Best Medical Services, Inc.

FIELD SUPERVISORY REPORT
HOME HEALTH AIDE/PERSONAL CARE STAFF

CLIENT'S NAME:____MR#____________________

EMPLOYEE NAME:_____________________________________REVIEW DATE:____________

MR = Meets Requirements - Fully meets high standards expected. Performance is completely satisfactory.
NI = Needs improvement - Some additional work/emphasis or training/experience is needed; is capable of improving performance.
U = Unsatisfactory - Falls short of expected requirements.. standards. or objectives. Significant improvement needed.
NO = Not observed.

	MR	NI	U	NO	Comments:
Reports to assignments on time.					
Demonstrates hand washing technique as per agency policy					
Demonstrates appropriate observation of universal precautions. Carries CPR shield.					
Follows written plan of care					
Documents care correctly. Documents in client's home record?					
Identifies client's needs or changes in condition and reports them appropriately.					
Adheres to agency policies and procedures.					
Maintains client confidentiality.					
Exhibits good self grooming habits and appropriate dress code. Wears ID badge.					
Demonstrates knowledge and application of principles of good nutrition.					
Maintains clean/safe environment.					
Demonstrates positive and helpful attitude towards the client.					
Interacts appropriately with Case Managers and office staff.					

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Client information packet is present in the home? _______Yes ________ No
Client understands rights/home health complaint & Abuse toll-free hotline phone numbers? _______Yes _______ No

COMMENTS (If expectations are not met):____
____

On-site return training offered, if any:____

Return new demonstration:____

Signature of supervisor:________________________________Date:____________________

A BIG IDEA HOME HEALTH

SUPERVISORY REPORT

Patient Name ______________________ MR# __________ Date ____________

Aide/LPN present: ❒ Yes ❒ No

Aide Name ______________________ ❒ Medicare ❒ Medicaid ❒ Other

❒ Discipline Involved (Supervisory visit for:) ❒ LPN ❒ HHA ❒ RN ❒ Other (Specify): ______________________

❒ Verbal approval for Supervisory Visit obtained from:

❒ Patient ❒ Other: ______________________

Name/Relationship

KEY:

MR= Meets Requirements – Fully meets high standards expected. Performance is *completely satisfactory*.

NI = Needs Improvement – Some additional work/emphasis or experience is needed; is capable of improving performance.

U = Unsatisfactory - Falls short of expected requirements, standards, or objectives. Significant improvement needed.

N/A= Not Applicable

Comment: If expectations are *not met* or *are exceeded* please specify: ______________________

____

	AIDE/LPN SUPERVISORY CRITERIA	MR	NI	U	N/A	Observed
						Yes/No
1.	Reports to assignments on schedule, and on time. Vital signs and all procedures taken					
2.	Follows written Plan of Care. Report any need of Medication/Emergency Form Updates					
3.	Documents Care/Observations accurately. Use of Blood Sugar Log if Applicable					
4.	Reports changes in condition/needs appropriately. Use of Team Communication Form					
5.	Maintains client confidentiality, following all HIPAA guidelines.					
6.	Maintains clean/safe client environment.					
7.	Adheres to Agency Policies and Procedures. Use Physician/Agency Communications when needed.					
8.	Exhibits good grooming habits and appropriate attire. Maintain Ethic manners.					
9.	Maintains positive and helpful attitude towards client.					
	OBSERVED DURING VISIT					
10.	Demonstrates proper hand washing technique.					
11.	Follows Standard/Universal Precautions.					
12.	Demonstrates proper body mechanics.					
13.	Follows safety measures.					
14.	Performs assigned duties in a safe and adequate manner.					

Comments/Recommendations (Include instructions given/training demonstrated) Patient's feedback:

____

____

____

____

❒ Patient has a continued need for services ❒ Meets Homebound Criteria ❒ Satisfied with Services

______________________ Evaluator's Signature/Title

______________________ Employee Signature (when applicable)

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"PLACING QUALITY HEALTH CARE AT YOUR FINGERTIPS"

HOME HEALTH AIDE / CNA SUPERVISORY VISIT AUTHORIZATION
(AUTORIZACION PARA VISITAS DE SUPERVISION A LAS AYUDANTES DE ENFERMERAS)

Date/*Fecha:* ______ / ______ / ______

Patient Name/*Paciente:* ______________________________ MR#: ______________

[ ] I hereby authorize Advanced Nursing Homecare Services, Inc. to make supervisory visits as deemed necessary, according to agency's policies and procedures and State and/or Federal requirements.
Yo autorizo Advanced Nursing Homecare Services, Inc. a hacer tantas visitas de supervisión como sea necesario, de acuerdo a las pólizas y procedimientos de la Agencia y requerimientos estatales y federales.

[ ] I refuse to have Advanced Nursing Homecare Services, Inc. make supervisory visits for the non-skilled services I receive. I have been informed by a representative of Advanced Nursing Homecare Services, Inc. that I will be at risk and totally responsible for the consequences of receiving services and refusing to have supervisory visits made for those services.
Yo rechazo que Advanced Nursing Homecare Services, Inc. haga visitas de supervisión por los servicios sin cuidados de enfermeria que recibo. Fui informado por el representante de Advanced Nursing Homecare Services, Inc. que corro un riesgo por esto, y que soy enteramente responsable de las posibles consecuencias de recibir servicios sin ser los mismos supervisados.

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Specific instructions: (if different from Q14D for skilled / Q60D for non-skilled) *(Instrucciones especificadas)*

____

____

____

Patient/Representative's Name: ____________________ Signature: ______________
Nombre de Paciente/Representante *Firma*

Date/*Fecha:* ______ / ______ / ______

TENDER CARE HOME HEALTH SERVICES CORP.

LPN/LVN/PTA SUPERVISORY VISIT NOTE

Employee Name: ______________________________ EMP #: __________

Patient Name: ______________________________ MR#: __________

Yes___/No___ Care provided according to the plan of care?

If "No" please comment: ______________________________

Yes___/No___ Care provided according to scope of practice?

If "No" please comment: ______________________________

Yes___/No___ Care provided in response to patient's needs?

If "No" please comment: ______________________________

Yes___/No___ Patient's care and/or service needs addressed appropriately and in a timely manner?

If "No" please comment: ______________________________

Yes___/No___ Plan of care remains appropriate to patient's needs?

If "No" please comment: ______________________________

Yes___/No___ Any changes to plan of care?

If "No" please comment: ______________________________

___ Physician order obtained and submitted
___ Report given to Supervisor/DPS

Additional Comments:

____

Signature of RN: ______________________________

Date: ______________________________

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FIELD SUPERVISORY REPORT
RN/LPN

CLIENT'S NAME:______________________________ MR#:________________

EMPLOYEE'S NAME: DATE:

	Please respond with Yes, No or NA to the following questions	Yes	No	NA
1	Did the RN/LPN identify herself/himself and explain her/his duties at the first visit with you?			
2	Did the RN/LPN explain your illness and medications so you could understand?			
3	Did the RN/LPN check your temperature, pulse, respirations and blood pressure at each visit and your weight as ordered by your physician?			
4	Did you feel the RN/LPN was concerned with your health?			
5	Were you able to express your feelings and opinions without reservation to the RN/LPN?			
6	Were you able to participate in the care planning process and in your care?			
7	Was the RN/LPN following dress code? Using ID badge?			
8	Was the RN/LPN prepared with appropriate supplies and equipment (i.e. blood pressure cuff, stethoscope, CPR shield)?			
9	Was the RN/LPN on time for the visit or did he/she contact the client to change time?			
10	Did the RN/LPN follow universal precaution and safety precaution?			
11	Did the RN/LPN maintain confidentiality while providing care to you in your home?			
12	Did the RN/LPN follow correct bag technique			
	Clinical Record Supervision	Yes	No	NA
1	Did the RN/LPN adequately document assessment, teaching and treatment performed in the home record?			
2	Did the RN/LPN notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was it noted in the home record?			
3	Is the RN/LPN carrying out the established Plan of Care? If No, use the comment section to identify areas not addressed and the reason?			
4	Does the RN/LPN report and document in the medication sheet any changes or new orders regarding the medications ordered by the MD. Do the medications match the medication sheet and the plan of care? If not is there a modification order to the plan of care for medication changes?			
5	Does the RN/LPN report every 14 days or less regarding the patients condition to the MD as per agency policy? (Physician status report)			

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COMMENTS:____

____

Client information packet is present in the home? _______Yes _________No

Client understands rights/home health complaint & Abuse toll-free hotline phone numbers? _______Yes _________No

CLIENT COMMENTS:____

SUPERVISOR'S SIGNATURE:______________________________ DATE:________________

FIELD SUPERVISORY REPORT
PT/PTA

CLIENT'S NAME:______________________________ M1?.#:______________

EMPLOYEE'S NAME:______________________________ DATE:______________

	Please respond with Yes, No or NA to the following questions	Yes	No	NA
1	Did the PT/PTA identify herself/himself and explain her/his duties at the first visit with you?			
2	Did the PT/PTA explain the care provided according to the plan of care?			
3	Did the PT/PTA provide care according to the scope of practice & in response to meet your needs?			
4	Did you feel the PT/PTA was concerned with your health?			
5	Were you able to express your feelings and opinions without reservation to the PT/PTA?			
6	Were you able to participate in the care planning process and in your care?			
7	Was the PT/PTA following dress code? Using ID badge			
8	Was the PT/PTA prepared with appropriate supplies and equipment as needed?			
9	Was the PT/PTA on time for the visit or did he/she contact the client to change time?			
10	Did the PT/PTA follow universal precaution and safety precaution?			
11	Did the PT/PTA document care provided in the client's home chart?			
12	Did the PT/PTA maintain confidentiality while providing care to you in your home.			
	Clinical Record Supervision	Yes	No	NA
1	Did the PT/PTA adequately document assessment, teaching and treatment performed in the home record?			
2	Did the PT/PTA notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was this noted in the home record?			
3	Is the PT/PTA carrying out the established Plan of Care? If No, use the comment section to identify areas not addressed and the reason?			
4	Does the PT/PTA report every 14 days or less the client's condition to the MD as per agency policy? (Physician status report)			
5	Does the PT/PTA report to the Case Manager, DON any new or changed medication orders or modification to the plan or care regarding treatment orders and are theses changes documented in the home record and medication sheet?			

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COMMENTS:____

____

Client information packet is present in the home? _______Yes _________No
Client understands rights? _______Yes _________No

CLIENT COMMENTS:____

SUPERVISOR'S SIGNATURE:______________________________ DATE:______________

Melanie Home Care, Corp.

FIELD SUPERVISORY REPORT

OT/OTA

CLIENT'S NAME:____MR#:___________________

EMPLOYEE'S NAME:____________________________________DATE:__________________

	Please respond with Yes, No or NA to the following questions	Yes	No	NA
1	Did the OT/OTA identify herself/himself and explain her/his duties at the first visit with you?			
2	Did the OT/OTA explain the care provided according to the plan of care?			
3	Did the OT/OTA provide care according to the scope of practice & in response to meet your needs?			
4	Did you feel the OT/OTA was concerned with your health?			
5	Were you able to express your feelings and opinions without reservation to the OT/OTA?			
6	Were you able to participate in the care planning process and in your care?			
7	Was the OT/OTA following dress code? Using ID badge			
8	Was the OT/OTA prepared with appropriate supplies and equipment as needed?			
9	Was the OT/OTA on time for the visit or did he/she contact the client to change time?			
10	Did the OT/OTA follow universal precaution and safety precaution?			
11	Did the OT/OTA document care provided in the client's home chart?			
12	Did the OT/OTA maintain confidentiality while providing care to you in your home.			
	Clinical Record Supervision	Yes	No	NA
1	Did the OT/OTA adequately document assessment, teaching and treatment performed in the home record? Are changes in treatments orders reported to the Agency?			
2	Did the OT/OTA notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was this noted in the home record?			
3	Is the OT/OTA carrying out the established Plan of Care? If No, use the comment section to identify areas not addressed and the reason?			
4	Does the OT/OTA report every 14 days or less the client's condition to the MD as per agency policy? (Physician status report)			
5	Does the OT/OTA report to the Case Manager, DON any new or changed medication orders or modification to the plan or care regarding treatment orders and are theses changes documented in the home record and medication sheet?			

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COMMENTS:____

____

Client information packet is present in the home? _______Yes _________No
Client understands rights? _______Yes _________No

CLIENT COMMENTS:____

SUPERVISOR'S SIGNATURE:____________________________________DATE:_________________

FIELD SUPERVISORY REPORT
ST/STA

CLIENT'S NAME:______________________________ MR#:____________________

EMPLOYEE'S NAME:______________________________ DATE:____________________

	Please respond with Yes, No or NA to the following questions	Yes	No	NA
1	Did the ST/STA identify herself/himself and explain her/his duties at the first visit with you?			
2	Did the ST/STA explain the care provided according to the plan of care?			
3	Did the ST/STA provide care according to the scope of practice & in response to meet your needs?			
4	Did you feel the ST/STA was concerned with your health?			
5	Were you able to express your feelings and opinions without reservation to the ST/STA?			
6	Were you able to participate in the care planning process and in your care?			
7	Was the ST/STA following dress code? Using ID badge			
8	Was the ST/STA prepared with appropriate supplies and equipment as needed?			
9	Was the ST/STA on time for the visit or did he/she contact the client to change time?			
10	Did the ST/STA follow universal precaution and safety precaution?			
11	Did the ST/STA document care provided in the client's home chart?			
12	Did the ST/STA maintain confidentiality while providing care to you in your home.			
	Clinical Record Supervision	Yes	No	NA
1	Did the ST/STA adequately document assessment, teaching and treatment performed in the home record? Are changes in treatments orders reported to the Agency?			
2	Did the ST/STA notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was this noted in the home record?			
3	Is the ST/STA carrying out the established Plan of Care? If No, use the comment section to identify areas not addressed and the reason?			
4	Does the ST/STA report every 14 days or less the client's condition to the MD as per agency policy? (Physician status report)			
5	Does the ST/STA report to the Case Manager, DON any new or changed medication orders or modification to the plan or care regarding treatment orders and are theses changes documented in the home record and medication sheet?			

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COMMENTS:____

____

Client information packet is present in the home? _______Yes _________No
Client understands rights? _______Yes _________No

CLIENT COMMENTS:____

SUPERVISOR'S SIGNATURE:______________________________ DATE:____________________