Comprehensive Home Care Provider
Client Review Form

Client Name: _____________________________
Client Identifier: __________________________
Diagnosis: _______________________
SOC: _______________                                   Service Plan Date: ___________________

A Client Review includes observations of the client and the care and services they receive, client record review, client drug therapy review and client and/or family interview utilizing the Home Visit Client/Family Interview form.

NOTE: The surveyor will review the language in the MN Home Care Statutes when evaluating compliance.

Section A: Client Daily Life Review
Observations are made throughout the survey of the clients and the care and services they receive. Observations are made throughout the survey of the staff providing care and services to the clients. Interviews of staff and clients are conducted throughout the survey to evaluate and validate surveyor observations and findings.

- Staff knowledge and implementation of the client’s service plan and the client’s Individualized Vulnerable Adult or Minor Abuse Prevention Plan.
- Client is free from physical and verbal abuse.
- Client with care needs including but not limited to: durable medical equipment, tube feedings, pressure ulcers, blood glucose checks, insulin, oxygen, dialysis, hospice care and falls.
- Care and services are provided in accordance with accepted medical and nursing standards.
- Infection control practices to determine if staff is following current standards of practice, including but not limited to: appropriate hand hygiene; handling and transporting linen to prevent spread of infection and the use of protective gloves when appropriate.
- Client is treated with courtesy and respect and that client’s rights are not violated.
- Staff listens and is responsive to client requests. (Note staff interaction with both communicative and non-communicative clients)
- Medication administration and/or assistance with self-administration of medications
- Client appears clean and neat.
- The use of physical and/or chemical restraints.
- Other observations/interviews as deemed necessary (behaviors).

Client Daily Life Reviewed: (Initial) ___
The surveyor documents concerns and follow-up on Surveyor Notes sheets.
Section B: Client Record Review

The client records are reviewed to gather information regarding the evaluation/assessment and services the client is receiving.

- Client has an Individual Abuse Prevention Plan that is current and includes an individualized assessment of the client’s susceptibility to abuse by other individuals, the person’s risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors.

- Registered Nurse – initial assessment within 5 days.

- Reassessment within 14 days and ongoing client monitoring at least every 90 days or when a change.

- Service Plan within 14 days and revised as needed.

- The services are provided as stated on the client’s Service Plan.

- Client-specific written instructions are present for delegated nursing procedures.

- Documentation that the client has received and reviewed the MN Home Care Bill of Rights.

- Documentation of complaints received and resolution.

- Client records are kept confidential and are secure.

- Entries entered in the client’s record are current, authenticated and are legible.

- Statement of Services.

- Documentation of significant changes or incident(s) and the actions taken in response.

Client Record Reviewed: (Initial) ____

The surveyor documents concerns and follow-up on Surveyor Notes sheets.
Section C: Medication Management

Review the client’s record for requirements related to medication administration. Review all the herbal supplements, over-the-counter and prescribed medications taken by the client.

- Registered Nurse – develop and implement individual medication management plan (before service provided) that is current and updated when there are changes.

- Individual Medication Management Plan – includes:
  - Includes medication management services to be provided.
  - A description of storage of medications, based on client needs.
  - Specific client instructions related to medication administration.
  - Identification of person responsible for monitoring medication supplies and refills.
  - Identify medication management tasks that may be delegated unlicensed personnel.
  - Procedures for staff notifying a registered nurse when problems arise.
  - Any client-specific requirements.

- Delegation of medication administration/written instructions.

- The client’s medication administration records are complete/medications are administered as ordered.

- Documentation of medication set-up and administration.

- Medication management for clients who will be away from home.

- There are written prescriber’s orders for medication administered and orders are complete.

- Verbal orders are received only by a nurse or pharmacist entered into the record and recorded and forwarded for signature.

- Electronically transmitted orders are recorded, communicated to the registered nurse and placed in record.

- Client’s medications are renewed at least every twelve months.

Client Drug Therapy Reviewed: (Initial) _____
The surveyor documents concerns and follow-up on Surveyor Notes sheets.