Recert Package

NATIONAL EXCELLENCE HOME HEALTH CARE, INC.

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RECERTIFICATION ORDER-EVALUATION/AGREEMENT UPDATE

(Recert evaluation must be completed within 5 days before ending episode)

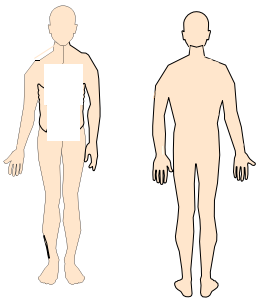
Patient Name _____ **Med. Record** _____
SOC: _____ **Recertification period:** _____ **to** _____
Primary Diagnosis _____ **Onset Date** _____
Secondary diagnoses _____ _____
_____ _____
_____ _____

What negative findings substantiate this Patient to be recertified?

_____
_____
_____
_____

Wound/decubitus/ulcer orders:

_____



_____
_____
_____
_____

Foley Yes No Size_____**FR** _____ **CC Change Q**_____ **Date last changed**_____
Problem:_____
Mental Status: _____ **Activity:**_____
Functional limitations/homebound status:

_____
_____
_____
_____

Diet: _____ **Need for Home Health Aide:**_____
_____
Who does patient live with?_____ **Caregiver**_____
Overwhelmed with ____ **Patient's care** ____ **Household duties. Medical Supplies**_____
Verbal order written during this certification:

_____
_____

Start Date	MEDICATION (changes, addition, deletions)	Dose	Route	Frequency	Duration	D/C Date

Services that need to continue (Frequency/Charges): **Medicare payer, no charges expected** **Charges changes below**
Agency regular charges explained in de Information Handbook

SN _____ **PT** _____
HHA _____ **ST** _____
MSW _____ **OT** _____

Discharge Plans _____
_____

MD Name/ Phone _____

Last MD visits _____ **Last MD contact by nurse/therapist** _____

Patient/Representative Signature: _____ Date: _____

RN/Therapist Name/Signature/Title_____ **Date** _____

Physician Signature: _____ Date: _____

Original (Patient Chart) *Copy (Patient)*

Chart Audit *(Recertification)*

Date of Review:_____	Client MR#:_____
Episode Dates:	Principle Dx:
Current Disciplines/Frequency: (circle) SN:_____ PT:_____ OT:_____ ST:_____ MSW:_____ HHA:_____	Primary Physician:_____ Discipline/frequency change in last 60 days? ☐ Yes ☐ No If Yes, is there an order for the change? ☐ Yes ☐ No Supporting documentation for change? ☐ Yes ☐ No Explain:_____

Admission	YES	NO	COMMENTS
Client admitted to service within 48 hrs of referral?			
Assessment of client's needs appropriate, including appropriate initial referral and diagnosis?			
Consents (Client Rights, Admission Agreement, Ins. Determination) present and signed?			
Plan of Care reflects client's needs?			
If applicable, is there a predictable end point of daily visits specified?			
Each 485 locater complete and accurate?			
Plan of Care signed/dated by physician?			
Physician's Orders (all disciplines)			
If missed visits occurred (as compared with orders), is there documentation that the physician was notified?			
Services delivered, as ordered (freq/duration)?			
Lab results, as ordered, are present and it is noted that physician notified?			
Telephone/verbal orders obtained/signed for all changes (treatment, frequency, etc.)?			
Physician has been informed of changes in client needs or status?			

Service Delivery	YES	NO	COMMENTS
Medication profile is present and reflects any changes that took place?			
Progress notes/documentation reflect involvement of client and/or family in planning process and care?			
Documentation reflects coordination among services?			
Supervisory visits completed per policy/regulation?			

Does documentation identify supplies used during each visit?			
Does documentation support that all medical supplies have a diagnostic or therapeutic use and have been ordered by physician?			
Evaluation/measurement of client's progress toward anticipated goals documented?			
If outcomes were not met by client, is reason documented?			
Care plans updated as interventions completed/goals met?			
Frequency/duration for each discipline appropriate per client's condition?			
Are visit notes for each discipline signed/dated and within ordered frequency?			
Is homebound status documented at least once twice monthly?			
For each visit, is skill documented and personal care performed?			
Oasis Assessment(s)			
Were all OASIS assessments completed within specified time frames per regulation and policy?			
Are diagnoses listed on the OASIS assessment(s) consistent with diagnoses listed on 485?			
Are therapy visits consistent with answer to MO825?			
Recertification			
Is the nursing care plan up to date?			
Is the medication profile up to date?			
Safety review sheet updated?			
HHA assignment sheet updated, if applicable?			
Physician order to continue care?			
60 Day Summary completed and sent to physician?			

Follow up action required:

Signature of Reviewer/Title:_____

Corrections completed

by:_____Date:_____

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 4 - 5	SOMETIMES 2 - 3	NEVER 1
1. Did you like your nurse/aide?			
2. Was your nurse/aide always there when she was expected to be there?			
3. Did your nurse/aide always wear a clean uniform?			
4. Did your nurse/aide appear to know her job?			
5. Was your nurse/aide a late comer?			
6. Would you say the nurse/aide took good care of you?			
7. Was your nurse/aide a good listener?			
8. Did you ever have problems communicating with your nurse?			
Other Comments			

_____ _____
Signature of Staff Patient Signature (optional)

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

Nombre del Paciente: _____ Med.Record_____

Direccion: _____ Fecha: _____

Escala desde **1** “No estoy de acuerdo” - **5** “Estoy completamente de acuerdo”

Preguntas	**Siempre 4 - 5**	**Algunas Veces 2 - 3**	**Nunca 1**
1. Le gusto la empleada (enfermera, 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. Llegaban tarde nuestros empleados?			
6. Diria que nuestros empleados le dieron un buen cuidado?			
7. Nuestros empleados oian sus opiniones?			
8. Tuvo algun problema de comunicación con nuestros empleados?			
Otros comentarios			

Firma de empleado: _____

Firma del paciente (optional): _____

HOME HEALTH CARE AGENCY (Reported to PAC)

NOTIFICATION OF CLIENT'S CLINICAL RECORD DEFICIENCIES

Client's Name: _____

Client's clinical record number: _____

Client's case manager: _____

Client's attending physician: _____

Client's principal diagnosis: _____

Client's admission date: _____

Client's discharge date: _____

Name of individual notified of client's clinical record deficiency(ies):

_____

Client's clinical record deficiency(ies): (Action Plan if needed)_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Individual who performed Date of Signature

Client's Clinical Record Discharge Analysis

CLINICAL RECORDS: **SUMMARY REPORTS** - COMMUNICATION NOTE

□ 60 day Summary Report □ Communication Note

Patient's name: _____

Date of this report: Medical Record: _____

Name of reporting staff: _____

Diagnosis:

_____

_____

Date started services to patient: _____

Brief summary/Communication:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(to include major services rendered, patient's response to treatment (progress or deterioration), any significant findings/communication, and recommendations to the physician)

Physician Contacted (summary sent/faxed) date: _____

Signed: _____

WEEKLY VISIT/TIME RECORD

Year: _____ Employee ID# _____ Employee Name/Title _____

Patient Name _____ Clinical Record # _____

Patient Address _____ Apt # _____

PLEASE SIGN *FOR ONLY ONE* VISIT AT A TIME

POR FAVOR SOLO FIRME POR UNA VISITA A LA VEZ

Day *Dia*	**Date** *Fecha*	**Visit Code**	**N/C Code**	**Time In** *Entrada*	**Time Out** *Salida*	**Units** *Unidades*	**Patient signature** *Firma del paciente*

TOTAL VISITS: _____ ***TOTAL UNITS:*** _____

VISIT CODES

P – Patient Visit (SN, PT, SLP, OT, MSS, AIDE, RD)
X – Psych RN Visit
HT – High Tech Infusion Therapy Visit
S/U – Sign Up Visit
WC – High Tech Wound Care
SV – Supervisory Visit
Hmk – Homemaker

N/C CODES (NO/CHARGE)

1 – Supervisory Visit
2 – RN S/U *Therapy Only*
3 – Not Home Or Refused
4 – Charity Visit
5 – Travel Only
6 – Supply Drop
7 – Not Qualified

HOME HEALTH AIDE CARE PLAN *(PLAN DE CUIDADO DE LA AYUDANTE DE ENFERMERA)*

Patient Address: _____ **Telephone No.** _____

Directions to Home: _____

Care Manager: _____ **Phone No.** _____

Frequency/Duration: _____

Supervisory visits: ❑ every 14 days ❑ every 30 ❑ every 60 ❑ Other _____

Patient problem: _____

PARAMETERS TO NOTIFY CARE MANAGER / PARAMETROS A NOTIFICAR

T° _____ BP _____

P _____ R _____

Urine _____

Other (pain) _____

DNR: ❑ Yes ❑ No

PRECAUTIONARY AND OTHER PERTINENT INFORMATION - Check all that apply. Circle the appropriate item if separated by slash.

- ❑ Lives alone/Vive solo
- ❑ Lives with other/Vive con otros
- ❑ Alone during the day/Solo durante el día
- ❑ Bed bound/Confinado a la cama
- ❑ Bed rest/BRPs/Descanso en la cama
  - ❑ Up as tolerated/Se levanta hasta donde puede
- ❑ Amputee (specify)/Amputación: _____
- ❑ Partial weight bearing/Soporte de peso parcial: ❑ R ❑ L

- ❑ Non weight bearing/No soporte de peso: ❑ R ❑ L
- ❑ Fall precautions/Prevención de caidas
- ❑ Special equipment/equipos especiales: _____
- ❑ Speech/Communication deficit/Habla deficiente
- ❑ Vision deficit/Visión def: ❑ Glasses/Espejuelos
  - ❑ Contacts/Lentes de contacto
  - ❑ Other/Otro: _____
- ❑ Hearing deficit/Def.Auditiva: ❑ Hearing aid/Ayuda para oir

- ❑ Dentures/Dentaduras: ❑ Upper/Sup. ❑ Lower/baja ❑ Partial/Parcial
- ❑ Oriented/Orientado x 3 ❑ Alert/Alerta
- ❑ Forgetful/Confused-Olvidadiso/Confuso
- ❑ Urinary catheter/Cateter urinario
- ❑ Prosthesis/Protesis (specify): _____
- ❑ Allergies/Alergias (specify): _____

- ❑ Diabetic/Diabetico ❑ Do not cut nails/No cortar uñas
  - ❑ Diet/Dieta: _____
- ❑ Seizure precaution/Precauciones con convulsiones
- ❑ Watch (observar por) for hyper/hypoglycemia
- ❑ Bleeding precautions/Prec. sangreamientos
- ❑ Prone to fractures/Posible fracturas
- ❑ Other (specify)/Otro (especificar): _____
- ❑ _____
- ❑ _____

Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc as needed beside the appropriate item

	ASSIGNMENT-TAREAS	Every visit	Weekly	Multi-Visits a day only 1	2	3	4	Other - Otro Comments/Instructions Comentarios/Instrucciones
VITALS / VITALES	Temperature/Temperatura	❑	❑	❑	❑	❑	❑	
	Pulse/Pulso	❑	❑	❑	❑	❑	❑	
	Respirations/Respiración	❑	❑	❑	❑	❑	❑	
	Blood Pressure/Presión	❑	❑	❑	❑	❑	❑	
	Weight/Peso	❑	❑	❑	❑	❑	❑	
	Pain Rating (0-10 scale)/Dolor	❑	❑	❑	❑	❑	❑	
BATH / BAÑO	Tub/Shower-Bañera/Ducha	❑	❑	❑	❑	❑	❑	
	Bath: Bed/Sponge - Baño:Cama/Sponja Partial/Complete-Parcial/Completo	❑	❑	❑	❑	❑	❑	
	Assist Bath-Chair - Asistir baño en silla	❑	❑	❑	❑	❑	❑	
HYGIENE /GROOMING / HIGIENE	Personal Care/Cuidado Personal	❑	❑	❑	❑	❑	❑	
	Assist with Dressing/Asistir vestirse	❑	❑	❑	❑	❑	❑	
	Hair Care/Cuidado del cabello	❑	❑	❑	❑	❑	❑	
	Shampoo/Champu	❑	❑	❑	❑	❑	❑	
	Skin Care/Cuidado de la piel	❑	❑	❑	❑	❑	❑	
	Foot Care/Cuidado de los pies	❑	❑	❑	❑	❑	❑	
	Check Pressure Areas/Ulceras de presión	❑	❑	❑	❑	❑	❑	
	Nail Care/Cuidado de las uñas	❑	❑	❑	❑	❑	❑	
	Oral Care/Cuidado oral	❑	❑	❑	❑	❑	❑	
	Clean Dentures/Limpiar dentaduras	❑	❑	❑	❑	❑	❑	
	Shave/Afeitar	❑	❑	❑	❑	❑	❑	
	Other/Otro: _____	❑	❑	❑	❑	❑	❑	
PROCEDURES / PROCEDIMIENTOS	Assist with Elimination/Asistir eliminación	❑	❑	❑	❑	❑	❑	
	Catheter Care/Cuidado de catetes	❑	❑	❑	❑	❑	❑	
	Ostomy Care/Cuidar ostomia	❑	❑	❑	❑	❑	❑	
	Record Intake/Output-Registro tomar/salida	❑	❑	❑	❑	❑	❑	
	Inspect/ Reinforce/Inspeccionar Dressing/Vendas (see specifics in comment section/ver comentarios)	❑	❑	❑	❑	❑	❑	
	Medication Reminder/Recordar medicinas	❑	❑	❑	❑	❑	❑	
	Other (specify)/Otro (especificar): _____	❑	❑	❑	❑	❑	❑	

	ASSIGNMENT-TAREAS	Every visit	Weekly	Multi-Visits a day only 1	2	3	4	Other - Otro Comments/Instructions Comentarios/Instrucciones
ACTIVITY / ACTIVIDADES	Assist with - Asistir con Ambulation/Ambulación W/C/Walker/Cane - Silla Rueda/Andador/Baston	❑	❑	❑	❑	❑	❑	
	Assist with Mobility/assistir con mibilidad Chair/Bed/Dangle-Silla/Cama/Oscilar Commode/Cuña-Pato Shower/Tub=Ducha/Bañera	❑	❑	❑	❑	❑	❑	
	ROM Active/Passive-Rango de Mov.Activo/Pasivo Arm R/L (Brazos D/I) Leg R/L (Pies D/I)	❑	❑	❑	❑	❑	❑	
	Positioning-Encourage / Cambio de Posiciones Assist/assistir _____ hrs	❑	❑	❑	❑	❑	❑	
	Exercise Per - Ejercicios por PT / OT / SLP Care Plan/Plan de cuidado	❑	❑	❑	❑	❑	❑	
	Other (specify)/Otro (especificar):	❑	❑	❑	❑	❑	❑	
NUTRITION / NUTRICION	Meal Preparation/Prep. de comida	❑	❑	❑	❑	❑	❑	
	Assist with Feeding/Asistir alimentar	❑	❑	❑	❑	❑	❑	
	Limit/Encourage-Limitar/Exigir Fluid/Fluidoss	❑	❑	❑	❑	❑	❑	
	Grocery Shopping/Comprar comida	❑	❑	❑	❑	❑	❑	
	Other (specify)/Otro (especificar):	❑	❑	❑	❑	❑	❑	
OTHER / OTRO	Wash Clothes/Lavar ropa	❑	❑	❑	❑	❑	❑	
	Light Housekeeping/Ligera limpieza Bedroom / Baño Bathroom/Cuarto / Kitchen /Cocina Change Bed Linen/Cambiar sábanas	❑	❑	❑	❑	❑	❑	
	Equipment Care/Cuidado de equipos	❑	❑	❑	❑	❑	❑	
	Other (specify)/Otro (especificar): _____	❑	❑	❑	❑	❑	❑	

Signature/Title: _____ Date: _____ Review and/or revise at least every 60 days

SIGNATURE/TITLE	DATE	SIGNATURE/TITLE	DATE

PART 1 - Clinical Record

PATIENT NAME - Last, First, Middle Initial

PART 2 - Patient Home Folder

ID#

As Nurse Aide you are an important member of the home care team. It is important that you check your Aide Care Plan before initializing care. Perform only the tasks assigned on the patient's Care Plan. If there are tasks being performed that are not on the patient care plan, notify your supervisor for approval before the changes are made.

REMEMBER TO RESPECT PATIENT'S PRIVACY/PROPERTY *pnsystem.com* *305.777.5580* *(855)PNSystem*

MEDICINE SCHEDULE* Patient's Name: _____ MR Number_____

Pharmacy Name:_____ Phcy Phone:_____ Date: _____

Address: _____ Primary MD Name: _____ MD ph:_____

N C O	**Date Ordered** *Fecha*	**Medications** **Dose, Route, Frequency** *Medicinas, Dosis, Ruta, Frecuencia*	**Breakfast** *Desayuno*	**Lunch** *Almuerzo*	**Dinner** *Comida*	**Bedtime** *Acostarse*	**Clasification** *Clasificación*	**Side Effects** *Efectos Secundarios*	MD Ordering Full Name *Doctor que ordena*	Level of Understanding Good Fair Poor	**D/C Date** *Alta*

Key To Side Effects/*Guía de Efectos Secundarios*

A-Nausea/Vomiting *Vómito*
B- Constipation *Estreñimiento*
C- Diarrhea *Diarrhea*
D- Hypertension *Presión Alta*
E- Hypotension *Presión Baja*
F- Skin Rash/Urticaria *Erupción de la piel*
G- Headaches *Dolor de Cabeza*
H- Dizziness *Mareos*
I- Hypoglycemia *Hypoglicemia*
J- Hyperglycemia *Hiperglicemia*
K- Edema *Edema*
L- Diaphoresis *Sudoración*
M-Hemorrhage *Hemorrageas*
N- Hematuria *Hematuria*
O- Dry Mouth **Thirst**/*Sed* *Boca Seca*
P- Bradycardia *Bradicardia*
Q- Tachycardia *Taquicardia*
R- Tremors *Temblores*
S- Tinitus *Zumbidos en oidos*
T- Fluid/Electrolyte Imbalance *Desbalance líquido*
U- Anorexia
V- Malaise *Malestar*
W- Dyspnea *Falta de Aire*
X- Confusion
Y- Flushing/Blurred Vision *Enrojecimiento/Visión borrosa*
Z. Other_____ *Otros*

Allergies: _____ *Alergías*

Firma Enfermera/Fecha
Nurse Signature/Date:_____

Reconciliation
Update on: _____ By: _____
Actualizado en *Por*

Reconciliation
Update on: _____ By: _____

Reconciliation
Update on: _____ By: _____

** Part of Emergency/Disaster Plan*

NATIONAL EXCELLENCE HOME HEALTH CARE, INC.

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CHAP Hotline *(Línea de CHAP)*
1-800-656-9656 Monday-Friday
(Lunes-Viernes)
8:30 am to 5:00 pm
At night, leave message about complaints and/or questions about the Agency
(Por la noche, deje mensaje por quejas y/o preguntas acerca de la Agencia)
After hours of operations, a message may be left with our Answering Service.
Después de horas de Oficina puede dejar un mensaje con nuestro servicio de respuesta telefónico.