earthquake | | | | | | | |
| Epidemic, External | | | | | | | |
| Epidemic, Internal | | | | | | | |
| Explosion | | | | | | | |
| Fire | | | | | | | |
| Flood | | | | | | | |
| Hail Storm | | | | | | | |
| Hazardous Material Incident-Decontamination | | | | | | | |
| Hazardous Material Incident-Nuclear Incident | | | | | | | |
| Hazardous Material Incident-Radiological Events | | | | | | | |
| Heat | | | | | | | |
| Hostage Event | | | | | | | |

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| Type of Emergency/Disaster | Probability of Emergency Occurring | Human Impact | Impact on Property | Impact on Business | Internal Resources Available | External Resources Available | Total |
|---|---|---|---|---|---|---|---|
| Hurricane | | | | | | | |
| Ice Storm | | | | | | | |
| Infant Abduction | | | | | | | |
| Landslide | | | | | | | |
| Mass-Casualty Incident | | | | | | | |
| Thunderstorm | | | | | | | |
| Tornado | | | | | | | |
| Transportation Accident | | | | | | | |
| Utility Failure-Communications | | | | | | | |
| Utility Failure-Electrical | | | | | | | |
| Utility Failure-Generator | | | | | | | |
| Utility Failure-HVAC | | | | | | | |
| Utility Failure-Medical Gas | | | | | | | |
| Utility Failure-Medical Vacuum | | | | | | | |
| Utility Failure-Natural Gas | | | | | | | |
| Utility Failure-Sewer | | | | | | | |
| Utility Failure-Steam | | | | | | | |
| Utility Failure-Telephones | | | | | | | |
| Utility Failure-Water | | | | | | | |
| Workplace Violence | | | | | | | |

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# MONTHLY CHECKS OF FIRE EXTINGUISHERS

Agency: ______________________________ Year: ____________

| Extinguisher Location | Enter Checks Date each month | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan. | Feb. | March | April | May | June | July | August | Sept. | Oct. | Nov. | Dec. |
| | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review |
| | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review | Date: ______<br>☐ Good, no signs of wear<br>☐ Needs review |

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Date of Annual External Review by authorized Fire Prevention Company: ____________________

Comments: ______________________________________________________________

______________________________________________________________

Approved by Administrator: ______________________ Date (quarterly): __________ __________ __________ __________