IN-HOME CARE FOCUS SURVEY
CLIENT Record Review

Agency: _____ Date: _____ Surveyor: _____ Client #: _____

Name of Client:	
Start of Service Date:	
Client's Date of Birth:	**M** □ **F** □
Significant diagnoses, conditions, or problems:	

Disclosure Statement & Clients Rights: Accurate/complete, signed/dated by client or rep, and includes: 333-536-0055(2) (a) A description of the license classification, services offered by the agency, extent of registered nurse involvement in the agency's operations and whether nursing services as described in OAR 333-536-0080 are provided; (b) If the agency provides medication reminding or medication services, the qualifications of the individual(s) providing oversight of the agency's medication administration systems and the medication training and demonstration; (c) A clear statement indicating that it is not within the scope of the agency's license to manage the medical and health conditions of clients who are no longer stable or predictable; (d) The qualifications /training requirements determined by the agency for individuals providing direct client care; (e) The charges for the services provided by the agency; (f) A description of how the service plans are developed and reviewed and the relationship between the service plans and the cost of services; (g) A description of billing methods, payment systems, and due dates; (h) The policy for client notification of increases in the costs of services; (i) The agency's refund policy; (j) Criteria, circumstances, conditions which may result in termination of services by the agency and client notification of such; (k) Procedures for contacting agency administrator or designee during all of the hours during which services are provided; and (l) A copy of the client's rights as written in OAR 333-536-0060.	

Current Service Plan: Specifies client-specific tasks to be conducted. 333-536-0065	
Current Service Plan: Includes pertinent information about client's function and needs. 333-536-0065	

Current Service Plan Changes: Changes to service plan documented and communicated. 333-536-0065	
Names of CGs for client: List individuals providing services for this client	
Medication Reminders: Is this client receiving medication reminders?	Circle one: **YES** **NO** (skip next question)
Self-Direct Medication Reminder form: If provided, is client evaluated at start of service and every 90 days. 333-536-0045	
Initial Site Visit: Conducted between the 7th and 30th day after start of service. 333-536-0065	
Monitoring Visits: Conducted quarterly. List dates. 333-536-0065	
Monitoring Visits: Documentation reflects whether: 333-536-0065(9) (a) Appropriate and safe techniques have been used in the provision of care; (b) The service plan has been followed as written; (c) The service plan is meeting the client's needs or needs to be updated; (d) The caregiver has received sufficient training for the client; (e) The client is satisfied with his or her relationship with the caregiver(s); and (f) Appropriate follow-up is necessary for any identified issues or problems.	
Documentation of all services provided: Paper and electronic records reflect provisions of all services. 333-536-0085	

If Medication Services provided complete this section:	Circle one: **Assistance** **Administration** **Set-up Only**
Medication Services reflected in Service Plan: Service plan specifies the medication services and tasks to be provided and who is responsible for the tasks. 333-536-0075	
Medication Set-up by client or family: Signed agreement from client, rep or family, includes list of medications and physical description of each with special instructions. 333-536-0075	
Medication Services Physician Orders: Written and telephone orders accurate/complete and appropriately signed and dated. 333-536-0075	
All Medication Services documented: Paper and electronic records reflect provision of all medication tasks and services including filling of secondary containers (set-up) and medication assistance. 333-536-0085	
Medication Administration documented on MARs to include for EACH medication at least: 333-536-0075(6) *Name with strength; *Dosage; *Route; *Frequency; *Client specific instructions for PRNs; and *Other special instructions necessary for safe and appropriate administration. *The MAR shall also identify and list the client's medication allergies and sensitivities.	
Medication Services: Integrity and security of narcotics and controlled substances maintained and documented. 333-536-0075	
RN Evaluation of client's med regimen: Conducted & documented every 90 days 333-536-0075	

If Nursing Services provided complete this section:	Circle all that apply: **RN provides LPN provides CG provides del. tasks**
Nursing Services reflected in Service Plan: Service plan specifies the nursing services tasks to be provided and who responsible for tasks. (333-536-0080)	
Nursing Services Physician Orders: Written and telephone orders accurate/complete and appropriately signed and dated. (333-536-0080)	
Nursing Services documented: Paper and electronic records reflect provision of all nursing tasks and services including those provided by RNs, LPNs, and delegated tasks by CGs. (333-536-0085)	
When Delegated Tasks provided: Name of RN responsible for the delegation and specify delegated task(s).	
RN Delegation doc. per OSBN OARs in Chapter 851, Division 047, including: *Assessment of client condition; *Rationale for deciding that the task of nursing care can be safely delegated; *Skills, ability and willingness of the unlicensed person; *Teaching of the task to the unlicensed person; *The written instructions left for the unlicensed person; *Evidence that the unlicensed person was instructed that the task is client specific and not transferable to any other client; *How frequently the client should be re-assessed by the RN for continued delegation; *How frequently the unlicensed person should be supervised and re-evaluated by the RN; *A statement that the RN takes responsibility for delegation of the task to the unlicensed person and for continued supervision. (OSBN OARs in Chapter 851, Division 047)	
RN Reassessment of client and Supervision/Reevaluation of CG: *Within 60 days of initial delegation; *Thereafter at intervals at intervals not longer than 180 days. (OSBN OARs in Chapter 851, Division 047)	
Changes to Delegation of Tasks: Delegations rescinded or transferred in accordance with OSBN OARs in Chapter 851, Division 047.	

IN-HOME CARE FOCUS SURVEY
PERSONNEL Record Review

Agency _____ **Date** _____ **Surveyor**_____ **Employee #**_____

Employee's name	
Employee's title	
Circle: CNA CMA RN LPN - Is OSBN lic/cert. current? 333-536-0050(9)	
Date of hire	
Date started providing care/services to clients	
Clients in sample to whom services provided (initials or identifier)	
Caregiver training: Date completed and includes at least: 333-536-0070(4)(a) (A) Caregivers' duties and responsibilities; (B) Recognizing and responding to medical emergencies; (C) Dealing with adverse behaviors; (D) Nutrition and hydration, including special diets, meal preparation and service; (E) Appropriate and safe techniques in personal care tasks; (F) Methods and techniques to prevent skin breakdown, contractures, and falls; (G) Hand washing and infection control; (H) Body mechanics; (I) Maintenance of a clean and safe environment; and (J) Fire safety and non-medical emergency procedures.	
Competency evaluation: Methods and date completed 333-536-0070(4)	
Medication training: Date completed and includes at least: 333-536-0075(10)(a) (A) Medication abbreviations; (B) Reading medication orders and directions; (C) Reading medication labels and packages; (D) Setting up medication labels and packages; (E) Administering non-injectable medications: (i) Pill forms, including identification of pills that cannot be crushed; (ii) Non-injectable liquid forms, including those administered by syringe or dropper and eye and ear drops; (iii) Suppository forms; and (iv) Topical forms. (F) Identifying and reporting adverse medication reactions, interactions, contraindications and side effects; (G) Infection control related to medication administration; and (H) Techniques and methods to ensure safe and accurate medication administration.	
Medication competency evaluation: Methods, including return demonstration, and date completed 333-536-0075(10)	
Continuing Education: Minimum 6 hrs annually 333-536-0070(5)	
If CG provides medication administration: One additional hour of CE related to medications 333-536-0070(5)	

Criminal records check vendor's name & state where business located:	
If Oregon DHS Background Check Unit is not used, the CRC vendor meets qualifying criteria in 333-536-0093: **(6)(b)(A)** Accredited by the National Association of Professional Background Screeners (NAPBS) **OR** **(6)(b)(B)** (i) Has been in business for at least 2 yrs; (ii) Has a current business license & private investigator license if required in the company's home state; and (iii) Maintains an errors and omissions insurance policy in an amount not less then $1 million.	

If hire date on or after October 1, 2012 was criminal records check completed prior to hire date? 333-536-0093(2)	
If hire date before October 1, 2012 was CRC completed as required? 333-536-0093(12)(13)	

CRC includes required elements: 333-536-0093(8) **Name & address history trace conducted**	
Records correctly identified via date of birth and social security number trace	
Local check conducted, including city and county records for last seven years	
Nationwide multi-jurisdictional search, including state and federal records	
Nationwide sex offender registry search completed	
Name & contact information of vendor	
Arrest, warrant & conviction data including charges, jurisdiction, & date	
LEIE (List of Excluded Individuals and Entities) query conducted and documented? 333-536-0093(9)	

Were there ORS 443.004(3) crimes identified? 333-536-0093(3)	
If crimes other than ORS 443.004(3), or if other potentially disqualifying conditions were identified, was weighing test conducted and documented? 333-536-0093(4)	

IN-HOME CARE FOCUS SURVEY
QAPI/Complaint Process Review

Agency _____ **Date** _____ **Surveyor**_____

Agency Staff Interviewed_____

1. Quality Assessment and Performance Improvement Program

Met	Not Met	Requirement(s)	Notes
		QAPI Program: establish and maintain an effective, agency wide quality assessment and performance improvement program that evaluates and monitors the quality, safety and appropriateness of services provided by the agency, and shall include at a minimum: 333-536-0090(1-4)	
☐	☐	A method to identify, analyze and correct adverse events;	
☐	☐	A method to select and track quality indicators by high risk, high volume, problem prone areas and by the effect on client safety and quality of care;	
☐	☐	The quality improvement activities shall be conducted by a committee comprised of, at a minimum, agency administrative staff, an agency caregiver, and if the agency is classified as an intermediate or comprehensive agency, an agency registered nurse; and	
☐	☐	Quality improvement activities shall be conducted and documented at least quarterly.	

2. Complaint and Grievance Process

Met	Not Met	Requirement(s)	Notes
		Complaint Process: Ensuring the timely internal investigation of complaints, grievances, accidents, incidents, medication or treatment errors, and allegations of abuse or neglect involving individuals providing services for the agency 333-536-0050(8)(i)	
☐	☐	An agency shall maintain in its records documentation of the complaint or event,	
☐	☐	the investigation,	
☐	☐	the results, and	
☐	☐	actions taken	
		Complaint Process: Ensuring the timely reporting of allegations of abuse or neglect to the appropriate authority 333-536-0050(8)(j)	
☐	☐	the Department of Human Services,	
☐	☐	Oregon Health Authority,	
☐	☐	Public Health Division,	
☐	☐	local law enforcement agency, or	
☐	☐	other	