



Individual Quality Review

Section 2a. Day Nurse Interview

Class Member	On-Site Date	Region	Surveyor	Case Judge

1. NURSING INTERVIEW

Guidance: Read the file thoroughly including each nursing note/quarterly to ensure that you know what evidence exists with respect to nursing oversight. That includes an understanding of whether the nurse is conducting visits as required (e.g., based on ER Visits, Hospitalizations, changes in personal circumstances, incident reports...). If you have questions, add those to the list below so you do not have to go back and get the information later. You won't have time!

Nurse's Name:	
Agency:	
Phone Number:	
Email address:	
Interview Date & Time:	
Interview Method:	
1.	How long have you been (Name's) Nurse?
1A.	
2.	How often do you see (Name) face-to-face?
2A.	
3.	Where do those visits usually take place?
3A.	
4.	What do you typically do during those visits?
4A.	
5.	Please describe any health-related needs (Name) may have. Please include current medical diagnoses. <i>Note: The information you receive here should be verified by the record, ask the case manager about any discrepancies.</i>
5A.	
6.	Are there any concerns regarding the individual's health? Is he/she having issues with incontinence, falls, constipation, aspiration, weight issues, etc.? Please explain
6A.	
7.	What specialists does the individual see? How often does he/she see the specialists? Are there any issues? What does he/she see the specialists for? <i>Note: not every chronic condition needs a specialist, as long as the condition is being addressed and monitored regularly by the PCP.</i>
7A.	
8.	Are there assessments that have not been completed this year? If yes, which ones? <i>(Note: if the recommended assessment is late, ask why.)</i>

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8A.	
9.	Does (name) have a CARMP, Health Care Plan(s) or Medical Emergency Response Plans? If so, what are they? What are staff to do? How often do you review the plans? <i>Note: If you have specific questions regarding a specific plan(s), be sure to add your questions below... you can ask them now or later, just be sure to record the answers with the question(s) you ask.</i>
9A.	
10.	How often are health indicators (such as seizure tracking records, weight records, bowel movements, labs, PRN medication use, etc.) monitored?
10A.	
11.	How often is medication assessed for effectiveness and to monitor for side effects? How do you make those determinations? (side effects and effectiveness?) What side effects are staff expected to monitor and/or report?
11A.	
12.	If (name) experiences pain, how does he/she communicate that? What is done? Is the management of pain shared with treating health care professionals?
12A.	
13.	Has (name) received all age and gender appropriate health screenings and immunizations? If not, please explain why.
13A.	
14.	What do you do to ensure nursing oversight? How do you provide oversight to ensure medical appointments are made/attended and medications changes occur timely?
14A.	
15.	Overall, has (name) experienced improved health, stable health or regressing health over the past year? Please provide examples or explanation for answer.
15A.	
16.	Does (Name) have any advanced medical directives, or any end-of-life directions? If so, what are the instructions? Do you know how these were chosen? If not , do you know why none have been prepared?
16A.	
17.	If you were to suspect abuse, neglect or exploitation, or note a suspicious injury, how and to what agency would you report it?
17A.	
	Add your additional questions here... add as many questions/rows as are needed.
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