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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			

_____ _____

Signature of Staff

Patient's Signature (optional)

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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			

_____ _____

Firma de empleado Firma del paciente (opcional)

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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				

Date:

Physician's signature:

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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					

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** _____

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									
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:_____

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

_____
_____
_____
_____

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:

_____
_____
_____
_____
_____
_____

_____

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**

ABANA HEALTH CARE, INC.

Patient's Satisfaction Survey
Cuestionario de Satisfaccion del Paciente

Date/Fecha: _____

	Excellent *Excelente*	*Satisfactory* *Satisfactorio*	*Deficient* *Deficiente*
Personal Appearance /Apariencia Personal			
Punctuality / Puntualidad			
Ethical / Cortesia			
Professional Knowledgement / Conocimiento de sus funciones.			
Perform all activitiest Cumplimiento de sus funciones			
Our employees are helpful to you/family/caregivers - Nuerstro empleado es de ayuda para usted o para la persona encargada de su cuidado			

Esta satisfecho con nuestro servicio? Si _____ No _____
Are you happy with our Services? Yes _____ No _____

Usted recomendaria nuestros servicios
a otras personas? Si _____ No _____
Do you recommend our Services? Yes _____ No _____

Participa en su cuidado habitualmente o es
motivado por nuestros empleados? Si _____ No _____
Were you involve in your care, or motivated by our employee? Yes _____ No _____

Se le informa los cambios en su tratamiento? Si _____ No _____
Were you inform of changes in your treatment? Yes _____ No _____

Usted conoce sus derechos como paciente de
nuestra Agencia? Si _____ No _____
Do you know your Bill of Rights? Yes _____ No _____

Sugerencias para mejorar nuestros servicios (How can we improve our services?)

_____

_____

_____

We periodically make a survey to our Patients to know their satisfaction grade, and by improve our Services. *Nuestra Agencia realiza encuestas periodicarnente para conocer ei grado do satisfaccOn de nuestros pacientes, esto nos ayuda a mejorar nuestros servicios a paitir de sus opiniones.*

Nombre del paciente: _____

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ABC HOME HEALTH CARE, INC.

C U E S T I O N A R I O

Nombre del Paciente: _____ **Med.Record**_____

Direccion: _____ **Fecha:** _____

Estamos interesados en la calidad del cuidado de la salud de muestros clientes, y apreciariamos su cooperacion. Por favor conteste las siguientes preguntas. Su evaluacion nos permitira servirle mejor en el futuro.

1. Estuvo satisfecho con nuestros empleados? ____ *Si* ____ *No*

2. Estuvieron nuestros empleados dándole el servicio en las fechas programadas? ____ *Si* ____ *No*

3. El personal estuvo vestido en forma etica, y con uniformes correctos y limpios? ____ *Si* ____ *No*

4. Nuestro personal parecian tener conocimiento del servicio que le ofrecieron? ____ *Si* ____ *No*

5. Se presentaban a darle el servico tarde algunas veces? ____ *Si* ____ *No*

6. Usted diría que nuestros empleados le dieron un buen servicio? ____ *Si* ____ *No*

7. Nuestros empleados le escucharon siempre sus preocupaciones o dudas? ____ *Si* ____ *No*

8. Tuvo algun problema comunicandose con nuestros empleados? ____ *Si* ____ *No*

9. Usaria los servicios de nuestra Agencia de nuevo en el futuro? ____ *Si* ____ *No*

Si no, por que?

_____

_____

_____

*Comentario:*_____

_____

_____

_____

Respuestas por: _____ *En persona* _____ *Pro telefono* ____ *Por correo*

Firma Entrevistador: _____

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ABC HOME HEALTH CARE, INC.

QUALITY ASSURANCE EVALUATION FORM
PATIENT / FAMILY QUESTIONNAIRE

Patient's Name: _____ Ph: _____ MR#: _____

DATE OF EVALUATION: _____ Date of Interview: _____

NAME and Title of EVALUATION: _____

NAME OF PERSON MAKING RESPONSES: _____
(person being interviewed/relationship to patient)

Please answer the question below and return this form to us as soon as possible. In answering, you will be helping us to further improve the quality of service provided. For your convenience, a self-addressed stamp envelope is enclosed.

Thank you for your assistance in this matter.

QUESTIONS	ALWAYS	SOMETIMES	NEVER
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?			
9. Will you use our Agency again in the future? If not, why?			
Other Comments			

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Interviewed by: phone: ____ in person: ____ by mail: _____

Signature of Staff: _____

Highlite Home Care
we are here for your every need

PATIENT SATISFACTORY SURVEY

Thank you for choosing Highlite Home Care for your home health care needs. To help us serve you better, please take a few minutes to complete this survey. Your comments are very important to us. When you complete the form, you fold the survey and place into the provided pre-addressed envelope, apply appropriate postage and mail.

Please circle your response to each question using the 1 - 5 scale. **5 = Very Satisfied** **1 = Not Satisfied**

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1. Did the nurse or therapist who admitted you explain the services ordered by your doctor?	5	4	3	2	1
2. Did you know when you nurse, therapist or aide was to visit?	5	4	3	2	1
3. Were all of your questions answered promptly and to your satisfaction by our staff?	5	4	3	2	1
4. Were you treated in a professional and courteous manner by our staff?	5	4	3	2	1
5. When you called our Office, was your call answered promptly and courteously?	5	4	3	2	1
6. Because of our care and service, is your condition improved or improving?	5	4	3	2	1
7. As a result of our care and service, do you better understand your condition?	5	4	3	2	1
8. As a result of our care and service, has your ability to care for yourself improved?	5	4	3	2	1

Please circle your response to the next two questions.

9. Overall, how would you rate the quality of care you received? **Excellent** **Good** **Fair** **Poor**

10. Would you choose our home health agency for your future health care needs? **Yes** **No** **Undecided**

Comments: _____

_____

Name: _____ (Optional)

CLIENT SATISFACTION SURVEY

Thank you for allowing us to provide your home care services. In order to continue to strive for the provision of the highest quality services possible, we need your in-put, comments and suggestions.

Please take a few minutes to complete this form and return it in the enclosed addressed, stamped envelope. Thank you.

1. How satisfied are you with services you received from:

Nurse	4	3	2	1	0
Home Health Aide	4	3	2	1	0
Physical Therapist	4	3	2	1	0
Social Worker	4	3	2	1	0

2. Please rate the staff who provided services:

Knowledgeable 2	Not Knowledgeable 1	No Opinion 0
Courteous 2	Discourteous 1	No Opinion 0
Professional Appearance 2	Unsatisfactory 1	No Opinion 0
Helpful 2	Not Helpful 1	No Opinion 0

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3. Are these services you would like that we did not offer? _____

_____

_____

_____

4. Telephone Contact:

Office Staff	4	3	2	1	0
Agency Administrator/Supervisor	4	3	2	1	0
Staff Providing Services	4	3	2	1	0

5. Would you use our services again and/or recommend our services to others: Yes _____ No _____

Comments: _____

6. We welcome suggestions on how we can improve our services: _____

Completed by (optional) _____ Date: _____

Client _____ Friend _____ Family Member _____ Other _____

If you have any further comments, please call our Agency Administrator.

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Patient's Satisfaction Survey
Cuestionario de Satisfaccion del Paciente

Date/Fecha: _____

	Excellent *Excelente*	*Satisfactory* *Satisfactorio*	*Deficient* *Deficiente*
Personal Appereance / Apariencia Personal			
Punctuality / Punctualidad			
Ethical / Cortesia			
Professional Knowledgement / Conocimiento de sus funciones			
Perform all activities / Cumplimiento de sus funciones			
Our employees are helpful to you/famiy/caregivers – Nuestros empleados es de ayuda para usted o para la persona encargada de su cuidado			

Esta satisfecho con nuestro servicio? Si _____ No _____
Are you happy with our Services?

Usted recomendaría nuestros servicios
a otras personas? Si _____ No _____
Do you recommend our Services?

Participa en su cuidado habitualmente o es
motivado por nuestros empleados? Si _____ No _____
Were you involve in your care, or motivated by our employee?

Se le informa los cambios en su tratamiento? Si _____ No _____
Were you inform of changes in your treatment?

Usted conoce sus derechos como paciente de
nuestra Agencia? Si _____ No _____
Do you know your Bill of Rights?

Sugerencias para mejorar nuestros servicios (How can we improve our services?)

_____
_____
_____
_____

We periodically make a survey to our Patients to know their satisfaction grade, and by improve our Services. *Nuestra Agencia realize encuestas periodicamente para conocer el grado de satisfacción de nuestros pacientes, estos nos ayuda a mejorar nuestros servicios a partis de sus opiniones.*

Nombre del Paciente: _____

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RENOVATION HEALTH CARE, LLC.

PATIENT SATISFACTION SURVEY & Q.A.
MEDICARE FRAUD PREVENTION PROGRAM HOME VISIT

Patient: _____ MR#:_____
Address: _____ Date: _____
_____ Phone: _____

1- Name of SN:_____ Freq. Visit:_____ Time: In____ Out____
2- Name of HHA:_____ Freq. Visit:_____ Time: In____ Out____
3- Name of Therapist:_____ Freq. Visit:_____ Time: In____ Out____

How long in time is the visit?(1)_____(2)_____(3)_____
Service Provided:(1)_____
(2)_____
(3)_____

Is SN/LPN/Therapist teaching you? YES___NO____ (if no see comments)
Are you understanding the teaching? YES___NO____(if no see comments)
SN/LPN/HHA/CNA/ Therapist report on time: YES___NO____(if no see comments)
Shar/Waste Container Box in home? YES___NO____(if no see comments)
Home Chart present? YES___NO____Complete_____
Do you have all your medication/ supplies? YES___NO___ (if no see comments)
Are you happy with our services? YES___NO___ (if no see comments)
Does the SN/LPN/HHA/CNA go to your home everyday? YES___NO___(if no see comments)
Does the SN/HHA go to your home on the weekends? YES___NO___(if no see comments)
Do you get paid by the SN /LPN/HHA/CNA or other representatives of this Agency?
YES___NO___(if YES see comments)
Does the SN/LPN/HHA/CNA/ or other representatives of this Agency pay you for not coming every day to your house?_____
Insulin: Bottle open date:_____ Expiration Date:_____

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Comments/ Recommendations:
_____
_____
_____
_____
_____

_____ _____
Patient signature/ date Caregiver signature/ date

Sweet and Gentle Home Health Care Co.

CUESTIONARIO DE SATISFACCION DEL PACIENTE

1-Cuando usted fue dado de alta en el hospital o salio de la oficina de su Doctor, recibio ustes suficiente informacion acerca de su servicio de cuidados de salud en el hogar(Home Care)

SI_____ No_____ OTROS_____

2- Cuando ustes tiene contacto telefonico con el personal de su agencia, fue tratado usted de una manera cortes y todas sus preguntas fueron contestadas?

SI_____ No_____ OTROS_____

3- Cuando el personal de la Agencia fue a su casa fueron amables y formales? Se sintio usted satisfecho con este servicio?

SI_____ No_____ OTROS_____

4- Recibio usted instrucciones y educacion adecuada respect a su cuidado de salud en el hogar, y se le permitio participar en su plan de cuidados?

SI_____ No_____ OTROS_____

5- Fue tratado usted siempre con respeto y apoyo durante las visitas que le hicieron en su hogar?

SI_____ No_____ OTROS_____

6- Fueron sus metas y tratamiento discutidos con usted en el momento que lo admitieron?

SI_____ No_____ OTROS_____

7- Fue su enfermera yo personal de la agencia siempre vestida correctamente?

SI_____ No_____ OTROS_____

8- Estuvo su enfermera y/o personal de la agencia a tiempo en su casa, y esta usted satisfecho con el tiempo que este personal estuvo con usted en cada visita?

SI_____ No_____ OTROS_____

9- Recibio used instrucciones y educacion adecuada por el enfermero sobre precauciones para evitar caidas?

SI_____ No_____ OTROS_____

Comentarios_____

_____

_____

Firma del Paciente_____ Fecha_____

Firma de Enfermera_____ Fecha_____

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T.L.C. Health Services, Inc.

PATIENT'S SURVEY AND HOME FILE AUDIT

DATE: _____

PATIENT'S NAME: _____ MR#: _____

SCHEDULE STAFF RN: _____ LPN: _____ HHA: _____ PT: _____

HOME FILE AUDIT:

1. Are copies of consent present at home Yes _____ No _____
2. Copy of medication schedule Yes _____ No _____
3. Copy of HHA care plan (if applicable) Yes _____ No _____
4. Are Emergency numbers posted on file Yes _____ No _____
5. Is team communication by the staff up to date Yes _____ No _____

Comments:

_____

_____

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PATIENT'S SURVEY

1. Is the patient satisfied with SN services (if applicable) Yes _____ No _____

Name of staff _____ **Schedule frequency** _____

2. Is the patient satisfied with Aide services (if applicable) Yes _____ No _____

Name of staff _____ **Schedule frequency** _____

3. Is the patient satisfy with PT/OT/ST services (if applicable) Yes _____ No _____

Name of staff _____ **Schedule frequency** _____

Other Comments:

_____

_____

Patient's Signature: _____

Supervisor Signature: _____

8345 SW 24 St. Miami, FL 33155 – Ph: (305) 263-3103 – Fax: (305) 263-3155

TOTAL HOME HEALTH INC.

Patient Satisfactory Survey

Dear Patient:

Thank you for allowing Total Home Health, Inc. to serve your home care needs. As you know, we are committed to the principle..."*We Treat You Like Family.*" We certainly hope we have met your expectations fully.

In order to continually improve, it is important to understand your level of satisfaction with the services we provided. If you will be so kind, please indicate how you rate the key aspects of your home care experience with us.

The following statements apply to your home care experience. Please CHECK the rating, which best describes how satisfied you feel. If a particular statement does not apply - circle NA.

	Highly Satisfied	Satisfied	Neutral	Dis-Satisfied	Highly Dis-Satisfied	N/A
Your understanding of the plan for your home care						
How your home care services will be paid for						
Your chance to participate in planning your care						
Your understanding of your rights & responsibilities						
The quality of the nursing care we provided						
The effectiveness of the therapy we provided						
The assistance of social services we provided						
The service of our home health aides						
The overall knowledge and skill of our team						
The timeliness of our visits						
The friendliness & helpfulness of our visits						
Our attention to the relief of your pain						
Our communications with your doctor						
The reasons for your discharge						
The timing of your discharge						

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Please share any comments or suggestions for improvement:

Name (optional): _____ Date: _____

Thank you very much for letting us serve YOU,

Sheldon Ramkisson, MBA
Administrator

Sophie Lamisere, BSN, RN
Director of Nursing

Total Home Health, Inc. (954) 962-2133