Cover Page

Patient Name: _____

Date of Birth: ___ /___ /_____

Gender: ○ Male   ○ Female

Admission ID#: CHR - _____

Phone#: _____

Visit Date: ___ /___ /_____

Visit Type: _____

RN Name: _____

RN CODE #: CHR - _____

Employee Information/Competencies/Notes/Signatures

1. ○ Telephonic (continue to #2)

○ In person (continue to #2)

○ No supervision performed at this visit. Reason: _____

2. Please complete:

a. Employee name

_____

b. Employee ID#

_____

c. Employee title

○ PCA   ○ HHA

d. Patient initials

_____

e. General competencies

	Satisfactory, observed	Satisfactory, Verbal	Unsatisfactory, Observed	Unsatisfactory, Verbal
Wearing ID badge	○	○	○	○
Wearing mask and appropriate PPE	○	○	○	○
Punctual, clocks in and out and is appropriately dressed	○	○	○	○
Able to communicate with patient and comprehend the plan of care	○	○	○	○
Good rapport with patient/family	○	○	○	○

Demonstrates competence and good judgement in carrying out assignments and following the POC. Able to recognize, and report incidents and accidents, unusual or emergency events to the appropriate person	O	O	O	O
Knowledgeable in use of DME, including wheelchair transfers and safety	O	O	O	O
Reminds patient to take medications	O	O	O	O
Understands their role in reporting changes in patient needs, conditions, and emergencies, and understands role in reporting suspected patient abuse	O	O	O	O
Provides oral hygiene/Denture care	O	O	O	O
Bathing: Bed/Tub/Shower	O	O	O	O
Grooming: Shampoo/Shave/Nail Care	O	O	O	O
Toileting or incontinence care – bedpan/urinal/incontinence brief/commode	O	O	O	O
Knowledgeable about skin care and measures to prevent and reduce impaired skin integrity	O	O	O	O
Maintains safe environment and safety practices. Demonstrates good transfer technique	O	O	O	O
Practices universal precautions and infection control measures including hand hygiene	O	O	O	O
Prepare/serve meals and simple diet in accordance with the Plan of care and patient's preferences	O	O	O	O
Maintains clean kitchen/bedroom/bathroom	O	O	O	O
Runs errands for patients and escort to doctors' appointments as necessary	O	O	O	O
Encourages and engages patient in diversional activities	O	O	O	O
Hoyer lift	O	O	O	O
Measuring intake/urine output	O	O	O	O
Assisting with changing a clean dressing	O	O	O	O
Care of infant/children	O	O	O	O
Assist with active range of motion (AROM) – coaching, reading, counting and supporting joints as requested	O	O	O	O
Assist with obtaining and recording the client's weight	O	O	O	O

	Satisfactory, observed	Satisfactory, Verbal	Unsatisfactory, Observed	Unsatisfactory, Verbal
Helping the client walk – ambulation/walker/cane	○	○	○	○
Making an unoccupied/occupied bed	○	○	○	○
Peri care with catheter/emptying or cleaning catheter bag	○	○	○	○
Other, see comment below	○	○	○	○

f. HHA only (skip if aide is a PCA)

	Satisfactory, observed	Satisfactory, Verbal	Unsatisfactory, Observed	Unsatisfactory, Verbal
Temperature O/R/A	○	○	○	○
Respiration/Pulse/BP	○	○	○	○
Prescribed exercises/Prom	○	○	○	○
Assist with dressing change	○	○	○	○
Assist with ostomy care	○	○	○	○
Complex modified diets	○	○	○	○
Oxygen management	○	○	○	○
Other, see comment below	○	○	○	○

g. Please explain if "Other" was selected in the grids above or if there are any specific competencies to note:

_____
_____
_____

h. If "Unsatisfactory" was selected for any competencies, comment below:

_____
_____
_____

i. Is this a live-in case?

○ Yes   -> ☐ The patient's home is adequate for live-in services. It is safe, it has a functional bathroom, and kitchen, and has adequate sleeping facilities. There is a reasonable provision of privacy for the aide as well as the ability of the aide to obtain a no-duty meal period, and 8 hours of sleep daily with 5 out of the 8 hours uninterrupted.

○ No

j. ☐ Medication reconciliation including, schedules and parameters documented in EMR, potential adverse effects, drug reactions, ineffective or duplicate drug therapy, and significant side effects, reviewed with patient/family.

k. ☐ Aide instructed on following POC and documenting care provided.

l. ☐ Aide educated on EVV

m. General comments:

_____

n. Aide comments

_____

o. Patient/family comments

_____

p. Additional Information

_____
_____

q. Nurse signature

X_____

r. Nurse print name

_____

s. Aide signature

X_____

t. Patient Signature
X_____   **OR**   ☐ Patient is unable to sign. Authorized agent signing on the patient's behalf:

Reason that patient is unable to sign:

_____

Authorized agent signature:

X _____

Print name:

_____

Relationship to patient:

_____